Published in final edited form as:
Int J Law Psychiatry. 2011 ; 34(4): 295–302. doi:10.1016/j.ijlp.2011.07.009.

Education, empowerment and community based structural reinforcement: An HIV prevention response to mass incarceration and removal☆

Jeffrey Draine[a,*], **Laura McTighe**[b], and **Philippe Bourgois**[c]

[a]School of Social Policy and Practice, University of Pennsylvania, 3815 Walnut Street, Philadelphia, PA 19104, USA

[b]Founding Director of Prison Services, Philadelphia FIGHT, and doctoral student, Department of Religion, Columbia University, Columbia, USA

[c]Department of Anthropology, University of Pennsylvania, Pennsylvania, USA

Abstract

In the context of US urban jails, incarceration is often seen as an opportune intervention point for prevention interventions in public health. For the detained individual, it is an opportunity to reflect on individual choices and the potential for changes in one's life course. For population focused public health professionals, jail detention facilities represent a concentration of health risks, and an opportunity to have an impact on a significant portion of those at risk for HIV and other health concerns. This paper presents an innovative education and empowerment model that bridges across jail walls, beginning on the inside, and continuing on the outside of jail where individuals continue to be challenged and supported toward positive health and social choices. The intervention also seeks to foment community activism in the communities to which jail detainees return, thus aiming to have a structural impact. This paper examines both the intervention model and the challenges of examining the effectiveness claims for the intervention at multiple levels.

Keywords

Jail; HIV prevention; Empowerment; Intervention research

In the US, the dominant interest of the jail is to maintain order under the constant threat of chaos. Each day hundreds of people will enter through the doors of large urban jail systems, transferred from district police stations for failure to make bail. The vast majority will only be held for a few days, moving quickly during their confinement from intake to cellblocks to make room for the next day's admissions. Any public health concern is subsumed to this more pressing concern for order in a system where security is the highest priority. Substance use, HIV prevention, mental illness, TB, HCV, and other health issues are addressed to the extent that they help the jail maintain order and adhere to constitutionally determined demands for adequate treatment. Jail administrators are rarely interested in case-finding for health problems that they will then be called upon to address. Moreover, jail detainees will often avoid being identified with a health problem. A detainee may be in jail for a day or for

☆The authors gratefully acknowledge the contributions of Jane Shull, Hannah Zellman, and John Bell, along with countless individuals who have participated in TEACH and Support Center for Prison Advocacy efforts. Funding: NIDA grant R01-DA027204.

*Corresponding author. jeffdraine@gmail.com (J. Draine).

months before a trial or a hearing on a probation violation. The typical detainee does not want any further complications to the chances that they may be released earlier rather than later.

Enter into this arena the community healthcare organization delivering HIV prevention, psychiatric or substance abuse services. How does the public health community identify and serve this especially vulnerable population in such a logistically punitive, complex, security driven setting? Many in jail are detained on substance abuse related charges, either directly or indirectly, i.e. activities related to income generation for drug purchases, enforcement of debts, control of sale turfs, or judgment impaired by intoxication. Typically, public health interventions in jail systems focus on professional case management to facilitate linkages to treatment and services (Jacob-Arriola, Braithwaite, Holmes, & Fortenberry, 2007; Needels, James-Burdumy, & Burghardt, 2005; Richie, Freudenberg, & Page, 2001; Sorensen et al., 2003). There are several weaknesses of this approach in the jail setting. Most importantly, it presumes a case manager's mastery over the flow of people through jails that most in this role cannot possess. The majority of referrals to a formal case manager will involve a referral process longer than modal jail stay, which is 2 days in the Philadelphia jails, for example, much shorter in others. While case managers may be helpful guides for people already in a service system, the formal casework structure has significant limitations as a response to public health problems in jail.

These limitations might be addressed by interventions geared to fit the flow of people through the jail, and capitalize on the “window of opportunity” of a “teachable moment” of personal crisis that is generated by being locked up, even if just for a day. Ideally, such interventions would be readily accessible inside jail, and delivered in a manner that could reach the population at risk in a form that did not require the individual to identify as a client or patient of health services while in jail. Such interventions might use the teachable moment of arrest to instill immediately useful knowledge about service access, HIV prevention, and how to usefully express needs and advocate for needed services and rights. In turn, such knowledge and advocacy might lead to greater access to services after release.

After a decade of engagement in jail-based public health, Philadelphia FIGHT, an AIDS Services Organization, has developed such an education, advocacy, and activism intervention, called TEACH Inside, TEACH Outside, or “TITO”, which is currently being tested for prevention effectiveness. The goals of TITO are to create an educational experience that delivers the following four messages: *you can live a healthy life, services are available to support you, activist work has put this in place, and you can be an activist for yourself and your community*. TITO uses two ongoing group meetings, TEACH Inside for participants in jail, and one ongoing TEACH Outside group, led by the same instructors, for TEACH Inside participants after release. This implementation aims to provide a seamless membership on both sides of the jail wall in a supportive, empowerment-based education intervention that supports healthy living to reduce substance use and HIV risk and violence and promote mental and physical health. Moreover, TITO strives to teach participants to advocate for needed health and social services and facilitate access to legal employment and supportive alternative social networks to ongoing substance abuse, crime, and violence. Co-led by service providers and peer leaders, the program uses an intentionally uplifting format that builds and encourages mutual support and community based activism. In so doing, TITO aims is to change perceptions of behavioral control by empowering individuals to plan and take action towards reducing their risk of HIV infection and advocating for their rights as citizens. In this peer-driven and activism-infused model, TITO participants learn that people like themselves can make changes that reduce their own risk for HIV and arrest; that they can help others do this as well; and that people like them have extricated themselves

from lives destabilized by substance abuse, violence, and crime by giving back to their communities as activists and advocates.

While innovative, such an intervention would not necessarily warrant a paper in a journal, except that the TITO model takes its model a step further, into structurally based community organizing in the neighborhoods most impacted by mass incarceration through the removal of community members by jail detention. The pivotal role of incarceration in exacerbating disparate sex ratios and facilitating concurrent intimate relationships has been widely identified in the public health literature as a root cause of community-level HIV vulnerability. Incarceration also interrupts continuity of care in services for mental illness, and in most cases, causes the cessation of health insurance and income benefits that are often onerous to reinsitute after jail, thus further interrupting needed supports and care for multiple health concerns. However, research is still needed to translate this analysis into a theoretical frame for intervening in the structural environment to reduce incarceration-related health disparities (Clear, Rose, & Ryder, 2001; Pouget, Kershaw, Niccolai, Ickovics, & Blankenship). This paper aims to present a framework that supports this model of interactive, structural intervention combining direct intervention in jails with community action (Auerbach, Parkhurst, Caceres, & Keller, 2009). It also aims to make a case that this is a more effective level of intervention than the dominant framework currently used, which focuses on individualistic casework and clinical intervention to change individual thinking and behavior, while leaving structural insecurities unaddressed.

1. From individualized HIV risk in prison to incarceration-related HIV structural

The rate of incarceration in the US has grown fivefold since 1970, a growth trajectory and rate that is unprecedented in the recorded history of criminal incarceration. This represents a natural experiment in social policy in the US on a scale that is unprecedented in its impact on individuals and communities (Garland, 2001; Whitman, 2003). In cities, high arrest rates are concentrated by neighborhood (Clear et al., 2001). The impact on the health and social stability of poor communities represents an urgent public health concern that is only now beginning to be understood (Freudenberg, 2001). In particular, epidemiological evidence documents that vulnerability to HIV infection in city neighborhoods is increased by incarceration through the: impact on social networks; interference in intimate partnerships; dislocation of households and housing arrangements; removal of young men and women from neighborhoods and families during their prime years for economic activity (Maruschak, 2006; Marushak, 2005; Pouget, Kershaw, Niccolai, Ickovics, & Blankenship, 2010; Rich et al., 1999); and entanglement in the prolonged systems of probation and parole (Belenko, Langley, Crimmins, & Chaple, 2004; Martin, O'Connell, Inciardi, Surratt, & Beard, 2003).

In addition to the community level impact, incarceration on this scale can change individuals as well (Pettit & Western, 2004). Qualitative research suggests that incarceration is increasingly interpreted as a “normal” rite of passage among poor young men and women (Alexander, 2010; Tonry, 2011). Undergoing this rite provides an initiation into a life on the street memorably documented in Philadelphia by Elijah Anderson (Anderson, 1999; Comfort, 2007). High rates of recidivism result in this life, providing a sense of belonging to a community network of friends and partners in crime that becomes more accessible, appealing and economically viable than the connections supported in mainstream life. Incarceration, thereby, tends to increase the chances of arrest and re-incarceration, which further isolates already disenfranchised people from jobs, schools, family and other healthy and supportive attachments (Bourgois, 2003). Individuals become adapted to a street life that discourages reaching out to either formal services or social ties associated with positive

healthy growth and reduced risk for HIV. In the long run, this isolation leads to a sense of social and personal disempowerment that can fuel risky behavior (*Criminal Justice/Mental Health Consensus Project*, 2002; Haney, 2003). For these reasons, the US experience of mass incarceration has been recently called the "new Jim Crow" (Alexander, 2010).

Through this combination of mutually reinforcing social and behavioral influences, incarceration becomes linked to increased risk for HIV infection (Arriola et al., 2001; Belenko et al., 2004; Inciardi, 1996; Needels et al., 2005; Richie et al., 2001). Recent research on how to reduce this HIV risk is less focused on behavior of individuals before, in, and after jail and prison, and more focused on the resources available through social networks and opportunity in communities on the outside (Edlin et al., 1994; Freudenberg, Galea, & Vlahov, 2005; Marlow, White, Tulsky, Estes, & Menendez, 2008). This undergirds a shift away from individualizing interventions to structural interventions, which are premised on the concept of fundamental cause, as cogently elucidated by Link & Phelan (Blankenship, Friedman, Dworkin, & Mantell, 2006; Link & Phelan, 1995). Using this framework, social determinants are understood to be the fundamental cause of disease in disadvantaged communities. Incarceration arguably represents an important social determinant of disease in the US today (Draine, Salzer, Culhane, & Hadley, 2002). As a result, structural interventions have at least two advantages over individual case based interventions. Because they address more fundamental structurally-rooted causes, they can address both the targeted disease condition (for instance HIV) while also addressing risk for other conditions (such as acute mental illness, HCV, TB, violence). Second, because they position intervention to influence the environment of vulnerability as opposed to individual micro-behaviors, they have structural capacity to impact larger populations of those at risk (Auerbach et al., 2009; Blankenship et al., 2006).

The scale of the problem of incarceration and HIV risk is impressive, especially at the local level of large urban jails. While over 900,000 individuals are leaving state and federal prisons and returning to the community every year (Petersilia, 2003; Visher & Travis, 2003), this figure is dwarfed by the approximate 9 million or more releases from local jails each year (Freudenberg, Daniels, Crum, Perkins, & Richie, 2005; Spaulding et al., 2009). Along with arrest, time in jail is one of the universal experiences of people exposed to the criminal justice system. To a far greater degree than prisons, jails are porous facilities engaged in dynamic interactions with their communities, much like emergency rooms, shelters, or train stations. Transition through jail facilities impacts the social and economic health of their communities, and more directly, the health of those who are brought into and released from jails. One in seven of all HIV-infected Americans pass through the U.S. correctional system annually (Braithwaite & Arriola, 2003; Hammett, Harmon, & Rhodes, 2002; Spaulding et al., 2009), and that 40% of a sample of individuals with HIV was in jail at some point over a 3 year period (Freudenberg, 2001). Furthermore, it is estimated that 77% of those who are arrested are under the influence of drugs or alcohol at the time of arrest (James, 1988; Teplin, 1994). Among those in jail with HIV, 85% of those infections are linked to intervenous drug use (IDU) (Vlahov & Putnam, 2006).

2. Finding people in jail

Jails provide a field for prevention intervention for especially vulnerable substance users at risk for HIV. Using jails as such a locus in interaction with the community, however, remains underdeveloped. Specifically in the jail environment, casefinding has not adequately been linked with continued care and with linkage to services and supportive networks in the community (White, Tulsky, Estes, Jamison, & Long, 2008). People at risk for HIV and HCV infection, or exacerbation of their mental illness, most of whom are substance users, are in the jails in disproportionately high numbers. Both the entry into and

the exit from jail represent a clear opportunity to identify people, initiate support for linkages, and provide for continuity of care during the transition back to the community (Freudenberg, 2006; Springer & Altice, 2005; Vlahov & Putnam, 2006; White et al., 2008).

Inmates leaving prisons have proved capable of successful follow up with health care in the community, if provided adequate supports (Jacob-Arriola et al., 2007; Rich et al., 2001). Does this evidence base from prison translate to the more chaotic, and transitory nature of jail incarceration? In prison settings, there is more stability and greater opportunity for case managers to plan for release and for case managers to make preliminary connections with community treatment. However, jails tend to be more inconducive to building a working relationship with case managers. Furthermore, the unpredictable releases complicate planning for aftercare and for service access on the outside.

3. From passive recipient of individualizing services to community-based structural empowerment through structural critique and health-promotion activism

While case management can be helpful for vulnerable individuals who are already in a system of care, it has limitations in the chaotic environment of jail entry and community reentry. The case manager's authority is their knowledge of a bureaucratic system of care, with multiple mechanisms for controlling access to scarce resources. It is provided as an individualized service by an authoritative expert professional, where issues and problems are conceptualized within the individual who seeks help. The intervention cannot begin in earnest until a one-on-one client relationship is established. While such a relationship may provide support and aid to clients, this model can also have elements that reinforce passivity and disempowerment in people who are already vulnerable in multiple ways. Furthermore, jail inmates often distrust authorities due to lives of social marginalization and repeatedly coercive mistreatment. In the context of the justice system, case management can unintentionally feed into a system of compliance demands that reinforce inmates' identities as an ‘offender.’ Many clients of substance abuse and social service programs refer to their time in post-release programs as an extension of “doing time” freeing which they continue to lack the liberties to make their own choices about how to spend their free time (Marlowe, 2006).

These mutually reinforcing dynamics of perceived coercion further build on the disempowerment associated with incarceration in general. Reentry to society from prison or jail often also means reentry into social circumstances and struggles that are complicated by difficult family relationships, violent interpersonal networks, economically deprived neighborhoods, perceived personal failings, and resignation to few options other than returning to chronic habits that may lead back to arrest. This is one of the most stressful transitions we impose on citizens in our country, even when that transition is not complicated by substance abuse and other health vulnerabilities. People reentering these circumstances after leaving incarceration have left one of the only institutionalized settings in our society that is explicitly designed to disempower and punish a citizen, coercively depriving them of their liberty in a purposefully hostile environment (Haney & Zimbardo, 1998). Some have argued that over the last 30 years, the increase in punitive measures and the decreased emphasis on rehabilitation inside correctional facilities have exacerbated this experience of disempowerment, further training individuals to be reliant on the power of others for the most basic needs of everyday life while cutting them off of resources to develop self-reliance and skills for healthy living (Clear et al., 2001; Golembeski & Fullilove, 2008; Haney, 2003). For these reasons, planning effective intervention for jail reentry is more complicated than simply referring inmates to health and social services like

so many pieces on a game board. To increase the resourcefulness of individuals leaving jail toward greater health and community integration and to increase their trust in the utility of accessing services, we need to both provide meaningful support for this stressful time and address the experience of disempowerment that occurs during arrest and incarceration.

To this end, a recent perspective in criminal justice, the good lives model, follows a similar line of reasoning as found in the concept of recovery in substance abuse. Both express dissatisfaction with a clinical focus on individuals in isolation from their structural problems and problematic life circumstances (Ward & Maruna, 2007). The good lives model, like the recovery perspective in addiction, seeks to reframe outcome in terms of the changes desired and defined by the person in reshaping their life. In this model, the individual can fit their positive change into their own life circumstances (Maruna, 2002). This perspective follows on the heels of the tortured history of the concept of rehabilitation in criminal justice policy, which was largely abandoned in the 1970s and 1980s in favor of a value on security and control when the war on drugs was escalated (Garland, 2001; Martinson, 1974). However, even as some concluded that rehabilitation is ineffective when measured in the more discrete terms of intensely focused clinical services, others have optimism in a more humanistic outlook (Maruna, 2002; Toch, 2002). Such an outlook can follow broader, interlocking aspects of a person's life, including civic engagement, activism, and advocacy for those in similar circumstances (Uggen, Manza, & Behrens, 2004).

Historians and epidemiologists have provided further documentation for a structural interpretation of vulnerability to substance abuse by demonstrating that there are large-scale, long-term patterns to drug abuse across history and that these are shaped by social inequalities (Agar & Reisinger, 2002; Bourgois, 2003; Bourgois & Schonberg, 2010; Courtwright, 2001; Golub & Johnson, 1999). Vulnerability to substance abuse, violence, engagement in criminal activity, and risk taking can be seen as expressions of politically structured suffering that has been imposed by larger, socially significant social power categories and vectors (ranging from institutional politics such as punitive rather than rehabilitative incarceration, daily experiences of discrimination, exclusion from the labor market, cultural capital barriers to services, and various other forms of structural violence). Economic, ideological, and institutional power relations shape risky practices at the level of the individual (Bourgois, 2002; Bourgois, 2003; Bourgois, Lettiere, & Quesada, 1997). This approach has been instrumental in developing the concept of risk environment in the field of HIV prevention (Jewkes, 2002; Pronyk et al., 2006; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005; Rhodes, Stimson, & Quirk, 1996). The TITO intervention as implemented by Philadelphia FIGHT uses this perspective, informed by the consciousness raising educational approaches associated with Paulo Freire (Freire, 1970) and reinforced by educational initiatives with incarcerated populations such as those documented by Michelle Fine (Fine et al., 2001), to reduce risk behavior among individuals by instilling in them a sense of empowerment and mobilizing them around community-based activism and social change in the context of individual healthy practices.

4. Positioning an empowerment and activism based intervention

The limitations of services like case management could be ameliorated by other, empowerment and education based interventions. An alternative is to design an intervention around the shared experience of jail reentry, rather than on relationships with professionals. Thus, the intervention is conceptualized as among individuals with common experiences who reinforce positive living strategies while also supporting one another in accessing needed services and action to improve the circumstances of all in like circumstances with similar aspirations (Ghose, Swendeman, George, & Chowdhury, 2008). To this end, TITO is positioned as a bridge from the jail experience to community reentry. Jail incarceration

serves as a personal crisis that may generate a teachable moment, perhaps even for those incarcerated many times before.

As represented in Fig. 1, TITO is conceptualized as a community-level intervention to provide a bridge from the jail to interlocking community ties for sustained healthy living. The TITO inside and outside elements are connected through a process of continuous engagement to alter the structural environment of HIV vulnerability—inreach into the jail and outreach into the community after release. In the TITO intervention boxes, the mechanisms for change are empowerment and activism. We expect that outcome should be mediated through individual growth in empowerment and advocacy behavior (both self advocacy and generalized advocacy). The outcomes of TITO are expressed as interdependent areas of community life. While not amenable to complete statistical testing, it does presage testing of moderating relationships among these realms along with strategic qualitative investigation of client experiences in TITO.

5. Development of TITO

While the TITO intervention easily maps onto, and was indeed informed by, a growing consensus in the research community around structural drivers of HIV vulnerability, it is important to note that the parent organization, Philadelphia FIGHT, was founded in the early days of the AIDS epidemic when the intertwining of research advocacy and service provision was assumed. Project TEACH (“Treatment Education Advocates Combating HIV”), Philadelphia FIGHT's hallmark program of education and empowerment, was originally launched in 1996 to train people with HIV in the skills of treatment and research advocacy, especially those with recent diagnoses. In Spring 2000, a group of activists, including HIV+ former prisoners, joined to develop a training program for the most vulnerable of Philadelphia FIGHT's client base: people with HIV who were recently released from jail. Leadership for this new TEACH initiative was provided by the second author, Laura McTighe, and formerly imprisoned HIV+ activist John Bell, who also collaborated a decade later to develop the TITO intervention explored in this paper. To address the concerns of this jail-removal-reentry loop for people with HIV, these organizers sought to help people through the lonely and confusing transition back home while also developing activists to win improved conditions for others living with HIV who are still behind bars or recently released. The result was the creation of TEACH Outside, a 5 week version of the TEACH intervention targeted to people recently out of jail. Most TEACH Outside participants enrolled within weeks of being released from jail. Many found out their HIV status while incarcerated, had little understanding of HIV, and had no support systems on the outside.

TEACH and, to a large measure, TEACH Outside were both built around the “teachable moment” of a recent HIV diagnosis, which motivated participants to engage the intervention. In creating TITO, the challenge was to develop a prevention-based motivation around another teachable moment: incarceration. Such a prevention intervention would need to establish the reality of the TEACH messages when a recent HIV diagnosis had not created a health crisis for individuals. To fully capitalize on the teachable moment of incarceration, the developers of TITO felt that the program needed to step into the jail-removal-reentry loop, and immerse participants in a process of collective reflection while inside the jail. Participants needed to be able to imagine new futures for themselves while they were still incarcerated, and they needed to develop solid mentoring relationships with former prisoners like them who were engaged in activist work in their communities. These principles grounded the launch of TITO in 2010.

Logistically, this meant engaging jail detainees in their first days of incarceration. The majority of jail-based programs are built around the stable jail populations consisting of people who have been detained long enough to be identified, referred, and inducted into a program. Like case management programs, such a strategy is systematically biased against the majority of jail detainees who are in jail less than a week, and most frequently less than a day or two (Draine, Blank Wilson, Metraux, Hadley, & Evans, 2010). TITO's engagement is purposefully set on the intake units of the Philadelphia jails, where detainees are waiting clearance for general population by the jail officials. Following this model, those in jail for even just one day can be introduced to the basic TEACH intervention, and given an invitation to the program's outside supports after release.

Through TITO in the Philadelphia jails, participants and program staff are immediately engaged in a process of collective reflection, structured in such a way as facilitate the development of positive living strategies, and group strategizing around how to access needed services and take action to improve the circumstances of others in similar situations. This is consistent with empowerment based interventions in the HIV prevention literature (Campbell & MacPhail, 2002; Ghose et al., 2008; Latkin, 1998). This foundation is crucial for ensuring that participants have the personal empowerment and community support necessary to make a successful transition out of incarceration and to stay connected with TITO in the community.

Critical to this formulation of TITO is the understanding that jail incarceration serves as a personal crisis that may generate a teachable moment, perhaps even for those incarcerated many times before. At the risk of minimizing the harshness of jail conditions, many TEACH Outside graduates describe jail as a break from the day-to-day street life hustle that brings with it the added benefit of a relatively safe place to sleep and three regular meals. Yet, with the exception of this respite from what is so taxing about street life, jails offer little in the way of support for people who might be open to pursuing a different way forward after release. Programming is at a minimum, and the programming that does exist is generally designed to keep people busy in order to maintain order and minimize security threats. Missing are programs that work with people in jail to help them imagine futures beyond street life punctuated by jail incarcerations, and provide them with the advocacy skills to create the lives they want to live, as well as the knowledge to keep themselves and their loved ones healthy.

TITO is designed to step into this teachable moment, offering evidence that things *can* change, the skills to realize these changes in their lives, and community support that continues throughout their transition back to the community. This is done through both the content and the format of TITO. Co-led by service providers and peer leaders, TITO embodies a model of community health where all people are working together for the betterment of their communities. As such, the program format establishes as normative the values of empowerment and mutual support. This TITO format is reinforced by a curriculum organized around four simple messages: *you can live a healthy life, services are available to support you, activist work has put this in place, and you can be an activist for yourself and your community*. Thus, the program content seeks to establish as reality the attitudes that will enable people to not only make healthy decisions about their lives, but also to act as agents of change in their communities upon release.

1. *You can live a healthy life.* Participants might be versed in some of the basics of HIV transmission, but the social forces in their lives have often made it difficult, if not impossible, for them to prioritize taking steps to protect their health. Moreover, participants are often struggling with extensive histories of trauma for which substance use has often been their only coping strategy. TITO sessions break down health topics and connect these to participants' life issues. For HIV transmission,

the group discusses the myths people have heard, what body fluids can actually transmit HIV, why people engage in risky behavior, and what it would take incorporate HIV-risk reduction strategies into their lives. Furthermore, TITO emphasizes how to educate the people who are close to them. In addition, TITO groups discuss the struggles that have often fueled people's addictions, strategies for getting the support they need around these past traumas, strategies for seeking support around future issues, and how to begin the process of making amends with people they have hurt/have hurt them.

2. *Services are available to support you.* Participants have numerous negative experiences of trying and failing to access services. Their mistrust of the social service system is based in their frequent experiences of waiting hours at clinics to see a doctor, seeing case managers who drop their cases without notice, and dealing with case workers who send them across the city for a piece of paper they did not need in the first place. Moreover, they are wading through decades of tough on crime policies designed to limit their access to these social services, and prevent them from getting needed financial support. On top of that, when they are released, they are also responsible to parole officers who often set infeasible conditions that are backed with a threat of returning to prison for noncompliance (Draine & Solomon, 2001). During TITO classes inside the Philadelphia jails, peer leaders talk about services and their tried and true strategies for dealing with red tape and bureaucracy. During TITO classes in the community, trusted service providers are invited to talk about how to navigate the social service system, including case managers to give an overview of the social service system, legal aid attorneys to talk about navigating the system with a record, and parole officers (POs) to what POs care about, what they can ignore, when POs have flexibility, and which city official can clear up the issues participants raise.

3. *Activist work has put this in place.* Participants have rarely seen individual change in their own lives, let alone systemic change in their communities. Moreover, after years of involvement in the criminal justice system, most participants are skeptical that real change is possible. They have firsthand experience negotiating insurmountable power structures, and they have often had to settle for less than they need when the system refuses to bend. TITO classes provide an oral history of the numerous instanced in which activists have fought for the needs of their communities and won. Leaders share personal stories of becoming involved in activist work, overcoming fears and misgivings, and initiating activist projects.

4. *You can be an activist for yourself, and your community.* Participants often carry very real fears about getting involved in activist work, including the possibility of getting arrested at a demonstration, or the possibility of being rejected by their communities if they speak out openly about health issues due to stigma around HIV and addiction. TITO helps participants think about the skills and qualities they bring to activist work, and how they can put these to work in making change in their communities. Additionally, during TITO classes in the community, former participants are invited to speak about their involvement in activist work. Most importantly, they ask current participants to *join them*.

Once released, TITO participants are welcomed into the dynamic network of the Philadelphia FIGHT treatment and education community. Interventionists meet with participants to discuss their incarceration and the most pressing challenges facing them on the outside. Participants are enrolled in the in-community TITO group session, a more comprehensive group empowerment program focused on the same curricular messages as the in-jail TITO intensive. TITO outreach workers continue to provide individualized support and strategy sessions. Upon completion of the in-community group sessions, TITO

participants are invited to participate in an ongoing program alumni support and activism group.

6. Activism capacity and capability

Once individuals are involved in TITO, they are the subjects of an intensive engagement process that includes peer activists recently out of jail, professional intervention workers, and community members. TITO staff members help ensure connections to family members after jail release and keep information lines working between TITO participants, the program, and ties to family and community. It is this level of engagement which has the potential to increase the likelihood that the TITO messages concerning community activism will be initially activated in community settings. It also provides a real opportunity for participants to practice the activism to an extent that may find reward affecting change by building new supports in the community.

7. A community-level “resource center without walls”

The TITO messages for health and activism are further supported by Philadelphia FIGHT's community organizing efforts in the neighborhoods of the city most impacted by incarceration and removal of community members. Launched with the aim of creating a citywide “Resource Center without Walls,” the Support Center for Prison Advocacy (SCPA) is a citywide coalition through which the TITO developers and participants work in tandem with faith leaders, health advocates, and neighborhood community organizers. As such, the SCPA provides a forum for the messages of health and activism to become reinforced by real, accessible opportunities to act on both. The traveling “Resource Center without Walls” meetings are attended by community members, staff of service providers, city officials, and community leaders from civic and faith organizations. At one recent meeting, an area pastor addressed a large crowd on the topic of getting a job with a record. He rose, wearing his clerical collar, and recounted that he had earned college, ministerial and doctoral degrees, and currently served as an established leader in his community. However, things that he did 40 years ago remain on his record; if for some reason he had to look for work now, his record would still haunt him today, regardless of what accomplishments he had to show. A powerful anecdote, the pastor's words were no mere testimony of personal inspiration. Rather they embody the SCPA's three-fold intervention into the structural environment of neighborhoods most affected. First, the “Resource Center without Walls” identifies leaders, like this pastor, who can stand and speak from experience concerning the impact of mass incarceration on their lives. Second, the SPCA highlights these leaders as examples of success for others with criminal records, thereby opening channels for neighborhood-based support and mentoring. Finally, these leaders' personal trials are answered with a systemic analysis of the policies impacting those with criminal records and a call to action for attendees, many of whom are veterans of TEACH Outside, TITO, and other prison and jail reentry efforts.

8. Researching the effectiveness of TITO

Socially complex interventions are notoriously difficult to study in conventional randomized trials (Wolff, 2000, 2001). Even so, as with any research endeavor, there is value to the process of attempting to accumulate evidence for effectiveness of TITO, even more so using the most widely accepted research methods available to strengthen the integrity of research findings. Our strategy in examining the effectiveness of TITO was to break away from the conventional logic of “controlling” the complexity of the intervention and thus limiting what could be found to one or two very limited hypotheses. Rather, we embraced the complexity with complimentary research methods in active and ongoing dialog (Agar, 1996, 1997; Bourgois, 1998, 1999; Carlson & Cervera, 1992; Clatts & Sotheran, 2000; Leshner, 1998;

Marshall, 1999; Sterk-Elifson, 1995). Randomized trial methods direct the collection of outcome data to test the most basic question of effectiveness toward the specific outcomes of reduced risk behavior and reduced likelihood of jail recidivism. Meanwhile, ethnographic methods serve to develop our understanding of how and why the social processes unfold in the context of the intervention. This qualitative analysis could lead to the development of new inquiry areas that can be operationalized quantitatively. For example, based on ethnographic observation, a quantitative item was added to a San Francisco area HCV incidence study among youth injectors to document the risks caused by participation in the moral economy. The new item "pooling money to buy drugs" proved to be the strongest risk factor for HCV seroconversions (Hahn et al., 2002). Likewise, quantitative hypotheses are practically meaningless without the conceptual narratives that contextualize them and develop theoretical understanding concerning what they mean. Early results from the ethnographic work on this project have revealed tensions between the ideal model as proposed here, and the formidable task of integrating an intervention based on an empowerment message into a security state-based apparatus such as the intake units of a large city jail. These challenges will be faced anywhere, though the particulars at each location will differ. The methodological challenge is to use what we know about these environments, and the experience in this environment in particular, to know what will inform the development of such interventions in other settings.

This is particularly important with regard to the elements of the TITO intervention having to do with activism. As evidenced by Fig. 1, the elements of the TITO model outside the jail are the least specified in conventionally measured and conceptualized ways. Yet, these are also among the most unique aspects of the TITO model when compared to other jail reentry research, and thus hold the potential to offer some of the richest new contributions to the research literature on structural HIV prevention interventions, jail and prison reentry, and behavioral health interventions more generally. As public health research becomes increasingly concerned with addressing the social determinants of health, all elements of the TITO research design—both those related to the randomized trial largely reflected on the left side of the model, and those related to qualitative assessments of activism and social integration captured on the right side of the model—will contribute valuable evidence concerning strategies for effectively intervening in politically structured social environments to reduce imprisonment-related HIV vulnerability and other health disparities such as those related to mental illness, other health conditions, and substance use.

References

Agar M. Recasting the "ethno" in "epidemiology". Medical Anthropology. 1996; 16(4):391–403. [PubMed: 8628120]

Agar M, Reisinger HS. A heroin epidemic at the intersection of histories: The 1960s epidemic among African Americans in Baltimore. Medical Anthropology. 2002; 21(2):115–156. [PubMed: 12126273]

Agar MH. Ethnography: An overview. Substance Use & Misuse. 1997; 32(9):1155–1173. [PubMed: 9261916]

Alexander, M. The New Jim Crow: Mass incarceration in the age of colorblindness. New York: The New Press; 2010.

Anderson, E. Code of the street: Decency, violence, and the moral life of the inner city. New York: W. W. Norton; 1999.

Arriola KR, Braithwaite RL, Kennedy S, Hammett T, Tinsley M, Wood P, et al. A collaborative effort to enhance HIV/STI screening in five county jails. Public Health Reports. 2001; 116(6):520–529. [PubMed: 12196611]

Auerbach, JD.; Parkhurst, JO.; Caceres, CF.; Keller, KD. Addressing social drivers of HIV/AIDS: Some conceptual, methodological, and evidentiary considerations. New York: 2009. aids2031o. Document Number

Belenko S, Langley S, Crimmins S, Chaple M. HIV risk behaviors, knowledge, and prevention education among offenders under community supervision: A hidden risk group. AIDS Education and Prevention. 2004; 16(4):367–385. [PubMed: 15342338]

Blankenship KM, Friedman SR, Dworkin S, Mantell JE. Structural interventions: Concepts, challenges and opportunities for research. Journal of Urban Health. 2006; 83(1):59–72. [PubMed: 16736355]

Bourgois P. The moral economies of homeless heroin addicts: Confronting ethnography, HIV risk, and everyday violence in San Francisco shooting encampments. Substance Use & Misuse. 1998; 33(11):2323–2351. [PubMed: 9758016]

Bourgois P. Theory, method, and power in drug and HIV-prevention research: A participant–observer's critique. Substance Use & Misuse. 1999; 34(14):2155–2172. [PubMed: 10573309]

Bourgois P. Anthropology and epidemiology on drugs: The challenges of cross-methodological and theoretical dialogue. The International Journal on Drug Policy. 2002; 13(4):259–269.

Bourgois, P. In search of respect: Selling crack in El Barrio. 2nd ed.. New York: Cambridge University Press; 2003.

Bourgois P, Lettiere M, Quesada J. Social misery and the sanctions of substance abuse: Confronting HIV risk among homeless heroin addicts in San Francisco. Social Problems. 1997; 44(2):155–173.

Bourgois, P.; Schonberg, J. The useless suffering of aging homeless heroin injectors. In: Besteman, C.; Gusterson, H., editors. What's wrong with America. Berkeley: University of California Press; 2010. p. 238-254.

Braithwaite RL, Arriola AR. Male prisoners and HIV prevention: A call for action ignored. American Journal of Public Health. 2003; 93(5):759–763. [PubMed: 12721138]

Campbell C, MacPhail C. Peer education, gender and the development of critical consciousness: Participatory HIV prevention by South African youth. Social Science & Medicine. 2002; 55(2): 331–345. [PubMed: 12144146]

Carlson BE, Cervera N. Inmates and their wives: Incarceration and family life. 1992

Clatts M, Sotheran J. Challenges in research on drug and sexual risk practices of men who have sex with men: Applications of ethnography in HIV epidemiology and prevention. AIDS and Behavior. 2000; 4(2):169–179.

Clear T, Rose DR, Ryder JA. Incarceration and community: The problem of removing and returning offenders. Crime and Delinquency. 2001; 47(3):335–351.

Comfort, M. Doing time together: Love and family in the shadow of the prison. Chicago: University of Chicago Press; 2007.

Courtwright, DT. Forces of habit: Drugs and the making of the modern world. Cambridge: Harvard University Press; 2001.

Criminal Justice/Mental Health Consensus Project. New York: Council of State Governments Document Number; 2002.

Draine J, Blank Wilson A, Metraux S, Hadley T, Evans AC. The impact of mental illness status on the length of jail detention and the legal mechanism of jail release. Psychiatric Services. 2010; 61(5): 458–462. [PubMed: 20439365]

Draine J, Salzer MS, Culhane DP, Hadley TR. Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. Psychiatric Services. 2002; 53(5):565–573. [PubMed: 11986504]

Draine J, Solomon P. Threats of incarceration in a psychiatric probation and parole service. The American Journal of Orthopsychiatry. 2001; 71(2):262–267. [PubMed: 11347368]

Edlin BR, Irwin KL, Faruque S, McCoy CB, Word C, Serrano Y, et al. Intersecting epidemics—Crack cocaine use and HIV infection among inner-city young adults. Multicenter Crack Cocaine and HIV Infection Study Team. The New England Journal of Medicine. 1994; 331(21):1422–1427. [PubMed: 7969281]

Freire, P. Pedagogy of the oppressed. New York: Continuum International; 1970.

Fine, M.; Torre, ME.; Boudin, K.; Bowen, I.; Clark, J.; Hylton, D., et al. Participatory action research: Within and beyond prison bars. In: Camic, P.; Rhodes, JE.; Yardley, L., editors. Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design. Washington, D.C: American Psychological Association; 2001.

Freudenberg, N. Jails, prisons, and the health of urban populations: A review of the impact of the correctional system on community health. 2001.

Freudenberg, N. Coming home from jail: A review of health and social problems facing US jail populations and of opportunities for reentry interventions. Washington, DC: Jail Reentry Roundtable Initiative, Urban Institute; 2006.

Freudenberg N, Daniels J, Crum M, Perkins T, Richie BE. Coming home from jail: The social and health consequences of community reentry for women, male adolescents, and their families and communities. American Journal of Public Health. 2005; 95(10):1725–1736. [PubMed: 16186451]

Freudenberg N, Galea S, Vlahov D. Beyond urban penalty and urban sprawl: Back to living conditions as the focus of urban health. Journal of Community Health. 2005; 30(1):1–11. [PubMed: 15751595]

Garland, DL. The culture of control: Crime and social order in contemporary society. Chicago: University of Chicago Press; 2001.

Ghose T, Swendeman D, George S, Chowdhury D. Mobilizing collective identity to reduce HIV risk among sex workers in Sonagachi, India: The boundaries, consciousness, negotiation framework. Social Science & Medicine. 2008; 67(2):311–320. [PubMed: 18455855]

Golembeski C, Fullilove R. Criminal (in)justice in the city and its associated health consequences. American Journal of Public Health. 2008; 98(9 Suppl):S185–S190. [PubMed: 18687612]

Golub A, Johnson B. Cohort changes in illegal drug use among arrestees in Manhattan: From the heroin injection generation to the blunts generation. Substance Use & Misuse. 1999; 34(13):1733–1763. [PubMed: 10540971]

Hahn J, Page-Shafer K, Lum P, Bourgois P, Stein E, Evans J, et al. Hepatitis C virus seroconversion among young injection drug users: Relationships and risks. Journal of Infectious Disease. 2002; 186(11):1558–1564.

Hammett TM, Harmon MP, Rhodes W. The burden of infectious disease among inmates of and releasees from US correctional facilities, 1997. American Journal of Public Health. 2002; 92(11): 1789–1794. [PubMed: 12406810]

Haney, C. The psychological impact of incarceration: Implications for postprison adjustment. In: Travis, J.; Waul, M., editors. Prisoners once removed: The impact of incarceration on children, families, and communities. Washington, D.C.: The Urban Institute Press; 2003.

Haney C, Zimbardo P. The past and future of U.S. prison policy. Twenty-five years after the Stanford prison experiment. American Psychologist. 1998; 53(7):709–727. [PubMed: 9699456]

Inciardi JA. HIV risk reduction and service delivery strategies in criminal justice settings. Journal of Substance Abuse Treatment. 1996; 13(5):421–428. [PubMed: 9142672]

Jacob-Arriola KR, Braithwaite RL, Holmes E, Fortenberry RM. Post-release case management services and health-seeking behavior among HIV-infected ex-offenders. Journal of Health Care for the Poor and Underserved. 2007; 18(3):665–674. [PubMed: 17675721]

James DV. Prison, mental illness, and identity. Lancet. 1988; 2(8624):1371. [PubMed: 2904091]

Jewkes R. Intimate partner violence: Causes and prevention. Lancet. 2002; 359(9315):1423–1429. [PubMed: 11978358]

Latkin CA. Outreach in natural settings: The use of peer leaders for HIV prevention among injecting drug users' networks. Public Health Reports. 1998; 113 Suppl 1:151–159. [PubMed: 9722820]

Leshner AI. Comments on “The moral economies of homeless heroin addicts: Confronting ethnography, HIV risk, and everyday violence in San Francisco shooting encampments,” by Phillippe Bourgois. Substance Use & Misuse. 1998; 33(11):2369–2374. [PubMed: 9758021]

Link BG, Phelan J. Social conditions as fundamental causes of disease. Journal of Health and Social Behavior. 1995:80–94. Spec No. [PubMed: 7560851]

Marlow E, White MC, Tulsky JP, Estes M, Menendez E. Recidivism in HIV-infected incarcerated adults: Influence of the lack of a high school education. Journal of Urban Health. 2008; 85(4):585–595. [PubMed: 18418714]

Marlowe DB. When “what works” never did: Dodging the “Scarlet M” in correctional rehabilitation. Criminology and Public Policy. 2006; 5(2):339–346.

Marshall, P. An approach to ethical decision making in ethnographic research on HIV prevention and drug use. In: Marshall, PL.; Singer, M.; Clatts, MC., editors. Integrating cultural, observational, and epidemiological approaches in the prevention of drug abuse and HIV/AIDS. Bethesda, MD: U.S. Dept. of Health and Human Services National Institute on Drug Abuse Division of Epidemiology and Prevention Research; 1999. p. 223-227.

Martin S, O'Connell D, Inciardi J, Surratt H, Beard R. HIV/AIDS among probationers: An assessment of risk and results from a brief intervention. Journal of Psychoactive Drugs. 2003; 35(4):435–443. [PubMed: 14986872]

Martinson RLL. What works? Questions and answers about prison reform. The Public Interest. 1974; 35(22–54)

Maruna, S. Making good: How ex-convicts reform and rebuild their lives. Washington, D.C.: American Psychological Association; 2002.

Maruschak, L. BJS, US Dept. of Justice; 2006. HIV in prisons 2004.

Marushak, LM. BJS, US Dept. of Justice; 2005. HIV in prisons, 2003.

Needels K, James-Burdumy S, Burghardt J. Community case management for former jail inmates: Its impacts on rearrest, drug use, and HIV risk. Journal of Urban Health. 2005; 82(3):420–433. [PubMed: 16014874]

Petersilia, J. When prisoners come home: Parole and prisoner reentry. New York: Oxford University Press; 2003.

Pettit B, Western B. Mass imprisonment and the life course: Race and class inequality in U.S incarceration. American Sociological Review. 2004; 69(2):151–169.

Pouget ER, Kershaw TS, Niccolai LM, Ickovics JR, Blankenship KM. Associations of sex ratios and male incarceration rates with multiple opposite-sex partners: Potential social determinants of HIV/STI transmission. Public Health Reports. 2010; 125(Suppl 4):70–80. [PubMed: 20626195]

Pronyk PM, Hargreaves JR, Kim JC, Morison LA, Phetla G, Watts C, et al. Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: A cluster randomised trial. Lancet. 2006; 368(9551):1973–1983. [PubMed: 17141704]

Rhodes T, Singer M, Bourgois P, Friedman S, Strathdee S. The social structural production of HIV risk among injecting drug users. Social Science & Medicine. 2005; 61:1026–1044. [PubMed: 15955404]

Rhodes T, Stimson GV, Quirk A. Sex, drugs, intervention, and research: From the individual to the social. Substance Use & Misuse. 1996; 31(3):375–407. [PubMed: 8834267]

Rich JD, Dickinson BP, Macalino G, Flanigan TP, Towe CW, Spaulding A, et al. Prevalence and incidence of HIV among incarcerated and reincarcerated women in Rhode Island. Joural of Acquired Immune Deficiency Syndromes. 1999; 22(2):161.

Rich JD, Holmes L, Salas C, Macalino G, Davis D, Ryczek J, et al. Successful linkage of medical care and community services for HIV-positive offenders being released from prison. Journal of Urban Health. 2001; 78(2):279–289. [PubMed: 11419581]

Richie BE, Freudenberg N, Page J. Reintegrating women leaving jail into urban communities: A description of a model program. Journal of Urban Health. 2001; 78(2):290–303. [PubMed: 11419582]

Sorensen J, Dilley J, London J, Okin R, Delucchi K, Phibbs S. Case management for substance abusers with HIV/AIDS: A randomized clinical trial. The American Journal of Drug and Alcohol Abuse. 2003; 29(1):133–150. [PubMed: 12731685]

Spaulding A, Seals R, Page M, Matthews A, Rhodes W, Hammett T. HIV/AIDS among inmates of and releasees from US correctional facilities 2006: Declining share of epidemic but persistent public health opportunity. PloS One. 2009; 4(11)

Springer SA, Altice FL. Managing HIV/AIDS in correctional settings. Current HIV/AIDS Reports. 2005; 2(4):165–170. [PubMed: 16343373]

Sterk-Elifson, C. Determining drug use patterns among women: The value of qualitative research methods. In: Lambert, EY.; Ashery, RS.; Needle, R., editors. Qualitative methods in drug abuse and HIV research NIDA research monograph. Vol. 157. Rockville, MD: National Institutes of

Health (U.S.) & National Institute on Drug Abuse. Division of Epidemiology and Prevention Research; 1995. (pp. iv, 267)

Teplin LA. Psychiatric and substance abuse disorders among male urban jail detainees. American Journal of Public Health. 1994; 84(2):290–293. [PubMed: 8296957]

Toch H. Everything works. International Journal of Offender Therapy and Comparative Criminology. 2002; 46(2):119–122. [PubMed: 12113158]

Tonry, M. Punishing race. New York: Oxford; 2011.

Uggen, C.; Manza, J.; Behrens, A. 'Less than the average citizen': Stigma, role transition and the civic reintegration of convicted felons. In: Maruna, S.; Immarigeon, R., editors. After crime and punishment: Pathways to offender reintegration. Portland, OR: Willan; 2004.

Visher CA, Travis J. Transitions from prison to community: Understanding individual pathways. Annual Review of Sociology. 2003; 29:89–113.

Vlahov D, Putnam S. From corrections to communities as an HIV priority. Journal of Urban Health. 2006; 83(3):339–348. [PubMed: 16739034]

Ward, T.; Maruna, S. Rehabilitation. London: Routhledge; 2007.

White MC, Tulsky JP, Estes M, Jamison R, Long HL. Health and health behaviors in HIV-infected jail inmates 1999 and 2005. AIDS Patient Care and STDs. 2008; 22(3):221–231. [PubMed: 18338943]

Whitman, J. Harsh justice. Oxford: Oxford University Press; 2003.

Wolff N. Using randomized controlled trials to evaluate socially complex services: Problems, challenges and recommendations. The Journal of Mental Health Policy and Economics. 2000; 3(2):97–109. [PubMed: 11967443]

Wolff N. Randomised trials of socially complex interventions: Promise or peril? Journal of Health Services Research & Policy. 2001; 6(2):123–126. [PubMed: 11357244]

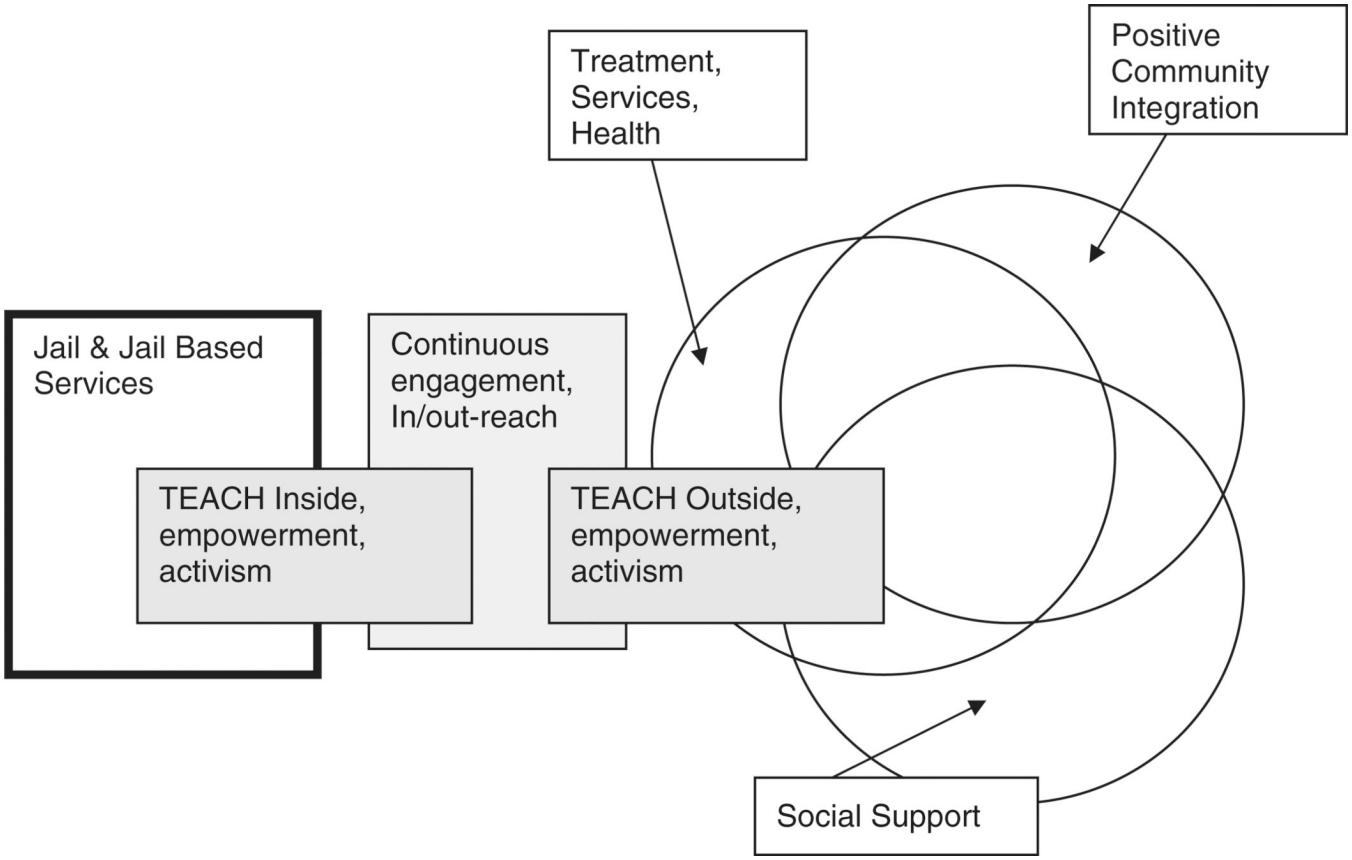

Fig. 1.
Conceptualizing TEACH Inside and TEACH Outside for jail reentry.