International Journal of Law and Psychiatry 37 (2014) 501–511

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

Community Wise: Paving the way for empowerment in community reentry

Liliane Cambraia Windsor [a,*], Alexis Jemal [a], Ellen Benoit [b]

[a] Rutgers, State University of New Jersey, School of Social Work, 360 Martin Luther King Jr. Blvd, Hill Hall, Room 401, Newark, NJ 07104, USA
[b] National Development and Research Institutes, Inc., 71 West 23rd Street, 8th Floor, New York, NY 10010, USA

ARTICLE INFO

Available online 12 March 2014

Keywords:
Substance abuse
Mental health
Health disparities
Community based participatory research
Health intervention
Critical consciousness theory

ABSTRACT

Theoretical approaches traditionally applied in mental health and criminal justice interventions fail to address the historical and structural context that partially explains health disparities. *Community Wise* was developed to address this gap. It is a 12 week group intervention informed by Critical Consciousness Theory and designed to prevent substance abuse, related health risk behaviors, psychological distress, and reoffending among individuals with a history of incarceration and substance abuse. This paper reports findings from the first implementation and pilot evaluation of *Community Wise* in two community-based organizations. This pre–posttest evaluation pilot-tested *Community Wise* and used findings to improve the intervention. Twenty-six participants completed a phone and clinical screening, baseline, 6- and 12-week follow-ups, and a focus group at the end of the intervention. Measures assessed participants' demographic information, psychological distress, substance use, criminal offending, HIV risk behaviors, community cohesion, community support, civic engagement, critical consciousness, ethnic identification, group cohesion, client satisfaction, and acquired treatment skills. Research methods were found to be feasible and useful in assessing the intervention. Results indicated that while *Community Wise* is a promising intervention, several changes need to be made in order to enhance the intervention. *Community Wise* is a new approach where oppressed individuals join in critical dialogue, tap into existing community resources, and devise, implement and evaluate their own community solutions to structural barriers.

1. Introduction

During the past several decades, scientific advancements in biomedical research have improved public health (National Institute on Drug Abuse, 2007). However, despite these advancements and overall improvement in the health of Americans in previous years, numerous reports and studies have clearly demonstrated that racial and ethnic disparities exist in healthcare access, delivery and outcomes in the U.S. (Braveman et al., 2011; LaVeist, Pollack, Fesahazion, & Gaskin, 2011; Smedley, Stith, & Nelson, 2002; U.S. Department of Health & Human Services & Services, 2010). According to Healthy People 2020, health disparities are differences in health closely associated with social, economic, and/or environmental disadvantage. Moreover, health disparities negatively affect groups of people who "have systematically experienced greater obstacles to health based on their racial or ethnic group or for a number of other characteristics historically linked to discrimination or exclusion" (U.S. Department of Health & Human Services, 2000).

Racial minorities and members of low socio-economic status (SES) groups tend to face a multitude of health disparities, including shorter life expectancy and higher rates of diabetes, cancer, heart disease, stroke and substance abuse (Centers for Disease Control, 2011; U.S. Department of Health & Human Services & Services, 2010). Moreover, some studies have found that differential exposure to stress and social adversity in the forms of racial/ethnic bias, discrimination and unfair treatment experienced by non-White and/or low SES groups is associated with a variety of health conditions, risk behaviors, and negative outcomes, including, for example, poor mental health (Williams, Neighbors, & Jackson, 2003), and problematic substance and tobacco use (Chae et al., 2008; Gee, Delva, & Takeuchi, 2007; Martin, Tuch, & Roman, 2003; Mulia, Ye, Zemore, & Greenfield, 2008). Thus, chronic stress exposure and risky coping responses may be a potential mechanism in the creation and perpetuation of health disparities.

Disparities related to race and SES are especially obvious when examining the consequences linked to drug use and addiction which include altered judgment and engagement in impulsive and/or unsafe behaviors (e.g., risky sex). Despite relatively uniform rates of abuse across race/ethnic groups (Substance Abuse & Mental Health Services Administration, 2011), African Americans followed by Hispanics suffer harsher consequences (e.g., higher rates of HIV/HCV and incarceration)

* Corresponding author at: 360 Martin Luther King Jr. Blvd, Hill Hall, Room 401, Newark, NJ 07104, USA. Tel.: +1 973 353 5729; fax: +1 973 353 1010.
E-mail address: lwindsor@ssw.rutgers.edu (L.C. Windsor).

http://dx.doi.org/10.1016/j.ijlp.2014.02.023
0160-2527/

for drug use than other groups (National Institute on Drug Abuse, 2005, 2012). For instance, in 2009, African Americans comprised 14% of the U.S. population but accounted for 44% of all new HIV infections (Centers for Disease Control, 2011).

Racial disparities in incarceration rates resulting from differential treatment of Whites and non-Whites by the criminal justice system also have a lasting impact on health functioning (Moore & Elkavich, 2008). Prison inmates are exposed to unhealthy conditions and suffer from high rates of mental illness, substance use, and infectious diseases (Moore & Elkavich, 2008). Because poor non-Whites are more likely than their counterparts to be exposed to the penal system and its negative effects – including deviant social peers, reduced labor market opportunities, and high levels of infectious diseases – the penal system contributes to racial health disparities (Centers for Disease Control, 2011; Hallfors, Iritani, Miller, & Bauer, 2007; Rubin, Colen, & Link, 2010; Windsor & Negi, 2009). Once released, previously incarcerated individuals with special needs (e.g., housing, employment, mental health and substance use treatment) return to marginalized, low-income, predominantly non-White communities that have many social and economic barriers (e.g., high rates of crime, poverty and unemployment) and limited or overwhelmed social resources (Blitz, Wolff, Pan, & Pogorzelski, 2005; Braveman et al., 2011; LaVeist, 2005; LaVeist et al., 2011). This formula of returning previously incarcerated individuals with complex needs to communities with inadequate supports harms the individual and the community, and perpetuates the cycle of racial disparities in incarceration and health disparities for non-White and/ or low SES populations (Caetano, 2003; Windsor & Dunlap, 2010).

Negative health effects (HIV, cancer, diabetes) and social consequences (incarceration, violence, school dropouts) disproportionately experienced by drug using racial/ethnic minorities may be exacerbated by prevention and treatment challenges. Researchers have reported difficulties with recruitment, engagement, and retention of minority populations in substance use research and treatment (Robinson & Trochim, 2007; Sheikh, 2006). Also, as suggested by the literature, racial minority populations may experience barriers to substance abuse intervention access and engagement (LaVeist, 2005; New Jersey Department of Health & Human Services, 2007; Schmidt, Greenfield, & Mulia, 2006). These barriers include lack of trust of clinical research initiatives (McKay et al., 2007); cost of treatment; fear and shame; belief they can recover without help; lack of knowledge about available services, as well as structural environmental stressors, such as lack of transportation or child care (Caetano & Clark, 2003; Esser-Stuart & Lyons, 2002; Fuller et al., 2004; Longshore, 1999).

These treatment difficulties are reflected in the treatment statistics. Although similar percentages of Blacks, Hispanics, and Whites use substances, 59.8% of White users were admitted to publicly funded substance abuse treatment programs in 2008, whereas only 20.9% of African Americans and 13.7% of Latinos or persons of Hispanic origin were admitted (National Institute on Drug Abuse, 2011). Similar to the drug use statistics across race, the Surgeon General's report on *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health & Human Services, 2001) highlighted the finding that non-White populations experience mental disorders at a rate that is similar to or higher than their White counterparts; yet, research suggests that racial minorities have low rates of service utilization. The report notes that a collection of barriers impede service utilization, such as a lack of availability of services, mistrust and fear of treatment, and language barriers (U.S. Department of Health & Human Services, 2001). The Surgeon General also concluded that a high proportion of non-Whites have unmet mental health needs due to racial/ethnic discrimination. As a result, the Surgeon General noted that when targeting minorities the research and practice communities should create and use culturally congruent interventions by incorporating historical, political, and cultural factors.

The interaction between disparities in drug abuse and its consequences, the associated stigma (National Institute on Drug Abuse, 2003) and prevention and treatment challenges creates a precarious situation that has led the Department of Health and Human Services and the National Institute on Drug Abuse to seek innovative ways to eliminate health disparities in the U.S. (National Institute on Drug Abuse, 2008). This paper addresses the need for culturally congruent interventions designed to address the historical and structural context that partially explains health disparities experienced by individuals with a history of substance abuse and incarceration residing in low-income and predominantly African American communities, by presenting the data from a pilot evaluation of *Community Wise*. An important method used to ensure cultural congruency was the application of Community Based Participatory Research (CBPR). CBPR is an approach that encourages researchers to involve the community in all phases of the research process, from question development to dissemination of results (Israel et al., 1998; Pinto, Spector, & Valera, 2011). As an approach, CBPR incorporates experiential and scientific knowledge by having researchers collaborate with community partners (Pinto et al., 2011). Through the community partners that represent the voice of the community, researchers are afforded access to information that can improve the applicability of the study for the target population (Pinto et al., 2011). CBPR provided the guiding principles that informed the development, implementation and evaluation of *Community Wise*, a new health intervention developed by a team of researchers, consumers, and service providers to improve substance use and related health among individuals with a history of incarceration and substance abuse residing in distressed communities (Windsor, 2013).

1.1. Community Wise

In 2010, the Newark Community Collaborative Board (NCCB) was created to apply CBPR principles in the development of *Community Wise*: a manualized, culturally-tailored, 12-week group intervention informed by Critical Consciousness Theory and designed to prevent substance abuse, related health risk behaviors, psychological distress, and reoffending among individuals transitioning from incarceration into a low-income and predominantly African American community struggling with violence, high HIV/HCV incidence, substance abuse, and poverty (Windsor, 2013). The use of CBPR methods allowed the *Community Wise* intervention to incorporate an understanding of the particular needs, worldviews, strengths, and challenges of the population such that the intervention is meaningful to the participants, which should improve recruitment, engagement and retention (Israel et al., 1998; Liberia, 2008; Pinto, Campbell, Hien, Yu, & Gorroochurn, 2011). *Community Wise* aims to empower participants to combat structural and internalized oppression by developing critical analysis skills and implementing social change projects. Specifically, the historical context and structural barriers impacting individuals with histories of substance abuse and incarceration residing in distressed communities are discussed in group meetings and in homework assigned for participants to complete every week. Critical thinking skills are used to assist participants in achieving a deeper level of analysis regarding how the historical context and structural barriers impact individual behaviors. Individual goals setting, community engagement, and social change projects are then used to address internalized and structural oppression.

1.2. Theoretical framework

Theoretical approaches traditionally applied in mental health, substance abuse, HIV/HCV and criminal justice interventions (e.g. cognitive behavioral therapy, pharmacotherapy, incarceration) fail to address the historical and structural contexts that partially explain health disparities experienced in low-income and predominantly African-American communities. *Community Wise* is grounded in Paulo Freire's