Community Readiness

ADVANCING HIV/AIDS PREVENTION IN NATIVE COMMUNITIES

Assessing community readiness for change
Increasing community capacity for HIV/AIDS Prevention
Creating a climate that makes healthy change possible

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COMMUNITY Readiness MODEL

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COMMUNITY Readiness MODEL

FOR HIV/AIDS PREVENTION

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Acknowledgments

This Community Readiness Handbook was prepared in response to the many requests from the field for an easy-to-use guide. In the pages that follow, the key concepts of the model are described in a practical, step-by-step manner. The purpose is to guide users in implementing the model so that they can better initiate the process of community change and develop effective, culturally-appropriate, and community-specific strategies for prevention and intervention. It is our hope that this handbook will facilitate those efforts in working toward healthier communities and a eventually, a reduction in HIV/AIDS in Native communities.

The Community Readiness Model represents a true partnership between prevention science and community experience. We are extremely fortunate to have shared the successful journey toward community change with many communities throughout the world. Some of those who have been instrumental in the development of key aspects of the model and the theory behind it, and/or have been key supporters in its development and use include:

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Pamela Jumper-Thurman

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Irene Vernon

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

~ Margaret Mead ~

The Center for Applied Studies in American Ethncity (CASAE: Advancing HIV/AIDS Prevention in Native Communities) And Capacity Building Assistance

CASAE: Advancing HIV/AIDS in Native Communities (funded by the Centers for Disease Control and Prevention) is now offering HIV/AIDS prevention and early detection/testing capacity building assistance (CBA) to:

- CDC funded Community Based Native Organizations
- State Health Departments
- Native Health Boards
- Indian Health Service Regional offices
- Other organizations serving Native communities

The CBA provided will assist communities in increasing their effectiveness of HIV/AIDS prevention by using the Community Readiness Model to:

- Assess readiness and develop strategies appropriate to the readiness stage of their constituents
- Raise the readiness level of the communities served to encourage early detection and testing

The term "Natives" as defined by CDC includes the following groups as eligible for CBA services:

- American Indians
- Alaska Natives
- Native Hawaiians

The goals of the project are to:

➢ Strengthen the capacity of community based organizations (CBOs), by conducting free Community Readiness Capacity Building Assistance specific to HIV/AIDS prevention. This will include:

  - Conducting local readiness interviews
  - Determining the level of community readiness
  - Developing a community diagnostic geared toward using readiness to address HIV/AIDS as a community issue
  - Developing strategies appropriate to levels of readiness
  - Creating readiness based local social marketing efforts, thus increasing the potential of success

➤Assist communities by increasing the proportion of HIV infected individuals who know the are infected through early detection/testing. The Center will provide assistance with:

- Development of community specific and culturally appropriate social marketing strategies to educate, raise awareness and increase early testing
- Assisting CBOs to increase the links to appropriate services for people with HIV/AIDS and their families

The products and services that will be available to organizations through this project include:

- The Community Readiness Training Manual
- Technical Assistance with Assessment and Application of the Model
- Technical Assistance with Development of a Readiness Action Plan
- Resource Information
- Regional Training
- Regularly Scheduled Training Events at the Tri-Ethnic Center
- Evaluation and Sustainability Training
- Social Marketing Technical Assistance for HIV/AIDS Prevention

Other organizations funded by the CDC to provide Capacity Building Assistance for HIV/AIDS prevention for Native communities are:

THE NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTER
436-14TH STREET, SUITE 1020 OAKLAND, CA 94612 (510)444.2051
FAX:(510)444.1593 WWW.NNAAPC.ORG INFORMATION@NNAAPC.ORG

INTER TRIBAL COUNCIL OF ARIZONA, INC.
2214 NORTH CENTRAL AVENUE, SUITE 100 PHOENIX, AZ 85004 (602)258-4822 FAX: (602) 258-4825 WWW.ITCAONLINE.COM/PROGRAM_HIV.HTML

"In our every deliberation
we must consider the impact of our decision
on the next seven generations."

~ Great Law of the Six Nations Iroquois Confederacy ~

What Is The Community Readiness Model?

The Community Readiness Model:

- Is a model for community change that integrates a community's culture, resources, and *level of readiness* to more effectively address HIV/AIDS prevention.
- Allows communities to define issues and strategies in their own contexts.
- Builds cooperation among systems and individuals.
- Increases community capacity for HIV/AIDS prevention and intervention.
- Encourages and enhances community investment in HIV/AIDS awareness.
- Can be applied in any community (geographic, issue-based, organizational, etc.).
- Can be used to address a wide range of issues.
- Is a guide to the complex process of community change.

What Does "Readiness" Mean?

Readiness is the degree to which a community is prepared to take action on an issue. Readiness…

- Is very issue-specific.
- Is measurable.
- Is measurable across multiple dimensions.
- May vary across dimensions.
- May vary across different segments of a community.
- Can be increased successfully.
- Is essential knowledge for the development of strategies and interventions.

Matching an intervention to a community's level of readiness is absolutely essential for success. Interventions must be challenging enough to move a community forward in its level of readiness. However, efforts that are too ambitious are likely to fail because community members will not be ready or able to respond. To maximize chances for successful HIV/AIDS prevention, the Community Readiness Model offers tools to measure readiness and to develop stage-appropriate strategies.

Why Use The Community Readiness Model For HIV/AIDS Prevention?

- HIV/AIDS is a sensitive issue that may have barriers at various levels. Community Readiness addresses this resistance.
- It conserves valuable resources (time, money, etc.) by guiding the selection of strategies that are most likely to be successful.
- It is an efficient, inexpensive, and easy-to-use tool.
- It promotes community recognition and ownership of HIV/AIDS issues.
- Because of strong community ownership, it helps to ensure that strategies are culturally congruent and sustainable.
- It encourages the use of *local* experts and resources instead of reliance on outside experts and resources.
- The process of community change can be complex and challenging, but the model breaks down the process into a series of manageable steps.
- It creates a community vision for healthy change.

What Should NOT Be Expected From The Model?

- The model can't make people do things they don't believe in.
- Although the model is a useful diagnostic tool, it doesn't prescribe the details of exactly what to do to meet your goals. The model defines types and intensity of strategies appropriate to each stage of readiness. Each community must then determine specific strategies consistent with their community's culture and level of readiness for each dimension.

Next is a brief overview of how the Community Readiness Model may be applied to address HIV/AIDS prevention in your community.

Process For Using The Community Readiness Model

HIV/AIDS as the Issue

⇨ Define "Community"

⇨ Conduct Key Respondent Interviews

⇨ Score to Determine Readiness Level

⇨ Develop Strategies/Conduct Workshops

⇨ COMMUNITY CHANGE!

Step-By-Step Guide To Doing An Assessment

- **Step 1**: *Identify your issue.* In this case, the issue is to advance HIV/AIDS prevention. This issue will not only provide us with valuable insight into the community's perspective on HIV/AIDS, but will also give us information on related issues such as the prevention of other sexually transmitted infections, access to prevention materials, testing sites, and healthcare.

- **Step 2**: *Define your target "community".* This may be a geographical area, a group within that area, an organization or any other type of identifiable "community." It could be youth, elders, a reservation area, or a system.

- **Step 3**: To determine your community's level of readiness to address HIV/AIDS prevention and implement strategies to encourage early detection and testing, *conduct a Community Readiness Assessment* using key respondent interviews. This process is described further starting on page 12.

- **Step 4**: Once the assessment is complete, you are ready to score your communities stage of readiness for each of the six dimensions, as well as your overall score. *Analyze the results of the assessment using both the numerical scores and the content of the interviews* (see pages 16-26).

- **Step 5**: *Develop strategies to pursue that are stage-appropriate.* For example, at low levels of readiness, the intensity of the intervention must be more low key and personal. See pages 27-30 for general types of strategies that are appropriate for each stage of readiness.

- **Step 6**: After a period of time, *evaluate the effectiveness of your efforts.* You can conduct another assessment to see how your community has progressed.

- **Step 7**: As your community's level of readiness to address HIV/AIDS prevention increases, you may find it necessary to begin to address closely related issues. *Utilize what you've learned to apply the model to another issue.*

In the following sections, the foundational concepts of the Community Readiness Model are defined. These are the *dimensions* and *stages* of readiness.

Dimensions Of Readiness For HIV/AIDS Prevention

Dimensions of readiness are key factors that influence your community's preparedness to take action on HIV/AIDS. The six dimensions identified and measured in the Community Readiness Model are very comprehensive in nature. They are an excellent tool for diagnosing your community's needs and for developing strategies that meet those needs.

A. **Community Efforts**: To what extent are there efforts, programs, and policies that address HIV/AIDS?

B. **Community Knowledge Of The Efforts**: To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?

C. **Leadership**: To what extent are appointed leaders and influential community members supportive of HIV/AIDS prevention?

D. **Community Climate**: What is the prevailing attitude of the community toward HIV/AIDS and early detection and testing? Is it one of helplessness or one of responsibility and empowerment?

E. **Community Knowledge About The Issue**: To what extent do community members know about or have access to information on HIV/AIDS, HIV/AIDS testing, consequences, and understand how the disease impacts your community?

F. **Resources Related To The Issue**: To what extent are local resources – people, time, money, space, etc. – available to support efforts?

Your community's status with respect to each of the dimensions forms the basis of the overall level of community readiness.

Next, each of the nine stages of readiness
in the Community Readiness Model are defined.


Stages of Community Readiness
1
No Awareness
2
Denial/ Resistance
3
Vague Awareness
4
Preplanning
5
Preparation
6
Initiation
7
Stabilization
8
Confirmation/ Expansion
9
High Level of Community Ownership

STAGE	DESCRIPTION
1. No Awareness	HIV/AIDS is not generally recognized by the community or leaders as a problem (or it may truly not be an issue).
2. Denial / Resistance	At least some community members recognize that HIV/AIDS is a concern, but there is little recognition that it might be occurring locally.
3. Vague Awareness	Most feel that there is local concern, but there is no immediate motivation to do anything about it.
4. Preplanning	There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.
5. Preparation	Active leaders begin planning in earnest. Community offers modest support of efforts.
6. Initiation	Enough information is available to justify efforts. Activities are underway.
7. Stabilization	Activities are supported by administrators or community decision makers. Staff are trained and experienced.
8. Confirmation/ Expansion	Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.
9. High Level of Community Ownership	Detailed and sophisticated knowledge exists about HIV/AIDS prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.

How To Conduct A Community Readiness Assessment

Conducting a Community Readiness Assessment is the key to determining your community's readiness by dimension and by overall stage. To perform a complete assessment, you will be asking individuals in your community the questions on the following pages. There are 28 questions, and each interview should take 30-60 minutes. Before you begin, please review the following guidelines:

- Identify a minimum of six individuals in your community who are committed to HIV/AIDS prevention and intervention. In some cases, it may be "politically advantageous" to interview more people. However, only six interviews are generally needed to accurately score the community. Try to find people who represent different segments of your community. Individuals may represent:
  - Health & medical professions
  - Social services
  - Mental health & treatment services
  - Schools/Universities
  - City/county/tribal government
  - Law enforcement
  - Clergy or spiritual community
  - Community at large, elders, or specific high risk groups in your community.
  - Youth (if appropriate to do so)

- Read through the questions on the following pages. The questions we provide here are appropriate for an HIV/AIDS assessment, so you may need to tailor the questions further if you are addressing another related issue. When applying questions to other topics, keep the following in mind:
  - In most cases, you can simply substitute your new issue for HIV/AIDS. However, if a question is clearly irrelevant to your new issue, you may need to drop the question. You may also want to add other questions that are more specific to your issue. If you want to add questions, add them to the end to avoid confusion when scoring. CAUTION: The HIV/AIDS questions that are listed in this manual are all necessary for scoring and may not be dropped.
  - Have two people apply the questions to your topic independently and then meet to arrive at consensus on the revision.

- You will note that Dimensions A & B are combined. This is to improve the "flow" of the questions. We have also found the information to score these Dimensions seems to be related and it is beneficial to read items from both Dimensions A & B to get a comprehensive score for each Dimension.
- If translating questions from English into another language, ask a person who is very familiar with the language and culture to translate. Then, have the translated version "back-translated" into English by another person to ensure that the original content of the questions was captured.
- Pilot test your revised questions to make sure they are easy to understand and that they elicit the necessary information for scoring each dimension.

- Contact the people you have identified and see if they would be willing to discuss the issue. Remember, each interview will take 30-60 minutes.

- Conduct your interviews.
  - Avoid discussion with interviewers, but ask for clarification when needed and use prompts as designated.
  - Record or write responses as they are given. Try not to add your own interpretation or to second guess what the interviewee meant.

- After you have conducted the interviews, follow the directions for scoring on pages 16-25.

On the following pages, you will find the questions for all six dimensions addressing HIV/AIDS that you will need to ask for the Community Readiness Assessment.

Community Readiness Assessment Interview Questions

A. COMMUNITY EFFORTS (programs, activities, policies, etc.) AND

B. COMMUNITY KNOWLEDGE OF EFFORTS

1. Using a scale from 1-10, how much of a concern is this issue in your community (with 1 being "not at all" and 10 being "a very great concern")? Please explain. *(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*

2. What services or efforts are available in your community to address HIV/AIDS prevention or early detection or testing of HIV/AIDS? (A)

4. What type of information does the community know about the efforts, (how at access, services provided, program mission, etc.)? (B)

5. Are there any plans for new efforts addressing HIV/AIDS prevention/testing in your community? Please explain.

6. Using a scale from 1-10, how aware are people in the community of the services (with 1 being "no awareness" and 10 being "very aware")? Please explain. *(NOTE: this figure between 1 and 10 is NOT figured into your scoring of this dimension – it is only to provide a reference point.)* (B)

7. What are the strengths of these services? (B)

8. What are the weaknesses of these services? (B)

9. How does one utilize these services? (i.e. referrals, waiting lists, criteria) (A)

10. Do you know if there's any evaluation of these efforts? If yes, on a scale of 1 to 10, how sophisticated is the evaluation effort (with 1 being "not at all" and 10 being "very sophisticated?")? *(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)* (A)

C. LEADERSHIP

11. Using a scale from 1 to 10, how much of a concern is access to HIV/AIDS services to the leadership (with 1 being "not at all" and 10 being "of great concern")? Please explain. *(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*

12. Using a scale from 1 to 10, how much of a concern is providing early detection and testing of HIV/AIDS services to the leadership (with 1 being "not at all" and 10 being "of great concern")? Please explain. *(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*

13. How do the leaders, Native and non-Native, support the current efforts? Please explain.

14. Would the leadership support additional efforts? Please explain.

D. COMMUNITY CLIMATE

15. What is the community's attitude about HIV/AIDS?

16. What is the community's attitude about utilizing HIV/AIDS services?

17. What is the community's attitude about testing for HIV/AIDS?

18. What are the primary obstacles to obtaining services in your community?

E. KNOWLEDGE ABOUT THE ISSUE

19. How knowledgeable are community members about HIV/AIDS? Please explain. (Prompt: For example, mode of transmission, signs, symptoms, local statistics, etc.)

20. In your community, what type of information is available about HIV/AIDS prevention?

21. In your community, what type of information is available about testing for HIV/AIDS?

22. Is local data on HIV/AIDS available in your community? If so, from where?

23. How do people obtain this information in your community?

F. RESOURCES FOR PREVENTION EFFORTS (time, money, people, space, etc.)

24. What resources such as time, money, volunteerism, natural resources are available in your community?

25. What types of resources are currently being used for HIV/AIDS prevention?

26. Are you aware of any proposals or action plans that have been written to address this issue in your community?

26. How have these services been supported by the community? (A)

G. ADDITIONAL QUESTIONS

27. Using a scale from 1 to 10, how much of a concern is access to HIV/AIDS prevention in your community (with 1 being "not at all" and 10 being "of great concern")? Please explain. *(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*

28. Using a scale from 1 to 10, how much of a concern is access to treatment and testing for HIV/AIDS in your community (with 1 being "not at all" and 10 being "of great concern")? Please explain. *(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*

28. What services are lacking in your community to address HIV/AIDS prevention?

Scoring Community Readiness Interviews For A Complete Assessment

Scoring is an easy step-by-step process that gives you the readiness stages for each of the six dimensions. The following pages provide the process for scoring. There is a scoring worksheet on page 18 and anchored rating scales on pages 20-25. Ideally, two people should participate in the scoring process in order to ensure valid results on this type of qualitative data. Here are step-by-step instructions:

- Working independently, both scorers should *read through each interview in its entirety before scoring any of the dimensions* in order to get a general feeling and impression from the interview. Although questions are arranged in the interview to pertain to specific dimensions, other interview sections may have some responses that will help provide richer information and insights that may be helpful in scoring other dimensions.

- Again, working independently, the scorers should read the anchored rating scale for the dimension being scored. Always start with the first anchored rating statement. Go through each dimension separately and highlight or underline statements that refer to the anchored rating statements. If the community exceeds the first statement, proceed to the next statement. In order to receive a score at a certain stage, all previous levels must have been met up to and including the statement which the scorer believes best reflects what is stated in the interview. In other words, a community cannot be at stage 7 and not have achieved what is reflected in the statements for stages 1 through 6.

- On the scoring sheet on page 18, each scorer puts his or her independent scores in the table labeled INDIVIDUAL SCORES using the scores for each dimension of each of the interviews. The table provides spaces for the six key respondent interviews.

- When the independent scoring is complete, the two scorers then meet to discuss the scores. The goal is to reach consensus on the scores by discussing items or statements that might have been missed by one scorer and which may affect the combined or final score assigned. Remember: Different people can have slightly different impressions, and it is important to seek explanation for the decisions made. Once consensus is reached, fill in the table labeled COMBINED SCORES on one of the scoring sheets. Add across each row to yield a total for each dimension.

- To find the CALCULATED SCORES for each dimension, take the total for that dimension and divide it by the number of interviews. For example: If two scorers have the following combined scores for their interviews:

Interviews	#1	#2	#3	#4	#5	#6	TOTAL
Dimension A	3.5	5.0	4.25	4.75	5.5	3.75	26.75

TOTAL Dimension A 26.75 ÷ # of interviews 6 = 4.46

Repeat for all dimensions, and then total the scores.

- To find the OVERALL STAGE OF READINESS, take the total of all calculated scores and divide by the number of dimensions (6). For example:

Dimension A:	4.46	
Dimension B:	5.67	
Dimension C:	2.54	
Dimension D:	3.29	
Dimension E:	6.43	
Dimension F:	4.07	
	26.46	26.46 ÷ 6 = 4.41

- The result will be the overall stage of readiness of the community. The scores correspond with the numbered stages and are "rounded down" rather than up, so a score between a 1.0 and a 1.99 would be the first stage, a score of 2.0 to 2.99 would be the second and so forth. In the above example, the average 4.41 represents the fourth stage or Preplanning.

- Finally, under comments, write down any impressions about the community, any unique outcomes, and any qualifying statements that may relate to the score of your community.

Community Readiness Assessment Scoring Sheet

Scorer:_____ Date:_____

INDIVIDUAL SCORES: Record each scorer's independent results for each interview for each dimension. The table provides spaces for up to six interviews.

Interviews	#1	#2	#3	#4	#5	#6
Dimension A						
Dimension B						
Dimension C						
Dimension D						
Dimension E						
Dimension F						

COMBINED SCORES: For each interview, the two scorers should discuss their individual scores and then agree on a single score. This is the COMBINED SCORE. Record it below and repeat for each interview in each dimension. Then, *add across each row* and find the total for each dimension. Use the total to find the calculated score below.

Interviews	#1	#2	#3	#4	#5	#6	TOTAL
Dimension A							
Dimension B							
Dimension C							
Dimension D							
Dimension E							
Dimension F							

CALCULATED SCORES: Use the combined score TOTAL in the table above and divide by the number of interviews conducted. Add the calculated scores together and enter it under total.

					Stage Score
TOTAL Dimension A ____	÷	# of interviews ____	=	____
TOTAL Dimension B ____	÷	# of interviews ____	=	____
TOTAL Dimension C ____	÷	# of interviews ____	=	____
TOTAL Dimension D ____	÷	# of interviews ____	=	____
TOTAL Dimension E ____	÷	# of interviews ____	=	____
TOTAL Dimension F ____	÷	# of interviews ____	=	____

Average Overall Community Readiness Score: ____

OVERALL STAGE OF READINESS: Take the TOTAL calculated score and divide by 6 (the number of dimensions). Use the list of stages below to match the result with a stage of readiness. *Remember, round down instead of up.*

TOTAL Calculated Score ____ ÷ 6 = ____

Score	Stage of Readiness
1	No Awareness
2	Denial / Resistance
3	Vague Awareness
4	Preplanning
5	Preparation
6	Initiation
7	Stabilization
8	Confirmation / Expansion
9	High Level of Community Ownership

COMMENTS, IMPRESSIONS, and QUALIFYING STATEMENTS about the community:

Anchored Rating Scales For Scoring Each Dimension

Dimension A. Existing Community Efforts

1 No awareness of the need for efforts to address HIV/AIDS in any capacity.

2 No efforts addressing HIV/AIDS prevention or early detection.

3 A few individuals recognize the need to initiate some type of effort, but there is no immediate motivation to do anything.

4 Some community members have met and have begun a discussion of developing community efforts.

5 Efforts (programs/activities) are being planned.

6 Efforts (programs/activities) have been implemented.

7 Efforts (programs/activities) have been running for several years.
.

8 Several different programs, activities and policies are in place, covering different age groups and reaching a wide range of people. New efforts are being developed based on evaluation data.

9 Evaluation plans are routinely used to test effectiveness of many different efforts, and the results are being used to make changes and improvements.

Dimension B. Community Knowledge Of The Efforts

-
-
-
1 Community has no knowledge of the need for efforts addressing HIV/AIDS.
-
-
-
2 Community has no knowledge about efforts addressing HIV/AIDS.
-
-
-
3 A few members of the community have heard about efforts, but the extent of their
- knowledge is limited.
-
-
4 Some members of the community know about local efforts.
-
-
-
5 Members of the community have basic knowledge about local efforts (e.g., purpose).
-
-
-
6 An increasing number of community members have knowledge of local efforts
- and are trying to increase the knowledge of the general community about these
- efforts.
-
7 There is evidence that the community has specific knowledge of local efforts
- including contact persons, training of staff, clients involved, etc.
-
-
8 There is considerable community knowledge about different community efforts,
- as well as the level of program effectiveness.
-
-
9 Community has knowledge of program evaluation data on how well the different
- local efforts are working and their benefits and limitations.
-
-

Dimension C. Leadership (includes appointed leaders & influential community members)

1 Leadership has no recognition of HIV/AIDS.

2 Leadership believes that HIV/AIDS is not a concern in their community.

3 Leader(s) recognize(s) the need to do something regarding HIV/AIDS.

4 Leader(s) is/are trying to get something started.

5 Leaders are part of a committee or group that addresses HIV/AIDS.

6 Leaders are active and supportive of the implementation of efforts.

7 Leaders are supportive of continuing basic efforts and are considering resources available for self-sufficiency.

8 Leaders are supportive of expanding/improving efforts through active participation in the expansion/improvement.

9 Leaders are continually reviewing evaluation results of the efforts and are modifying support accordingly.

Dimension D. Community Climate

-
-
-
1 The prevailing attitude is that HIV/AIDS is not considered, unnoticed or overlooked within
- the community.
- "It's just not our concern."
-
2 The prevailing attitude is "There's nothing we can do," or "Only 'those' people do that,"
- or "Only 'those people' have that."
-
-
3 Community climate is neutral, disinterested, or believes that HIV/AIDS does not affect
- the community as a whole.
-
-
4 The attitude in the community is now beginning to reflect interest in HIV/AIDS.
- "We have to do something, but we don't know what to do."
-
-
5 The attitude in the community is "We are concerned about this," and community members are
- beginning to reflect modest support for efforts.
-
-
6 The attitude in the community is "This is our responsibility" and is now beginning
- to reflect modest involvement in efforts.
-
-
7 The majority of the community generally supports programs, activities, or policies.
- "We have taken responsibility."
-
-
8 Some community members or groups may challenge specific programs, but the
- community in general is strongly supportive of the need for efforts. Participation level
- is high. "We need to keep up on this issue and make sure what we are doing is effective."
-
9 All major segments of the community are highly supportive, and community members
- are actively involved in evaluating and improving efforts and demand accountability.
-
-

Dimension E. Community Knowledge About The Issue

1 HIV/AIDS is not viewed as an issue that we need to know about.

2 No knowledge about HIV/AIDS.

3 A few in the community have basic knowledge of HIV/AIDS, and recognize that some people here may be affected by the issue.

4 Some community members have basic knowledge and recognize that HIV/AIDS occurs locally, but information and/or access to information is lacking.

5 Some community members have basic knowledge of HIV/AIDS, including modes of transmission, means of prevention, and options for testing. General information on HIV/AIDS is available.

6 A majority of community members have basic knowledge of HIV/AIDS, including modes of transmission, means of prevention, understanding of high-risk groups and behaviors, and that it occurs locally. There are specific local data on HIV/AIDS available.

7 Community members have knowledge of, and access to, detailed information about local prevalence.

8 Community members have knowledge about prevalence, causes, risk factors, and related health concerns.

9 Community members have detailed information about HIV/AIDS and related health concerns as well as information about the effectiveness of local programs.

Dimension F. Resources Related To The Issue (people, money, time, space, etc.)

1 There is no awareness of the need for resources to deal with HIV/AIDS.

2 There are no resources available for dealing with HIV/AIDS.

3 The community is not sure what it would take, (or where the resources would come from), to initiate efforts.

4 The community has individuals, organizations, and/or space available that could be used as resources.

5 Some members of the community are looking into the available resources.

6 Resources have been obtained and/or allocated for HIV/AIDS.

7 A considerable part of support of on-going efforts are from local sources that are expected to provide continuous support. Community members and leaders are beginning to look at continuing efforts by accessing additional resources.

8 Diversified resources and funds are secured and efforts are expected to be ongoing. There is additional support for further efforts.

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

Using The Assessment To Develop Strategies

With the information you've gained in terms of dimensions and overall readiness, you're now ready to develop strategies that will be appropriate for your community. This may be done in a small group or community workshop format.

The first thing to do is look at the distribution of scores across the dimensions. Are they all about the same? Are some lower than others?

If you have one or more dimensions with lower scores than the others, focus your efforts on strategies that will increase the community's readiness on that dimension or those dimensions first. Make certain the intensity level of the intervention or strategy is consistent with, or lower than, the stage score for that dimension. **To be successful, any effort toward making change within a community must begin with strategies appropriate to its stage of readiness**.

On the next three pages, you will find a list of generic strategies appropriate for each stage of readiness to guide you in developing strategies for your community.

Following the list of generic strategies, you will find blank forms for recording community strengths, conditions/concerns and resources, and samples of completed forms.

Goals And General Strategies Appropriate For Each Stage

1. No Awareness

   Goal: Raise awareness of the issue

   - Make one-on-one visits with community leaders/members.
   - Visit existing and established small groups to share information with them about local HIV/AIDS statistics and general information.
   - Make one-on-one phone calls to friends and potential supporters.

2. Denial / Resistance

   Goal: Raise awareness that the problem or issue exists in this community

   - Continue one-on-one visits and encourage those you've talked with to assist.
   - Approach and engage local educational/health outreach programs to assist in the effort with flyers, posters, or brochures.
   - Begin to point out media articles that describe local statistics and available HIV/AIDS services.
   - Prepare and submit articles on HIV/AIDS early testing for church bulletins, local newsletters, club newsletters, etc.
   - Present information to local related community groups.

   (Note that media efforts at the lower stages must be lower intensity as well. For example, place media items in places where they are very likely to be seen, e.g., church bulletins, smaller newsletters, flyers in laundromats or post offices, etc.)

3. Vague Awareness

   Goal: Raise awareness that the community can do something

   - Get on the agendas and present information on HIV/AIDS at local community events and to unrelated community groups.
   - Post flyers, posters, and billboards.
   - Begin to initiate your own community health events (pot lucks, potlatches, etc.) and use those opportunities to also present information on HIV/AIDS.
   - Conduct informal local surveys and interviews with community people by phone or door-to-door about attitudes and perceptions related to HIV/AIDS, HIV/AIDS testing, etc.
   - Publish newspaper editorials and human interest articles with general information and local implications.

4. Preplanning

   Goal: Raise awareness with concrete ideas

   - Introduce information about HIV/AIDS and HIV testing through presentations and media. Focus on reducing stigma and raising general awareness.
   - Visit and invest community leaders in the cause.
   - Review existing efforts in community (curriculum, programs, activities, etc.) to determine who the target populations are and consider the degree of success of the efforts.
   - Conduct local focus groups to discuss HIV and related issues and develop some basic strategies.
   - Increase media exposure through radio and television public service announcements.

5. Preparation

   Goal: Gather existing information with which to plan more specific strategies

   - Seek out local data sources about HIV, AIDS, TB, STDs, Hepatitis C, etc.
   - Conduct more formal community surveys.
   - Sponsor a community health event to kick off the effort.
   - Conduct public forums to develop strategies from the grassroots level.
   - Utilize key leaders and influential people to speak to groups and participate in local radio and television shows to gain support.
   - Plan how to evaluate the success of your efforts.

6. Initiation

   Goal: Provide community-specific information

   - Conduct in-service training on Community Readiness and other health related topics for professionals and paraprofessionals (HIV, AIDS, TB, STDs, Hepatitis C, etc).
   - Plan publicity efforts associated with start-up of activity or efforts.
   - Attend meetings to provide updates on progress of the effort.
   - Conduct consumer interviews to identify service gaps, improve existing services and identify key places to post information.
   - Begin library or Internet search for additional resources and potential funding.
   - Begin some basic evaluation efforts.

7. Stabilization

   Goal: Stabilize efforts and programs

   - Plan community events to maintain support for HIV/AIDS efforts and HIV testing.
   - Conduct training for community professionals.
   - Conduct training for community members, parents, elders and youth.
   - Introduce your program evaluation results through training and newspaper articles.
   - Conduct quarterly meetings to review progress, modify strategies.
   - Hold recognition events for local supporters or volunteers.
   - Prepare and submit newspaper articles detailing progress and future plans.
   - Begin even wider networking among service providers and community systems, perhaps not specific to HIV, but related to health and wellness.

8. Confirmation / Expansion

   Goal: Enhance and expand services

   - Formalize the networking with qualified service agreements.
   - Prepare a community risk assessment profile.
   - Publish a localized program services directory.
   - Maintain a comprehensive database available to the public.
   - Develop a local speaker's bureau.
   - Initiate policy change through support of local city officials.
   - Conduct media outreach on specific data trends related to HIV/AIDS.
   - Utilize evaluation data to modify efforts.

9. High Level of Community Ownership

   Goal: Maintain momentum and continue growth

   - Maintain local business community support and solicit financial support from them.
   - Diversify funding resources.
   - Continue more advanced training of professionals and paraprofessionals.
   - Continue re-assessment of issue and progress made.
   - Utilize external evaluation and use feedback for program modification.
   - Track outcome data for use with future grant requests.
   - Continue progress reports for benefit of community leaders and local sponsorship. At this level the community has ownership of the efforts and will invest themselves in maintaining the efforts.

Workshop/Presentation Script For Community Readiness Results For HIV/AIDS Prevention & Strategy Development

The following is a script that can be used to present the Community Readiness Model and/or the community's readiness score for development of HIV/AIDS prevention strategies. It refers to slides that can be requested from the Tri-Ethnic Center website or you can us the handouts included with this script. If you have attended a Community Readiness workshop, you may give audience members several handouts from the workshop you attended. In the script below, bold statements are subject headings and instructions to you. Slide names are in *bold italics*. Finally, the regular print is information for you to give to the audience.

Handouts mentioned in this script include the following:

The Purpose of the Community Readiness Model
What Does the Model Do
What the Model CAN Do
What the Model CAN'T Do
Take Home Message
Process for Using the Community Readiness Model
Who Is Interviewed
Conducting an Interview
Dimensions of Community Readiness
Stages of Community Readiness
Appropriate Strategies for Readiness Level

I. **What is community readiness? Give a background of the community readiness model using the information below. Use the handouts or slides *Purpose of the Community Readiness Model, What Does the Model Do, What the Model CAN Do, What the Model CAN'T Do*, and *Take Home Message,* as appropriate to the material below.**

A. Community Readiness is an innovative method for assessing the level of readiness of a community to develop and implement HIV/AIDS prevention and other intervention efforts.

B. It defines 9 stages of community readiness ranging from "no awareness" of the problem to "high level of community ownership" in the response to the issue.

C. It was developed by the Tri-Ethnic Center for Prevention Research at Colorado State University after much research and testing in communities.

Its validity and reliability have been demonstrated in many communities and with many issues.

D. It was originally developed to address community alcohol and drug abuse prevention efforts, but has also being used for intimate partner violence, child abuse, transportation issues, HIV/AIDS, head injury, cultural competence, suicide, animal control issues, and many more issues.

E. The model identifies specific characteristics related to different levels of problem awareness and readiness for change. It is:
   - a step-by-step system for developing an effective prevention strategy. It gives a clear map of the prevention/intervention journey.
   - issue-specific, community-specific, culturally specific and most important, measurable.

F. Community readiness is culture-embracing; it encourages the development of creative cultural strategies. The methods used to implement change in community readiness are all translatable to the differing styles of communication, values, experience, networking, and policy change of the various cultures of a community. The decision as to the specific interventions used and the avenues chosen are based on the fundamental principle that community change is, and should be, in the hands of the community.

G. **What can the model do and what can't the model do? Use the two slides *What the Model CAN Do* and *What the Model CAN'T Do*.**

   The model can:
   - Help identify resources
   - Help identify obstacles
   - Provide an assessment of how ready the community is with respect to accepting a given issue as something that needs doing
   - Identify types of efforts that are appropriate to initiate, depending on the stage of readiness
   - Help build cooperation among systems and individuals

   The model cannot:
   - Make people do what they don't believe in
   - Tell you exactly what you should do to accomplish your objectives

SUMMARIZE THIS SECTION WITH "WHY USE COMMUNITY READINESS?" Use the slide *Take Home Message*.

In order to stand a chance of success, interventions introduced in a community must be consistent with the awareness of the problem and the level of readiness for change present among residents of that community. Strategies of intervention must be appropriate for the community's stage of readiness!

II. **Why your community chose to use this model.**

Explain why your community decided to use this model. For example, did you want to develop a program that had local control and used local resources, were you particularly concerned about finding a model for intervention that was consistent with your community's cultural values. There may be a number of reasons for choosing to use the Community Readiness Model. Explain these reasons to your audience to guide the rest of the discussion.

III. **A brief description of the community readiness model.**

A. **Show the slide *Process for Using the Community Readiness Model*, and briefly run through the steps. Let the participants know that you will be giving more details of some of these steps in just a few minutes.**

The process for using the model:

1. Identify the issue, e.g. drug prevention among adolescents.
2. Define "community", e.g. it can be more than just a geographical community but can be any subgroup of a geographical community, an organization, an occupation group such as law enforcement, health professionals, etc.
3. Conduct "key respondent" interviews.
4. Score the interviews to determine the readiness level.
5. Develop the strategies for your issue and conduct workshops.
6. Community change!

B. **What is a key respondent and what are the key respondent interviews? Use the slides *Who is Interviewed* and *Conducting an Interview.***

- Key respondents are individuals who are knowledgeable about the community, but not necessarily a leader or decision-maker. They are involved in community affairs and know what is going on. By using a cross section of individuals, a more complete and accurate measure of the level of readiness for this issue in the community can be obtained – remember to avoid using only those professionals involved in the issue because their readiness level will be higher than the community at large and the

community at large is generally the audience in which you want to make change.

- Who is chosen will depend on the issue. Examples of key respondents:
  School personnel
  Law enforcement
  City/county/tribal government and leaders
  Health/medical representatives
  Social services
  Clergy or other spiritual/religious leaders
  Mental health and treatment services
  Community members at large
  Youth and/or elders

- What does a key respondent interview involve?
  - There are approximately 35-40 questions that are adapted to the community and the issue being addressed.
  - 6 key respondents are interviewed for about 30 – 60 minutes.
  - The questions asked provide information about 6 dimensions of the community readiness for the targeted issue.
  - Interviewers transcribe the interviewee responses as accurately as possible, avoiding discussion and only clarifying when necessary.

C. **The six dimensions of community readiness. Use the slide *Dimensions of Community Readiness* to quickly give the audience a quick overview of the six dimensions.**

Community readiness is multi-dimensional – six dimensions. A community can be at somewhat different stages on different dimensions, this is where the diagnostic aspect is determined. All dimensions are used to obtain a final community readiness score for the particular issue being addressed. However, the individual dimensions are more telling when making the decision where and how to develop your strategies.

Use the slides *The Dimensions of Community Readiness* and select some of the examples below to describe the kinds of questions that are asked to assess or measure these dimensions during the key respondent interviews.

1. **Community Efforts – programs, activities, policies, etc.**
   and
2. **Community Knowledge of Efforts**

Using a scale from 1-10, how much of a concern is this issue in your community, with one being not at all and ten being a very large concern? Please explain.

What efforts are currently available in your community that relate to this issue?

Using a scale from 1 to 10, how aware are people in the community of these efforts, with one being no awareness and ten being very aware? Please explain.

3. Leadership (includes appointed leaders and influential community members)

Who are leaders specific to this issue in your community?

Using a scale from 1 to 10, how much of a concern is this issue to the leadership in your community, with one being not at all and ten being a very large concern? Please explain.

4. Community Climate

Describe your community.

What is the community's attitude about this issue?

5. Knowledge About the Issue

How knowledgeable are community members about this issue. Please explain.

What type of local data on this issue is available in your community?

6. Resources for Prevention Efforts (time, money, people, space, etc.)

To what extent are local resources – people, time, money, space, etc. – available to support efforts?

D. **Scoring of interviews to determine readiness level.**

Interviews are scored one at a time by at least 2 scorers following specific instructions and guidelines given to the scorers. Based upon statements and references in the interviews that refer to specific dimensions, for each interview each dimension receives a score from 1-9 according to a scale for that particular dimension. The scorers then come together and agree on the scores of each dimension for each interview. Scores are then averaged

across interviews for each dimension, and the final score is the average across the 6 dimensions. This final score gives the specific stage of readiness for this issue in your community.

E. **Stages of readiness. Show slide *Stages of Community Readiness* that has a graphic of the stages. Remind the audience that one stage is not necessarily better than another; rather the point of identifying stages is to direct the development of appropriate strategies.**

Then show the slide entitled *Stages of Community Readiness* that have the stages of readiness briefly explained. Refer your audience to its handout that has further details about the stages of community readiness.

- No Awareness– No identification of the issue as a problem. "It's just the way things are." Community climate may unknowingly encourage the behavior although the behavior may be expected of one group and not another (i.e., by gender, race, social class, age, etc.)
- Denial– Recognition of the issue as a problem, but no ownership of it as 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 it locally. "It's not our problem." "It's just those people who do that." "We can't do anything about it."
- Vague Awareness– Beginning of recognition that it is a local problem, but no motivation to do anything about it. Ideas about why the problem occurs and who has the problem tend to be stereotyped and/or vague. No identifiable leadership exists or leadership lacks energy or motivation for dealing with this problem.
- Preplanning– Clear recognition of the issue as a problem that needs to be addressed. Discussion is beginning, but no real action planning is taking place. Community climate is beginning to acknowledge the necessity of dealing with the problem.
- Preparation– Planning on how to address the issue is underway and decisions are being made on what to do and who will do it. There is general information about local problems and about the pros and cons of prevention activities, actions, or policies, but it may not be based on formally collected data.
- Initiation– An activity or action has been started and is ongoing, but it is still viewed as a new effort. There may be great enthusiasm among the leaders because limitations and problems have not yet been experienced.

There is often a modest involvement of community members in the efforts.

- Stabilization– One or two efforts or activities are underway and stable. Staff are trained and experienced, but there is no in-depth evaluation of effectiveness. There is little perceived need for change or expansion. Community climate generally supports what is occurring.
- Confirmation/Expansion– Standard efforts are in place and leaders support improving the efforts. Original efforts have been evaluated and modified. Resources for new efforts are being identified, and modified and new efforts are being planned or tried in order to reach more people. Data are regularly obtained on extent of local problems, and efforts are made to assess risk factors and causes of the problem.
- High Level of Community Ownership– Detailed and sophisticated knowledge about the issue exists within the community. Community members want to know what's going on and feel ownership and involvement. Highly trained staff are running programs or activities, leaders are supportive, and community involvement is high. Special efforts are targeted at specific populations as well as more general efforts for the whole community. Effective evaluation is routinely used to test and modify efforts and this evaluation information is provided back to the community on a regular basis through newspaper articles, media, etc.

F. **Strategies**

Once a community knows its level of readiness in dealing with a specific issue, it can then develop strategies for prevention/intervention. The model gives appropriate strategies for each stage of readiness. These strategies are not specific answers; they are general statements or examples of approaches that may be effective. Specific answers must come from the community itself.

Instead of going through all 9 stages and their associated strategies, you can show the audience just a few of the slides *Appropriate Strategies for Readiness Level* so that they can get some idea of how the stages and strategies are related. You can also direct them to the handout with these strategies on it.

IV. **Discussion about *Your* community's level of readiness.**

A. **Ask the audience what stage they believe the community falls into for the targeted issue. Have participants briefly explain their answer. Allow participants to have a brief discussion about their opinions.**

B. **Present the readiness score for your community (you can write the number on the slide *Our Community's Readiness Score.* Remind participants exactly what that readiness score means. For example, if your community scores a "3", describe the Vague Awareness stage of readiness. You can show the overhead that describes this stage of readiness (from the *"Stages of Readiness"* slides).**

C. **Allow for a brief discussion of this readiness score and answer any questions from the participants. If people take issue with the score, simply explain that differing viewpoint provide the richness in the strategy development and this score reflects the perceptions of those who were interviewed. However, avoid discussion of strategies at this time; you can let the audience know that you will soon move on to strategies.**

D. **Move to the strategies for that particular readiness score. Show a slide of your community's stage of readiness, the goal of this stage of readiness, and the general types of strategies that are appropriate for this stage of readiness (from *"Appropriate Strategies for Readiness Level _____)".***

E. **Have a discussion about the Next Steps that the group should take.**

F. **If the group wants to develop an action plan consistent with the stages their community falls into, use instructions that follow this section.**

Workshop Presentation Slides

Purpose Of The Model

The purpose of Community Readiness is to provide communities with the stages of readiness for development of appropriate strategies that are more successful and cost effective

What Does The Model Do?

- Facilitates community-based change
- Uses a nine stage, multi-dimensional model
- Creates interventions that are community-specific and culturally specific
- Provides a road map for the HIV/AIDS prevention journey
- Builds cooperation among systems and individuals

What The Model Can Do

- Helps identify resources
- Helps identify obstacles
- Provides an assessment of how ready the community is with respect to accepting an intervention as something that needs doing
- Identifies types of efforts that are appropriate to initiate, depending on stage of readiness

What The Model Can't Do

- Make people do what they don't believe in
- Tell you exactly what you should do to accomplish your objectives

Take Home Message

Strategies Of Intervention
For HIV/AIDS Prevention Efforts
Must Be Appropriate
For The Community's Stage Of Readiness!

Process For Using The Community Readiness Model

- Identify Issue
- Define "Community"
- Conduct Key Respondents Interviews
- Score to Determine Readiness Level
- Develop Strategies/Conduct Workshops
- Community Change!

Who Is Interviewed?

Depending on the issue:

- School personnel
- Tribal/city/county/government and leaders
- Tribal health/medical professionals
- Community members at large
- Social services
- Spiritual/religious leaders
- Mental health and treatment services
- County public health

Conducting Community Readiness Interviews

- There are 20-35 questions; interviews can last 10-60 minutes
- Understand the purpose, the issue, and how results will be used
- Use the telephone or face-to-face; avoid written format
- Ask questions exactly as they are written; avoid interjecting personal bias or opinions
- Record all responses as accurately as possible, including non-verbal cues
- There is no right or wrong answers; no good or bad interview all provide essential information!

Dimensions Of Community Readiness

- Community Efforts (programs, activities, policies, etc.)
- Community Knowledge of the Efforts
- Leadership (formal and informal)
- Community Climate
- Community Knowledge About HIV / AIDS
- Resources Related to HIV / AIDS (people, time, money, space, etc.)

Appropriate Strategies for Readiness Level

1 - No Awareness

Goal: Raise awareness of HIV/AIDS

Strategies...

- One on one visit with others
- Visit existing and established small groups
- Phone calls to friends and potential supporters - inform others, get them excited and solicit their support – be creative!

2 - Denial / Resistance

Goal: HIV/AIDS exists in this community

Strategies...

- Continue strategies from previous stage
- Put up flyers and brochures
- Put information in church bulletins, club newsletters, etc.
- Low intensity but visible media

3 - Vague Awareness

Goal: Community can make positive changes

Strategies...

- Continue strategies from previous stage
- Hold special events: potlucks, dances, etc.
- Conduct informal surveys to see how people feel about HIV / AIDS and early detection
- Publish newspaper editorials/articles and creative media consistent with community visibility

4 - Preplanning

Goal: Develop concrete strategies

Strategies...

- Continue strategies from previous stage
- Use media for newspaper articles/posters
- Conduct assessment of what's already going on in the community
- Hold focus groups and listen to ideas

5 - Preparation

Goal: Gather pertinent information

Strategies...

- Continue strategies from previous stage
- Gather and present local statistics (Compile the facts: local statistics, local stories, emotional cost to the community, consequences to the community, future impact on the community, financial cost to the community, etc.)
- Conduct informal surveys to see how people feel about HIV / AIDS
- Increase media exposure (radio spots, talk shows, newspaper, etc.)

6 - Initiation

Goal: Provide community specific information

Strategies...

- Continue strategies from previous stage
- Begin training community providers / people
- Conduct public forums to gather ideas
- Sponsor larger community events

7 - Stabilization

Goal: Stabilize efforts or establish programs

Strategies...

- Continue strategies from previous stage
- Maintain business and other support for the project / efforts
- Introduce new programs and identify support
- Increase and further develop media exposure
- Utilize evaluation to improve efforts

8 – Confirmation And Expansion

Goal: Expand and enhance services

Strategies...

- Continue strategies from previous stages
- Expand community awareness through: speakers bureaus, events, media, etc.
- Maintain and report trends from data base
- Continue to survey and solicit public opinion
- Utilize evaluation to improve efforts and provide feedback to community and other professionals

9 - High Level Of Community Ownership

Goal: Maintain momentum, grow and use what's learned

Strategies...

- Continue strategies from previous stage
- Diversify funding resources, identify new sources
- Maintain and expand local business support
- Continue to track data trend for grant writing
- Begin work on related issues

Our Community's Readiness Score:

Dimension A
Efforts:

Dimension B
Knowledge of efforts:

Dimension C
Leadership:

Dimension D
Community Climate:

Dimension E
Knowledge of issue:

Dimension F
Resources:

Brainstorming An Action Plan

Use Brainstorming to develop strategies

- Allow the team to "brainstorm" as many ideas as possible. Point out that during this next eight minutes, there will be no in-depth discussion but just random ideas thrown out. If someone begins what could be a lengthy discussion, tell the group you will hold up two fingers to signal them to hold that thought until the discussion time later and move on.
- Consider all suggestions and be creative, there are no right or wrong answers.
- Use a flip chart to write down all ideas.
- Get creative, outlandish, consider all ideas.
- Never brainstorm on one topic for more than two minutes, remember you're going for quantity of ideas at this point, not quality.

What is Brainstorming?

Brainstorming is a quick and fast approach to developing creative ideas - it allows participation from all - it works within a specific set time limit and it allows no time for discussion of ideas - that comes later.

Easy Steps for Brainstorming:

Step One: Describe brainstorming and set up the rules, the two finger signal, and the time limit.

Step Two: Do a test run with a simple question, i.e. What are your "comfort foods", the foods that make you feel good and reduce your stress? Don't tell me why, just name them.

Step Three: Identify the issue, i.e. prevention of HIV/AIDS, need for raising awareness of early testing, or whatever your issue is, etc. but deal with only one topic at a time.

Step Four: First, write Strengths on the top of a flip chart page. Tell the participants they have two minutes to brainstorm ideas about strengths, then ask "What strengths do we have in this community to prevent HIV/AIDS" or "What strengths do we have already in place to raise awareness of early testing, etc."? Move fast and write down all the things that people throw out. This must move as quickly as the issue of comfort foods. Tape the sheet(s) up so that all can see it.

Step Five: After two minutes, go on to the next part and write Conditions/Concerns on the top of the flip chart. Tell the participants once more that they have two minutes, then ask them to "Identify your conditions or concerns, i.e. what might stop us from reaching our goals?". Conclude at two minutes and tape the sheet up on the wall.

Step Six: Then move on to Resources. These differ from strengths in that they are things that are already established or in place. Some of these may be the same as resources, but that's okay. Remind the participants once more of the two minutes rule, title your flip chart page, then ask "What are our resources, i.e. what do we have in place that we can draw from to reach our goal?". Conclude in two minutes and tape the sheet alongside the others. You now have several sheets of really good ideas that were developed in less than ten minutes.

Step Seven: Here's where the discussion comes in, but still keep a time limit (whatever you decide is appropriate) and keep the group focused. Look at the readiness scores one more time and set the priorities (dimensions with lowest readiness scores). Look at the types/intensity of strategies used at the stage in which you scored. Then ask the group "Knowing that our readiness score for this dimension is _____, and using the strengths and resources, what strategies can we use to best meet our conditions/concerns?" Allow the group to formulate some specific strategies that can be completed in reasonable steps.

Step Eight: Create an "Action Plan or Action Strategies" (see examples) and list each strategy, then identify specific action steps in reaching the strategy.

Tips for successful and focused strategy development for your community:

1. **Reach consensus about which dimensions are the greatest priority based on readiness scores. Identify the dimensions you want to focus on short term, then long term.**
2. **Break the participants into groups of three to five each allowing them to group themselves in respect with which dimension they want to work with (each group will take one or two dimensions that they will work specifically with.**

3. **Have each group review the types of strategies that are used at that level of readiness consistent with the dimension they are focusing on.**

4. **Develop three detailed strategies for each dimension of focus.**

For each strategy developed, identify what is to be done, who should do it (agency, person, etc.), by when, and where or how it should be done. It is also helpful to identify three activity steps toward achieving the strategy.

Step Nine: At the next meeting, get the update on tasks completed and tasks outstanding. If necessary, do more brainstorming to overcome any obstacles that might arise.

Record of Community Strengths, Conditions/Concerns, and Resources

Community Name: _____ Date of Workshop: _____

Staff Name(s): _____

Overall Readiness Score and Stage: _____

Strengths	Conditions/Concerns	Resources

- EXAMPLE -

Record of Community Strengths, Conditions/Concerns, and Resources

Community Name: **Anywhere, USA** Date of Workshop: **5/1/2005**

Staff Name(s):

Overall Readiness Score and Stage: **4, Preplanning**

Strengths	Conditions/Concerns	Resources
Community pride	Negative attitude	School
Caring for one another	Stigma	Church
Strong family units	Powerful and inaccurate gossip	Community and civic groups
		Spiritual leaders
Religious / spiritual support	Self righteousness	
Education	School involvement is low	Good healthcare and clinic
Strong work ethic	Tough to challenge	Volunteer EMS
Cultural heritage	Lack of program buy-in from general community	Lake
Low crime / safe community		School activities and clubs
Honesty (painfully so)	Low socioeconomic status	Family
	Lack of youth input	Neighbors
Low cost of living		Finances
Lake resources	Large minority population that is ignored by the state	Health fairs
Recreation (baseball, track, golf)		
	Few programs available locally	Sports opportunities
Tribal suppoart	No confidentiality	Strong political connections
	Everyone knows everyone	
		Local newspaper that is supportive
		Local radio station

Record of Community Interventions and Strategies: Action Plan

Community Name: _____ **Date of Workshop:** _____

Staff Name(s): _____

Overall Readiness Score and Stage: _____

Intervention / Strategies

1.)	Who's Responsible: Target Date for Completion: Date of Completion:
2.)	Who's Responsible: Target Date for Completion: Date of Completion:
3.)	Who's Responsible: Target Date for Completion: Date of Completion:
4.)	Who's Responsible: Target Date for Completion: Date of Completion:
5.)	Who's Responsible: Target Date for Completion: Date of Completion:

Record of Community Interventions and Strategies: Action Plan

Community Name: **Anywhere USA** Date of Workshop: **7/31/2006**

Staff Name(s):

Overall Readiness Score and Stage: **4, Preplanning**

Intervention / Strategies

1.) Educational / Presentations to Adult Groups What: Information Dissemination When: 1st parent-teacher conference for ½ hour; Health Fair Where: During Middle school and High school conferences How: Table with information on STDs, HIV, and HIV testing	Who's Responsible: Prevention Specialist, Regional Community Health Representative (CHR) (to provide the information) and PTA president (to coordinate with Healthy Communities, Healthy Youth Coalitions) Target Date for Completion: Early November Date of Completion:
2.) Increase Awareness of HIV Information and Effort What: Pow Wow When: September Where: Pow Wow grounds How: 1.) Booth with HIV testing information, condoms, general information on STDs, TB, etc. 2.) Get MC to announce booth every ½ hour 3.) Advertise on radio show 4.) Hold honor dance for healthy youth	Who's Responsible: Prevention Specialist (Regional Prevention Specialist to help if Prevention Specialist is not available), youth, elder, CHR Target Date for Completion: September Date of Completion:
3.) Information Dissemination What: General information about HIV/AIDS, TB, STDs, and Hepatitis C Where: clinics, dental offices, social services, restaurants, theaters, etc. How: Leave information, posters and thank you letters for displaying the information	Who's Responsible: Prevention Specialist (to provide information to disseminate) Target Date for Completion: November 15th Date of Completion:

4.) Community School-Based Activities to the General Community	Who's Responsible: - Prevention Specialist, Pastor, youth and elder
When: - Announcements to the local newspaper will be published 2 times prior to every pertinent event - Public Service Announcements on HIV awareness and testing will be made every week How: Announcements prior to the event shall be made by: - Local newspaper - PSA's on TV / radio - Factoids will be provided monthly	Target Date for Completion: Thanksgiving Day
	Date of Completion:

Important Points About Using the Model

Keep in mind that **dimension scores provide the essence of the community diagnostic**, which is an important tool for strategizing. If your Community Readiness Assessment scores reveal that readiness in one dimension is much lower than readiness in others, you will need to focus your efforts on improving readiness in that dimension. For instance, if the community seems to have resources to support efforts but lack committed leadership to harness those resources, strategies might include one-on-one contacts with key leaders to obtain their support.

As another example, if a community has a moderate level of existing efforts but very little community knowledge of those efforts, one strategy may be to increase public awareness of those efforts through personal contacts and carefully chosen media consistent with the readiness stage.

Remember:

"Best practices" are only best for your community if they are congruent with your stage of readiness and are culturally appropriate for your community.

Note On How To Do A Brief Assessment

Although it is preferable to do a complete assessment, sometimes there is insufficient time or resources, but it is critical to develop an understanding of where your "community" is on each dimension before making plans for efforts.

When there is a group of people representative of the community, such as a coalition, the assessment can be done in the group with discussion targeted toward building consensus for scoring for each dimension.

For such an assessment, one person should serve as facilitator. Each participant should have a copy of the anchored rating scales for each dimension.

The facilitator should start with the first dimension and read the questions under that dimension. The facilitator should then ask the group to refer to the anchored rating scale for that dimension and using their responses to the questions asked, look at the first statement and see if they feel they can confidently say that their community meets and goes beyond the first statement.

The facilitator should then lead the group through the statements until one is reached that even just one member cannot agree that the community has attained that level. **Everyone's input is important**. Don't try and talk someone out of their opinion – they may represent a different constituency than other group members. A score between the previous statement where there was consensus and the one where consensus cannot be attained should be assigned for that dimension. You may assign scores in intervals of .25 or even less to accurately reflect a score on which consensus can be attained.

Remember, it is the dimension scores which provide the community diagnostic to serve as the "roadmap" – showing you where efforts need to be expended before attempting advancement to strategies for the next stage.

How Other Communities Have Used The Model For Other Issues

The following case studies demonstrate successful applications of the Community Readiness Model since 1995. We present them first by issue, then by other applications. These examples highlight the versatility of the model in addressing a wide variety of issues in different contexts.

- Drug Abuse: Over 150 rural and ethnic communities have used the model to develop prevention strategies appropriate to their cultures and community values. For example, early in the development of the model, our team was asked to train community groups in addressing solvent abuse on Native reserves in Canada. As a result of this training, solvent action teams were developed for each of the provinces in Canada and remain an ongoing part of Canada's response to substance use.

- Alcohol Abuse: In a small community where there was extensive alcohol abuse among adults and youth, one woman utilized the model to develop community support to reduce public alcohol use and violence related to alcohol abuse. After four years of efforts by the woman and others who joined her, over one-fourth of the adults in the community had entered treatment. Further, community members voted into law a prohibition against any chronic alcohol abusers having positions of authority in the community.

- Intimate Partner Violence: One community in a southern state had significant problems with intimate partner violence, but the problems were not being addressed by law enforcement or any other agency in a constructive manner. Two women used the model to mobilize the community to actively address the issue. A direct result of their efforts was the election of a chief law enforcement official who was more supportive than the previous official of domestic violence intervention, and who created a domestic violence advocate position within the department. The local newspaper also began publishing the names of domestic violence offenders and resources available for victims and perpetrators. The community now has an annual domestic violence conference. It took this grassroots group two years to move the readiness of this community from resistance to preparation. The community is now at a stabilization stage and continues to move forward.

- Child Abuse: A national children's group used the model for development of cultural competency within the organization. They subsequently recommended

the model to their regional child advocacy centers for addressing child abuse. These regional centers then shared the model with community-level advocacy centers.

- Head Injury: A research project aimed at reducing head injuries from farming and recreational pursuits in rural Colorado communities used the model to identify readiness level and to target interventions appropriately. Over a one-year period, all participating communities saw increased awareness and overall levels of readiness.

- Environmental Trauma: A western Native American tribe experienced widespread health problems and fatalities because of radiation contamination of tribal lands from atomic-bomb testing. Seventeen-year-old girls were being diagnosed with breast cancer, many of the tribe's medicinal plants and animals had disappeared, and the community was immobilized by grief. As a result of efforts following community readiness training, community members were able to develop strategies to move forward, including sending mobile mammogram vans to high schools for early detection, distributing pamphlets of early symptoms of cancer, beginning efforts to get the groundwater cleaned, and finding other ways to replace the traditional plants and animals on the reservation. These efforts were written up in a national magazine article.

- Transportation Issues: A national transportation group utilized the model to develop plans for building highways and bridges on tribal lands. As another example, the Community Readiness team worked with transportation engineers and planning staff of a Western city to help reduce the amount of traffic on streets.

- Cultural Competency: This example describes a unique application of the model, because it was the first time that it was applied within an organization. The "community" was defined as the Executive Board, administrative staff, provider staff, and consumers of the organization, and the goal was to make the organization more culturally competent. The administration realized that cultural competency can be a very emotionally sensitive topic, and they believed that the model gave them the structure to proceed in a respectful and stage-appropriate manner. Using the model, they developed many creative and stage-appropriate strategies to improve the level of cultural competency within their organization. They highly recommend that other agencies use the model for similar projects.

- HIV/AIDS: The Tri-Ethnic Center has used the Community Readiness Model to examine attitudes about HIV/AIDS prevention in 40 communities and across four ethnicities. The project has developed a greater understanding of community perceptions and ideas for early prevention.

- Environmental and Weather Conditions: Foresters, climatologists, and environmental consultants are applying the model to a variety of environmental issues. For example, a climatologist is proposing to use the model to help communities cope with the effects of major heat waves on health, particularly among the elderly.

- Animal Control Issues: A group in Georgia was funded by the Centers for Disease Control and Prevention to use the Community Readiness Model to reduce injuries from dog bites. They are using the model to develop community support for animal control and devise strategies that are compatible with the culture of their community.

- Suicide: After hearing about the model at a conference, a Native woman came to the Center seeking help. In her village of 600 people, there had been 18 suicides in the previous six months. She requested that the team go to her community and help them to use the Community Readiness Model. The staff were expecting no more than 15-20 people from the village to attend, but were very moved when they were greeted by almost 100 Native people, young and old, from six different villages. Many people had overcome great challenges to come to the meeting.

  Initially, community members spoke of their grief and helplessness because of the pain of their losses. The model was presented, and participants divided into village groups. Each group used the model to assess their village's stage of readiness and to identify their strengths and resources. An outsider might think that these small villages had very little in the way of resources (no clinics, shelters, etc.). But the village groups recognized many resources – human resources to cultural resources. They later talked about how grateful they were to rediscover those strengths because they had forgotten them in their grief, or because they hadn't really recognized them as strengths.

  Community members offered their time, their creativity, and their knowledge of the culture. The youth formed their own group to develop strategies to offer support to friends in school. At the conclusion, each village summarized the strategies that they had developed. Finally, the entire group formed a circle and again, using the model, worked together to brainstorm an action plan to maintain inter-village communication and support.

They indicated that for the first time in a long time, the communities felt hope and empowerment. The group was so motivated that they were able to move from a lower to a higher stage of readiness in only two days.

The villages continue to work toward their goals, and their strategies have been remarkably successful. From having experienced 18 suicides in a six-month period before the training, *they did not lose a single person to suicide* in the three years following the training and the suicide rate has continued to be very low.

Ways The Community Readiness Model Can Be Used

- Program Evaluation: The evaluation of multi-component, community-wide efforts can be challenging because it is difficult to measure complex change over time. The Community Readiness Assessment offers an easy-to-use tool that can help assess the overall effectiveness of efforts. It can give insight into key outcomes (such as shifts in community norms, support of local leadership, etc.) in ways that traditional evaluation methods may not bring to light.

  Numerous programs have utilized the Community Readiness Assessment for evaluation of community-wide efforts. As an example, a project involving ten counties in Oklahoma developed a planning program to improve services to Native American children with serious emotional disturbances and their families. The Community Readiness Assessment offered not only an accurate way to measure readiness before and after program implementation, but also essential qualitative data to help guide program development. Based on information from the baseline Community Readiness Assessment, community members were able to identify strengths and resources and to gain public support. Another assessment conducted two years later showed that all counties had moved ahead in their stages of readiness. The community support for this project continues to be overwhelming.

- Funding Organizations: As stewards of funds, grant making organizations need to utilize their resources in the most efficient way possible. They recognize that good projects often fail because the efforts are more advanced than what some communities are prepared to accept. Because of this, some funding organizations have used the model to quickly assess whether or not proposed projects stand a chance of success in a given community based on the readiness of the community to address the issue. Many times, they recommend that the grantee use the model to develop the infrastructure and support that will make it possible to implement projects successfully.

Validity and Reliability
Of The
Community Readiness Model Assessment Tool

The Community Readiness Assessment tool provides an assessment of the nature and extent of knowledge and support within a community to address an issue at a given point in time. Both "the community" and "the issue" change from application to application, so applying standard techniques for establishing validity are not easily followed. In establishing validity of a measure, it is customary to find another measure that has similar intent that is well documented and accepted and see if, with the same group of people, results on the new measure agree with results on the more established measure. It is difficult to apply this methodology to the Community Readiness Assessment tool since each application is unique and the constructs or ideas that the tool is measuring have not been addressed by other measures. There are, however, still ways validity can be established.

Establishing Construct Validity. The theory of the Community Readiness Model is a "broad scale theory." A broad scale theory deals with a large number of different phenomena such as facts or opinions and a very large number of possible relationships among those phenomena. Although it is not possible to have a single test to establish construct validity for a broad scale theory, it is possible to test hypotheses that derive from the theory and, if the hypotheses prove to be accurate, then the underlying theory and the instrument used to assess the theory are likely to be valid (Oetting & Edwards, in press). This approach has been taken over the course of development of the Community Readiness Model and construct validity for the model has been demonstrated. An explication of the hypotheses tested and results are presented in the Oetting & Edwards article which is available from the Tri-Ethnic Center (www.TriEthnicCenter.ColoState.edu).

Acceptance of the Model. Although it is not a scientific demonstration of validity, the widespread acceptance and the breadth of application of the Community Readiness Model, lends credence to its validity. Literally hundreds of workshops have been conducted by Tri-Ethnic Center staff and colleagues presenting the Community Readiness Model and they have been enthusiastically received. Further, from simply reading about the model on our website or in a publication, many individuals and groups request handbooks and apply the model to their own issues in their own communities without assistance. In the first six months this handbook was available on our website, we received over 150

requests for free, downloadable copies of the handbook. These requests came from all over the United States and Canada as well as from other countries around the world. This level of adoption occurs because people see the value of the assessment in giving them information that accurately assesses their community's readiness to address a particular issue and, even more important, gives them a model that offers guidance to them in taking action.

As with measures of validity, the Community Readiness Assessment tool does not lend itself well to traditional measures of reliability. For many types of measures, the best evidence for reliability may be *test-retest reliability*. That type of methodology assumes that whatever is being measured doesn't change and, if the instrument is reliable, it will obtain very similar results from the same respondent at two points in time. Readiness levels are rarely static, although they may remain at approximately the same level for very low stages and very high stages for some time. Once an issue is recognized as a problem in a community (Stage 3, Vague Awareness or Stage 4, Preplanning), there is almost always some movement, often resulting in some efforts getting underway (Stage 6, Initiation) and likely becoming part of an ongoing program (Stage 7, Stabilization) or beyond. This movement from stage to stage can take place in a relatively short period of time depending on circumstances in the community and movement can occur at different rates on the different dimensions. For this reason, calculating a *test-retest reliability* is inappropriate.

Consistent Patterns. We have, however, taken a careful look at changes in community readiness over time, and there are consistent patterns that reflect on reliability. In one of those studies, for example, communities that were assessed as being low in readiness to deal with methamphetamine abuse were also assessed as being low in readiness over the next three years. In contrast, communities that were above Stage 4, Preplanning, were likely to change in readiness. For this pattern to occur, the measures of readiness had to be reasonably consistent over time.

An aspect of reliability that is highly important in determining how useful this model can be is *inter-rater reliability*. There are two ways of looking at this type of reliability for the Community Readiness Model—consistency among respondents and inter-rater reliability in scoring.

Consistency Among Respondents. One aspect of inter-rater reliability is the level of consistency among the respondents who are interviewed about readiness in their community. We have calculated consistency across respondents, and it is generally very high. We improve accuracy by restricting respondents to persons

who have been in the community for a year or more, which generally results in a valid interview--an interview that accurately reflects what is actually happening in the community.

At the same time, we do not expect or want to obtain exactly the same information from each respondent – that is why we select respondents with different community roles and community connections. Each respondent is expected to have a unique perspective and their responses will reflect that perspective. The information that is collected through the interviews is never "right" or "wrong" – it simply reflects the understanding of the respondent about what is going on in the community. There are, of course, occasions when respondents do not agree; when they have radically different views of what is going on in their community. If one respondent gives responses vastly different from the others in the same community, we add further interviews to determine what is actually occurring in that community. The very high level of agreement among respondents is, therefore, enhanced because of these methods that we use to assure that we are getting an accurate picture of the community.

Inter-rater Reliability in Scoring. Transcripts of interviews with community respondents are scored independently by two scorers to obtain the level of community readiness on each dimension. We have tested inter-rater reliability on over 120 interviews by checking the agreement between scores given for each interview by the two raters. The two scorers, working independently, gave the exact same score when rating dimensions on an interview 92% of the time. This is an exceptionally high level of agreement and speaks to the effectiveness of the anchored rating scales in guiding appropriate assignment of scores.

It is part of the scoring protocol that after scoring independently, scorers meet to discuss their scores on each interview and agree on a final consensus score. We interviewed the scorers following this process and for nearly all of the 8% of the time they disagreed, it was because one scorer overlooked a statement in the interview that would have indicated a higher or lower level of readiness and that person subsequently altered their original score accordingly.

The inter-rater reliability is, in a sense, also evidence for validity of the measure in that it reflects that each of the two persons reading the transcript of the same interview, were able to extract information leading them to conclude that the community was at the same level of readiness. If the assessment scales were not well grounded in the theory, we would expect to see much more individual interpretation and much less agreement.

Learning More About Capacity Building Assistance (CBA) Using The Community Readiness Model

At CASAE, we offer a variety of resources to help you learn more about the Community Readiness Model.

- Visit our Web site at www.ColoState.edu/Depts/CASAE. Select "Advancing HIV/AIDS in Native Communities" from the home page menu to learn about available training and resources, to access full-text articles about the model, to get staff contact information, to view a brief slide show about the model, and to request a free, downloadable file copy of this handbook. Select "HIV/AIDS Prevention" to learn more about the initiative to advance HIV/AIDS prevention in Native communities and how you can request CBA.

- Contact our staff by phone or e-mail. Our staff members will be more than happy to answer your questions about the model.

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- Schedule a Community Readiness Training for Your Community. In response to considerable interest, CASAE staff has developed a training workshop on using the Community Readiness Model in general, as well as CBA targeted to HIV/AIDS prevention in Native communities. Using group exercises, discussion, and audio and visual aids, our staff members will provide comprehensive training to enable you to implement the model successfully in your community. Topics include background of the model, dimensions, stages, the assessment process, scoring, and strategy development. Training generally takes 6 hours but can be tailored to fit your needs. We can arrange a session in your community or at our location in Fort Collins, Colorado. Please contact the Center for more information.

In learning about the model, you have taken an important step in your journey toward community change. We wish you every success in working toward solutions that honor the wisdom, the culture, and the resources of your community.

Bibliography

Donnermeyer, J. F., Oetting, E. R., Plested, B. A., Edwards, R. W., Jumper-Thurman, P., & Littlethunder, L. (1997). Community readiness and prevention programs. *Journal of Community Development, 28*(1), 65-83.

Edwards, R. W., Jumper-Thurman. P., Plested, B. A., Oetting, E. R., & Swanson, L. (2000). Community readiness: Research to practice. *Journal of Community Psychology, 28*(3), 291-307.

Jumper-Thurman, P. (2000). In D. Bigfoot (Ed.), *Community Readiness: A promising model for community healing*. (Native American topic specific monograph series). The University of Oklahoma Health Sciences Center, U.S. Department of Justice.

Jumper-Thurman, P., Edwards, R. W., Plested, B. A., & Oetting, E. R. (2003). Honoring the differences: Using community readiness to create culturally valid community interventions. In G. Bernal, J. Trimble, K. Burlew, & F. Leong (Eds.), *Handbook of Racial & Ethnic Minority Psychology* (pp. 591-607). Thousand Oaks, CA: Sage Publications.

Jumper-Thurman, P. & Plested, B. A. (2000). Community Readiness: A model for healing in a rural Alaskan community. *The Family Psychologist*, (Summer), 8-9.

Jumper-Thurman, P., Plested, B. A., Edwards, R. W., Foley, R., & Burnside, M. (2003). Community readiness: The journey to community healing. *Journal of Psychoactive Drugs, 35*(1), 27-31.

Jumper-Thurman, P., Plested, B. A., Edwards, R. W., Helm, H. M., & Oetting, E. R. (2001). Using the Community Readiness Model in Native communities. *Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence, CSAP 9,* 129-158.

Kelly, K., Edwards, R. W., Comello, M. L. G., Plested, B. A., Thurman, P. J., & Slater, M. D. (2003). The Community Readiness Model: A complimentary approach to social marketing. *Journal of Marketing Theory. 3*(4), 411-425.

Oetting, E. R., Donnermeyer, J. F., Plested, B. A., Edwards, R. W., Kelly, K., & Beauvais, F. (1995). Assessing community readiness for prevention. *The International Journal of the Addictions, 30*(6), 659-683.

Oetting, E. R., Jumper-Thurman, P., Plested, B., & Edwards, R. W. (2001). Community readiness and health services. *Substance Use and Misuse, 36*(6&7), 825-843.

Plested, B.A., Jumper-Thurman, P., Edwards, R. W., & Oetting, E. R. (1998). Community readiness: A tool for effective community-based prevention. *Prevention Researcher, 5*(2), 5-7.

Plested, B. A., Smitham, D. M., Jumper-Thurman, P., Oetting, E. R., & Edwards, R. W. (1999). Readiness for drug use prevention in rural minority communities. *Substance Use and Misuse, 34*(4&5), 521-544.

Slater, M. D., Edwards, R. W., Plested, B. A., Thurman, P. J., Kelly, K. J., Comello, M. L. G., & Keefe, T. J. (2005). Using Community Readiness key informant assessments in a randomized group prevention trial: Impact of a participatory community-media intervention. *Journal of Community Health, 30*(1),39-53.

Slater, M. D., Kelly, K., & Edwards, R. W. (2000). Integrating social marketing, community readiness and media advocacy in community-based prevention efforts. *Social Marketing Quarterly, 6*(3), 125-137.

Vernon, I & Jumper-Thurman, P. (2006) The changing face of HIV/AIDS among Native Populations: What's Changed and What Remains the Same? *Journal of Psychoactive Drugs*.

Vernon, I. & Jumper Thurman, P. (2002). Prevention of HIV/AIDS in Native communities: Promising interventions. *Public Health Reports, 7*(Suppl. 1), S96-S103.

Selected readings relevant to the theoretical foundation of the Community Readiness Model

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. American Psychologist, 47(9), 1102-1114.

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

Warren, R. (1978). The Community in America (3rd ed.). Chicago: Rand-McNally.

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Barbara A. Plested, Ph.D. is a Center for Applied Studies in American Ethnicity Researcher, Co-Project Director of *CASAE: Advancing HIV/AIDS Prevention in Native Communities* and directs the Community Readiness training team. An expert in community action planning, she has conducted countless workshops on the Community Readiness Model. She has been a psychotherapist for all age groups and she serves as a consultant to treatment and prevention programs nationwide. Dr. Plested has co-authored numerous articles on the Community Readiness Model, including applications of the model to prevent substance use among ethnic youth, partner violence among adults, partner violence in Native communities and inhalant use. She served on one of Roslyn Carter's Caregiving Panels and participated in the Laura Bush "Helping America's Youth" Initiative.

Pamela Jumper-Thurman, Ph.D. has her Ph.D. in Clinical Psychology and is the Project Director for the CASAE: *Advancing HIV/AIDS Prevention in Native Communities* project. She has served as Project Director for a project funded by the OJJDP on prevention of delinquency among American Indian youth and a project funded by NIDA evaluating the effectiveness of the Community Readiness Model in two states for methamphetamine prevention. She has facilitated numerous workshops for diverse populations across the country using the Community Readiness Model. Dr. Thurman served on the Adolescent Task Force and the Rural Women's Task Force (American Psychological Association) and has served on the Council for the Center for Substance Abuse Prevention and Roslyn Carter's Caregiving Panels. She also has numerous publications focused on bridging science to practice on issues such as culture, prevention and treatment of inhalant use, HIV/AIDS, and women's health and participated in the Laura Bush "Helping America's Youth" Initiative.

Ruth W. Edwards, Ph.D. is a Senior Research Scientist at the Tri-Ethnic Center at Colorado State University. Her doctorate is in Social Psychology. She has been involved in research on social problems in rural communities, including substance use, intimate partner violence and other deviant behaviors. Community level factors and how they may interact with substance use patterns in youth and community and cultural factors related to inhalant use by children. She has publications on substance use among majority and minority culture youth in rural communities as well as on development and application of the Community Readiness Model.

CASAE: Advancing HIV/AIDS
Prevention in Native Communities

Handbook For Using The Community Readiness Model

Available From:
CASAE: Advancing HIV/AIDS in Native Communities
Center for Applied Studies in American Ethnicity
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