

Assessing Community-level Capacity and Readiness for Comprehensive Alcohol and Drug Prevention Activities: A Brief Review of Concepts and Methods

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November 2007

Purpose of this review

Community capacity assessment is part of the five step SPF process at the community level, but specifics as to how this is to be done must be determined by each state in a manner that is consistent with the needs and objectives of that state. Within the past 2 decades building community capacity, readiness, and empowerment have emerged as key strategies for reducing health disparities and promoting public health. This paper reviews the concept of community capacity (especially with respect to prevention), and related concepts such as resources and readiness, and their use in previous state and community planning and evaluation efforts.

Defining Capacity, Readiness, and Resources

We begin by distinguishing conceptual differences between what is meant by community capacity, as opposed to readiness, as opposed to resources. While related, each represents a slightly different, yet equally important, community characteristic that may influence the success or failure of an intervention. The literature uses terms such as social capital, community empowerment, and collective efficacy to refer to elements of community capacity, readiness, and resources. Social capital and community empowerment increase as communities build their capacity and readiness to address a problem and in turn, building capacity and readiness is, in part, building social capital and empowering community. Indeed, the underlying assumption behind capacity, readiness, and resources is that each can be changed, enhanced, and strengthened with appropriate effort and strategies and that by doing so, the health of a community can be improved. It should be noted that states and communities may find that some aspects of capacity, readiness, and resources are more or less relevant with regard to their SPF SIG priorities. In addition, capacity, readiness, and resources should be assessed within the context of the SPF SIG priority or priorities being addressed and not prevention in general. Finally, it will be helpful to include in the assessment items regarding various types of interventions and capabilities that are especially pertinent to the objectives and underlying philosophy of the SPF (e.g., environmental strategies, use of data for planning, interagency collaboration, etc.).

Community **capacity** has been defined broadly as a community's ability to address social and public health problems and may include community knowledge of a problem, systems in place, (i.e., infrastructure), skills, and resources developed to address a particular health problem. Goodman and colleagues (1998) suggest that community capacity includes the characteristics of communities that affect their ability to identify, mobilize and address social and public health problems and the cultivation and use of transferable knowledge, skills, systems, and resources that affect community and individual level changes consistent with public health-related goals and objectives. Table 1 presents some dimensions of community capacity and defines them. (Also see Freudenberg, 2004) Capacity encompasses a large number of facets on which a community may differ greatly. For example, a community may have highly motivated and experienced leaders and yet the social and organizational structures within the community do not exist to address a problem or a community may not recognize an existing problem that the community coalition wants to address. Building capacity is a multi-level, multi-organizational approach providing

access to resources that would not otherwise be identified or used. Building capacity requires an ongoing level of commitment and investment to ensure these resources are enhanced rather than depleted (Center for Primary Health Care, 2002).

Table 1. Dimensions of Community Capacity Relevant to Health

Dimension	Definition
Leadership	Presence of experienced, skilled leaders (formal and informal) willing to address the health issue(s), providing direction and structure to participants, and training new leaders
Participation	Extent to which broad cross section of citizens participate actively in addressing health concern(s)
Skills	Level of relevant organizational, scientific, political, and information seeking skills among range of participants; the ability to engage in group process
Resources	Financial, human, and social resources available for addressing health concern(s) (funding, skills, coalitions, community & partnership power, etc.); access and sharing of resources internal and external to the community
Social and Organization Networks	Horizontal and vertical linkages among participants and their organizations and other relevant local, regional, and national groups; overlap with other networks within a community; frequent supportive interactions
Sense of Community	Extent to which participants have a shared identity related to community as a physical and social environment and a willingness to take action based on that identity; a shared sense of concern for community issues; sense of connection with people and place
Understanding of Community History	Awareness of previous efforts by a community to address related problems and an understanding of how the community fares relative to others; awareness of other organizations and groups present in community;
Community Power	Ability to act to make or resist change that affects the community's health; power with others not control over them; influence across a variety of domains
Community Values	Defined and shared norms and standards related to health, environment, social justice, and democracy
Critical Reflection	Ability to analyze successes and failures, to reflect on one's experience and to assess the arguments and motivation of other stakeholders; the ability to reflect on the assumptions underlying our and other's ideas and actions
SOURCES: a combination of (Freudenberg, 2004 & Goodman et al., 1998)	

Community **readiness** refers to how ready a community may be to implement a program or intervention. In one sense, it can be subsumed under the umbrella of community capacity because if a community is not ready then it is missing a key component of capacity. The Tri-Ethnic Institute is perhaps most recognized for their development of a "Community Readiness Model" that defines 9 stages of community readiness and allows one to evaluate and categorize a community within one of those stages (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000). Table 2 presents the 9 stages and defines each distinctive stage. By knowing how "ready" a community is, it is possible to apply appropriate strategies to increase readiness and move a community towards a level of

readiness where an intervention is more likely to be successful. Edwards and colleagues argue strongly that a community that is not at a stage to recognize and deal with a health problem will likely not benefit from most interventions. Furthermore, to expect that a community will sustain an intervention once the SPF SIG is over is unlikely if they see no reason to or do not have the organization to do so.

Community **resources** are important to both readiness and capacity. Resources refers not only to financial resources available for interventions but also refer to human resources such as having motivated, trained, and competent staff people in place to make sure the necessary work takes place and takes place correctly, and social resources including a motivated and energized community decision makers, political power base, health department, administrators, law enforcement, school personnel, church leaders, etc. Also included in resources are concepts such as social capital, political will, and infrastructure. A community is neither ready, nor has adequate capacity, without having good resources, yet resources are not the only component of readiness nor capacity.

Table 2: Stages of Community Readiness

Stages	Definition
No Awareness	The community or the leaders do not generally recognize the issue as a problem. "It's just the way things are." Community climate may unknowingly encourage the behavior although the behavior may be expected of one group and not another (i.e., by gender, race, social class, age, etc.).
Denial	There is little or no recognition that this might be a local problem but there is usually some recognition by at least some members of the community that the behavior itself is or can be a problem. If there is some idea that it is a local problem, there is a feeling that nothing needs to be done about it locally. "It's not our problem." "It's just those people who do that." "We can't do anything about it." Community climate tends to be passive or guarded.
Vague Awareness	There is a general feeling among some in the community that there is a local problem and that something ought to be done about it, but there is no immediate motivation to do anything. There may be stories or anecdotes about the problem, but ideas about why the problem occurs and who has the problem tend to be stereotyped and/or vague. No identifiable leadership exists or leadership lacks energy or motivation for dealing with this problem. Community climate does not serve to motivate leaders.
Preplanning	There is clear recognition on the part of at least some that there is a local problem and that something should be done about it. There are identifiable leaders, and there may even be a committee, but efforts are not focused or detailed. There is discussion but no real planning of actions to address the problem. Community climate is beginning to acknowledge the necessity of dealing with the problem.
Preparation	Planning is going on and focuses on practical details. There is general information about local problems and about the pros and cons of prevention activities, actions or policies, but it may not be based on formally collected data. Leadership is

	active and energetic. Decisions are being made about what will be done and who will do it. Resources (people, money, time, space, etc.) are being actively sought or have been committed. Community climate offers at least modest support of efforts.
Initiation	Enough information is available to justify efforts (activities, actions or policies). An activity or action has been started and is underway, but it is still viewed as a new effort. Staff is in training or has just finished training. There may be great enthusiasm among the leaders because limitations and problems have not yet been experienced. Community climate can vary, but there is usually no active resistance, (except, possibly, from a small group of extremists), and there is often a modest involvement of community members in the efforts
Stabilization	One or two programs or activities are running, supported by administrators or community decision-makers. Programs, activities or policies are viewed as stable. Staff are usually trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is no in-depth evaluation of effectiveness nor is there a sense that any recognized limitations suggest an immediate need for change. There may or may not be some form of routine tracking of prevalence. Community climate generally supports what is occurring.
Confirmation/Expansion	There are standard efforts (activities and policies) in place and authorities or community decision-makers support expanding or improving efforts. Community members appear comfortable in utilizing efforts. Original efforts have been evaluated and modified and new efforts are being planned or tried in order to reach more people, those more at risk, or different demographic groups. Resources for new efforts are being sought or committed. Data are regularly obtained on extent of local problems and efforts are made to assess risk factors and causes of the problem. Due to increased knowledge and desire for improved programs, community climate may challenge specific efforts, but is fundamentally supportive.
Professionalization	Detailed and sophisticated knowledge of prevalence, risk factors and causes of the problem exists. Some efforts may be aimed at general populations while others are targeted at specific risk factors and/or high-risk groups. Highly trained staff are running programs or activities, leaders are supportive, and community involvement is high. Effective evaluation is used to test and modify programs, policies or activities. Although community climate is fundamentally supportive, ideally community members should continue to hold programs accountable.

SOURCE: (Edwards et al., 2000)

Many communities in recent years have begun to form community coalitions with the purpose of increasing community capacity and readiness to address health related problems. These coalitions function with varying degrees of competency and success. It may be worthwhile for those communities with coalitions in existence to evaluate the functioning of the coalition. Table 3 presents factors associated with the functioning of coalitions that might be assessed.

Why should we be concerned community capacity and readiness?

Community capacity is seen as both a means and an end towards greater program effectiveness and sustainability. Communities differ from one another in many ways including resources, political climates, challenges, and strengths, not to mention size and diversity. It is not surprising then that what might work well in one community may not work well in another. Successful prevention efforts need to be community and culturally relevant. Therefore assessing community capacity and readiness is an essential component of planning an effective intervention.

Table 3: Factors of coalition functioning identified in the literature

Member Characteristics & Perceptions	member benefits member participation member satisfaction and commitment member skills and training representativeness of members member recruitment member expectations ownership
Organizational or Group Characteristics & Climate	community context and readiness group relationships and collaboration communication strong leadership
Organizational or Group Processes	conflict resolution decision making clear mission quality of action plan formalized roles and procedures technical assistance resources available
Impact and Outcomes	linkages to other groups in community policy advocacy & change empowerment & social capital community capacity institutionalization

SOURCE: Granner, M. L., & Sharpe, P. A. (2004). Evaluating community coalition characteristics and functioning: a summary of measurement tools. *Health Educ. Res.*, 19(5), 514-532.

Research examining the link between community functioning and behavior has long history. Shaw and McKay (Shaw & McKay, 1942) first proposed that inequality and a concentration of poor economic conditions leads to social disorganization, which in turn leads to health and social problems. Based on this premise, research in the field of violence prevention has led to perhaps the strongest evidence that the breakdown of community and social capital, or social disorganization, leads to (or at least is strongly associated with) increases in violence (Sampson, Raudenbush, & Earls, 1997). It is argued that this link is due to a lack of shared common values and ability to maintain effective social controls (Bursik, 1988; Sampson & Groves, 1989). In this sense, community is characterized by a complex system of friendships, family ties, links to other acquaintances, and social systems that work together to create a unified social cohesion and building a sense of community is protective against many social ills.

One way that health prevention experts have attempted build community, and therefore, community capacity, is to focus on coalition building. Coalitions build community capacity by bringing together community leaders to influence local services, programs, or policies. One study looking at the effectiveness of the Fighting Back (FB) program found that sites with greater organizational capacity "received more funds for coalition building; delayed

establishing new lead agencies; were housed in agencies supportive of FB; maintained stable, participatory decision-making bodies; cultivated active involvement of local government; practiced collaborative leadership; and had effective, long-serving project directors," (Zakocs & Guckenburg, 2006).

Additional reasons why focusing on building community capacity include that 1) it increases participation and inclusions, e.g., seeks to include all groups, including the marginalized, in decision making; 2) it is holistic, i.e., takes into account the interdependence that exists between groups within communities, between communities, and more broadly; 3) it celebrates diversity, i.e., works with the diversity within communities through identification and utilization of resources from many settings; 4) it is responsive in that it recognizes that change is an integral part of community life and emphasizes the value of working in an evolving and adaptive manner; 5) it builds in sustainability (Center for Primary Health Care, The University of Queensland, 2002).

While most research on the association between community capacity and readiness and health outcomes relies on anecdotal accounts rather than empirical research, theoretically, high community capacity and readiness should increase the likelihood of a successful and *sustainable* intervention. Therefore, assessing community capacity within the context of a particular SPF SIG priority will allow communities and states to determine what work remains to be done that will enable a community to truly benefit as intended from the SPF SIG intervention(s). Finally, it should be noted that studies have found that building community capacity takes considerable time and resources and that it is difficult to translate these increases in community capacity into changes in individual behavior (Chervin et al., 2005). This does present a challenge for SPF-SIG grantees, as these grants are designed to fund the implementation of strategies, and not just building capacity (e.g., by increasing readiness). Grantees therefore, will need to work towards moving their communities to higher levels of readiness, but at the same time be willing to begin implementation of strategies even if not yet at the optimal stage of readiness. Most likely, continuing efforts to build capacity and also implement strategies will need to occur simultaneously during the grant period.

Linking assessment approach to underlying criteria and objectives

A number of measures exist for measuring and assessing community capacity and readiness as well as coalition functioning. However, as with any tool, each reflect those dimensions viewed as most important by the authors and therefore, worth assessing. For example, the South Carolina Adolescent Pregnancy Prevention Initiative Evaluation (SCAPPIE) focused on evaluating collaborative community capacity and organizational capacity. Within their framework, they measured community participation, resources, leadership, advocacy, planning, community involvement, communication, and creativity. They interviewed 5 key community leaders in 8 different categories such as media, religious, and health organizations. Another community capacity index assesses four domains: network partnerships, knowledge transfer, problem solving, and infrastructure (Center for Primary Health Care, The University of Queensland, 2002).

In violence prevention research, researchers have assessed and intervened at various levels of community that might provide control such as family and close social interactions, churches & volunteer groups, and county and state law enforcement, for example. The focus mostly depends on where they believe the break down of community is most destructive and where fixing it can be the most constructive (Sabol, Coulton, & Korbin, 2004).

Yet another example is work by colleagues at the Tri Ethnic Center for Prevention Research, who created a community readiness measure and who strongly believe that community readiness is the most important aspect of community capacity to address (Edwards et al., 2000).

What is most important for states and communities to consider as they make decisions about how to measure capacity, is that they should use their knowledge and understanding of their communities in deciding what aspects community capacity should be the focus of their efforts. Therefore, states and communities must first decide what are the important considerations for THEIR community-level assessments, and then be sure to use (or develop) an assessment tool that is consistent with those considerations.

Sources of Information about Community Capacity, Readiness, and Resources

There are many sources of information on community capacity. At a resource level, a state should be able to gather information on any state and federal funds received by counties, coalitions and/or communities to address ATOD concerns (one aspect of resources). States should have knowledge of where community coalitions exist within the state and what concerns they are addressing and how long they have been in existence. Resource mapping is a technique typically used to visually display the distribution of various resources across the state.

Ideally, states will also have information (perhaps anecdotal) on how successful the coalitions have been in meeting their goals and how well they run overall, but that may not be easily obtainable information. States should also have access to information on population density, poverty levels, school drop out rates, and other population level information that may indicate greater social disorganization and possibly less capacity. Finally, states may have information as to who key political figures within counties and communities are and who may be more or less willing to put time and attention towards addressing ATOD concerns in their communities.

For more detailed information, it will be important to gather information directly from community members. Key informant interviews, focus groups, workshops, and/or surveys are most frequently how detailed information is gathered on community capacity and readiness.

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