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The Oregon Community Engagement Initiative: A Multi-Case Study of a Disability Coalition Development Process

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The Oregon Community Engagement Initiative: A Multi-Case Study of a Disability Coalition Development Process

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This article reports on the development and implementation of a community development technique focusing on local access issues for people with disabilities called the Community Engagement Initiative (CEI). The CEI methodology includes a town hall meeting with the disability community, an infrastructure meeting, and resource mobilization activities. Between 2001 and 2004, the CEI methodology was implemented in two rural communities and four urban settings in Oregon. Communities were noted to vary in the number and type of barriers identified, and in the effectiveness of implementing the procedure. Insights into these variations are provided through examination of patterns in the quantitative data and through two case studies. Future activities will focus on developing methods for supporting and measuring change as a result of community development.

Keywords: accessibility, community engagement, disability

INTRODUCTION

More than one in six adult Americans reports having a disability (Erickson & Lee, 2008). People with disabilities experience more social isolation, fewer opportunities to participate in their communities (e.g., Kinne, Patrick, & Doyle, 2004; USDHHS, 2001), and less satisfaction when they do participate compared to people without disabilities (National Organization on Disability, 1994; 2000). These findings persist despite passage of the Americans with Disabilities Act of 1990 (ADA; 42 U.S.C. § 12101, et seq.), federal legislation that provides people with disabilities with the legal right to equal access to private spaces (e.g., retail locations), public spaces (e.g., state and local parks), and public programs. Under the ADA, an individual has a “disability” if she or he has a physical or mental impairment that substantially limits one or more major life activities, a record of an impairment, or is regarded as having an impairment. In this article,

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individuals with disabilities are defined broadly to include persons with physical, intellectual, mental health, and sensory limitations.

While the past decade has seen a number of research efforts focused on developing measures of access, less attention has focused on developing processes for improving community accessibility at the local level. For example, although lack of transportation is frequently cited as an access barrier for people with disabilities (NOD/Harris, 2004), local information is needed to identify specific problems with buses, bus shelters, or routes, and a local approach is necessary to resolve them. Community engagement is a method that holds promise for identifying, prioritizing, and developing solutions for the communities in which people with disabilities live.

LITERATURE REVIEW

Community developers and community psychologists have long recognized the value of community engagement methods to provide a voice for marginalized groups that can then lead to local action (e.g., Minkler, 1985; Rappaport, 1981). Community engagement refers to a process of working collaboratively with groups of people—related by location, interest, or similar issues that affect their well-being—to achieve changes at the community level (Centers for Disease Control and Prevention, 1997; Fawcett et al., 2004). The term *community engagement* is often used interchangeably with *community development*. Community development efforts typically involve long-term capacity-building and collaboration. Other names include *grassroots development*, *community-based development approaches*, and *participatory development* or *participatory social action* (Bhattacharyya, 1995; Hernandez, Balcazar, Keys, Hidalgo, & Rosen, 2006). The literature on community development is extensive and includes descriptions of collaborative efforts to improve communities, tools that can be used by practitioners and researchers, and core principles and values (e.g., Balcazar, Keys, & Suarez-Balcazar, 2001; Collie-Akers, 2007; Dowrick & Keys, 2001; Fawcett, 1991; Fawcett, Francisco & Schultz, 2004; Fawcett et al., 2000; Fawcett et al., 2008; Hathaway, 2001; Keys & Factor, 2001; Marmot et al., 1997; Roussos & Fawcett, 2000; Surowiecki, 2004; Wolff, 2001).

While persons with disabilities constitute a marginalized group (Drum, Krahn, Culley, & Hammond, 2005), efforts to address their needs through community engagement activities are relatively new (Dowrick & Keys, 2001). A special issue of *Community Development: Journal of the Community Development Society* focused on projects involving people with disabilities. These projects demonstrate an emerging confluence of disability issues and community development (Seekins, 2006). For example, Sylvestre et al. (2006) described efforts to develop housing options for people with serious mental illness using community development techniques. They described the importance of starting with key stakeholder groups who represent the interests of their communities, identifying appropriate change agents at the systems level, and allowing adequate time for buy-in while also focusing on concrete actions with short-term milestones. Guillory, Everson, and Ivester (2006) illustrated these stages with disability coalitions using the framework of *forming* (building the organization's structure and membership), *storming* (developing goals, roles, and processes), *norming* (focusing on actions), and *performing* (maintaining and evaluating the group's progress). While change was sometimes slow to materialize using these approaches (e.g., Sylvestre et al., 2006), rapid changes were also reported. For example, Hernandez, Balcazar, Keys, Hidalgo and Rosen (2006) reported

significant increases in accessibility of entrances, access to goods and services, and accessibility of restrooms occurring as a result of one-day trainings for African-Americans and Latinos on how to conduct accessibility assessments of local businesses.

There are two primary purposes of this article. The first is to describe the history and collaborative development of a method to engage communities to improve accessibility for the participation of members with disabilities. The method involved working with community members with disabilities to list and prioritize accessibility issues, presenting the issues to representatives of community infrastructure in positions to affect change, and facilitating collaborative identification of strategies to address barriers and action steps to implement the strategies. This method became known as the Community Engagement Initiative (CEI). The CEI process was intended to empower disability advocates to engage in community planning, increase the knowledge of representatives of the community infrastructure about disability and accessibility, and support the mutual and respectful dialogue of these two groups in addressing the accessibility of the community for its members with diverse disabilities on an ongoing basis.

Through this increased involvement, awareness, and dialogue, CEI was ultimately expected to serve as a catalyst for community changes leading to improved accessibility. The theoretical basis for this community development approach is rooted in the behavioral-community paradigm which holds that issues for a particular group in a community derive from individual behaviors and environmental conditions (Fawcett, Francisco, & Shultz, 2004). CEI is equally informed by Harlan Hahn's theory on the institutional creation of disability (Hahn, 1993). Hahn's three major premises are that (a) social attitudes rather than physical inabilities are the primary source of the problems confronted by disabled women and men, (b) all aspects of the social and built environment are shaped or molded by public policy, and (c) public policy is a reflection of pervasive social attitudes and values.

The second purpose of this article is to describe the application of the CEI method across multiple communities, documenting the types and nature of barriers, and illustrating the method through case studies. We will also discuss lessons learned in the process of repeated applications of the method.

As noted above, persons with disabilities was used as a broadly inclusive term that included persons with physical, intellectual, mental health, and sensory limitations. Accessibility was also considered broadly to include physical, attitudinal, and policy barriers. However, CEI was limited to issues at the local level (e.g., concerns about the local health clinic) and not at the state or federal level (e.g., concerns about state or national Medicaid policy).

METHODOLOGY

Development of the Community Engagement Initiative Methodology

The CEI has been an integral focus of the Oregon Office on Disability and Health (OODH) for the past decade. In 1997, OODH established a Community Living Workgroup to understand, assess and improve accessibility of Oregon communities for persons with various disabilities. The Workgroup consisted of people with disabilities, disability service providers, researchers from Oregon Health & Science University, and representatives from the Oregon Disabilities Commission (ODC). The Oregon Disabilities Commission is a Governor appointed commission

charged by state statute to advise the state on issues related to achieving the full economic, social, legal, and political equity of individuals with disabilities.

Community Accessibility Measurement

The initial charge of the Workgroup was to develop a framework and process for assessing community accessibility and inclusion. The intent was to provide a system of measurement using extant data sets for profiling that could be used to compare accessibility across communities and document change over time within communities. The Workgroup developed a matrix of life areas and database indicators that could be used to profile a community's accessibility status. The matrix addressed the life areas of education, employment, health care, housing, public places, recreation, and transportation. Potential indicators were identified for each domain. For example, in the housing domain, a potential indicator was number of accessible public housing units in a community. Initial hopes were that the matrix could serve as a method to compare accessibility profiles across communities. Lack of consistently available data across communities precluded this use. The matrix did, however, become an organizing framework for implementing the community engagement methodology in each community.

The Community Engagement Initiative Methodology

In 1999, the Oregon Disabilities Commission conducted single-session town hall meetings in a number of rural communities around the state. These meetings focused on obtaining information on disability issues in rural Oregon communities and providing technical assistance to resolve barriers to community participation. The OODH and members of the Workgroup participated in these meetings, co-sponsoring several of them and expanding the town hall format from a single meeting to the established CEI methodology described below.

Implementation of CEI in Multiple Communities

The CEI methodology consists of three primary steps and several supporting activities. The primary components of the CEI methodology are (a) a town hall meeting for persons with disabilities and their families, (b) a meeting with representatives from the community's infrastructure, and (c) a mobilization process. Each of these steps is described in greater detail below.

Step 1: Disability Town Hall Meeting

The target audience for the town hall meeting was the local disability community, including the leadership of existing disability groups, community members not involved with local disability groups, and family members. The town hall meeting was designed to give people with disabilities, family members, and advocates an opportunity to openly discuss local barriers and assets to community participation within the seven community living domains, prioritize barriers for subsequent discussion at a community infrastructure meeting, and identify representatives to attend the community infrastructure meeting and participate in mobilization activities.

The first activity in planning a town hall meeting was targeting a specific geographic community. The communities were chosen purposefully based on a range of factors, including size of the community, urban or rural population density, geographic distribution, previous experience with the community, and presence of a center for independent living (CIL) or other disability organization. CILs offer a wide variety of services to people with disabilities to support independent living. Services include information and referral, independent living skills training, peer counseling, and advocacy. Second, local cosponsors and coleaders were identified through contacting former collaborators, or recruiting new partners from the local CIL or other disability organizations in the community. Dates and times for the meeting were established by working with local partners.

Town hall participants were recruited through notices to various disability organizations and their mailing lists, posting large print flyers, and using radio and print advertisements. Efforts were made to recruit people with a range of disabilities. The recruiting organization was highlighted as sponsoring the disability community meeting, with the university as a cosponsor. In some communities, reimbursement for transportation costs was advertised to increase participation. Recruitment efforts were extensive, with planned follow-up calls made several days prior to the meeting. To model accessibility throughout the process, selected town hall meeting sites needed to be physically accessible (i.e., with parking, doorways, restrooms in compliance with accessibility requirements of the Americans with Disabilities Act), centrally located, and accessible by public transportation if available. In some communities, no facility could meet all criteria, and OODH supported accommodations such as renting an accessible portable restroom.

Two hour meetings with light refreshments were scheduled, balancing sufficient time for discussion with avoiding fatigue among participants. Each meeting followed a standard format—introductions, review of the agenda, and facilitated discussion. Typically, two meeting coleaders were present, one with local and one with statewide knowledge of and experience with disability issues and resources. Meeting leaders always included at least one leader with a visible disability. These leaders were experienced in facilitating large group discussion that accommodated persons with visual, hearing, attention, mental, and intellectual disabilities.

Based on the Community Living Indicators matrix, the guided discussion identified accessibility barriers and facilitators in seven key areas of community life (housing, transportation, education, employment, accessing public places, recreation, and health care). Discussion leaders asked participants to identify positive aspects of their community as well as to describe the nature and location of barriers. Two staff members recorded notes on the discussion, including all barriers and assets discussed. Meeting leaders guided discussion away from issues that were not local in nature (e.g., state Vocational Rehabilitation policies). They used probes to determine if the community had current or planned activities to address the local barriers. Participants were also asked to provide ideas on what additional steps were needed to improve community participation. The leaders assisted participants in prioritizing the issues to be presented during the subsequent community infrastructure meeting (described hereafter). Representatives from the Town Hall meetings were chosen to participate in the community infrastructure meeting.

Step II: Community Infrastructure Meeting

The target audiences for the community infrastructure meeting were representatives of local government and service infrastructure and decision makers (e.g., mayors, city planners,

local school board, transportation and disability service providers, legislators), and included representatives from the disability Town Hall meeting. The purposes of the community infrastructure meeting were to increase the participants' knowledge about disability issues and awareness of community barriers encountered by people with disabilities, validate the issues identified in the Town Hall meetings, and stimulate a dialogue on potential strategies and actions to address the barriers. The meeting was generally conducted two to three weeks after the disability Town Hall meeting.

Meeting participants were recruited to represent each of the seven community living areas. Staff reviewed governmental and service directories and Web sites, sent personal invitations to potential participants, and made follow-up telephone calls. Considerable effort went into recruitment, with reminder calls made several days prior to the meeting. To maximize participation, the meeting was held during the week and included a catered working lunch. The meeting typically was scheduled for two and a half hours. Each community infrastructure meeting followed a standard format: sign-in, introductions, review of the agenda, a brief description of CEI, a PowerPoint presentation with a disability community profile and the specific community assets and barriers identified in the disability Town Hall meeting, and discussion about the identified barriers and strategies to address them.

The PowerPoint presentation served as a focal point to frame the discussion in the community infrastructure meeting. The disability profile contained extant data to demonstrate local disability demographics including prevalence, education and employment rates, and health status from the Census Bureau or the Behavioral Risk Factor Surveillance System. The presentation also contained direct quotes or summary statements from Town Hall participants, digital images of local barriers and assets collected by project staff after the town hall meeting, and, where available, Geographic Information Systems (GIS) maps linking barriers to a spatial location and an image. After the presentation of each barrier, the discussion leaders asked the community infrastructure participants for comments and reactions.

Step III: Mobilization of Disability Community and Community Infrastructure Resources

The purpose of the community mobilization step was to bring together a broad network of community members to (a) develop community solutions to identified barriers, (b) foster action steps to remove or modify those barriers, and (c) build community capacity by including disability perspectives in ongoing community decision-making. The community mobilization step was initiated in the community infrastructure meeting. After the presentation of each identified barrier, the discussion leaders asked the community infrastructure participants to respond to the issue. If the meeting participants validated the barrier, the discussion leaders worked to get commitments to allocate resources to solve the problem or examine the barrier in more depth. OODH staff provided support for the subsequent six months to aid communities in getting mobilization underway. This support consisted primarily of letters to participants summarizing the decisions made during the infrastructure meeting, provision of information about available participation opportunities and resources, training about the Americans with Disabilities Act and other disability laws when requested by the community, and periodic phone calls to check progress and encourage follow through on agreed upon actions.

Data Collection

Number, Nature and Context of Barriers

OODH staff took detailed notes of discussions in meetings and subsequently summarized them. They recorded the number of barriers and strategies to address barriers in each community within each domain of community living. To prioritize problem areas and control for verbosity of participants across communities, rank scores for community living domains were calculated based on the number of problems identified within each domain in a particular community.

Resources Required to Implement CEI

To facilitate the potential future applications of the CEI methodology, we noted the resources that were required for implementation. This included resources that the community brought to the process, as well as the costs incurred by the Oregon Office on Disability and Health.

RESULTS

Development of the CEI Methodology

The development activities resulted in a document called the Community Action Guide (Drum et al., 2002). With funding from the National Institute on Disability and Rehabilitation Research, U.S. Department of Education, a revised and expanded version was published as the Community Action Guide, 2.0 (Drum et al., 2007). The Oregon Office on Disability and Health is currently implementing the CEI methodology in a multi-state research study in Kansas, Missouri, and Oregon with a specific focus on improving accessibility of healthcare settings, and on an ongoing basis with funding from the Centers for Disease Control and Prevention, National Center on Birth Defects, and Developmental Disabilities.

Implementing CEI Across Communities

Between 2001 and 2004, the CEI methodology was implemented in two rural communities and four urban settings in Oregon. A regional approach was tested once in a frontier area of Oregon by conducting a town meeting in one town and a subsequent community infrastructure meeting approximately one hundred miles away in another town. In all communities, all three steps of implementation were completed. Once communities were engaged in the process, all expressed interest in staying engaged. Enthusiasm was typically very high during the meetings phase of the implementation; much more variability in enthusiasm was evident in implementing the action steps over time. Unfortunately, because of limited resources, OODH was not fully successful in supporting and documenting all the changes that occurred during the six-month follow-up period as the number of communities involved in CEI grew.

Representation in Meetings

Participation rates were typically high in both the disability town hall and community infrastructure meetings. In the community infrastructure meeting, at least one representative in each of the seven domains was invited to the meeting, and total attendance usually ranged from fifteen to twenty-five persons. The numbers of participants in each meeting are presented in Table 1. Despite fairly consistent recruitment methods used, the nature of participants for both the disability community meeting and the community infrastructure meeting varied considerably across communities. In some communities, disability advocates from the mental health population were more prominent, while in other communities advocates with physical disabilities or developmental disabilities were more strongly represented. This appeared related to how organized different disability groups were in specific communities. Similarly, in the community infrastructure meetings, the different roles of participants varied across communities.

Barriers Identified and Actions Taken

The number of barriers as recorded in discussion notes was summarized for each community. Communities varied in the total number of barriers identified, with the more rural communities generally identifying more total barriers. Across communities, the most barriers were identified in accessing health care, housing and public places, while fewer barriers were identified for recreation and employment.

Transportation was the area with the most variability in number of barriers across communities, with the most rural community reporting most problems with transportation and more urban communities reporting fewer. Least variability was reported for recreation, with all communities reporting relatively few problems in this area.

The number of participants, total number of barriers per community, and ranked frequency of barriers are presented in Table 1. Communities are ordered from most rural to most urban based on size, interstate highway access, and proximity to the state's largest metro area.

Areas identified as most problematic also suggested differences among communities. In general, more rural communities reported health care to be one of the most problematic areas. Health

TABLE 1
Rank of Community Living Barriers by Town Hall Participants in CEI Sites

	<i>No. of participants^a</i>	<i>Health care^b</i>	<i>Housing</i>	<i>Public places</i>	<i>Transportation</i>	<i>Education</i>	<i>Employment</i>	<i>Recreation</i>
Community 1 ^a	42	1.5	7.0	5.0	1.5	3.0	5.0	5.0
Community 2	58	1.5	1.5	3.5	3.5	5.0	6.0	7.0
Community 3	46	2.5	1.0	6.5	6.5	4.5	4.5	2.5
Community 4	60	5.0	5.0	1.0	2.0	5.0	3.0	7.0
Community 5	76	6.5	2.0	1.0	4.5	3.0	6.5	4.5
Community 6	56	1.5	1.5	3.5	6.5	6.5	3.5	5.0
Average	56	3.08	3.00	3.42	4.08	4.50	4.75	5.17

Note. ^aCommunities ordered from *most rural* (1) to *most urban* (6). ^bCommunity living area ranks where 1 = *most problematic*, 7 = *least problematic*; ties in rankings across areas within a community are shared to allow averaging.

care was less of a problem for urban communities, with the exception of one of the oldest suburbs of Portland and where numerous health care barriers were reported. The most rural community identified health care and transportation as most problematic. On the other hand, another community known for its tourism and recreation identified problems with housing, followed by recreation and health care. These rank scores provide some opportunity to relate differences across communities by the nature of the community. Housing was reported as a problem for most communities, likely reflecting the state's population growth and competition for affordable housing during this time period.

Resources Required for Implementation

Resources required of the community included a disability group able to collaborate in reaching out to community members with disabilities, a site in which to hold meetings, and community infrastructure representatives willing to participate in the process. Community infrastructure members were overall remarkably interested in the process and in improving services to their constituents with disabilities.

The largest additional cost of implementation related to project staff time. Recruitment of participants and planning meeting logistics required at least one half-time staff person for at least two months prior to each meeting, or the equivalent number of hours if completed by multiple staff. Assembling community specific information related to disability statistics could usually be completed by dedicating 2 to 3 days of a staff person's time. Conducting the meetings required 1 or 2 staff persons in addition to the meeting leaders. Staff ensured that facilities were ready, participants' needs could be addressed, detailed notes were taken, and support was provided to the meeting leaders. Summarizing meeting notes and distributing them required about one week of full-time work. At the follow-up stage, staff members were typically only able to devote about 2 hours per week per community for six months; however, 1 to 2 days per week would have been more optimal. The project contracted for the services of the meeting leaders, including compensation for travel time. Meeting facilities were usually provided free of charge, but refreshments and catering averaged a cost of about \$50 per meeting for light refreshments and \$200 for lunches. Travel costs for staff were minimal for communities close to the project site, but became a significant consideration for communities where long drives and overnight accommodations were necessary.

Community Case Studies

The following case studies provide a deeper understanding of how the CEI methodology was implemented in different types of communities. One case study from an urban community and one from a rural community are presented in the following sections.

Urban Community

The example urban community had a population of more than 140,000 people at the time of the study. It is the location of one of Oregon's major public universities and has a reputation for being socially progressive. One-third of the local population had completed 4 or more years of college, and the city had a high percentage of professionals including doctors, lawyers, architects, and educators.

The Disability Town Hall participants consisted of 35 self-advocates with a variety of physical, cognitive, and sensory disabilities. Although the community did not have a Center for Independent Living (CIL), many of the participants knew each other prior to the meeting. The meeting was lively and included extensive discussion of specific community assets and barriers to participation. Participants discussed the benefits of creating a CIL. A broad range of assets and barriers was identified within each of the seven community domains. During the last part of the meeting, the participants prioritized the barriers. Top priority barriers included access to the county fairgrounds and public transportation issues. Specific transportation concerns included difficulty navigating the downtown transit center and fear of using the wheelchair lift on buses.

The Community Infrastructure meeting included invited representatives from the Town Hall meeting and over 25 local government officials, including the mayor, city commissioners, city planners, service providers, educators, and employers. The meeting participants validated many of the issues identified by the Town Hall participants. For example, participants generally agreed that it was important to have accessible restrooms at the county fairgrounds. The Community Infrastructure meeting also served as a means to increase awareness of other existing opportunities in the community. For instance, the local transportation district promoted its Committee on Accessible Transportation, inviting people with disabilities to increase their participation on the committee. The transportation district also made a commitment to publicize its unique one-on-one training program for riders with disabilities, in which an off-duty bus is driven to the home of a rider with a disability to provide training in using the wheelchair lift.

During the community mobilization phase, the county fair board allocated resources to build accessible restrooms at the county fairgrounds. People with disabilities increased their involvement in the transportation district's Special Transportation and Advisory Council and Accessible Issues Committee. Through this committee, citizens with disabilities had an opportunity for continued input on local transportation issues.

People with disabilities in the community also decided to pursue the development of a Center for Independent Living. While there had been previous discussion about the need for a local CIL, there had not been sufficient joint action to develop such a center. During the mobilization phase, participants formed a new organization, applied for, and obtained grant funding to establish a CIL.

The community mobilization strategies adopted in the urban community reflected both the cohesiveness and enthusiasm of the participants with disabilities and the community leaders' commitment to inclusion. The strategies utilized included (a) reframing an identified access barrier as a lack of communication about the existing resources, (b) making a commitment to increase awareness about the transit district's one-on-one training program, (c) adding members with disabilities to an existing committee to focus on transportation access issues, (d) allocating resources to address accessibility of restrooms at the fairgrounds, and (e) forming a new organization to address disability issues generally.

A number of factors likely contributed to the successful outcomes of the community engagement process in this community. Recruitment of key town hall and community infrastructure participants was facilitated through prior relationships developed by OODH staff conducting other events in this town. Many of the participants with disabilities knew each other, were well versed in advocacy and empowerment issues, and were articulate in communicating about access issues in their community. Finally, the socially progressive community approach meant that the

local government had already been involved in disability issues. These factors were all regarded as contributing to the success of CEI this particular community.

Rural Community

The rural community had about 19,000 residents, with an additional population of more than 25,000 in the surrounding urban growth boundary. It was the largest town in the area and was known for agriculture and natural attractions.

About 25 people with disabilities attended the Disability Town Hall meeting. Participants included people with mental health, physical, and sensory disabilities, seniors, and several disability service providers. There was little evidence that participants knew each other prior to the meeting. Town Hall participants identified a number of specific barriers to community participation within each of the community living domains, including difficulty recruiting and retaining general health care practitioners and specialists, lack of transportation serving outlying areas, and a paucity of full-time employment opportunities. Particular issues were prioritized by the Town Hall participants. Top priority was mental health services; people needing mental health services had to go to the hospital emergency room, and from there be transported to another facility many miles away. Participants also described emergency room doctors as insensitive to the needs of people with mental illness.

The Community Infrastructure meeting included representatives from the city planning and human resources departments, as well as disability service providers, educators, and employers. Issues regarding delivery of mental health services resonated strongly among participants. The meeting provided an opportunity for information to be exchanged about a number of efforts already underway to alleviate the problems that the town hall participants had identified. These included education of hospital emergency staff to improve attitudes, and procedures to decrease response time and streamline the referral process.

The second priority issue related to a recent change to the local public bus route that reduced safe access to the town's largest retail store. According to the town hall participants, the store manager and the local transit service recently had moved the bus stop from directly in front of the store to a location on the street that required passengers to traverse a large parking lot. While the relocation of the bus stop increased bus route efficiency for the transit authority and reduced wear-and-tear on the parking lot for the store, it also decreased safe transit from the bus stop to the store. Getting from the bus to the store entrance across the parking lot became more difficult and more hazardous for people with mobility limitations and visual impairments.

A small group was formed to try to move the bus stop back directly in front of the store. A CEI participant spoke with the store manager who indicated willingness to have the bus route returned to its original location. However, the head of the transit service was unwilling to relinquish the newly gained route efficiency. The store manager made a request to the chain's head office to add an accessible sidewalk down the middle of the parking lot, and discussed the possibility of providing service along a frontage road in the future after an addition to the store was completed. However, these changes had not yet occurred by the end of the 6-month follow-up period.

CEI in the rural community was regarded by OODH staff as moderately effective, with a number of factors mitigating greater success. These included the lack of experience among local disability advocates in working together as a "community." Community mobilization efforts

were primarily coordinated through the local CIL. Although other community members were involved in some of the efforts, very few took on lead roles. Further, the city planner for transportation did not appear amenable to changing the bus route.

SUMMARY AND CONCLUSION

Repeated implementation of the CEI methodology revealed useful aspects, challenges in its implementation, and potential use with other populations.

Lessons Learned in CEI Implementation

Implementing Disability Town Hall Meetings

Keys and Factor (2001) emphasized the importance of engaging the disability leadership and recruiting participants in community development. This proved to be a difficult task in some communities. Considerable time and effort were expended to ensure that people with disabilities knew about and were able to attend the Town Hall meetings. The preferred recruitment strategy was seeking co-sponsorship of the event by a local CIL and having CIL staff recruit participants. This method was successful in many of the communities with CILs. However, recruitment in communities without a CIL may be less effective in recruiting diverse and experienced self-advocates.

A critical ingredient to the success of CEI was the use of experienced discussion leaders who had obvious credibility with the participants. The combination of facilitation experience and disability community membership contributed significantly to creating a safe and comfortable environment in which to express access issues. The discussion leaders were particularly instrumental in delimiting topics to local community issues, as opposed to state or national concerns. For example, while people with disabilities often identified Medicaid (public health insurance for low-income individuals) as a problem, the leaders would shift the focus to local issues and inquire as to how it influenced local access to health care. Adept facilitation also encouraged participation from all participants and from individuals who experienced less-represented disabilities. The leaders also encouraged participation by community members who are not accustomed to speaking in public settings. At times, the leaders were able to describe resources that could address a perceived community access barrier. Because communities typically identified many access barriers, the leaders helped community members prioritize the issues to be presented during the community infrastructure meeting.

A final lesson learned pertained to the use of GIS mapping. A number of community-based projects have utilized GIS in community participatory projects. GIS has proven to be a useful tool in engaging some of the community members in the participatory process, especially activists, while other groups have shown less interest in utilizing maps (Elwood, 2002; Geertman, 2002; Kyem, 2001). In CEI, community members with disabilities seemed less experienced in documenting access barriers and facilitators on maps and were reticent to interact with community information compiled on maps. Interestingly, while persons with disabilities found the GIS mapping less helpful, the community infrastructure representatives found the GIS information useful and highly interesting.

Implementing Community Infrastructure Meetings

The high degree of participation may be attributable in part to the advertised university sponsorship of the event. In general, participants in the community infrastructure meeting did not demonstrate a high level of knowledge about disability issues. For some participants, the idea of barriers to community access was fairly new, while others were more familiar with the concept from a civil rights perspective. The use of formal presentations clearly had an impact on community infrastructure participants. The use of photographs and GIS maps of barriers faced by people with disabilities visually depicted the issues described verbally by people with disabilities in each community. Physical access barriers were the easiest to demonstrate in the presentations, while policy and attitudinal barriers were harder to present visually. The incorporation of GIS data into the presentations, using extant data and data gathered from the field, varied widely from community to community. Extant data was more difficult to obtain for rural communities than urban communities.

The community infrastructure meeting, where identified barriers were first presented, served as a naturalistic validation mechanism of issues and concerns. Some community representatives rejected the validity of issues as either inaccurate or insufficient from a broader population perspective. For example, in one community, the city administrator rejected the specified barriers, dismissing them as “anecdotal.” In other communities, barriers were redefined. For example, in one community, town hall participants identified a lack of physically accessible computer workstations as an access barrier. When presented with this issue, representatives of the local community college identified their accessible computer stations as a community resource. The issue was reframed from lack of access to lack of communication between the resource-holders and potential resource-users. This emerged as a significant theme among many of the communities: barriers were redefined as a “communication disconnect” between the individuals who identified an issue as a barrier and existing resources. In other cases, participants clarified that they either knew about the issue and had plans in place to address it or knew about the issue but lacked resources to resolve it.

Implementing Community Mobilization

Community mobilization was typically the most difficult part of the community engagement process from several perspectives. Community mobilization generally consisted of (a) allocation of appropriate resources to address an issue or (b) using organizational strategies such as forming alliances, task forces, or linking with existing institutions to address the barrier.

Particular difficulties encountered during this phase were centered on allocating or assuming responsibility for taking action. These difficulties included developing enough specificity about what actions needed to be taken and who would report back on it. This resulted in the dissipation of action through good but vague intentions. Another difficulty in assuming responsibility was evident in communities where the CIL representatives assumed most responsibility for follow-through. Not only did CILs typically not have sufficient resources to assume all responsibility, but this strategy also deprived the community infrastructure of a legitimate role in and responsibility for problem solving.

Several communities had difficulty in maintaining the momentum derived from participating in the community engagement process. In the first communities where CEI was implemented,

a follow-up representative for each strategy was not systematically identified. With later communities, this practice was added and proved successful. Identifying volunteer field coordinators, including representatives from both the town hall and change agent meetings, facilitated clarifying responsibility. These local coordinators also helped track actions taken in the community, along with the outcomes of these actions. This role has been formalized in our current implementations of CEI, as basis for assessing the effectiveness of community engagement.

Only occasionally did the CEI process result in the allocation of substantial direct resources to address a particular issue. For example, one community devoted resources to replacing cross walk signal buttons that were too small to be easily manipulated by people with fine motor limitations. As noted earlier, another community built accessible restrooms at the local fairgrounds. The CEI process, however, did appear to empower disability advocates to engage in community planning, increased the knowledge base of community infrastructure representatives, and supported dialogue of these two groups in problem-solving around community accessibility for its members with diverse disabilities.

Usefulness of Measures for Summarizing Across Communities

The Community Profile Matrix proved not to be useful for comparing disability profiles across communities, but was helpful as a framework for identifying access barriers across areas. A simple tally of problems, as well as rank scores within areas, provided a way of reflecting the characteristics and barriers experienced by specific communities. Examination of the areas of most barriers could be tied to the rural or urban nature of the community, as well as to other characteristics of communities.

Challenges in Implementation

As described above, a number of challenges confronted the implementation of CEI including recruiting participants, representativeness of the participants, technical knowledge of mapping and disability issues, acceptance of the identified issues as “legitimate,” and difficulties in quantifying changes within communities. CEI implementation communities varied substantially, not only by the demographic factors of population size, economic base, and relative levels of citizens’ education and income levels, but also by less immediately apparent factors. Examples of these less apparent factors included the city hall orientation toward supporting businesses relative to services, personal styles of key community leaders, history of cohesion and influence of the disability advocates, and others. CEI implementation suggests that the community engagement goal of increasing the participation of people with disabilities in city planning is a developmental process.

Disability advocates varied in how united and empowered they were, and community infrastructures varied in their awareness and amenability to disability inclusion. The CEI methodology was most effective in achieving participation outcomes when disability advocates were cohesive and empowered, when community infrastructure representatives were aware and engaged, and when the groups could mutually and respectfully engage in dialogue to identify specific barriers to address. For other communities, the CEI process fostered greater networking among people with disabilities, or increased formal dialogue by the community infrastructure around accessibility planning, but did not lead to clear and substantial participation outcomes.

Application to Other Community Development Efforts

Rappaport (1981) described the evolution of views about marginalized groups of people as moving from a deficit emphasis (highlighting the need of the targeted population) to a rights emphasis (i.e., focusing on rights to access and responsibilities for barrier removal) and, ultimately, to an emphasis on empowerment that addresses both needs and rights as well as individuals' choices and control of their own lives. Within this framework, the CEI methodology can perhaps be most successful when it supports the empowerment of the disability advocates in developing their sense of community, both as a disability network that could reach agreement on priority areas for action and as empowered participants in the process of governance in their larger community, ideally on an ongoing basis. In some CEI sites this was reflected in the disability advocates becoming more aware of local resources, in understanding and mastering the mechanisms to have their issues heard and addressed, and in obtaining membership in the community infrastructure processes. From this perspective, the CEI process may have significant utility for community development with other populations. Regardless of which population CEI is used with, the process would benefit from measuring the participant's sense of empowerment or community.

Since 2004, CEI has been implemented in 11 additional communities in Oregon. In addition, a research study funded through the Research and Training Center on Measurement and Interdependence in Community Living (<http://www.rtcil.org/mcpi/>) has begun to test the effectiveness of the approach on the single topic of health care. The project is using a multi-site/case-embedded study design to assess the efficacy of CEI to increase access to and responsiveness of healthcare facilities to people with disabilities. *Case studies* are rigorous examinations that focus on the "how" and "why" questions of the research enterprise; *embedded case studies* are studies where different levels or sources of data are collected (Yin, 2002, 1989). For this study, CEI is planned with a total of nine communities (three each in Oregon, Kansas, and Missouri). Outcome data are being collected at the individual, environmental, and organizational level.

CONCLUSIONS

This article summarizes the development of a standardized community engagement methodology on disability issues, demonstrates the feasibility of its implementation in a range of communities, and describes the results of applying a standard process for community engagement to increase accessibility of communities to their members with disabilities. Communities were noted to vary in the number and type of barriers identified, and also in the effectiveness of implementing the procedure. Insights into these variations are provided through examination of patterns in the quantitative data and through the case studies. Future research results will focus on developing methods for supporting and measuring change as a result of community development.

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