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A Community Psychologist's involvement in policy change at the community level: Three stories from a practitioner

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Abstract

Influencing social policy is a natural part of the everyday activities for community psychology practitioners working in partnership with communities. Most dilemmas faced by communities not only have programmatic solutions but looking at the root causes of the issue we can also see the structural policy issues that require change. Often our task is to build the capacity of the communities to become effective advocates involved with local office holders on issues requiring policy change. Community psychologist practitioners frequently become involved in the world of policy. It is the reality of how one form of change occurs in communities. Small “p” policies can mean negotiating the tricky waters among institutional players in a community. Capital “P” policies are illustrated by community psychologists involved in advocating for specific policy or legislation on crucial issues. Three examples presented in this paper illustrate the range of possibilities available for engaging in social policy change. They include building healthy communities coalitions, focusing in on a policy agenda on a specific issue (health care access), and building the capacity of local communities to address social change issues such as systemic racism. The paper encourages more community psychologists to write of their experiences in the pursuit of social policy change at the community level in order to learn how to be most effective in these roles and to learn about the range of possibilities.

Keywords: community psychology, policy change, practitioner stories

As a practitioner of community psychology, policy change has always been an integral part of my work. Influencing social policy can be a natural part of the everyday activities for community psychologists working in partnership with communities. Most dilemmas faced by communities not only have programmatic solutions but looking at the root causes of the issue we can also see the structural policy issues that require change. Often our task is to build the capacity and willingness of the communities to become effective advocates involved with local office holders on issues requiring policy change.

Community psychologist practitioners can find themselves quite comfortable being involved in the world of policy. It is the reality of how one form of change occurs in communities. Small “p” policies can mean negotiating the tricky waters among institutional players in a community – the police chief, school superintendent, director of the mental health center, CEO of the hospital. Capital “P” policies are illustrated by community psychologists involved in advocating for specific policy or legislation on crucial issues such as health care coverage, environmental pollution, school policies that lead to educational disparities for students of color, etc.

Increasingly, we are hearing of real world community psychologists who are also getting involved in capital “P” policy directly through politics. Debbie Starnes

(2004), recent award winner for Distinguished Practice in Community Psychology, has been an elected city councilor in Atlanta for years and describes this job as part of her community psychology practice. I inadvertently discovered a few years ago that I shared the distinction with Thom Moore, a community psychologist from the University of Illinois, of being an elected school board member. I am sure there are numerous other examples of elected officials in the community psychology ranks. Yet, until recently we have not said very much about this aspect of our lives. Can something as seemingly “unacademic” as holding public office be seen as community psychology practice?

Much of my involvement in policy change, social change and advocacy comes from who I am both professionally and personally. This I believe is true for many of us who become community psychologists.

I am a social activist and always have been, driven by a commitment and deep belief in the values of social justice and social change. This has carried me through many, varied movements in the US: starting with the anti-war protests in the Viet Nam era, involvement in civil rights struggles, and most recently in creating a Peace Commission for our small town.

I am also a political animal. I've been an elected official to our local School Committee (Town of 2,000 residents). In volunteer positions in town I have also tackled local issues such as being a member of our School Building Committee for a new expansion to our school, and now being a leader in town efforts to create affordable housing. I was also chair of the town Democratic Committee (political party) for over a decade.

As a community psychology practitioner I have always tried to integrate my political and social activism into my community psychology work (my guess is that this is true for many of us). In fact my career path could be characterized as constantly seeking positions that would allow me to integrate my social activist work and values into my job description.

As a community psychology practitioner the most powerful way I have of conveying my policy work and beliefs is to share stories of that work. In this article I will relate three stories of my work in policy change in communities and how that work is embedded in the principles of community psychology: 1) Healthy Community Coalitions and community advocacy; 2) Health Access Networks – statewide advocacy on health access issues, and 3) Boston's Center for Health Equity and Social Justice – work on supporting health equity coalitions in communities.

Community Story # 1: Healthy Community Coalitions and Community Advocacy

I have spent a large part of my professional career building healthy community coalitions in communities. The healthy communities approach to improving people's lives emerged from the World Health Organization's Ottawa Charter (World Health Organization 1986). This powerful example of an ecological approach to improving health recognizes the interdependence of all the parts of a person's life situation. In its ecological approach, healthy communities is a natural model for community psychologists and an excellent opening to policy level work in communities.

Basic to the healthy communities approach is "the process of enabling people to increase control over and to improve their health," with health defined as a "resource for everyday life" (World Health Organization 1986). The healthy communities approach is a way of viewing health that differs radically from the individualistic, remedial medical services system that dominates in the United States (Wolff 2003, 2010). The Ottawa Charter declares that the prerequisites for health are peace, shelter,

education, food, income, a stable ecosystem, sustainable resources, social justice and equity (1986).

It is important to remember that the research tells us that in the United States only 10 percent of people's health is determined by access to health care (McGinnis, Williams-Russo, & Knickman, 2002). The remaining 90 percent is explained by the social determinants of health, along with biological factors such as genetics. The World Health Organization's list of the social determinants of health include stress, early life factors, social exclusion, work and unemployment, social support, addiction, food, transportation, social justice, and the social gradient (the social and economic circumstances that strongly affect health throughout life) (Wilkinson & Marmot, 2003). Approaching health and quality of life issues from this ecological framework creates tremendous opportunities for community psychologists to make a difference.

The Ottawa Charter opened up the possibility for me as a community psychologist to tackle the creation of a healthy community from avenues other than health care or even the traditional public health system. Early support for the healthy communities movement in the United States was spread across a wide range of sponsors, including the World Health Organization, the United States Public Health Service, and the National Civic League (<http://www.ncl.org>). The partnership of the U.S. healthy communities movement with the National Civic League, an organization whose theme is "making citizen democracy work," encouraged a wide variety of players to enter the healthy communities arena. With the Ottawa Charter healthy communities had a clear mandate to work on policy change and advocacy, and with the National Civic League we had a partner who could pave the way

As the Director of Community Partners, a program of the Office of Community Programs of the University of Massachusetts Medical Center we were committed to building capacity for communities in Massachusetts. We developed and supported three specific geographically defined healthy community coalitions and expanded the healthy communities concept statewide to create Healthy Communities Massachusetts. Community Partners provided training, facilitation, and guidance to 51 other cities and towns in Massachusetts. The community example of the North Quabbin Community Coalition illustrates how healthy community initiatives can create policy change.

Example: The North Quabbin Community Coalition

For more than twenty five years, the people of the North Quabbin region of Massachusetts have been creating collaborative solutions for many community issues through the North Quabbin Community Coalition (NQCC). The coalition serves a nine town area with approximately 30,000 residents. These communities have brought together diverse groups of people and institutions to solve seemingly intractable problems facing the area's residents (<http://www.nqcc.org/>). This was Community Partners' first coalition.

When we started the coalition the area had been hard hit economically. During the 1980s, the formerly thriving mill towns of north-central Massachusetts nearly died. In 1984, one of two large manufacturers in the North Quabbin region closed, and many people were thrown out of work. At this bleak moment, the Office of Community Programs was sponsoring two medical students in a community practicum in the North Quabbin region. The students reported back the dire straits of the community and the Office asked me, as a consultant, to help create a community coalition. We thought this was a short-term intervention. No one had any sense that we were starting a twenty-five-years-plus adventure (my consulting position evolved into being Director of Community Development at the Office of Community Programs). But we were about to discover something about each other and about the amazing process of building collaborative solutions. From the start, the goals of this coalition explicitly included developing an advocacy capacity in order to create policy changes.

One of the coalition's major policy accomplishments was the creation of Community Transit Services. Both the involvement of everyday citizens and the healthy community processes played into this policy change success story. The lack of access to public transportation had been identified as a major problem from the coalition's first days. It limited access by residents to grocery stores, health care, social services, community college, etc. Year after year, task forces tackled the issue without producing much change. Transportation issues in this rural area seemed difficult if not impossible to fix.

Then the participants in the local literacy program, the North Quabbin Adult Education Center, became partners with the NQCC. Together they created the North Quabbin Transportation Co-Op, which provided volunteer rides for those in need. The adults in the literacy program began to learn more than literacy skills. They also started to become active community members. They advocated for their needs with the coalition, and then with state and national

legislators. Their work resulted in policy and funding changes that helped create the region's first-ever transportation system, one that connected the nine towns to the major cities to both the east and the west.

The resources to make this transportation system happen came from policy changes in the form of committed resources at all levels. The local congressman identified federal resources. The state legislators found state resources. The regional transit authorities and towns came up with matching funds. Within its first year, this system provided more than 23,000 rides. It delivered residents to doctor's appointments, hospitals, community colleges, jobs, and grocery stores. The intractable problem of transportation that had plagued the area for decades and had kept it isolated was finally being resolved. The coalition and its grassroots partners had fixed the apparently unfixable, by working together on policy changes.

Advocacy has always been a significant part of this coalition's work. The coalition has strived to make local change at the same time that it has promoted greater statewide changes that would improve local conditions. It has built strong relationships with local legislators, and its members regularly advocate for new services to the area and against cuts in local services.

Broadening the Healthy Communities Work across the State

In my work in Massachusetts, working with community coalitions to build healthy communities (Wolff, 2003), we were not only building local healthy community coalitions, we were also building the political support with legislators and state agencies to keep the coalitions going over time and move the healthy communities agenda forward. To this end we counted on state legislators as our crucial supporters, especially for funding and policy purposes.

After the North Quabbin experience we began two more coalitions across the state with the specific support and in one case at the request of a local legislator. These three legislators were key players in and supporters of the coalitions (interestingly, two of them were Republicans, in a very Democratic state).

Our relationship with the legislators grew consistently and slowly over twenty years. We would regularly invite them to coalition meetings to tell us what was happening on "the Hill", to hear the community's concerns and to problem solve issues together. They were terrific advocates for new programs (i.e., domestic violence pilot projects, and

rural transportation systems) and for fighting off funding cuts (i.e. closing of court houses, welfare offices). They were also our key financial support since they ear-marked specific funds to support the coalitions every year in the state budget. This was no easy task. Each January, we would have a joint meeting with the state senators and representatives from each of the three coalition regions. Between nine and twelve elected officials would sit with the coalition leaders and myself in an impressive room at the statehouse and review the coalitions' accomplishments for the year and the strategies we would employ to get the funding passed in the budget.

The legislators were our partners, we did projects together, they helped us with issues, and we honored them and provided them with forums and "hero" opportunities (Meredith & Dunham, 1999).

At some point over these twenty years with the NQCC and Community Partners I became the Chair of my town Democratic Committee, and attended the annual state party convention for many years. (Our healthy communities work also had strong support from a number of Republican legislators so this was by no means a strictly partisan lobbying effort). In the convention settings, these same legislators had the opportunity to see me as a political supporter, someone who would take their signature papers around, donate money etc. My involvement certainly did not hurt our community causes. This is politics with a capital "P". It was an intimate part of the work to create healthy communities. This personal political role was distinct from my job, but it helped with some of the legislators to be seen as someone willing to work directly in the political process.

Although we never called it lobbying, the coalitions were always 'educating' our legislators on the key issues affecting our communities and training community members in the fine art of influencing legislation. It was central to many of our successes, including passage of a bill guaranteeing universal health care coverage for all children in Massachusetts. (Massachusetts Legislation 1997 Children's Health Insurance Program)

Over more than two decades, the North Quabbin Community Coalition has addressed a wide range of issues. These include housing, economic development, youth development, racism, education, substance abuse, domestic violence, child sexual abuse, mediation, after-school activities, access to health care and dental care, and more. With that broad a reach—and with a philosophy that the group wants to engage the people most affected by the issue and those most able to help reach solutions—this

coalition has had a positive influence on almost every aspect of the community and on a very large number of the area's residents.

The NQCC continues today as a vital force in the community. The coalition sees itself as the "kitchen table" around which the various sectors of the community gather to identify and solve problems. The NQCC demonstrates sustainability and longevity. Having recently celebrated its twenty-fifth birthday (2009), it continues to thrive as a gathering place for the entire community. This coalition also provides support to neighboring communities that want to develop similar coalitions.

My role with the NQCC evolved over the years. At the start I was the facilitator who gathered and mobilized the community and helped them create the vision and the mechanism of the NQCC. Over time I was the consultant to the coalitions' coordinator and a key partner in helping them find the needed financial resources to survive.

What work in Healthy Communities illustrates about community psychology and policy change

The first thing to note about the work in this example is that it involves a whole community. In community psychology we talk about 'community' all the time but usually dissect the community and work with some components of the whole. The work of healthy communities aims to engage all the sectors of the community and thus the policy change described is in that context.

With the work of the NQCC the policy changes involved both local changes in local systems (health care access, transportation, etc.) and being part of statewide coalitions advocating for changes (welfare reform, health coverage, etc.). Policy change was created by directly working with local legislators and also by building the capacity of residents to advocate for policy change. These were all roles I took on during my years working with the NQCC.

Local community psychology based community development and community organizing can focus on policy change and can create organizations that are positioned to become powerful forces for creating local and statewide policy change. Much of this involves building the capacity of the organization to succeed in the policy change arena by training, modeling, and linking them to policy change opportunities.

In the case of the North Quabbin when first faced with the dire situation of a closed plant and sudden unemployment I could have promoted many solutions other than a community-wide development

approach (i.e. job counseling, services for the unemployed, etc.). Knowing my community psychology values I instead suggested a community-wide ecological, preventive, organizing approach. Advocacy and policy change were part of that approach.

Community Story # 2: Health Care Access Networks

Over my years as a community psychology practitioner my most consistent policy focus was on health care access. Working with local community coalitions, the communities always raised the issue of the uninsured as a major community issue, so our coalitions were always scrambling to find solutions for those residents without health care access. The coalitions helped develop health centers, low income dental centers, etc., but the real solution was in the creation of legislation and policies that would expand health access and create universal coverage statewide. So the community groups we created and worked with often were involved in joining statewide efforts advocating for universal access (Wolff, 2010).

While working at the University of Massachusetts Medical School (UMMC) as the Director of Community Development, on one occasion I arranged a meeting in Western Massachusetts for local health care providers on issues of health care access. We invited the Boston-based statewide health care advocacy group, Health Care for All, to present. Initially we thought our audience would want to work on matters of government policy, because we felt sure that people's lack of health care resulted from the failure of the state and federal government to pass legislation expanding coverage to the uninsured. At the event, we learned from the people working on the front lines in health care, in advocacy and at health centers, that what they perceived was that we needed to first solve an *information* problem, not a policy problem. It turned out that the health centers and clients were not fully aware of what health programs were already in place. The audience wanted to focus on connecting those in need to existing programs rather than policy change. So we started there. We started with information exchange and made our way to policy change through that route.

In response to this local expression of need, we created a small pilot project with UMMC support and financial resources involving four part-time health care access outreach workers. We initially called these our "health care warriors," because it was such a battle for them to get the most up-to-date information on eligibility and then also to disseminate it to those who needed it. In addition to

the pilot project, we later applied for and received federal dollars for a Rural Health Outreach Grant. With this pilot program in place we began to gather these outreach workers and many other providers for a monthly meeting with Health Care for All, to simply share information and keep us all up to date. Policy issues were naturally a part of these discussions.

At this time we also joined a statewide advocacy effort to pass a Children's Health Bill that would provide universal health care coverage for all children in the state. The ultimate passage of this bill created a new environment in which Mass Health, the state Medicaid agency, needed community help in order to reach its new enrollment goal – enrolling all children. For Mass Health/Medicaid this focus on enrolling all children was a huge shift from being expected by the Legislature and Governor to keep enrollment numbers down. To meet the challenge Mass Health thought of launching a public relations campaign, but instead we lobbied for funding for minigrants to communities (ultimately getting \$1million) for outreach workers of every stripe – culture, race, geography – and we succeeded.

Once the Children's Health bill had passed, Mass Health turned to the Medical School for help in enrolling all eligible children. Our office was very well positioned and wrote a very short proposal with a relatively large budget (to support 60 meetings a year, etc.) and were funded. We then set up a system to encourage enrolling all kids by building collaboration among all the key parties, a variation of what we already did in Western Mass but now focused on the whole state. We called them Health Access Networks (HANs). The HANs met in all six regions of the state and had 10 meetings per year in each region. Managing and facilitating all this was quite a challenge for our small office.

Over the four-year span from 1998 to 2002, the Health Access Networks (HANs) brought the power of collaborative solutions to the pursuit of enrolling uninsured people in an existing patchwork of programs, connecting coverage with residents in need. The networks brought together people in the communities who were on the front lines enrolling the uninsured (community health workers from hospitals, health centers, and other organizations) with state agencies responsible for providing coverage (Mass Health–Medicaid and the Department of Public Health) and most critically a state health care advocacy group that tracked issues affecting the uninsured (Health Care for All). Community Partners, the organization that I had

founded, coordinated the effort by providing the glue—facilitation and direction for the meetings.

The ultimate mission of the HAN meetings was to increase health care access throughout the state. Our goals for the HAN meetings were to: exchange information about changes in programs and policies; share promising practices for outreach and enrollment; serve as a link, and feedback loop, between communities, state agencies, and institutions; advocate for policies that expand access and increase enrollment; and always to keep a focus on issues of culture and race in outreach.

Policy change was always the top priority. In every aspect of their work the HANs illustrated the principle of taking action to address policy issues and of using appropriate social change strategies to modify regulations, laws and funding amounts.

How did we do it? The meetings, based on the principles of collaborative solutions all had a similar rhythm and structure. People sat in a circle, with a designated facilitator. (Between 20 and 60 people attended each meeting, with a total of 250 people attending one meeting each month across the six regions.) Each meeting began with introductions, followed by updates from the communities. (By beginning with community members, we gave them, rather than the state agencies, the first access to air time.) These updates highlighted practices that had worked over the past month (such as passing out information at the town dump) along with those that had not worked (such as getting no response to a mailing sent out with electricity bills).

The updates also included comments about gaps in coverage and the workers' frustrations. We always highlighted areas where there was a need for policy changes. People from the state agencies gave updates. Health Care for All (HCFA), the advocacy organization, then had time to share updates in policies, practices, and legislation that were new or on the horizon. HCFA usually brought us an advocacy agenda. Finally there was time to focus on a single topic or issue, or to have a presentation on a new program.

The Outcomes: When you look at the events in an individual meeting, they seem tiny. One person shares a grievance about paperwork. Someone else passes along a compliment. Yet another says, "Let's consider mental health" . . . or "transportation" . . . or "teen parents". Over time, though, the results of these interactions add up. They even produced major changes in apparently intractable systems.

Ingrained assumptions and behaviors changed in revolutionary ways. As they sat in a room together

and solved problems all parties were able to change their views of each other. This increased mutual understanding and respect. It also prepared everyone to work together on the next difficult issue they determined to tackle. For example the relationship between the community outreach workers and the staff at Mass Health changed dramatically over the years. Where they used to be adversaries battling over coverage for individuals, they became strong allies in making the system work.

Due to the HAN meetings, among other interventions across the state, Massachusetts was number two in the nation in terms of success at enrolling children under the federally sponsored State Children's Health Insurance Program (CHIP), designed to cover uninsured youngsters who did not qualify for Medicaid. Real enrollment numbers did increase.

During the last year that I worked at UMMS, the HAN meetings took on the topic of outpatient access to mental health care. Outreach workers had noted that they did not know where to send people who had serious mental health problems but no insurance for outpatient care. So we held six meetings across the state and discovered in black and white what we had known intuitively all along: there was no coordinated outpatient mental health system. We documented the comments made at the meetings and issued a report entitled *A Tangle of Yarn*. This report was similar to many others we had released.

However, this particular information aggravated the Commissioner of Mental Health, who let her ire loose on the Vice Chancellor of the Medical School, who then let loose on me. After eighteen years at UMass Medical School, I was given three days to make the choice of resigning with a small severance package or being fired for acting against the school's best interests. The medical school had hundreds of thousands of dollars of state contracts, and many of those were from the Department of Mental Health. Consequently, the vice chancellor was very concerned. As he saw it he could not afford to lose that business. My choices were very limited, so I resigned.

I would not have predicted that this report would have been one that would cause so much trouble. While the work we did was often political and controversial, our goal was always to serve the best interests of the community and the state. Many other projects we were working on at the same time contained more obvious potential for throwing us into the middle of controversy and battle. We were not reckless in the issues that we raised but we were guided by community psychology values of social justice.

As community psychologist Jim Kelly has written, risk-taking is an integral part of this work: “risk taking in this context refers to being an advocate for real causes and helping the community move beyond its present steady-state” (Kelly 1971, 901).

What HANs illustrate about CP practice and policy:

The HANs were designed explicitly to implement and modify policies around health care access. Policy change was always the top priority. In every aspect of their work the HANs illustrated the community psychology principles of taking action to address policy issues and of using appropriate social change strategies to modify regulations, laws and funding amounts.

Looking at the big picture, we learned that the fact that people were eligible for insurance was not the same as having those people enrolled in insurance. We discovered that when we celebrate legislative successes that expand health coverage, we should not assume that all those who are eligible for the new coverage will actually receive it (DeChiara and Wolff 1998).

The work of the Health Access Networks illustrates community psychology working at multiple levels of policy change: within state organizations, across the state, and on state money allocations. It is an example of a community psychologist taking action, and working for social change with a policy focus at multiple levels. The HANs were set up and structured to focus on policy change and they succeeded in doing just that. They also illustrate the SCRA mission of “Enhancing well-being and promoting social justice for all people by fostering collaboration where there is division and empowerment where there is oppression.”

Community Story # 3: Health Equity and Social Justice

A third policy story involves my recent work as consultant to the Boston Public Health Commission’s Center for Health Equity and Social Justice (BPHC). This work focused on health disparities, health equity, and racial justice. In the first two stories, my own organization initiated and managed the efforts described. In the work with the BPHC, I was a consultant and trainer for their processes and programs.

For six years, from 2006-2013 my work with this Center has been an especially exciting engagement, with policy change regarding health equity driven by local coalitions and communities. The simple fact that a big U.S. city health department has an office

named the Center for Health Equity and Social Justice is surprising, and attests to the cutting-edge vision that is being manifested by the people in this organization. Their efforts were led by Nashira Baril and her very talented and young staff (Baril, 2011). An early video on the work of the BPHC and their framework provides a good overview:

<http://www.youtube.com/watch?v=TCnDZW-sJXU>

In the work with the BPHC my role was that of consultant. In that role I was able to support this important work in social change through a) organizational consultation to their goals, mission and structure, b) specific training to the various sites on topics such as sustainability, and differentiating solutions that were policy solutions from program solutions, and c) ongoing coaching of individual coalition staff and the steering group, helping them set goals and manage barriers. This is an illustration of a community psychologist in a role as a consultant pursuing policy change.

I began my work with this innovative grassroots program when it was called Boston REACH 2010 and focused on racial disparities in breast and cervical cancer survival rates for Black women in Boston. Boston REACH provides an excellent example of what a community can accomplish when it acknowledges the issue of racism in health and then creates a comprehensive social-change effort to address inequalities. The success of the Boston REACH allowed it to receive funding as a Center of Excellence in the Elimination of Disparities to fund and support seventeen other communities across New England that have followed their example and created community responses to promote health equity. As they expanded I became a consultant to many of these communities across New England.

All of these new efforts were built around the following six key concepts. These concepts are all central to the Center for Health Equity and Social Justice’s beliefs and are also illustrative of the best of community psychology principles. When I find community change efforts that are consistent with community psychology principles and values it allows for the full use of my consulting skills to support their efforts to accomplish their goals.

1. Addressing institutional and structural racism

The Boston Public Health Commission operates with an explicit understanding that racism is at the root of racial and ethnic health inequities. Racism affects health directly by causing stress and anxiety, and it also affects health indirectly by its impact on the social determinants of health. Every community that receives a grant, following the lead of the BPHC

itself, engages in a three-day workshop on undoing racism for its core team and for community members. Although the central role of racism in health disparities may seem obvious, the Boston REACH program was one of the few funded efforts in the nation that named racism as the issue and addressed it directly. My consulting work on this principle often involved supporting project staff in addressing the “push back” that they encountered when explicitly using the term ‘racism’.

2. Focus on social determinants of health (SDOH) and in relation to racism and health

As the REACH 2010 group moved to become a Center of Excellence, they also expanded their approach to include an explicit focus on the social determinants of health. These social determinants are factors that have an exceptionally strong and well-

demonstrated influence on health, such as education, socioeconomic status, housing, jobs, economic opportunity, transportation, food access, safety, environmental exposures, and so on. By looking at community health from the perspective of the social determinants, groups can examine the ways in which institutional racism plays out in each realm. (See Figure 1). As the powerful film series “Unnatural Causes” makes clear, “your zip code may be more important than your genetic code in determining your health” (<http://www.unnaturalcauses.org>). This could be a wonderful phrase to summarize all of community psychology. On this principle my consultation was to the staff and their community coalitions on how the social determinants influenced health in their community. An ecological community psychology framework really was helpful to them.

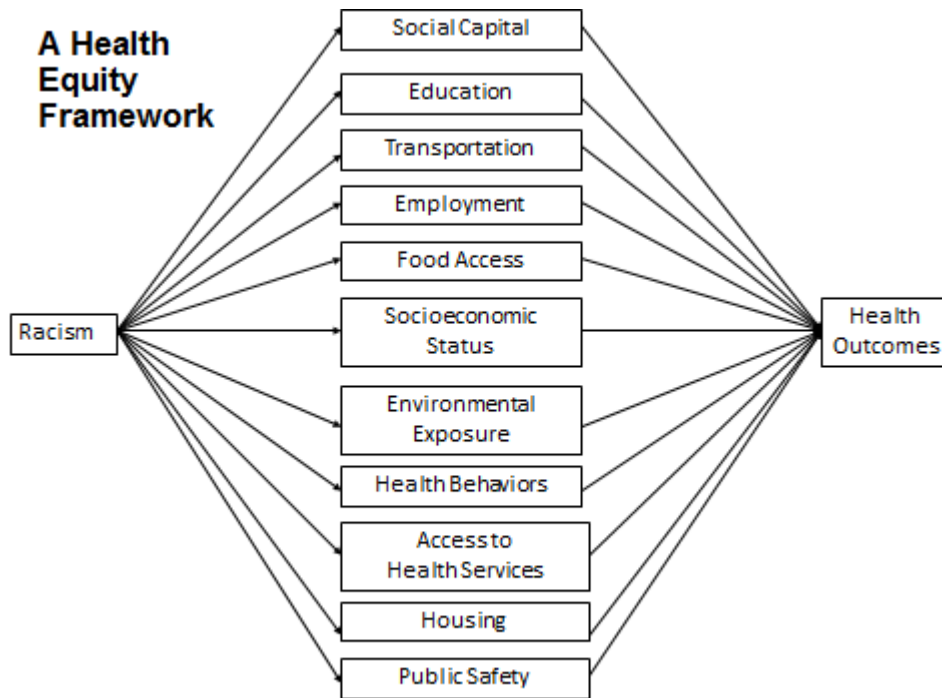


Figure 1. Baril et al 2011

3. Grassroots community engagement

The Center’s approach is based on a core belief that grassroots involvement is essential to solving problems. Barbara Ferrer, the Commissioner of Public Health for the City of Boston, put it this way: “The role of a public health department is to create a space for residents to come together to define a problem, to define the solutions, and then enter into a

dialogue with us—not the other way around. Not we define the problem, we define the solution, and then we invite you in to help us implement the solution, which is what we’re most comfortable doing. We felt like part of the solution lay in being able to get a broad-based coalition that would tackle issues like racism. And that would bring together the provider community with the resident community to tackle those issues.” (Boston Public Health Commission,

2013). Here I had to both push the community coalitions that consisted mainly of traditional service providers to reach out to the resident community, and also work with them to welcome the residents into their circle (not an easy task for many).

4. Policy change

The project has an explicit focus on creating long-lasting policy and social change that will endure as a legacy in each participating community. This approach insists that communities explore policy changes that will improve community health, not just develop programs. Thus all grant-recipient communities were required to develop and implement policy-based solutions for addressing racism and the social determinants of health.

Examples of success in local communities include:

- Creating zoning changes to allow for construction of a new supermarket in a low-income community. Video on the work of getting a supermarket into the neighborhood in Springfield— <https://vimeo.com/51135321>.
- Successfully advocating with the Governor for funding for summer jobs for teens.
- Working with the Superintendent of Schools to create an annual Racial Justice Review of educational and disciplinary disparities in the schools for students of color. Video on educational reform in Worcester: <https://vimeo.com/50828134>.
- Creation of a Food Policy Council by City Hall.
- City Council creates areas where community gardens can be created for extended periods of time.

All organizations in the Jamaica Plain coalition created and then had their agencies adopt a Racial Equity Statement adhering to the principles of racial equity. My consultation on policy change involved helping the coalitions conceive of policy solutions to the racial inequities that they uncovered, and then developing appropriate policy change strategies ranging from working with political figures to community organizing.

5. Focus on a shift from social service to social change

For traditional nonprofit agencies that work with the Center, the greatest challenge often was found in the explicit shift in focus from social service to social change. For example, the Center is less interested in the creation of new education programs for Black men at risk of diabetes than in promoting efforts that will change the institutional racism in housing, food access, and employment policies that put Black men

at higher risk for diabetes. For nonprofits accustomed to delivering social services, this was a huge change in emphasis.

6. Collaboration

Finally, the Center understands that in order to accomplish systems changes of this large scope a community must develop a broad-based coalition of residents, agencies, government, the private sector, and so on that will work together collaboratively. My expertise in coalition building was a great asset on this principle.

Together these six key concepts became a powerful force for transformative community change. This work is described in a new manual describing the work of the BPHC Center for Health Equity and Social Justice, “Creating a Health Equity Coalition: Lessons from REACH Boston (2013; also in Baril, 2011).

One community’s story: The Jamaica Plain Youth Health Equity Collaborative

How does this model translate into action in local communities supported by the BPHC Center? The BPHC model becomes concrete in describing one local coalition that was being supported by the center. Jamaica Plain (JP) is a fascinating neighborhood in Boston. It includes an affluent white community along with low-income Black and Latino communities — there are really two JPs, the rich one and the poor one. Accompanying this economic division are social and health inequities. To address the gap, the Southern JP Health Center (SJPHC) became the sponsor for the development of the Jamaica Plain Youth Health Equity Collaborative.

The goals for the JP Youth Health Equity Collaborative were to: involve residents, organizations, and youth; examine health disparities; identify causes, including social determinants; create a common language and framework; and define and implement programs and change policies.

My role with the JP Youth Health Equity Collaborative was to help design and facilitate their meetings, with a special emphasis on ensuring that the youth in the coalition were respected, engaged and active in the meetings. The staff had the health equity, youth development, and racial justice knowledge; I brought the coalition building and community development techniques and skills.

In its first year of planning, the collaborative held a series of interactive Youth Health Equity meetings, called “bucket meetings.” Each bucket meeting engaged a cluster of young people and focused on one social determinant of health. The purpose of the

meetings was to gather youth perceptions on that social determinant of health. Collaborative members presented each small group of young people with a case example; the examples were variations on real stories about community members.

The facilitators then asked the small discussion groups the following questions: What are the employment inequities for low-income African American/Latino youth illustrated by this story? What is the role of institutional racism in the story? How will this affect the youth's health? And what could we do about this? What possible action steps and strategies come to mind?

The bucket meetings were well attended by JP young people, who had no difficulty addressing these questions, for each bucket. Young members of the community implicitly understand the issue of social determinants of health and institutional racism. Ultimately they choose to focus on youth employment.

As part of the collaborative's work on youth jobs, the group helped plan and took part in a youth-led protest rally at the State House urging the legislature to reinstate funds for summer jobs for young people. The orderly yet powerful rally of 700 young people caught the attention of both the media and the legislators. The money was re-instated, a significant policy victory.

The project also issued a report on health in young people in JP, titled "02130 Health and Youth". Inside the report, each social determinant is examined, and the coverage includes youth stories, youth quotes, data, and ideas on what actions can be taken. The report is available on the BPHC web site: <http://www.bphc.org/programs/healthequitysocialjustice/toolsandreports/Pages/Home.aspx>

As the work with the youth progressed, the Southern Jamaica Plain Health Center brought together 16 youth, half of whom identify as white and half of whom identify as people of color, to participate in a year-long racial healing and reconciliation process. (See video in GJCPP <http://www.gjcpp.org/en/photovid.php?issue=12&photovid=38>).

The remarkably skilled staff of the SJPHC led this effort but reported the consultation that they received to be crucial to their success both in strategizing upcoming meetings, helping to facilitate meetings, and supporting staff.

What the work with the BPHC on health equity illustrates about community psychology and policy change:

The BPHC's approach to the issues of health disparities makes a clear statement on the key role played by institutional racism in all the social determinants of health sectors. They follow this with actions to address policy change and societal change at the community level. This is a wonderful model for community psychology and for all those addressing racial health disparities. The communities and staff engaged in this work were deeply moved as illustrated in this video of project directors discussing how the experience affected them: <https://vimeo.com/52888087>

There is a striking similarity of six key guiding concepts of the Center for Health Equity and Social Justice and basic community psychology principles. The principles that guide their work also parallel the six key community psychology principles I've written about in *The Power of Collaborative Solutions* (Wolff, 2010). (Engage the full diversity of the community, encourage true collaboration, practice democracy, build on community strengths, take action for social change, engage spirituality as your compass for social change). The Center's work illustrates these six key principles in action. The consultation they received helped them to manifest their principles into real community and policy changes.

The work of the JP Youth Health Equity Collaborative is especially noteworthy for putting youth at the forefront of the creation of community and social change. For community psychology this sets a model for supporting the next generation, our youth, to come forward and own the community change process by being the key players in it.

Conclusions:

When we think of community psychology and policy we often think of academic researchers presenting research-based findings in position papers or legislative testimony. The work described in this paper presents an alternative model wherein the work of practitioners of community psychology provides examples of community psychology policy change.

Practitioners of community psychology can regularly engage in policy change. We have much to offer to such efforts through our roles as organizer, facilitator, energizer and coach while the community partners remain the decision makers.

A root cause analysis on most community issues can highlight the underlying issues and allow for the creation of a social policy change agenda. This process is not often followed but is always available. Following such a root cause analysis and development of a social change agenda the

community psychologist practitioner must find the courage, support and avenue to pursue the change agenda which may frequently involve risks. Or more likely the community practitioner will need to work with their community partners to make the decision to move forward on this more risky social change path. Not all community partners are interested, willing or able to join in. However, a community psychologist's role is to point out the social change policy options.

The three examples presented in this paper illustrate some of the possibilities available for engaging as a community psychologist in social policy change including building healthy communities, focusing a policy agenda on a specific issue (health care access), and building the capacity of local communities to address social change issues such as systemic racism. These examples evolved over time and in all the examples the community psychologist was able to support these efforts at their various stages of development.

On the personal side the work for me calls on my passion for social justice. Over time doing the work has come with an understanding that it is indeed 'political'. The process actively involves elected officials and government staff as partners not enemies; this can actually be a fun experience.

On the other hand the work comes with risks. When at age 58 I was given three days of notice to leave a position I had had for 18 years, I was quite stunned and disoriented. I never felt that what we had done was deserving of the harsh response by the Medical School nor was it wrong to issue the report. But at that point it was clear to me that working for social change in that position was over. So it was time to move on and make the best of it. There were many hard months ahead but I made a promise to myself to never work for another institution as an employee, and that has been a wonderful path.

We need to encourage more community psychologist to tell of their experiences in the pursuit of social policy change at the community level in order to learn how to be most effective in these roles and to learn about the range of possibilities. By sharing these exemplars of policy practice we might inspire others and legitimize this important work.

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