Edwards, R. W., Jumper-Thurman. P., Plested, B. A., Oetting, E. R., & Swanson, L. (2000). Community readiness: Research to practice. Journal of Community Psychology, 28(3), 291-307

The Community Readiness Model: Research to Practice

Ruth W. Edwards, Pamela Jumper-Thurman, Barbara A. Plested,

E. R. Oetting, and Louis Swanson

Tri-Ethnic Center for Prevention Research

Colorado State University

ABSTRACT

Communities are at many different stages of readiness for implementing programs, and this readiness is a major factor in determining whether a local program can be effectively implemented and supported by the community. The Community Readiness Model was developed to meet research needs, (e.g., matching treatment and control communities for an experimental intervention) as well as to provide a practical tool to help communities mobile for change. The model defines nine stages of community readiness ranging from "no awareness" of the problem to "professionalization" in the response to the problem within the community. Assessment of the stage of readiness is accomplished using key informant interviews, with questions on six different dimensions related to a community's readiness to mobilize to address a specific issue. Based on experiences in working directly with communities, strategies for successful effort implementation have been developed for each stage of readiness. Once a community has achieved a stage of readiness where local efforts can be initiated, community teams can be trained in use of the community readiness model. These teams can then develop specific, culturally appropriate efforts that use local resources to guide the community to more advanced levels of readiness, eventually leading to long-term sustainability of local community efforts. This article presents the history of the development of the model, the stages of readiness, dimensions used to assess readiness, how readiness is assessed and strategies for change at each level of readiness.

The Community Readiness Model: Research to Practice

Over the past few decades we have learned that, for prevention to be maximally successful, it should include a variety of methods and utilize a systematic approach. Ideally, prevention efforts should emphasize collaboration and cooperation among community agencies and generally be part of a broader community health and wellness vision. How does a community achieve such interlacing of efforts and programs? By becoming, as a community, deeply involved in the planning and implementation of the prevention program. Efforts by local people are likely to have the greatest and most sustainable impact in solving local problems and in setting local norms. When community resources are tapped, efforts are more likely to be based on concepts and ideas that are ethnically and culturally appropriate for that unique community. Successful prevention programs are "owned" by the targeted community itself.

Can a single program addressing a social or health problem be ethnically and culturally appropriate for large, diverse communities such as Los Angeles? Of course not. Defining community is complex - and becomes even more so when definitions must be applied to large populations. For the purposes of prevention efforts, a community is where residents experience their society and culture. Indeed, a "community" can be a professional society or group - a community of interest. However, we are usually more concerned with community of place - a group of people sharing specific geographic and social contexts for activities. A small town or Indian reservation is a community of place. So is a city, but with increasing size, a city can become so heterogeneous that by virtue of "shared social contexts" its populations can be broken down into numerous smaller, more intimate, communities. Within a community, and staying with our definition, we can find still more communities: a high school, a hospital, a neighborhood, a church, etc.

No community, large or small, has an easy time of it when it comes to developing, implementing and sustaining any kind of prevention program. The reasons are many. Attitudes vary across communities; in one place a behavior can be recognized as a problem and in another the same behavior can be accepted as the way things are and have always been. Resources also vary from community to community: one group may be rich with volunteers and energy and another group may be struggling for input and attention. Political climates are constantly varied and changing - always a challenge when it comes to developing and implementing a new program of any sort. Even when prevention programs do get up and running, all too often they meet with failure after a relatively short period of time. This frequently is because they are poorly planned or not potent enough to change the status quo of the community; people are insufficiently trained, or get bored waiting for results or move on - leaving less motivated people behind. Money runs out. Frustration rises. Interest fades. Why did it work in the neighboring community, people want to know? Why didn't it work here? Considering our country's vast array of ethnically, culturally and geographically diverse communities, is it any wonder that a prevention program that worked in one community may not be even minimally effective in another? Communities are fluid - always changing, adapting, growing; they are ready for different things at wholly different times. A starting point for the development of a prevention program in Loveland, Colorado may be very different than the starting point

for a similar program in Camarillo, California. Identification of the starting point is key to the eventual success and sustainability of any prevention program.

How is a community's level of readiness measured? And once the community's level of readiness is established, what methods should be applied to ensure that the program is effective and sustained? The Tri-Ethnic Center for Prevention Research at Colorado State University developed the community readiness theoretical model to answer these questions (Plested, Smitham, Thurman, Oetting, & Edwards, 1999; Plested, Jumper-Thurman, Edwards, & Oetting, 1998; Thurman, Plested, Edwards, & Oetting, in press; Donnermeyer, Plested, Edwards, Oetting, & Littlethunder, 1997; Oetting et al., 1995; Oetting, Jumper-Thurman, Plested, & Edwards, in press). The community readiness theoretical model was originally created for use with alcohol and drug abuse prevention programs. It is now being used in a broad and varied arena of prevention programs. Health and nutrition programs such as those dealing with the reduction of sexually transmitted diseases, the elimination of heart disease, depression awareness and AIDS awareness have used the model. It has also been used in environmentally-centered prevention programs (water and air quality, litter, recycling). Finally, social programs have benefited - the model has been used in numerous ways, including readiness assessment of communities before implementation of suicide prevention and intimate partner violence prevention programs.

Within a few short years, the community readiness model - along with the methods and instrumentation produced by the Center - has become an accepted and essential element in prevention program implementation. It is being used internationally. It has been presented as the centerpiece for community change by Donna Shalalla, the United States Secretary of Health and Education Welfare. Two of the five volumes on prevention of drug abuse produced by the National Institute on Drug Abuse are concerned with community readiness and use the Center’s model. When a model leads so quickly to a paradigm shift, it is a sign that the field was ready for the concept. There was a strong need for a model and the field had already been moving in the direction of producing just such a model. It only needed to be provided with a final stimulus.

THE IMMEDIATE ROOTS OF COMMUNITY READINESS THEORY

Mary Ann Pentz, who headed the Midwest Prevention Project, deserves the credit for presenting the original concept of "community readiness." In a paper, presented at the Kentucky Conference for Prevention Research in 1991, she made it clear that unless a community was ready, initiation of a prevention program was unlikely, and if a program was started despite the fact that the community was not ready, initiation was likely to lead only to failure. The presentation was a direct stimulus that led Tri-Ethnic Center senior faculty to bring together their research and applied experiences in an intense focus on the question of community readiness, and, eventually, to the development of the community readiness model.

In recent years, there have been parallel efforts leading toward - but not yet arriving at - some version of the community readiness model. For example, a number of prevention

scientists have pointed out that communities vary greatly in their interest and willingness to try new prevention strategies (Weisheit, 1984; Aniskiewicz & Wysong, 1990; Bukoski & Amsel, 1994). These authors have discussed many of the issues involved in community readiness, but did not provide an integrated theory that shows how these issues relate to an overall underlying model.

Prochaska and DiClemente had been working on a general model for personal readiness for change since the early 1980's (DiClemente & Prochaska, 1982; Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992). They provided a model for personal readiness for psychotherapy that showed that, for an individual, readiness was an essential element underlying initiation of a treatment and successful implementation of treatment. They refer to their theory of readiness as a "transtheoretical model." They name five stages of personal readiness for treatment: the precontemplation stage (minimal awareness of a problem and consequently no intent to invest in change), the contemplation stage (awareness but no commitment to action), a preparation stage (clear recognition of the problem and exploration of options), the action stage (implementation of proposed changes in behavior), and the final maintenance stage (both consolidation and relapse prevention).

The personal stages of readiness have, by analogy, some parallels to community readiness, but there are problems. The major difficulty is that communities are not individuals - they are groups. Group processes and conditions do not readily translate into the five stages of individual readiness. For example, leadership has no place in individual stages of readiness but it is an essential element of community readiness. In addition, there is no real analogue in individual readiness for stabilization of a program - the stage of community readiness where a program becomes an accepted and expected part of a community's ongoing activities. Individual readiness also did not include all of the different levels of community readiness - distinctly different from one another - that needed to be incorporated into the community readiness model. Finally, individual readiness for change in relation to a particular problem is unidimensional, while community readiness is multidimensional. A community may be at slightly different levels of readiness on different dimensions. Despite these limitations in applying the Prochaska et al. model to community readiness, their personal readiness for change model made a critical contribution. It demonstrated the need for, and the value of, a theory of readiness and showed that the theory needed to accurately describe stages of readiness as they applied to community.

The field of community development had also been moving toward a concept of community readiness. In 1983, Rogers established a set of stages for the innovation decision-making process: knowledge (first awareness of an innovation), persuasion (changing attitudes), decision (adopting the idea), implementation (trying it out), and confirmation (where it is used again or discontinued after initial trial). Warren's (1978) social action approach parallels these stages, focusing on the group processes involved. The stages include: stimulation of interest (recognition of need), initiation (development of problem definition and alternative solutions among community members who first propose new programs), legitimization (where local leaders accept the need for action),

decision to act (developing specific plans which involve a wider set of community members), and action (or implementation). These stages of decision making in communities are more useful than Prochaska's and DiClemente's stages (1983) -they do incorporate group characteristics. But, they still do not define all of the stages of community readiness and they do not adequately characterize the multidimensional nature of community readiness.

During this developmental period, Wandersman was working with community coalitions and was also moving toward a theory of readiness. He even used the term "coalition readiness" in one of his papers. Wandersman's focus was on community stress and environmental stress and how those factors inhibit community motivation (Hallman & Wandersman, 1992). Community motivation is a construct similar to community readiness. It derives from community climate, and Wandersman and his colleagues distinguish between individual climate, participant climate, and organizational climate. They describe these climates as "catalysts for action," and point out that the sense of community has a catalytic effect on local action (Chavis & Wandersman, 1990; Florin, Giamartino, Kenny, & Wandersman, 1990).

While all of these efforts adumbrate the community readiness theoretical model, until the Tri-Ethnic Center actually developed community readiness theory - determined the dimensions of community readiness, created methods for measuring readiness, and developed suggestions for the specific interventions that are needed at each stage of readiness - the ideas did not provide usable tools and could not lead to the paradigm shift that has finally occurred: the incorporation of the community readiness theoretical model as a basic and routinely accepted construct for understanding how communities change and how to change communities.

DEVELOPMENT OF THE COMMUNITY READINESS THEORETICAL MODEL

The Tri-Ethnic Center for Prevention Research has been in existence at Colorado State University since 1964 - as a laboratory studying social issues and social problems. Since 1974, the Center has focused on understanding deviance and the prevention of substance use, violence and victimization. At the time of Pentz's seminal paper at the Kentucky Conference, the Tri-Ethnic Center was trying to get prevention programs started on American Indian reservations, in Mexican-American communities (in western states), in Native Alaskan communities, and in rural Anglo communities. The goal of these prevention programs was to deal with problems ranging from drug abuse to violence. Pentz's idea about community readiness, therefore, fell on fertile ground. We were already deeply aware of the problems inherent in developing and maintaining community programs, and it was clear that we were in immediate need of a basic theory of community readiness. If we were going to be successful, we had to learn how to increase a community's readiness for prevention.

The foundation for community readiness as a theory came primarily from experiences in two independent studies that were being conducted simultaneously by Center faculty: (1) development and testing of media programs aimed at preventing drug and alcohol abuse

in small communities, and (2) consultation and training of field professionals from Mexican American, American Indian, and Alaskan Native communities.

The first project held a workshop to train teams from ten small communities who were interested in drug prevention in how to use a media campaign to support their efforts. The training included use of needs assessment techniques, information on prevention programs, how to implement a media campaign as well as how to write grant proposals. The teams then went back to their communities to initiate or improve local prevention efforts using the media campaign. Although the media campaign had been successful in pilot testing, it did not demonstrate the desired effects in this study; the trainees learned a lot about prevention programming, but when they returned home, some had little effect on their communities, some were highly successful and others fell in between. Follow-up interviews suggested that in some communities the nature of the problem was not well understood and local community members were not ready to invest more in prevention programming. In these communities, training the teams did not lead to any changes. In order to make sense of the results of this project, a crude measure of participation level was used which was developed after the fact. The major lesson learned from this project was that initiating or improving prevention or intervention programs first required learning how to prepare a community for the intervention.

Yet another project occurring at the same time provided technical assistance to underserved communities on development of prevention and intervention strategies. The Center faculty on this project had extensive experience in providing treatment to individuals and found in working with these communities, that communities were much like people in treatment, i.e., they were all at different stages of readiness for intervention. Further, the experience of our faculty was that while often a program had been successful in getting funding to provide intervention, if the community was not invested or accepting of the intervention, even good ideas were failures. These two experiences led to recognition of the need for a strong theory and a useful tool for understanding community readiness. Over the next few months, Tri-Ethnic Center's senior staff: Oetting, Edwards, Jumper-Thurman, Plested, and Beauvais (joined later by Donnermeyer) shifted attention from many other issues in order to meet that need.

First, in order to know how ready a community was, we needed useful descriptions of the real stages of community readiness. Second, we needed a method for reliably assessing community readiness. Finally, since we wanted to get a community to a stage where installing and maintaining a prevention program was feasible, we needed tested strategies for moving communities to higher levels of readiness. The community readiness theoretical model is based on several underlying premises: 1) that communities are at different stages of readiness for dealing with a specific problem, 2) that the stage of readiness can be accurately assessed, 3) that communities can be moved through a series of stages to develop, implement, maintain, and improve effective programs and, 4) that it is critical to identify the stage of readiness because interventions to move communities to the next stage differ for each stage of readiness.

The Prochaska and DiClemente (1983) stages of personal readiness for quitting smoking were used as an initial outline of stages, but it was immediately apparent that an individual's readiness for smoking cessation provided only a loose analogy for community readiness.

Some aspects of personal readiness for change did apply; for instance, implementation (trying it out) is a stage that is present in both personal and community readiness. Also, like individual readiness, community readiness is specific to the problem - a community may be at a high stage of readiness to deal with one problem and a low stage or readiness for another problem. Further, like readiness for therapy, stages of readiness are not Guttman Scales where each level incorporates and retains content of all the prior stages and all the prior stages continue to exist (something is just added at each new stage). Readiness stages dictate that, at each new stage, prior ways of dealing with a problem or issue are superceded by more effective ways of thinking about and dealing with the same problem. As new competencies develop, the earlier stages disappear.

It was soon apparent that community readiness has many more than the four stages used for individuals in the Prochaska and DiClemente model. The stages of readiness in a community have to deal with group processes and group organization - characteristics that are not relevant to personal readiness. It was also clear that, unlike the Prochaska and DiClemente model, community readiness could not be a unidimensional construct; there were multiple dimensions of readiness and a community could be at somewhat different stages on different dimensions. Tri-Ethnic Center senior staff drafted a model with the initial descriptions of the stages of community readiness and a listing of the dimensions of community readiness. At that point, a scientific method for validating the stages and dimensions of readiness was required. That method, anchored ratings, was adapted from industrial psychology.

Anchored ratings have a long history of successful application (Dickenson & Tice, 1977; Hamilton, 1970; Ivancevich, 1980; Jacobs, Kafrey, & Zedeck, 1980; Kavanagh & Duffy, 1978; Porter, Steers, Mowday, & Boulian, 1974; Ronan & Schwartz, 1974; Saal, Downey, & Lahey, 1980; Sechrest, 1968; Smith & Kendall, 1963). Nutt (1980) compared various methods for weighting decision criteria and found that anchored rating scales provided an excellent approach for assessment. Michaels and Oetting (Michaels, 1982) had already adapted the anchored ratings method to the evaluation of psychotherapist traits, creating a model that is multidimensional and that involves stages of development, so it served as a close analogy for the task of developing content and discriminant validity for the community readiness model.

The first task was to have experts write a very large number of critical incidents or events - descriptive statements that represent community attitudes and behaviors that are assumed to relate to community readiness. Next, individuals with extensive experience in working with communities were provided with these statements, shuffled into random order. These experts were required to place each statement on a specific dimension establishing, by agreement, content validity for the statements. When essentially all of the experts agreed that a statement was descriptive of a dimension, it provided evidence that

the dimension existed and that the definition of that dimension was consistent across the mental frameworks that different raters used to understand communities. In the first rotation, as expected, some of the defined dimensions proved to be invalid - raters could not reliably place statements on certain dimensions. Those dimensions were redefined, combined with other dimensions into a broader definition, or dropped. Also, as expected, there were anchor statements that could not be placed reliably by different raters on a specific dimension - these were also discarded or revised. After revision of dimensions and of anchor statements, the task was repeated. This process continued through several replications, until the dimensions were clearly defined and raters could reliably place individual anchor statements on dimensions.

The original theoretical model that grew out of this experimental process included five dimensions of readiness: (1) Existing Prevention Efforts (programs, activities, policies, etc.); (2) Community Knowledge of Prevention Efforts; (3) Leadership (included appointed leaders and influential community members); (4) Knowledge About the Problem; and (5) Funding for Prevention (people, money, time, space, etc.). Later in the process of developing the theory, "Funding for Prevention" was changed to "Resources for Prevention" - to emphasize that money is not the only resource. Community members also played a major role in the development and revision of the model. Their suggestions were invaluable in that they came from the experience of translating research in practice. For example, after participating in a workshop in which the model was presented, members of one community advised us that another dimension was needed to reflect the underlying "personality" or characterization of a community. They were, of course, right and as a result, a sixth dimension called Community Climate was added and pilot tested. Further, we had initially identified eight stages of readiness. Again, communities using the model advised us that there was yet another stage -- a stage before denial where the problem is so pervasive, it has become a way of life. Again, they were, of course, right and as a result of their input, the model became a nine-stage model.

The next task in development of the model consisted of accurately and reliably defining the stages of readiness, again using expert raters. A preliminary set of stages of community readiness were first described and defined. The set of anchor statements that had been selected as reliable for a specific dimension were shuffled and provided to expert raters. The raters were asked to place the statements anywhere on the continuum produced by the stages, either at a stage or anywhere between stages. This process provided discriminant validation for both the stages and for the anchor statements, since reliable placement of an anchor at a particular stage across raters requires that both the stages and anchors be valid descriptors in the mental frameworks of different raters. If anchors could not be reliably placed at a particular stage or were placed on more than one dimension, the definition of that stage was revised, and anchors were discarded or revised.

"Community readiness" is a term that is being used more and more by various authors and in many contexts. Although different terms and descriptions can be used to describe the stages of readiness and the dimensions of readiness, it should be noted that the specific terms and descriptions that are part of this model have been thoroughly tested. If

other names or descriptors are used, it should be incumbent on those using such terms to provide data showing that they have been subjected to an equivalent process. Following are the stages of community readiness and the definitions of those stages developed at the Tri-Ethnic Center for Prevention Research:

STAGES OF COMMUNITY READINESS

1. 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.).

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

EVALUATING COMMUNITY READINESS: KEY INFORMANTS

Once the stages and dimensions of readiness were tested and validated, a reliable method was needed for assessing community readiness. The obvious way to find out about a community is to ask the people in that community what is going on. The key informant method has a long and successful history in needs assessment (Aponte, 1978; Hagedorn, Beck, Neubert, & Werlin, 1976; Warheit, Bell, & Schwab, 1977). A key informant is a person who is likely to know about the problem or issue of concern - not necessarily a leader or decision-maker. Depending on the problem, different key informants would be used, but they are all going to be people who are involved in community affairs and who know what is going on. We have found that, depending on the problem, three or four carefully selected primary key informants are usually enough. In a small community, a key informant's role is less critical. In a large community, there may be different subpopulations at different stages of readiness (or sub populations that have different concerns), and separate assessments of readiness may need to be made for each of these critical groups with regard to each concern. Thus, in a large community, a key informant's community role becomes more critical.

Telephone interviews are usually fully adequate to assess community readiness. Most of the semi-structured questions asked are about specifics such as whether an existing

prevention program is in place. Although there are a few questions that ask about community attitudes, most questions are relatively concrete and ask for specific information. It is also usually not necessary to develop a strong personal relationship to obtain accurate data about most problems, although there may be some problems relating to behaviors viewed as highly deviant, that could require a high level of trust between interviewers and key informants. The informants do not rate readiness themselves, and do not need to know anything about the theoretical model of community readiness.

Tri-Ethnic Center faculty developed the semi structured questions to ask the key informants. Interviewers are trained in the community readiness theoretical model, and seek information that will allow them to rate the community on each of the dimensions. The semi-structured questions vary depending on the problem that is being addressed, but questions are highly similar across problems and can be easily adapted. Other scientists have produced sets of questions that can be used to interview key informants about different types of problems, but before using such questions, they should be evaluated to determine whether the answers will lead to an accurate assessment of the stage of readiness for each dimension of readiness. The questions must lead to a description of the community for each dimension of readiness. That description can then be compared with the anchor statements on the rating scale for that dimension and placed on the readiness scale at a particular point. This procedure has been tested and its reliability established.

It was essential to test the reliability of interviewers and key informants. Two methods were used. For the initial test, Center scientists compared results from key informants within a community. In rural communities, and for drug abuse prevention readiness, information obtained from fourth and fifth key informants proved to be essentially completely consistent with the judgements of community readiness based on the first three interviews. For the second test, highly trained interviewers separately interviewed key informants from a set of communities. The experimental results indicated that key informant interviews, when well done and when done by highly trained interviewers, are highly reliable and that, at least in small communities, a few key informants are enough to provide accurate information.

INCREASING COMMUNITY READINESS

Community readiness is similar to a medical or psychological diagnostic system. For a particular problem, it classifies a community at a particular stage of readiness. That stage is analogous to a diagnosis, and every diagnosis indicates that specific types of treatment are needed. The treatment may not work - sometimes for reasons that are beyond the scope of anything that could be suggested by the "diagnosis." In the case of community readiness, the "treatment" may fail. If this happens, it is may be the case that the original diagnosis of the stage of readiness was wrong. If this happens, it suggests the need to step back, assume an earlier stage of readiness, and re-attack the problem from that earlier point.

The next task was to define, describe, or devise appropriate strategies for each stage of readiness. The strategies are not specific answers; they are general statements or

examples of approaches that may be effective. Specific answers have to come from the community itself. The initial impetus for this development came from the same community groups that we had used to test the final community readiness model. As part of the process, we pulled together and summarized the ideas provided by these groups and then showed them how the ideas related to community readiness theory. Some of these workshops led, without our specific intent, to the formation of community action teams. Experience showed that those local action teams could use the community readiness concepts to plan and develop their own prevention programs.

One of the first times that the model was used to change community readiness occurred in March of 1995. The Childhood Cancer Foundation of Boston asked Jumper-Thurman and Plested to speak at a meeting with two American Indian tribes. These tribes had experienced considerable environmental distress due to uranium dust contamination and the resultant radiation poisoning. They had lost many tribal members to cancer and suffered other health consequences from radiation. The destruction caused by mining had destroyed many of their traditional plant and animal medicines. The tribes needed to reduce further threat, implement prevention, and install early cancer detection programs. All of this had to be done in ways that were congruent with tribal culture. Jumper Thurman and Plested presented community readiness theory to the tribal elders and asked them how the model might be adapted to address these health problems within the context of their own cultural values. The community readiness model was accepted as a useful tool, made cultural sense, and they had no difficulty adapting it to their needs. These tribal elders were able to classify each of their communities at a specific stage of readiness for each separate goal. For most goals in both communities, the stage of readiness was "vague awareness." The elders developed an action plan to move forward, one community readiness step at a time.

Their first strategy was for respected members of the tribe, knowledgeable about tribal culture, made personal home visits to develop support for the programs. Earliest visits were made to similar respected members, and those visited then began visiting others, and momentum grew rapidly. Once community climate reached the stage of readiness where preparation was possible, informal focus groups were held to determine how to move to the next stage of readiness. These interventions involved culturally appropriate potlucks, public forums, visits to churches and tribal gatherings. Several groups evolved from these meetings and divided up the tasks. One group has now arranged for mobile mammogram vans to visit the high school and smaller clinics and has provided early cancer detection materials and health resources contacts to members of the community. The program leaders continue to call from time to time and report that they are still moving ahead. One group found - on its own - that when it was not making progress, it was because the community was not ready. They used the model to reassess their stage of readiness and to find out why they were blocked. They then moved back a stage and found that they could go on from there. This experience showed that these local action teams could use the community readiness concepts to plan and develop their own prevention programs.

Development of appropriate strategies for each stage is another area where communities have made major contributions to the development of the model. Each time the model has been presented in communities, their suggestions for interventions at each stage have been noted and incorporated into the model where there is convergence and the strategy is fairly generic in nature. The community readiness strategies include a defined treatment, or goal, for each level of community readiness. A community can adapt the suggestions to produce a better fit with ethnic and cultural beliefs and values of the community and can identify local resources and local problems that are barriers to movement -- generally they adapt the model to fit local conditions. The following table is an example, showing how specific interventions differ in relation to the stage of readiness. Since the use of media is a frequent facet of mobilizing communities, to make this example more specific and concrete, this table focuses specifically on the use of media as an adjunct to change and uses the issue of domestic violence prevention as an example for sample messages.

COMMUNITY READINESS STRATEGIES

No Awareness

Goal: Raise Awareness of the Issue

Strategies:

One on one visits with community leaders and members.

Visit existing and established small groups to inform them of the issue.

Make one-on-one phone calls to friends and potential supporters

Denial

Goal: Raise Awareness That the Problem or Issue Exists in the Community

Strategies:

Continue one-on-one visits and encourage those you've talked with to assist.

Discuss descriptive local incidents related to the issue

Approach and engage local education/health outreach programs to assist in the effort with flyers, posters, or brochures.

Begin to point out media articles that describe local critical incidents.

Prepare and submit articles for church bulletins, local newsletters, club newsletters, etc.

Present information to community groups.

Sample Message:

"Is Child Abuse Somebody Else's Business? Domestic Violence Affects Children"

Vague Awareness

Goal: Raise Awareness that the Community Can Do Something About the Problem

Strategies:

Present information at local community events and to unrelated community groups

Post flyers, posters, and billboards.

Begin to initiate your own events (pot lucks, potlatches, etc.) to present information on the issue.

Conduct informal local surveys/interviews with community people by phone or door to door.

Publish newspaper editorials and articles with general information - but relate information to local situation.

Sample Message:

"Our Community Can Change Their World" (with photo of children)

Preplanning

Goal: Raise Awareness with Concrete Ideas to Combat Condition

Strategies:

Introduce information about the issue through presentations and media.

Visit and develop support from community leaders in the cause.

Review existing efforts in community (curriculum, programs, activities, etc.) to determine who benefits and what the degree of success has been.

Conduct local focus groups to discuss issues and develop strategies.

Increase media exposure through radio and public service announcements.

Preparation

Goal: Gather Existing Information to Help Plan Strategies

Strategies:

Conduct school drug and alcohol surveys with general violence prevalence questions.

Conduct community surveys.

Sponsor a community picnic to kick off the effort.

Present in-depth local statistics.

Determine and publicize the costs of the problem to the community.

Conduct public forums to develop strategies.

Utilize key leaders and influential people to speak to groups and to participate in local radio and television shows.

Initiation

Goal: Provide Community-Specific Information

Strategies:

Conduct in-service training for professionals and para-professionals.

Plan publicity efforts associated with start-up of program or activity.

Attend meetings to provide updates on progress of the effort.

Conduct consumer interviews to identify service gaps and improve existing services.

Begin library or internet search for resources and/or funding.

Stabilization

Goal: Stabilize Efforts/Program

Strategies:

Plan community events to maintain support for the issue.

Conduct training for community professionals.

Conduct training for community members.

Introduce program evaluation through training and newspaper articles.

Conduct quarterly meetings to review progress and modify strategies.

Hold special recognition events for local supporters or volunteers.

Prepare and submit newspaper articles detailing progress and future plans.

Begin networking between service providers and community systems.

Confirmation/Expansion

Goal: Expand and Enhance Service

Strategies:

Formalize the networking with Qualified Service Agreements.

Prepare a Community Risk Assessment Profile.

Publish a localized Program Services Directory.

Maintain a comprehensive database.

Develop a local speakers bureau.

Begin to initiate policy chance through support of local city officials.

Conduct media outreach on specific data and trends related to the issue.

Professionalization

Goal: Maintain Momentum and Continue Growth

Engage local business community and solicit financial support from them.

Diversify funding resources.

Continue more advanced training of professional and para-professionals.

Continue re-assessment of issue and progress made.

Utilize external evaluation and use feedback for program modification.

Track outcome data for use with future grant requests.

Continue progress reports for benefit of community leaders and local sponsorship.

Many communities have maintained contact with the Center, reporting on their experiences using the community readiness model to implement community change. Most have experienced few difficulties in moving forward through the stages. Some communities have not moved forward and even though the reasons are varied, consistent themes have included political changes within the communities/tribes/villages and/or personnel changes in which those trained in using the model leave the area. For some, a critical community crisis has arisen which has forced the problem originally being addressed into the background as the community dealt with an even more immediate problem. The majority of communities who have utilized the model, however, have experienced success in developing and applying their strategies. Even those that had to switch their energies to other problems that became more imminent report that they have been able to use the model to address the new priority problem as well. Many communities report having made plans for implementation and are seeking additional resources for startup of the programs. Some communities have chosen not to utilize funding, but rather to engage the community in volunteer action. In any case, many of the communities have indicated that they will continue to utilize the model to monitor their progress and to assist them in developing their future plans.

Effective and sustainable community intervention must be based on involvement of multiple systems and utilization of within-community resources and strengths. Efforts must consider historical issues, be culturally relevant and be accepted as long term in nature. The community readiness theoretical model, and the training methods based on that model that we use to work with community teams, take these factors into account and provide a practical tool that communities can use to focus and direct their efforts toward a desired result. The tool will help the community to maximize their resources and minimize discouraging failures.

Acknowledgments

This paper was funded, in part, by grants from the National Institute on Drug Abuse, (P50DA07074), The Tri-Ethnic Center for Prevention Research and (R01 DA09349) Adolescent Drug Use in Rural America) and the Center for Disease Control and Prevention (R49/CCR812737, Preventing Intimate Violence in Rural Minority Communities). The scales may be reproduced and used only for research purposes without further permission of the authors. Any commercial application, sale, or adaptation requires specific permission of the authors. Users are responsible for making sure that any use meets American Psychological Association's ethical standards.

Training in use of the Community Readiness Model is available through the Tri-Ethnic Center for Prevention Research. A selection of articles on the development and

application of the model along with a guide to utilization of the model are also available through the Center. The National Institute on Drug Abuse publications on Community Readiness and Prevention (NIH Publications No. 97-4111, 4112) are based on the Tri-Ethnic Center's community readiness theory. They were produced by Kumpfer, Wandersman, and Whiteside and are published by the National Institute on Drug Abuse, Washington, D. C.

Literature Cited

Aniskiewicz, R., & Wysong, E. (1990). Evaluating DARE: Drug education and the multiple meanings of success. Policy Studies, Rev. 9, 727-747.

Aponte, J. F. (1978). A need in search of a theory or an approach. Journal of Community Psychology, 6, 42-44.

Bukoski, W. J., & Amsel, Z. (Eds.) (1994). Drug abuse prevention: Sourcebook on strategies and research. Westport, Connecticut: Greenwood Publishing Company.

Chavis, D. M., & Wandersman, A. (1990). Sense of community in the urban environment: A catalyst for participation and community development. American Journal of Community Psychology, 18(1), 55-81.

Dickenson, T. L., & Tice, T. E. (1977). The discriminant validity of scales developed by retranslation. Personnel Psychology, 30, 217-228.

DiClemente, C. C., & Prochaska, J. O. (1982). Self-change and therapy change of smoking behavior: A comparison of processes of change in cessation and maintenance. Addictive Behaviors, 7, 133-142.

Donnermeyer, J. F., Plested, B. A., Edwards, R. W., Oetting, E., & Littlethunder, L. (1997). Community readiness and prevention programs. Journal of the Community Development Society, 28(1), 65-83.

Florin, P., Giamartino, G. A., Kenny, D. A., & Wandersman, A. (1990). Levels of analysis and effects: Clarifying group influence and climate by separating individual and group effects. Journal of Applied Social Psychology, 20(11), 881-900.

Hagedorn, H. J., Beck, K. J., Neubert, S. F., & Werlin, S. H., (1976). A working manual of simple program evaluation techniques for community mental health centers. Washington, D. C., National Institute of Mental Health, DHEW Publication (ADM) 76-404.

Hallman, W. K., & Wandersman, A. (1992). Attribution of responsibility and individual and collective coping with environmental threats. Journal of Social Issues, 48(4), 101-118.

Hamilton, D. L. (1970). The structure of personality judgements: Comments on Kuushner's paper and further evidence. Scandinavian Journal of Psychology, 11, 261-265.

Ivancevich, J. M. (1980). A longitudinal study of BES: Attitudes and performance. Journal of Applied Psychology, 65(2), 149-146.

Jacobs, R., Kafrey, D., & Zedeck, S. (1980). Expectations of BARS. Personnel Psychology, 33(3), 595-640.

Kavanagh, H. J., & Duffy, J. F. (1978). An extension and field test of the retranslation method for developing rating scales. Personnel Psychology, 31, 461-470.

Michaels, L. F. (1982). The development of an anchored rating scale for evaluating psychotherapy skills. Doctoral Dissertation, Colorado State University, Fort Collins, CO

Nutt, P. C. (1980) Comparing methods for weighting decision criteria. Omega, The

International Journal of Operations Research, 8: 163-72.

Oetting, E. R., Donnermeyer, J. F., Plested, B. A., Edwards, R.W., Kelly, K., & Beauvais, F. (1995). Assessing community readiness for prevention. The International Journal of Addictions, 30(6), 659-683.

Oetting, E. R., Jumper-Thurman, P. J., Plested, B., & Edwards, R. W. (in press). Community readiness and health services. Substance Use and Misuse.

Plested, B. A., Jumper-Thurman, P., Edwards, R. W., & Oetting, E. R. (Spring, 1998). Community readiness: A tool for effective community based prevention. Prevention Researcher.

Plested, B., Smitham, D. M., Thurman, P. J., Oetting, E. R., & Edwards, R. W. (1999). Readiness for drug use prevention in rural minority communities. Substance Use and Misuse, 4(4&5), 521-544.

Porter, L. W., Steers, R. M., Mowday, R. T., & Boulian, P. V. (1974). Organizational commitment, job satisfaction and turnover among psychiatric technicians. Journal of Applied Psychology, 59, 603-609.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. American Psychologist, 47(9), 1102-1114.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change in smoking: Toward an integrative model of change. Journal of Consulting and Clinical Psychology, 5, 390-395.

Rogers, E. M. (1983). Diffusion of innovations, 3rd ed. New York: Free Press.

Ronan, W. W., & Schwartz, A. P. (1974). Ratings as performance criteria. International Review of Applied Psychology, 32(2), 71-82.

Saal, F., Downey, R., & Lahey, M. (1980). Rating the raters. Psychological Bulletin, 88(2), 414-428.

Sechrest, L. (1968). Personal constructs and personal characteristics. Journal of Individual Psychology, 24, 162-166.

Smith, P. C., & Kendall, L. H. (1963). Retranslation of expectations: An approach to the construction of unambiguous anchors for rating scales. Journal of Applied Psychology, 47, 149-155.

Thurman, P. J., Plested, B. A., Edwards, R. W., & Oetting, E. R. (in press). Using the community readiness model in native communities. CSAP monograph.

Warheit, G. W., Bell, R. A., & Schwab, J. J. (1977). Needs Assessment approaches: concepts and methods. Washington, D. C., National Institute of Mental Health, DHEW Publication (ADM) 77-472.

Warren, R. (1978). The community in American, 3rd ed. Chicago: Rand-McNally.

Weisheit, R. A. (1984). The social context of alcohol and drug education: Implications for program evaluation. Journal of Alcohol and Drug Education, 30, 27-35.