Readyess for Drug Use Prevention in Rural Minority Communities

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ABSTRACT

An assessment of community readiness for drug use prevention in rural communities indicated that most rural communities are at relatively low stages of readiness. Minority communities were particularly low in readiness, with only 2% having functioning drug prevention programs. Rural communities at different levels of readiness require different types of programs to increase readiness, i.e., communities at the no awareness stage require analysis of the historical and cultural issues that support tolerance of drug use, those at the denial and vague awareness stages need specific information about local problems, and communities at the preplanning and preparation stages need information about effective programs, help in identifying resources, and assistance with staff training. In addition, building and maintaining effective programs requires continued evolution of readiness through the stages of initiation, stabilization, confirmation and expansion, and professionalization. Revised and updated scales and methods for assessing community readiness are provided. [Translations are provided in the International Abstracts Section of this issue.]

Key words. Community readiness; Drug use; Prevention; Methodology; Tolerance; Denial

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INTRODUCTION

Edwards (1992) reported that, when drug use rates among youth in rural communities are averaged, the averages are only slightly lower than those for urban youth, but taken individually, rural communities show considerable variation in drug use. However, only a few rural communities had negligible rates of drug use; like the rest of America, most rural communities had significant levels of drug use. Despite meaningful levels of drug use, observation suggests that rural communities are not heavily invested in prevention. Some communities deny that they have a drug problem or believe that drug use is centered only in a small group of people who are not part of the mainstream community culture. Other communities admit that there is a problem, but have no concept of prevention; they don't know what prevention is or how it is supposed to work. Others believe that they do not have the resources for prevention. Still others are deeply invested in school-based and general community prevention. Until recently, there has been no effective way of describing these differences in community readiness for prevention or of assessing readiness. Without a theory of community readiness and methods for measuring readiness there has been no way of determining the distribution of community readiness in rural communities or whether minority communities differ in readiness for prevention.

ASSESSING COMMUNITY READINESS FOR PREVENTION

Oetting et al. (1995) provided the tools for assessing community readiness for prevention. They developed a theoretical model of the stages of community prevention readiness, along with methods for assessing community readiness. The model and methods were developed using a modified Delphi procedure to produce anchored ratings, a technique that emerged from industrial psychology for assessing job performance in complex tasks (Saal et al., 1980; Ronan and Schwartz, 1974; Smith and Kendall, 1963). Developing the anchored rating method as applied to the task of evaluating community readiness involved several steps. The first step was to produce a tentative model of community readiness, consisting of 10 sequential stages of community readiness (Oetting et al., 1995, p. 667) and brief descriptive statements that illustrated each stage. The development of this preliminary model drew on two different conceptual frameworks, psychological readiness (Prochaska et al., 1992) and community development (Beal, 1964; Rogers et al., 1989; Warren, 1978). Five dimensions that described different aspects of readiness for prevention emerged. For each dimension the descriptive statements were then evaluated by a number of experts who had considerable experience in community-based prevention programs, and each anchor statement was located on the readiness continuum. Thus, some statements
were dropped, others revised, and some descriptions changed to clarify the model. The raters then reevaluated each anchor statement. The process was continued until an anchor statement was available for each stage for each dimension of community readiness, and the final scale was again rated. There was 100% agreement for all but four anchors and over 80% agreement for those four. In the process the stages of readiness and their descriptive statements were changed, and further changes have evolved with use of the model. The nine stages of community readiness are now defined as follows:

1. **No awareness.** The behavior, when occurring in a particular social context, is tolerated by community leadership. “It’s just the way things are.” (“Leadership” can include anyone in the community who is appointed to a leadership position or is influential in community affairs, i.e., an individual, a parent, a child, a teacher, a clergy person, etc.). There are no formal or informal policies in place in the community. Community climate may 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 usually some recognition by community leadership that the behavior itself is or can be a problem, but there may be little or no recognition that this might be a *local* 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.” There may or may not be policies in place; if there are, they are ignored. Community climate tends to match the attitudes of leaders and may be passive, guarded, or apathetic.

3. **Vague awareness.** There is a general feeling among community leaders 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. Policies exist and are known by to officials; however, they may be inconsistently followed. 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 leaders that there is a local problem and that something should be done about it. There are leaders, and there may even be a committee, but efforts are not focused or detailed. The policies are known and generally followed. There is discussion but no real planning of actions to address the problem. Community climate may or may not support leadership efforts to deal 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 are followed by officials, 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 may or may not support these efforts.

6. **Initiation.** Enough information is available to justify prevention 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. Policies are known to a subset of the community that are affected by the policies, i.e., offenders and victims. Community climate may or may not support these efforts.

7. **Stabilization.** One or two programs or activities are running, supported by administrators of community decision makers. Programs, activities or policies are viewed as permanent. Staff are usually trained and experienced. There is little perceived need for change or expansion. Policies are known to most community members. 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. There may be some criticism, but community climate generally supports what is occurring.

8. **Confirmation/expansion.** There are standard programs, activities and policies in place and authorities or community decision makers support expanding or improving programs. Original efforts have been evaluated, modified, and new efforts are being planned or tried in order to reach more people, those more at risk, or different geographic groups. Resources for new efforts are being sought or committed. Policies are consistent and followed with new policies being implemented as needed. Data are regularly obtained on extent of local problems and efforts are made to assess risk factors and causes of the problem. Community climate may challenge specific programs, and is fundamentally supportive, but all groups may not support every activity.

9. **Professionlization.** 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, authorities are supportive, and community involvement is high. Effective evaluation is used to test and modify programs, policies or activities. Community climate should challenge specific programs, but is fundamentally supportive and supports continued evaluation, seeking improvement.
The resulting scales are filled out by a rater who interviews community key informants. The key informants are community individuals who are likely to be in touch with what is occurring in relation to prevention. Since community readiness differs depending on the problem, key informants have to be carefully selected. For example, a community may be deeply committed to drug use prevention programs, but at the same time may view domestic violence as traditional and acceptable. The key informants could differ for assessing readiness for these different problems. When assessing readiness for prevention programs aimed at reducing drug use, key informants usually include someone from a school; a school counselor, health science teacher or the principal; a community authority such as the mayor or a city council member; a media representative; and a community leader. When assessing readiness for prevention of domestic violence programming, the key informants would probably include professional and para-professional staff working in domestic violence shelters, mental health workers, police or law enforcement personnel, clergy, physicians, and nurses. Most often, key informants are interviewed by telephone, but personal interviews and focus groups can also be used.

With the development of this new technology for assessing readiness, it became possible to accurately evaluate community readiness in rural communities. The National Institute on Drug Abuse provided a supplement to the Tri-Ethnic Center for Prevention Research to assess community readiness for drug use prevention in rural communities, comparing nonminority rural communities with American Indian and Mexican American communities.

METHOD

The Sample

Using 1990 census data, a total of 102 communities was randomly selected from a list of all communities in the contiguous states of the United States with populations under 10,000. Three separate target groups were chosen—Mexican American, American Indian and White American (Anglo). Minority communities selected had to have a 50% or higher percentage of one of the two minority groups. Anglo communities were at least 75% White American.

Key Informants

During the development of the community readiness scale, focus groups were convened in representative communities. The purpose of these focus groups was twofold: 1) to gain a better understanding of who the initial key informants should be, and 2) to develop and clarify the appropriate questions to ask key informants to best determine their understanding of community readiness for drug use pre-
vention. In the majority of communities the school counselor had the best understanding of the issues as well as networking resources to effectively identify others in the community who could offer the type of information for the assessment. Therefore, in this study, first contact was made with the school counselor. During the initial call, names of four or five other key community members were obtained. These were usually the sheriff, chief of police, public health nurse or local doctor, mental health workers, social workers, or other informal community leaders who were aware of community issues related to drug use prevention. Those individuals were called on the telephone and asked to provide additional names and/or organizations that might provide relevant information. All were asked specifically to include the names of people who might offer a different point of view. From the list generated by all those called, three contacts were selected to be used as the key informants for the study. When one of the first three contacts could not be reached, or when the three contacts provided inconsistent information or information that was not complete enough to assess community readiness, a fourth contact was selected and interviewed.

Interviewers

Prior to beginning the interviews, interviewers were trained in interviewing methods to develop an in-depth understanding of the stages of community readiness for prevention, the five different dimensions of readiness, and how the anchor statements related to the stages for each dimension. Interviewers practiced mock interviews over the phone until they could complete smooth and successful interviews. They also practiced until they could make reliable ratings for each dimension. Interviewers with experience or substance use issues were more efficient since many respondents used typical treatment and prevention nomenclature.

Key Informant Interviews

During the initial stages of the interview, the interviewer stated that the focus was on the use of illicit drugs, and that alcohol or tobacco were not included. Although they are drugs, readiness for alcohol prevention and readiness for tobacco prevention can be at a very different readiness stage than readiness for prevention for other drugs. Interviews were conducted by telephone. The semistructured interview questions that were used with key informants appear in Appendix I of this paper.

It was not always necessary to ask every question, since the key informant often answered later questions in responding to earlier questions. Interviewers were free to interpolate additional questions at any point to gain more specific-
ity on a particular issue. Detailed interviewer notes were taken on each response. When the questions had all been answered in depth, the result was a qualitative description of community drug use prevention readiness.

Interviewers learned that they needed to be patient and persistent. The length of each interview was approximately 25 to 30 minutes. Many callbacks were often required to reach the key informants when they had enough time to talk. From initial contact to completion of the interviews, the average length of time for three key informant interviews in a single, rural community was approximately 5 weeks. Because of the communication delays, this type of key informant study is most feasible when interviewers are able to contact several communities at the same time. The use of cellular phones for callbacks was also very helpful, allowing the interviewers to be reached when the respondents had time to talk.

**Ratings of Community Readiness**

Immediately after each interview, the interviewer/rater wrote a brief statement summarizing the information for each specific dimension. He or she then placed a graphic rating (0–10) on each of the anchored scales (see Tables 1–6 for examples of the anchored rating scales) marking the position at or between the anchor statements that best described the community. For each community it was helpful to have two or more interviewers who could discuss the information in order to obtain a general consensus and to assign a community stage of readiness. The final assignment to a particular stage of readiness was not made simply on the basis of average ratings on the dimensions, but rather utilized the interviewers' qualitative expert judgment based on all of the interview information and the scores on the anchored rating scales. The stage of readiness, with the descriptive material, provided an adequate understanding of the community's level of readiness for prevention.

**RESULTS**

The nonparametric Kolmogorov–Smirnov two-sample, two-sided test was used to compare the distributions (Goodman, 1954). Using a two-tailed test, the distributions of community readiness for both samples of minority communities were significantly different from the distribution of the Anglo communities at the .05 level of confidence (Mexican American, $D = 13$, American Indian, $D = 12$). The two samples of minority communities did not have significantly different distributions of community readiness for drug use prevention ($D = 1$).

Comparisons between the groups, however, do not provide detailed information on the distribution of community readiness. Each stage of readiness requires a different intervention approach in order to move the community to a higher
stage, so it is important to know the actual distribution of communities across stages. Figure 1 shows this distribution for the three types of communities.

Figure 1 shows that, in general, rural communities are at a low level of readiness for drug use prevention. Only one-third of the Anglo communities had prevention programs in operation and very few of the minority communities had any kind of prevention program. The modal stage of readiness in rural communities for all three groups is "vague awareness," i.e., the community leaders have some awareness that there may be a problem, but there is no motivation to do anything about it. Ethnicity differences are greatest at the higher stages of readiness. Only 2% of the rural communities surveyed were at the initiation stage for drug prevention efforts, and none of the minority communities were at a higher stage of readiness. In contrast, 33% of the Anglo communities had prevention programs and were at or beyond the initiation stage of readiness. Minority communities also showed less readiness at the opposite end of the scale, i.e., a few minority communities were at the no awareness stage, while none of the nonminority communities were rated at this lowest stage of readiness.

DISCUSSION

Assessing readiness for prevention has two purposes: 1) it provides a basis for understanding how community dynamics relate to prevention and 2) it has direct implications for effectively intervening to move communities to higher stages of readiness.

Communities at the No Awareness Stage of Readiness

The lowest level of readiness is community tolerance, where the behavior is accepted and viewed as "normal." Although very few rural communities were found to be at this level, it is notable that they were all minority communities. Why would some communities tolerate drug use?

Our observations from the key informant interviews provide some insight into why some minority communities may be tolerant of drug use. One factor was the extent of serious problems in the community; other issues were simply more important than drug use. Where there was high unemployment, limited opportunity, and severe economic stress, basic survival issues pushed drug use lower on the list of concerns. Even concern about alcoholism could reduce interest in drug use as a problem. Where people were dying because of alcoholism, recreational use of marijuana did not seem as important. One respondent commented, "We all know that kids go out into the back woods and smoke dope, but at least we know where they are ... they aren't drinking and driving."
Fig. 1. Readiness for drug use prevention in rural minority communities.
These observations, however, are only initial steps in trying to understand the nature of no awareness. Detailed ethnographic studies are needed that will provide information about these specific communities, thus leading to a deeper understanding of how no awareness is developed and maintained. Such a study should include key informant interviews, focusing on history and cultural traditions, why traditional beliefs fail to increase awareness, how historical events may have led to no awareness, and what current conditions support no awareness. The study could include community focus groups to identify shared beliefs and attitudes about drug use. Interviews with drug users and nonusers would identify their beliefs and values to better understand why, despite the atmosphere of no awareness, some people do not engage in drug use. In addition to better understanding no awareness, this information may point the way toward culturally appropriate ways of increasing awareness. Our experience suggests that increasing awareness may have to start with one-on-one interaction or small group activities (home visits, talking circles, sewing groups, phone discussions).

The no awareness stage of readiness illustrates the difference between community readiness and prevention programming. Prevention programming might be concerned about no awareness because it encourages drug use. But no awareness is important as a stage of community readiness not merely because it encourages drug use but because it keeps a community from ever starting a prevention program. If drug use is tolerated in the community, there is no motivation to start a program to prevent drug use. No awareness tolerance must be changed in order to move the community to one of the next higher stages of readiness. If this process is continued, the community will eventually reach a stage of readiness where prevention can be implemented.

**Communities at the Denial Stage of Readiness**

Figure 1 shows that about 20%, or one of five, rural communities are at the denial stage of readiness. Placing a community at the denial stage requires careful assessment since denial of drug use could be accurate, i.e., a community may not have a drug use problem and additional key informant interviews. The interviews done for this study indicated that to determine whether there actually is no drug use or whether the community is at the denial stage may require there was good reason to believe that there were actual drug use problems in these rural communities and that placing them at the denial stage was appropriate. Again, more minority than nonminority communities were rated at the denial stage.

The key informant interviews suggested several hypotheses about communities in the denial stage. Denial can involve either denial of the problem or denial that anything can be done about the problem. Most leaders did admit there was drug use, but the leaders in these rural communities appear to be strongly
influenced by a community climate that was passive or apathetic. Leaders stated that nothing could be done and were reluctant to intervene, in part because they felt that they would meet with community resistance. Many key informants also indicated that they had attempted to intervene in the past but were unsuccessful; it just seemed easier to overlook the problem or deny that it was an issue.

The focus of any program to reduce community denial should be on creating general awareness of the problem, developing specific awareness that it is a local problem, and creating awareness that prevention efforts are possible. At this stage, personalized local case reports and critical incidents are likely to be of more value than statistical data. Media reports, presentations to community groups, and other educational interventions can focus on general problems in community in the denial stage, can create awareness that there is a local problem, and can let people know that there are things that can be done about it.

**Communities at the Vague Awareness Stage of Readiness**

More than a third of these rural communities are at the vague awareness stage. Key informants know there is a local problem and have some knowledge that it is possible to intervene, but that knowledge does not generate motivation for action. For communities at the vague awareness stage, there is a need to increase the amount of information about the extent and nature of the local problem and to stimulate planning. National or regional data are likely to be viewed as meaningless since every rural community, with some justification, sees itself as unique, so local survey data may be valuable in moving the community toward action. In-school surveys, for example, are economical, and can provide reliable and valid data. The biggest problem with in-school surveys is when communities develop their own. Those surveys rarely yield comparative data with national or other surveys, and bad items often lead to confusing results. These communities need help to locate appropriate surveys and instruction in how to use them and how to interpret results. They also need to learn how to protect confidentiality. For example, rural schools often have small classes, so school-based survey results must be combined across classes to assure confidentiality. Phone or mail surveys of adults are possible, but are difficult in rural areas since there are often serious problems in providing assurances of confidentiality.

**Communities at the Preplanning Stage of Readiness**

About one-fourth of rural communities in this study were reported by key informants to be at the preplanning stage. These communities are ready to try something, but they lack information and may need help with organization. This is the stage where content oriented training can have maximum impact, includ-
ing focus groups for potential leaders and decision makers to develop practical and culturally appropriate prevention strategies. This is also the stage where contact-oriented media can be useful, including books, manuals, papers, videotapes, and articles. It is crucial to recognize, however, that many people do not learn as well from media as they do from personal interactions, particularly people in minority communities. Media communication should be implemented and enhanced with personal lectures and discussion.

The Initiation Stage of Readiness and Beyond

One of the more important findings of this study is that only 2% of these minority rural communities had operating prevention programs. This does not mean that these communities have never had prevention programs. In fact, many American Indian communities are aware of their drug use problems and have tried prevention programs. Some of these programs were creative and elaborate. Some writers also believe that these prevention programs have helped reduce the drug use problems of American Indian youth (Beauvais, 1992). However, prevention programs in American Indian communities have usually been funded by special grants or funds. Once the grant is finished or the funds are used up, there are no resources to provide further prevention programming and the program stops until a new grant proposal can be prepared. The task is made more difficult because of employment instability in these communities. By the time a grant ends, the people who prepared the grant are engaged in new jobs and, after grant funding stops, those who staffed the program had to seek new jobs. The result is a “phoenix phenomenon,” so that prevention programs have to be reborn from the ashes of the old ones. The low number of American Indian communities with existing prevention programs may be due, in part, to the fact that this survey was completed in a period when federal and state funding for drug use prevention was at a very low level.

This illustrates a major point about community readiness—it is essential to continue the process of community readiness beyond the initiation stage in order to produce prevention programs that are both maintained and effective. The preparation and initiation stages describe stages where programs get started. This involves selecting prevention programming, obtaining approval from gatekeepers, identifying and assigning resources, training staff, and getting the program started. But the next stage of community readiness is stabilization, which involves building a solid basis for continuing interventions despite routine annual changes in resources and changes in community attitudes about the importance of the problem.

A stable program is one that is expected to continue using locally available resources. No minority communities in this study had stabilized programs,
perhaps in part because continuing resources are needed for other purposes in those communities. A stabilized program is a valuable asset because it continues, but it also represents a danger, since an ineffective program can be institutionalized and can then prevent resources from being used for effective programs. That is why the stages following stabilization are important. They involve the use of evaluation and feedback to continually assure that programs are effective and to find ways for improvement.

Revising the Community Readiness Theory and Assessment Methods

This study was the first major attempt to use community readiness theory and the anchored rating scales to assess readiness in a large number of communities. In the process we learned a great deal about readiness and about assessing readiness. One of the first things we learned was that it was essential to add a measure of community climate that was separate from the basic five readiness dimensions. The key informants reported that the community leaders were often ahead of the rest of the community and that leaders could be working on prevention efforts while the community was not involved. The community merely had to be willing to tolerate the program for progress to be made. For example, communities reported there were groups of community leaders who were developing a prevention program, but there was little or no community knowledge of, support for, or understanding of the need for the program. As long as some form of external funding for the program was available, and as long as the community was not actively against the program, this condition could continue. Of course, without community support the future was limited once funding dried up. Therefore, at levels of readiness higher than initiation, community climate again became critical to further development. A new scale was therefore added to the anchored rating scales to assess community climate as a separate dimension.

We also found that we could improve the descriptions of readiness stages. The stages remained the same, but the descriptions were clarified. A major change was altering descriptions to make it clear that prevention could involve a range of activities. Where the word "program" was used in the earlier version, the new descriptions clarify the fact that the prevention can involve programs, activities, or policy changes. These clarifications help the people using the community development scale become aware of the many prevention options. Those changes have been included in the descriptions of stages of readiness that appear in the Introduction to this article.

Another change was in the readiness dimension that had originally been titled "Funding for Prevention." While completing this study, we were also implement-
ing community development activities to try to improve readiness (Jumper-Thurman et al., in press). One of the things we learned was that focusing on "funding" as a dimension of readiness could be counterproductive, particularly in rural communities. Rural communities often lack money and rarely have people with the skills needed to write competitive grant proposals for funding. At the same time, rural communities often have a strong tradition of volunteerism and may have more flexibility in assigning tasks to community institutions. Therefore, we have changed the name of the dimension "funding for prevention" to "resources for prevention." These resources could still involve funding, but can also involve identifying of local resources that do not involve direct funding. The scale anchors were also altered to match this principle.

Tables 1–6 show the modified anchored rating scales for all six dimensions of community readiness.

Table 1.

*Dimension A: Prevention Programming (programs, activities, policies, etc.)*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>Prevention is not important.</td>
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<tr>
<td>1</td>
<td>No plans for prevention are likely in the near future.</td>
</tr>
<tr>
<td>2</td>
<td>There aren't any immediate plans, but we will probably do something sometime.</td>
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<tr>
<td>3</td>
<td>There have been community meetings or staff meetings, but no final decisions have been made about what we might do.</td>
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<tr>
<td>4</td>
<td>One or more programs or activities are being planned or changes in policies are being considered and, where needed, staff are being selected and trained.</td>
</tr>
<tr>
<td>5</td>
<td>One or more prevention programs, activities, or policies are being tried out now.</td>
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<tr>
<td>6</td>
<td>One or more efforts have been running for several years and are fully expected to run indefinitely. No specific planning for anything else.</td>
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<tr>
<td>7</td>
<td>Several different programs, activities, and policies are in place, covering different age groups and reaching a wide range of people. New programs or efforts are being developed based on evaluation data.</td>
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<tr>
<td>8</td>
<td>Evaluation plans are routinely used to test effectiveness of many different efforts, and the results are being used to make changes and improvements.</td>
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<tr>
<td>9</td>
<td></td>
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<tr>
<td>10</td>
<td></td>
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Table 2.
\textit{Dimension B: Community Knowledge of Prevention}

\begin{tabular}{|c|l|}
\hline
0 & \\
1 & Community has no concept of what prevention is. \\
2 & Community has no knowledge about prevention programs, activities, or policies. \\
3 & Heard about community prevention efforts, but no real information about what is done or how it is done. \\
4 & Some leaders, groups, or committees in the community are beginning to seek information about existing prevention programs, activities, or policies. \\
5 & Some leaders, groups, or committees have general knowledge about programs or activities and who they would affect. (Who would do what and for whom.) \\
6 & A group or groups have general knowledge and may be complacent about local efforts regardless of their effectiveness and without supporting data. \\
7 & There is evidence that a group or groups have specific knowledge of local efforts including contact persons, training of staff, clients involved, etc., but minimal perceived need for expansion. \\
8 & There is considerable community knowledge about a variety of different community prevention efforts, as well as supporting data related to level of program effectiveness. \\
9 & Community has accurate knowledge based on thorough evaluation data about how well the different local efforts are working, their benefits and limitations. \\
10 & \\
\hline
\end{tabular}

\section*{SUMMARY}

Despite drug use problems that are essentially at the same level as those found in urban environments, a survey of community readiness for drug use prevention showed that rural communities are not likely to be involved in prevention activities. Only a third of the nonminority rural communities that were surveyed have some kind of prevention program in operation. American Indian and Mexican American rural communities are even less likely than nonminority communities to have ongoing prevention programs; only 2% of these minority communities have any kind of program, and those programs are at the initiation stage,
Table 3.

Dimension C: Leadership
(includes appointed leaders and influential community members)

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<tbody>
<tr>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Leadership resistant to prevention efforts.</td>
</tr>
<tr>
<td>2</td>
<td>Leadership passive, apathetic, or guarded.</td>
</tr>
<tr>
<td>3</td>
<td>People have talked about doing something, but so far there isn't anyone who has really &quot;taken charge.&quot; There may be a few concerned people, but they are not influential.</td>
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<tr>
<td>4</td>
<td>There are identifiable leaders who are trying to get something started; a meeting or two may have been held to discuss problems.</td>
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<tr>
<td>5</td>
<td>Leaders and others have been identified; a committee or committees have been formed and are meeting regularly to consider alternatives and make plans.</td>
</tr>
<tr>
<td>6</td>
<td>Leaders are involved in programs or activities and may be enthusiastic because they are not yet aware of limitations or problems.</td>
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<tr>
<td>7</td>
<td>Authorities and political leaders are solid supporters of continuing basic efforts.</td>
</tr>
<tr>
<td>8</td>
<td>Multiple efforts are supported by leaders. Authorities, program staff, and community groups are all supportive of extending efforts.</td>
</tr>
<tr>
<td>9</td>
<td>Authorities support multiple efforts; staff are highly trained, community leaders and volunteers are involved, and an independent evaluation team is functioning.</td>
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just getting started. These findings suggest that major efforts aimed at providing prevention programs in rural communities are needed, particularly in minority communities.

The evaluation of community readiness for prevention provides useful information about what is actually needed to get prevention programs started and to keep them working. Communities at different stages of readiness need different approaches in order to move them to the next stages of readiness. Some minority communities are at the lowest stage of readiness, where drug use is tolerated. Until that fundamental attitude can be changed, prevention is moot. Others are at a denial stage and need assistance that helps them see that they do have a local problem and can do something about it. Other communities are willing and
<table>
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<tr>
<th>Level</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>The community does not see this behavior as a problem. It is an accepted part of community life. &quot;It's just the way things are.&quot;</td>
</tr>
<tr>
<td>1</td>
<td>There is little or no recognition that this is a community problem, or prevailing attitudes are &quot;there's nothing we can do&quot; or &quot;only 'those' people do that.&quot;</td>
</tr>
<tr>
<td>2</td>
<td>Community climate may not support but would not block prevention efforts.</td>
</tr>
<tr>
<td>3</td>
<td>Leadership may be functioning independently of community climate during Preplanning, Preparation, or Initiation stages of programs, activities, or policies. The community in general may or may not be involved in these efforts.</td>
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<tr>
<td>4</td>
<td>The majority of the community generally accepts programs, activities, or policies. Support may be somewhat passive.</td>
</tr>
<tr>
<td>5</td>
<td>Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for prevention. Participation level is high.</td>
</tr>
<tr>
<td>6</td>
<td>All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.</td>
</tr>
</tbody>
</table>

Even eager to get prevention started, but need information about prevention programs and staff training.

The first step in trying to get prevention started is to assess the community's actual level of readiness. The methods presented in this article provide the tools for assessing readiness. Once the stage of readiness is known, plans can be made to intervene to increase readiness for prevention. The model, in fact, can be used as a training device for a group of local leaders. They can learn about the stages of readiness from the model, and can then evaluate their own community's level of readiness. A sequential series of stages can then be developed by this local team to move the community through each stage of readiness until drug use prevention becomes an important part of the community's ongoing program. The inter-
Table 5.
Dimension E: Community Knowledge about the Problem

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not viewed as a problem.</td>
</tr>
<tr>
<td>1</td>
<td>No knowledge about the problem.</td>
</tr>
<tr>
<td>2</td>
<td>Some people here may have this problem, but no immediate motivation to do anything about it.</td>
</tr>
<tr>
<td>3</td>
<td>There is clear recognition that there is a local problem, but detailed information is lacking or depends on stereotypes.</td>
</tr>
<tr>
<td>4</td>
<td>General information on local problems is available, but not based on formally collected data.</td>
</tr>
<tr>
<td>5</td>
<td>There is enough information about the problem to justify doing something.</td>
</tr>
<tr>
<td>6</td>
<td>Detailed information about local prevalence may be available and people know where to get specific information.</td>
</tr>
<tr>
<td>7</td>
<td>There is considerable specific knowledge about prevalence and causes, risk factors, and consequences.</td>
</tr>
<tr>
<td>8</td>
<td>Specific information about the problem is being used to target high risk groups and plan the types of prevention programs needed. Information about the effectiveness of local programs is available.</td>
</tr>
</tbody>
</table>

Inventions used to move a community from one stage to another should be monitored in some manner to assist the community in knowing which interventions worked and which did not.

APPENDIX: KEY INFORMANT INTERVIEW QUESTIONS

These are the questions to be asked to assist in measuring each of the following six dimensions:

A. Prevention Programming (Programs, activities, policies, etc.)
B. Community Knowledge about Prevention
C. Leadership (includes appointed leaders and influential community members)
D. Community Climate
E. Community Knowledge about the Problem
F. Resources for Prevention (people, money, time, space, etc.)
Table 6.

Dimension F: Resources for Prevention (people, money, time, space, etc.)

0

1 There is no need for resources to deal with this problem.

2 Belief that there are no resources available for prevention or barriers to obtaining resources seems insurmountable.

3 It might be possible to initiate prevention efforts, but not sure how much it would take, or where the resources would come from.

4 A committee or person is finding out what might be needed for a prevention effort and is considering how the resources might be found.

5 What is needed to staff and run a program or activity is known. A proposal has been prepared, submitted, and may have been approved. The people who will be involved have agreed to participate.

6 Resources are available, but they are only from grant funds, outside funds, or a specific one time donation, or volunteers are running a program or activity, but it is temporary.

7 A considerable part of support of on-going efforts are from local sources that are expected to provide indefinite and continuous support.

8 More than one program or activity or prevention policy is in place and is expected to be permanent, and there is some additional support for further prevention efforts.

9 There is continuous and secure support for basic programs and activities, evaluation is routinely expected and completed, and there are substantial resources for trying new efforts.

10

The following questions are designed for assessing readiness for prevention of adolescent drug use. The name and description of the problem can be changed to assess readiness for prevention for other types of problem. The letters in parentheses indicate to which dimension(s) the question is generally related.

A and B. Prevention Programming and Community Knowledge about Prevention

What types of adolescent drug use prevention programs or activities have occurred in your community? Expand the description of the problem if necessary, i.e., not tobacco or alcohol use. (A and B)
How long have these efforts been going on in your community? (A and B)
What are the strengths and weaknesses of these efforts? (A and B)
Who is served by these efforts? (A and B)
Is there a need to expand these services? If no, why not? (A and B)
Does the leadership see adolescent drug use as a problem?
Are the “leaders” in your community involved in prevention efforts? (list) (C)
Would the leadership support prevention efforts? If yes, how? (C)
Are there plans to expand or develop new activities? (A and B)
How are these efforts viewed by the community? (A and B)

What types of policies or practices (rules, regulations, or procedures) related to
preventing adolescent drug use are in place in your community? (A and B)
    Prompt: Formal—police must arrest the offender, or the school expels
           anyone found with drugs. (A and B)
    Prompt: Are there informal policies or rules? Informal—for example, the
           police or teachers may have informal rules to ignore or punish certain
           behaviors.
How long have these policies or rules been operating in your community? (A and B)
Are there groups where these policies or rules do not apply? (A and B)
Is there a need to expand these policies? If no, why not? (A and B)
Are there plans to expand the policies? If yes, what are the plans? (A and B)
How are these policies viewed by the community? (A and B)

C. Leadership (“Leadership” can include anyone in the
    community who is appointed to a leadership position or is
    influential in community affairs, i.e., an individual, a parent, a
    child, a teacher, a clergy person, etc.)

    Who, in your opinion, are the leaders, formal or informal, in your community?
    (C)
    Prompt: People whose opinion is respected and/or are influential and who
            may be contacted informally when issues arise.
    (If informal) How did they become the “leaders”? (C)
    Does the leadership see adolescent drug use as a problem? (C)
    Are the “leaders” in your community involved in prevention efforts? (list) (C)
    Would the leadership support prevention efforts? If yes, how? (C)
    What community organizations have a focus on prevention? (list) (C)

D. Community Climate

What is the general attitude about adolescent drug use in your community? (C and D)
READINESS FOR DRUG USE PREVENTION

Does the community see adolescent drug use as a problem? (D)
Is there ever a time when, or circumstances in which, members of your community might think adolescent drug use should be tolerated? (D)

Prompt—For example, age, religion, ethnicity, gender, or socioeconomic status.

Would the community support prevention efforts? If yes, how? (D)
What are the primary obstacles to prevention efforts in your community? (D)

Prompt—Obstacles can be people, groups, organizations, attitudes, or resources.

Is there a sense of apathy or hopelessness among community members regarding adolescent drug use? (D)

E. Community Knowledge about the Problem

(For a different problem, additional questions may be needed, i.e., if the problem were domestic violence, who would a victim of domestic violence turn to first for help?)

Is there information available on the extent of adolescent drug use? If yes, from who? (C)

How is that information disseminated? And to whom? (C)

F. Resources for Prevention Efforts (people, money, time, and space)

Who provides resources for these efforts and how long will they continue? (F)
What is the community’s attitude about supporting prevention efforts with either people, money, time, or space? (F)

Is your community aware of the resources involved in running these programs or activities? (C and F)

Are you aware of any proposals or action plans that have been written to address the issue of adolescent drug use? (F)

What is the level of expertise and training among those working toward prevention of adolescent drug use? (F)

Additional Questions to Be Asked if Programs or Policies Are in Place

Are you aware if there are any efforts being made to evaluate the prevention efforts or policies that are in place? (A and B)

Are the evaluation results being used to make changes in programs, activities, or policies or start new ones? (A and B)
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REFERENCES


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