Clinical Practice Guideline

TITLE: **Managing HIV Non-Disclosure in Refusing (Unable or Unwilling) Clients**

APPROVED BY: Healthy Sexuality and Harm Reduction Working Group				TARGET REVIEW DATE	PAGE
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Purpose

To ensure an appropriate and consistent approach to the public health management of HIV-positive clients who do not disclose their HIV status before engaging in activities that put others at risk of contracting HIV.

Scope and Goal

Public Health Nurses (PHNs) working within the WRHA Healthy Sexuality and Harm Reduction team, in collaboration with other relevant health care practitioners will use appropriate and consistent approach with respect to HIV positive clients who are refusing to disclose their HIV status to sex and/or drug-sharing partners.

Definitions

Refusing Client: one who meets all of the following criteria:

1. Has been tested and confirmed to be HIV-positive,
2. Has been informed of HIV-positive status,
3. Has been counseled on the risk of HIV transmission, the appropriate risk reduction strategies that must be practiced, and the responsibility of disclosure concomitant with HIV-positive status,
4. Has been offered assistance in reducing risk of HIV transmission, and
5. Is not informing HIV status to Risky Activity partners.

Unable Client: a Refusing Client who meets any of the following 3 criteria:

1. Lacks the capacity to understand fully the risk of HIV transmission he/she poses,
2. Lacks the capacity to disclose HIV-positive status to Risky Activity partner(s), OR
3. Is prevented from disclosing his or her HIV status by an external factor.

An Unable Client may be permanently disabled (e.g. developmental disorder, psychiatric diagnosis, organic mental illness, head injury) or intermittently disabled (e.g. periods of substance use, coercion by or fear of other persons).

Unwilling Client: a Refusing Client who meets all of the following 4 criteria plus 1 of either the 5th or 6th criteria:

1. Has been given additional counseling after confirmation as a Refusing Client,
2. Capable of understanding that he/she puts others at risk of harm by his/her actions,
3. Is capable, without additional assistance, of overcoming any barriers to disclosing HIV-positive status,

4. Lacks concern for putting others at risk of HIV transmission, and instead willfully and knowingly puts priority on his or her own lifestyle preferences, AND
5. Is likely to continue not disclosing HIV-positive status in the future OR
6. Refuses to accept counseling within a reasonable time period.

Risky Activity: Low-Risk Activities or High-Risk Activities (as defined below).

Risky Activity Partner: The partner with whom an HIV-positive individual engages in Risky Activity.

No Risk Activity: Transmission of HIV is theoretically not possible, and no observations of transmission have been published. E.g. kissing, body rubbing, and injecting substances that have not been shared or exposed to another person's blood using a new needle and syringe (Canadian AIDS Society, 2004).

Negligible Risk Activity: Transmission of HIV is theoretically possible but unlikely, and no observations of transmission have been published. Examples include fellatio, cunnilingus, or anilingus with barrier (i.e., sex dam), and digital stimulation of genitals (Canadian AIDS Society, 2004). More recent discourse has suggested that penile-anal or penile-vaginal intercourse with barrier (i.e., condom) in conjunction with documented low or undetectable viral load may present a negligible risk of HIV transmission.

Low-Risk Activity: Transmission of HIV is theoretically possible. Published reports confirm the transmission of HIV through these activities, though reports are mostly case reports and anecdotal reports, and often may occur only under certain conditions. E.g. fellatio, cunnilingus, or anilingus without barrier; injection of substances that have not been shared or exposed to another person's blood using a used needle and syringe that has been cleaned with bleach (Canadian AIDS Society, 2004); penile-anal or penile-vaginal intercourse with barrier (i.e., condom) with no documented low or undetectable viral load; penile-anal or penile-vaginal intercourse without condom but with documented low or undetectable viral load.

High–Risk Activity: Transmission of HIV is theoretically possible. Published scientific studies repeatedly confirmed an association of these activities with HIV transmission. E.g. penile-anal or penile-vaginal intercourse without condom (in the

absence of a documented low or undetectable viral load or with any other concomitant sexually transmitted infections), sharing needles or syringes, and sharing sex toys (Canadian AIDS Society, 2004).

Background

All interventions are aimed at providing improved quality of life for the HIV infected person, as well as protecting the health of the public. The determinants of health of the person(s) are addressed through the use of a comprehensive assessment and various interventions such as community support and harm reduction counseling. HIV-positive individuals may put others at risk of contracting HIV when they do not disclose their HIV status and engage in activities with others that have a risk of transmitting HIV. In Canada, it is a criminal offence to transmit or expose another person to HIV through nonconsensual unprotected sex. Legislators and courts have decided that the criminal law requires people living with HIV to disclose their HIV status before engaging in behaviours that risk transmitting HIV. Failure to do this has been successfully prosecuted under the *Criminal Code* as common nuisance, assault, aggravated assault, or aggravated sexual assault. Non-disclosure of HIV-positive status therefore carries risks to both the HIV-positive individual, and to the individuals with whom the HIV-positive individual engaged in Risky Activity.

The primary goal of public health officials should be to reduce HIV transmission to uninfected individuals. This can be achieved by:

- facilitating/supporting individuals to disclose their HIV-positive status prior to engaging in activity whereby HIV can be transmitted to another individual; and,
- encouraging/supporting HIV positive individuals to reduce their risk of transmitting HIV; and
- encouraging the public to take precautions against HIV transmission.

A secondary role of public health officials is to support infected individuals and help them to cope with their HIV status.

When an HIV-infected client of public health refuses to disclose their HIV status to partners with whom they are engaged in Risky Activity, that individual places the public health system into a difficult position. Public health officials must balance their role as counselors and facilitators to the client with their role in protecting the

public from a source of HIV infection. In order to discharge these responsibilities in a way that maintains the ability of the public health system to engage in surveillance and prevention of HIV transmission, it is generally agreed by experts that an adversarial role vis-à-vis clients is to be avoided. Unlike the justice system which must denounce and punish criminal activity, the public health system should attempt to maintain a therapeutic relationship with clients in order to successfully counsel behaviour changes, reduce harm and transmission of HIV.

Where repeated attempts to counsel behaviour change fail, an important distinction must be made between Unable Clients and Unwilling Clients. Although not the best descriptors of such clients, this terminology has wide usage in the public health literature and defining these terms serves to illustrate both extremes of the challenges at hand. Experts advise treating both of these groups differently, particularly when it comes to intrusive measures. Unable Clients are unlikely to be deterred by intrusive measures because of their inabilities to fully understand; hence intrusive measures may be seen as imparting more harm and no benefit and are rarely justified is such instances. Unwilling Clients on the other hand should be capable of responding to the deterrence of intrusive measures, and their use and escalation may be necessary to bring about compliance with HIV status disclosure responsibilities.

The measures available through use of *The Public Health Act* by Medical Officers of Health (MOHs) in the Winnipeg Health Region (WHR) are as follows:

1. Issuing a Section 43(1) Communicable Disease Order under *The Public Health Act* (C.C.S.M. c. P210), and the subsequent enforcement of the Order, if violated, by the MOH who may proceed to the next step;
2. Application to a justice under Section 47(1) for an Order to Apprehend under *The Public Health Act* (C.C.S.M. c. P210), and the subsequent enforcement of the Order, if deemed appropriate, by the justice who may proceed with an Order to Examine, Treat and Detain under Section 49(1);
3. Application of penalties under *The Public Health Act* (C.C.S.M. c. P210), should any of the above Orders be ignored or contravened, consisting of a fine of not more than $50,000 or imprisonment for a term of not more than six months, or both; and;
4. Referral to a crown prosecutor for criminal charges and prosecution under the federal *Criminal Code*.

Underlying Principles

Several advisory documents have been prepared on the topic of HIV clients refusing to disclosure their HIV status to appropriate partners. As well, other jurisdictions have prepared frameworks for addressing this problem. The Underlying Principles that frame this set of guidelines is drawn largely from the consensus of these advisory documents (see Validation section).

The basic principles and values around managing persons who are “unwilling” or “unable” to take appropriate precautions to prevent the transmission of HIV are:

1. The primary public health mandate is to protect people not punish them. The primary concern of public health officials should be to reduce the risk of HIV transmission; casting blame and punishment should not be the concern of the public health system;
2. The most effective measures for controlling HIV spread within the population are participation in universal voluntary testing, education, and health promotion programs with particular emphasis on reaching persons or groups who may be at present or future risk;
3. Failure to disclose one’s HIV-positive status may be influenced by more than an inherent unwilling disposition of the client. Public health’s goal should be to reduce the barriers to disclosing HIV status wherever possible, and enable the client to comply with this legal responsibility;
4. Public health recognizes and values working in partnership and cooperation with physicians, other health care providers and community groups to prevent difficult cases from arising, and in the management of difficult cases as they occur;
5. Every effort is taken to identify and arrange for provision of necessary support or interventions for persons who may be unwilling or unable to protect themselves and others. Public health must strive to recognize and protect the needs of all groups in society, including those who are marginalized for whatever reason;
6. Action taken by public health officials should be proportional to the risk of HIV transmission posed by the client. A high relative risk of HIV transmission should bring about more intrusive measures than a low relative risk:

a. The assessment of the relative risk posed by the client should take into account both the client's actions, as well as the actions of partners of the client (for example, a client engaging in Risky Activity with one's married partner who assumes safety from HIV transmission because of implicit fidelity to each other may have a higher relative risk of transmission than a client engaging in Risky Activity with sex trade workers where there is implicit agreement that they have other sex partners);
b. No risk and negligible risk activities should lead to nothing more intrusive than counseling of clients. Engagement in high-risk activities should result in greater and quicker escalation to intrusive measures than engagement in low-risk activities;

7. Actions taken by public health to address a Refusing Client should follow a graduated approach of beginning with less intrusive measures and progressing to more intrusive measures as necessary;
8. Public health interventions must balance the rights of the individual with the duty to protect the public, where risk to public safety can sometimes override the rights of the individual;
9. Public health officials should acknowledge progress towards complying with disclosure responsibilities. Persistent refusal to disclose should be met with reminders of the risks of refusal, as well as the potential of more intrusive action by public health officials;
10. Refusing clients should not be subjected to a rigid algorithm of escalating measures. Rather, public health officials should exercise judgment in employing the set of available options taking into consideration the context of the client, the specifics of the case, and the likelihood of success;
11. The burden of evidence against a client must be stronger for more intrusive measures to be justified. Counseling which carries little restriction of freedom may be justified by circumstantial evidence of non-disclosure. Detention under *The Public Health Act* which temporarily denies most freedom can be justified only if there is very strong evidence of non-disclosure combined with Risky Activity. Criminal prosecution should require enough evidence to meet the standards of criminal conviction.

12. Even when consistent disclosure of HIV-positive status is achieved by the client, counseling on reduction of Risky Activities should continue to be offered, preferably by the client's ongoing Health Care Providers;
13. Unwarranted punitive measures taken against a relative "few" difficult cases could impair the effectiveness of voluntary programs for the "many" other cases, through increased stigmatization or fear of discrimination, and lead to increased spread of HIV;
14. A real or perceived failure to deal effectively with difficult cases could impair the credibility of the public health service, and perhaps lead to public pressure for unnecessarily coercive measures to be taken against HIV-infected persons;
15. As no public health service can guarantee protection against HIV infection, it is necessary for everyone to understand how HIV is spread, and to take action to protect themselves and others.

Procedure

1. Initiation
    1.1 Public Health awareness of an individual who may be refusing to disclose their HIV status to Risky Activity Partners may come from a variety of sources such as phone call/letter from an individual in the community, health care provider or social service agency; or a laboratory result may be received by Public Health for another sexually transmitted or blood borne infection on an individual with known HIV.

2. Determination of Risk:
    2.1 The Public Health Nurse (PHN) will first confirm that the client is in fact infected with HIV and refusing disclosure of their HIV status. This should include the following:
        2.1.1 Confirm that an HIV test was conducted and that the client tested positive.
        2.1.2 Confirm from the client record that the client was informed of HIV status and counseled to disclose status to Risky Activity Partners.
        2.1.3 Confirm there is evidence that the client did not disclose his/her HIV-positive status to a Risky Activity Partner(s). At this stage, evidence need not be strong and may be only suggestive (e.g. documented client statements, documented statements of contacts,

positive sexually transmitted or blood borne infection (STBBI) tests).

2.2 If the client does not satisfy the criteria for being a Refusing Client for any reason, the rest of this procedure will not apply yet. At this point in time, the PHN should focus on confirming HIV status (if not already done), disclosing the HIV status to the client (if not already done), assessing the client's behaviours and likelihood to transmit HIV infection, supporting connection (or reconnection) to primary health care, counseling the client on the need to disclose HIV-positive status to Risky Activity Partners, and to counsel the client on reducing their risk of HIV transmission to others and of their contraction of STBBI from others. The client should be informed that non-disclosure to a Risky Activity partner may open up the possibility of more intrusive coercive action under *The Public Health Act* or criminal prosecution.

3. Counseling of Refusing Client:
   - 3.1 Counseling of a Refusing Client should begin by exploring their past contact with public health or primary health care and their understanding of those sessions. In particular, the PHN should explore the client's:
     - 3.1.1 belief in the accuracy of the HIV-positive diagnosis,
     - 3.1.2 understanding that lack of explicit disclosure of HIV-positive status to Risky Activity partners may open up the possibility of more intrusive coercive action under *The Public Health Act* or criminal prosecution, and
     - 3.1.3 their understanding of ways to reduce their HIV transmission risk and contraction of other STBBI.
   - 3.2 Upon assessment of client's current knowledge of their HIV status including obligation to disclose HIV-positive status to Risky Activity partner(s) and risk reduction strategies, the PHN should educate to fill any gaps in client knowledge.
   - 3.3 The PHN should also identify barriers to the client's refusal to disclose HIV status to Risky Activity partners. A plan should be negotiated with the client to reduce and eventually eliminate these barriers. As part of the plan, the PHN may need to recruit other social services (e.g. housing, nutrition, addiction services, primary care services, mental health services) for the aid of the client.

3.4 The PHN and health care partners should facilitate treatment of co-morbid conditions as well as investigate whether antiretroviral therapy is indicated for the client. Treatment of HIV should follow, as necessary, with the consent of the individual.

3.5 Clients suspected of refusal to disclose their HIV status to High Risk Activity Partners should be offered regular testing for other STBBI such as syphilis, gonorrhea, and chlamydia.

3.6 Where the PHN or care partners have questions about the mental status of a client who may be deemed "unable", a mental status assessment should be undertaken. Consultation with client's care provider(s) will assist to determine where to refer client for assessment. Referral resources to consider:

   3.6.1 Client's current care provider e.g. community mental health worker, psychiatrist or shared-care counselor,

   3.6.2 Informal consultation with local community mental health staff in the geographic community area or shared care counselor.

   3.6.3 Phone call and referral to the WRHA Mobile Crisis Service (MCS) 940-1781. MCS can determine what type of assessment and intervention may be available including a psychiatric assessment. In the event where a client is not willing to receive the involvement of MCS, MCS can assist the PHN and care team to identify next steps and whether steps should be taken to facilitate a involuntary psychiatric assessment through the justice system under the Mental Health Act.

3.7 The PHN should try to identify if there is any well-identified individual(s) or group of people at particular proximate risk of contracting HIV from the Refusing Client (e.g. partner who regularly practices unprotected sexual intercourse with the client, and who is unaware of the client's HIV status). If the client is engaging in High-Risk Activity and there is an imminent threat of HIV transmission to a well-identified group or individual, the Communicable Diseases (CD) Coordinator and MOH should be consulted using **HIV Nondisclosure Initial Notification Form** **(Appendix A)**.

3.8 The PHN should inform the CD Coordinator and MOH of the identification of the Refusing Client and the interventions initiated using the **HIV Nondisclosure Initial Notification Form** **(Appendix A)**. In the intervening period, the CD Coordinator and MOH should be updated regularly (every 1

to 6 months depending on the circumstances) on the status of the client using the **HIV Nondisclosure Progress Update Form** **(Appendix B)**. Once the client is no longer deemed to be refusing to disclose or is no longer engaging in High-Risk Activity behaviours, the PHN should inform the CD Coordinator and MOH of this development using **HIV Nondisclosure Progress Update Form** **(Appendix B)**.

4. Continued Counseling & Reassessment
   - 4.1 The PHN will meet regularly with the client to assess progress, to identify new issues to address, and to reinforce counseling around disclosure of HIV-positive status and risk reduction of HIV transmission.
   - 4.2 Where the client continues to participate in counseling and in the other elements of the management plan, this phase of counseling and barrier-reduction may continue indefinitely.
   - 4.3 As barriers to compliance are reduced, the PHN should expect evidence of improved behaviour which could include reduced contraction of sexually-transmitted infections and/or statements by Risky Activity Partners that disclosure is occurring.
   - 4.4 If the client becomes uncooperative in participating with counseling and the management plan, or there continues to be evidence that the client is participating in High Risk Activity without informing partners, the PHN should remind the client that non-disclosure opens up the possibility of more intrusive coercive action including Communicable Disease Orders under *The Public Health Act* or potential criminal prosecution if their nondisclosure is reported to the police by any of their partners.
   - 4.5 At this point the PHN should consider forming an **oral (documented) or written (signed) behaviour contract/agreement** with the client, offering to provide certain incentives for the client in exchange for certain changes in behaviour. Such an agreement should outline the agreed-upon course of action, establish a timeframe for this action, and clarify a follow-up schedule including regular PHN and/or clinic visits for counseling and/or testing (e.g., urine for STI testing).

5. Consideration for Additional Involuntary Measures
   5.1 Once the PHN feels that all supportive non-coercive voluntary avenues to facilitate client disclosure have failed, the PHN should discuss the issue with the CD Coordinator and MOH, and if requested by the MOH refer the client to an advisory committee using the **HIV Nondisclosure Referral Form for Non-Progressing Client (Appendix C)**.
   5.2 The MOH may convene an advisory committee that may include the following:
      5.2.1 PHN case manager for the Refusing Client
      5.2.2 Other MOHs
      5.2.3 WRHA legal representative
      5.2.4 WRHA ethics representative
      5.2.5 Representative(s) from the client's primary care team
      5.2.6 Mental health expert (e.g. psychiatrist, mental health counsellor)
      5.2.7 First Nations, Inuit or Metis elder representative as necessary
   5.3 The advisory committee will consider the client's case and determine, with the advice and recommendation of the PHN and Primary Care representative, whether the client should be considered an Unwilling Client or Unable Client. This assessment may require a formal mental status evaluation.
   5.4 If deemed an Unable Client, the PHN and the care team will discuss how best to support the client and continue to counsel the client to reduce risk of HIV transmission as much as possible. *The Public Health Act* will only be used against such an individual in rare extreme circumstances when imminent danger to a significant number of vulnerable person(s) is deemed to exist.
   5.5 If deemed an Unwilling Client, the advisory committee will formulate the plan of action taking into consideration the following in forming a proportional response:
      5.5.1 The client's anticipated ability to follow the plan of action
      5.5.2 Intention to commit harm
      5.5.3 Concern for others vis-à-vis self-gratification
      5.5.4 Availability of other non-coercive options
      5.5.5 Anticipated success of coercive measures to changing behaviour
      5.5.6 Willingness to participate in continued counseling
      5.5.7 Specificity, immediacy, and "vulnerability" of potential contacts

5.5.8 Risk of activities in which the client is engaging

5.6 The advisory committee will consider the following options:

5.6.1 Continued counseling,

5.6.2 Behaviour contract if not already initiated (see 4.5),

5.6.3 Issuing a Section 43(1) Communicable Disease Order under *The Public Health Act* (C.C.S.M. c. P210), and the plan of action should this order be violated (i.e. application for temporary detention to a justice under Section 47(1) for an Order to Apprehend under *The Public Health Act* (C.C.S.M.c. P210)),

5.6.4 Warning of potential third-party victims under *The Public Health Act* and the *Personal Health Information Act*, or

5.6.5 Referral to a crown prosecutor for consideration of criminal charges under the federal *Criminal Code* (as a rare absolute last resort option).

5.7 If a Section 43(1) Communicable Disease Order is issued by the MOH, delivery of the Order to the client will not be undertaken by a public health nurse, but will instead be referred to a "process server" in accordance with WRHA Population and Public Health Program guideline "*Process of Public Health Medical Orders for sexually transmitted and blood borne infections*".

6. <u>Resolution of Refusal to Disclose</u>

6.1 Where a client begins to consistently disclose his or her HIV-positive status to Risky Activity Partners, the client will no longer be considered a Refusing Client. However, counseling should continue on reducing Risky Activity, and the PHN should ensure that adequate support remains to reduce the likelihood as much as possible that the client revert to refusing to disclose.

Validation

Disclosure of HIV-Positive Status to Sexual and Drug-Injecting Partners: A Resource Document. Ontario Advisory Committee on HIV/AIDS Working Group on HIV Disclosure. January 2003.

Guidelines for Medical Health Officers: Approach to people with HIV/AIDS who may pose a risk of harm to others. British Columbia. June 2017.

Guidelines for Reducing HIV Transmission by People who are Unwilling or Unable to Take Appropriate Precautions. Draft 2. Manitoba Health & Healthy Living. April 13 1996.

HIV Transmission: Guidelines for Assessing Risk 5th ed. Canadian AIDS Society. 2004.

Keith Culver. Persons Unwilling or Unable to Prevent HIV Transmission: A Concise Guide to a Legislative Analysis and Literature Review. Prepared for the Federal/ Provincial/Territorial Advisory Committee on AIDS. Ottawa: Health Canada. Sept 2002.

Management of Unwilling or Unable Persons with HIV. Alberta Health Services, Calgary Health Region. Revised January 2003.

Persons who Fail to Disclose their HIV/AIDS Status: Conclusions Reached by an Expert Working Group. *Canada Communicable Disease Report*. Public Health Agency of Canada. Volume 31(5) 2005.

Canadian HIV Aids Legal Network. http://www.aidslaw.ca/EN/issues/criminal_law.htm

HIV Non-Disclosure Algorithm

- Suspected HIV Non-Disclosure reported to HSHR PHN
- → Open to PHN
- → Determination of Risk
  - → High Risk Activity
    - → Counseling of Refusing Client → Identify and reduce barriers (housing, nutrition, addiction services, mental health services, risk of violence, HAART)
    - → Mental Health Assessment if suspect "unable" → HIV Nondisclosure Initial Notification Form (Appendix A)
    - → Continue Counseling and Reassessment (consider PHN/client contract) → HIV Nondisclosure Progress Update Form (Appendix B)
    - → If continued HIV Nondisclosure and High Risk Activity → HIV Nondisclosure Referral Form for Non-Progressing Client (Appendix C)
    - → Advisory Committee (MOH, PHN, legal, ethics, primary care, etc) → (back to Continue Counseling and Reassessment)
      - → Section43(1) MOH Order
      - → Warn Third Party Victim(s)
      - → Referral to Crown for criminal charges (rare last resort)
  - → No, Negligible, or Low Risk Activities
    - → Counseling of Refusing Client → Identify and reduce barriers (housing, nutrition, addiction services, mental health services, risk of violence, HAART)
    - → Follow up and reassess risk

HIV Nondisclosure Initial Notification Form

Date:	
To:	Communicable Diseases Coordinator Medical Officer of Health (Communicable Diseases)
From:	[Click here and type name], Public Health Nurse
Re:	**Client Refusing HIV Disclosure: New Client**
Client Name: **PHIN:**	

The above named client under my care has been diagnosed as HIV-positive and has been counseled about HIV-disclosure requirements. I have reason to believe that the client is consistently not disclosing HIV-positive status to High-Risk Activity Partners, and as per our guidelines, I am notifying you of this client. Until the situation is resolved, I will provide regular updates (every one to six months).

Date of Positive HIV Test:	
Date of Initiation of Counseling:	
Number of Counseling Sessions to Date:	
Health Care Services in Use by the Client:	
Evidence of High Risk Activities:	
Evidence of Non-Disclosure:	
Plan of Management:	
Additional Comments:	

HIV Nondisclosure Progress Update Form

Date:	
To:	Communicable Diseases Coordinator Medical Officer of Health (Communicable Diseases)
From:	[Click here and type name], Public Health Nurse
Re:	**Client Refusing HIV Disclosure: Update**
Client Name: **PHIN:**	

This is a regular update on the above named client who is an HIV-positive person whom I believe is not disclosing HIV-positive status to High-Risk Activity Partners. The client remains recalcitrant and I will continue to update you on progress.

Date of Positive HIV Test:	
Date of Initiation of Counseling:	
Number of Counseling Sessions to Date:	
Number of Counseling Sessions since Last Update:	
Health Care Services in Use by the Client:	
Evidence of High Risk Activities:	
Evidence of Non-Disclosure:	
Evidence of Progress toward Disclosure:	
Plan of Management:	
Additional Comments:	

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HIV Nondisclosure Referral Form for Non-Progressing Client

Date:	
To:	Communicable Diseases Coordinator Medical Officer of Health (Communicable Diseases)
From:	[Click here and type name], Public Health Nurse
Re:	**Client Refusing HIV Disclosure: Referral to MOH for consideration of establishing an Advisory Committee**
Client Name **PHIN:**	

This is an update on the above named client who is an HIV-positive person whom I believe is not disclosing HIV-positive status to High-Risk Activity Partners. The client continues to refuse to disclose and I no longer believe that I can make progress with this client. I am therefore referring the client to you for consideration of establishing an advisory committee to determine next steps.

Date of Positive HIV Test:	
Date of Initiation of Counseling:	
Number of Counseling Sessions to Date:	
Number of Counseling Sessions since Last Update:	
Health Care Services in Use by the Client:	
Evidence of High Risk Activities:	
Evidence of Non-Disclosure:	
Evidence of Non-	

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Progress:	
Psychiatric or Mental Health Assessment (as applicable):	
Assessment of Whether Client is “Unwilling” or “Unable”:	
Management thus far and Outcomes:	
Additional Comments:	