CHAPTER EIGHTEEN

Advocating Policies to Promote Community Reintegration of Drug Users Leaving Jail

A Case Study of First Steps in a Policy Change Campaign Guided by Community Based Participatory Research

Juliana van Olphen
Nicholas Freudenberg
Sandro Galea
Ann-Gel S. Palermo
Cassandra Ritas

Public health professionals increasingly recognize policy analysis and advocacy as a crucial intervention strategy for improving the health of communities and populations. In the past two decades, many observers have advocated for health educators and other public health professionals to become more involved in policy analysis and advocacy (see, for example, Holtgrave, Doll, & Harrison, 1997; Krieger & Lashof, 1988; Steckler & Dawson, 1982; Steckler, Dawson, Goodman, & Epstein, 1987). A growing body of scientific literature provides evidence for the role that policies play in determining adverse health outcomes (Brownson, Newschaffer, & Ali-Abarghoui, 1997; Geronimus, 2000; McKinlay, 1993) and in increasing social and racial inequalities in health (James, 1993; Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997; Krieger, 1993; Krieger, Rowley, Herman, Avery, & Phillips, 1993; Williams &

Note: The New York Urban Research Center is supported by the U.S. Centers for Disease Control and Prevention. The Robert Wood Johnson Foundation and the New York City Department of Health supported additional work described in this chapter. All views expressed herein are those of the authors and do not necessarily represent the positions of the funders or other institutions. The work described here would not have been possible without the active participation of the Center for Urban Epidemiological Studies Community Action Board.

Collins, 1995). This evidence provides further impetus for political action aimed at improving health.

Despite these advances, there remains a significant gap between our understanding of the social, political, and economic determinants of health and the application of that knowledge. Only recently has the public health literature begun to more regularly include policy recommendations (Boufford & Lee, 2001; Kates, Sorian, Crowley, & Summers, 2002), and others still grapple with the question of whether public health professionals should be policy advocates (Krieger & Lashof, 1988). Although most authors have argued that public health professionals have a responsibility to participate in public health policymaking, there is little consensus on strategies for participation in this process (Holtgrave et al., 1997; Krieger & Lashof, 1988; Steckler & Dawson, 1982; Steckler et al., 1987).

Public health professionals may make use of several avenues to influence policies. They can, for example, act as policymakers themselves, assume administrative positions, effectively communicate research to policymakers, and empower communities to influence policymaking themselves (Holtgrave et al., 1997; Krieger & Lashof, 1988; Steckler et al., 1987). It is this last strategy—the political empowerment of communities—that will be the focus of this chapter. In particular, we will present a case illustration of how public health professionals have been involved in the early stages of policymaking in a community based participatory research framework.

The growth of research about the role of social determinants and structural processes in public health has been accompanied by a broader understanding of political factors as determinants of health and disease (Diez-Roux, 1998; McMichael & Powles, 1999). The recognition that these processes and structures are important health determinants has led to a search for better ways to study community-level influences on health (Israel, Schulz, Parker, & Becker, 1998). Public health professionals have increasingly embraced a community based participatory research approach because it recognizes that socially and economically marginalized communities often lack the power to tackle many of the problems they face. Moreover, such an approach can empower communities to become more involved politically in order to bring resources and decision-making power into communities. At the same time, communities with few resources to alter the fundamental socioeconomic or political causes of morbidity and mortality may have modest potential to bring about this scale of change.

Therefore, while it is important to both mobilize and strengthen the assets, resources, and relationships within communities, it is equally important to attend to the power differentials between communities that produce and maintain social inequalities in health (James, Schulz, & van Olphen, 2001). A significant challenge in integrating policy analysis and advocacy in community based participatory research is to find an appropriate balance between taking action to

improve health in the short run and building partnerships that will in the longer run change the resource allocation policies that harm poor communities.

Finally, community based participatory research recognizes the importance of local knowledge in designing and implementing interventions to create and sustain healthy policies. This ensures that community experience informs the policy analysis and design phases and that a community's interests drive the policy development process. Communities can create, reinforce, or undermine policies, and people are less likely to comply with policies if the process that created them is perceived as unfair (Tyler, 1990). When communities are centrally involved in policy design and implementation, participatory decision making becomes an integral part of the policy process. Public health researchers engaged in CBPR are both independent stakeholders and liaisons between policymakers and community members. In these newly defined roles, researchers and community members collaborate to develop the necessary tools, information, and language to influence policymakers and mobilize communities to improve health.

In this chapter, we describe the first stages of a campaign to change local policies that contribute to the adverse health consequences of illegal drug use in two New York City neighborhoods: Central and East Harlem. We describe the evolution of the community based participatory research center that initiated this project, with attention to how diverse stakeholders came together and selected drug use as a priority focus. We then show how the complex nature of the drug problem in Central and East Harlem called for an ecological approach to inform a multilevel model of the determinants of substance use. This facilitated the development of various interventions targeting different pathways through which substance use affects health.

In describing our process, we adopt the stages of policy development described by Steckler and Dawson (1982) and reviewed in Chapter Seventeen. Because we are still in the early phase of the intervention, we will focus in particular on the first three stages: problem awareness and identification, problem refinement, and setting policy objectives. Finally, we explore the strengths and challenges involved in developing and implementing a policy intervention in a CBPR framework. Throughout the chapter, we pay close attention to the tension between maintaining a community based and participatory focus and also addressing the broader external forces that shape health and disease.

THE CENTER FOR URBAN EPIDEMIOLOGICAL STUDIES

As discussed in Chapter Three, the U.S. Centers for Disease Control and Prevention initiated in 1995 a new program, the Urban Research Centers (URC), designed to develop innovative strategies to improve the health and well-being

of urban low-income populations (Higgins, Maciak, & Metzler, 2001). Centers were established in Detroit, Seattle, and New York City, the site described in this case history.

The New York URC, founded in 1996 as part of the Center for Urban Epidemiological Studies (CUES), is located at the New York Academy of Medicine, a 150-year-old organization dedicated to improving health and health care in New York City (Freudenberg, 2001a). Its original goals were to bolster the research capacity of several New York City medical institutions to carry out epidemiological studies of urban health problems.

Over the next four years, CUES was transformed from a traditional academic research organization, whose investigators chose projects based primarily on their own interests and the availability of funding, into a more community-oriented, participatory institution committed to bringing some direct benefits to the neighborhoods in which it worked. Some manifestations of these changes include decisions to focus on the geographic communities of Harlem and East Harlem in which CUES was located; to concentrate on a few health problems regularly identified as community priorities—HIV, hepatitis C, and related infectious diseases, substance abuse, and asthma; to join and work with several neighborhood coalitions and networks on these local health problems; and to establish a community action board to provide ongoing guidance to all CUES projects.

The CUES Community Action Board (CAB) includes community service providers, representatives of citywide health organizations (such as the department of health and several medical and academic centers), representatives of advocacy groups, and neighborhood residents. Diverse stakeholders were invited to participate on the CAB, based on their perceived interest and expertise in local health problems, and these stakeholders in turn identified other community partners. The CAB meets monthly to review CUES projects and to plan new initiatives. In 1998, the CAB planned a citywide conference on childhood asthma that included researchers, service providers, and parents of children with asthma. In 2000, it sponsored a community forum on substance use called "Breaking the Barriers," in which service providers, policymakers, and current and former drug users met to identify needs, critique policy, and suggest new directions for city, state, and federal policies. These forums helped bring greater visibility to the URC and to bring together a wide range of diverse stakeholders. Although both meetings were marked by disagreements and controversy on the underlying causes of the high rates of asthma and substance use in these communities and on appropriate solutions, most participants welcomed the opportunity to exchange views. Both conferences helped characterize CUES as a place that could bring together diverse stakeholders to consider practical, scientific, and policy dimensions of community health issues.

In 1999, when CUES decided to focus on substance use as one of its priorities, the CAB articulated the goal of "making it easier to get help for a drug problem in Harlem than to get drugs." This aim explicitly recognized the perception that the easy availability of drugs and the limited access to both formal and informal substance abuse services contributed to the harm that drugs and alcohol imposed on these communities.

Based on its analysis of the substance use problem in Central and East Harlem, on the scientific staff's interpretation of previous epidemiological and social science research on this issue, and on the life and work experience of CAB members, URC participants developed a multilevel model of the determinants of substance use. This ecological model (Sumartojo, 2000; Waldo & Coates, 2000) identified factors that contributed to substance use at the individual, family, neighborhood, service provider, and policy levels. It was designed for use in developing interventions that could operate at one or more levels to reduce the harm associated with illicit drugs and alcohol (Galea et al., in press).

SUBSTANCE ABUSE IN HARLEM

In East and Central Harlem, substance abuse has long been a significant problem and an important contributor to the high rates of other conditions such as HIV, homicide, and violence (McCord & Freeman, 1990). The Harlem Household Survey, conducted from 1992 to 1994, found that 10 to 35 percent of respondents had used either heroin, cocaine, or crack cocaine in their lifetime—a rate four to ten times the average for New York City or for the United States (Fullilove et al., 1999). It has been estimated that in the early 1990s, some 11,050 people in East Harlem and 13,100 people in Central Harlem were injection drug users, constituting 18.8 and 11.9 percent of the respective communities' populations, the highest rates in New York City (New York City Health Systems Agency, 1991; Rose, 1992).

Previous research suggests that substance use is both a direct precursor to poor health and a contextual factor that contributes to a breakdown in the social environment that in turn affects health (Currie, 1993; Fullilove et al., 1999; Rose, 1992; Wallace, Fullilove, & Wallace, 1992). Specifically, poverty and lack of employment opportunities can make the illegal drug market more attractive, and the wide availability of drugs both makes use easier and contributes to health-damaging community norms and values (Anderson, 1999). The crack epidemic beginning in the 1980s has been linked to increases in STDs, violence, and community disorganization (Bourgois, 1995; Cohen et al., 2000). Substance abuse is also thought to be a consequence of the harsh socioeconomic conditions of a neighborhood (Bachman, O'Malley, & Johnston, 1984; Currie, 1993; Wallace et al., 1992), as well as a problem that is exacerbated by unhealthy

public policies. Drug policies that impede access to sterile syringes (Coffin, 2000) and housing policies that evict families from public housing when a household member is convicted of a drug crime (Vera Institute of Justice, 2000) are among these unhealthy policies. In sum, substance use both shapes and is shaped by the social environment.

As noted, based on a model depicting the multiple pathways through which substance use affects health (Galea et al., in press), CUES developed a variety of interventions. Several community research studies had documented widespread agreement among service providers and substance users concerning the lack of available information about, and barriers to access to, job training, job opportunities, housing services, and services for people who have been in jail (Galea et al., in press). The experience of CAB members also suggested the need to improve job training and placement, housing, and other services for drug users with complex problems. To address these problems, CUES, in partnership with current and former drug users, is developing a "survival guide" designed to help drug users and their families find the information and resources needed to meet their needs (Factor et al., 2002). CUES also created a Web based resource guide to help community service providers make more appropriate referrals for drug users.

The survival guide and the resource guide are designed to help drug users and service providers to find more readily and efficiently the information, services, and ongoing social support they need. The guides seek to break down the isolation that both users and providers often experience and to relieve the frustration involved in searching for help at the moment a user is ready to seek assistance. The guides also aim to contribute indirectly to a more integrated network of formal and informal services. The guides have the advantage of being relatively easy to produce and distribute, of being visible products that bolster the self-confidence of CUES participants, and of equally involving researchers and CAB members. Their primary drawbacks are their limited potential for impact and their inability to address the deeper underlying social determinants of drug use. The CUES Policy Work Group set out to address these more fundamental issues.

Beginning in 1999, the CUES CAB began to discuss how to develop a policy-level intervention to reduce substance use in Central and East Harlem. The goal was to develop and then evaluate an intervention designed to support and be supported by the other levels of intervention (for example, the survival guide, the community forums, and the resource guide for providers). In 2000, the CAB formed the Policy Work Group, which included both members and CUES staff, to develop a plan for the policy initiative. Over the next two years, five to ten individuals participated actively in this group.

Early in the development of the intervention, the Policy Work Group recognized the need to collect more information in order to better understand the

problem of substance use at the policy level. The Policy Work Group launched a set of activities to investigate the issue in more depth. In the early phase of this stage, identified as stage 1, problem awareness and identification, in Steckler and Dawson's framework, researchers from Hunter College at the City University of New York, a partner collaborating with CUES, carried out a survey of seventy-nine counselors, social workers, and managers in drug treatment and social service agencies to assess their perceptions of policy obstacles to meeting the need for drug users in Central and East Harlem (McKnight, 2000). Interviews with CAB members and policy experts identified eight policy arenas for investigation: drug treatment; public assistance; child protective services; housing; Medicaid and managed care; mental health; police; and corrections, probation and parole. Survey participants were asked to rate thirty specific policies in terms of how harmful or helpful they were to their clients and how the policies served as barriers to getting services and reducing drug use. In addition, study participants were asked to identify the three policies that served as the biggest obstacles for their clients. Eleven policies were rated as harmful to their clients by more than 50 percent of the study participants. Of these, three addressed drug treatment policies, three addressed correctional policies, and two addressed Medicaid regulations. Fewer than 20 percent of those participating in the study said these eleven policies did not affect their clients, and fewer than 15 percent (and in most cases, fewer than 5 percent) said these eleven policies were helpful to their clients. Two policies were rated as helpful by more than half of those participating: mandatory drug treatment for people on welfare was rated as helpful by more than 60 percent of service providers, and an aggressive police response to domestic violence reports was rated as helpful by about half of the participants. Finally, the study documented that many service providers were unaware of various policies and their impact on clients, with more than 30 percent reporting that they were unaware of eight of the thirty policies investigated.

CUES staff also organized two facilitated discussions with local service providers on policy obstacles, one at the Community Forum on Substance Use and the other at a conference sponsored by a major Harlem service provider. About twenty people attended each session. Using the previous survey findings as a starting point, these groups discussed and refined the problem list and then ranked policy issues on their importance as deterrents to their clients' receiving services.

As a third source of information, Policy Work Group members reviewed published papers and previous reports on policy issues related to substance abuse in New York City and Central and East Harlem and identified policies that other groups had suggested for action (for example, Davis and Johnson, 2000; Nelson & Trone, 2000; Office of the Comptroller, 2000; Vera Institute of Justice, 2000).

Based on these sources of information and their own experience working with drug users in Harlem, the group identified several possible policy issues. These included lack of housing for drug users, insufficient quantity and quality of drug treatment services, welfare policies that put unrealistic demands on users in recovery, and jail discharge planning and aftercare policies. The Policy Work Group asked several questions to assess which of these policies to target for action, including these:

1. How important is this policy to getting needed and appropriate services for drug users in Central and East Harlem?
2. How likely is it that the CAB members and the Policy Work Group can make a difference on this issue with the resources, previous experience, and time frame available?
3. Can a community based intervention make a difference on this issue, or would we need to work on a city, state, or national level to effect change?
4. What other organizations are working on this issue? Are some willing to work with us? Is there a need for another organization to become involved?
5. To what extent will work on this issue support and be reinforced by other CUES projects?

In the summer of 2001, based on a discussion of these questions, the CUES Policy Work Group selected the topic of jail based discharge planning and community reintegration of released inmates as its focus for action. Several factors led to this decision. First, the survey and discussions with community service providers had consistently identified jail policies related to discharge and aftercare as one of the top three problems affecting their drug-using clients. Second, previous policy reports had identified several dimensions of jail policies that contributed to drug problems (for example, lack of drug treatment in jail and lack of discharge planning), making it easier to consider options for action than in more uncharted areas. Moreover, substantial evidence suggested that community reintegration from jail constituted a critical moment in the natural history of several public health problems—substance abuse, infectious disease, mental health, lack of health care—and provided an opportunity for intervention to promote health and prevent disease (Freudenberg, 2001b; Hammett, 2001; Hammett, Gaiter, & Crawford, 1998; Hammett, Roberts, & Kennedy, 2001).

Third, a few members of the Policy Work Group had already been working in the New York City jails on community reintegration and discharge planning for almost a decade, giving them an intimate knowledge of the relevant barriers and facilitators to action, possible partners, and the existing policy

climate. Choosing this issue
experience. Fourth, the sel
opportunity to begin a dialo
other areas such as crimina
safety, all issues of concern t
discussion of community rei
for addressing other importa
of drug use from primarily a
community problem. More
period of declining crime ra
tration and city council coul
(Longest, 2001) on the issu
among jail policy, substan
(Freudenberg, 2001b), maki

JAIL DISCHAR
AND TH

Critical to making the case
demonstrating that current
(see Chapter Seventeen). Su
and adjunct to the second a
ment and setting policy obje
and statistics on jail dischar
total of 124,501 people wer
get for the New York City De
complete data on home add
it was estimated that abo
Manhattan (Harlem and a
their arrest. Four-fifths wer
ing that about 12,800 peopl
year. The average length o
20 percent were sentenced
50 percent; that is, half of t
the year. The average annua
was about $56,000, or abo
York City Department of Co
Surveys of drug users arr
cent had used illicit drugs i

climate. Choosing this issue would give the CUES policy focus the benefit of this experience. Fourth, the selection of this issue would provide CUES with an opportunity to begin a dialogue between the community and stakeholders in other areas such as criminal justice, health care, law enforcement, and public safety, all issues of concern to many Harlem residents. We believed that an open discussion of community reintegration of people leaving jail could pave the way for addressing other important policies in the future and help reframe the issue of drug use from primarily an individual law enforcement issue to a more social community problem. Moreover, we believed that the combination of a long period of declining crime rates in New York City and a new mayoral administration and city council could create a window of opportunity for policy change (Longest, 2001) on the issue of community reintegration. Finally, the links among jail policy, substance abuse, and community health seemed clear (Freudenberg, 2001b), making action squarely within the mission of CUES.

JAIL DISCHARGE POLICIES IN NEW YORK CITY AND THEIR IMPACT ON DRUG USE

Critical to making the case for policy change is "doing your homework" and demonstrating that current approaches and programs are seriously inadequate (see Chapter Seventeen). Such data gathering is also an important precursor of and adjunct to the second and third steps in the policy process, problem refinement and setting policy objectives (Steckler et al., 1987). In their review of data and statistics on jail discharge policies, CUES members learned that in 2000, a total of 124,501 people were admitted to New York City jails. The annual budget for the New York City Department of Correction was $834 million. Although complete data on home addresses of arrestees are incomplete and inaccurate, it was estimated that about 16,000 inmates (13 percent) had an Upper Manhattan (Harlem and adjacent neighborhoods) address at the time of their arrest. Four-fifths were released directly back to their community, meaning that about 12,800 people returned from jail to Harlem communities in that year. The average length of incarceration was forty-five days. The remaining 20 percent were sentenced to state prison. The annual readmission rate was 50 percent; that is, half of those released from jail were reincarcerated within the year. The average annual direct cost for incarceration in a New York City jail was about $56,000, or about $6,904 for the average forty-five-day stay (New York City Department of Correction, 2001; Office of the Mayor, 2001).

Surveys of drug users arrested in New York City suggested that about 80 percent had used illicit drugs in the days prior to their arrest (Arrestee Drug Abuse

Monitoring Program, 2000). Between a quarter and a half of inmates had a drug charge as their highest offense (New York City Department of Correction, 2001). The New York City Health and Hospitals Corporation estimated in 1997 that 25 percent of detainees made use of mental health services while in jail. Despite receiving services while incarcerated, however, there was no routine discharge planning for inmates to ensure that upon release, they would have ongoing access to treatment and services or assistance in obtaining Medicaid or other benefits (Vera Institute of Justice, 2000; Office of the Mayor, 2001).

Partners in this CBPR effort also learned that previous reports (Lynch & Sabol, 2001; Mead, 1996; Nelson, Deess, & Allen, 1999; Nelson & Trone, 2000; Travis, Solomon, & Waul, 2001) had identified several policies that harm community reintegration, including the following six:

- *Correctional policies* such as the release of inmates in the middle of the night without a specific discharge plan, limited availability of substance abuse treatment services within the jail, and inadequate procedures to provide inmates with the identification papers needed to gain access to services after release. The consequences of these policies are the release of inmates who are not ready to get help for the problems that had sent them to jail or are unable to find the help they want. As a result, they are more likely to return to drug use or crime, damaging their own health as well as the well-being of their families and communities.
- *Health care policies* such as a waiting period for Medicaid eligibility after release and inadequate systems for sharing medical information from jail health services (such as lab tests and prescriptions) with community based health providers. These policies make it difficult for ex-offenders to comply with prescribed treatments for HIV, tuberculosis, or psychiatric illness or to get help for health problems before they require hospitalization.
- *Substance abuse service policies* such as having to wait for Medicaid eligibility to pay for drug treatment; for women, requiring postponing reunification with children if they want to enter a residential drug treatment program; and funding shortfalls that limit the intensity and quality of available treatment services. These problems make it more difficult for drug-using ex-offenders to find or complete drug treatment services after release.
- *Housing policies* such as the requirement that public housing projects evict people convicted of drug crimes and their families, the refusal of city homeless shelters to accept people coming out of jail, and the lack of programs that allow inmates to enter the rental housing market. Without adequate housing, many newly released inmates return to street life, crime, and drug use.
- *Employment policies* that allow discrimination against former inmates, and the lack of sufficient job training or educational programs for sectors of the economy where jobs are available. These policies make it more

difficult for inmates to avo
drug use.

- *Broader city policies* tha
ning of services and policie
and nonprofit organization
fact that many city, state, a
on services for newly rele
limited accountability, gap
recidivism.

Having developed the lis
CUES Policy Work Group f
and setting objectives that
health impact on Central
Dawson (1982), the process
lem is key to problem refin
ing some agreement amon
problem. It is only then tha
tives (stage 3 of the policy
cussions among the work g
of the problems identified,
agencies charged with prov
communities. For example
referrals to mental health t
ing, or employment service
of, on the one hand, und
inmates faced were conn
mental health care, some i
on the other hand, ackno
issues if it wanted to succ
always, mindful of selectin
initiatives that are commu
the likelihood of commu
(Themba, 1999).

By the end of 2001, the
within which specific obje
possible policy objectives t
to their release from jail, (2
ing inmates, (3) improving
inmates, and (4) obtaining
bility after release from jail.
tive and complex, it is cruci

difficult for inmates to avoid the illegal economy, with its pull to continuing drug use.

- *Broader city policies* that do not provide a mechanism for coordinated planning of services and policies among the many city, state, and federal agencies and nonprofit organizations that serve inmates leaving jail. Thus, despite the fact that many city, state, and federal agencies spend significant public money on services for newly released inmates, the lack of coordination results in limited accountability, gaps in and duplication of services, and high rates of recidivism.

Having developed the list of policy barriers to community reintegration, the CUES Policy Work Group faced the daunting task of focusing on a few issues and setting objectives that were achievable yet capable of having some public health impact on Central and East Harlem. As described by Steckler and Dawson (1982), the process of investigating the nature and extent of the problem is key to problem refinement (stage 2 of the policy process) and to achieving some agreement among stakeholders about the nature and extent of the problem. It is only then that stakeholders can begin to formulate policy objectives (stage 3 of the policy process). Problem refinement involved in-depth discussions among the work group members about the common causes of several of the problems identified, such as the lack of coordination among various city agencies charged with providing services for people returning from jail to their communities. For example, inmates are often discharged from jail without referrals to mental health treatment, social services, shelter or affordable housing, or employment services. The Policy Work Group thus faced the dilemma of, on the one hand, understanding that all the problems newly released inmates faced were connected and required action (for example, without mental health care, some inmates would have difficulty getting housing) and, on the other hand, acknowledging that CUES needed to choose one or two issues if it wanted to succeed. In addition, the Policy Work Group was, as always, mindful of selecting issues that reflected community concerns. Policy initiatives that are community-driven build community capacity and increase the likelihood of community participation in the implementation phase (Themba, 1999).

By the end of 2001, the group had begun stage 3, setting out general areas within which specific objectives could be developed and narrowing its list of possible policy objectives to four: (1) obtaining identification for inmates prior to their release from jail, (2) improving coordination among city agencies serving inmates, (3) improving access to substance use treatment for newly released inmates, and (4) obtaining a waiver for the waiting period for Medicaid eligibility after release from jail. Because this phase of the policy process is interactive and complex, it is crucial to go back to key players for their input, however.

To make its decision on which of these options to pursue, the group decided to carry out the following activities:

- Organize several focus groups with recently released inmates to elicit their perceptions and priorities for action
- Interview local and city officials to assess the political and financial barriers to change in the proposed areas
- Meet with local and citywide advocacy groups to learn both their prior experiences on these four issues and their willingness to join a campaign to change policy (In addition, these consultations will help the group decide whether to begin a communitywide versus a citywide effort.)
- Develop detailed policy briefs analyzing policy history, current status, and opportunities for change

After these tasks are completed, the information will be used to refine the specific policy objectives in order to ensure that these objectives are feasible and likely to meet with success. As we move into this next phase, we will proceed through the subsequent stages of the policy process as outlined out by Steckler and Dawson (1982): designing alternative actions, estimating consequences of alternative actions, selecting a specific course of action, assigning implementation responsibility, and evaluation. Investigating and designing different courses of action for achieving our policy objectives will require the involvement and buy-in of stakeholders from many different areas, including criminal justice, health care, and public safety. A significant challenge in the action phase concerns the mobilization of support among constituencies with differing political ideologies. This will require framing the policy issues and their solutions realistically but also creatively in order to suggest significant payoff in the long run.

IMPLICATIONS FOR POLICY ANALYSIS AND ADVOCACY WITHIN A COMMUNITY BASED PARTICIPATORY FRAMEWORK

Integrating policy analysis and advocacy in a CBPR framework recognizes that disparities in health are, in part, consequences of policies that are unfriendly and unhealthy to communities with fewer resources. Although this case study describes only the first stages of our policy-level work to reduce the harm associated with substance use in Central and East Harlem, the intervention as a whole addresses the multiple and interacting factors that contribute to the substance use problem at the individual, service provider, and community levels. Framing the problem of substance use in this way recognizes the complexity of the problem.

The CBPR approach calls for a process that is inclusive and comprehensive in defining health problems and their solution. In this project, academics, service providers, community groups, drug users, and community residents have played active roles throughout the process. Since many community partners live and work in the communities of East and Central Harlem, they are intimately familiar with their neighborhood's history and concerns, enabling them to see connections among various problems (such as the connection between substance use and the lack of affordable housing and jobs that pay a living wage) and to assist in identifying the sources of these problems. Moreover, community leaders' linkages to social networks and community institutions serve as the basis for building community partnerships and mobilizing communities for social change. These linkages are essential in identifying those in the community already working to address similar issues and in recruiting resources and expertise. The Policy Work Group benefited from community input in identifying policy priorities, which reflected local understanding of the community context, and in mobilizing resources for change.

In this case history, we have focused on the first phase of the policy process, what Longest (2001) calls policy formulation and what Steckler and Dawson (1982; Steckler et al., 1987) define as the first three of seven stages. Participatory strategies can make unique contributions in each stage (see Chapter Seventeen). It should also be noted that participatory approaches have their disadvantages. In this case, it took almost two years for a working group to emerge, define a problem, and achieve a common plan of action. Others have noted that CBPR can be a slow and time-consuming process (Higgins et al., 2001). The time and energy required for this process can be especially burdensome to community partners who have limited time, financial, and human resources and few personnel to devote to the process. Since coming together, CAB members have collaborated on many efforts to secure additional funding to support community partners. These have included working with investigators on research proposals to study community reintegration from jail as a social process that affects HIV infection and seeking public funds to open a drop-in center for returning inmates. Though not always successful, these activities have been crucial to building trust and commitment between CAB members. In addition, the investments of time and energy by community partners and other institutions have immediate benefits, such as sharing of resources and creating social ties across organizations. These investments, properly nurtured, can become social capital to invest in later projects.

In the long run, using a community based participatory research approach to influence policy is important not only for mobilizing community resources and expertise but also for building the capacities of politically disadvantaged communities to advocate for change. This presents a dilemma if we consider that community members control limited resources because of the long-term

social, political, and economic exclusion they have experienced (Geronimus, 2000). As Halpern (1995, p. 5) notes, "Those who have the least role in making and the largest role in bearing the brunt of society's economic and societal choices [are left] to deal with the effects of those choices." How do we thus avoid unrealistic expectations of what community based participatory approaches can be expected to achieve? In this project, we have attempted both to set achievable goals and to link our efforts to other community struggles (horizontal integration) and broader citywide, state, and national efforts (vertical integration). We have also sought to engage advocacy organizations, service providers, and elected officials, demonstrating our desire to develop linkages among diverse stakeholders and to try new options should one strategy fail. This approach follows Green and Mercer's (2001) recent proposal for a model of community research that includes all relevant constituencies, not just the residents of a specific geographic neighborhood. Broner, Franczak, Dye, and McAllister (2001) describe a similar process, emphasizing the benefits of working to achieve consensus among diverse participants. Whether we will be successful in connecting our modest goals to the larger social movement seeking more basic reforms of the criminal justice system remains to be seen (Rodriguez & Stoller, 2000).

Approaching policy change through a community based participatory framework is critical to widening the base of advocacy for achieving directed social change. This framework emphasizes an ecological approach that views any given problem (in this case, substance use) as a complex interaction of biological, social, economic, cultural, historical, and political factors. Framing the question in this way creates the potential for addressing more fundamental causes of the problem but also increases the risk of biting off more than we can chew and ultimately failing.

The Policy Work Group, through addressing policies focusing on jail based discharge planning and community reintegration, recognizes that substance use is a social problem exacerbated by the lack of affordable housing, educational, and economic opportunities. Through CBPR, we identified policy barriers in the areas of housing, employment, corrections, and health. We then engaged in an in-depth discussion and investigative process devoted to more fully understanding each policy area and identifying the barriers to intervention. Achieving success in addressing and changing policies will require joining forces with new partners, such as correctional facilities, housing agencies, and advocacy organizations. In order to mobilize support among these partners, the Policy Work Group will need to frame the issues in ways that are meaningful to systems with vastly different missions and cultures.

An unanticipated challenge in this effort has been finding the right balance between defining specific policy objectives and acknowledging the multiple policy determinants of inmates' vulnerability. On the one hand, political success

requires choosing a fe
our analysis of the pr
discharge planning, i
better access to healt
people leaving jail. L
engages in an ongoing
ulate our broader visi

Our optimism tha
consensus among ma
in Central and East
approaches to addicti
have not proved adeq
and East Harlem hav
the harm that extern
(see Bascom, 1999; M
1971). Our success in
our ability to become
cle by which public he
aims of improving livi
justice.

Anderson, E. (1999). *The*
inner city. New York: N

Arrestee Drug Abuse Mon
on Drug Use Among A
Institute of Justice. Res

Bachman, J. G., O'Malley,
adults: The impacts of
Social Psychology, 47, 6

Bascom, L. (1999). *Renais*
New York: Bard Books.

Boufford, J. I., & Lee, P. R.
recommendations for th
York: Milbank Memoria

Bourgois, P. (1995). *In sear*
bridge University Press.

Broner, N., Franczak, M., D
policymaking and comm
providing public mental
Quarterly, 72, 79–102.

requires choosing a few achievable targets for policy change. On the other hand, our analysis of the problem has taught us that multiple policy changes (more discharge planning, improved drug treatment, more low-income housing, and better access to health care) will be needed if we are to improve the health of people leaving jail. Like other community advocates, the Policy Work Group engages in an ongoing struggle to define realistic goals while continuing to articulate our broader vision.

Our optimism that we can make progress on this issue is based on the consensus among many stakeholders that the harm caused by substance abuse in Central and East Harlem requires urgent action and that traditional approaches to addiction, public safety, criminal justice, and community health have not proved adequate to solve the problem. Most important, both Central and East Harlem have a long history of mobilization to confront and reduce the harm that externally shaped policies imposed on these communities (see Bascom, 1999; Meier, 1996; Smith & Sinclair, 1994; Young Lords Party, 1971). Our success in achieving our policy goals will depend in large part on our ability to become part of this tradition. CBPR approaches provide a vehicle by which public health professionals can link their efforts with the broader aims of improving living conditions, reducing inequality, and promoting social justice.

References

Anderson, E. (1999). *The code of the street: Decency, violence, and the moral life of the inner city.* New York: Norton.

Arrestee Drug Abuse Monitoring Program (ADAM). (2000, June). "1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees." A Program of the National Institute of Justice. Research Report.

Bachman, J. G., O'Malley, P. M., & Johnston, L. D. (1984). Drug use among young adults: The impacts of role status and social environment. *Journal of Peers and Social Psychology, 47,* 629–645.

Bascom, L. (1999). *Renaissance in Harlem: Lost voices of an American community.* New York: Bard Books.

Boufford, J. I., & Lee, P. R. (2001). *Health policies for the 21st century: Challenges and recommendations for the U.S. Department of Health and Human Services.* New York: Milbank Memorial Fund.

Bourgois, P. (1995). *In search of respect: Selling crack in El Barrio.* New York: Cambridge University Press.

Broner, N., Franczak, M., Dye, C., & McAllister, W. (2001). Knowledge transfer, policymaking and community empowerment: A consensus model approach for providing public mental health and substance abuse services. *Psychiatric Quarterly, 72,* 79–102.

Brownson, R. C., Newschaffer, C. J., & Ali-Abarghoui, F. (1997). Policy research for disease prevention: Challenges and practical recommendations. *American Journal of Public Health, 87,* 735–739.

Coffin, P. O. (2000). Syringe availability as HIV prevention: A review of the modalities. *Journal of Urban Health, 77,* 302–326.

Cohen, D., Spear, S., Scribner, R, Kissinger, P., Mason, K., & Wildgen, J. (2000). "Broken windows" and the risk of gonorrhea. *American Journal of Public Health, 90,* 230–236.

Currie, E. (1993). *Reckoning: Drugs, the cities, and the American future.* New York: Hill & Wang.

Davis, W. R., & Johnson, B. D. (2000). Criminal justice contacts of users and sellers of hard drugs in Harlem. *Albany Law Review, 63,* 877–922.

Diez-Roux, A. V. (1998). Bringing context back into epidemiology: Variables and fallacies in multilevel analysis. *American Journal of Public Health, 88,* 216–222.

Factor, S. H., Galea, S., Garcia de Dueñas, L., Saynisch, M., Blumenthal, S., Canales, E., et al. (2002). Development of a "survival" guide for substance users in Harlem, New York City. *Health Education and Behavior, 29,* 312–325.

Freudenberg, N. (2001a). Case history of the Center for Urban Epidemiologic Studies in New York City. *Journal of Urban Health, 78,* 510–520.

Freudenberg, N. (2001b). Jails, prisons, and the health of urban populations: Review of the impact of the correctional system on community health. *Journal of Urban Health, 78,* 214–235.

Fullilove, R. E., Fullilove, M. T., Northridge, M. E., Ganz, M. L., Bassett, M. T., McLean, D. E., et al. (1999). Risk factors for excess mortality in Harlem: Findings from the Harlem Household Survey. *American Journal of Preventive Medicine, 16*(3S), 22–28.

Galea, S., Factor, S. H., Bonner, S., Foley, M., Freudenberg, N., Latka, M., et al. (in press). An Urban Research Center in Harlem, New York City: A case study in collaboration between the community, service providers, and academics. *Public Health Reports.*

Geronimus, A. T. (2000). To mitigate, resist, or undo: Addressing structural influences on the health of urban populations. *American Journal of Public Health, 90,* 867–872.

Green, L. W., & Mercer, S. L. (2001). Can public health researchers and agencies reconcile the push from funding bodies and the pull from communities? *American Journal of Public Health, 91,* 1926–1929.

Halpern, R. (1995). *Rebuilding the inner city: A history of neighborhood initiatives to address poverty in the United States.* New York: Columbia University Press.

Hammett, T. M. (2001). Making the case for health interventions in correctional facilities. *Journal of Urban Health, 78,* 236–240.

Hammett, T. M., Gaiter, J., & Crawford, C. (1998). Reaching seriously at-risk populations: Health interventions in criminal justice settings. *Health Education and Behavior, 25,* 99–120.

Hammett, T. M, Roberts, C., & Kennedy, S. (2001). Health-related issues in prisoner reentry. *Crime and Delinquency, 47,* 390–409.

Higgins, D. L., Maciak, B., & Metzler, M. (2001). CDC Urban Research Centers: Community-based participatory research to improve the health of urban communities." *Journal of Women's Health, 10,* 9–15.

Holtgrave, D. R., Doll, L. S., & Harrison, J. (1997). Influence of behavioral and social science on public health policymaking. *American Psychologist, 52,* 167–173.

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health, 19,* 173–202.

James, S. A. (1993). Racial and ethnic differences in infant mortality and low birth weight: A psychosocial critique. *Annals of Epidemiology, 3,* 130–136.

James, S. A., Schulz, A. J., & van Olphen, J. (2001). Social capital, poverty, and community health: An exploration of linkages. In S. Saegert, J. P. Thompson, & M. R. Warren (Eds.), *Social capital and poor communities* (pp. 165–188). New York: Russell Sage Foundation.

Kates, J., Sorian, R., Crowley, J. S., & Summers, T. A. (2002). Critical policy challenges in the third decade of the HIV/AIDS epidemic. *American Journal of Public Health,* 92, 1061–1063.

Kawachi, I., Kennedy, B. P., Lochner, K., & Prothrow-Stith, D. (1997). Social capital, income inequality, and mortality. *American Journal of Public Health, 87,* 1491–1498.

Krieger, N. (1993). Epidemiology and the web of causation: Has anyone seen the spider? *Social Science and Medicine, 39,* 887–903.

Krieger, N., & Lashof, J. C. (1988). AIDS, policy analysis, and the electorate: The role of schools of public health. *American Journal of Public Health, 78,* 411–415.

Krieger, N., Rowley, D. L., Herman, A. A., Avery, B., & Phillips, M. T. (1993). Racism, sexism, and social class: Implications for studies of health, disease, and well-being. *American Journal of Preventive Medicine, 9*(Suppl.), 82–122.

Longest, B. B., Jr. (2001). The process of public policy making: A conceptual model. In P. R. Lee & C. L. Estes, *The nation's health* (6th ed., pp. 109–115). Sudbury, MA: Jones & Bartlett.

Lynch, J. P., & Sabol, W. J. (2001). Prisoner reentry in perspective. *Crime Policy Report, 3,* 1–26.

McCord, C., & Freeman, H. (1990). Excess mortality in Harlem. *New England Journal of Medicine, 322,* 173–178.

McKinlay, J. B.(1993). The promotion of health through planned sociopolitical change: Challenges for research and policy. *Social Science and Medicine, 36,* 109–117.

McKnight, C. (2000). *A survey of perceptions of Harlem and East Harlem service providers on policies affecting drug users.* Unpublished master's thesis, Hunter College, New York.

McMichael, A. J., & Powles, J. W. (1999). Human numbers, environment, sustainability and health. *British Medical Journal, 319,* 977–980.

Mead, D. M. (1996). *A profile of the Citizens' Budget Commission.* New York: Citizens' Budget Commission.

Meier, D. (1996). *The power of their Ideas: Lessons for America from a small school in Harlem.* Boston: Beacon Press.

Nelson, M., Deess, P., & Allen, C. (1999). *The first month out: Post-incarceration experiences in New York City.* New York: Vera Institute of Justice.

Nelson, M., & Trone, J. (2000, October). Why planning for release matters. *Issues in Brief,* pp. 1–8.

New York City Department of Correction. (2001). *Summary statistics, FY 2000.* New York: Author.

New York City Health Systems Agency. (1991). *Data book.* New York: Author.

Office of the Comptroller, Office of Policy Management. (2000). *Quitting drugs, quitting crime: Reducing probationers' recidivism through drug treatment programs.* New York: Author.

Office of the Mayor. (2001). *Mayor's management report, 2001.* New York: Author.

Rodriguez, D., & Stoller, N. (2000). Reflections on critical resistance. *Social Justice, 27,* 180–194.

Rose, D. (1992). The epidemiology of HIV infection and AIDS in East and Central Harlem, New York. *Mount Sinai Journal of Medicine, 59,* 493–497.

Smith, K., & Sinclair, A. (1994). *The Harlem cultural/political movements, 1960–1970.* New York: Gumbs & Thomas.

Steckler, A., & Dawson, L. (1982). The role of health education in public policy development. *Health Education Quarterly, 9,* 275–292.

Steckler, A., Dawson, L., Goodman, R. M., & Epstein, N. (1987). Policy advocacy: Three emerging roles for health education. *Health Education and Promotion, 2,* 5–27.

Sumartojo, E. (2000). Structural factors in HIV prevention: Concepts, examples, and implications for research. *AIDS, 14*(Suppl. 2), S3–S10.

Themba, M. N. (1999). *Making policy, making change: How communities are taking law into their own hands.* San Francisco: Jossey-Bass.

Travis, J., Solomon, A. L., & Waul, M. (2001). *From prison to home: The dimensions and consequences of prisoner reentry.* Washington, DC: Urban Institute.

Tyler, T. R. (1990). *Why people obey the law.* New Haven, CT: Yale University Press.

Vera Institute of Justice. (2000). *Why planning for release matters.* New York: Author.

Waldo, C. R., & Coates,
prevention science:
S18–S26.

Wallace, R., Fullilove, M
Implications for sub
(Eds.), *Substance ab*
Baltimore: Williams

Williams, D. R., & Colli
health: Patterns and

Young Lords Party. (197

Waldo, C. R., & Coates, T. J. (2000). Multiple levels of analysis and intervention in HIV prevention science: Exemplars and directions for new research. *AIDS, 14*(Suppl. 2), S18–S26.

Wallace, R., Fullilove, M. T., & Wallace, D. (1992). Family systems and deurbanization: Implications for substance abuse. In J. H. Lowinson, P. Ruiz, & R. B. Millman (Eds.), *Substance abuse: A comprehensive textbook* (2nd ed., pp. 944–955). Baltimore: Williams & Wilkins.

Williams, D. R., & Collins, C. (1995). U.S. socioeconomic and racial differences in health: Patterns and explanations. *Annual Review of Sociology, 21*, 349–386.

Young Lords Party. (1971). *Palante: Young Lords Party.* New York: McGraw-Hill.