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Community Readiness: A Tool for Effective Community-Based Prevention

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Attempting to solve community problems through national policy simply will not work. Locally initiated efforts are not always successful either, however. Many groups led by excellent prevention professionals have received federal and state funding to implement what appear to be very good ideas but experience frustration when they meet with limited success in their communities. In our experience, successful local prevention efforts must be both community specific and culturally relevant.

Most communities are very different from one another. Types of reliable resources vary from community to community as do strengths, challenges and political climates. It is not really surprising then, that what works in one community may be ineffective in another community.

There are many anecdotal accounts of how outside consultants have been called into a community to prescribe solutions for community problems which have met with only minimal success. This does not necessarily reflect on the expertise of the consultant, but rather is a result of the fact that it is rarely possible, in a short period of time, to acquire an understanding of the cultural nature and political climate of a community that is necessary to develop appropriate strategies and programs. When "experts" leave, their "prescription" often falls by the wayside. Further, because so many different sectors of a community may be affected by a community problem, prevention efforts are often fragmented. In order to affect long-lasting community change, it is essential that a community pull together in the development of interventions appropriate to their unique situation. It is our contention that there are experts within each community if they are given the proper tools to use. The Community Readiness Model is one such tool.

The Community Readiness Model is an innovative method for assessing the readiness of a community to develop and implement prevention programming. Although the Community Readiness Model was originally developed at the Tri-Ethnic Center for Prevention Research at Colorado State University to address community alcohol and drug abuse prevention efforts, it has the broader aim of assessing readiness for a gamut of problems ranging from health and nutritional issues such as sexually-transmitted diseases, heart disease, and diet; to environmental issues such as water and air quality, litter and recycling, to other social issues such as poverty, homelessness, and violence. The model identifies specific characteristics related to different levels of problem awareness and readiness for change. In order to stand a chance of success, interventions introduced in a community must be consistent with their awareness of the problem and their readiness for change.

The Community Readiness Model identifies nine stages of readiness.

1) **Community Tolerance,** which suggests that the behavior is normative and accepted.

2) **Denial,** which involves the belief that the problem does not exist or that change is impossible.

3) **Vague awareness,** which involves recognition of the problem, but no motivation for action.

4) **Preplanning,** a stage indicating recognition of a problem and agreement that something needs to be done.

5) **Preparation,** which involves active planning.

6) **Initiation,** which involves implementation of a program.

7) **Institutionalization,** which indicates that one or two programs are operating and are stable.

8) **Confirmation and expansion,** which involves recognition of limitations and attempts to improve existing programs.

9) **Professionalization,** marked by sophistication, training, and effective evaluation.

Stages are assessed by evaluating the community on six dimensions:

A) **Existing Prevention Efforts,** including programs, activities, and policies

B) **Community Knowledge** of Prevention Efforts

C) **Leadership** including appointed leaders and influential community members

D) **Community Climate**

E) **Knowledge** About the Problem

F) **Resources for Prevention,** including people, money, time, and space

The Community Readiness Model was developed using two solid theoretical traditions: (1) psychological readiness for treatment, and (2) factors related to community development. The former is as simple as a therapist's recognition of not pushing the client to a level of therapy that he or she is not yet ready to embrace. If the client is pushed beyond his or her level of readiness the treatment may fail. Communities are much the same. The tradition of community development recognizes the complex and dynamic interactions that are involved in community level, consensus-seeking, collective action. It focuses on the group process involved in making decisions.

The first step is to determine the community's stage of readiness for the particular problem involved. For example, a community may have a strong, institutionalized program for drug abuse prevention, but still be at the denial stage for preventing a problem. Planning strategies in collaboration with key people in the community results in cultural integrity and the investment of community residents which enhance the potential of success. Community members assist in identifying and owning the problem, identifying potential barriers in their own language and context, and collaborating in the development of interventions that are culturally consistent with their populations.

Since the consequences of a community problem affect many segments in that community, it is unlikely that any one organization or person will have the complete picture. The consequences of substance abuse, for example, may include violence, birth defects, child abuse and neglect, property damage, injuries and fatalities, criminal activity, lost productivity, on-the-job problems, and "co-dependent" emotional distress. To assess community readiness to address a problem, a key informant survey is used to obtain information from community people knowledgeable about the issue(s).

Key informants.

The key informants should be selected from members of the community who know about the problem being examined, existing prevention programs aimed at that problem, and various segments of community leadership. They should be leaders or working in the community on a day-to-day basis. For substance abuse, key informants could include school drug and alcohol counselors, community agency representatives, law enforcement representatives, community government officials, senior citizens, youth, or a media representative. If key informants are chosen appropriately, four to five interviews are usually sufficient to gather the needed information in a given community. If inconsistencies are found among the responses of key informants, additional interviews should be conducted until the interviewer is confident they have enough understanding of the community dynamics.

In order to conduct and score the interviews, two sets of materials are necessary which can be obtained by contacting the authors. These materials include 1) questions for the semi-structured interview, and 2) scoring sheets for each dimension of community readiness.

Semi-structured interview.

Interviews can be conducted in person or by telephone. The questions used are easily adaptable to address a wide range of community problems and relate to the six dimensions noted above that form the basis for scoring the interviews. Detailed notes are taken and the result should be a qualitative description of what is occurring in that community related to each of the six dimensions.

Scoring.

The scale for scoring each dimension is anchored by descriptive statements and utilized for ranking the responses of each interviewee on each dimension. In order for a score to be assigned, the conditions set forth in all lower ranking anchor statements must have been satisfied. After reviewing the ratings on all six dimensions for all interviews in a given community, the interviewer assigns the community to the stage which best represents the aggregate ratings of the dimensions. The assignment should not be made simply on the basis of average ratings on the dimensions, but rather should be a qualitative judgment based on all of the interview information in combination with the scores on the individual anchored rating scales. As an example, the ratings on the dimensions of leadership, prevention knowledge, and knowledge about the problem in a community may be relatively high, but if the community climate rating is very low, it suggests that despite the core of active and knowledgeable leaders, they lack community support and are not likely to succeed. In this case, additional weight must be given to the community climate dimension in rating the overall readiness of the community.

Once community readiness has been assessed, it is time to develop strategies for moving the community from their current level to the next higher one. The interventions suggested below are by no means comprehensive but have been utilized effectively by some communities. For communities in the first four stages (tolerance through preplanning) strategies are generally aimed at raising awareness that a problem exists. For instance, activities at the stage of community tolerance should be restricted to one-on-one and/or small group activities. Home visits to discuss the issues and win people over, small activity groups, talking circles, and one-on-one phone calls have been used effectively by some communities who assessed themselves at this stage.

At the denial stage, the focus is on creating awareness that there is a problem in this community. Statistics may be less important than descriptive incidents. At this stage personalized case reports and critical incidents are likely to be of more impact than general statistics or data. Media reports, presentations to community groups, and similar educational interventions can focus on the general problem in similar communities, but also must include local examples to create awareness that there is also a local problem.

At the vague awareness stage, communities can utilize small group events, pot lucks or potlatches, and newspaper editorials or articles. Although use of national or regional data may make little impression on community residents, local survey data may be of value, including results of school surveys, phone surveys, or focus groups. It should be noted that at this stage of readiness, some elements of the community such as school officials and parents may be resistant to initiating these types of activities. However, they should be encouraged to do so for the growth of the community.

At the preplanning stage, communities can begin to gather information related to effective prevention programming, examine existing curricula and educational materials that are culturally relevant, make efforts to invest key community members in the planning process, conduct local focus groups or small public forums to discuss the issues, and increase media exposure.

For communities in the stages of preparation and initiation, efforts are generally aimed at gathering and providing community specific information to the general public. Addressing substance use for example, at the preparation stage a valid and reliable school drug and alcohol survey might be initiated so that accurate local data are available. Community telephone surveys could be conducted to gain information about community attitudes and beliefs about drug and alcohol use, in-depth local statistics should be gathered, more diverse focus groups should be held to gain a wider representation of the community and develop practical prevention strategies and proposals for grants could be begun.

Communities at the initiation stage might conduct training for professionals and paraprofessionals, conduct consumer interviews to gain information about improving services, identify service gaps, and utilize computer searches to identify potential funding sources that match community needs.

For communities in the final three stages, institutionalization, confirmation and expansion, and professionalization, strategies are more programmatic in nature. Activities at the institutionalization stage consist of initiating basic evaluation

techniques in an effort to modify and improve services, provide in-service training to increase the number and quality of trained community professionals, plan community events, offer community volunteer recognition, and conduct community workshops.

At the confirmation and expansion stage, the same types of activities can be utilized, but at a higher level of sophistication. This might include external evaluation services to provide a more comprehensive community data base, activities that change local community policy or norms, media outreach that provides information about local programs and reports local data trends, and community focus groups or public forums to maintain grassroots involvement. For the rare community which has achieved the final stage, professionalism, interventions could consist of a very high level of data collection and analyses, sophisticated media tracking of trends, local business sponsorship of community events, and diversifying funding resources.

In summary, effective community prevention must be based on involvement of multiple systems and utilization of community resources and strengths. Efforts must be culturally relevant and accepted as long term in nature. The Community Readiness Model takes these factors into account and provides a tool communities can use to focus and direct community efforts toward a desired result, maximizing their resources and minimizing discouraging failures.

It is hoped that communities who utilize this method will provide feedback to the authors on their experience with the model. Many communities have maintained contact with the Center, allowing follow-up on their experiences using the Community Readiness Model. Most have moved forward through the stages. For those communities that have not moved forward the reasons are varied, but consistent themes have been political changes within the communities, tribes, or villages and/or personnel changes. For some, a critical community crisis has arisen which has forced the problem originally being addressed into the background as the community deals with an even more immediate problem.

The majority of communities who have utilized the model, however, have already been successful in developing plans and strategies to the point of implementation, or have made plans and are seeking resources for starting these programs. Some communities have chosen not to utilize funding, but rather to engage the community in volunteer action.

In any case, the communities will continue to utilize the model to monitor their progress and assist in developing their future plans.

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For a more complete discussion of the Community Readiness Model, including interview questions, scales and detailed scoring instructions, contact the authors at the Tri-Ethnic Center for Prevention Research, Colorado State University, Ft. Collins, CO 80523 800-835-8091.

References

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

Bukoski, W.J., & Amsel, Z. (Eds.) (1994). Drug Abuse Prevention: Sourcebook on Strategies and Research. Westport, Connecticut: Greenwood Publishing Company.

Donnermeyer, J.F., Oetting, E.R., Plested, B.A., Edwards, R.W., Jumper-Thurman, P., & Littlethunder, L. (1997). Community readiness and prevention programs. Journal of Community Development.

Garkrovich, L.E. (1989). Local organizations and leadership in community development. In J.A. Christenson & J.W.

Robinson Jr. (Eds.), Community Development in Perspective. Ames, Iowa: Iowa State University Press.

Jumper-Thurman, P., Plested, B.A., Edwards, R.W. & Oetting, E.R. (in press). Using the community readiness model in Native communities. Center for Substance Abuse Prevention Monograph, Rockville, MD: National Institute on Drug Abuse.

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 the Addictions, 30(6), 659 - 683.

Plested, B.A., Smitham, D.M., Jumper Thurman, P., Oetting, E.R., & Edwards R.W. (in press). Readiness for drug use prevention in rural minority communities. Journal of Substance Use and Misuse.

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.

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

Warren, R. (1978). The Community in American, 3rd ed. Chicago: Rand-McNally. Weisheit, R. (1984). The social context of alcohol and drug education: Implications for program evaluation. Journal of Alcohol and Drug Education, 30, 27-35.

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