

**Emerging City Planning Trends in Richmond, CA:
Learning to Integrate the Community's Public Health Goals**

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ABSTRACT

Environmental and public health issues led to the development of city planning, yet the present lack of interdisciplinary communication limits the attainment of shared goals. Under California state law, local governments are required to create a General Plan that includes land use, circulation, housing, conservation, open-space, noise, and safety elements. The City of Richmond, California has recently solicited coordination between the City Planning Commission and Contra Costa Health Services to create an additional Community Health and Wellness element (HWE). This innovative element, the first of its kind in California, establishes citywide goals for improving public health, transportation, food security, health education, community design, sustainability and environmental quality to make Richmond a healthier and more equitable city. Richmond's process of developing and implementing this element can serve as a model for other communities striving towards similar goals. Therefore, to assess the process of creating this document, I ask the following questions: 1) How did Richmond develop its Community Health and Wellness element? 2) What was the city's public outreach strategy? Who participated and why? 3) What lessons can be learned from Richmond? I completed a literature review, analyzed data from the Richmond Community Survey, attended City meetings, and conducted interviews with leaders involved in developing the HWE. Richmond's successes in part can be attributed to its strong community organizations, engaged community, and ability to fund community participation meetings. Other cities can learn from Richmond that improving community health while engaging the community is not a simple task. To become more inclusive of community voice, communities can invest in translation services and streaming public meetings on the Internet. Once a health element is completed, city leaders must be prepared for a subsequent process in order to prioritize projects, allocate funding, and adopt policy. Maintaining democratic decision-making and inclusiveness during this time will require cities to invest additional effort and resources.

KEYWORDS

General plan, urban land use, public participation, policy, procedural justice.

INTRODUCTION

Although environmental and public health issues were influential to the development of city planning, interdisciplinary communication between health and city planning departments has since dwindled, limiting the effectiveness of city projects to improve quality of life. During the late 19th century, rapidly industrializing cities in the United States faced issues such as overcrowded living quarters, inadequate sewage treatment, dangerous releases of chemicals, and infectious disease outbreaks (Corburn 2009). In response to these poor conditions, the planning and public health fields formally emerged within government (Greenberg et al. 1994). Planning departments established the first zoning regulations to segregate industry and housing (Fulton and Shigley 2005) and public health departments installed sewers to improve sanitation and prevent epidemics such as Cholera (Stair et al. 2008). But, after solving these initial issues, the city planning and health professions diverged. Planning professionals independently focused on housing, jobs, and land use while health departments worked towards disease prevention, education, and treatment (Stair et al. n.d.).

Today, chronic diseases present vastly different challenges than infectious disease outbreaks, public health officials are beginning to notice that poor city design is a large contributing factor, once again. Chronic diseases, such as heart disease, cancer, and stroke, account for 70% of annual deaths in the United States (Centers for Disease Control and Prevention 2011). Furthermore, many of these health problems are disproportionately affecting low-income populations and people of color (Corburn 2004). Chronic diseases such as asthma and obesity are exacerbated by community designs that rely on autos, lack open space, have perpetual smog because of poor transportation networks, and only provide limited access to healthy food.

Fortunately, the field of public health is beginning to research the role of land use decisions in the prevention obesity, asthma, and mental health issues (Corburn 2004). And, in light of the nation's declining health, increasing health care costs, and focus on preventative measures to improve health, some city governments have begun to include language in city documents addressing public health. Planners and the public health community have been working together to develop land use policies with the understanding that the built environment has a substantial impact on health (Public Health Law and Policy [PHLP] 2009). This strategy

encourages varying perspectives, while working towards similar goals. Rather than relying on traditional public health programs such as disease prevention and health education, cities are incorporating public health by altering the built environment through effective transportation systems, density requirements, and urban design (Stair et al. 2008).

California state law requires local governments to produce a General Plan that includes the city's long-term goals for development, projected land uses, and objectives and that is intended to help inform current decisions (Governor's Office of Planning and Research 2003). Each general plan must include land use, circulation, housing, conservation, open-space, noise, and safety elements. Cities may choose to include additional elements focused on issues such as air quality, water conservation, design guidelines, economic development, energy generation, parks and recreation, or water conservation (Governor's Office of Planning and Research 2003). Traditionally, general plans have not included elements focused solely on public health, and there has been limited overlap between city planning and public health professions (Greenberg et al. 1994).

Planning and public health in Richmond, California

The City of Richmond, California has created a partnership between the Richmond Planning Department and Contra Costa Health Services (the county health department) to incorporate an innovative Community Health and Wellness Element (HWE) into the City's General Plan. It establishes citywide goals for improving public health, transportation, grocery availability, health education, community design, sustainability and environmental quality while focusing on compact community design, sustainability, walkability, smart growth, and improving community health (City of Richmond 2011). The HWE would also address "socio-economic conditions that largely explain health disparities among low-income and minority communities" and "the link between public health and the built environment" (Moore Iacofono Goltsman, Inc. [MIG] 2007). After receiving funding from the California Endowment, the City of Richmond Planning Department was able to dedicate resources towards developing the HWE while it concurrently updated its General Plan. The Planning Department drew on extensive input from many community organizations and individuals and spent several years creating drafts before the final draft was adopted in May of 2012. However, despite positive publicity, it has not been

determined whether the aspirations of the HWE will be realized. Furthermore, it is unclear if there were equal opportunities for citizens to participate in the decision-making and development of the HWE.

Research objectives and questions

Because Richmond received a sizeable grant and notoriety for its innovative approach, professionals in the planning and public health fields are anticipating the outcome of Richmond's HWE. Therefore, it may be able to serve as a popular model for other California communities looking to creating a health element within their General Plan. To assess how Richmond's HWE can serve as a both a structural and procedural model for other California communities, I analyzed which aspects of the process were successful and which can be improved. While investigating the development of Richmond's HWE, I also paid special attention to how stakeholders and community members were able to participate. Specifically, I asked:

- 1) How did Richmond develop its Community Health and Wellness element?
- 2) What was the city's public outreach strategy? Who participated and why?
- 3) What lessons can be learned from Richmond?

The answers to these questions highlight some of the key challenges and successes evident in the development of the Richmond General Plan, and may serve as a starting point for other California communities looking to effectively incorporate health into city planning while ensuring citizens have equal opportunity to participate.

METHODS

Study system

The City of Richmond, California is located in Contra Costa County, along the eastern shore of the San Francisco Bay. Richmond grew into an industrial powerhouse during World War II, and later became a major center for oil refinery and a "dumping ground for private and commercial interests all over the Bay Area (Rogers 2011)." The city's industrial history

Environmental problems, such as poor air quality, have plagued Richmond and contributed to sizeable health disparities. Today, the city's industrial past remains a "source of pride as well as a significant challenge that affects the health and well being of its current residents, especially vulnerable population groups such as children, elderly, people of color and low-income households" (MIG 2007). Richmond residents are at a higher risk of developing health issues -- such as diabetes, asthma, cancer, heart disease, and stroke -- as compared to residents living elsewhere in Contra Costa County (City of Richmond 2011). For example, Richmond children under 15 years old, especially African Americans, face hospitalization from asthma at a rate double the state average (Contra Costa Asthma Coalition 2006).

In 2010, Richmond's population was roughly 103,000 people, the majority of which were White (31%), Black (27%), and Asian (14%) (US Census Bureau 2010). In addition to its large African American community, 40% of Richmond's residents identify as Latino (US Census Bureau 2010). Within the Bay Area, Richmond has the most extreme economic segregation and concentrated poverty (The California Endowment). Furthermore these higher rates of poverty are especially true for African Americans and Latinos (Rein, unpublished report). Nearly one third of Richmond's residents were born outside the United States, and 45% speak a foreign language at home (City of Richmond 2011).

These health and social inequalities affecting low-income communities grew in part out of land use choices and political decisions over many years (Rein, unpublished report). Several community based organizations and grassroots movements have organized around the social, economic, and environmental issues facing Richmond. Richmond's community has successfully organized on several occasions, and values community participation as a method to get their voice heard.

Literature review

To set my study in both city planning and public health contexts and identify key ideas and policies associated with public health planning, I drew on several online databases, journals, and books. I searched LexisNexis, the Urban Studies and Planning Journal, PolicyFile, and Google Scholar using combinations of phrases such as: 'city planning,' 'public health,' 'general plan,' 'health policy,' 'healthy city,' etc. I also researched community participation and

procedural justice within city planning and group decision-making contexts. I searched using combinations of phrases such as: ‘participation,’ ‘procedural justice,’ ‘decision-making,’ ‘democracy,’ ‘justice,’ ‘community engagement,’ etc. To understand California planning and health policy trends, I conducted a literature review of planning books, particularly the Guide to California Planning by Fulton and Shigley (2005). I also used information found on the State’s website and reports published by independent health policy organizations.

To understand the complicated and lengthy process through which Richmond created its new HWE, I relied on both a literature review and interviews. The literature review included using online research databases, reports from independent organizations, and websites of local community groups and the City of Richmond. I depended largely on Marcy Rein’s report from UrbanHabitat, titled Richmond Residents Fight to Shape a Healthy City: REDI’s General Plan Campaign (Final Internal Draft) (Rein, unpublished report). This information helped me construct a timeline of the HWE development, from the visionary phase to its adoption. Second, it enabled me to construct an organized diagram of the key players that contributed to the HWE.

Analysis of community participation

To analyze the degree and influence of public participation in the planning process, I relied on resources from the City of Richmond as well as personal narratives from those involved. Information from Richmond’s General Plan update website outlined the city’s strategy for engaging the public. Additionally, the 2011 Richmond Community Survey provided data on Richmond resident’s viewpoints on their city. After hiring The National Citizen Survey, City of Richmond staff worked with the group to select questions about the quality of life in Richmond, community characteristics, city performance and resident behaviors. For my research, I excerpted the questions about citizen participation and outreach on behalf of city government. The survey was sent at random to community members, and responses were tabulated showing comparisons between demographic subgroups (National Citizen Survey 2011).

To supplement the survey results, I also attended community meetings to observe the process firsthand. First, I attended a City Council meeting on October 6th, 2011, which focused on discussing the recently drafted General Plan and accompanying Environmental Impact Report (EIR). I took note of who spoke, what their viewpoint was, and the procedure the City Council

used to receive public comments. Second, I attended a Health Equity Partnership meeting on April 25, 2012. This focus group included leaders from the West Contra Costa Unified School District, the Richmond Planning Department, and the Contra Costa Health Department who discussed the implementation of the City's health goals. I took note of who spoke, their attitude towards the partnership, how they plan to implement the goals, and what challenges they are facing.

Interviews with key players

I conducted several interviews to gain a deeper understanding of the planning process and document opinions about the successes and pitfalls of Richmond's HWE. I recruited participants based on their involvement in developing Richmond's HWE. Seeking a well-rounded perspective on the process, I interviewed four participants from diverse group affiliations.

I interviewed Christy Leffal, an employee of Richmond Equitable Development Initiative (REDI) on March 30, 2012. Second, I interviewed Lisa Feldstein, a professor within University of California, Berkeley's Department of City and Regional Planning. Third, I interviewed Alex Schafran, a PhD candidate in University of California, Berkeley's Department of City and Regional Planning (who had also worked at REDI) on April 4, 2012. Finally, I interviewed Richard Mitchell, Richmond's Director of Planning and Building, on April 20, 2012.

I used a flexible, semi-structured interview style guided by a set of pre-established questions (Appendix A), which allowed for clarifications or expansions to responses. If participant agreed, I used a voice recorder to capture the conversation; otherwise, I took written notes. I used interview data to understand relationships between stakeholders, the effectiveness of community participation, and any successes or pitfalls of Richmond's process.

FINDINGS

Planning in California

Planning in California was designed to regulate land uses and protect our state from over-development, but has evolved into a political and often confusing process. Since planning is a

public decision-making process, and influences our environment, it becomes an opinionated and political process (Fulton and Shigley 2005). In California, most planning decisions depend on the votes of a handful of elected officials working within their city's competitive political sphere (Fulton and Shigley 2005). Several groups often argue over how to enhance the quality of life: whether the land should be preserved, developed, or used for community building. "[P]lanning is a lever used by virtually every interest group on the local scene to get what it wants" (Fulton and Shigley 2005).

Health policy trends in California

Throughout the past decade, in response to chronic disease rates, communities throughout California have attempted to incorporate health into city policies. So far, more than 30 California cities have incorporated health into their general plans (Healthy Eating Active Living [HEAL] Cities Campaign). While the nature of each plan varies to accommodate needs of the particular communities, commonalities can be seen throughout the state. Topics span from the traditional, such as land use and transportation to topics such as healthy food access and health equity (PHLP 2009). These elements usually include goals to improve health, but may also include specific policies (PHLP 2009).

Cities have several options to tailor plans to their goals. Some communities have introduced an independent health element to house these goals, while others have woven health goals into the traditional elements in their general plan (Feldstein, personal communication). Although other cities have addressed health in their general plans, Richmond was the first city in the state to focus on creating an independent, standalone element focusing on health. This trend of incorporating health goals and policy is strong and growing, as demonstrated by the number of cities such as Anderson (adopted May 2007), Sacramento (adopted March 2009), and Ventura (adopted August 2005) that have also incorporated independent health elements into their general plan (PHLP 2009). As Alex Schafran, a PHD candidate in UC Berkeley's Department of City and Regional Planning, explained, the applicability of health draws everyone into the discussion. "Health seems to have that potential to really reach across race and class and ideological boundaries and bring people together around some set of common goals" (Schafran, personal communication).

Creating Richmond’s Health and Wellness Element

Around 2003, a discussion about health in Richmond was sparked by the county health department, and led to a multi-year, city-wide health initiative (Figure 1). Richard Mitchell, Director of Planning and Building within the Richmond Planning Department, recounted that leaders from Contra Costa Health Services initiated a meeting with the Planning Department to discuss the data they had been tracking, and to look at ways in which city engineers could incorporate that knowledge to improve city health (Mitchell, personal communication). In



Figure 1. Development of Richmond’s HWE. The HWE was developed as part of the broader General Plan update process. *Several drafts were issued throughout this period.

November 2005, the City Council formally announced they would begin the General Plan update process. Since the City of Richmond was preparing to update its General Plan, it seized the opportunity to focus on health and decided to incorporate an element focused on health. In November of 2006, Richmond received a grant of \$255,000 from The California Endowment to address public health by way of the HWE as part of the overall General Plan update (TCE).

The Planning Department hired consulting group Moore Iacofono Goltsman, Inc. (MIG) and together began to research existing conditions, gather public opinion and draft a new General Plan (Rein, unpublished report). Between 2006 and 2011, amidst gathering opinions from stakeholders and incorporating revisions, the Planning Department issued several drafts of the General Plan, including the HWE. In the fall of 2011, the Planning Commission voted on the final draft of the General Plan (and accompanying Final Environmental Impact Report) and formally recommended that the City Council adopt these two documents (City of Richmond). On April 24, 2012, the City Council formally adopted the General Plan 2030, and also certified the accompanying Environmental Impact Report (City of Richmond).

Now that the HWE is adopted, the City must form a strategy to work towards achieving each of the goals stated within. At the Health Equity Partnership meeting on April 25, 2012 I had the opportunity to understand one way in which the City's health goals within the Health and Wellness Element will be implemented. The West Contra Costa Unified School District, the Richmond Planning Department, and the Contra Costa Health Department have formed a partnership and have begun pilot programs to improve the health of children and their families. The partnership will continue its work by selecting additional projects, prioritizing funding, and tracking health outcomes over the next several years.

Key Players

There were several key players involved and partnerships formed throughout various stages of the HWE's development (Figure 2). The City Council and Planning Commission oversaw the entire General Plan process. The City's Planning Department managed the General Plan update as well as the development of the HWE. A special HWE Project Team was comprised of city staff within the Planning Department, hired consultants from MIG, and public health representatives (including Contra Costa Health Services staff) (MIG 2007). Although a committee had been formed to assist in the General Plan update, the Project Team appointed a

separate Technical Advisory Group (TAG) to give technical input and help write the HWE. This group included a wide variety of stakeholders including scholars, consultants, community members, public officials, and community leaders who contributed to the process (MIG 2007).

Contra Costa Health Services (CCHS) provided and continues to provide statistics and knowledge about the prevalence of disease within the city. The department's Community Wellness and Prevention Program specifically aims to "work in partnership with individuals, diverse communities and organizations to increase individual knowledge and skills, educate and mobilize communities, build coalitions and advocate for changes in organizational and public policy" (CCHS). The California Endowment, a large private health foundation, provided Richmond with the capital funding to develop their HWE. The California Endowment had

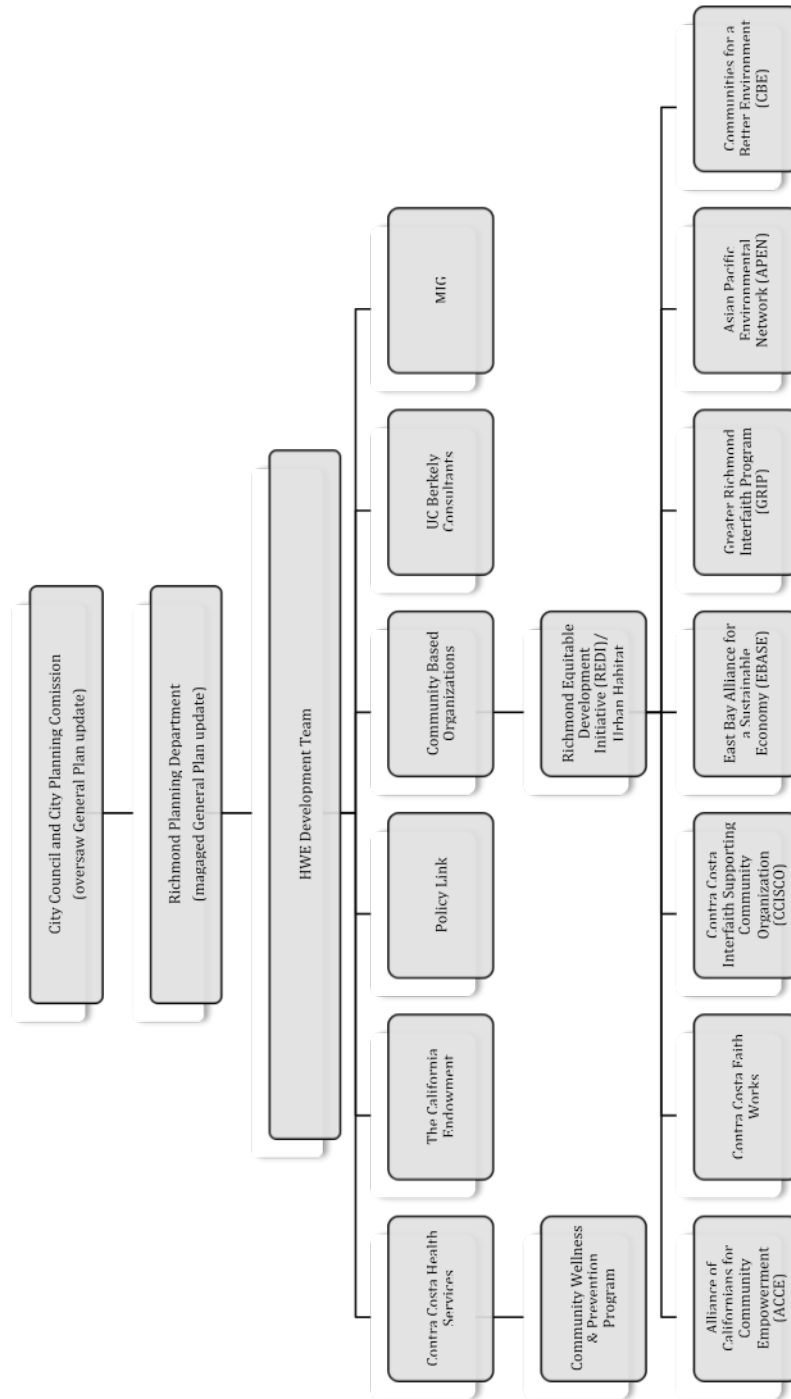


Figure 2. Key players in the HWE development process.

chosen Richmond, along with 13 other California communities, as part of a multimillion-dollar, decade-long effort to build healthy communities through policy (The California Endowment). Policy Link, a social equity institute headquartered in Oakland, administered Richmond's grant from The California Endowment of \$255,000. Policy Link also provided feedback and suggestions to improve the language of the HWE. Consultants from MIG were hired by Richmond to conduct community outreach, provide direction in land use planning, and put together the General Plan. Some consultants from UC Berkeley such as Jason Corburn and Lisa Feldstein (Department of City and Regional Planning) were used because of their knowledge in general plans and health policy.

In addition to citizens that voiced their concerns, several community-based organizations (CBOs) organized and advocated for their missions to be addressed in the plan. A coalition of several CBOs formed under the group name Richmond Equitable Development Initiative (REDI), and organized within environmental and social justice organization Urban Habitat (Leffal, personal communication). The coalition's major contributing groups are the Alliance of Californians for Community Empowerment (ACCE), Contra Costa Faith Works, Contra Costa Interfaith Supporting Community Organization (CCISCO), East Bay Alliance for a Sustainable Economy (EBASE), Greater Richmond Interfaith Program (GRIP), Asian Pacific Environmental Network's Laotian Organizing Project (APEN/LOP), and Communities for a Better Environment (CBE) (Urban Habitat 2011). REDI participated by conducting policy research, galvanizing the CBOs already working in the area, advocating for their campaigns, recommending language for Richmond's General Plan update, and bringing a larger focus to the topic of equity (Rein, unpublished report).

Richmond's strategy to engage the public

The City of Richmond adopted an *inclusive city framework* to guide decisions throughout the General Plan update process. This framework embodies the philosophy that a healthy city will be achieved by addressing the "physical, economic, cultural and social needs of people of all physical abilities, social strata and income levels" (City of Richmond 2011). Furthermore, the City made a commitment to ensure decisions were based on "justice, equity, and

nondiscrimination” by adopting the Universal Declaration of Human Rights to (City of Richmond 2011).

In 2006, the City of Richmond launched a campaign to compile public opinion regarding the General Plan update. The Planning Department and MIG consultants used a medley of approaches to engage the public, including workshops, roundtables, interviews, and traveling in the Plan Van (a mobile van equipped with educational and outreach materials). The workshops educated residents on the process while giving them the opportunity to communicate their ideas and concerns (City of Richmond). To publicize these workshops, the Planning Department mailed bilingual newsletters to Richmond residents; sent announcements via the local newspaper, churches, and neighborhood councils, and the Plan Van (City of Richmond 2011). Furthermore, the Planning Department and MIG consultants conducted stakeholder interviews with community members and leaders from community based organizations, public agencies, city government, and the business community (City of Richmond 2011). Additionally, the City provided the project with a website (www.cityofrichmondgeneralplan.org), another source of information regarding the General Plan update that provided a schedule of events, a document library, and forum to post comments (City of Richmond 2011). Throughout the duration of the General Plan outreach phase, between 2006 and 2011, over 1,000 community members participated in the form of meetings, workshops, or outreach events (City of Richmond 2011). Out of these workshops came a series of papers identifying “issues and opportunities” for various topics to be covered in the General Plan update, one of which was the Community Health and Wellness Issues and Opportunities Paper (MIG 2007).

After gathering a sense of the issues that the community was most concerned about, the Planning Commission began to draft the language of the General Plan, including the HWE. The advisory committee and community stakeholders helped develop the vision statements within the HWE (City of Richmond 2011). However, it is unclear who developed goals, policies and implementing actions. Once a draft document was released, a public comment period began in which community members could make a two-minute comment regarding any aspect of the General Plan during City Council and Planning Commission meetings.

Community participation

For illustration purposes, I excerpted results from the Richmond Community Survey that specifically assessed community participation (Figure 3). Statistically significant differences are highlighted in gray (a p-value of 0.5 or greater) (National Citizen Survey 2011). There were several results that were determined to show a significant difference. Household income did not have a significant effect for any category, but length of time living in Richmond, race/ethnicity, and age were significant for some categories. Residents that had lived in Richmond longer reported higher rates of attending a meeting, watching a meeting online, and reading the Richmond newsletter. Second, there were more whites that felt there were good opportunities to participate and that the city did an “excellent” or “good” job welcoming citizen participation. There was a greater percentage of whites that had attended meetings, visited the City website, and that had personal contact with a City employee. Furthermore, a higher percentage of whites felt that the City is moving in an “excellent” or “good” direction. Third, while older residents reported a larger meeting attendance or online meeting viewing, a greater percentage younger residents reported using the City website.

My attendance at community meetings also provided insight into the planning and public participation dynamics. The primary purpose for the October 6th City Planning meeting was to discuss the final draft of the General Plan and accompanying Environmental Impact Report (EIR) for the City of Richmond. Throughout the meeting, members from the City Council, employees in the city’s planning department, and members of the public had a turn in speaking. At the start of the meeting, the General Plan drafting process was discussed in detail, giving a background on the work that went into making this document. Following this introduction, attendees that chose to speak were given two minutes to introduce themselves, their organization (if applicable), and share their regard or concern with any aspect of the General Plan. Attendees at the meeting represented a wide range of races and socio economic statuses. Speakers addressed a variety of issues including land use, economic viability of the city, open space preservation, and construction of bike lanes, but the members within a certain community-based organization often represented the same race and held similar opinions regarding an issue.

Figure 3. Richmond Community Survey results (excerpted)

* A p-value of >0.5 is statistically significant, and indicated in gray (National Citizen Survey 2011).

| Category | Number of years in Richmond | | | | Annual household income | | | |
|--|-----------------------------|---------------|--------------------|---------|-------------------------|----------------------|-------------------|---------|
| | 5 years or less | 6 to 20 years | More than 20 years | Overall | \$49,999 or less | \$50,000 to \$99,999 | \$100,000 or more | Overall |
| Opportunities to participate in community matters are "excellent" or "good" | 44% | 42% | 40% | 42% | 42% | 43% | 49% | 44% |
| Attended a meeting of local elected officials or other local public meeting at least once in the past 12 months | 23% | 34% | 38% | 31% | 31% | 29% | 33% | 31% |
| Watched a meeting of local elected officials or other City-sponsored public meeting on cable television, the Internet or other media at least once in past 12 months | 31% | 50% | 59% | 47% | 44% | 46% | 52% | 46% |
| Read Richmond Newsletter at least once in past 12 months | 60% | 70% | 81% | 70% | 70% | 71% | 67% | 70% |
| Visited the City of Richmond Web site (at www.ci.richmond.ca.us) at least once in past 12 months | 60% | 57% | 52% | 56% | 55% | 61% | 59% | 58% |
| The service quality of the City's land use, planning and zoning is "excellent" or "good" | 22% | 24% | 16% | 21% | 22% | 23% | 14% | 21% |

| | | | | | | | | |
|---|-----|-----|-----|-----|-----|-----|-----|-----|
| The City of Richmond's government services are "excellent" or "good" | 32% | 30% | 23% | 28% | 32% | 28% | 24% | 29% |
| Have had any in-person, phone or email contact with an employee of the City of Richmond within the last 12 months (including police, receptionists, planners or any others) | 45% | 37% | 48% | 43% | 43% | 44% | 45% | 44% |
| The overall direction that Richmond is taking is "excellent" or "good" | 38% | 31% | 19% | 29% | 29% | 28% | 39% | 31% |
| The job Richmond government does at welcoming citizen involvement is "excellent" or "good" | 29% | 39% | 22% | 30% | 32% | 24% | 40% | 32% |

Figure 3 continued.

| Category | Race/ethnicity | | | Age | | | |
|---|---------------------------|----------------------------|---------|-------|-------|-----|---------|
| | White alone, not Hispanic | Hispanic and/or other race | Overall | 18-34 | 35-54 | 55+ | Overall |
| Opportunities to participate in community matters are "excellent" or "good" | 59% | 36% | 43% | 46% | 32% | 51% | 42% |
| Attended a meeting of local elected officials or other local public meeting at least once in the past 12 months | 42% | 26% | 31% | 23% | 30% | 41% | 31% |

| | | | | | | | |
|---|-----|-----|-----|-----|-----|-----|-----|
| Watched a meeting of local elected officials or other City-sponsored public meeting on cable television, the Internet or other media at least once in past 12 months | 51% | 45% | 47% | 36% | 49% | 53% | 46% |
| Read Richmond Newsletter at least once in past 12 months | 71% | 69% | 70% | 69% | 70% | 69% | 70% |
| Visited the City of Richmond Web site (at www.ci.richmond.ca.us) at least once in past 12 months | 65% | 53% | 57% | 66% | 58% | 44% | 57% |
| The service quality of the City's land use, planning and zoning is "excellent" or "good" | 19% | 21% | 21% | 18% | 18% | 25% | 20% |
| The City of Richmond's government services are "excellent" or "good" | 33% | 27% | 29% | 25% | 27% | 34% | 28% |
| Have had any in-person, phone or email contact with an employee of the City of Richmond within the last 12 months (including police, receptionists, planners or any others) | 52% | 39% | 43% | 36% | 45% | 49% | 43% |
| The overall direction that Richmond is taking is "excellent" or "good" | 40% | 26% | 30% | 33% | 25% | 31% | 30% |
| The job Richmond government does at welcoming citizen involvement is "excellent" or "good" | 48% | 24% | 31% | 26% | 28% | 39% | 30% |

DISCUSSION

Historically, many discussions regarding land use or allocation of public resources were limited to unrepresentative committees operating behind close doors (Innes and Booher 2000). Contemporary city planning within the United States has shifted to include a high degree of citizen participation, which is seen as necessary both for the approval of plans and satisfaction of residents. Social and environmental justice advocates value this trend as a means of ensuring that city planning gives value to all voices, includes democratic decision-making, and does not favor one group over another. Alongside the City of Richmond's dedication to engage the community, several factors have contributed to its unique city planning atmosphere.

City efforts to increase public participation

The City of Richmond sought to increase public participation and include community voice throughout their General Plan process. By holding community meetings and touring the plan van, they spent resources reaching out to various groups in the community. The City's efforts to include community voice were twice as great because the City was able to allocate grant money to create special advisory committees and to hold workshops dedicated specifically to health issues (Schafran, personal communication). The planning director, Richard Mitchell, as well as others engaged in the process, felt that many people were deeply committed to the outcome and that there was a high degree of public participation.

When assessing public participation, it is a fallacy to make a determination that it is either absent or present. Instead, it should be looked at on a scale. Sherry Arnstein describes varying degrees of citizen participation, ranging from degrees of non-participation and manipulation, to those of full participation in which "have-not citizens obtain the majority of decision-making seats" (Arnstein 1969). There appears to be a spectrum of fairness, within which a city can always strive to be more inclusive, more just, and to improve the level and quality of community participation. Barbara Illsley identifies four elements that are key to a fair process: inclusion of the voice of those affected by the decision, use of credible information, fair and consistent treatment of participants, and lack of bias of decision-makers (Illsley 2003). Further, while community dissatisfaction may be attributed to dissatisfaction with the final decision, research

also indicates that dissatisfaction with the validity of the decision-making process may also play a role (Illsley 2003). While participatory planning plays an important role in the city planning process, democracy depends on citizens electing effective city leaders (Sirriani 2007). Since city council members hold the final decision-making ability when adopting policy, diversity in opinion should be prioritized when voting council members into office in order to represent the whole city accurately.

Strong community organizations

Several community members have expressed their feelings on the effectiveness of community participation throughout the HWE process. Sheryl Lane, a Richmond Planning Commissioner, feels that “[a]t every step of [the General Plan update] process, historically under-represented groups have provided input in the planning processes that most affect their lives and livelihoods (Lane 2012).” Not only did community leaders play a larger role, but also there was a much more diverse group participating. Sheryl Lane felt that the dynamic of the REDI coalition was different than in the past; “what was different about it was the diversity. You did have black, Latino, Asian, and white working together” (Rein, unpublished report). Members of Communities for a Better Environment (CBE), a group within the REDI coalition, also felt a stronger connection to the decision making process. CBE leader Jessica Tovar reported, “there’s more engagement with [CBE members] by decision makers, which is really important and unique in comparison to five or more years prior” (Rein, unpublished report). The formation of the REDI coalition enabled the community groups to gain a strong presence within the community. Now, Tovar said, “they feel like they see decision makers on more of a regular basis, like they’re being heard and that these people actually care” (Rein, unpublished report).

An engaged community

Richmond residents show a high degree of community engagement, especially in the political sphere (42% of whites and 26% of non-whites) (National Citizen Survey 2011). This is in part due to the expectation in the Bay Area that residents will contribute to the future of their

community through involvement in government decisions (Mitchell, personal communication). Perhaps this high participation rate is due to the fact that Richmond is not a commuter city and citizens have extra time to attend public meetings.

However, Richmond's high level of participation can be most attributed to its deep history of activism and dedication to improving social conditions. Richmond's unique past has included stark poverty and a multitude of environmental problems, leading to severe health disparities. Historically, Richmond's low-income groups have not contributed to land use decisions, even though their health is often the most affected (The California Endowment 2007). Because of this past, community members have a strong commitment to environmental and social justice, and community-based organizations have been successful in organizing around these issues. Many residents have lived in Richmond for decades, feel a strong connection to the community, and are willing to get involved in city revitalization efforts. "Many of the... community members involved with REDI have also lived in Richmond for 30, 40, or 50 years" (Rein, unpublished report). Coalitions such as REDI have encouraged community activism and played a large role in prioritizing the community's voice.

Equally engaging all races/ethnicities

"Recent studies have shown that despite steady improvements in the overall health in United States, racial and ethnic minorities experience a lower quality of health services, are less likely to receive routine medical procedures, and have higher rates of morbidity and mortality than non-minorities" (MIG 2007). Since race is such a strong determinant of health, it is important to keep this in mind when planning to ensure that those most adversely affected are properly represented in the decision-making process.

The Richmond Community Survey results suggest that whites feel they have more opportunities to participate and actively participate than their Hispanic and non-white counterparts feel. This could reflect structural barriers such as language differences or inability to attend city meetings due to work, familial, or cultural conflicts. For example, if non-native speakers within the city didn't have the English proficiency to understand city planning vocabulary, this may prevent them from feeling comfortable attending a meeting or sharing their opinion. Second, if certain members of the community were undocumented, this may also

contribute to their choice to remain inactive in city government. This said, there was not a significant difference between the number of whites and the number of Hispanic non-whites that were able to watch a meeting online. This indicates that technological advancements that allow taping and online streaming of meetings helps include more community members not able to physically attend due to time constraints, lack of transportation, or other preventative measures. Because of this, the City of Richmond should continue investing money in these alternative forms of information distribution, to keep all community members as involved as possible.

Choosing a separate element

There are two ways to approach the inclusion of health into general plans. The city can incorporate an independent element (such as Richmond's) that specifically addresses health on its own, or a city may entwine health goals into other elements such as transportation and land use (Feldstein, personal communication). Creating an independent element has its benefits and its drawbacks.

Sometimes, "having a separate element may undercut its strength, make it less read, and make implementation more difficult (Stair et al. 2008)." Alex Schafran feels in hindsight that having a separate health element was a flawed approach that prevented health concepts from being thoroughly infused throughout the General Plan. Placing the health goals in a separate document was a distraction and took resources away from Richmond's legally-binding elements of the general plan, such as zoning and land-use sections (Schafran, personal communication). It created an entirely separate process, with the HWE's Technical Advisory Group conducting a different set of meetings, separate from the General Plan Advisory Committee (Schafran, personal communication). Rather than incorporating the discussion of health into those regarding the General Plan, conducting a separate set of meetings was time consuming, inefficient, and a waste of resources (Schafran, personal communication).

On the other hand, a separate element may give "special preeminence and political visibility" to the city's health goals (Stair et al. n.d.). Since health in city planning is a new and emerging trend in California, Richmond has gained significant attention for pioneering this project. Richmond has gained recognition as the first city in California to create an independent health element and other cities are looking to Richmond as a leader. Ultimately, this positive

publicity and attention has encouraged Richmond to overcome obstacles within the process and retain stamina in their quest to make Richmond a healthier city.

Limitations of a General Plan

Although many citizens hope that a General Plan can provide the immediate change they hope to see in their city, there are limitations to this approach. A General Plan is intended as a scoping document, for a city to plan out their goals for the next 20-30 years. Whether an element's language says the City "shall" do a definable action or that the City "will explore" working towards a goal has a large impact on the authority of the document (Rein, unpublished report). While the document was effective at promoting partnerships goal setting, some community groups hoped that the HWE would have included stronger language, and would be able to effect change immediately.

The City Planning Department has limited authority to create policy from a goal written within the Element (Mitchell, personal communication). For example, the City cannot force produce markets to open in an area with limited food access, but instead can encourage businesses through zoning regulations or incentives. Hence, implementation of Richmond's General Plan will require the adoption of additional tools such as the zoning ordinance, design review process, capital improvement decisions, and other ordinances (City of Richmond 2011). Furthermore, it will depend on establishing a robust timeline and economic plan as well as additional decisions within Richmond government.

Future plans for implementation

The city has moved to the next phase of the project by creating a health equity partnership between the School District, Planning Department, and Health Department. They are currently working to develop a set of indicators to track health as it improves or worsens in the future. These measures will hopefully indicate whether the city's programs to improve health are successful. However, since many health problems don't show up overnight or improve overnight, it may take years to see the effects of a program (Feldstein, personal communication).

Unfortunately, although the partners are dedicated to this project, the implementation phase may prove to be difficult. Setting goals does require diligence and coordination, but is in many ways simpler than the implementation phase. Implementation requires leaders to prioritize projects, allocate funding, and put ideas into action. Often, this is where teams are delayed by challenges. So, although Richmond has laid out goals in their HWE, it will take continued dedication and communication, but most importantly patience. Although we may not see cancer or asthma rates drop overnight, we must go forward with faith that the newfound partnerships, programs, and initiatives are worth the time and effort required to make them successful.

Study limitations and future directions

Because I did not participate in the creation of the HWE, and only did a historical analysis, my perspective is second hand as compared to those directly involved. Second, although I did strive to gain a wide range of perspectives in my research (in reading documents, and in interviewing leaders), the time constraints of this project limited me to getting a complete view of the process. Although I did have the opportunity to hear community members and the health department leaders speak at meetings, I did not get the opportunity to personally interview anyone from the consultant team MIG that put together the HWE, any community members not affiliated with community based organizations, or leaders within the public health department. Since a large factor in my paper is analyzing community voice, not being able to interview community members would potentially cause the exclusion of their voice in my results. With additional time, I would interview Brian Soland of MIG consultants, Nancy Baer or Tracy Rattray of Contra Costa Health Services, Jme McLean of PolicyLink, Marcy Rein of Urban Habitat, and community members that had been involved during the development of the HWE. I would also use extra time to translate this report into Spanish, to ensure that my results would not be exclusive to English speakers.

The next phase of studying the HWE would be tracking its progress throughout the implementation stage. How will the city implement the goals of the HWE, and more importantly, how will they prioritize which goals they will address first and devote funding to? How will the public remain engaged in these decisions? Will the HWE's goals to improve community health be realized?

Ultimately, because each city is unique in its needs and priorities, my conclusions presented on Richmond's process will not be applicable to all cities, but instead provide a working case study. Although my conclusions can provide direction to other cities looking to implement a similar process, "[p]lace matters. No policy, no matter its merits, works in every community; local needs, appropriate standards, and implementation strategies will vary" (PHLP 2009).

Conclusion

Because Richmond received funding from The California Endowment, they were able to devote significant resources towards developing their HWE, as well methods to engage the community. Richmond succeeded in reaching out to the community, gathering their input, and incorporating the community's concerns into its health goals. However, now that the goals have been established, the city must create policies and programs in order to improve the city's health. Although the partners involved are extremely dedicated and passionate about the project, this portion will be even more challenging for those involved. Beyond creating the document that spelled out goals for Richmond's health, the next steps of prioritizing goals, allocating funding, and implementing successful programs will be a long and arduous process. It will be difficult to stay energized, overcome political obstacles, and maintain collaboration amidst varying opinions. And, although including community voice was a priority when establishing goals of the HWE, the City must find ways to make the decision-making processes just throughout the implementation phase as well. If community voice is forgotten during the implementation phase, then efforts to include the community during the development of the HWE will have been a wasted effort and their opinions will become trivial.

As other cities look to Richmond for direction on developing a health element, it is important not only to understand Richmond's methodology, but also which aspects of the approach were successful and which can be improved. Significant lessons learned from the first independent health element in California can be summarized as follows:

1. To improve community satisfaction in decision-making, a city should incorporate principles to engage the community. A city can always strive to be more inclusive, more just, and to improve the level and quality of community participation.
2. The formation of strong coalitions (i.e. REDI) enables community groups to gain a strong presence within the community.
3. To equally engage all community members, cities should invest money in translation services and alternative forms of information distribution, such as Internet media.
4. The decision of creating an independent health element versus entwining health goals into all elements of a General Plan is not straightforward.
5. Choosing the language within a health element is not the last step. Additional tools such as the zoning ordinance, design review process, capital improvement decisions, and other ordinances will need to be decided upon as well, and may influence outcomes even more than the health element.
6. Implementation of health goals will require leaders to prioritize projects, allocate funding, and engage the community. City leaders must be prepared for this more arduous, complicated, and frustrating phase.
7. Lastly, although the city planning discipline has identified guidelines for including the community in the goal-setting and element-development processes, maintaining democratic decision-making in later phases is less routine and more complicated. To compensate for this, the City will need to invest significant effort and resources when adopting policy or initiating programs to achieve health goals established in the health element.

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APPENDIX A: INTERVIEW QUESTIONS

Involvement

- 1) Can you tell me about you and your organization's involvement in developing Richmond's Health & Wellness Element?
- 2) What was a typical public meeting like to discuss the element?
- 3) What were some of the main issues your organization was advocating around?

Collaboration

- 4) How well do you think the city planners, health department, and community organizations worked together?
- 5) How could their dialogue and communication have been improved?

Voice

- 6) How well were you able to voice your concerns? Any time where you felt your voice was neglected or shut down?

Democracy

- 7) Were all groups given the opportunity to share their opinion? What was public participation like?
- 8) Are the goals in the element reflective of your group's goals for Richmond?
- 9) Who would you consider were the key players? Where did their interests lie and how much power did they have in this process?
- 10) How did Richmond decide to do this element? Who was proponent?

Creation Process

- 11) How was Richmond's strategy or goals different than other cities?
- 12) How were the document's foci chosen? (public, city council, etc.)
- 13) Where is the city in terms of progress right now? What are the challenges up ahead?

Future Improvements

- 14) What improvements could have been made to this process of creating the Community Health

and Wellness element?

15) Can I email you if I have any follow up questions?

16) Do I have permission to use your responses in senior research paper?

APPENDIX B

The TAG members were selected by the project team to represent diverse interests in the areas of planning, health and the community. The TAG included the following representatives (MIG 2007):

- Richard Jackson, MD, MPH, Adjunct Professor, School of Public Health, UC Berkeley
- Richard Kreutzer, MD, Branch Chief, Environmental Health Investigations Branch, California Department of Health Services
- Wendel Brunner, MD, Public Health Director, Contra Costa Public Health
- Poki Stewart Namkung, MD, MPH, Public Health Officer, Santa Cruz County Health Services Agency; and President of the National Association of County and City Health Officials (NACCHO)
- Dennis M. Barry, Director, Contra Costa County Community Development
- Richard Mitchell, Planning Director, City of Richmond
- Victor Rubin, PolicyLink
- Sharon Fuller, Ma'at Academy
- Sheryl Lane, Urban Habitat
- Barbara Becnel, North Richmond Neighborhood House
- Delphine Smith, Communities for a Better Environment