

University of Rhode Island

DigitalCommons@URI

Infectious Diseases in Corrections Report (IDCR)

10-2007

IDCR: Infectious Diseases in Corrections Report, Vol. 9 No. 20

Infectious Diseases in Corrections

Follow this and additional works at: <https://digitalcommons.uri.edu/idcr>

Recommended Citation

Infectious Diseases in Corrections, "IDCR: Infectious Diseases in Corrections Report, Vol. 9 No. 20" (2007). *Infectious Diseases in Corrections Report (IDCR)*. Paper 91.

<https://digitalcommons.uri.edu/idcr/91>

This Article is brought to you by the University of Rhode Island. It has been accepted for inclusion in Infectious Diseases in Corrections Report (IDCR) by an authorized administrator of DigitalCommons@URI. For more information, please contact digitalcommons-group@uri.edu. For permission to reuse copyrighted content, contact the author directly.



IDCR

INFECTIOUS DISEASES IN CORRECTIONS REPORT

JOINTLY SPONSORED BY MEDICAL EDUCATION COLLABORATIVE, INC.

FORMERLY HEPP Report

Oct/Nov 2007 Vol. 9, Issue 20

Release Date: October 01, 2007

End Date: November 30, 2008

ABOUT IDCR

IDCR, a forum for correctional problem solving targets correctional physicians, nurses, administrators, outreach workers, and case managers. Published monthly and distributed by fax and email, IDCR is ACCME accredited and free of charge. Since its founding in 1998, IDCR has served as an important resource for correctional health care providers by offering the newest and most relevant information on the management and treatment of infectious diseases within the correctional setting. Continuing medical education credits are provided by Medical Education Collaborative (MEC). This publication is jointly sponsored by IDCR and MEC.

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of MEC and IDCR. MEC is accredited by the ACCME to provide continuing medical education for physicians.

Medical Education Collaborative designates this educational activity for a maximum of 1 AMA PRA Category 1 Credit™. The target audience for this educational program is physicians.

EXECUTIVE EDITOR

Anne S. De Groot, MD

Associate Professor of Medicine (Adjunct)
The Warren Alpert Medical School
of Brown University

CHIEF EDITOR

David A. Wohl, MD

Associate Professor of Medicine
University of North Carolina
AIDS Clinical Research Unit

DEPUTY EDITORS

Joseph Bick, MD

Chief Medical Officer,
California Medical Facility, California
Department of Corrections

Renee Ridzon, MD

Consultant

PREVENTION IN PRACTICE: PRISONER ACCESS TO CONDOMS – THE CALIFORNIA EXPERIENCE

Spotlight I:

Project Bridge: A Transitional Case Management Program for HIV-Infected Men and Women

Spotlight II:

The BRIGHT Project: Bridges to Good Health and Treatment for HIV-Infected Individuals Being Released from Prison

IDCR-O-GRAM:

Proportion of BRIGHT Program participants not receiving routine HIV care following-prison release

OBJECTIVES

- The learner will be able to describe the condom access programs in both the Los Angeles and San Francisco jails.
- The learner will be able to summarize the elements and data related to Project Bridge in Rhode Island.
- The learner will be able to explain the elements and data related to Project BRIGHT in North Carolina.

Purpose Statement

The purpose of this monograph is to increase the knowledge of physicians in correctional systems on understanding the latest prevention measures being implemented in correctional systems in the US.

DISCLOSURES AND CREDENTIALS:

Associate Editors

Rick Altice, MD
Yale University AIDS Program

David Paar, MD
Director, Clinical Virology
The University of Texas Medical
Branch
Correctional Managed Care

Dean Rieger, MD
Officer/Corporate Medical Director
Correct Care Solution

Karl Brown, MD, FACP
Infectious Disease Supervisor
PHS-Rikers Island

Ralf Jürgens
Consultant

Joseph Paris, PhD, MD, FSCP,
CCHP
Former Medical Director
Georgia Dept. of Corrections

Lester Wright, MD, MPH
Chief Medical Officer
New York State Dept. of Correctional
Services

Bethany Weaver, DO, MPH
Infectious Disease Consultant
Armor Correctional Health Services

David Thomas, MD, JD
Professor and Chairman,
Division of Correctional Medicine
NSU-COM

Editorial Board

Neil Fisher, MD
Corporate Medical Director
The Geo Group, Inc.

Lynn Taylor, MD
Assistant Professor of Medicine
The Warren Alpert Medical School
of Brown University

Michael Poshkus, MD
Associate Clinical Professor
The Warren Alpert Medical School
of Brown University
Medical Program Director
Rhode Island Department of
Corrections

Josiah Rich, MD
Associate Professor of Medicine and
Community Health
The Warren Alpert Medical School
of Brown University

Steven F. Scheibel, MD
Medical Director
Community Oriented Correctional
Health Services

Mary Sylla
Director of Policy and Advocacy
Center for Health Justice
Barry Zack, MPH
Executive Director
Centerforce

Eric Avery, MD
Associate Clinical Professor of
Psychiatry
University of Texas, Medical Branch

Zelalem Temesgen, MD, AAHIVS
Associate Professor of Medicine
Mayo Clinic College of Medicine
Director, HIV Clinic Disease
Consultant
Division of Infectious Disease Mayo
Clinic

Jim Montalto
The Corrections Connection

Layout
Jose Colon
The Corrections Connection

Distribution
Screened Images Multimedia

Managing Editor
Elizabeth Closson
IDCR

FACULTY DISCLOSURE

The employees of Medical Education Collaborative have no financial relationships to disclose. In accordance with the Accreditation Council for Continuing Medical Education Standards for Commercial Support, the faculty for this activity have been asked to complete Conflict of Interest Disclosure forms.

DISCLOSURES: MAIN ARTICLE

Mary Sylla, JD, MPH
Director of Policy & Advocacy
Center for Health Justice
West Hollywood and Larkspur, CA

Disclosures: Nothing to Disclose

DISCLOSURES: SPOTLIGHT I

Leah Holmes, LICSW
Disclosures: Nothing to Disclose

DISCLOSURES: SPOTLIGHT II

David Alain Wohl, MD
Disclosures: Speaker: Abbott Laboratories, Gilead Sciences, Inc., Tibotec Therapeutics, Roche Pharmaceuticals, Merck & Co., Boehringer-Ingelheim, Bristol-Myers Squibb.

PREVENTION IN PRACTICE: PRISONER ACCESS TO CONDOMS— THE CALIFORNIA EXPERIENCE

Mary Sylla, JD, MPH

Director of Policy & Advocacy
Center for Health Justice
West Hollywood and Larkspur, CA

Disclosures: Nothing to Disclose

Introduction

Providing prisoners access to condoms is controversial. To some it seems hypocritical – why would we give prisoners condoms when it's illegal to have sex in jail and prison – and to others it seems like common sense, unless we pretend to ignore the fact that some sexual activity takes place in jails and prison. There are clearly pros and cons and unusual challenges to adopting a harm reduction strategy in a law and order environment.

On October 15, 2007, California Governor Arnold Schwarzenegger vetoed the latest “prison condom bill” to hit his desk. But this time he directed the California Department of Corrections and Rehabilitation to determine the “risk and viability of such a pro-

gram” by establishing a pilot program. What follows is a review of the prisoner condom access programs in two correctional facilities – one in Los Angeles and one in San Francisco – administered by the Center for Health Justice, a community-based non-profit organization focused on HIV and incarceration, and on-going research on those programs. This article is a written version of a presentation given at the National Convention on Correctional Health Care in Nashville on October 17, 2007.

Condom Access for Prisoners: Pros and Cons

There are serious concerns about providing prisoners with condoms. Introducing anything new into the security environment provides prisoners with an additional potential tool for conducting illegal activities including secreting contraband and assaulting staff with bodily fluids or excrement (called “gassing” in California). Further, in a rule-based environment it can be considered hypocritical to tell prisoners it's illegal to engage in sexual activity and then provide

the means to “safely” engage in that activity. From this viewpoint it sends the wrong message, and could be used by assailants to prevent evidence of sexual assault from remaining.

There are reasons why provision of condoms to prisoners might be a good idea. Even though it is illegal to have sex in jail or prison, that rule cannot be perfectly enforced in the many overcrowded and understaffed institutions in this country. Both scientific evidence and popular media point to the fact that sexual activity takes place behind bars. Last year the Centers for Disease Control and Prevention (CDC) published in the *Morbidity and Mortality Reports (MMWR)* a study that documented seroconversion during incarceration.¹ Those who became HIV-infected were 8 to 10 times as likely to report engaging in male-to-male sexual activity while in prison than those who did not.

The prevalence of known HIV among prisoners is extremely high: the rate of HIV infection among prisoners is 5 to 7 times that of the general population.^{2,3} The very behaviors that put people at risk for HIV infection – injection drug use and sex work – are also behaviors that can lead to incarceration. In the U.S., approximately one in four persons with HIV infection passes through a jail or prison each year – and many of those do not know they are infected.⁴ Therefore, a considerable number of HIV-infected prisoners may not know they are HIV-infected and as such unwittingly may transmit their infection to others.

Where are condoms provided to inmates?

Condoms are provided to prisoners in county jails in Los Angeles, San Francisco, Philadelphia, Washington, D.C. and New York and in the state prisons in Vermont and Mississippi. The manner in which condoms are made available varies widely among these facilities. In Los Angeles, the Center for Health Justice distributes free condoms to a segregated gay male population only, one condom per week per inmate, a limit imposed by the Los Angeles Sheriff's Department. San Francisco's Forensic AIDS Project (part of the Department of Public Health) distributes condoms upon request through its public health nurses in one-on-one health counseling sessions, one per person, per request, and upon release. Earlier this year the Center for Health Justice in San Francisco installed a condom dispensing machine – a vending machine set to require no payment – in a gym to which 800 prisoners have access. About 70 condoms per week are taken from the machine.

In Washington, D.C., prisoners in the D.C. jail system have access to free condoms during health education classes, voluntary HIV pretest or posttest counseling, or upon request to members of the health care staff. The jail's health educator and staff of a community-based AIDS service provider distribute about 200 condoms to prisoners each month. In Philadelphia, prisoners can get condoms from the medical services department or through the commissary. These

LETTER FROM THE EDITOR

Dear Correctional Colleagues,

There are few more controversial issues in correctional health than the distribution of condoms in prisons and jails. The arguments on both sides are well known and have been described in the pages of *IDCR* in the past. But, while condoms remain unavailable to most of those who are incarcerated, there are a few facilities where they can be found. In Mississippi and Vermont state prisoners are provided condoms, and they are also made available in several jails in parts of the country. These condom distribution programs have continued quietly, with many in our field unaware of their existence.

In California, that condoms are distributed to some jailed inmates is now no secret. A recent veto of a bill to make condoms available to prisoners by that state's governor and his subsequent directive to study the feasibility of condoms in correctional settings placed the issue squarely in the spotlight. Not a state to shy from social experimentation, California has actually had condom programs in place in certain jails for years. The experience of these facilities provides valuable lessons that can inform future HIV/STD prevention policies in our nation's correctional facilities.

In this issue Mary Sylla, JD, MPH, Director of Policy & Advocacy Center for Health Justice in California provides a brief overview of the potential merits and disadvantages of the provision of condoms in jails and prisons and describes two jail-based condom programs in her state. Her report is balanced and informative and makes clear that in these facilities condoms have not been found to be dangerous but they were no prevention panacea as inmates often did not use them – hardly a surprise to anyone trying to get people in the free world to adopt condoms as part of safer sex.

Also in this issue Leah Holmes from Rhode Island provides an update on Project Bridge, an innovative program of case management that spans the periods before and after release. Accompanying her report is a description of a study of a similar program we have launched in North Carolina. These programs are both successful and serve as important examples of the value of continuity of care in the reintegration of the HIV-infected into their communities.

Your thoughts regarding what you read in *IDCR* are important to us. Email your comments to me at wohl@med.unc.edu. Please indicate if you would like to have your comment posted on our letters to the editor section of the *IDCR* website.

David A. Wohl, MD
Associate Professor of Medicine
Division of Infectious Diseases
AIDS Clinical Research Unit
The University of North Carolina - Chapel Hill

P.S. New (2007) modified format on first page is made to comply with the ACCME requirements

PREVENTION IN PRACTICE: PRISONER... (continued from page 2)

methods of providing prisoners access to condoms vary, and most reach only a small subset of the prisoner population in the jail and prison systems in which they operate.

Two pilot programs of condom distribution in California

The Los Angeles County Jail Model

The Los Angeles condom access program was the result of a unique set of circumstances: a new Custody Chief – who had just been promoted from Medical Services – approached the Center for Health Justice about the possibility of designing a program that could provide gay male prisoners in dormitory-style housing units access to condoms without involving custody staff or time. The program today exists as it did when implemented: once a week a health educator from the Center for Health Justice goes in to each dorm, provides a brief, interactive HIV education session, the rules of the program (including that sex is still illegal in jail under California law and that the condoms are not to leave the dorm or they will be considered contraband) and hands one condom to each prisoner who lines up to receive one. Although the average has changed over time, the Center for Health Justice currently distributes about 120 condoms per week to the 300+ prisoners in this unit.

To evaluate this program, 101 of the approximately 300 prisoners who live in the unit for segregated gay males were asked a series of questions through a computer-assisted self-interview program. Although the formal data analysis has not been completed, interesting statistics compiled so far include that 93% of respondents were aware of the condom program and 82% had received at least one condom from the program. Fifty-three percent of respondents reported anal sex during the past 30 days – but despite access to condoms, 75% of those who reported anal sex during the past 30 days said it was unprotected. The three top reasons for not using condoms were: (1) my partner and I are both HIV negative (or positive); (2) I ran out of condoms; and (3) I don't like the way condoms feel. Information was gathered about other methods of condom access: 66% preferred the current method of distribution; other methods of distribution that would be to others who indicated Medical (41%), Vending (10%), or Canteen (8%). The results of this evaluation will be finalized and published during the coming year, but support the assertion that some risk-reduction is achieved in this population through access to condoms.

The San Francisco County Jail Model

In San Francisco, the Center for AIDS Prevention Studies and Dr. Olga Grinstead are conducting research on a novel way to provide prisoners access to condoms that has been successful in other countries. As mentioned earlier, in San Francisco, prisoners have had access to condoms since 1987 through the Forensic AIDS Project's health educators in one-on-one individual consultations. In the fall of 2006, the Center for Health Justice, Dr. Grinstead and the

Forensic AIDS Project approached the Sheriff of San Francisco about installing a condom dispensing machine, in part because of reports from Forensic AIDS Project staff that the demographic characteristics of the health educator seemed to influence whether a prisoner being counseled took a condom. The Center for Health Justice sought to evaluate a more anonymous method of providing prisoners access to condoms, as well as being less staff-intensive.

The dispensing machine program and its pilot feasibility are being conducted by the Center for Health Justice in collaboration with the Forensic AIDS Project. The machine was installed in April 2007 in a gym to which 800 prisoners have access every week for their three hours of recreation. Sheriff Michael Hennessey himself, to provide a large number of prisoners access to it, suggested the precise location of the machine. Prior to installing the machine, brief written surveys were conducted with prisoners to elicit baseline information about their HIV status, knowledge of the existing condom program and risk behavior. Interviews were conducted with Sheriff's Department staff to assess attitudes about condom access for prisoners and determine potential security concerns. Center for Health Justice staff also made presentations to all deputy staff and prisoners affected by the program before the machine was installed. The same written survey and similar interviews were conducted after the machine was operational for four months.

The machine itself is a low-profile tamper-resistant unit, designed to withstand break-in attempts. The machine dispenses condoms in a cellophane wrapped paper box. Inside the box the condoms are enclosed in another cellophane wrapper. The "Condom Machine Rules" posted next to the machine indicate that condoms are to be removed from the box and carried only in the clear wrapper, with the condom inside visible.

The Condom Machine Rules, in full, read:

- Take only one condom per visit to the gym.
- Immediately open condom package and discard the external paper box and cellophane wrapper.
- Condoms enclosed in the clear sealed plastic wrapper are not contraband.
- Condoms remaining in the orange box or removed from the clear sealed plastic wrapper are contraband and will be confiscated.
- Having sex in jail is illegal under California Penal Code § 286(e).
- Failure to obey these rules will result in discontinuation of this condom access program.

During the study period the Center for Health Justice successfully installed, stocked and maintained the condom machine. Data analyses of the pre- and post-surveys and interviews are currently underway. Preliminary data analyses indi-

cate that prisoner self-report of sexual activity did not increase during the study period; in addition the custody staff have reported no increase in reported sexual activity or any other security problems related to increased condom access. We have encountered few operational problems, the most notable falling on the staff restocking the machine: the machine was difficult to open and close for restocking and sometimes jammed. A new model of machine has been purchased to address these problems.

Evaluations of these two pilot programs are currently being analyzed. In Los Angeles, Charles R. Drew University's Dr. Nina Harawa and the Center for Health Justice (with funding from the California HIV/AIDS Research Program-funded Institute for Community Health Research) are evaluating the current Los Angeles County Sheriff's Department program to determine whether the program is reducing sexual risk activity.

Conclusions: Condoms coming soon to a facility near you?

While controversial, there is a trend toward increased prisoner access to condoms. The CDC now recommends that prison systems with existing condom distribution programs evaluate those programs, and those without such programs consider the feasibility of implementing condom distribution programs. Governor Schwarzenegger's "friendly" veto of legislation requiring prisoner access to condoms may result in a pilot project across the state. At the federal level, Representative Barbara Lee's JUSTICE Act of 2007 (H.R. 178), modeled on the California bill, requires federal prisoners to have access to condoms. Even where legislation is not pending, jails and prisons are considering the issue.

Regardless, programs that involve corrections cannot be successful without the support of the administration of corrections systems. The best circumstances for risk-reduction involve input at the development stage, and any success these programs have is a credit to the professionalism of the corrections staff in the facilities where they exist.

References

1. CDC. *HIV Transmission Among Male Inmates in a State Prison System ---Georgia, 1992-2005*. *MMWR Morb Mortal Wkly Rep*. 2006;55(15):421-26.
2. Maruschak, L. 2005. *HIV in Prisons*. 2003. U.S. Department of Justice, Bureau of Justice Statistics Bulletin.
3. Weinbaum CM, Sabin KM and Santibanez SS. 2005. *Hepatitis B, hepatitis C, and HIV in correctional populations: a review of epidemiology and prevention*. *AIDS* 19 3, S41-6.
4. Hammett TM, Harmon P and Maruschak LM. 1999. *1996-1997 update: HIV/AIDS, STDs, and TB in correctional facilities*. Washington, DC: National Institute of Justice.

SPOTLIGHT I: PROJECT BRIDGE: A TRANSITIONAL CASE MANAGEMENT PROGRAM FOR HIV-INFECTED MEN AND WOMEN

Leah Holmes, LICSW

Project Bridge
Principal Investigator and Project Director
The Miriam Hospital,
Providence, Rhode Island

Disclosures: None

Introduction

Project Bridge is an intensive case management program for HIV-positive ex-offenders at The Miriam Hospital in Providence, Rhode Island. The program is located off-site from the hospital in the neighborhood where a majority of offenders lived before incarceration. The program staff consists of two master's level social workers who are responsible for the overall management of each case and two paraprofessional outreach workers who locate missing clients and provide support to access concrete services, such as food stamps and housing applications. The social worker meets with prospective clients from 30 to 60 days before release at the correctional facility to identify the most pressing needs facing the client. After release, they provide supportive counseling, and coordinate medical, legal, substance use, and mental health treatment. The primary goal of the program is to enhance continuity of medical care through increasing social stability. Attending to basic survival and social support needs is fundamental to retaining ex-offenders in medical care.

Program Overview

Client enrollment began in February 1997. Since that time, we have learned several lessons. The first lesson is the importance of having the social worker attend medical visits with the client. Clients rate this as the most salient factor in keeping medical appointments and adhering to medications. They welcome the emotional support and the assistance in understanding medical terms

and directives. It facilitates in obtaining medications, and assuring that comprehension of dosing schedules, and requirements to prepare for medical tests and procedures exist.

The second lesson is that clients need to be in very close contact during the initial phase of re-entry. We request that they either come to the office or have telephone contact daily for the first month. The outreach worker assists them to access many service needs, while the social worker creates a treatment plan and provides supportive counseling. Frequency of contact builds a working relationship and develops trust.

The third lesson is the importance of visiting reincarcerated clients as quickly as possible after their arrest. They are at a point of crisis and change is most likely to occur when usual coping strategies are ineffective. Clients who have visits during reincarceration are more strongly committed to the program following re-release.

The final lesson is to tailor length of enrollment to the client's needs. A very small number of clients stabilize within six months. Generally, these people were first-time offenders and have intact social and financial support in the community. Most clients remain enrolled for 18 – 24 months and then transfer to other providers for continuing services.

Participant Demographics

Project Bridge's most recent evaluation covered the period between 2003 and 2005. Sixty-five participants enrolled in the study. Participants were primarily male (66%) with one being transgender. They were also primarily heterosexual (82%). Race was nearly even between African American (41%) and White (42%) with the remainder Native American or Other (6%) or more than one race (5%). Hispanic ethnicity was reported by

14% and 6% were primarily Spanish speaking. The attrition rate was 20%. One participant died, three moved out-of-state, two withdrew from the study shortly after prison release, and seven were re-incarcerated and received sentences that exceeded six months. It was at that time an SPNS funded project began to find methods of outreach for out-of-care or sporadic users of care. It ended in 2006. Project Bridge has continued as a Part B (formerly Title II) funded program. The staffing has been reduced to one MSW and one BA outreach worker.

Effectiveness of Medical Retention

In the first six months of enrollment, 98% of the clients received medical care. In the final six months of their enrollment, 100% received medical care. The evaluation included a chart review six months after clients graduated from the program to see if there was decay in the program effects. This showed that 89% had continued to seek medical care.

Future Steps

Project Bridge is continuing thanks to ongoing Ryan White Part B funding provided by the Rhode Island Department of Health. This model can and should be tailored to other facilities in other states. It can also be tailored to other disease states. Drs. Peter Friedman and Lynn Taylor have recently received a National Institutes of Health (NIH) grant that will use the Project Bridge model to provide care for offenders with hepatitis C virus (HCV) infection being released from incarceration. This will allow us to start offenders on HCV treatment while incarcerated and continue therapy following community release. Presently, offenders only receive this treatment if they are serving a sentence with at least a year remaining before release.

SPOTLIGHT II: THE BRIGHT PROJECT: BRIDGES TO GOOD HEALTH AND TREATMENT FOR HIV-INFECTED INDIVIDUALS BEING RELEASED FROM PRISON

David Alain Wohl, MD

Associate Professor of Medicine
Division of Infectious Diseases
AIDS Clinical Research Unit
The University of North Carolina- Chapel Hill

Disclosures: Speaker: Abbott Laboratories, Gilead Sciences, Inc., Tibotec Therapeutics, Roche Pharmaceuticals, Merck & Co., Boehringer-Ingelheim, Bristol-Myers Squibb.

Introduction

The Bridges to Good Health and Treatment (BRIGHT) Project began as a National Institutes of Health (NIH)-supported clinical trial that aimed to understand if an intensive case management intervention that began within the three months prior to state prison release and continued for six months post-release could increase access to HIV care and services, and reduce recidivism and enhance safe sex practices among HIV-infected releasees in North Carolina. The trial began in 2001 and enrolled 104 individuals who were randomized to the intervention or to standard discharge planning, which does not include post-release activity. Preliminary

results indicate the intervention is successful at increasing access to routine HIV care and reducing risk of re-arrest. Based on these findings, the BRIGHT intervention has now been made a non-research service offered to the majority of HIV-infected inmates facing release.

Program Overview

The BRIGHT Program is a unique intervention designed to improve the well-being of HIV-infected prison releasees. The case management approach used in the program is based on the Strengths Model. This model holds that all individuals have strengths, desires, aspirations, interests, experience talents, knowledge, resiliency and ascribed meaning. It is these that are the focus of a healthy helping relationship, and not the concentration on weaknesses or deficits. The work is done with participants within the context of a collaborative and mutually enriching and respectful partnership in order to identify, secure and sustain a range or resources (both external and internal) needed to live in a normally interdependent manner in the community. Unlike traditional case manage-

ment, the Strengths Model permits the participant to be an active part of the decision-making process rather than be passive or dependent on others.

The BRIGHT case managers begin to work with participants as soon as three months prior to scheduled release, meeting with them regularly to assess for strengths and developing a personal wellness plan together. After release, the BRIGHT case manager will work intensively along side the participant to realize the plans established during incarceration, refining them as needed to confront new goals and challenges. After six months, the participant is slowly transitioned to community case management services. BRIGHT case managers are permitted a maximum case load of 15 participants as a heavier case load would compromise the quality of the intervention.

All HIV-infected inmates in North Carolina, including the BRIGHT Program participants, also receive discharge planning assistance during their incarceration from North Carolina Department of Corrections (NCDOC) HIV Outreach Nurses. These nurses and the

SPOTLIGHT II: THE BRIGHT PROJECT:
(continued from page 4)

BRIGHT case managers work closely especially as release nears.

Accomplishments to Date

The program began as a clinical trial of 104 inmates. Preliminary results following the release of the first 91 participants have been previously presented at the 2006 International AIDS Society Conference in Toronto. At the time of the analysis, 81% of the participants were African-American, 26% were women, median CD4 cell count was 350/mm³ and median viral load was 1,430 copies/mL; and 74% were taking antiretroviral medications. Ninety percent had a history of substance abuse and at baseline, 51% had major depression based on standardized screening assessment with the CES-D.

At three months post-release, only 21% of those receiving bridging case management had not attended a routine HIV clinic visit compared to 43% of those not receiving the

intervention (p=0.059). Similarly, emergency room visits, a measure of inadequate access to routine medical care, occurred in 28% of those assigned to the case management versus 44% of the controls. Re-arrest rates for those under case management are generally half that of the controls. Final analyses of the complete cohort are ongoing as the final on-study visit occurred in September 2007. All participants are followed for a year post release.

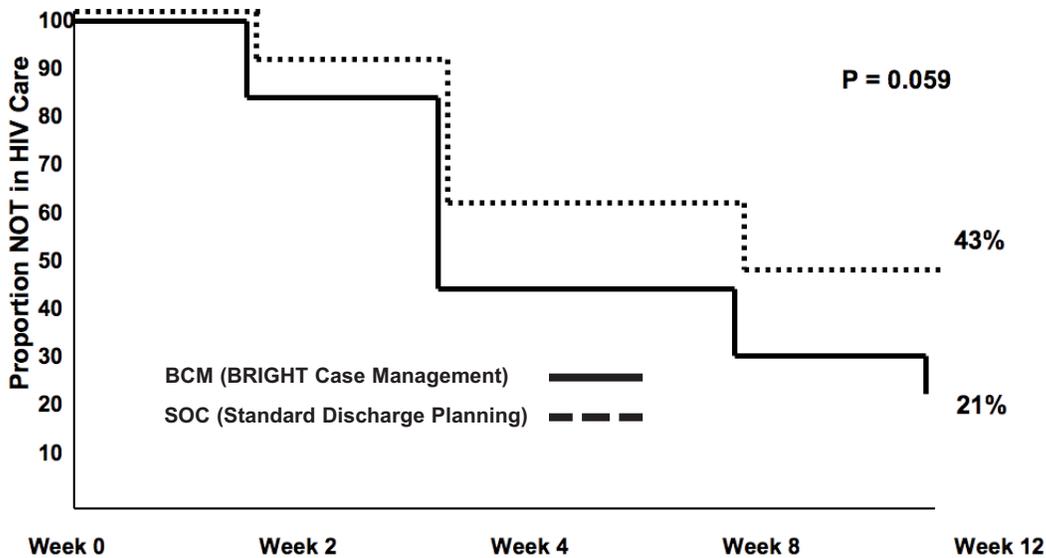
Following the early success of this trial, the investigative team sought and received funding from private foundations to continue the program and expand access to the intervention. During the trial three bridging case managers were employed and worked with participants returning to the three largest metropolitan areas of North Carolina (Raleigh-Durham, Greensboro-Winston-Salem, Charlotte). With the expansion of the program, BRIGHT is now in almost 30 counties statewide, including Asheville in the western part of the state and rural areas well outside of urban centers. Over 45 participants have now been enrolled in the post-study program since February 2007 and six

case managers are administering the BRIGHT intervention.

Future Steps

While the BRIGHT program continues through the generosity of private funding sources, other support will eventually need to be identified to maintain the program. Following the final analysis of the trial results, support from governmental and other sustainable sources will be sought. Meanwhile, the program has established strong collaborations with community AIDS Service Organizations, training case managers within these organizations in Strengths Model based bridging case management. In a unique arrangement the BRIGHT Program clinically supervises these community case managers. The benefits of this program have been evident to the staff and participants, as well as community service providers. During the next year, we will disseminate our instruments, manuals and procedures so that others can also develop and implement transitional programs to identify and capitalize on the strengths of HIV-infected releasees.

IDCR-O-GRAM: PROPORTION OF HIV-INFECTED PARTICIPANTS RECEIVING ROUTINE HIV CARE FOLLOWING PRISON RELEASE DURING THE BRIGHT STUDY – A RANDOMIZED CONTROLLED TRIAL OF BRIDGING CASE MANAGEMENT VS. STANDARD DISCHARGE PLANNING



RESOURCES

Center for Health Justice
<http://healthjustice.net/>

Community HIV/AIDS Mobilization Project
<http://www.champnetwork.org/>

CDC's National HIV Testing Resource Website
<http://www.hivtest.org/>

CDC's Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>

National HIV/AIDS Clinician's Consultation Center
Warmline: National HIV Telephone Consultation Services
 1-800-933-3413
PEpline: National Clinician's Post-Exposure Prophylaxis Hotline
 1-888-448-4911
Perinatal Hotline: National Perinatal HIV Consultation and Referral Services
 1-888-448-8765

Department of Health and Human Services
2006 Adult and Adolescent Antiretroviral Treatment Guidelines
<http://www.aidsinfo.nih.gov/guidelines/>

International AIDS Society-USA Panel
2006 Recommendations of the Treatment for Adult HIV Infection
<http://jama.ama-assn.org/cgi/content/full/296/7/827>

American Academy of HIV Medicine
<http://www.aahivm.org/>

CME-accredited web-stream of "Occupational & Non-Occupational Post-Exposure Prophylaxis"
www.amc.edu/hivconference

Slides from the NCCHC Pre-conference Seminar Infectious Diseases in Corrections: An Expert Panel October 28, 2006
<http://www.idcronline.org/archives.html>

SAVE THE DATES

National HIV Prevention Conference

Atlanta, GA
December 2-5, 2007
Visit:<http://www.2007nhpc.org>

AIDS in Culture IV: Explorations in the Cultural History of AIDS

Mexico City
December 9-13, 2007
Visit:www.aidsinculture.org

American Correctional Association Winter Conference

Grapevine, TX
January 11-16, 2008
Visit:<http://www.aca.org/conference/s/Winter08/>

Conference on Retroviruses and Opportunistic Infections (CROI)

Boston MA
February 3 - 6, 2008
Visit:<http://www.retroconference.org/2008/>

2nd Annual Academic and Health Policy Conference on Correctional Health

Boston Marriott, Quincy, MA
March 27-28, 2008
Visit:http://www.umassmed.edu/Correctional_Health_Conf/index.aspx



Go to www.AAHIVM.org to learn about membership, continuing education and the new partnership with IDCR

NEWS AND LITERATURE REVIEWS

FDA Approves Raltegravir as First in New Class of Antiretrovirals

The U.S. Food and Drug Administration approved the use of raltegravir tablets in treating infections of HIV-1 in treatment-experienced individuals. The approval of raltegravir offers hope to individuals who have evidence of resistance to other antiretroviral drugs and represents one of a handful of new classes of antiretroviral drugs that have been approved in recent months. Raltegravir, which received a priority review by the FDA, is the first in a new class of antiretroviral drugs, known as HIV integrase strand transfer inhibitors that are designed to interfere with the enzyme that HIV-1 needs to multiply.

Raltegravir was approved for use in treatment-experienced patients after the review of data from two double-blind, placebo-controlled studies in 699 HIV-1 infected patients with a history of extensive antiretroviral treatment and evidence of resistance to at least one antiretroviral drug. Individuals who received raltegravir in combination with other antiretrovirals experienced lower plasma HIV viral loads when compared to individuals who received a placebo in combination with other antiretroviral drugs. This trial did not include the use of raltegravir in persons less than sixteen years of age or in pregnant women. Some of raltegravir's most common side-effects include diarrhea, nausea, and headache, along with elevated levels of CPK.

U.S. Food and Drug Administration.
<http://www.fda.gov/bbs/topics/NEWS/2007/NEW01726.html>.

Rapid Fibrosis Progression Among HIV/Hepatitis C Virus Co-infected Adults

Between 15-30% of all HIV-infected individuals are also co-infected with hepatitis C (HCV) and HCV-related liver disease has grown to become a leading cause of death among persons infected with HIV.

Recent studies have sought to examine possible links between the use of HIV antiretroviral drugs and the progression of HCV-related liver disease. Some retrospective studies have found a lower prevalence of cirrhosis and mortality in HCV-infected individuals who were receiving antiretroviral treatment for HIV-infection. Other studies have demonstrated an association between antiretroviral use and acute and chronic liver inflammation.

To examine the pace of fibrosis progression in HIV-HCV co-infected patients and identify predictors of fibrosis advancement, the medical records of 184 HIV/HCV co-infected individuals from the Johns Hopkins University HIV clinic cohort with at least two liver biopsies performed between January 1998 and July 2006 were studied. The majority of patients were African American men and past or active drug use was reported in 78% of all patients.

Nearly a quarter of co-infected patients in this study had evidence of significant fibrosis progression over a three-year interval. Antiretroviral and HIV disease measures were not associated with liver disease progression. Moreover, this study did not find evidence of long-term liver injury as a result of antiretroviral treatment. Only elevated levels of serum AST (but not ALT) between biopsies was shown to be an independent indicator of liver-disease progression.

Rapid fibrosis progression among HIV/hepatitis C virus-co-infected adults. Sulkowski, M. et al. AIDS. 2007;21:2209-2216.

ACLU's Efforts Lead to More Equal Treatment of HIV-Positive Prisoners in Alabama

After years of advocacy, the American Civil Liberties Union (ACLU), Alabama state legislators, and the AIDS service organization AIDS Alabama, have made headway with the Alabama Department of Corrections

(ADOC) to allow HIV-positive prisoners greater access to educational programs, visitation, substance abuse treatment programs, and religious services. These programs and services have historically been denied to HIV-positive inmates. This decision comes after a letter from the ACLU was sent to ADOC Commissioner Richard F. Allen. The letter urged Commissioner Allen to put a stop to the discriminating segregation policies at the ADOC. Alabama remains the only state in the union to segregate HIV-positive prisoners and deny them access to programs and services available to the greater prisoner population. Before the changes, HIV-positive inmates at the Julia Tutwiler Prison for Women and the men's Limestone Correctional Facility were completely isolated from the general population and given limited access to family visits, library, work opportunities, other services available to the general population. Since 1997, the ACLU, and advocates for people living with HIV have lobbied against these policies in two trials in the Eleventh Circuit Court of Appeals and the Alabama Supreme Court. The campaigns led to the release of a major report by the Alabama's Governor's HIV Commission for Children, Youth, and Adults, finding that there was overwhelming evidence to suggest that the segregation policies had no public health or safety justification.

HIV-Positive Prisoners Receive More Equal Treatment in Alabama After ACLU's Efforts. (11/1/2007). <http://www.aclu.org/prison/restrict/32510prs20071101.htm>

Trends in HIV Testing and Differences Between Planned and Actual Testing in the United States, 2000-2005

Researchers at the Duke University Health Inequalities Program recently conducted a pooled cross-sectional analysis of data from the 2000-2005 National Health Interview Surveys (NHIS) in order to examine longitudinal trends in planned and actual HIV testing. The study, which appeared in the Archives of Internal Medicine, pooled data from six consecutive nationally representative cohorts of adults participating in the NHIS and examined the relationship between HIV testing rates and self-reported risk of HIV. Researchers also focused on understanding the relationship between planned and actual testing, as well as how demographic characteristics, HIV risk, and other health behaviors might impact testing rates.

The researchers found that rates of HIV testing remained low and relatively unchanged during the six year span of this study's data. Minority women had both the highest rates of lifetime HIV tests and the highest rates for HIV tests in the past twelve months. Conversely, white men were found to have both the lowest rates of lifetime HIV tests and the lowest rates for HIV tests in the past twelve months. The study also reported both white and minority women as having modest increases in lifetime HIV testing rates. Over 60% of participants who reported a specific HIV risk factor or had high current risk had ever been tested for HIV and more than twenty-percent of this group reported having been tested for HIV in the past year. Of all of the respondents who had previously been tested for HIV, 23.7% had a reason for getting tested for HIV, whereas 44.2% of tests had been administered as a part of routine care. In addition, 20.9% of tests were conducted to fulfill an insurance, marriage, immigration, or military requirement. Also, more than one-sixth of HIV tests were related to prenatal care. These findings are significant as they demonstrate the effectiveness of incorporating HIV testing into routine health care, as is recommended by the Centers for Disease Control and Prevention.

Trends in HIV Testing and Differences Between Planned and Actual Testing in the United States, 2000-2005. Ostermann, J. et al. Arch Intern Med. 2007;167:2128-35.

Compiled by Christine Devore

SELF-ASSESSMENT TEST FOR CONTINUING MEDICAL EDUCATION CREDIT

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for continuing Medical Education through the joint sponsorship of Medical Education Collaborative, Inc. (MEC) and IDCR. MEC is accredited by the ACCME to provide continuing medical education for physicians.

Medical Education Collaborative designates this educational activity for a maximum of 1 AMA PRA Category 1 Credit™. The target audience for this educational program is physicians. Physicians should only claim credit commensurate with the extent of their participation in the activity. Statements of credit will be mailed within 6 to 8 weeks following the program.

Objectives:

- The learner will be able to describe the condom access programs in both the Los Angeles and San Francisco jails.
- The learner will be able to summarize the elements and data related to Project Bridge in Rhode Island.
- The learner will be able to explain the elements and data related to Project BRIGHT in North Carolina.

- | | |
|---|--|
| <p>1. In the main article, which of the following was NOT cited as a reason for providing condoms to prisoners?</p> <p>A. Even though sex in prison is illegal, the rule cannot always be enforced.</p> <p>B. The prevalence of known HIV among prisoners is estimated is five to seven times greater than that of the general population.</p> <p>C. Condom access programs have proven to be very successful in European correctional facilities.</p> <p>D. In the US approximately one in four persons infected with HIV infection pass through a correctional facility each year.</p> <p>2. The Forensic AIDS Project's health educators have distributed condoms in San Francisco's jails since 2005.</p> <p>TRUE or FALSE</p> <p>3. The preliminary data analyses of the condom dispensing machine access program in the San Francisco jail indicate which of the following?</p> <p>A. Prisoners have been using the condoms as weapons.</p> <p>B. Custody staff have reported no increase in reported sexual activity or security problems related to the condom dispensing machine access.</p> | <p>C. Prisoner self-report of sexual activity has stayed the same.</p> <p>D. Both B and C</p> <p>4. Commonalities between North Carolina's BRIGHT Project and Rhode Island's Bridge Project include:</p> <p>A. Clients begin intensive case management several months before their release date.</p> <p>B. Clients maintain very close contact with their caseworkers during the initial phase of re-entry.</p> <p>C. The primary goal is to increase access to HIV care and services and reduce recidivism.</p> <p>D. All of the above.</p> <p>5. Which program, the BRIGHT Project or Project Bridge utilizes the Strengths Model in its approach to case management.</p> <p>A. The Bright Project</p> <p>B. Project Bridge</p> <p>C. Both A and B</p> <p>D. None of the above</p> |
|---|--|

In order to receive credit, participants must score at least a 70% on the post test and submit it along with the credit application and evaluation form to the address/fax number indicated. Statements of credit will be mailed within 6-8 weeks following the program.

Instructions:

- Applications for credit will be accepted until November 30, 2008.
- Late applications will not be accepted.
- Please anticipate 6-8 weeks to receive your certificate.



Please print clearly as illegible applications will result in a delay.

Name: _____ Profession: _____

License #: _____ State of License: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Please check which credit you are requesting ACCME or Non Physicians

I certify that I participated in IDCR monograph November 2007 Issue

Please fill in the number of actual hours that you attended this activity.

Date of participation: _____

Number of Hours (max. 1): _____

Signature: _____

Please Submit Completed Application to:

Medical Education Collaborative
 651 Corporate Circle, Suite 104, Golden CO 80401
 Phone: 303-420-3252 FAX: 303-420-3259
 For questions regarding the accreditation of this activity, please call 303-420-3252

COURSE EVALUATION

I. Please evaluate this educational activity by checking the appropriate box:

Activity Evaluation					
	<i>Excellent</i>	<i>Very Good</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>
Faculty					
Content					
How well did this activity avoid commercial bias and present content that was fair and balanced?					
What is the likelihood you will change the way you practice based on what you learned in this activity?					
Overall, how would you rate this activity?					

II. Course Objectives

Were the following overall course objectives met? At the conclusion of this presentation, are you able to:

- | | | | |
|--|------------|-----------|-----------------|
| ■ The learner will be able to describe the condom access programs in both the Los Angeles and San Francisco jails. | YES | NO | SOMEWHAT |
| ■ The learner will be able to summarize the elements and data related to Project Bridge in Rhode Island. | YES | NO | SOMEWHAT |
| ■ The learner will be able to explain the elements and data related to Project BRIGHT in North Carolina. | YES | NO | SOMEWHAT |

III. Additional Questions

a. Suggested topics and/or speakers you would like for future activities.

b. Additional Comments
