

Community Readiness: A Model for Healing in a rural Alaskan Community

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Intervention with a community in crisis has similarities to intervention with a family in crisis. Both can present quite a challenge. In fact, even the term "community" reflects similar concepts to family: a group of people, kinship, unity, identity, cooperation, cooperative spirit. A community, like a family, is defined by the people who live within it. The connectedness between those living in rural communities is very similar to family systems. For instance, a tragedy will touch most everyone in a small community on some level. Small towns are notorious for everyone knowing everyone else's business. In fact, the reader might be challenged to also consider ways in which community systems parallel family systems.

Our previous work in family therapy led us directly into our work with communities. We have been working with communities for about ten years and the experience has greatly enriched us. We've had the opportunity to interact with ethnic communities both nationally and internationally and we've learned that, like families, they all have unique histories and stories to tell. They share commonalities as well as differences, but each is unique. They all have challenges that they wish to overcome and drug and alcohol use is a problem that is all too common. Though the problem may be shared, in our experience, successful community prevention efforts, like family interventions, must be both specific to the community and culturally relevant in order to be effective.

The Community Readiness Model, developed by psychologists and based loosely

on the treatment readiness theory, is an innovative method for assessing the level of readiness of a community to develop and implement prevention or treatment. 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, we have found that 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; environmental issues such as water and air quality, litter and recycling, as well as other social issues such as poverty, homelessness, and violence. The model has been found to be effective in rural and isolated areas as well as urban areas. 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 the awareness of the problem and the level of readiness for change present among residents of that community and most important, the culture of the community.

The Model was developed using two 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 family is pushed beyond their level of readiness, the treatment will very likely fail. Communities are much the same. The tradition of community development recognizes the complex and dynamic interactions that are involved in com-

munity level, consensus-seeking, collective action. It focuses on the group process involved in making decisions. It has proven to be an effective model for community healing. The following case study illustrates the effectiveness of the model.

This particular Community Case Study has several interesting facets that make it quite fascinating. The community is located in a remote village in Alaska. There are no roads into the village, and it is accessible only in summer when the river isn't frozen, or by tiny planes if the weather is acceptable. It is a subsistence village, with no jobs or industry but rather only that sense of community that gets the people through the long hard months of winter and darkness. The community comes together first for fish camp and later for caribou camp. They all work on cutting the meat and share the results among themselves. There were approximately 25 families who lived in the community and of those, most suffered from problems with alcohol and drugs. Drunken behavior was commonplace in the village and had, in fact, become a way of life for most families.

One woman, who had left the village years earlier decided she wanted to return to the village to fill a helping professional position. When she arrived back in the village she was greatly saddened by all of the drunken behavior and loss of culture. Unable to find support in her village, she decided to seek help outside of the village. She happened to cross paths with our Center by attending some workshops held on the Community Readiness model. Those workshops caught her attention and as she said later "gave her hope that changes could be made and that she could make them."

(Continued on page 9)

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(Continued from page 8)

Because the model offers a structure to follow, it is a tool that can be utilized by anyone to begin community change. The process begins by an assessment of the community using a semi-structured questionnaire that solicits information about readiness on six dimensions: A. Existing Efforts (programs, activities, policies, etc.), B. Community Knowledge of Efforts, C. Leadership (includes appointed leaders and influential community members), D. Community Climate, E. Community Knowledge About the Problem, and E. Resources (people, money, time, space, etc.). These dimensions are scored using anchored rating scales and scores are obtained on each dimension as well as an overall community readiness score.

There are two ways the information can then be used, as an assessment tool and as an intervention tool. Interventions have been developed that are appropriate for each of the nine stages of readiness. By knowing the readiness score, a community can implement strategies consistent with that stage. The stages are: No Awareness (the behavior is normative and accepted as a way of life), Denial (the problem does not exist or change is impossible), Vague Awareness (recognition of the problem, but no motivation for action as yet), Preplanning (recognition of a problem and agreement that something needs to be done), Preparation (active planning), Initiation (implementing strategies), Stabilization (one or two programs are operating and are stable), Confirmation/expansion (recognition of limitations and attempts to improve existing programs), and Professionalization (marked by sophistication, training, and effective evaluation dissemination).

Community members become involved in identifying and owning the problem just as family member identify the problems in therapy. They identify potential barriers in their own language and context, and collaborate in the development of interventions (similar to a family treatment plan) that are culturally consistent with their populations.

For example, at the denial stage, the focus is on creating awareness that there is

a problem in the 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, i.e., results of school surveys, phone surveys, focus groups, etc. 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.

Now let's return to the case study. The woman determined that her community, due to its isolation and long history of alcohol abuse, was in the stage of no awareness. She used the strategies recommended for that stage. She started in a grass roots way, going door-to-door to talk with neighbors and family members. She talked with other mothers who had concerns for their children growing up in a toxic environment and attended small existing groups to just sit and talk informally. She approached leaders as well, but most were drinking at the time. She used the pressure garnered from enlisting neighbors and youth to make leaders conform. She began to count the incidents of public drunkenness and the number of people who seemed to have problems with alcohol use. She kept track and then shared the information with her church groups and businesses. She posted some of those "statistics" in public places to create more awareness. It wasn't long until she began

to have more support from other mothers, teens, and businesses.

Today she believes her village to have moved up to the fifth stage. Over twenty people have gone into treatment, peer support groups are now active in the community and the youth have begun village clean up activities as part of their sobriety movement. It is no longer acceptable to be drunk in the streets of this community. One woman made this change. We know that effective community prevention must be based on involvement of multiple systems and utilization of within-community resources and strengths, but it takes only one committed individual. Margaret Mead said "Never doubt that a small group of thoughtful, committed citizens can change the world; Indeed, it's the only thing that ever has."

As in family therapy where one person may present wanting changes and encouraging others to participate, so this community made a major change based on the stimulus of one person. Like the therapeutic process, there was a crisis that brought people to action. Though the initial agendas may have been different, there became a shared vision of wellness and a willingness to cooperate.

Prevention or intervention 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 that communities can use to focus and direct community efforts toward a desired result, maximizing their resources and minimizing discouraging failures. While it may be true that it takes a village to raise a child, that village must be ready to take on the task and that readiness can begin with just one person. Just as with George in "A Wonderful Life", one person can make a big difference in a community!

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