The TB Challenge

"Partnering to Eliminate TB in African Americans"

A Newsletter from the Division of Tuberculosis Elimination, Field Services and Evaluation Branch

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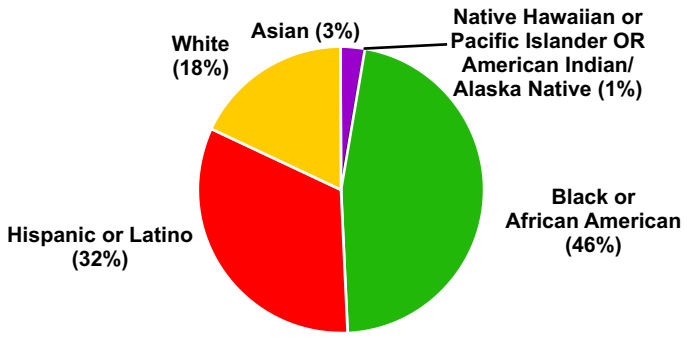
Raising the Awareness - Educating the Incarcerated Population about TB: A Nurse's Perspective

Ellen R. Murray, RN, BSN, Training Specialist/Nurse Consultant, Southeastern National TB Center
and Elvin Magee, MPH, MS, Health Scientist, Surveillance, Epidemiology, and Outbreak Investigations Branch, CDC

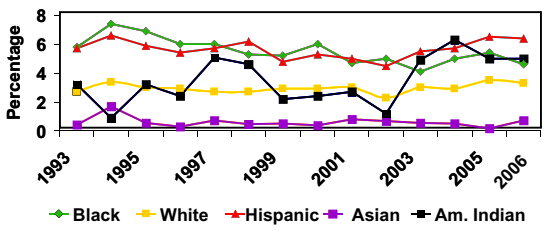
Figure 1. Reported TB Cases in Correctional Facilities by Race/Ethnicity*, United States, 1993−2006**



**All races are non-Hispanic. Persons reporting two or more races Accounted for less than 1% of all cases.*
***Updated April 7, 2007, N=9353, Age ≥15*

Black or African American persons have historically had a disproportionate share of the TB cases diagnosed in correctional facilities in the United States. As shown in Figure 1, this group represented 46% of all TB cases (4276 cases) reported in correctional facilities from1993 through 2006. Of this total, 3709 were male and 567 were female.

Figure 2. Percent of TB Cases in Correctional Facilities by Race/Ethnicity*, United States, 1993−2006**



**All races are non-Hispanic. Persons reporting two or more races accounted for less than 1% of all cases.*
***Updated April 7, 2007, N=9353, Age ≥15*

Correctional facilities in the United States house people of every race, ethnicity, and cultural background. Figure 2 illustrates the difference by race and ethnicity of persons with TB diagnosed in correctional facilities. Of the total TB diagnoses made from 1993 through 2006, an average of 5 to 6% were black inmates, while inmates of all other races and ethnicities, excluding Hispanics, averaged 3% or less.

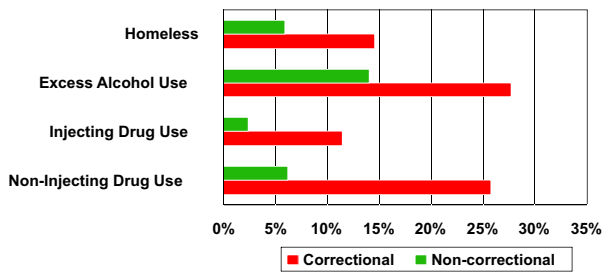
Corrections, present and the future

At the end of 2006, the U. S. Department of Justice reported greater than 7.2 million people were either: (1) on probation, (2) on parole, (3) in jail, or (4) in prison. This number represented 3.2% (1 in every 31 adults) of all U.S. adult residents.[1]

It is estimated that 32% of all black males will enter state or federal prison in their lifetime. This figure is in sharp contrast to the 17% estimated for Hispanic males and 5.9% of white males.

Figure 3 shows that from 1993 through 2006, the incarcerated were more likely to have a history of the following risk factors: homelessness, excessive alcohol use, injecting drug use, or non-injecting drug use.

Figure 3. TB Cases by Correctional Status and TB Risk Factors*, United States, 1993−2006**



**History of risk factor in year prior to diagnosis*
N=9353 in Correctional, N=225522 in Non-correctional
***Updated as of April 7, 2007.*

Education is the Key

In addition to other TB control measures, TB education in the correctional populace should be a priority to affect the rate of disease. In short, education in correctional facilities can be an intervention for TB infection control.

Education of prison inmates often occurs sporadically rather than systematically, with information about controlling and containing infectious disease not given high priority. Further, dwindling resources for public health education have resulted in cutbacks in community-wide TB programs. The higher proportion of 4276 total cases of TB in black inmates along with other health disparities present in the incarcerated population, demonstrate a need for education about TB. The development of educational programs for the incarcerated should be a priority for local health departments, working hand-in-hand with corrections administration to raise awareness and educate their medical and non-medical corrections staff about tuberculosis. Education about tuberculosis prevention and control is best done by those who are knowledgeable about the disease. Vehicles for also educating inmates about TB are prison ministries and other community-based programs that have gained inmates' trust and respect are already in place in the facilities. There are many educational programs currently available in correctional facilities, such as General Education Diploma (GED) classes, drug and alcohol programs, and rehabilitation programs that help inmates learn a trade. Programs such as these can be used to help TB programs educate the incarcerated population.

In summary, health department and correctional facilities should work collaboratively to ensure prompt disease detection, isolation, management, and discharge planning for infectious inmates. In addition, correctional facilities should develop an infectious disease plan focused on TB and offer education for their staff. Fundamental TB prevention and control activities in correctional facilities would include: (1) screening for TB disease and testing for latent tuberculosis infection (LTBI); (2) treating persons with TB and LTBI; (3) preventing TB transmission; and (4) enhancing collaboration between corrections, public health, and community partners.[2]

With public health and corrections working together, educating the incarcerated population about TB becomes a powerful tool for change.

[1]U.S. Department of Justice. (2007). Bureau of Justice Statistics. Retrieved from the website on 12/19/07 at http://www.ojp.usdoj.gov/bjs.

[2]CDC. Prevention and control of tuberculosis in correctional and detention facilities: Recommendations from CDC. MMWR 2006: 55(RR-9), 1-44.

Public Health and Corrections: Lessons from a prevention program tailored for men after their release from jail

Samantha Williams, Research Psychologist, NCHHSTP/DSTDP

Samantha P. Williams, Ph.D.

The promotion and preservation of public health and safety is a goal that is often challenged by private decisions and acts with unintended public consequences. Although communities are affected by strained public health and safety systems, people who are incarcerated are all too often at the mercy of, as well as perceived as the root cause of, two burdened systems of care and control.

Health issues that are present at the time of a detainee's incarceration are a testament to the health issues of the person's community and evidence of how the public health system may have failed. Most, if not all, correctional facilities conduct some form of infectious disease screening to minimize institutional transmission. When a detainee leaves with health issues, especially ones that developed during incarceration, it is evidence of how health in the context of public safety can be overshadowed; this has implications reaching beyond the facility to the community to which the inmate returns.

In a Bureau of Justice Statistics (BJS) report released in 2006, prevalence of medical problems did not increase with time served. Over one-third (38%) of inmates who served 7 days or fewer reported medical problems comparable to inmates who served more than one week to as much as a year (range 34% to 38%). Given that approximately 40% of the surveyed inmates reported receiving a medical examination while detained, the reports of medical problems by inmates quickly released may represent a combination of pre-existing conditions that are poorly managed and undiagnosed conditions that may have gone undetected.

Mobility among correctional populations is considerable, and once released, persons often return to circumstances and/or networks that facilitate risk of acquisition and transmission of infectious diseases including sexually transmitted infections (STIs), HIV, and tuberculosis.

"Programs that address not only health risk behaviors, but the criminogenic risk factors that bring people into correctional facilities, are needed to reduce recidivism and re-offending in the community. It is not the health risk (other than substance use or violence) that brings someone into a jail or prison, but the health risk enters the facility with them and will return to the community if not addressed through secondary prevention of all forms of risk behavior."

Roberto Hugh Potter, Ph.D.

Goal Team Leader, Healthy Institutions

Prevention through Collaboration

Jail detention, though an unfortunate event, is an opportune time to provide health screenings and care to an underserved population. In 2000, the MISTERS (Men Involved in STD Training Empowerment Research) Project was developed to determine the feasibility of implementing a behavioral intervention tailored for male inmates exiting jail. With support from the Division of STD Prevention (DSTDP) and the Cross Center Corrections Work Group (CCCWG), Charles Sperling, MA, the Executive Director of Standing to Achieve New Direction (STAND), Inc., co-developed and conducted research that evaluated the merits of their tailored intervention.

During the development of the MISTERS project, with a central goal of improving STI prevention with men released from jail, strong partnerships were formed between DSTDP; CCCWG; STAND, Inc.; the Georgia Department of Health, Division of STIs; the DeKalb County Jail; the DeKalb County Health Department; and the Georgia Department of Human Resources (GDHR), and the Georgia State Lab. The three year research study, which included semi-structured assessments at four time points, a multi-session cognitive behavioral/skill building intervention, and STI testing, ended in 2005. The findings have been used to support the community-based organization (CBO) collaboration and CBO-led interventions.

Results

Men who participated in the study (N=265) were mostly African American (93%), never married (65%), unemployed (88%), with at least 12 years of education (65%), and a median age of 38 years. Median jail stay was 30 days, and 71% were on probation or parole. Prior to the last arrest, most (78%) men reported a main partner, with half of the men reporting concurrent partners. Half (54%) reported exchanging sex for drugs, money, or housing. Although 67% of the men reported practicing safe sex, most (77%) did not use condoms during their last sexual encounter. One out of four men (24%) reported ever being diagnosed with an STI. In the year prior to their last arrest, 7% of the total sample reported having an STI, and 2.6% of the total sample reported a previous diagnosis of hepatitis C or genital herpes.

More than half of the men (53%) reported sexual activity since their jail release; one fifth (22%) of these men reported having had two or more partners (range 2 to 9). Prevalence of new STIs after release from jail was 10%. Chlamydia (3.4%) was the most common STI found in the sample, followed by gonorrhea (2.6%), syphilis (2.6%) and HIV (2.2%). Of the 27 men who tested positive for an STI, three (11%) reported an STI in the previous year.

One of the study's findings that was not unexpected yet still striking, was the number of men who did not have a stable place to live: over 65% lived with a partner or family and only 10% lived on their own. Twenty percent of the men were either homeless or lived in transitional housing or shelters all of which are associated with communicable disease risk.

The challenges to keeping men in the study included substance use, substance use networks, family dynamics, lack of child care, probation/parole commitments, work schedules, and efforts to find work. From these challenges, program staff learned important lessons which contributed to the strength of STAND Inc., and will inform future work with similar populations.

Lessons Learned

- Provide resources and referrals for housing, employment, and substance use and abuse treatment
- Be aware of challenges that may prohibit participation
- Provide child care when possible, even for men
- Have a protocol in place for handling persons who are intoxicated or high
- Have a protocol in place to address attrition related to recidivism

Other Efforts

Prevention programs for incarcerated men are needed to interrupt the STI transmission cycle that begins prior to incarceration and continues once inmates are released. Although MISTERS was a unique project, its focus is not. For example Project START targeted men released from prison: www.cdc.gov/hiv/topics/research/projectSTART. CDC is committed to correctional health: http://www.cdc.gov/correctionalhealth/, and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) is starting a Corrections Workgroup which will work closely with the Healthy Institutions Goals Team to reduce health disparities among correctional populations.

"Due to a variety of structural, social and behavioral circumstances, pre and post release correctional populations have an elevated risk of a variety of infections and chronic diseases including TB, STDs, HIV and Hepatitis. For this NCHHSTP has formed the Corrections Workgroup committed to facilitating effective collaboration within and on the Center priorities related to reducing health disparities and to promote service integration for incarcerated populations."

Laurie C. Reid, MS, RN

Corrections Workgroup Lead

Captain, U.S. Public Health Service

Life after MISTERS

Since the end of the MISTERS Study, Mr. Sperling of the STAND organization has integrated the STI intervention into his repertoire of re-entry solution services for men who come to the organization looking for "life stabilizing" skills and a fresh restart. The findings have been presented at multiple national conferences; one paper is in peer review, and two are in preparation. A dissemination plan was developed and efforts are being made to make the MISTERS curriculum available to other CBOs that work with men after they are released from jail. However, a long term commitment, along with effective prevention strategies and collaboration is needed to improve the health of correctional populations. Continued multilevel work within CDC and support of projects like MISTERS will contribute to the health of correctional populations and the communities to which they return.

Note: Charles Sperling, MA, is the Executive Director of STAND, Inc. which offers comprehensive re-entry solutions for ex-offenders by addressing substance abuse, employment, and family preservation http://www.standinc.com.

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