

# Faith, Health, and Policy



## PUBLIC HEALTH REENTRY IN SAN DIEGO

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*April 2009*

# Faith, Health, and Policy: *Public Health Reentry in San Diego*

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## Executive Summary

IN AUGUST 2006, a collaboration of African American clergy, community-based organizations and state and county representatives joined together to form a Public Health Reentry Task Force to address the health care needs of San Diego County's rapidly growing population of formerly incarcerated persons. The group set out to examine the implications of Public Health Reentry in San Diego County, and to develop a set of policy recommendations that would result in increased access to medical services for formerly incarcerated persons and their families. Regional Congregations and Neighborhood Organizations (RCNO) Training Center reinforced this effort by providing strategic planning, leadership development, meeting facilitation and capacity building technical assistance services.

Since 2004, RCNO Training Center has been engaged in a statewide Public Health Reentry (PHR) Policy Initiative across the five California counties receiving the majority of the individuals being released by the California Department of Corrections and Rehabilitation (CDCR). Led by organized groups of community minded pastors with churches in San Diego, Los Angeles, San Bernardino, Riverside and Alameda counties, the PHR Policy Initiative focuses on identifying the connection between the health status of recently released offenders and its link to, and impact on, the health of Californians. RCNO launched the initiative after research and analysis conducted nationally, statewide, and in local communities revealed both the potentially devastating impact of a public health crisis in these communities, and the potential negative fiscal impact that disease, whether isolated or widespread, can have on local institutions.

This report focuses on the organizing efforts of RCNO in the San Diego area, in particular the challenges and successes of organizing the faith community to address the public health reentry problem, and to create a ready base of faith community leaders to participate in the public life of their communities.

## Why Public Health Reentry?

THE PROCESS of reintegrating formerly incarcerated individuals into the daily life of their communities is loaded with potential problems from the outset, among these, whether they can find gainful employment and otherwise become contributing members in their communities, as well as the safety of both the parolee and members of the community. A potentially explosive issue that has gone largely unaddressed by public officials is that of the health of parolees as they reenter the larger society and the potential effect they have in their communities. For a variety of reasons noted below, this should be an issue of significant public concern, yet it has gone largely unnoticed and unaddressed. Public health reentry is an issue that directly impacts the lives of individuals in the communities into which parolees are released, and one that also has a significant fiscal impact on the public health systems in those counties where parolees will settle.

Statistics show that parolees are often far less healthy than other residents of the communities in which they live, and are often infected with highly contagious diseases such as tuberculosis, HIV/AIDS, hepatitis C, and may have other problems such as mental illness. The overall lack of quality health care provided to prisoners, and the lack of communication with them about their health when they are released, allows them to carry their health problems with them into their communities and into

all of their involvements with family, friends, churches and community organizations, and even intimate relationships.

This lack of communication about, and provision of, health care — and what amounts to a code of silence between the prison system, local government officials, the communities, and even between individuals in intimate relationships — can be a deadly bargain indeed. To the extent that parolees either do not know, or do not disclose, their health problems, the potential for a major public health crisis is created, particularly, but not limited to, those communities into which parolees are released and live. The solution to this problem then must include more communication and coordination between community leaders and local officials, with all working toward the better health of their community. In what follows, we detail one effort to organize community leaders to engage with public officials in the policy realm in the service of building a better, and more inclusive, public square.



## Public Health Reentry in San Diego

PUBLIC HEALTH REENTRY is defined as the way in which external health delivery systems interact with state prisons and county jails to ensure institutional and community public health preparedness, particularly given the disproportionate impact of communicable disease on incarcerated and formerly incarcerated individuals, their families and communities.

According to the Department of Justice's Bureau of Justice Statistics, San Diego ranks among the top five counties in the nation with the highest number of formerly incarcerated persons returning to its local neighborhoods as residents. (Bureau of Justice Statistics, "Reentry Trends in the United States," 2004)

Most of San Diego County's parolees are released from a state prison system whose health service system is, by any measure, in shambles. Since 1988, a series of successful lawsuits have argued that this system violates the Eighth Amendment of the U.S. Constitution, which prohibits "cruel and unusual punishment." On June 30, 2005, U.S. District Judge Thelton Henderson concluded that the court had no option other than to transfer oversight of California's prison health care system for inmates to a court-appointed receiver. In the court's decision, Judge Henderson cited "horrific details," particularly an "uncontested assertion" that "a prisoner needlessly dies an average of roughly once a week." (Jennifer Warren, "U.S. to Seize State Prison Health System," *Los Angeles Times*, July 1, 2005)

It is not surprising then that parolees who leave this dysfunctional health care system are in far poorer health than the general population of San Diego County.

According to the Department of Justice's Bureau of Justice Statistics, San Diego ranks among the top five counties in the nation with the highest number of formerly incarcerated persons returning to its local neighborhoods as residents.

According to a report on public health challenges ("Prisoner Reentry: What Are the Public Health Challenges?" RAND, 2003), parolees in San Diego County experienced:

- 4 times greater rate of active tuberculosis
- 9 - 10 times greater rate for hepatitis C
- 8 - 10 times higher rate of HIV
- 5 times higher rate of AIDS
- 1.5 - 5 times higher rate of mental illness
- Higher rates of substance abuse
- Higher rates of chronic diseases.

Further exacerbating the public health challenges of reentry are the following realities:

# The general population of people residing in San Diego's low-income communities already suffer from a disproportionate amount of health-related challenges.

- Estimates of diseases that have been contracted in prison and that are carried by parolees are likely understated because of a lack of internal electronic data gathering and tracking, limitations regarding accurate and adequate diagnoses of inmates, and almost nonexistent communications within California's prison-based medical systems.
- California's prison-based health care system does not prepare parolees to use public and private health clinics in the counties where they will reside. The state system makes no attempt to create links with county health and human services that might provide supportive medical services for parolees.
- Public health programs experience difficulty in identifying parolees who need their services. There is no coordination between counties and prisons in planning for the continued care of inmates after they are released.
- After release, although still wards of the state (California Department of Corrections and Rehabilitation), most parolees do not have medical insurance or stable sources of medical services. Very few have any form of private insurance or belong to Health Maintenance Organizations. Eligible parolees may sign up for Medicaid or Medicare, the Community Support System for the Mentally Disabled, and programs offered by California's Department of Aging, but few do, often because they are unable to complete required application forms, do not possess appropriate personal identification documents, and/or have no permanent address. If parolees do succeed in applying for public health insurance programs, they often experience long delays while their enrollments are finalized.
- Parolees cluster in many of San Diego County's most impoverished neighborhoods. These neighborhoods are located in every region of the county. They are located in all of the county's supervisory districts.
- The general population of people residing in San Diego's low-income communities already suffer from a disproportionate amount of health-related challenges including poor nutrition and diet, premature death due to chronic illness and communicable and non-communicable disease, limited access to adequate health care — especially preventive health care and a lack of education about personal health maintenance.
- A summary of reentry trends by the Bureau of Justice Statistics (BJS) revealed that almost 25 percent of state prisoners



released by the end of 1999 were alcohol-dependent, 14 percent were mentally ill, and 12 percent were homeless at the time of arrest, suggesting preexisting conditions of poor physical and mental health.

- Females represent a growing number of parolees.

(Source: Regional Congregations and Neighborhood Organizations, “Policy Perspectives: San Diego County Public Health Reentry Project,” February 2008)

Given the great need, and the threat, to both the health of the parolees and the communities they return to, PHR is an ideal initial issue around which to organize community involvement. The goal, however, is not simply to create a reasonable and humane PHR policy, but also to organize, train, and empower community leaders who will be able to address other social issues that they see in their communities. In the end, it is the community itself which must make itself heard in the halls of power, to demonstrate its knowledge and expertise related to these problems, and the ability to work with government officials toward crafting and implementing effective public policies.

The goal is to create a reasonable and humane PHR policy, but also to organize, train, and empower community leaders who will be able to address other social issues that they see in their communities.



# The RCNO Organizing Process

*The first question that must be asked is why are we organizing? Are we responding to a crisis? Are we trying to address a specific issue, or, are we attempting to build an organization that will respond to multiple issues?*

## **The RCNO Approach**

RCNO teaches its affiliates how to organize and build public power. RCNO defines power as an ability to act effectively in the public arena or, an ability to achieve organizational objectives.

## **Benefit of RCNO's Approach**

RCNO's organizing approach produces strong, multi-issue organizations. Poverty, inequity and neglect require multi-issue organization development. Rarely do organizing efforts that arise out of a crisis, or surface in response to a specific issue, build enough public power to create lasting community change.

## **Defining Your Constituency**

Clearly defining the constituency is essential to the organizing process. Who are we organizing? Who are we trying to organize? Are we organizing congregations? Are we organizing civic groups? Are we organizing some combination of both?

## **Use of RCNO's Theory of Change**

"Culture, Historical Analysis and Epistemology" are the basis for effective community building. Defining the people to be organized allows RCNO staff to examine their culture and history. It also allows staff to understand how the constituency to be organized constructs knowledge. These important steps demonstrate respect for the people being organized.

## **Forming the Sponsoring Committee**

The first major task in the RCNO organizing process is the formation of a Sponsoring Committee: a group of leaders that accepts the responsibility for overseeing the development of the organization. The Sponsoring Committee has three major responsibilities: (1) Defining the area to be organized; (2) Securing funding for the organizing project; (3) Recruiting additional leaders to sit on the Sponsoring Committee.

## **Identifying Primary Leaders**

RCNO staff is responsible for identifying primary leaders for the Sponsoring Committee. Primary leaders have a large identifiable following and can deliver that following. Primary leaders can commit themselves to a vision larger than their own. Primary leaders are identified through one-on-one interviews with RCNO staff.

**RCNO's organizing approach produces strong, multi-issue organizations.**

### **Building an Interview List**

RCNO staff begins to identify primary leaders by constructing a list of primary candidates to be interviewed. The purpose of the interview is to ascertain the leader's interest in joining the Sponsoring Committee.

### **How to Construct an Interview List**

When organizing congregational based organizations, staff members begin building a list of faith leaders who are pastors of local congregations. The list is organized by denomination, conference, convention, and faith tradition. Staff members obtain the lists by contacting denominational offices, newspapers, relationships with existing clergy and internet searches. Staff members also compile lists of civic group and service delivery organization leadership.

### **Congregation Size: Bigger Does Not Mean Better**

RCNO staff members do not discriminate against small to mid-size congregations during the recruitment process. Eighty percent of the faith communities in the United States have fewer than 100 members. Ninety percent of the faith communities in the country will never see more than 100 members during weekly services. Large congregations are important institutions in local communities. RCNO also encourages its staff members to include these congregations in the recruitment process. The most important rule in the recruitment process is to interview as many leaders as possible, regardless of the size of their congregation.

### **Listening is Important**

Recruitment begins by conducting one-on-one interviews with primary leaders. The purpose of RCNO's listening campaign is to attract institutional leaders that agree to sit on the Sponsoring Committee. RCNO staff members do not try to sell participation in the organizing project. Rather, staff attempt to help leaders discover the value of participating in the project. Staff also assess the qualities and characteristics of the leaders to determine if the leaders will be productive Sponsoring Committee members.

Staff members must exhibit two important skills during the recruitment process: listening and asking effective questions. RCNO staff are taught how to use their ears instead of their mouths.

(Source: RCNO, "A Mind to Build: A Guide to New Organization Formation," 2006)

## Challenges of Organizing

DURING THE FIRST YEAR of the project, RCNO, in its efforts to identify leaders in the San Diego area faith community and to recruit several to be members of the Sponsoring Committee, interviewed approximately sixty pastors individually, and conducted three policy briefings. The policy briefings were organized to provide pastors with a clear understanding of the public health policy challenges and implications, to assist in identifying local stakeholders, and to detail RCNO's statewide and local approaches to addressing the challenges faced by formerly incarcerated individuals. Subsequently, four leadership development training sessions were held with Sponsoring Committee members, the purpose of which was to teach pastors the concept of building public power, to develop institutional practices, and to understand and appreciate the significance of their role as the faith community in this process. By all reports, the Sponsoring Committee members who participated in the educational and training process saw it as a fairly intensive experience with a steep learning curve. However, once

the Sponsoring Committee members gained an understanding of county processes and the role that they as pastors could play in those processes, their educational efforts proved to be a rewarding and exciting experience for them.

Currently, the Sponsoring Committee, which is now organized as the San Diego Area Congregations for Change (SACC), consists of eighteen members, each representing a different congregation or community organization in the greater San Diego area. While there was a fair amount of turnover in the membership of SACC in the first year or so, it is now a stable group of community leaders who have established a covenant together to be a "learning community" that is concerned about the larger issues that impact the communities where they live, work and worship. They have been transformed into a group that seeks to be proactive in meeting these issues, working to break through the silo structure of county organization and management systems, with the intent to work with county officials towards solving the issues that impact their communities.

According to several members of the Sponsoring Committee and RCNO staff, there were several challenges to getting people mobilized to participate in the public health reentry project. For pastors who were interested in being a part of this effort, the most significant challenge to participation was the constraints on their



time. Most of these pastors were already committed to many different responsibilities, to their families, to their churches, and to other community organizations. Many pastors are also bi-vocational, effectively splitting their time into even smaller available units, and adding one more responsibility to their already full list of duties. Similarly, the size of the congregation impacts the level of engagement in the organizing process that pastors and their congregations are able to provide. It should be noted here that the majority of the participating congregations are small in size, ranging from 20 to 150 members. In this regard, these congregations are similar to most American congregations, which average less than 250 members.

Religious leaders who participate in the policy arena need to be able to articulate their goals in public policy language.

A second challenge to overcome was the gap in language between the religious world and the political/policy world. For many faith leaders, the rhetoric and language of public policy are new forms of communication that they must learn in order to interact meaningfully with governmental agencies, boards, and the like. Religious language on the other hand, (such as parables, biblical stories and biblical references, and pastors talking about their efforts as “ministry”) which is often the “first language” of pastors, has very little authority in the political arena, and in fact can conjure images of religious fanatics to public officials. As such, religious leaders who participate in the policy arena need to

## Health Reentry Organizing Implementation Timeline: First Year

### *Month 1: Start-Up*

- Establish a Monthly Meeting Schedule
- Identify Assets and Opportunities
- Identify Facilitator/Staff Support
- Establish Communications Methods

### *Month 2: Key Lessons*

- Clarify Expectations
- Identify Negotiables
- Identify Up-line Decision Makers

### *Month 3: Information Gathering*

- Overview of State and County
- Reentry Numbers, Health Services
- Mapping

### *Month 4: Increasing Awareness*

- Major Outbreaks of HIV and hepatitis C

### *Month 5: Response*

- Health Department, Department of Corrections and Rehabilitation, County Jail, Hospitals, Community Clinics, Faith Community

### *Months 6-10: Developing Policy Recommendations*

- Public Health Department, Public Safety Department, Community, Faith-based Community

### *Months 11-12: Preparing Board of Supervisors Presentation*

- Overview of Task Force Work
- Task Force Recommendations
- Collaboration with other counties



be able to articulate their goals in public policy language that meaningfully takes into account the realities being addressed.

A third challenge similarly relates to the two different worlds of the faith community leaders and the world of government and policy. Within the faith community, leaders are generally accorded deference and authority by their congregations and colleagues as a matter of course. That is, their authority lies in the respect that congregants have for the office of pastor. Yet religious leaders do not automatically have authority outside of their own religious communities, particularly in the government dominated policy arena. Thus faith community leaders need to understand their role in the policy process in which they are becoming involved, become informed and educated on the issues, and be able to talk about the issues in language appropriate to the policy context.



Religious faith motivates them to expand their model of ministry to include all those who live, work, and worship in their communities.

In the world of public policy, faith community leaders must also be able to honestly assess their ability to work with leaders from other religious traditions, and no religious tradition, as well as across gender lines. Regarding gender, the leadership of most faith communities is predominantly male — African American churches are no exception in this regard — with women generally operating in important support roles in their congregations. Thus to have women as equal partners in the organizing effort, especially when they are not clergy, can be a challenge that needs to be acknowledged and overcome, keeping in mind the Sponsoring Committee's ultimate policy oriented goals. As regards working with leaders from other faith traditions, there were some cases where leaders were unable to participate in the program out of a religious conscience that would not allow them to participate with those who were from other faith traditions, or who had different conceptions of the same faith tradition, particularly in terms of living out their faith commitments in the public sphere. That is, for some, their faith instructs them to be more exclusive, choosing to work primarily with those who embrace a particular faith perspective. By extension, this perspective effectively contracts the public square by removing a component of the faith community from public dialogue over important issues. For others, their religious faith motivates them to expand their model of ministry to include all those who live, work, and worship in their communities. This in turn, expands the public sphere by injecting a faith perspective into public dialogue over important issues that impact their communities.

In a similar manner, government officials often conceive of their role as one of authority and leadership in this process rather than seeing themselves as partners with faith community members who are

## Quick solutions to such intractable problems as health care reentry are rare or nonexistent.

engaged in a collaborative effort to respond to the public health implications of residents returning from prison. In this, officials often operate in “information silos,” that is, management systems where the focus tends to be inward, with managers serving as information gatekeepers, and less focused on communicating across departmental boundaries. This makes coordination and communication among departments, as well as working with external parties, such as constituency-based citizens organizations, difficult to achieve. These “silo” systems impact the ability of officials to perceive the magnitude of the challenges facing the larger public. As such, one of the major thrusts of the organizing process is to change the nature of power relationships between government institutions and the communities they serve, transforming the relationship from one of government officials giving directives and faith leaders absorbing their directives passively, to one of sharing ideas and information, working together toward solutions. The faith community and its leaders need to constantly press the point that they have ownership of their own processes in this effort, and they are seeking support and collaboration, not directives from county health officials as they work to address the problem of public health reentry. Thus as potential points of conflict arise over authority and who might be able to best serve the needs in their communities,

faith leaders need to remain focused on their goals and objectives, pushing forward to accomplish them, to understand the gaps in health service delivery and to establish relationships with county officials in order to produce policy recommendations which will increase access to public health services for ex-offenders and their families.

A final challenge to organizing successfully is evidenced by those who have a great enthusiasm to participate in the process, yet are oriented toward quick solutions. Quick solutions to such intractable problems as health care reentry are rare or nonexistent, which then may lead people so oriented to drift away once their initial enthusiasm for a solution is not met. This is not to suggest that enthusiasm isn't a good thing, rather, that it can only go so far, and beyond that, participants must be committed to the process and to seeing that process pursued to success. Similarly, once the basic objectives of any organizing effort have been met, there is the tendency for participants to feel as though their work is done. This then raises the challenge of maintaining the interest and commitment to the process of producing results in the long term. That is, even though there are successes in the near term, there are larger goals still to be met, and in some ways will always remain.



## Successes

BESIDES THE CLEAR SUCCESS of the program to meet the goals that it set out for itself at the beginning of the project — in particular, organizing the Sponsoring Committee and working in partnership with county officials on the PHR Task Force toward crafting policy recommendations for public health reentry — other successes can be identified, particularly those that are a result of the organizing process itself. These will likely have a long term impact in the communities served by the congregations and community organizations involved with SACC. It is clear that for organizing efforts like SACC to succeed, there needs to be a thorough understanding of the problem that is being addressed, and then a strategy to get potential program leaders to “buy in” to being a part of the process for change. As well, it is important to remember that one of the primary goals of the organizing process is not simply to mobilize community members around one specific problem, but to increase the pool of publicly skilled leaders in a particular community through those efforts. That is, the “buy in” is not simply for one

issue, but for a process that then results in more community voices contributing to policy discussions, thus in turn expanding the public square by their inclusion, and increasing democratic participation by the community members who have a stake in helping to create positive change in their own communities and in the larger region.

The initial recruitment efforts and leadership training sessions sponsored by RCNO to form the SACC Sponsoring Committee, served both to make leaders from the faith community aware of the problem of access to health care for parolees, and to provide them with the necessary information about the issue of public health reentry — much of it requiring significant effort from the community leaders to study and engage in what was often an entirely new world to understand. Sponsoring Committee member Pastor Archie Robinson, of New Birth Christian Fellowship, said that these sessions, and the subsequent “listening campaigns” that his church undertook in the community, were invaluable for him, as he “hadn’t even heard about the problem” of public health reentry before the RCNO sponsored sessions.

In addition to gaining a thorough understanding about the particular problem of public health reentry, or more generally about the public policy arena from study or formal lectures or presentations, a personal experience with the health issue was formative in gaining “buy-in” from participants. In this, the personal experience, whether as one pastor reported, a deep personal heartache for young kids in Balboa Park involved in the sex trade, or for others who had personal or family histories with the criminal justice system, or just having an individual conversation with a supportive public official, or, hearing

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directly from a person who suffers from HIV/AIDS or has some other health issue, serves to link the personal experience to the public issue. This can, and often does, serve to gain initial buy-in, but is insufficient in the long term to sustain participation in the program. Tanissha Harrell, also a member of the Sponsoring Committee, and someone who has worked in a variety of community organizing efforts, said that once people become involved, her job then is to continually emphasize the long term commitment they must have in order to see change happen. In fact, she says that she often tells members of the group sponsored by her congregation, that they may not even see change in their lifetime, but nonetheless, must continue the commitment to changing the system.

One way to drive home the importance of the long-term view, to hear of successes along the way, and to develop a sense of camaraderie within the Sponsoring Committee was to establish the consistency of monthly meetings. These meetings provided a real time opportunity for the leaders to understand how this type of long-term project manifests itself from theory to practice. Not only did these meetings provide the Sponsoring Committee with opportunities for observation, but it helped them to develop their listening skills — a key part of RCNO's leadership training — as different guest speakers or different thought exercises were presented to the group. The regular Sponsoring Committee meetings also helped to build the relationships and trust between the different members, which had the benefit of encouraging a transparent process where frank and open discussions of agreements and differences would be pursued, without threat to the relationships in the Sponsoring Committee or the larger PHR Task Force. In turn, the trust engendered by the

The regular Sponsoring Committee meetings helped to build the relationships and trust between the different members, which had the benefit of encouraging a transparent process where frank and open discussions of agreements and differences would be pursued.

developing relationships served to empower the faith community to pursue the tasks it had set before itself, in that the Sponsoring Committee then represents a much broader segment of the faith community than just one or another congregation would be able to represent.

Since the primary goal of the organizing effort was to develop a set of public policy recommendations that would increase access to public health services for incarcerated individuals as well as after their release from incarceration, PHR Task Force members needed to be well versed in how to think about the different elements needed in such a recommendation. Task Force members were asked by RCNO to develop a detailed report and presentation based on a hypothetical public health scenario involving HIV and hepatitis C outbreaks in Oceanside and Southeast San Diego. This report would then provide one starting point to then develop the public policy recommendations in that it would show the existing procedures for dealing with different public health issues.

For this assignment, the county public health officials on the Task Force were asked to answer questions such as: What policies

and procedures currently exist that dictate how they would proceed with respect to their departments? How would the state or county jail be notified? How would the community be notified? What would be the investigative costs for the county? Is the response quality disaster preparedness?

Not only was the goal to provide the larger PHR Task Force with the information necessary to develop the public policy recommendations, but to provide the type of information that could assist the faith community in understanding the areas in which they can be most effective in their role as community and service providers.

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At the PHR Task Force meeting in which the results of the learning exercise were to be reported, the group was informed of an actual occurrence involving an inmate who had been found to have active (airborne) tuberculosis as he was being transferred from county to state prison facilities. This revelation only came about as a response to some county officials who had minimized SACC's learning exercise as purely hypothetical, with a member

of the State of California Department of Corrections and Rehabilitation, pointing out that the scenario was actually taking place in county facilities. This official was willing to divulge this occurrence, at least in part, because it was the county that was the most liable in the situation as the inmate's condition had gone undiagnosed while in their care. However, because of contradictory policies between state and county agencies regarding health testing of inmates — the county's policy was to test when symptoms were evident, while the CDCR has a mandatory requirement for testing — the inmate's active tuberculosis was not discovered until the inmate was tested upon arrival at the state facility. Although the county has since changed its policies in response to this, and to prevent future, similar, situations, its initial response was limited to a one paragraph mention in the San Diego Union-Tribune. This initial, minimal response served to reinforce the faith community's belief that the policies it was advocating for were needed, that it could help increase awareness about these types of outbreaks, and to provide resources for those who believe they have been exposed to an infectious disease. The experience of a real-time outbreak scenario was instrumental to the group's communications processes and their relative ability to respond comprehensively. Further, given the availability of an actual occurrence, more specific questions were developed to address each phase in the process, from incarceration to release. These questions were distributed for response, primarily focusing on tuberculosis and the county's actual response.

The Sponsoring Committee learned several important lessons through this process. On the one hand, they realized that the actual tuberculosis situation called for an emergency response entirely

different from what they had prepared for the hypothetical HIV or hepatitis C situations. More broadly though, they saw firsthand the limitations and policy gaps of the existing system, such as a lack of mandatory screening for all communicable diseases at county jails and prisons, and the absence of electronic information sharing about important public health issues, which further emphasized the limitation of silo systems approaches where information is produced and kept vertically within the agency but not shared with the broader community or even other government agencies.

As the members of the Sponsoring Committee interacted and worked together, and learned how to participate knowledgeably within the political and policy sphere, they were also able to achieve one of the goals of all RCNO organizing: to form closer and more meaningful relationships among themselves as leaders in their communities. As such, the pastors began to see themselves in the related roles they play in both the security of the congregations and communities they lead, and as intermediaries between those

they serve and the broader environment that influences their constituents. As a result, the pastors began to see their role as one that was shifting from reactive leadership, to proactive leadership, thus expanding their role in both in their local and in the larger community of greater San Diego.

Finally, through all these different efforts, SACC members developed an appreciation for the complexity, difficulties, and possibilities that surround the issue of public health reentry, and have come to the point where they believe that they now have a mechanism to produce a powerful voice in public health reentry for ex-offenders in California.



## Laying the Groundwork for Broader Community Work

THROUGH OUR INTERVIEWS and in reading previous program reports, it is evident that the successes of the organizing effort have resulted in preparing the SACC Sponsoring Committee for community work that goes beyond the immediate issue of public health reentry. This is an outcome that RCNO expects and works toward — preparing community leaders for future organizing efforts beyond the particular issue around which they originally organized their actions, with the goal of expanding community participation in the public square.

Further, participation in the organizing process has led to the creation of intentional relationships between and among faith leaders, thus developing connections to each other in ways that they had never been connected before. This helped to create a sense of support for each other and a better sense of the capacity of the faith community in the San Diego area to act on different county issues. A second result of being a part of the organizing process, for leaders and congregational participants alike, is that it has energized a broader sense of the need to participate in the socio-political system as a component of their faith commitment. RCNO National Director Rev. Eugene Williams calls this “democracy maintenance,” that is, the necessary

organizing of community members to work with elected officials in their communities in order to create more healthy environments for all residents. This was true both for members of the Sponsoring Committee and for members of the congregations they serve. For example, Tanissha Harrell related that a twenty-eight year old woman told her that, as a result of being involved in her congregational committee, she realized the importance of political participation as a Christian, and that as a result, she had just registered to vote for the first time in her life. This new desire to be involved in the political process, even at so limited a level as simply voting, was awakened because of her experience on the committee at her church. Third, participants were energized spiritually in that they began to see in very practical ways that their faith and their activism in this arena were both necessary and related to each other, allowing them to unite in their lives, what had previously been more compartmentalized. Fourth, the process of organizing has increased the sensitivity toward the health needs of formerly incarcerated persons among all those who are involved in the churches and community organizations in the San Diego area. Pastors have begun to preach and teach in terms that include both the physical and spiritual health of this population, as well as for their

It is evident that the successes of the organizing effort have resulted in preparing the SACC Sponsoring Committee for community work that goes beyond the immediate issue of public health reentry



congregations as a whole. Community-based organizations are also beginning to include this population in their discussions of the health care needs of the communities they serve. Finally, participants discovered the power they had as citizens, first to penetrate and understand government systems and bureaucracy, second to understand and experience the process of working for positive change with government officials, and third, to effect positive change in their communities through their efforts.

## Conclusion

RCNO'S ORGANIZING among the small and mid-size congregations in the San Diego area has resulted in a renewed concern with the civic life of the community. It is proving to be a catalyst in reviving a segment of the population that felt helpless about its ability to impact its own neighborhoods, much less the policy agenda of San Diego County legislators. RCNO has developed leadership among congregations through SACC, which is proving to be helpful in changing the perspective of the faith community and creating a vision for how they may be able to address social problems in their communities and the region. None of this was easy, and the struggle continues, as leaders understand better their potential to address social problems in the policy arena, but also realizing that much work remains to be done. Organizers were able to overcome challenges, meet the goals of the project and to organize and motivate people to become participants in the health care reentry project through a variety of means, in particular through a commitment to the process of organizing toward the ultimate goal of gaining greater access to health care for the formerly incarcerated who are reentering society. In this process they

have begun to overcome the "conspiracy of silence" between individuals, churches, and public institutions and leaders, thus helping to create more healthy individuals and communities.

Through their efforts, public decision makers and faith community leaders were brought together to address this important issue. Perhaps more importantly, several hundred ordinary citizens found their voice, overcoming their sense of anger when realizing how county policies disregarded the concerns and needs of their communities by maintaining their self discipline and their focus on the issue at hand and achieving their goals.

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## Additional Resources

Michael Massoglia and Jason Schnittker. “No Real Release.” *Contexts* (2009), 8: 38-42. An excellent overview of the problem of public health reentry. For more in-depth studies, these authors suggest the following resources:

National Commission on Correctional Health Care. “The Health Status of Soon-To-Be-Released Inmates.” (National Commission on Correctional Health Care, 2002)

Mark V. Pauly and Jose A. Pagan. “Spillovers and Vulnerability: The Case of Community Uninsurance,” *Health Affairs* (2007), 26:1304-1314.

Becky Pettit and Bruce Western. “Mass Imprisonment and the Life Course: Race and Class Inequality in U.S. Incarceration,” *American Sociological Review* (2004), 69:151-169.

Jeremy Travis. “Public Health,” in *But They All Come Back: Facing the Challenges of Prisoner Reentry*. (The Urban Institute, 2005).

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