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OUTCOMES

COMMUNITY READINESS AND HEALTH SERVICES

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ABSTRACT

Community readiness theory is a practical tool for implementing changes in community health services. The theory provides methods for assessment, diagnosis, and community change. First, community key informants are asked semi-structured questions that provide information about what is occurring in the community in relation to a specific problem. The results evaluate readiness to deal with that problem on six dimensions; existing efforts, knowledge about the problem, knowledge about alternative methods or policies, leadership, resources, and community climate. The eventual result is a diagnosis of the overall stage of community readiness. There are nine stages, tolerance or no awareness, denial, vague awareness, preplanning, preparation, initiation, institutionalization or stabilization, confirmation/expansion, and professionalization. Each stage requires different forms of

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interventions in order to move the community to the next stage until, eventually, initiation and maintenance of health services programs and policies can be achieved. [Translations are provided in the International Abstracts Section of this issue.]

Key Words: Community readiness; Health services; Community development; Community climate; Leadership.

INTRODUCTION

Several years ago, the faculty of the Tri-Ethnic Center for Prevention Research were involved in a series of tests of community based media programs aimed at drug use prevention. Media teams were formed in rural communities and were provided with a training program to help them implement the media campaign. Training these media teams and watching them try to put on the media campaign was a frustrating, but valuable, experience. Both training and implementation ran into unexpected problems and barriers. At the same time, the Center was pilot-testing a program to train members of minority communities so they could start drug use prevention programs. We provided them with up-to-date training, including needs assessment, information on prevention programs, and even knowledge of grant writing, and sent them back to their communities. The program did not work; the trainees returned home, but with a few exceptions, had little effect on their communities. Follow-up interviews showed that each of the unsuccessful trainees had tried to implement what we had taught them, but their community leaders had their own agendas and were not ready to invest more in drug abuse prevention programming, and they had no effective community support, so their extensive training did not lead to any changes.

Our understanding of these problems fell into place when Center faculty attended the 1992 session at the University of Kentucky Society for Prevention Research Conference, where Mary Ann Pentz presented a paper that talked about community readiness. The concept made immediate sense. Starting a new prevention program is only appropriate when a community is "ready." Pentz made it clear that, if we were going to be successful, we had to learn how to increase a community's readiness. First, we had to know how ready the community was, so we had to assess community readiness. Then we had to get that community to a stage where installing a prevention program was feasible, so we had develop techniques to move communities to higher levels of readiness.

Community readiness applies directly to provision of health services. It has already been utilized for assessing readiness for a gamut of problems ranging from substance use, to health and nutrition issues (sexually-transmitted diseases, heart disease, diet, etc.), to environmental issues (water and air quality, litter and recycling, etc.), to social issues (poverty and homelessness, drug use, and violence), to personal problems (depression, suicide, etc.). Following are brief descriptions of the theoretical base for community readiness, the empirical development of the Community Readiness Scale, and what we have learned about changing community readiness. If more detail is needed, please see references 1, 2, 3, and 4. Those papers will provide a detailed description of community readiness theory, instrumentation, and methods of application.

DEVELOPMENT OF COMMUNITY READINESS THEORY

Creating the Original Model

The creation of community readiness theory began with a focus group of our senior faculty. The participants were Oetting, Edwards, Jumper-Thurman, Plested, and Beauvais. We started by defining community readiness levels and stages. Prochaska, DiClemente, and Norcross (5) had listed the stages in personal readiness for psychotherapy, but it was immediately clear that an individual's readiness for treatment provided only a loose analogy for community readiness. Community readiness has many more than four stages. There are, for example, stages of readiness in a community that deal with group processes and group organization, for example, leadership and community climate, and 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. Donnermeyer, a rural sociologist, arrived at the Center as a visiting scholar, and brought insights from community development and rural sociology to building the model. The outcome of this initial effort consisted of a hierarchy of stages of community readiness, descriptions of those stages, and a set of dimensions on which communities were expected to differ in readiness.

The original model included five dimensions of readiness:

- Existing Efforts (Programs, activities, policies, etc.),
- Knowledge about the Problem,
- Knowledge about Alternative Methods or Policies,

- Leadership (includes appointed leaders and influential community members), and
- Funding (People money, time, space, etc.).

Later, Funding was changed to Resources, to emphasize that money is not the only resource, and another dimension was added, Community Climate.

The process of development led to many changes in names and descriptions of the stages. Community readiness theory is an organic system that is flexible, that can change over time and can be changed to apply to new and different problems; a system that grows and evolves over time. Following are the current stages of community readiness and definitions of those stages:

STAGES OF COMMUNITY READINESS

1. *Tolerance or No Awareness*. The issue is not generally recognized by the community or the leaders 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 this 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 are in training or have 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. *Institutionalization or 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 commu-

nity members should continue to hold programs accountable for meeting community needs.

DEVELOPING METHODS TO ASSESS READINESS

Once a basic framework was created, it was necessary to fill in the details and develop effective methods for assessing community readiness. Construction of the community readiness assessment instrument drew on methods developed by industrial psychologists. Anchored rating scales are particularly valuable when the actual behaviors of different people may be very different because they work in different jobs, but where we need to compare levels of performance. Anchor statements are developed that are representative of every level. The actual behaviors of the individuals can be described, and even if the behavior is not listed, the rater can make a good judgement about whether the behavior is similar to, above, or below the validated anchors.

Anchored ratings have a long history of successful application (6,7,8,9,10,11,12,13,14,15). Michaels and Oetting (16) adapted the method to a multidimensional evaluation of psychotherapist traits. They also created a new method for producing scale anchors using a Delphi approach. The Delphi approach was developed by futurists to improve prediction by expert judges. It involves first obtaining independent judgements, then informing judges about the distribution of judgements by the other judges and asking each of them to adjust their ratings taking that information into account. The mean of the adjusted ratings provides the predictor. Delphi results lead to greater predictive accuracy than other methods that use a group of experts.

The first task was to produce a large series of descriptive statements for each dimension of readiness. The statements described typical behaviors of communities that might occur at different stages of readiness. A group of psychologists and sociologists, who had extensive experience working with a variety of communities, then rated each of these statements. They first decided which dimension the statement described, and then placed it at the stage of readiness that they felt was appropriate. The model was then revised and the entire task was repeated. Finally, the Delphi procedure was used.

Evaluating Readiness: Key Informants

With the anchored rating scales, if we knew a community well, we could now write statements describing a particular community on each of

the dimensions of community readiness, and then rate each statement, placing it on or between the descriptive anchors that marked each stage. But when community readiness is assessed from outside of the community, a method for collecting information about the community is needed, and community key informants are used to obtain the needed information. The key informant method has a long and successful history in needs assessment (17,18,19). It is a technique taken from community psychology and adapted to obtain actual and specific data about what is going on in a community. A key informant may be, but is not necessarily, a leader or key decision maker; it is simply a person who knows the community, who knows about the problem or issue, and who can provide specific data about what is happening in that community. For example, to assess readiness for a drug use prevention program, three or four primary key informants are identified, usually the school's drug counselor or, if there is no drug counselor, another teacher or administrator, someone from law enforcement, medical/health, and/or a city official. If one of these is not available, an influential community member, a mental health professional, or a juvenile probation officer can provide the information that is needed. For different health problems, different key informants would be needed. The question is, "*Who would know about what is going on in this area?*"

Key Informant Interviews

Interviewers are trained in community development theory, and directly seek information that will allow them to rate the community on each of the dimensions. The semi-structured questions used will vary depending on the health services problem that is being addressed, but questions are highly similar across problems and can be easily adapted from standard questions. Telephone interviews are usually fully adequate, since the informants do not directly rate community readiness, and it is not usually necessary to develop a strong personal relationship to obtain accurate data.

To determine reliability, different highly trained interviewers interviewed key informants from the same communities. The interviewers were in very close agreement on the stage of readiness for each dimension and on their total assessment of the communities' stages of readiness. We also 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. While agreement between key informants may vary

depending on the problem and the nature of the key informants, the experimental results indicate that key informant interviews can be highly reliable and, at least in small communities, a few key informants are enough to provide accurate information.

RESULTS OF COMMUNITY READINESS ASSESSMENTS

We conducted community readiness assessments for drug use prevention in three groups of rural communities (4). The modal readiness for all three groups is Vague Awareness. Hardly any rural communities are at the Tolerance stage, so there is no need to convince people that drug use is really a problem, but the results show that there is a national need to increase awareness in rural communities that drug use is occurring locally and that prevention is possible. Only 2% of rural ethnic minority communities had initiated programs. Many of them had programs in the past, but clearly had not been ready for drug use prevention, because those programs had died. In contrast, 30% of Anglo (White American) rural communities were at the Initiation stage or above. Health services policy at state, regional and national levels needs to be revised to help ethnic minority rural communities increase their readiness for drug use prevention. We also conducted community readiness assessments for HIV prevention. Almost three-fourths of the rural Mexican-American communities were at the Denial stage, while Anglo and African-American communities were more likely to be at the Vague Awareness stage, and no rural community was at or beyond the Initiation stage. There is clearly a great need to increase readiness for HIV prevention in rural communities in general, but the need to do something about Mexican-American communities may be urgent, since rates of HIV infection arc relatively high among Mexican-Americans.

The CDC provided funding to survey rural communities on readiness for prevention of intimate partner violence. The mode for Native American and Native Alaskan communities was the Preparation stage of readiness. Mexican-American communities were less ready, but most were at the Vague Awareness stage or beyond. In contrast, none of the rural Anglo communities were above the Preparation stage and Denial was the modal stage. Many of the rural Anglo communities did not acknowledge that there was a local problem and there was no consideration that anything could or should be done about the problem.

INCREASING COMMUNITY READINESS

Training a Community Team to Deal with a Health Services Problem

In March of 1995, Jumper-Thurman and Plested were invited to speak at the meeting of two western region American Indian tribes. These tribes had experienced a great deal of environmental distress due to radiation poisoning and uranium dust contamination. They had to deal with grief due to the loss of many tribal members to cancer and with other health consequences derived from exposure to deadly substances. Further, because of the environmental destruction, many traditional plant and animal medicines were gone. They wanted to bring the communities together to reduce further threat, to implement prevention efforts, and to install early cancer detection mechanisms, all within a framework that supported tribal culture. The Childhood Cancer Foundation out of Boston had heard of the community work done by Jumper-Thurman and Plested and asked them to work with these two tribes. They decided to teach the theory and model to the group and ask the elders for help to adapt the model to these health problems and to their own cultural values.

The community readiness model was accepted as a useful tool, made cultural sense, and the tribal members had no difficulty adapting it to their needs. They were able to classify each community at a specific stage of readiness for each of their goals. They used that information to develop a step by step action plan. For example, in a small community, the group decided to make personal home visits to educate people in the community to develop community support for the programs. The visitors were chosen because they were respected members of the tribe who knew tribal culture. The earliest visits were made to similar respected members, and those visited then became part of the group, began visiting others, and momentum grew rapidly.

Once that community moved to the next level of community readiness, small informal focus groups, including potlucks, public forums, and visits to churches and tribal gatherings were held to determine how to move to the next stage of readiness. For example, one group organized mobile mammogram vans to the high school and smaller clinics and provided all members of the community with early detection materials and contacts for resources. Another group found, on its own, that when it was not making progress, it was because the community was not ready. They reassessed community readiness to find out why they were blocked and moved on from there.

Utilizing the Community Readiness Training Program

Over 40 workshops have now been held in the U.S. and Canada, and 60 focus groups have been held in rural communities. The training workbook is available from the Tri-Ethnic Center. It contains effective language for communicating readiness concepts as well as useful exercises to stimulate team building and demonstrate concepts.

There are other available resources for material on community readiness training. Abe Wandersman has been working with community coalitions for a number of years. His focus has been on community stress and environmental stress and how those factors inhibit community motivation (20). His most impressive work is his discussion of community climate, one of the dimensions of community readiness. He distinguishes between individual climate, participant climate, and organizational climate, describing them as "*catalysts for action*," and pointing out that the sense of community has a catalytic effect on local action (21,22). Because it was a natural extension of his previous work, when Karol Kumpfer was asked to produce the NIDA manuals on use of community readiness for prevention, she recruited Wandersman and Henry Whiteside to assist her. They used our community readiness theory as the basis for the two manuals that they produced; manuals that were published by the National Institute on Drug Abuse (NIH Publications No. 97-4110, 4111).

THE EFFECTS OF TRAINING COMMUNITY READINESS TEAMS

During the training workshops, community teams develop strategies with local contexts. An evaluation of these strategies shows that the teams understand and can use the model; that plans are appropriate for the stages of readiness of the communities; that provisional plans are practical and reasonable, that plans take into account the availability of community resources; that they are culturally sensitive and congruent with community attitudes and community climate; that they are sensitive to barriers and facilitating factors in that community; and plans show an awareness of responses of various agencies to the plans (e.g., law enforcement, justice, health services, human service providers, school personnel, etc.). The focus groups also provide examples that show the need to consider cultural differences in prevention planning and that the community readiness teams can be sensitive to these cultural issues. For example, our research shows that Anglo women who were victims of intimate partner violence can turn to a family member or close friend for support. Hispanic and American Indian

women disagree, feeling that revelation of the problem would lead to shame, and would hide the problem from friends and family. But they might seek help from a priest or someone who would maintain secrecy. Local plans showed cultural sensitivity by taking these differences into account.

We have also been able to observe the effects on communities. As one example, we recently worked with five Alaska Native communities on alcohol abuse. In two of these communities, we trained the community teams ourselves, in the other three, we trained Alaska Natives who worked with the community teams. All five communities have now made major social changes related to alcohol abuse. Although alcohol abuse is still occurring, each community has developed strong public sanctions against drunkenness and these sanctions are expressed in ways that they were not expressed before. The major, directly observable, effect is that there is no more drinking on the street, on front porches, or in public, in any of these five communities.

INTERVENING AT EACH STAGE OF COMMUNITY READINESS

The following sections provide brief explanations of the types of interventions that may be appropriate at each stage of community readiness to move to the next stages. Every problem, however, is going to be different, every community will be different, and the methods chosen must be appropriate to the problem and the community.

Tolerance or No Awareness

(Note: For professional audiences, "Tolerance" may be the best technical descriptor of this stage, but the term may be inappropriate for some issues such as HIV infection. "No Awareness" is always used to describe this stage in working with community teams.) The goal at this stage is to raise awareness that the behavior is a problem or needs changing. Activities may have to begin outside of the community, since tolerance means that the behavior is normative or an accepted practice or there is no acknowledgement of the problem. It is possible that a few individuals within the community may recognize that there is a problem; if so, they can be of great assistance. It is usually too early to start a community team until the next stages of community readiness have been reached. The external group may have to start by identifying influencers within the community and working with them to create awareness that the behavior or malady is a problem.

The next step within this stage is to begin to change community attitudes, a difficult task when a behavior is viewed as normative. Trying to change things too fast will almost always produce resistance. It is better to change a few people's minds and let it grow from there. To effectively change attitudes that are this ingrained, it is usually necessary for influencers to use personal contacts. Depending on the problem, this might include other professionals, friends, other families, or even neighbors. Media may be used in conjunction with this effort, but it is essential to pretest any presentations to make sure that the media messages do not simply create resistance. Once there is some reason to feel that attitudes are changing, informal or brief presentations can be made in existing small groups (church gatherings, Sunday School, etc.). Phone calls may be another effective intervention late in this stage.

Denial

The goal is to create awareness that there is a problem in *this* community, and that, indeed, it might be possible to do something about it. It is usually possible to form a community team at this stage. Statistics are less important than descriptive local incidents. Personalized case reports and critical incidents often have more impact among community members than data. You can argue against a number, but it is hard to argue against a mother who has lost a child to a drunk driver. On the other hand, if the community involves professionals, statistics may be of great value if they are presented effectively. Community teams have often used critical events that occur in that community to create awareness that there is a local problem. Media articles, presentations to community or civic groups, and educational posters/flyers/brochures are also specific interventions that can focus greater awareness on the problem.

Vague Awareness

The goal is to bring awareness of the problem to the level were it provides motivation to do something and to raise awareness that *this* community can, in fact, do something. From this point on, the community team is responsible for change and external help is supportive, providing training and further support in understanding the community readiness model and how it applies, and providing information and access to external resources when those are essential. Community teams can utilize interventions that include small group events, perhaps sponsored by a church or civic organi-

zation. For example, in American Indian communities, hog fries, pot lucks, and potlatches have been used to increase community awareness and begin initiating action. Other specific interventions include use of newspaper editorials or articles. National or state-wide data may still make little impression on community residents, however, local survey data can bring the problem home to *this* community, i.e., results of school surveys, phone surveys, focus groups, etc.

Preplanning

The goal is to produce awareness of concrete ideas that might be used in the community. The community team gathers information about what is already being used, who is using it, and how it is working. The team starts by evaluating policy and procedures. How do they support the continued existence of the problem? How could they be changed to reduce the problem or change what is occurring? Do the policies apply to everyone equally or are special segments of the community held to different standards? Key community leaders are brought into the process of planning and encouraged to offer support and resources. Often, a useful intervention at this stage is to conduct local focus groups or small public forums to put the problem in context and identify strengths and resources. Media interventions are still focused on local information, although they may now usefully present data comparisons with national data and information about what is occurring elsewhere. Media messages can be developed about what is being done about the problem in other places and how it is working or not working so that people are aware and can comment with a broader knowledge base. Preplanning often leads to formation of working teams that take on the next tasks involved in the Preparation stage.

Preparation Stage

The goal is to gather existing information and plan strategies. The trainers may play a very active role at this stage, since they have access to information on alternatives and how they work. For example if the focus of the team is adolescent drug abuse, the team would explore programs that are culturally relevant to their community as well as appropriate for their community, i.e. DARE, All Star, Growing Up Strong, etc. While the team is functioning independently, the trainer may help the team access information about assets and limitations of programs or methods. Local data may be essential at this stage. If local data are not available, it is too easy to state

that "*We have no problem here*" moving the process back to the vague awareness stage. If establishing a supportive community climate is essential, community telephone surveys can also be initiated to gain information about community attitudes and beliefs, more diverse focus groups can be held to gain a wider representation of the community and development of practical strategies and the availability of resources to implement alternative strategies can be established. All community teams do not need to engage in all of the described activities; the teams are expected to have a good basis for knowing what is needed in their community. Teams are also taught to recognize that when they appear to be blocked from moving forward, they have misjudged the stage of readiness and need to move back and reexamine earlier stages.

Initiation

Communities are ready to write and submit grants or applications for supporting funds, but are encouraged to view resources broadly and to try to find local resources that can be maintained over the long haul. They know their community, they know their resources and what types of activities or programs are appropriate for their community. To move to this stage, they have gained the support of leaders and of many community members. They can work toward getting policies in place, and begin to conduct training for professionals and paraprofessionals. They can conduct consumer interviews to gain information about improving services, identify service gaps, and utilize computer searches to identify potential resources that match community needs.

Institutionalizatiou or Stabilization

(Again, while professional audiences understand Institutionalization, lay audiences are bothered by this term. They confuse it with institutionalization of individuals. "Stabilization" is always used to describe this stage in training programs.) The goal is to stabilize or institutionalize policies or programs and tie them to existing supportive structures. Community-wide events can be planned to maintain support. Training can be offered to community professionals as well as community members and evaluation can be introduced to determine impact. Media can be very important, providing continuous information about what is occurring and how it is working. Evaluation and consumer comments can be distributed to the public through media. Special recognition events for local support—businesses, agencies or volunteers—can be held. If there are programs

based on grant funds or temporary funds, major efforts are made to find ways to maintain programs with local resources. Formal networking between programs should be established.

Confirmation/Expansion

Communities focus on expanding and enhancing services. Evaluation plays a critical role. One limitation of institutionalization is that programs become "traditions" or "treatments of choice" and are not really evaluated; they are just maintained. Community climate should be supportive, but not unquestioning. "Is it working?" and "How can we make it work better?" are the critical questions. Data trends are published regularly to keep consumers informed. Focus groups are geared more toward consumer satisfaction and identification of service gaps or needed modifications.

There are other aspects to this stage. For example, in thc casc of adolescent drug user programs, Qualified Service Agreements should now be in place. A community risk assessment profile should be developed to assist in maintaining or expanding funding resources. Larger communities at this stage frequently publish localized program services directories for consumers. There should be efforts to maintain a comprehensive database of consumcr profiles and service units. A speakers bureau drawing on the strengths of local people can be formalized and offered to other agencies, groups, or communities, increasing the visibility of the community and as a result, perhaps the funding base as well. Policy change should continue to occur through support of local city officials, public demand, and more informed consumers.

Professionalization

For the rare community which has achieved this final stage, the goals are to maintain momentum, maintain evaluation, and continue enhancing effectiveness. These communities maintain a very high level of data collection and analysis, sophisticated media tracking of trends, maintain and increase local business sponsorship of community events, and utilize external evaluation for consistent feedback and program modification. There is regular publication and dissemination of their learnings to other programs, and diversification of resources.

SUMMARY: THE PHOENIX PHENOMENON

These examples provide only the highlights of the intervention process, and the description makes it appear all too smooth. In reality, changing community readiness is like driving on a bumpy, muddy, country road. You sometimes have to move things out of the way. You get lost and stuck. You get flat tires and breakdowns. Sometimes you don't think you will *ever* get there. But community readiness theory is a combination map and repair kit. It shows you where you are and what you need to do to get moving again. Quite often a community working group will find that it is not making progress. When that happens, several possibilities should be checked. Most likely is that the team has been impatient. Changing people and changing communities takes time. It takes time to get people to think in a new way, then it takes them time to become comfortable with that way of thinking. When you don't seem to be getting anywhere, check carefully to make sure that you are not just the kid in the back seat saying, "*Daddy, are we there yet*?"

Second, you may have tried to move too fast. Driving too fast on country washboard and rutted roads shakes the whole system and you are likely to slide right off the road. You may have to slow down and make sure you stay on the road. Third, you may have taken a wrong turn and skipped an essential part of the road. If you skipped over a stage of readiness or did not really complete it, you may have to drop back and take the right road, redo an earlier stage. Fourth, the hitch might have broken and you left your trailer behind. There are six dimensions of community readiness, and one or two of those may not have progressed as fast as the others. You may have to go back and pick them up before you can go on to the next stage. Whenever progress seems to be stalled, it is essential to reevaluate readiness and construct interventions that will move you forward again.

Even when many of your goals have been accomplished, the trip is never actually finished. There are always new places to go, and new problems to solve. Furthermore, communities never just stay at a given stage of readiness. They will move back and forth. People will get complacent. There will be local incidents that destroy programs. Leaders will leave, and continuity will be lost. Political changes will take place. Health prevention programs are particularly subject to these processes. If the problem doesn't disappear, then people begin to feel that prevention has failed and try to kill the program. If the problem does disappear, then obviously we don't need prevention anymore and people will try to kill the program. Prevention is also hard to keep going because its results are anonymous. With treatment, there is an identified individual that is cured. With preven-

tion, we may know statistically that someone did not get the disease, but we don't know who it was. The natural flow of events is for health service prevention programs, of whatever kind, to degenerate or disappear over time.

To maintain programs and assure progress, we need to produce the phoenix phenomenon. We expect the phoenix to die. In any community, policies, programs and people will disappear. This is not a disaster, it is a normal part of the process. We simply need to produce the egg from which the new phoenix will grow. Genesis comes from retaining our memory of the need and remembering our goals so that, when the time comes, we can start a new community team, train it in community readiness theory and implementation, and raise the phoenix from its ashes once again.

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