

HIV Education Strategies within Correctional Services - The South Australian Experience

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The Acquired Immune Deficiency Syndrome (AIDS) was first reported in the United States of America in 1981. By December 1988, the number of reported infections had grown to 132 976 cases worldwide. To date the actual scope and magnitude of the Human Immunodeficiency Virus (HIV) is unknown. The only certainty is that globally it is continuing to spread and the numbers of HIV infections and HIV related illnesses including AIDS, will increase.

Australia unfortunately is not unaffected by the transmission of HIV infection and continues to follow patterns similar to those occurring in other Western countries, where most cases of reported HIV infection have occurred amongst men who have sex with other men, and in people who choose to inject substances. Heterosexual transmission in Western countries, unlike many underdeveloped countries, accounts for only a small percentage of cases of HIV infection. Current data suggests this trend is on the increase (Heilpern & Egger 1989).

It has been suggested that prisons provide an environment which can further the spread of HIV/AIDS, not only to those incarcerated, but also to the broader community. The containment of HIV in prisons is vital in reducing its transmission throughout the community. There have been both national and international efforts to deal with HIV/AIDS in prisons. This paper outlines the South Australian experience, examines the educational strategies developed in this State to raise awareness amongst inmates and the obstacles which have prevented such strategies from being successful.

Overview

AIDS first became an issue for correctional services in South Australia in early 1983; soon after the first case of HIV infection was identified in Australia. Concerns were raised by the correctional officers' union which expressed fears for the safety and possible health risks to its members and uninfected prisoners.

In response to these fears, correctional services attempted to gather information, data and advice for officers on the then, limited knowledge available on HIV infection. Particular emphasis was placed on hygiene practices and procedures which were aimed at reducing the probability of occupational transmission. There was little emphasis on the social and

behavioural situations of either inmates or officers or the probability of transmission through these modes.

The fear, mystery and lack of knowledge about HIV, contributed to officers' genuine concerns, especially given hysterical messages conveyed through the media at the time. The Department of Correctional Services responded to these concerns by consulting with the South Australian Health Commission's Communicable Diseases Control Unit, and over the following twelve months presentations were made, discussion groups convened and information pamphlets distributed to all staff members. Whilst fear continued and issues still needed to be addressed, this was in effect the start of a correctional services' HIV education program.

In June 1985, through a voluntary testing program, the first South Australian prisoner with HIV antibodies was detected, bringing to a head many of the underlying fears previously discussed.

Officers responded to this with a series of industrial stoppages. They demanded more information, protection and the isolation of prisoners who were found to have HIV antibodies. The Minister of Correctional Services, Mr Frank Blevins, intervened and announced the establishment of a working party which would be responsible for developing infection control guidelines, examining the issues at hand and making appropriate recommendations.

In the meantime, HIV positive prisoners were isolated from fellow prisoners and received virtually no other contact. The infamous correctional officer 'space suits' were introduced to protect officers from any perceived infection. Fortunately these regimes did not last and, as officers began to receive more accurate messages about HIV infection, a calmer, more rational approach was developed. Following the recommendations handed down by the working party, known as the 'Cameron Committee', more appropriate procedures for dealing with HIV positive prisoners were implemented.

Inmates who were HIV positive were integrated back into the mainstream of the prison and provided with single cell accommodation, with a Departmental commitment to provide single cell accommodation for all inmates through the long term restructuring of its goals. By 1990 this had been achieved in all institutions except for a very small number of cells.

The Department also developed a management regime through its Departmental Instructions to deal with prisoners identified as having a communicable disease (not necessarily HIV infection). These Departmental Instructions cover all aspects of managing prisoners who have a communicable disease, ranging from the use of gloves when searching a cell, through to a commitment to provide education and information to all staff and inmates, on all areas of communicable diseases ranging from infection control to lifestyle issues.

Despite this, fear and concern continued to prevail, not only amongst staff, but also amongst other inmates. Following attempts to integrate HIV positive prisoners into the mainstream population, there were a number of sit-ins with inmates refusing to allow seropositive prisoners to mix with them. The Department responded with discussions and negotiations on an issue by issue basis.

In addition to practical and physical responses, such as the provision of disinfectants and gloves, an AIDS Education Officer was seconded from the South Australian Health Commission for a six-month period to assist in the development of an education program which would address the management of HIV infection in the correctional setting.

During this period the AIDS Education Officer facilitated the development of booklets, posters and other publicity materials, aimed at raising awareness of HIV issues amongst correctional officers. These materials were used in conjunction with lectures and videotape presentations shown to staff and new trainees. Nearly all initiatives and strategies aimed to reduce anxiety levels amongst staff concerning HIV transmission. This was seen as crucial before education amongst inmates could begin.

Following the completion of the secondment, the AIDS Education Officer returned to the Health Commission and there was a six-month delay before a new Education Officer was appointed. Due to the delays in the appointment of this new officer, many of the

initiatives previously undertaken ceased to exist. In essence this meant the new Education Officer was required to start from the beginning again.

At this time, the media in South Australia had once again managed to raise fears and anxieties through a new wave of hysteria in their reporting. This necessitated further targeting of staff with education and dealing with potential industrial problems which were developing because of perceived risks.

A training package was developed and incorporated into the new officers' induction programs and into in-service training. Because of the nature of correctional institutions, it was difficult to reach all officers, and much of the information dissemination had to occur through individual discussions and informal talks with staff at their work sites and during lunch breaks. Whilst this system was not able to reach all staff, it did provide officers with the opportunity to discuss issues of concern in detail, and on a more personal level.

Throughout this process, information on HIV infection for prisoners was disseminated via formal presentations and lectures, or informal talks to inmates at their request. Without formalised programs, however, many prisoners missed out on this information or did not have the opportunity to internalise information appropriate for their individual needs or situation.

With the appointment of the Health Project Officer the education program was expanded to deal with communicable diseases and sexually transmitted diseases more generally. Its main thrust was on hepatitis B and HIV in gaols, largely because of the similarities in transmission patterns, recognising that by this time the issue of HIV/AIDS had been laboured for so long that many people had begun to 'switch off' when they heard about it.

Education Needs

It has long been recognised, in the absence of any cure for HIV infection, that education and awareness remain the only effective weapons in attempting to prevent the spread of the virus. Research appears to indicate that whilst there is some basic knowledge about HIV infection amongst prisoners, there has been no substantial reduction in risk behaviours, particularly amongst intravenous drug users.

Stories told by inmates include intravenous drug users being unwilling to share their syringe with people who have HIV infection, but willing to use the syringe of an HIV positive person thinking they are not at risk. Tales are also told of users cleaning syringes in hot water unaware that this causes blood to coagulate providing little, if any, protection against the virus (Behrens-Peters 1990).

Education delivered in lecture format to inmates does not meet their needs. To be effective, the content and style of delivery needs to be modified. Education programs on HIV infection need to be tailored to the attitudes, beliefs and practices of the target group and, where possible, involve inmates in the development and presentation of the education programs.

In research conducted into the knowledge of HIV amongst prisoners and prison officers, most prisoners and officers responded accurately to statements about HIV and its transmission but 13 per cent and 16 per cent respectively thought it was possible to be infected with HIV by sharing drinking cups' (Gaughwin et al. 1990, p. 61).

The majority of prisoners and officers were of the opinion that information about HIV has not reduced risk behaviours, particularly the use of intravenous drugs.

Sixty four per cent of prisoners and 46 per cent of prison officers disagreed that prisoners are not worried about risks of contracting HIV in prison while 68 per cent of prisoners and 51 per cent of prison officers thought that prisoners did not know enough about HIV to protect themselves from it (Gaughwin et al. 1990, pp. 61-2).

Experiential Learning Model

The experiential learning method known also as student-centred, self-directed or adult learning has been used to develop HIV education programs for prisoners in correctional institutions in South Australia.

This educational theory is based on the principle that people learn most effectively when:

- they are involved in deciding what and how they will learn, and are allowed to take responsibility for their learning;
- learning is perceived to be relevant to their needs;
- learning is grounded in practical experience with time allowed for reflection and analysis;
- all learners are respected for the existing knowledge, skills and experience they bring to the task;
- relationships are valued and support is provided; and
- the community is used as a resource for learning.

For learning to occur and to be effective, participants need to be willing to participate and their ability to provide input and contribute to the development of a program is fundamental to the success or failure of a session.

Consideration needs to be given to individual personalities and what they identify their needs to be in relation to HIV infection. Often the incentive for their participation needs to be acknowledged. In essence, when working with prisoners, the question 'What's in it for me?' is often important, especially when many inmates perceive that they already know all they need to know about HIV, or think it does not affect them. In the course of running a program, many inmates reveal that they were not as well-versed about HIV infection as they had assumed they were, but the initial problem of encouraging inmates to participate is a basic problem.

Many community-based programs have been developed with specific target groups in mind. Many prisoners do not identify with these groups or they simply are not available in many prisons. For example, many inmates do not identify with the gay community. Therefore, community-based programs targeting gay and bisexual men do not reach them.

Prisoners themselves are not a homogenous group. There are many subgroups, each with differing needs in the prison population. Often the only thing these groups have in common is that they are incarcerated. Groups may include gay men, people who choose to inject, child molesters, Aboriginals, women, people from non-English speaking backgrounds, or developmentally delayed people.

In developing HIV education programs in the correctional setting, the correctional system itself can be a major issue. Gaols are made up of two diametrically opposed, highly developed and hard-to-access groups: the officers and the prisoners. These two groups are quite different, yet are administratively interwoven and driven by a range of unpredictable political agendas (Scagliotti 1990, p. 3).

Before working with inmates on the establishment of HIV education programs, the entire prison system needs to be addressed to establish a climate and infrastructure in which both officers and prisoners are administratively and personally willing to participate in the educational process.

To achieve this goal the various institutions need firstly to develop a recognition for, and a commitment to, HIV education for inmates and for staff. Due to staffing shortages and a preoccupation with security issues, this goal often receives little priority in the day-to-day management of institutions. Therefore before beginning work with inmates, discussion and negotiation needs to occur at all levels of individual institutions, commencing with the manager through to officers who work on the floor with the inmates on a day-to-day basis.

Discussion involves outlining the role of education in HIV infection, the process of education and how these objectives are to be achieved from a corrections viewpoint and also from a public health perspective. If the educator is new or unknown to the officers this process can be lengthy and often time-consuming, generally because many officers are cautious about upsetting prison routines and creating precedents. However, this process should be viewed as fundamental to the success of implementing such programs. Indirectly, it also serves as part of the education process for staff, through raising general awareness and support for what is happening within the institution and the broader community, therefore creating a climate in which the fostering of HIV education amongst prisoners can be successful.

As experiential learning relies heavily on individual support and commitment to the program, the support of the officers is often useful in helping identify key inmates who are influential in the informal but powerful prisoner hierarchy. Such inmates are crucial participants in any program, if it is to receive the overall support of other prisoners. Often, inmates do not wish to be identified as being involved in a HIV education program unless it is seen to be supported by other prisoners. They fear being labelled HIV positive or gay.

After identifying key inmates within the target group, the process of linking educational strategies with the specific needs of the group can begin. Through consultation and discussion with a range of prisoners in a unit or area, a program of specific needs and issues relevant for that group can be developed and implemented accordingly.

Many inmates would prefer information about HIV infection to be placed in a broader context. Others have a preference for a particular type of presenter depending on the composition of the group. Such presenters might be a gay man, an Aboriginal, a woman, an ex-inmate or an IV drug user.

As a result, HIV issues have been presented in sexuality workshops, women-only groups, sports medicine and AIDS, first aid courses and HIV infection, or Aboriginals and AIDS groups. Others prefer information on HIV discussed in conjunction with drug use and abuse or sexually transmitted diseases, thus removing the purely AIDS flavour to any presentation.

Within South Australian institutions, many inmates report interest and enthusiasm for HIV education programs, but often express concern and frustration at the lack of resource material such as pamphlets, or the absence of bleach or condoms to provide protection in prison.

In South Australia, both sex and drug use are expressly prohibited in prisons, and consequently neither bleach nor condoms are made available to inmates. There are also severe restrictions on the type of information material considered appropriate. Material which explicitly shows safe practices such as needle cleaning, and condom use is not allowed in prison.

Having accessed inmates and negotiated a commitment for a specific program, a proposed program is drawn up. Its contents and format are negotiated with inmates and institutional staff. Community groups such as the AIDS Council, STD clinics or community health centres often assist in the co-presentation of a session.

Outside groups are used largely as a linking exercise which recognises that prisons are not insular communities, but rather fluid groups of individuals who interact regularly with the rest of the community. This is often useful in assisting inmates to develop resource contacts with other agencies when released from gaol. Other programs have used inmates to assist in the presentation of a program, drawing on their experiences of gaol life or IV drug use to establish credibility with other inmates.

For example, Port Augusta Gaol has a high proportion of non-urban Aboriginal inmates, so an HIV education program was developed with this consideration in mind. Initially this was through an introduction to an elder from an Aboriginal drug and alcohol worker. Following negotiations and discussions with the elder and several Aboriginal inmates, it was proposed that a workshop on HIV and Aboriginal communities be run in conjunction with the local Pika Wrya Aboriginal Community Health Centre. This program

proved so successful that of thirty-two Aboriginal inmates at Port Augusta at the time, twenty-nine of those attended.

Likewise, in discussing the development of a program in the women's section of Northfield Prison Complex the education program was developed by the women. It comprised thirteen sessions, and examined a range of women's health issues, including pregnancy, sexually transmitted diseases, AIDS, drug use and abuse, lifestyles and relationships. The program was presented by a doctor and community health nurse from the Adelaide Women's Community Health Centre, and was very successful.

This method of education enables the inmates to own the program and, therefore, increases the chance of success and continued attendance. It also provides a critical link to the rest of the community through the presenters, as well as complementing additional services offered by corrections. This is an important factor when it is recognised that the majority of inmates serve sentences of less than twelve months and are often back in the community after having served only short periods 'inside'.

To date, the educational experience with South Australian prisoners is only in the first phase of a much broader program. Having established an environment in which conducting HIV education programs is seen as a norm within institutions, phase two will aim to develop a prisoner peer educational model, educating inmates to be educators to other prisoners.

The implementation of this next phase should not be seen as a deviation from using the experiential learning approach to teaching. Rather, it uses this model to build further on accomplishments already achieved. In establishing a peer education program amongst inmates, consultation on the involvement of inmates will be an important element in the process.

The needs of officers should not be overlooked in this educational process. An officer education program needs to be developed (*see* Appendix 1). Educational programs for officers and inmates need to be implemented in parallel and drawn together.

Human Immunodeficiency Virus is recognised as one of the greatest public health issues to confront the world this century. Its role in prisons is no exception. Although inmates and officers are often seen as being on opposite sides of the fence, HIV is an issue that affects them equally and needs to be dealt with as a complete package.

The South Australian correctional services' experience does not purport to have all the solutions to the problems. The policy of integration and the management of HIV in prisons has been complemented with a series of educational strategies which will continue to develop, thus leading to a safer environment for those who live and work in prisons, and at the same time, having positive benefits for the whole community.

Appendix 1

Communicable Diseases Education Program Implementation Structure Issue: Communicable Diseases

Problem: Lack of Knowledge, Awareness of Procedures,
Fear, Hysteria and High-Risk Behaviours

Stage One - Education and Development

Aim: To develop a recognition and commitment to ongoing Communicable Diseases Education programs for all staff and inmates, whilst ensuring issues of policy and procedures are addressed and dealt with.

Officers	Policies and Procedures	Prisoners
Staff workshops through recruit training program, institutional workshops and sessions, community corrections staff and CSO supervisors.	AIDS Strategy Review	Workshops at all institutions for inmates including the use of outside agencies, plays and co-facilitation.
Study of Education Strategies employed in New South Wales.	Staff AIDS Education Strategy	Study of New South Wales Prison AIDS Project
Establishment of a Staff AIDS Education Strategy.		Development of Prison Peer Education Training Package.

Stage Two - Education and Training Implementation

Aim: To build on Stage One and implement strategies identified in Stage One.

Formalised workshops for Managers, Chief Correctional Officers, New Recruits, Custodial Staff, Programs/ Social Work, Correctional Industry Officers Community Corrections staff.

AIDS Strategy tabled and presented to Minister for endorsement.

Implementation Prisoner Peer Education Program.

Negotiate with agency to conduct program.

Pilot program in an institution

Evaluate pilot.

Implement Peer Education Program in all institutions.

Ongoing support for Peer Educators.

Such Workshops will involve information sessions and skills based workshops.

Development of new policies and procedures.

Coming together of Prisoner Education, Officer Education and policy through the formation of Institutional AIDS/ Health Committees.

Each institution will assume responsibility for the Education and Management of Communicable Diseases in their gaol via these committees which will consist of inmate and staff representatives.

Stage Three - Program Maintenance

Aim: To maintain Communicable Diseases Education Program, reviewing and modifying the program where appropriate at an institutional level.

To maintain and assist ongoing education services to staff at an institutional level.

Identify areas of policy which require further development.

To support Prison Peer Educators in their programs and identified education strategies.

To support and strengthen local AIDS/Health Committees and Occupational Health and Safety Committees to redress local issues.

It is anticipated these AIDS/Health Committees may develop local initiatives through their Prison Peer Educators and such activities may include Quiz nights, T-shirt printing, possible poster competitions just to mention a few.

Outcomes should result in the containment of Communicable Diseases infections, a greater awareness and concern for issues around Communicable Diseases and more caring and assistance for those who are infected.

References

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