SAMHSA Tribal Training and Technical Assistance Center

Community Readiness Manual on Suicide Prevention in Native Communities

Assessing community readiness for change and increasing community capacity for suicide prevention

Creating a climate that makes healthy community change possible

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Overview

The Tribal Training and Technical Assistance (TTA) Center is a project of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services being implemented by Tribal Tech, LLC (prime contractor) and Kauffman & Associates, Inc. (KAI) (subcontractor). Tribal Tech and KAI are both American Indian-owned, women-owned small businesses with extensive experience working on federal contracts in Indian Country. Through our SAMHSA work, the Tribal Tech/KAI Team will provide comprehensive broad, focused, and intensive training and technical assistance (TTA) to federally recognized tribes and other American Indian and Alaska Native (AI/AN) communities seeking to address and prevent mental and substance use disorders and suicide, and to promote mental health.

KAI will provide Intensive TTA to AI/AN communities to build community capacity for planning, implementing, and sustaining culturally relevant, evidence-based holistic prevention efforts. The Tribal TTA Center's Intensive TTA Team will engage 40 AI/AN communities by 2018. In January 2014, KAI worked with Pamela Jumper-Thurman and Barb Plested to revise the Community Readiness Manual (this document) and the Community Readiness Assessment questions to focus on the issue of suicide prevention. Training on the Community Readiness Model was also conducted with the Tribal TTA Center's intensive team members. In turn, the Intensive TTA Team will provide training to the participating tribal communities on the use and application of the Community Readiness Assessment tool to help build community capacity to address suicide prevention, and to develop culturally appropriate and community-specific prevention strategies based on their respective readiness scores.

Acknowledgments

Barbara Plested and Pam Jumper-Thurman prepared this Community Readiness Handbook for KAI. This project will work with American Indian and Alaska Native communities as they focus on community mobilization and planning related to SUICIDE PREVENTION. 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 eventually, a reduction in suicide 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:

Eugene Oetting	Kathleen Kelly	Zili Sloboda
Elizabeth Robertson	Fred Beauvais	Joe Donnermeyer
Michael Slater	Mary Ann Pentz	Jill Erickson

We are very grateful to the entire staff of the National Center for Community Readiness as well as the many community based organizations and tribes for supporting our work with professionalism and zeal. In particular, the following individuals have contributed to the dissemination of the model by working directly with communities, conducting trainings, and helping to develop materials.

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Robert Foley	Pamela LeMaster	Nori Comello
Martha Burnside	Gerald Rivera	Kristin Kirk
Linda Stanley	Dean Helzer	Mary Stimps

From the front lines of community advocacy and service provision, we acknowledge the many people over the years who have helped field-test the model and who have shared their insights. Among those who have contributed in this way are:

Donna Briones	Deanna Chancellor	Sandra Stroud
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		….and many more

Finally, we acknowledge those who choose to read this manual—community members and researchers who share our vision for healthier communities through positive change. You are our inspiration and our best teachers! Thank you.

Pamela Jumper-Thurman
Barbara A. Plested

"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 SUICIDE PREVENTION
- Allows communities to define issues and strategies in their own contexts.
- Builds cooperation among systems and individuals
- Increases capacity for SUICIDE PREVENTION and intervention
- Encourages community investment in SUICIDE PREVENTION and awareness
- Can be applied in any community (geographic, issue-based, organizational)
- 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 SUICIDE PREVENTION, the Community Readiness Model offers tools to measure readiness and to develop stage-appropriate strategies.

Why use the Community Readiness Model for suicide prevention?

- SUICIDE PREVENTION is a serious issue that may have barriers at various levels. The Community Readiness Model addresses this resistance.
- It conserves valuable resources (time, money) 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 SUICIDE PREVENTION 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 SUICIDE PREVENTION in your community.

Process for using the Community Readiness Model

Suicide Prevention as the Issue

- Define "Community"
- Conduct Key Respondent Interviews
- Score to Determine Readiness Level
- Develop Strategies/Conduct Workshops
- **CREATE COMMUNITY CHANGE!**

Step-by-step guide to doing an assessment

- **Step 1:** Identify your issue. In this case, the issue is to advance SUICIDE PREVENTION. This issue will not only provide us with valuable insight into the community's perspective on SUICIDE PREVENTION, but will also give us information on related issues such as the prevention of mental and substance use disorders, the promotion of mental health, and access to prevention materials.
- **Step 2:** Define your "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 SUICIDE PREVENTION, 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 community's stage of readiness for each of the six dimensions, as well as compute your overall score. Analyze the results of the assessment using both the numerical scores and the content of the interviews.
- **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.
- **Step 6:** After a period of time, evaluate the effectiveness of your efforts. It is best to conduct another assessment to see how your community has progressed.
- **Step 7:** As your community's level of readiness to address SUICIDE 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 suicide prevention

Dimensions of readiness are key factors that influence your community's preparedness to take action on SUICIDE PREVENTION. 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 SUICIDE PREVENTION?

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 SUICIDE PREVENTION?

D. **Community climate:** What is the prevailing attitude of the community toward SUICIDE PREVENTION? 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 SUICIDE PREVENTION, consequences, and understand how it impacts your community?

F. **Resources related to the issue:** To what extent are local resources (people, time, money, space) available to support the prevention 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

Stages of Readiness	Description
1. No Awareness	SUICIDE PREVENTION 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 SUICIDE 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 SUICIDE and SUICIDE PREVENTION prevalence 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 30 questions, and each interview should take 30 to 60 minutes. Before you begin, please review the following guidelines:

- Identify a minimum of eight individuals in your community who are committed to SUICIDE PREVENTION and intervention. In some cases, it may be "politically advantageous" to interview more people. However, only eight interviews are generally needed to accurately score the community. Try to find people who represent different segments of your community. Individuals may represent:
  - Health and medical professions
  - Social services
  - Mental health and treatment services
  - Schools or universities
  - Tribal, city, and county 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 and parent or guardian permission may be required)
- Read through the questions on the following pages. The questions we provide here are appropriate for a SUICIDE PREVENTION assessment, so you may need to tailor the questions further if you are addressing another related issue.
  - You will note that Dimensions A and 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 and 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 to 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 second guess what the interviewee meant.
- After you have conducted the interviews, follow the directions for scoring.

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

Community Readiness Assessment suicide prevention interview questions

Introductory script

"Hello, my name is _____, and I am a community-based coordinator (or community readiness assessment assistant) of the Tribal Training and Technical Assistance (TTA) Center. We are conducting interviews in our community to ask questions about suicide prevention. The center is federally funded by Substance Abuse and Mental Health Services Administration (SAMHSA) to address and prevent mental and substance use disorders and suicide, and to promote mental health.

I'm contacting key people and organizations in our community that represent a wide range of community-based organizations and community members. The purpose of this interview is to learn how ready our community is to address suicide prevention. Each interview will last about 30 to 60 minutes, is voluntary, and individual names will not be associated with interviews. These questions will cover six dimensions, which include: existing community efforts, community knowledge about prevention, leadership, community climate, knowledge about the problem, and resources for prevention efforts.

"Is this a good time to talk? Ok, well, let's get started." (If needed, schedule another time to talk.)

Dimension A. Existing community efforts

1. On a scale from 1 to 10, how much of a concern is suicide in our community? (With 1 being "not at all" and 10 being "a great concern"). Please explain your rating.

2. What suicide prevention programs or services are available in our community?

3. How long have these programs or services been available?

4. What suicide prevention programs or services are being planned for our community?

5. What mental health treatment efforts or services are available in our community?

6. How long have these services been available?

7. What mental health treatment efforts or services are being planned for our community?

8. Generally, do people in the community use these services? Are there plans to expand additional services or efforts? Please explain.

9. What policies related to suicide or mental health are in place in the community?

10. Can you describe efforts to involve the community, including youth and elders, in the planning of prevention programs or mental health services?

Dimension B. Community knowledge about prevention

11. Based on your knowledge, what does the community know about efforts for suicide prevention and the treatment of mental illness? Include information such as the name of programs, the services provided, how to access services, who they serve (such as youth, adults, males, females), whether they treat both mental health problems and alcoholism, etc.

12. On a scale from 1 to 10, how aware is the general community of these prevention and treatment efforts? (With 1 being “not at all” and 10 being “a great deal”). Please explain your rating.

13. What are the strengths of the available prevention programs and treatment services?

14. What are the limitations of the available prevention programs and treatment services?

Dimension C. Leadership

15. On a scale from 1 to 10, how concerned are our elected leaders with providing suicide prevention and mental health services for community members? (With 1 being "not at all" and 10 being "a great concern"). Please explain your rating.

16. On a scale from 1 to 10, how concerned are our informal or influential leaders with providing suicide prevention and mental health services for community members? (With 1 being "not at all" and 10 being "a great concern"). Please explain your rating.

17. How are these leaders (elected or informal) involved in efforts regarding suicide prevention in our community? In other words, what are they doing?

18. Would the leadership (elected or informal) support additional efforts to address suicide prevention planning in our community? Please explain.

Dimension D. Community climate

19. How would you describe our community?

20. What are the community's feelings about suicide prevention?

21. How does the community support the prevention and treatment efforts?

22. What are the primary obstacles to obtaining or adding more suicide prevention programs or mental health treatment services in our community?

Dimension E. Knowledge about the problem

23. How knowledgeable are community members about the issue of suicide? Please explain.

24. In our community, what types of information are available about suicide prevention?

25. Is local data on suicide prevention available in our community? If so, from where?

Dimension F. Resources for prevention efforts

26. Who would a person turn to first for help if he or she was thinking about suicide?

27. What are the community's feelings about getting involved in suicide prevention efforts (e.g., talking to a person thinking about suicide, volunteering time, financial donations, providing space)?

28. Please describe any prevention plans or grants to address the issue of suicide in our community.

29. Do you know if any of these prevention activities or grants are being evaluated?

30. These are all of the questions we have for you today, do you have anything else to add?

Thank you for taking the time to do this interview. Your information will be used to help our community build a prevention plan to address and prevent mental and substance use disorders, suicide, and to promote mental health. It will be based on the information from this and other interviews, and an assessment of our community strengths and needs. Your time and your commitment to our community is greatly appreciated.

Scoring Community Readiness interviews

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 26 and anchored rating scales starting on pages 28. 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 26, 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 eight 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	#7	#8	Total
Dimension A	3.5	5.0	4.25	4.75	5.5	3.75	2.75	3.00	32.50

TOTAL Dimension A: 32.50 ÷ # of interviews (8) = 4.06

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).

- Example of final scores for each dimension:

Dimension A: 4.06

Dimension B: 5.67

Dimension C: 2.54

Dimension D: 3.29

Dimension E: 6.43

Dimension F: 4.07

26.06 ÷ # of dimensions (6) = 4.34 Overall Stage of Readiness

In the example above, the average 4.34 represents the fourth stage of readiness (preplanning).

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.

- 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.
- Strategies are developed per dimension based on their individual readiness scores.

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 eight interviews.

Interviews	#1	#2	#3	#4	#5	#6	#7	#8
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	#7	#8	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 ____	=	____

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

You may assign scores in intervals of .25 to accurately reflect a score on which consensus can be attained. The hyphens ("-") under each of the levels of readiness (i.e., 1 through 9) for each dimension indicates intervals of .25 (e.g., 1.00, 1.25, 1.50, 1.75, 2.00).

Dimension A. Existing community efforts

1 No awareness of the need for efforts to address SUICIDE PREVENTION.
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2 No efforts addressing SUICIDE PREVENTION.
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3 A few individuals recognize the need to initiate some type of effort, but there is no immediate motivation to do anything.
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-
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4 Some community members have met and have begun a discussion of developing community efforts.
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-

5 Efforts (programs or activities) are being planned.
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-
-

6 Efforts (programs or activities) have been implemented.
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7 Efforts (programs or activities) have been running for at least 4 years or more.
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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.
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-
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9 Evaluation plans are routinely used to test effectiveness of many different efforts, and the results are being used to make changes and improvements.
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Dimension B. Community knowledge of the efforts

1 Community has no knowledge of the need for efforts addressing SUICIDE PREVENTION.

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2 Community has no knowledge about efforts addressing SUICIDE PREVENTION.

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-

3 A few members of the community have heard about efforts, but the extent of their knowledge is limited.

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4 Some members of the community know about local efforts.

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-

5 Members of the community have basic knowledge about local efforts (e.g., purpose).

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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.

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7 There is evidence that the community has specific knowledge of local efforts including contact persons, training of staff, clients involved, etc.

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8 There is considerable community knowledge about different community efforts, as well as the level of program effectiveness.

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9 Community has knowledge of program evaluation data on how well the different local efforts are working and their benefits and limitations.

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

1 Leadership has no recognition of the SUICIDE issue.

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2 Leadership believes that SUICIDE is not a concern in their community.

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3 Leaders recognize the need to do something regarding SUICIDE PREVENTION.

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4 Leaders are trying to get something started.

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5 Leaders are part of a committee or group that addresses SUICIDE PREVENTION.

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

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

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

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

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Dimension D. Community climate

1 The prevailing attitude is that SUICIDE is not considered, is unnoticed, or overlooked within the community, "It's just not our concern."

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2 The prevailing attitude is, "There's nothing we can do," or "Only 'those' people do that," or "Only 'those people' have that."

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3 Community climate is neutral, disinterested, or believes that SUICIDE does not affect the community as a whole.

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4 The attitude in the community is now beginning to reflect interest in SUICIDE PREVENTION, "We have to do something, but we don't know what to do."

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5 The attitude in the community is, "We are concerned about this." and community members are beginning to reflect modest support for efforts.

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6 The attitude in the community is, "This is our responsibility." and is now beginning to reflect modest involvement in efforts.

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7 The majority of the community generally supports programs, activities, or policies, "We have taken responsibility."

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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."

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9 All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.

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Dimension E. Community knowledge about the issue

1 SUICIDE is not viewed as an issue that we need to know about.

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2 No knowledge about SUICIDE.

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

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

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5 Some community members have basic knowledge of SUICIDE, including signs and symptoms. General information on SUICIDE PREVENTION is available.

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6 A majority of community members have basic knowledge of SUICIDE and SUICIDE PREVENTION, including the signs, symptoms, and behaviors. There are local data available.

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

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

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9 Community members have detailed information about SUICIDE and SUICIDE PREVENTION and related health concerns, as well as information about the effectiveness of local programs.

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Dimension F. Resources related to the issue (people, money, time, space)

1 There is no awareness of the need for resources to deal with SUICIDE PREVENTION.

2 There are no resources available for dealing with SUICIDE PREVENTION.

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 SUICIDE PREVENTION.

7 A considerable part of support of ongoing 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 and community members.
   - Visit existing and established small groups to share information with them about local SUICIDE PREVENTION 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 or 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 SUICIDE PREVENTION or intervention services.
   - Prepare and submit articles on SUICIDE PREVENTION for tribal newsletters, 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 highly likely to be seen like church bulletins, smaller newsletters, flyers in laundromats or post offices.)

3. Vague Awareness

   Goal: Raise awareness that the community can do something.

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

4. Preplanning

   Goal: Raise awareness with concrete ideas.

   - Introduce information about SUICIDE PREVENTION 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) to determine who the focused populations are and consider the degree of success of the efforts.
   - Conduct local focus groups to discuss SUICIDE PREVENTION 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 SUICIDE PREVENTION.
   - 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 related topics for professionals and paraprofessionals (bullying, suicide, date violence, alcohol and drug use).
   - 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 SUICIDE PREVENTION efforts.
   - 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 and 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 SUICIDE PREVENTION, but related to health and wellness.

8. Confirmation/Expansion

   Goal: Enhance and expand services.

   - Formalize the networking with memorandum of 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 SUICIDE PREVENTION.
   - 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.

Brainstorming an action plan

Use brainstorming to develop strategies

- Allow the team to "brainstorm" as many ideas as possible. Point out that during the next 8 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, and consider all ideas.
- Never brainstorm on one topic for more than 2 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, “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., SUICIDE PREVENTION) and the need for raising awareness, but deal with only one topic at a time.

Step Four: First, write “Strengths” on the top of a flip chart paper. Tell the participants they have 2 minutes to brainstorm ideas about strengths, then ask, “What strengths do we have in this community to prevent SUICIDE PREVENTION?” or “What strengths do we have already in place to raise awareness?” 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 sheets on the wall so that all can see it.

Step Five: After 2 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 2 minutes, then ask them to "Identify your conditions or concerns (e.g., What might stop us from reaching our goals?)" Conclude at 2 minutes and tape the sheet on the wall.

Step Six: 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 strengths, but that's okay. Remind the participants once more of the 2 minutes rule, title your flip chart paper, then ask "What are our resources or what do we have in place that we can draw from to reach our goal?" Conclude in 2 minutes and tape the sheet alongside the others. You now have several sheets of really good ideas that were developed in less than 10 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 and 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 and 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 starting on page 42) 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.
5. Schedule another meeting to review progress and to identify next steps.

For each strategy developed, identify what is to be done, who should do it (agency, person), 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 an update on tasks completed and tasks outstanding. If necessary, do more brainstorming to overcome any obstacles that might arise.

Record of community strengths, conditions or concerns, and resources

Community Name: _____ Date of Workshop: _____

Staff Name(s): _____

Overall Readiness Score and Stage: _____

Strengths	Conditions or Concerns	Resources

- EXAMPLE -

Record of community strengths, conditions or concerns, and resources

Community Name: Anywhere, USA Date of Workshop: 8/1/2014

Staff Name(s):

Overall Readiness Score and Stage: 4, Preplanning

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

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 lacks 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 for a full assessment, but it is critical to develop an understanding of where your "community" is on each dimension before making plans for efforts.

If 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.

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 4 years of efforts by the woman and others who joined her, over one quarter 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 2 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 1-year period, all participating communities saw increased awareness and overall levels of readiness.

Environmental trauma: A western American Indian 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.

Methamphetamine: The Tri-Ethnic Center has used the Community Readiness Model to examine attitudes about methamphetamine 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 6 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 to 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), but the village groups recognized many resources—from 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 2 days.

The villages continue to work toward their goals, and their strategies have been remarkably successful. From having experienced 18 suicides in a 6-month period before the training, they did not lose a single person to suicide in the 3 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) 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 2 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 Model 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 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). 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.

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 6 months this handbook was available on our website, over 150 requests were made 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 3 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.

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About The Authors

Barbara A. Plested, Ph.D., is a research scientist at The National Center for Community Readiness at Colorado State University. She is also the co-project director of Commitment to Action for 7th-Generation Awareness & Education (CA7AE): 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., is a senior research scientist. She received a doctorate in clinical psychology. She is the director of The National Center for Community Readiness at Colorado State University. She is also the project director for the CA7AE: Advancing HIV/AIDS Prevention in Native Communities project. She has served as project director for a project funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) on the prevention of delinquency among American Indian youth and a project funded by the National Institute on Drug Abuse (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, methamphetamine, 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. She received a doctorate is in social psychology. Dr. Edwards 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.