

# **Community Readiness: A Promising Model for Community Healing**

**March 2000**



## Native American Topic-Specific Monograph Series

### **Purpose**

**The purpose of the Native American Topic-Specific monograph project is to deliver a variety of booklets that will assist individuals in better understanding issues affecting Native communities and provide information to individuals working in Indian Country. The booklets will also increase the amount and quality of resource materials available to community workers that they can disseminate to Native American victims of crime and the general public. In addition to the information in the booklet, there is also a list of diverse services available to crime victims and resources from the Department of Justice.**

### **Acknowledgements**

The Center on Child Abuse and Neglect (CCAN) acknowledges the assistance of the many consultants who contributed their expertise in the preparation of this series of monographs. These materials were developed and reviewed by individuals with diverse backgrounds, expertise and experience in victim services, legal experience, and mental health providers.

CCAN believes that the information contained herein is factual and that the opinions expressed are those of the consultants/writers. The information is not however, to be taken as warranty or representations for which the Center on Child Abuse and Neglect assumes legal responsibility. Any use of this information must be determined by the user to be in accordance with policies within the user's organization and with applicable federal, state, and tribal laws and regulations

### **Project Staff**

Project Director/Editor - Dolores Subia BigFoot, Ph.D., CCAN OUHSC  
Project Coordinator - Lana Grant, CCAN OUHSC  
Project Staff - Janie Denton and Lisa P. Rhoades, CCAN OUHSC  
OVC Program Specialist - Cathy Sanders, OVC, OJP, DOJ

## Community Readiness: A Promising Model for Community Healing

*"Never doubt that a small group of thoughtful, committed citizens can change the world; Indeed, it's the only thing that ever has."*

*Margaret Mead*

Daniel Quinn (1999), in "The Story of B" suggests that if the world is to be saved, it will be saved by people with changed minds, people with a new vision - if the time isn't right for a new idea, it will fail. If however, the time is right, an idea can sweep the world like wildfire. He believes that the measure of change is not the level of ease or difficulty with which the changes are made, but the willingness or unwillingness to accept the change.

In our experience, community change, or community healing works much the same way. We now know that truly successful prevention efforts must be conceived from models that are community specific, culturally relevant, and consistent with the level of readiness of the community to implement an intervention. Rural and reservation communities are very different from one another. Resources vary from community to community, as do strengths, challenges and political climates. Therefore, it is not really surprising then, that what works in one community may not be even minimally effective in another community. Readiness is an important factor because differences in readiness indicate what can be done and what needs to be done. But each community also needs to use its own knowledge of its assets and limitations, its culture and characteristics, its values and beliefs, to build policies, programs, and interventions that are congruent with the community's characteristics and that meet the community's needs.

Community readiness theory is based on the premise that communities, using a step by step method, can be moved through a series of stages to develop and implement effective prevention programs. The first step is to form a responsible local team and prepare that team to use the readiness model. The next step for the team is to determine their community's stage of readiness for the particular problem involved. The level of readiness holds great importance in that specific interventions exist appropriate to each stage of readiness. If a community is at a lower stage of readiness for intervention, higher level interventions will likely be met with failure (examples will be provided later in the text). 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 and their stage of readiness.

Community readiness theory has attracted a great deal of attention. Two recently published NIDA manuals on prevention deal with community readiness and several articles have now been published. One tribe in the Southwestern U. S. is using the approach to develop interventions to deal with the effects of pollution and radiation poisoning from atomic testing. Another study is determining the levels of community readiness in rural communities to address prevention of intimate partner violence. Alaska communities are continuing to successfully use the model to build coalitions to prevent and intervene in alcohol and inhalant problems. Yet another study is utilizing community readiness to examine readiness to address and prevent HIV/AIDS. Even so, community readiness theory is only five years old, and the defined intervention methods based on the theory are even younger. Despite the increasing influence of the theory, it is still an innovative approach. The rapid spread of the model only demonstrates the level of need that existed prior to creation of the theory. We know thus far that community readiness can lead to development and implementation of local prevention programs. The type of programs produced may vary from community to community. It's still too early to tell if the programs developed through community readiness are more sustainable and effective yet we speculate that they are because they are developed and driven and therefore owned by the community as a whole.

The concept of community readiness evolved from the Center's pilot studies that initiated drug abuse prevention programs and/or improved on-going prevention programs for youth in rural Mexican American and American Indian communities. In particular, the notion of assessing and increasing community readiness emerged from two sets of experiences; (1) our experience in developing and testing media

programs aimed at preventing drug and alcohol abuse in small communities, and (2) Center faculty consultations and training of field professionals from Mexican American and American Indian communities.

Several years ago Center faculty were involved in pilot tests of media programs. Media teams were formed in a few rural communities and were provided with a training program to help them implement the media campaign that the Center faculty had developed. Training these media teams and watching them try to put on the campaign was a valuable experience. Both training and implementation ran into unexpected problems and barriers. The Center faculty were flexible enough to help them work around these barriers, but there was increasing recognition that more knowledge about how communities could be mobilized to implement prevention programs was needed.

At about the same time, one of the early projects within the Tri-Ethnic Center focused on pilot testing a workshop to train members of ethnic communities interested in drug, alcohol, and inhalant prevention. The plan was to train small community teams from rural and reservation areas, provide them training (including needs assessment techniques, information on prevention programs, and grant writing), and assist them in the development of action plans to improve or increase local prevention efforts. The trainers noticed that communities, like people, were at varying stages of readiness to implement interventions. This was a major breakthrough in thinking for Center faculty.

Finally, all of these field experiences fell into place when Center faculty attended a session at the Kentucky Society for Prevention Research Conference. Mary Ann Pentz presented a paper that talked about community readiness for prevention. The concept made immediate sense. Initiating or improving prevention programs required learning first how to change a community's readiness for prevention. Training staff in how to implement a prevention program was only appropriate when a community was already primed to initiate a program or ready to expand an existing program. But this is already a high level of community readiness. What was needed was much more information about communities that were not yet ready to implement prevention programs, including a method for assessing community readiness and then stage appropriate strategies for moving communities through the planning and implementation stages. The first steps were to create a theoretical model of community readiness and then to develop and validate methods for accurately measuring community readiness. This had not yet been done.

First a theoretical base was needed. (refer to Plested, Jumper-Thurman, Edwards, & Oetting, 1998; Oetting, Donnermeyer, Plested, Edwards, Kelly, & Beauvais, 1995 and Donnermeyer, Plested, Oetting, Edwards, Jumper-Thurman, & Littlehunder, 1995 for a detailed description of model development). Researchers and practitioners alike have found that communities vary greatly in their interest and willingness to try new prevention strategies (Weisheit, 1984; Aniskiewicz and Wysong, 1990; Bukoski and Amsel, 1994). While some communities may reject public recognition of a local problem, other communities show considerable interest in an identified problem, but have little knowledge about what to do about it, and still other communities may have highly developed and sophisticated prevention programs. Prior to our work, no standard method for describing community readiness nor specific methods for assessing community readiness existed. The closest approach in the literature was community development theory, but those theories didn't really directly address readiness, particularly at the earliest stages.

The community readiness model was built on two research traditions: psychological readiness for treatment and community development, although it links to ideas from a variety of fields. Psychological readiness is defined as an individual's sense of dissatisfaction resulting from perceived discrepancy between what is and what should be with subsequent motivation to seek information, to learn, and to adopt new behaviors aimed at alleviating this discrepancy. Prochaska, DiClemente, and Norcross (1992) provide the best example. They present a five stage model for psychological readiness that includes:

- a precontemplation stage (involves minimal awareness of a problem and consequently no intent to invest in change);
- the contemplation stage (includes awareness but no commitment to action);

a preparation stage (involves clear recognition of the problem and exploration of options);  
the action stage (involves implementation of proposed changes in behavior);  
and the final maintenance stage (includes both consolidation and relapse prevention).

The field of community development provides two approaches that are partially relevant: the innovation decision-making process (Rogers, 1983) and the social action process (Warren, 1978). Garkovich (1989) has noted that both of these models recognize the complex dynamic interactions involved in community-level, consensus-seeking, collective action. Rogers' stages for the innovation decision-making process include:

- 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 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).

Sociology also looks at community dynamics. Though the individual may have specific assets, there is a growing realization that those assets are both limited by and enhanced by assets that exist in the community (Kretzmann & McKnight, 1996). Wilkinson (1991) defines the essential ingredient of a community as social interaction: residents live together, share a common life, act together to solve common problems, engage in squabbles and fights as well as affection and cooperation, and seize opportunities to improve their common life. If interaction is suppressed, community becomes limited. A community typically deals with its issues and problems in a purposive and positive manner even though it may not always be successful.

It was then necessary to develop a method for assessing readiness. Since the literature supports that the planning, funding, implementation and sustainability of prevention programs lies in the hands of community leaders, and since they are the ones who would know what was going on in their community, a key informant survey seemed to be the most appropriate method for assessing readiness. The key informant method has a long and successful history in needs assessment (Apont, 1978; Hagedorn, 1976; Warheit et al., 1977). It is a technique taken from community psychology and adapted to obtain actual and specific data to allow us to determine the stage of community readiness for each community. A key informant may be, but is not necessarily, a key decision maker; it is a person who knows the community and can provide specific data about what is happening in that community. Key informants are selected to be similar across communities, to be types of people who play similar roles in the life of the different communities. There are actually quite a few people in any rural community that can provide this kind of detailed information. Further, essentially everyone in smaller rural communities are at least acquainted with everyone else, and in larger communities, all of the community leaders know each other well. Identifying rural or reservation key informants is relatively easy. A hierarchy is developed of who is to be called. For example, for one project the four primary key informants were from the school, law enforcement, medical/health, and city government. If one of these was not available or was unwilling to participate, the key informant hierarchy then moved to a community member, a mental health professional, or a juvenile probation officer. The method involved obtaining enough information to clearly

assess readiness. Semi structured interview questions that are specific to the issue are used to interview key informants and their responses are classified and scored by the rater to identify the stage of readiness of the community.

Interview questions are specifically related to each of six dimensions:

- (1) Existing Prevention Efforts (Programs, activities, policies, etc.),
- (2) Community Knowledge of Prevention Efforts,
- (3) Leadership (includes appointed leaders and influential community members),
- (4) Knowledge About the Problem, and
- (5) Funding for Prevention (People money, time, space, etc.).

Each of the six dimensions have specific anchor statements on a scale. 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 using the average but paying close attention to the cut off scores within each stage. 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 emphasis must be given to the community climate dimension in rating the overall readiness of the community and specific strategies addressing the lower stage for community climate should be initiated to make it consistent with the other dimensions.

The Community Readiness Model identifies nine-stages of readiness:

- No Knowledge (formerly community tolerance) stage - suggests that the behavior is normative and accepted.
- Denial stage - involves the belief that the problem does not exist or that change is impossible.
- Vague awareness stage - involves recognition of the problem, but no motivation for action.
- Preplanning stage - indicates recognition of a problem and agreement that something needs to be done.
- Preparation stage - involves active planning.
- Initiation stage - involves implementation of a program.
- Stabilization (formerly Institutionalization) stage - indicates that one or two programs are operating and are stable.
- Confirmation/expansion stage - involves recognition of limitations and attempts to improve existing programs.
- Professionalization stage - is marked by sophistication, training, and effective evaluation.

The next effort by Center staff involved translating the stage of readiness into a means for moving communities to increase their readiness for prevention. (Note: although "readiness" sounds like it might merely be an attitude, increasing community readiness beyond the preparation stage requires both vision and action, so changing readiness beyond the initial stages means that effective community action has taken place.) A number of the community workshops that have been used to explore readiness concepts have led to formation of community action teams, and the workshops have shown that those teams can use community readiness concepts to plan and develop prevention efforts and strategies.

With the stage of readiness assessed, the team then assists the community in the development of strategies for moving the community from their current level of readiness to the next higher one for each dimension of readiness. The community team is encouraged to generate its own ideas for moving to the

next stage of readiness, but the trainers can also provide a list of interventions consistent with the level of readiness and that have been found to be effective for moving from one level to the next. It is important to note that community readiness is not a program but a model that allows communities to identify and implement programs and approaches appropriate to their level of readiness as well as to their community's needs. The following offers brief explanations of the interventions appropriate to each stage to encourage and support movement through the stages.

Activities at the stage of no awareness, when the one to a few members of a community may not realize that a behavior is a problem, may have to start with identifying influencers and working with them to create awareness of the problem. It may not even be possible to form a local team until this homework has been done in order for the first movement in readiness to be made. Interventions at that stage include visiting other families and neighbors in a one-on-one setting in order to increase awareness of the problem. Informal or brief presentations can be made in existing small groups (church gatherings, Sunday School, etc.). Phone calls can be another effective intervention at this stage. It is important that the trainer use his/her own knowledge of local context and local culture to select influential people who may be sympathetic toward viewing the behavior as a problem. In the case of prevention of drug abuse, none of these communities will be at the no awareness stage, although some communities might be at that stage in terms of alcohol abuse.

At the denial stage, the focus is on creating awareness that there is a problem in this community, and that, indeed, it might be possible to do something about it. There is usually enough recognition of the problem by some people, that a small team can be formed from the support garnered in the no awareness stage; although the trainer may have to work carefully in selection of the team and in providing an early influence to help that team recognize that there is a local problem and that there are possibilities for doing something about it. Generally, statistics are much less important than descriptive local incidents. At this stage personalized case reports and critical incidents are interventions that carry more impact for a community than general statistics or data. Media articles, presentations to community or civic groups, and educational posters/flyers/brochures are also specific interventions that focus greater awareness on the problem. Community teams have also used critical events that occur to create awareness that there is a local problem.

At the vague awareness stage, community teams can utilize interventions that include small group events, pot lucks or potlatches, perhaps sponsored by a church or civic organization, to increase community awareness and begin initiating action. Other specific interventions include use of newspaper editorials or articles and printing of local survey data. National or state-wide data may still make little impression on rural community residents, however, local survey data can be used to great advantage, i.e., results of school surveys, phone surveys, focus groups, etc.

At the preplanning stage, community teams focus on raising awareness with some concrete ideas about how to begin making changes. The primary goal is to gather information about what's already being used and who is using it. This includes exploring existing policy and how it is used. 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 to offer support and resources. A key intervention at this stage includes conducting 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 though they begin to pull in national data that can be used as a comparison. Stories should be developed about the various programs/curricula that are available for use so that people are aware and can comment with a broader knowledge base.

For communities in the stages of preparation the goal is to gather existing information with the intention to plan strategies. The working group can continue to examine pre-existing curricula and educational materials but with an eye to what is working and what isn't. They can also begin to 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., although information is provided by the trainer on assets and limitations of these programs when they are examined. When addressing general adolescent drug use and methamphetamine use for example, at the preparation stage, a valid and reliable school drug and

alcohol survey can be initiated so that accurate local data are available. Community telephone surveys could also be initiated to gain information about community attitudes and beliefs related to drug use, in-depth local statistics can be gathered, more diverse focus groups can be held to gain a wider representation of the community and development of practical prevention strategies resources for alternative activities identified. 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, it usually means that they have misjudged the stage of readiness and need to move back and reexamine earlier stages.

Communities at the initiation stage are ready to write and submit grants when there are funds that may be available to be used as resources. They are, however, 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. Another intervention at this level is to conduct consumer interviews to gain information about improving services, identify service gaps, and utilize computer searches to identify potential resources that match community needs.

For communities in the stabilization stage the goal is to stabilize or institutionalize their efforts. The interventions allow for planning of community-wide events which community members may now attend since more are invested in the process. Training can be offered to community professionals as well as community members and evaluation tasks can be introduced so determine impact. 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 to spark more interest in support. If there are programs based on grant funds or temporary funds, efforts are made to find ways to maintain programs with local resources. Formal networking between programs should be established.

Communities at the confirmation/expansion stage focus on expanding and enhancing the services they now have. Qualified Service Agreements, particularly important in rural communities, should now be in place and a community risk assessment profile could be developed to assist in maintaining or expanding funding resources. Larger rural communities at this stage frequently publish localized program service directories for consumers. There should be efforts to maintain a comprehensive database of consumer profiles and service units. A speakers bureau drawing on the strengths of local people can be formalized and offered throughout the state, increasing the visibility of the community and as a result, perhaps the funding base as well. Policy change can now occur through support of local city officials, public demand, and more informed consumers. Data trends are published regularly to keep consumers informed. Focus groups at this stage are geared more toward consumer satisfaction and identification of service gaps or needed modifications.

For the rare community which has achieved the final stage, professionalism, interventions are aimed at maintaining the momentum and continuing growth. These communities maintain a very high level of data collection and analyses, 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 funding resources.

These examples provide only the highlights of the intervention menu. It should be noted that an important aspect of using the community readiness model for intervention and program planning is continuous assessment of progress and introduction of efforts that are culturally relevant to the community. Sometimes a community working group will find that it is not making progress. When that happens, it indicates that one of the two things may have happened. First, it may be that at least some elements (one of the six dimensions) of the community are still at a lower stage of readiness than the overall stage indicated (not all dimensions may be within the same stage in the first scoring). Second, the team may have tried to move too fast, perhaps skipping too quickly through the interventions in an

earlier stage of readiness. Readiness is then carefully reassessed, with particular attention to the dimensions where the stage is lower than the others. New interventions can be developed that more appropriately recognize that dimensions and movement to the next stage can then occur with few problems.

Early in the model development process, Center staff were invited to speak at the meeting of two tribes and their leaders. These tribes had experienced a great deal of environmental trauma due to weapon testing and contamination. The communities had to deal with grief due to the loss of many tribal members to cancer and other health consequences due to exposure to deadly substances. Further, because of the environmental destruction, many of their traditional plant and animal medicines were gone. They wanted to bring the communities together to reduce further threat and implement preventative and early cancer detection mechanisms. They had tried, but were having difficulty getting things started to their satisfaction. Community Readiness had not been used at this point in any area other than drug and alcohol prevention. However, because of the request from this group, Center staff decided to offer the theory and model to the group and the elders to help in adapting the model to this tribe's situation. The tribal members had no difficulty adapting it to their needs. They were able to classify their communities to a specific stage of readiness. They used that information to develop a step by step action plan. For example, one group decided to make personal home visits to educate people in the community to develop community support for the programs. Those visited then became part of the group, began visiting others, and momentum grew quite quickly. Once the community moved to the next level of community readiness, small informal focus groups were held to determine what nature the intervention should assume to move to the next stage of readiness, i.e., potlucks, public forums, visits to churches and tribal gatherings, etc. The groups decided to take several different directions and divided up the tasks. The group has now implemented mobile mammogram vans to the high school and smaller clinics and has provided all members of the community with early detection materials and contacts for resources available. This experience helped immensely in proving the utility of the basic model for the community teams in readiness theory.

As a result of these experiences, Center staff have developed a training program and have pilot tested the training model in American Indian and Alaska Native communities. The feedback they receive continues to shape the Community Readiness model. They continue to provide workshops for local teams in many Native communities. It is important to note that, at this point, the Center has completed more than 750 key informant interviews in rural communities throughout the U.S., including Alaska Native, American Indian, Mexican American and Anglo rural communities specific to HIV/AIDS prevention, drug abuse prevention, alcohol abuse prevention, intimate partner violence prevention and early pilot studies on methamphetamine prevention. Over forty workshops on community readiness have been held in the U.S. and Canada, and sixty focus groups have been held in rural communities. The training model is now well developed and contains effective language for communicating readiness concepts to teams in rural communities. In addition, useful exercises to stimulate team building and demonstrate concepts have been created. A major asset of community readiness training is that the model is open ended. Unlike programs that lead to a particular prevention effort and then stop, the model using stages of readiness suggest the opportunity, even the need, for continued evolution and improvement. Once an interim goal is reached, such as starting a school based prevention activity, the team moves on to the next stages. Even when the prevention efforts in a particular area have reached a high stage of readiness, the team can use the knowledge and expertise with the model to address other community problems or issues.

Results from follow up interviews and focus groups suggest a high level of success from workshops training community teams in the use of community readiness theory. In the workshops, community teams were given the opportunity to develop strategies with local contexts. An evaluation of the strategies showed that the teams understood and could use the model; that plans were appropriate for the stages of readiness of the communities; that they were practical and reasonable, given the availability of community resources; that they were congruent with community attitudes and community climate; that they were sensitive to barriers and facilitating factors in that community; and that they showed an awareness of responses of various agencies to the plans (e.g., law enforcement, justice, health services, human service providers, school personnel, etc.)

Community Readiness does indeed, help a community to create a shared vision. Referring back to Quinn (1998), vision is like the flowing river. The river wasn't always flowing, but one after another, tiny springs bubbled up and began to flow together - it became a brook, a stream and eventually, a river, awakened and sustained and enhanced entirely by vision. Vision is the goal, vision pursues the desirable, it doesn't oppose, it proposes, and it opens the way to success.

**Table 1. Stages in Community Readiness**

1. 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." "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 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. Improved attitude in community climate is reflected by 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 a 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

more 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. However, community members should continue to hold efforts accountable for meeting community needs, although fundamentally they are supportive.

## REFERENCES

- Aniskiewicz, R., and 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., and 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., and Littlethunder, L. (1997). Community readiness and prevention programs. Journal of Community Development Society, 28 (1), 65-83.
- Garkovich, L.E. (1989). Local organizations and leadership in community development. In J.A. Christenson and J.W. Robinson Jr. (Eds.), Community development in perspective. Ames, Iowa: Iowa State University Press.
- 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.
- Jumper-Thurman, P., Plested, B.A., Edwards, R.W., Helm, H.M., and 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.
- Kretzmann, J. & McKnight, J. (1996). Assets-based community development. National Civic Review, 85, 23-29.
- 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., and Edwards R.W. (in press). Readiness for drug use prevention in rural minority communities. Journal of Substance Use and Misuse.
- Plested, B.A., Jumper-Thurman, P., Edwards, R. W., & Oetting, E. R. (1998). Community readiness: A tool for effective community-based prevention. Prevention Researcher, 5(2).
- 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.
- Quinn, D. (1996). The Story of B. Bantam Books, New York: New York. Pp 48-52.
- Rogers, E.M. (1983). Diffusion of innovations, 3rd ed. New York: Free Press.
- 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 America, 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.
- Wilkinson, K. P. (1991). The Community in Rural America. New York: Greenwood Press.

Author

Pamela J. Thurman, Ph.D.  
Department of Psychology  
C138 Andrews G. Clark  
Colorado State University  
Ft. Collins, CO 80523

Dr. Thurman is a Clinical Psychologist at the Tri-Ethnic Center for Prevention and Research at Colorado State University. She can be reached at (970) 491-0251.

Acknowledgments

This paper was funded, in part, by grants from the National Institute on Drug Abuse, (P50DA07074, RO1, [Drug Use Among Young Indians - Epidemiology and Prediction](#)) and the Center for Disease Control and Prevention (R49/CCR812737, [Preventing Intimate Violence in Rural Minority Communities](#)). The scales may be reproduced and used for research purposes only 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.

## RESOURCES

### **Office for Victims of Crime**

810 Seventh Street, NW  
Washington, DC 20531  
(202) 307-5983  
<http://www.ojp.usdoj.gov/ovc>

### **Office for Victims of Crime Resource Center**

Box 6000  
Rockville, MD 20849-6000  
800-627-6872  
<http://www.ncjrs.org>

### **Center on Child Abuse and Neglect**

CHO 3B-3406  
940 NE 13th Street  
P.O. Box 26901  
Oklahoma City, OK 73109  
<http://pediatrics.ouhsc.edu/ccan>

### **Bureau of Indian Affairs**

Office of Tribal Services  
1849 C Street, NW, MS 4603  
Washington, DC 20240  
(202) 208-2721  
<http://www.doi.gov/bia>

### **Office of Justice Programs**

American Indian and Alaska Native Desk  
810 Seventh Street, NW  
Washington, DC 20531  
(202) 616-3205

### **Tribal Law and Policy Institute**

P.O. Box 460370  
San Francisco, CA 94146  
(415) 647-1755  
<http://www.tribal-institute.org>

### **U.S. Department of Justice**

Office of Tribal Justice  
10<sup>th</sup> and Constitution Ave., NW, Room 1509  
Washington, DC 20530  
(202) 514-8812

### **American Indian Development Associates**

Ms. Ada Pecos Melton  
7301 Rosewood Court, NW  
Albuquerque, NM 87120  
(505) 842-1122

**National Congress of American Indians**

1301 Connecticut Avenue NW, Suite 200  
Washington, DC 20036  
(202) 466-7767  
<http://www.ncai.org>

**National American Indian Court Judges Association**

1301 Connecticut Avenue, NW  
Washington, D.C. 20036  
(509) 422-6267  
<http://www.naicja.org>

**Native American Rights Fund**

1506 Broadway  
Boulder, CO 80302  
(303) 447-8760  
<http://www.narf.org>

**National CASA Association**

100 W. Harrison St., North Tower #500  
Seattle WA 98119  
1-800-628-3233  
<http://www.casenet.org>

**National Children's Alliance**

1319 F Street, NW, #1001  
Washington, DC 20004  
(800) 239-9950  
<http://www.nncac.org>

**Colorado State University**

Tri-Ethnic Center  
C138 Andrews G. Clark  
Ft. Collins, CO 80523  
(970) 491-0251

**Northern Plains Tribal Judicial Institute**

University of North Dakota Law School  
Box 9000  
Grand Forks, ND 58202  
(701) 777-6176  
<http://www.law.und.nodak.edu/lawweb>

## **Native American Topic Specific Monograph Project Titles**

- Abusers Who Were Abused: Myths and Misunderstandings**  
Dewey J. Ertz, Ph.D.
- Community Readiness: A Promising Model for Community Healing**  
Pam J. Thurman, Ph.D.
- Confidentiality Issues in Victim Advocacy in Indian Country**  
Eidell Wasserman, Ph.D.
- Dealing with Disclosure of Child Sexual Abuse**  
Eidell Wasserman, Ph.D.
- The Differences Between Forensic Interviews & Clinical Interviews**  
Jane F. Silovsky, Ph.D.
- Guidelines for Child Advocacy Centers in Indian Country**  
Eidell Wasserman, Ph.D.  
Roe Bubar, Esq.  
Teresa Cain
- History of Victimization in Native Communities**  
D. Subia BigFoot, Ph.D.
- Interviewing Native Children in Sexual Abuse Cases**  
Roe Bubar, Esq.
- Memorandums of Understanding Between Indian Nations, Federal, and State Governments**  
Jerry Gardner, Esq.
- Native Americans and HIV/AIDS**  
Irene Vernon, Ph.D.
- An Overview of Elder Abuse in Indian Country**  
Dave Baldrige  
Arnold Brown, Ph.D.
- Psychological Evaluations**  
Eidell Wasserman, Ph.D.  
Paul Dauphinais, Ph.D.
- Public Law 280: Issues and Concerns**  
Ada P. Melton, Esq.  
Jerry Gardner, Esq.
- The Role of the Child Protection Team**  
Eidell Wasserman, Ph.D.
- The Role of Indian Tribal Courts in the Justice System**  
B.J. Jones, Esq.
- The Roles of Multidisciplinary Teams and Child Protection Teams**  
Eidell Wasserman, Ph.D.