COMMUNITY READINESS AND PREVENTION PROGRAMS

By Joseph F. Donnermeyer, Barbara A. Pletters, Ruth W. Edwards, Gene Oetting and Lawrence Littlethunder

ABSTRACT

Community norms and values are important factors affecting the support of community-based development efforts. This is particularly the case when the programs are prevention efforts, including drug education programs. The purpose of this article is to describe a way to measure the readiness of a community to support drug prevention education. The readiness scale was based on the classic community development models of the social action process (Beal, 1964) and the innovation decision-making process (Rogers, 1994). Development of the scale was based on construction of 45 anchor rating statements for five dimensions of a prevention program and nine stages of community readiness. The community readiness scale was designed for use by community development practitioners working in the field of prevention, through key informants interviews with selected community leaders. Results from 45 communities indicated a bi-modal distribution of readiness levels. Implications of the results and experiences in developing and measuring community readiness are discussed in terms of community-based strategies and the potential to apply the concept of readiness to other areas of community development.

INTRODUCTION

Large cities and small towns alike are increasingly confronted by a host of problems that call for community-based prevention efforts. These problems run the gamut from health and nutrition issues (sexually-transmitted diseases, eating disorders, cancer, and heart disease), to public safety issues (drugs, violence, crime, child and spouse abuse), from environmental issues (water and air quality, solid waste disposal and landfills, litter and recycling) to social problems (homelessness, poverty, literacy) and personal problems (depression, suicide).

As an issue reaches a critical level of awareness among the public, the political system reacts by proposing federal, state and local initiatives to prevent...
or solve the given problem (Wade, 1989; Boggs, 1991). These clarion calls for action inevitably attempt to incorporate grassroots strategies based on feedback from the public, all of which are aimed toward development of programs for implementation at the local level.

Nowhere is the factor of community support more apparent than in the area of drug abuse prevention and education. After a decade of decline, drug use, especially among young adults and adolescents, is once again rising. Further, rates of substance use are nearly identical for urban, suburban, and rural youth (Donnemeyer, 1994). Via the Drug-Free Schools Act and other efforts of various federal, state, and local government agencies, toward prevention of substance abuse, there have been hundreds of attempts to establish community-based prevention programs aimed at reducing rates of usage among adolescents. Some prevention programs are poorly conceptualized and are not based on sound epidemiological information and tested scientific theories of risk factors associated with substance abuse. Other prevention programs are poorly planned and implemented, or simply lack sufficient funds to carry out program goals (Beatty & Cazares, 1984). However, a large share of the failure is attributable to the fact that prevention programming often receives little or no moral support in many communities, and some prevention efforts are met with outright resistance (Hawkins et al., 1994). Failed programs may be the result of the simple fact that implementation was attempted before the community was ready to accept the idea that there was a problem and that something needed to be done; and neither success nor failure can be attributed to the soundness of the concept of prevention or the quality of planning put into a program’s blueprint for action. In other words, the relative level of a community’s readiness to accept and support a program is a key element in its success, and one that is often neglected during the planning process.

The purpose of this article is to more fully define the concept of community readiness and to describe a way of measuring readiness so that prevention programmers specifically, and community development practitioners in general, have available a tool that improves chances for success by their becoming more cognizant of the importance of timing in the planning and implementation of programs (Lackey & Pratuckchai, 1991). Toward this end, the article will (1) define the concept of community readiness; (2) describe the development of a scale of community readiness for drug abuse prevention efforts which utilizes anchor rating statements and key informant interviews; (3) present the results of initial findings from application of the community readiness scale; and (4) discuss implications of community readiness for prevention programs and of its application to other community development efforts.1

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1 This article expands on a previous article on community readiness by Oetting et al. (1995). Please refer to Oetting et al. (1995) for a more detailed description of the initial development of the community readiness scale.
THE CONCEPT OF COMMUNITY READINESS

One of the few attempts to systematically study a community's readiness level comes from research by Miller (1990), who examined readiness of a community for a public education program on wastewater treatment alternatives. Miller began by distinguishing between three types of readiness: individual, group and community. Individual readiness is based upon psychological needs, which is an individual's dissatisfaction based on the perception of a discrepancy between what is expected and what is reality. Group readiness is similar to individual readiness because it is also based upon the identification of a need or discrepancy between expectations and reality. However, the decision-making process of the group can modify the way in which problems are identified, solutions are examined, and action is taken. Group readiness is a slower process because decision-making involves more than one person. Values and norms salient to the need or issue are shared and require consensus among members. Leadership within the group becomes an important dimension because members of the group vary in their influence on decision-making (Miller, 1990).

In many ways, community readiness is no different from group readiness, including shared norms and values, group decision-making and the dimension of leadership (Miller, 1990). However, a community is a unique type of human grouping. According to Warren (1978), a community is a combination of people and groups which perform certain functions that are locality-based, including the production/distribution/consumption of goods and services, socialization, social control, social participation and mutual support. What makes a community a unique social group is how one becomes a member. The minimal membership requirement is that of residence. Residence, and therefore membership, is determined by address: an individual is eligible to vote, pays taxes and in other ways has the opportunity to participate in the life of the community and in community-level decision-making based on this address (Warren, 1978; Rogers et al., 1988). In many American communities, however, a high percentage of members participate minimally or not at all in community decision-making (Rogers et al., 1988). They fail to vote, do not show up for public hearings, do not attend council meetings of their elected representatives, refuse to sign petition drives, never join local volunteer groups, and are unwilling to establish friendships with and assist neighbors. Usually only a small percentage of members participate actively and fully in the life of a community. These few express their participation through neighborhood associations, civic groups and political parties and other groups that engage in the five locality-based functions outlined in Warren's (1978) definition.

The uniqueness of community leads to two implications for the concept of readiness. The first is that readiness is based on the consensus of values and norms between groups and organizations within the community (Garkovich, 1989). Hence, the three types of readiness (psychological, group and commu-
nity) described by Miller (1990) represent three different levels of decision-making respectively: the psychological or individual level, the intragroup or inter-individual level, and the intergroup or inter-organizational level. Second, since participation in community affairs is limited, expressions of community values and norms are distributed unevenly. What this means is that local leaders and professionals who have a stake in the issue under consideration, sometimes referred to as gatekeepers and stakeholders, become very important for assessing community readiness (Simpson & Simpson, 1979; Mays & Beckman, 1989).

Based on the above considerations, a definition of community readiness was developed that plays off Warren's (1978) concept of community and Miller's (1990) distinction between individual, group, and community levels of readiness: community readiness is the relative level of acceptance of a program, action or other form of decision-making activity that is locality-based.

A SCALE OF COMMUNITY READINESS FOR PREVENTION PROGRAMS

Stages of Community Readiness

The idea that communities have stages of acceptance or readiness is not a new one. Community readiness is implied in the concept of the social action process, which has been part of the community development literature for decades and continues to be an important theme up to the present time (Alinsky, 1946; Beal, 1964; Warren, 1978; Kaufman, 1985; Garkovich, 1989; Littrell & Hobs, 1989). The social action process, according to Garkovich's (1989) review, assumes that communities are action fields with various degrees of overlapping interests among individuals and groups concerning local issues. Alinsky, Beal, Warren, Kaufman, and many others describe this social action as a series of stages which begins with a convergence of these interests, progresses through development of an action plan and concludes with its implementation.

The community readiness scale for prevention programs was based upon revision and expansion of two well-known processes that have been utilized in community development for several decades. The first is the social action process of Beal (1964) and the second is the innovation decision-making process from Rogers' diffusion of innovations model (1994). Both processes refer to how decisions are made, but at two very different levels of readiness (Miller, 1990). However, their stages are parallel, and are defined in a way so that they represent a logical progression along a continuum. The social action process describes decision-making at the community level, and includes the five stages: (1) stimulation of interest: an initiation set or small group of community members (and possibly outsiders) develop an early interest in a new idea or practice; (2) initiation: a larger group (called the diffusion set) considers the new idea or practice and alternative ways for implementation; (3) legitimation: community leaders decide whether or not to proceed with an action; (4) decision to act: a
specific plan of action is developed; and (5) action: the plan is implemented. Rogers' innovation decision-making process also has five stages: (1) knowledge: an individual becomes aware of a new idea or practice; (2) persuasion: an individual develops an attitude (favorable or unfavorable) about the new idea or practice; (3) decision: an individual makes an initial decision to adopt or not adopt the new idea or practice; (4) implementation: an individual tries out the new idea or practice for the first time; and (5) confirmation: an individual decides to use the idea or practice again (perhaps with modifications).

However, neither the social action process nor the innovation decision-making process are adequate, especially when the focus is on a community's readiness to adopt a prevention program. The first shortcoming is that the knowledge stage and the stimulation of interest stage of the two processes respectively do not describe in enough detail the process that a community goes through as it attempts to define the local situation and whether or not some type of action is required. The second inadequacy is later on in the process, when communities have already initiated one type of program or another, but must consider its redefinition, modification or expansion. In other words, the confirmation stage and the action stage of the two processes respectively fail to recognize that prior experience (in many cases, previously implemented programs) may either help or hinder new initiatives of a related nature. Sometimes tourism and the vested interests of existing programs may reduce support or even create opposition for new efforts, while at other times the new program or action benefits from these groups (Fitzpatrick & Gerard, 1993). This was an important consideration since it would be rare today to find a community that has not already started some form of drug abuse prevention program. However, prevalence rates among different age groups are constantly changing, different types of illicit substances go in and out of fashion, and new federal and state initiatives are always occurring with changeovers in administrations. New community-based prevention programs are constantly being initiated, and rarely in an environment where something similar has not already been attempted, and may be currently on-going. The same situation is probably true for most other community-based issues and actions, from wastewater treatment to business retention and expansion programs.

Several preliminary models, with stages ranging from five to ten, were proposed. The authors debated the merits of these models and consulted with prevention program practitioners in order to test out these ideas. Eventually, a nine-stage community readiness model was developed (Table 1) and settled upon as most promising for field testing.

On one end of the scale is community tolerance, which refers to the case where the situation is not only considered normal, but in the case of drug abuse, abstinence would be considered deviant. On the other end of the scale is the stage of professionalization. This stage refers to the case of a community that not only supports a program, but constantly reviews and revises the program in
### Table I. Stages of Community Readiness for Prevention Programs

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<tr>
<th>Stage</th>
<th>Characteristics</th>
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<tr>
<td>1. Community tolerance</td>
<td>Community norms encourage substance-using behavior. However, norms may indicate that substance-using behavior is appropriate for only certain groups and not for others (i.e., by gender, race, social class, or age). Norms may indicate specific social contexts in which substance use is appropriate.</td>
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<td>2. Denial</td>
<td>Community norms do not approve of substance-using behavior. There may be no recognition that there is a local problem, or there could be some recognition of a problem but a feeling that nothing needs to be done or nothing could be done about it. It is possible that community may be aware of a problem, but it is among a group in which it is perceived that nothing can be done or should be done. Note: It is possible that some communities actually have no problem, in which case the denial stage is an inaccurate description of readiness.</td>
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<tr>
<td>3. Vague awareness</td>
<td>There is a recognition that substance-using behavior is a local problem, but little or no specific knowledge of its extent and nature. Knowledge is limited to stereotypes and anecdotes. Leadership and motivation to do something about the problem is minimal.</td>
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<td>4. Preplanning</td>
<td>There is a recognition that substance-using behavior is a problem. Community leaders and/or a group of community members have discussed the situation and defined the problem, but do not necessarily have good information on factors influencing substance use. There may be a committee, but there is no real planning of actions to address the problem.</td>
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<td>5. Preparation</td>
<td>There is a definition of the local problem and an understanding of at-risk groups for substance use. There is general, anecdotal information about prevention and educational programs. There is a committee or identifiable group of leaders who are actively developing a plan of action and soliciting support for programming.</td>
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<td>6. Initiation</td>
<td>A program has been started and staff (paid or volunteer) are either in training or have recently been trained. Support from key leaders is positive and enthusiastic and community-wide support may also be in evidence. The program may still be considered on trial, and has not yet been reviewed or evaluated, and the program has not been renewed or continued past initial period of support and funding.</td>
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<tr>
<td>7. Institutionalization</td>
<td>The program is currently running and has established funding. There has been a program around long enough to have experienced staff. There is little perceived need to expand or change the program. There may be some routine measurement of prevalence rates of substance use locally, but no in-depth evaluations of program effectiveness or of changing program needs.</td>
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Table 1. Continued

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<th>Stage</th>
<th>Characteristics</th>
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<tr>
<td>8. Confirmation/expansion</td>
<td>The standard program continues to receive support and is perceived by community leaders as useful and may also receive widespread support/recognition in the community at large. The original program has been evaluated and revised to some extent, and new programs to address new and related problem areas are being developed. Data on extent of the problem locally and on risk factors associated with substance use are collected periodically.</td>
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<td>9. Professionalization</td>
<td>A multi-objective program that identifies and targets specific at-risk groups in the community has been developed. The program receives support locally from community leaders and community members. Data on prevalence rates and risk factors are collected periodically and used by staff to adjust program goals and target high risk groups. Staff are highly trained and periodically receive in-service training.</td>
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order to proactively target specific situations in the community as problems develop.

The community readiness scale in Table 1 includes two early stages, where the social action and innovation decision-making processes have none. These are the denial and vague awareness stages. The denial stage is akin to the NIMBY (not in my backyard) syndrome. At this stage, the community recognizes, for example, that drug abuse can be a problem, but a problem in other communities. The vague awareness stage describes a community where there is recognition of a local problem, but awareness is in terms of anecdotes. There is no sense of the true scope of the problem or motivation to try new initiatives.

The four middle stages encompass a considerable amount of the stages the social action and innovation decision-making processes have already described. The preplanning stage is similar to the stimulation of interest and knowledge stages respectively, that is, there is recognition of a problem and agreement that something needs to be done. The preparation stage refers to when individuals and groups within the community decide that some type of action should take place, and begin to examine various alternatives, their costs, and their benefits. The initiation stage is when a trial program is launched or tried out and is similar to the implementation and action stages. Institutionalization is a stage that is very similar to the confirmation stage in the innovation decision-making process. It refers to a community readiness level in which programs have been implemented and are operating (that is, they are past the stage of being tried out), but there is no sense of evaluating and adjusting on a regular and systematic basis. The feeling among local supporters is that the program is doing fine and there is no sense in "fixing something that is not broke." The final two stages in the community readiness scale go beyond those identified in either the social
action process or the innovation decision-making model. Confirmation and expansion refers to a situation in which standard programs are operating, and there is planning for new programs or revisions of those in operation. Professionalization is achieved in communities if established programs are periodically being revised, initiation of new efforts is a regular feature, and these activities are supported by local leaders and gatekeepers.

**Measuring Community Readiness**

An anchor rating technique was adopted for development of descriptors for each of the nine stages (Smith & Kendall, 1963). Anchor rating is a technique that utilizes experts in order to develop statements that describe stages in a process. In this case, the experts were individuals associated with administration of drug abuse prevention programs. Initial statements are developed, then reviewed by experts, then revised and reviewed again. Drafted statements go through several iterations before field testing can occur.

The authors confronted an immediate problem relative to development of a community readiness scale. Community-based programs include several dimensions, and statements representing each stage for each dimension had to be developed. In the case of prevention programming, and based on the authors' own experiences and in consultation with prevention program practitioners, five dimensions were identified. These were: (1) the prevention program itself; (2) knowledge about prevention programming; (3) leadership and community involvement; (4) information about the problem locally; and (5) funding/support for prevention programming. This meant that 45 anchor statements (five dimensions by nine stages) had to be developed.

Experts ranked a large pool of potential anchor statements along a continuum representing the nine stages of the community readiness scale. Experts could rate a statement anywhere between stages, or directly on a specific stage. This allowed for the assignment of numerical scores for each expert's rating of the anchor statements. From this, averages were calculated to match up anchor rating statement with a single stage of the community readiness scale. Anchor statements with averages midway between stages were eliminated, as well as statements with standard deviations larger than the numerical space between stages. This expert ranking procedure was conducted several times until a pool of 45 anchor statements was developed.

Table 2 includes the anchor statements that were subsequently used to measure readiness for prevention programming based on the key informant interviews during the first field test. These statements were developed and refined through a series of validity and reliability tests during two pre-tests with prevention program practitioners (Oetting et al., 1995). The process of measuring community readiness was relatively straightforward. Interviews with key informants included a short set of open-ended questions about drug education and prevention programs. Then scores representing readiness stages for each of the five dimensions were developed based on comparing answers by key infor-
Table 2. Anchor Rating Statements By Readiness Stage

A. Prevention Programming
   1. Why should we be trying to prevent that behavior?
   2. Prevention programs won't work here.
   3. There aren't any immediate plans, but the community will probably do something sometime.
   4. There have been community meetings or staff meetings, but no final decisions have been made about what we might do.
   5. One or more programs are being planned and staff are being selected and trained.
   6. One or more prevention programs are being tried out now.
   7. One or more programs have been running for several years and are fully expected to run indefinitely, no specific planning for anything else.
   8. Several different programs in both the community and schools are running, covering different age groups and reaching a wide range of people.
   9. Evaluation plans are routinely used to test effectiveness of many different programs, and the results are being used to change and improve programs constantly.

B. Knowledge About Prevention Programming
   1. Why would we want to do anything about that?
   2. Nothing can be done or nothing will work here.
   3. Heard about prevention programs, but no real information about what is done in the programs or how it is done.
   4. Some leaders are actively seeking information about prevention programs.
   5. Community knows generally about the content of standard programs, who runs them and who the clients would be.
   6. Community has an exaggerated belief in the effectiveness of a local program or stereotypes general belief without supporting data that a program is a failure.
   7. Community has specific knowledge of local programs or programs including staffing, training of staff, and clients involved, but minimal awareness of need for other programs.
   8. Considerable knowledge about a variety of different programs that are being run.
   9. Accurate knowledge about how well local programs are working, their benefits and limitations; a lot of information about programs aimed at other age groups.

C. Leadership and Community Involvement
   1. A very large proportion of males and/or females in this community routinely engage in the behavior.
   2. There is no need, people in the community wouldn’t support any attempt at prevention.
   3. People have talked about doing something, but so far there isn’t anyone who has really taken charge.
   4. There are identifiable leaders who are trying to get something started, a meeting or two may have been held to discuss problems.
   5. Leaders and others have been identified, a committee or committees have been formed and are meeting regularly to consider alternatives and make plans.
   6. A program or programs are being run and supported by their own groups or committees; little coordination or overall planning.
Table 2. Continued

7. School authorities and political leaders are solid supporters of a continuing basic program.
8. Authorities, program staff and community groups are all supportive of extending efforts to reach other people and high risk groups.
9. Authorities support programs, staff are highly trained, community leaders and volunteers are involved and an independent evaluation team is functioning.

D. Knowledge About the Problem
1. There is little or no community belief that the behavior is a problem or causes problems.
2. Yes, that behavior is a problem, but there is no problem in this community.
3. Some people here may have this problem, but community has no immediate motivation to do anything about it.
4. There is clear recognition that there is a local problem, but detailed information is lacking or depends on stereotypes.
5. Information on local prevalence is available, but only the broad outlines have been published or presented to the community at large.
6. Information on local prevalence has been widely disseminated to both community leaders and the general community.
7. Detailed information about local prevalence is available; it has been disseminated widely and people know where to get specific information.
8. There is considerable specific knowledge about prevalence and of etiology, risk factors, and consequences.
9. There is considerable specific knowledge about prevalence, etiology and consequences, and efforts to keep up with research and program-related literature.

E. Funding for Prevention
1. Why would anybody spend money to prevent that?
2. Prevention programs cost too much. This place is poor.
3. It should be possible to fund a program, but not sure how much it would cost or where the money would come from.
4. A committee or person is finding out how much this would cost and is considering where the funds might come from.
5. Costs in staff time and dollars are known. A proposal for funding has been written, submitted, and may have been approved.
6. There is funding for a running program, but it is only from grant funds, outside funds, or a specific one time donation.
7. A considerable part of support of ongoing programs is from local sources that are expected to provide indefinite and continuous funding.
8. There is continuous and secure funding for at least two basic programs and some funding for additional prevention efforts.
9. There is continuous and secure funding for basic programs, evaluation is routinely funded, and there are substantial funds for trying new programs.
ments with the anchor rating statements. A preliminary set of interview questions were developed and reviewed by several of the same experts in prevention programming used in the process of creating anchor rating statements (Table 3). In addition, the questions were initially field tested in 20 communities in order to check for whether or not key informants gave responses that were relevant to measuring community readiness along each of the five dimensions.

Since communities are groups in which many members fail to participate, it was felt that assessing the views of local leaders and gatekeepers was the best strategy (Simpson & Simpson, 1979; Mays & Beckman, 1989). The goal was a practical and usable tool. Prevention programmers have limited time and resources to conduct comprehensive and scientifically representative surveys of community members (often program guidelines severely limit or even prohibit use of funds for research). Assessing community readiness should be something that can be completed through interviews with a small number of key informants, that is, with community members who would know the views of local leaders and gatekeepers (Spradley, 1979; Shaffir & Stebbins, 1991). In terms of

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<th>Table 3: Key Informant Interview Questions</th>
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<tr>
<td>1. What types of drug prevention programs or activities have occurred in your community?(a,b)</td>
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<td>a. How long have these programs been in your community?(a)</td>
</tr>
<tr>
<td>b. Who is served by these programs?(a,b)</td>
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<td>c. Is there a need to expand these services? If no, why not?(a,b)</td>
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<td>d. Are there plans to expand? If yes, what are the plans?(a)</td>
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<td>e. How are these programs viewed by the community?(b)</td>
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<td>2. What is the general attitude about substance abuse in your community?(c,d)</td>
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<tr>
<td>a. Does the community see substance abuse as a problem?(c,d)</td>
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<td>b. Would or does the community support a prevention plan? If yes, how?(c)</td>
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<td>c. Are the leaders in your community involved in prevention efforts? (list)(c)</td>
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<td>d. What community organizations have a focus on prevention? (list)(c)</td>
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<td>3. Is there information available on local substance abuse prevalence? If yes, from whom?(c)</td>
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<td>4. How is that information disseminated? And to whom?(c)</td>
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<td>5. Who provides funding for these programs and how long will it continue?(c)</td>
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<tr>
<td>6. What is the community's attitude/belief about funding prevention programs?(c)</td>
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<td>7. Is your community aware of the costs of running a prevention program?(c)</td>
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<td>8. Are you aware of any proposals that have been written that address the issue of prevention? Are any funded or waiting?(c)</td>
</tr>
<tr>
<td>9. What are the primary obstacles to prevention efforts in your community?(c,b,a,d,e)</td>
</tr>
<tr>
<td>10. What is the next step your community needs to take in the area of prevention?(c,b,a,d,e)</td>
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*Prevention Programming  
*Knowledge About Prevention Programs  
*Leadership and Community Involvement  
*Knowledge About the Problem  
*Funding for Prevention Programs
prevention programs, four types of key informants were identified: (1) a school
counselor or staff member with responsibility for alcohol and drug abuse educa-
tion and/or counseling (replacements could include a school drug use preven-
tion coordinator or volunteer, a health science teacher or the principal); (2) a
community authority, such as the mayor (replacements could include a city or
county council member); (3) a local media representative (preferably the editor
of the local newspaper, but a newspaper or radio reporter who covers local
events could serve as replacements); and (4) a community leader in the area of
drug abuse prevention, such as a program chair (replacements could include an
official of a parent/teacher organization or member of the school board with an
interest in the topic).

Initial Results

Key informant interviews were conducted in 46 communities with popula-
tions below 10,000 from throughout the United States. This limitation was
imposed in order to assure that during this first full-scale field test problems of
defining the community boundaries of large metropolitan areas was not a con-
 founding factor. Also, the 46 communities were not randomly selected. Their
inclusion was based on the authors’ personal knowledge of prevention program
practitioners and advocates. These individuals helped identify key informants
within each of the four categories to be interviewed.

Key informants were interviewed by telephone. The first full-scale field test
was considered successful for several reasons. First, remarks of individual key
informants were very consistent in rating a community on each of the five di-
ensions. Generally, if one dimension was at the stage of preplanning, the other
dimensions were either at the same or adjoining stages. This made it easier than
anticipated for the authors to arrive at a combined score and to place a commu-
nity at a certain level of readiness. Second, key informants from the same com-


individuals who would help carry out the action. At first it was thought that this might present a biased assessment, but experiences from the first full-scale field test now indicate that community readiness can be measured in no other way. Key informants must be members of the community with some knowledge or potential interest in prevention programming before they are can respond to questions along the five dimensions from which readiness levels are determined. In other words, it is essential to interview gatekeepers and stakeholders (Mays & Beckman, 1989). It is can be argued that focus groups, comprehensive community surveys, and non-random surveys at supermarkets and shopping malls, town meetings and other community events could be used to measure readiness levels. One area for future testing would be to compare the results of key informant versus other information-gathering techniques.

Another potential problem, which the initial field test could not help evaluate, is the use of the same key informants over a period of time as a community-based program moves forward (or backward) from one readiness level to another. It is possible that bias in their assessments could be introduced by repeated interviews. One way to avoid this problem is for the community development practitioner to create a pool of potential key informants. If readiness levels are to be assessed periodically, such as after an intervention that attempts to move a community to a new stage of readiness, then one (or a few) additional key informants could be used in order to examine the extent they agree with the initial group. Another possible solution is to rotate interviews within a pool of key informants.

Figure 1 shows the distribution of communities from the initial field test. Three important findings are immediately apparent. First, there were no communities found at either extreme of the readiness scale. In other words, communities neither tolerated drug use nor had arrived at the stage of professionalization in regard to prevention efforts. This does not mean such communi-

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**Figure 1. Frequency distribution: Results of first field test of community readiness scale (N=46).**
ties do not exist. The field test was not meant to be comprehensively representative of American communities. Second, within the seven middle stages, there was a great deal of variability in readiness levels. This confirms what practitioners have long noted, that support for prevention programming is community specific. Third, these initial results showed a bi-modal distribution of community readiness. One cluster of communities was found at or around the stage of vague awareness. These communities were struggling with defining the problem locally. The practitioner who finds this level of readiness would have many excellent opportunities to conduct awareness programs and educational seminars that would move the community up to the preplanning stage. These could be community-wide activities, but it would also be a good idea to target local leaders and gatekeepers.

A second cluster of communities centered around the institutionalization stage and the two stages either side of it. These communities already had programs up and running, but they varied in how well they were supported and in their potential to continue, revamp and expand. During these stages, the practitioner could be engaged in networking activities, that is, facilitating community supporters and encouraging program staff to evaluate and revise their own efforts. The practitioner can also be important at these stages in helping the community to identify outside expertise, speakers for recognition banquets, development of news stories about the prevention program for the local press, and other activities that promote continuing support.

COMMUNITY READINESS AND COMMUNITY DEVELOPMENT APPLICATIONS

The first and most obvious use of a readiness scale is to measure the status of a community relative to its ability to support a program. Community readiness is not unlike rapid rural appraisal, which is used in the field of international agricultural development as a way to assess the needs and potential barriers to use of new farming techniques within a village or small area (Carruthers & Chambers, 1981; Gow, 1990). Rapid rural appraisal was developed as a way of overcoming the expense and time associated with data collection and analysis of more comprehensive needs assessments, and as a way of linking research and action more directly (Gow, 1990). Neither community readiness nor rapid rural appraisal are meant to be substitutes for rigorous scientific research. However, both were designed to help the practitioner more systematically assess the local situation and go beyond his/her personal impressions of what to do next. Both were also designed to help the practitioner interact with persons who are important to the program or action being considered for adoption.

A second advantage of readiness for community development practitioners involved in prevention programming is in the identification of strategies for helping programs to start, and to receive continued local support for programs already in existence. The suggestions listed in Table 4 are not meant to be com-
<table>
<thead>
<tr>
<th>Stage</th>
<th>Strategies and Goals</th>
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<tbody>
<tr>
<td>1. Community tolerance</td>
<td>Small group and one-on-one discussions with community leaders in order to identify perceived benefits of drug use and how norms reinforce use.</td>
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<td>Small group and one-on-one discussions on health, psychological and social costs of drug use with community leaders in order to change perceptions with those most likely to be part of the initiation set that begins development of programs.</td>
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<tr>
<td>2. Denial</td>
<td>Educational outreach programs on health, psychological and social costs of drug use to community leaders and community groups interested in sponsoring local programs.</td>
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<td>Use of local incidents that illustrate harmful consequences of drug use in one-on-one discussions and educational outreach programs.</td>
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<tr>
<td>3. Vague awareness</td>
<td>Educational outreach programs on national and state prevalence rates of drug use, and prevalence rates in other communities with similar characteristics to community leaders and possible sponsorship groups. Programs should include use of local incidents that illustrate harmful consequences of drug use.</td>
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<tr>
<td></td>
<td>Local media campaigns that emphasize consequences of drug use.</td>
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<tr>
<td>4. Preplanning</td>
<td>Educational outreach programs that include prevalence rates and correlates/causes of drug use to community leaders and sponsorship groups.</td>
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<td></td>
<td>Educational outreach programs that introduce the concept of prevention and illustrate specific prevention programs adopted by other communities with similar profiles.</td>
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<td></td>
<td>Local media campaigns emphasizing consequences of drug use and ways of reducing demand for illicit substances through prevention programming.</td>
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<tr>
<td>5. Preparation</td>
<td>Educational outreach programs open to the general public on specific types of prevention programs, their goals and how they can be implemented.</td>
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<tr>
<td></td>
<td>Educational outreach programs for community leaders and local sponsorship groups on prevention programs, goals, staff requirements and other start-up aspects of programming.</td>
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<td></td>
<td>Local media campaign describing benefits of prevention programs for reducing consequences of drug use.</td>
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<tr>
<td>6. Initiation</td>
<td>In-service educational training for program staff (paid and/or volunteer) on drug use consequences, correlates and causes, and nature of problem in local community.</td>
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<td>Publicity efforts associated with kick-off of program.</td>
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<td></td>
<td>Special meeting to provide update and review of initial program activities with community leaders and local sponsorship groups.</td>
</tr>
<tr>
<td>Stage</td>
<td>Strategies and Goals</td>
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<tr>
<td>7. Institutionalization</td>
<td>In-service educational programs on evaluation process, new trends in drug use, and new initiatives in prevention programming. Either trainers are brought in from the outside or staff sent to programs sponsored by professional societies.</td>
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<tr>
<td></td>
<td>Periodic review meetings and/or special recognition events for local supporters of prevention programs. C. Local publicity efforts associated with review meetings and recognition events.</td>
</tr>
<tr>
<td>8. Confirmation/expansion</td>
<td>In-service educational programs on conducting localized epidemiologies in order to target specific groups in the community for prevention programming. Either trainers are brought in from the outside or staff are sent to programs sponsored by professional societies.</td>
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<tr>
<td></td>
<td>Periodic review meetings and/or special recognition events for local supporters of prevention programs.</td>
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<td></td>
<td>Results of research and evaluation activities of the prevention program are presented to the public through local media and/or public meetings.</td>
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<tr>
<td>9. Professionalization</td>
<td>Continued in-service training of staff.</td>
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<td></td>
<td>Continued assessment of new drug-related problems and reassessment of targeted groups within community.</td>
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<td></td>
<td>Continued evaluation of program effort.</td>
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<tr>
<td></td>
<td>Continued update on program activities and results for benefit of community leaders and local sponsorship groups and periodic stories through local media and/or public meetings.</td>
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Prehensive, but do illustrate ways in which prevention program practitioners, and community development specialists in general, can help carry action and decision-making forward so that the community moves to the next level of community readiness.

Strategies associated with the first four stages (community tolerance through preplanning) are largely awareness-creating in nature. Activities at the stage of community tolerance are restricted to behind-the-scenes activities which the community development practitioner could engage in on a one-on-one and small group basis. At the denial stage, the emphasis is on awareness creating relative to the harmful effects of drug use, while at the vague awareness stage, the emphasis shifts more towards knowledge of drug use prevalence and local examples of the costs of using drugs if such anecdotes are available. At the preplanning stage, educational efforts about the concept of prevention and the philosophies of various programs may be more effective. It is not until a community is beyond the denial stage that a publicity campaign through local media and other information dissemination outlets is recommended (i.e., newspaper ads, billboards, radio and television announcements).
Associated with the stages of preparation and initiation comes the need for information of a more specific nature about systematic identification of the drug problem locally, and about how to plan and implement a prevention program. The initiation stage begins the need for some type of staff training. Activities suggested at the institutionalization stage are designed to encourage an already existing program toward self-evaluation and revision. In-service training is especially important at this stage as well as at the confirmation/expansion stage. At these two final stages, it is also important to continue to review program activities with local leaders and sponsorship groups, and on occasion to initiate publicity efforts through public meetings and local media outlets.

A third use of community readiness is as a tool to augment other forms of program evaluation. Periodic assessments of readiness can be used to monitor community support for a program. Related to this is that the key informants used in community readiness can help practitioners identify objections and negative perceptions that some community members and groups may have of a prevention program, and how program staff and supporters can overcome them. Finally, community readiness can be used to identify and solve potential territorial problems that may arise when a new initiative is introduced in a community that has programs of a related nature.

**SUMMARY AND CONCLUSIONS**

The purpose of this article was to define the concept of community readiness, describe the development of a community readiness scale for prevention programming in the area of drug abuse, and outline ways in which readiness can be used by community development practitioners for increasing local support of programming efforts of all sorts. Utilizing anchor rating statements and key informants provides a way of measuring community readiness without incurring the costs of more comprehensive and time-consuming needs assessments.

Preliminary results indicate that a useable scale can be developed. Comments from prevention programmers who assisted in development of the community readiness scale indicated that if it had been available, they would have used it to help design their original program. Others suggested that it is a useful way for a new administrator to get introduced to the community. One commented that the nine stages of community readiness, and the five dimensions of prevention programs are something that can be “kept in the back of the head,” and used on an everyday basis during regular interactions with clients, program board members, and sponsors.

The readiness scale for prevention programming in the area of drug abuse will continue to undergo revisions. Meanwhile, scales for other types of programming can be developed and tested, ranging from such closely related problems as alcohol abuse to areas such as health and nutrition, public safety, the environment, various social problems, and local economic development among others. The stages of readiness may need to be modified as the diversity of issues
expands (perhaps there will be entirely different stages for different issues), but it is more likely that the primary investment will be in development and testing of reliable and valid anchor rating statements and of appropriate key informant interview questions. The authors make this supposition with some confidence, since this readiness scale was based upon the prior work of Beal (1964) and Rogers (1994), as well as the more recent attempts by Miller (1990).

A future area of research is to examine the co-variance of readiness for programs within specific problem areas with characteristics of the community. It could provide a way of identifying general traits of communities with various readiness levels. For example, it is already known that alcohol abuse prevention is more difficult to introduce in communities whose employment base is dominated by occupations where drinking is part of the after-work lifestyle (Hawkins et al., 1992). But beyond anecdotal accounts that point to high levels of tolerance in certain communities, what are the characteristics of areas associated with other levels of readiness? Do these vary by the employment and economic make-up of a location, or the demographic composition of an area, or cultural factors associated with religious denominations and other local groups who influence the socialization and social control functions of a community?

REFERENCES


