Constructing Hope: a Multi-Agency Programme model for Young Sex Offenders living with HIV/AIDS in South Africa

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Abstract

Many young sex offenders in South Africa have HIV/AIDS. This fact both complicates and underlines the importance of delivering effective multi-agency sex offender programmes to these individuals. Reducing reoffending rates is of obvious importance, as stopping these young offenders from offending also means limiting the spread of HIV to new victims. We are proposing an integrative programme that incorporates proven models of sex offender treatment in combination with medical, educational and family support systems to facilitate community reintegration of young sex offenders living with HIV/AIDS. It is our hope to work in partnership with the Department of Correctional Services in South Africa to facilitate such programming in the near future.

Key words: HIV, AIDS, Sex OffendersIntroduction

Introduction

While HIV/AIDS is present on every continent, the epidemic has hit Africa the hardest relative to all other continents according to United Nations statistics (UNAIDS & WHO, 2003). Southern Africa remains the worst affected sub-region with South Africa the country with the highest prevalence of people living with HIV/AIDS in the world. The South African Department of Health estimated, based on a recent survey (2005), that there were 6.29 million people living with HIV/AIDS in the country. Official total population estimates for 2001 and 2007 were 44.8 and 47.9 million respectively, indicating conservatively, that at least 7.5% of the current population is infected by HIV/AIDS in South Africa.
To compound the difficulties of dealing with the high prevalence of HIV/AIDS, South African women and children are exposed to high levels of sexual violence. In surveys completed by Community Information, Empowerment and Transparency (CIET) in 1998 to 2000 (see http://www.ciet.org/), funded by The International Development Research Centre (IDRC) of Canada, it was found that one in every 20 women aged fifteen to eighteen had been raped in the previous year. This high incidence coupled with the high prevalence of HIV in the population contributes to the overall growing South African HIV/AIDS epidemic.

Statistics are not yet available on the rates of HIV transmission during rape and other sexual offences, in part because the prevalence of HIV amongst sexual offenders is unknown. It is therefore difficult to determine whether HIV-related criminal behaviour is increasing the rate of HIV transmission, although logic dictates that this is the case given the prevalence of HIV in the general population. There is some South African research that shows that the AIDS epidemic is creating

conditions of fear, hopelessness and resignation which may be driving a desire to spread the virus (Leclerc-Madlala, 1996). In support of this contention, there is some evidence that adherence to a variety of myths by HIV positive men, such as belief that sex with a virgin will alleviate HIV infection results in victimization of young girls (see for example, Andersson, et al., 2004; Leclerc-Madlala, 2002).

An Australian study published in 2003 addressing these issues examined gender-based violence and gender inequality as possible determinants of a woman s risk to being exposed to HIV. The research was conducted by interviewing 1,395 woman attending antenatal clinics in Soweto between November 2001 and April 2002 who agreed to undergo routine HIV testing. The research showed that 55.5% of the female participants reported a lifetime history of physical or sexual assault by a male partner as well as being sexually assaulted by non-partners as an adult (7.9%), being sexually assaulted as a child (8.0%), and having their first intercourse experience forced upon them (7.3%). In summary, this study found that gender-based violence could be a determinant of a woman s risk for HIV exposure. Similar data are not available for males, but one could assume that male children would be assaulted at a similar rate as female children. However, this paper is not an epidemiological paper on HIV/AIDS; rather, the purpose of the above information is to alert the reader to HIV/AIDS prevalence and sexual assault statistics.

The main purpose of this paper is to move forward from acknowledging the frequency of HIV/AIDS and sexual assault in South Africa and work collaboratively with interested agencies, including the Department of Correctional Services in South Africa to design a multi-agency programme (MAP) approach to the emerging problem of youth offenders who are HIV/AIDS sufferers. The problem we are concerned about is simple: there are many HIV/AIDS-infected youth who are also sexual offenders and these offenders can infect more victims during the commission of sexual offences. In addition, the availability of sex offender treatment is limited in the South African Correctional Service. Hence, the suggested adoption of a MAP response to the needs of HIV/AIDS sex offenders may serve several functions: reduce violent recidivism, reduce new infections, and reduce over-crowding in prisons by enabling early release of sexual offenders who participate in risk relevant programming.

Multi-Agency Programmes: a selective review

There are a variety of Multi-Agency Programmes (MAPs) and related effectiveness studies in the literature. One of the most rigorously studied is the Multisystemic Therapy (MST) model by Henggeler, Schoenwald, Borduin, Rowlands, and Cunningham (1998). MST has been shown to be effective in reducing recidivism and other indicators of antisocial behaviour amongst various subgroups of serious young offenders. Some of the subgroups examined in clinical trials have included young sexual offenders (e.g., Bourduin & Schaeffer, 2002), and drug-using violent young offenders (e.g., Henggeler, Clingempeel, Brondino, & Pickrel, 2002). A recent article by Ellis, Naar-King, Cunningham, and Secord (2006) showed that MST may be useful in improving treatment adherence and therefore health outcomes amongst pediatric patients living with HIV. The study had a very small sample (19), but the authors suggested that improved knowledge of HIV and patient care issues by the caregivers was an important contributor to the overall improvements found. There have been other applications of MST, such as treating serious emotional disturbances in students (see www.nichcy.org), albeit without effectiveness analysis.

In sum, it appears that MST is effective as shown in numerous clinical trials and research designs with juvenile offenders and the MST organization s (www.mstservices.com) website provides a great deal of information about how to access MST services. Perhaps the biggest problem with MST as it is currently designed is cost of implementation in a financial climate in which many

organizations struggle to deliver basic services. A cursory inspection of the MST Services program design and implementation document (http://www.mstservices.com/text/program.html), suggests that the costs are considerable. However to be fair, the costs are clearly linked to an effective product involving a great deal of consultation and support all clearly delineated on the MST website. The United States National Institute on Drug Abuse (NIDA; www.nida.nih.org) publications state that the effectiveness of MST in reducing out-of-home referrals offset the costs of the programme. This conclusion was reached despite the acknowledgement in this same document that MST was significantly less effective than found in other studies in decreasing crime by the juvenile offenders (http://www.nida.nih.gov/BTDP/Effective/Henggeler.html).

There are other MAP approaches besides MST; however, none have the research support and infrastructure of MST. MAP approaches such as Assertive Community Treatment , predate MST in the treatment of drug abuse but reports rarely provided very good data to support the suggested practice (e.g., Bond, McDonel, Miller, & Penesec, 1991). More recent attempts at MAPs by NIDA include Brief Strategic Family Therapy (BSFT) for adolescent drug abuse and other behaviors that are problematic including violence, associating with anti-social peers, and unsafe sexual practices (see for example, http://www.drugabuse.gov:80/TXManuals/bsft/BSFT2.html). Parenthetically, this website provides a link to a free treatment manual that looks promising, but does not provide effectiveness data of the BSFT model.

There are other MAP approaches to drug treatment (e.g., Ogunpipe & Bloor, 2001) that use a MAP approach and appear effective. However, this article is not intended to be a comprehensive review of all MAPs. Rather, we wanted to show that MAP approaches may have promise in treating HIV/AIDS sufferers who are also sexual offenders. To our knowledge, this cross-over area is not one that has been designed to date.

Commonalities across Multi-Agency Programmes

All MAPs appear to strive to be comprehensive treatment approaches that address a variety of client need-defined treatment components. Most offer individualized treatment, various other group or educational treatment strategies, a variety of types of therapists and health-care workers, and increased accessibility of other relevant services. The MST program by Cunningham, Naar-King, Ellis, Pejuan and Secord (2006) for enhancing antiretorviral medication with pediatric HIV patients involved caregivers and medical staff. MAPs for reducing drug misuse also involve medical staff (general practitioners, psychiatrists, and nurses), social workers, case management staff, and drug workers (e.g., Ogunpipe & Bloor, 2001). Obviously, MAP models for offenders involve case management staff, drug workers, social workers, police and custody staff (e.g., Seeling, King, Metcalfe, Tober, & Bates, 2001). Essentially, the staffing and programme component needs of any particular MAP appear to be designed to meet the needs of the client in his/her setting.

A Proposed Model: the South African Multi-Agency Risk Intervention (SAMARI) Programme

The SAMARI programme we are proposing for consideration to the Department of Correctional Services in South Africa is a multi-agency programme (MAP) model for risk intervention and risk reduction. The MAP we are proposing may hold promise for reducing offending by HIV/AIDS sufferers who are also sex offenders. We are proposing development of the model for use with young offenders at this time as the majority of MAP models (and certainly most MST programmes) have been designed and tested with juvenile offenders.

The basic programme will follow the general MAP model delineated above. The main difference is that there are two distinct but overlapping areas of focus: HIV/AIDS illness management and HIV/AIDS infection reduction which coincides with offence prevention. Hence the SAMARI model must include both medical and correctional management aspects to succeed.

The rigour and academic infrastructure of the MST model is not financially possible in the South African situation; however, many of the lessons learned in the MST framework can be applied to the SAMARI model. For example, the encouragement of attendance and the importance of programme completion (e.g., Henggeler, Pickrel, Brondino, & Crouch, 1996) are both key to the success of MST. A comprehensive structured treatment team is another key component to the MST model, as well as a research basis for evaluating change and programme effectiveness. Even if the SAMARI programme cannot approach the complexity and organizational structure of the MST programme, the MST website provides a model that we can aspire to in terms of rigour and effectiveness evaluation.

In the SAMARI model, young sex offenders with HIV/AIDS will be recruited in prison for the programme. It is our belief that a separate treatment unit is key to facilitating change. Various agencies, besides the South African Correctional Service obviously, need to participate to make the programme work. Departments of Health, Education, Social Services, Welfare, Police, Community Services agencies, all will have to participate to make such a programme work. Interlinkages between such government departments will have to work quickly to support a unified vision for change and treatment.

Basic sex offender treatment will follow a sex offender programme model for young sex offenders such as the Good Way model by Ayland and West (2006), along with other aspects of the Self-Regulation and Good Lives treatment model of Ward (e.g., Ward, Hudson, & Keenan, 1998; Ward, 2002), and general treatment programmes such as that of Marshall and others (e.g., Marshall, Marshall, Serran, & Fernandez, 2006). Health services and medication management programming will occur alongside regular sex offender treatment programming. Overlap groups, involving nursing staff or medical doctors to discuss HIV/AIDS transmission issues which coincide with offending behaviour will be held to reinforce the overall view that sex offending increases disease amongst youth, besides making their own personal situation that much worse (such as losing family contact by imprisonment).

Time outside of group therapy sessions could be spent in educational classes, workshop skill-building (e.g., learning carpentry, gardening or other sellable skills) to enhance the offender s reintegration prospects. It is also important that the parents (if available and if interested) become involved as the client begins to participate in the programme to ensure that the parents are aware of the treatment process and the importance of their support for his eventual successful reintegration into the community. In fact, there is good research which shows that family involvement helps to curb HIV infection amongst adolescents (e.g., Perrino, Gonzalez-Soldevilla, Pantin, & Szapocznik, 2000).

SAMARI programme services must continue beyond the prison gates and include home-based service delivery for health care, family counseling, drug-testing, health advice and monitoring, as well as continued relapse prevention and risk management services (preferably group-based). Education, work-skills, and of course, medication and health care monitoring of the client s HIV/AIDS illness are all essential components of a MAP approach in the SAMARI model. While complete delineation of the model is beyond the scope of this article, we envision a very comprehensive programme that will leave the young offender very little time or opportunity to consider offending. Finally, the implementation of the programme will likely follow an experimental

design as there is little chance of securing sufficient funds to treat all offenders who require the programme. While this dilemma provides important ethical issues, the positive aspect is that we can provide effectiveness data in a more convincing fashion which may increase the treatment opportunities for other young offenders living with HIV/AIDS.

Discussion

Changes to South African law may increase the numbers of incarcerated sex offenders. Intentional spreading of HIV/AIDS, forced anal intercourse being changed from indecent assault to sexual assault , mandatory HIV testing of sex offenders, continued overcrowding of prisons, and sexual offender registries will logically serve to increase incarceration rates. However, in 2005, the White Paper for the Department of Corrections in South Africa recommended the adoption of sexual offender treatment programmes (see the DCS website at http://www-dcs.pwv.gov.za/Publications/WHITE%20PAPER%208.pdf). While this focus is both commendable and adroitly based on available international evidence, it is our contention that an integrated multi-agency programme, such as the SAMARI programme described in this paper would be more successful than using current international models for sex offender programmes in reducing HIV infection, over-crowding and recidivism.

One could argue that the HIV epidemic is largely a public health issue and not a criminal law issue, and therefore it would be reasonable that it should be dealt with through public health methods and programmes. However, given that the prevalence of HIV/AIDS in the prison population is about five times that in the general population, it is also a risk-related issue for the South African Department of Correctional Services and the public. As a result, treatment efforts with all prisoners, and perhaps most particularly with sex offenders, needs to ensure that risk reduction to the public includes addressing HIV infection reduction. It is our contention that this can be done most effectively using a multi-agency approach that includes health care, police, and the Correctional Service at a minimum.

In his closing address to the International Association for the Treatment of Sexual Offenders (IATSO) conference in Hamburg in 2006, the first author of this paper proposed that a workshop be held prior to the 2008 IATSO conference in Cape Town to concentrate on an exchange of ideas between South Africa treatment professionals, judges, lawyers, and government officials interested in this issue and the IATSO group to find the best ways to ensure that once accused are convicted of sexual offences that when released they will not commit similar offences again. The IATSO executive and membership are committed to assisting and training all who are interested in helping to develop the best possible programs for sexual offenders. Hopefully this workshop will help in the development of a comprehensive multi-agency strategy which will be useful to the South African government and the prisoners under its care that will foster both effective correctional programming and public safety.

Additionally, we intend to present the details of the SAMARI model at a full-day pre-conference workshop at the 2008 IATSO conference in Cape Town, South Africa. Prior to that workshop, we will continue engage in dialogue with the appropriate personnel from the South African Correctional Service to ensure cooperative relations and program involvement by the Service.

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