Chapter 2
Community Readiness Stages of Change to Achieve Community Transformational Resilience

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"Local people are likely to have the greatest and most sustainable impact in solving local problems and in setting local norms" (Oetting, Jumper-Thurman, Plested, & Edwards, 2001).

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Abstract The Community Readiness Model for Change describes nine stages of incremental changes for community prevention. In this chapter, we utilize this model to describe 8 years of change led by South Tucson Prevention Coalition (STPC) that transformed one community from a level of tolerance of adolescent alcohol use to a level of professionalization of prevention strategies. This model helps to identify the incremental changes over time in community alcohol norms that indicate how ready the community is to receive different prevention strategies. The Community Readiness Model for Change requires community involvement to develop prevention strategies that are rooted in community strengths. This model also requires that the community assesses their own level of readiness for change in order to develop their capacity to determine the type and level of intervention that would be most appropriate. In this chapter, we describe the model and then apply it to 8 years of work by STPC to highlight changes in community alcohol norms, changes in prevention strategies, and integration of research techniques. Utilizing community readiness interviews and retrospective interviews with coalition members, we describe the community transformations that occurred.

Keywords Community readiness • Coalition • Adolescent alcohol prevention • Community transformation

Community prevention of underage drinking is an important and necessary work, as identified by researchers (Burrow-Sanchez, 2006; Plested, Edwards, & Jumper-Thurman, 2006). Communities are not all "ready" to engage in prevention activities; the readiness of the community refers to the degree to which they are equipped and have the capacity to take action on issues of health promotion and disease prevention (Plested et al., 2006). When prevention strategies are a mismatch with the readiness of the community, they are more likely to be rejected, to fail, or to not be sustainable (Oetting et al., 1995). Community Readiness is a research-based model that describes how interventions can and should be tailored to be appropriate to make incremental changes in the current community norms for adolescent alcohol use (Thurman, Plested, Edwards, Foley, & Burnside, 2003). When prevention efforts are appropriately matched to the community level of readiness, adolescent alcohol and substance use prevention is more likely to be effective and sustainable (Kelly et al., 2003). In this chapter, we describe 8 years of work by the South Tucson Prevention Coalition (STPC) to transform their community in order to enhance community transformational resilience to prevent adolescent underage drinking.

A central component of the Community Readiness Model for Change is to help communities mobilize for change through the cyclical use of assessment as a tool to guide intervention strategies (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000). One of the strengths of this model, and one of the reasons it was chosen by the STPC, was so that the community themselves could assess their own readiness for change as a source of empowerment to improve adolescent health. This model also highlights the importance of community involvement at every level of prevention,

which is particularly key with minority communities. Walters, Canady, and Stein (1994) identify several common errors in prevention with minority youth which include: (1) lack of community participation, (2) inappropriate reading levels and jargon, (3) disregard of differences between and within cultures, (4) no consideration of specific behaviors associated with risky behavior within cultures, and (5) inappropriate use of language, symbols, and visual images of culture to portray values. STPC highlights the role of community involvement and adolescent involvement in the creation and implementation of prevention programs for their own community.

This chapter will first describe The Community Readiness Model for Change and then apply it to examine adolescent alcohol prevention strategies over a period of 8 years in one city with a high rate of poverty and predominantly Mexican and Native American families (see Chap. 1 for city description). We describe how STPC Phase 1 began with adolescent after-school prevention programming and minimal community involvement and evolved into STPC Phase 2 which was driven by coalition activities that raised awareness, integrated research to focus strategies, and ultimately resulted in transformation of community infrastructure to promote positive factors and reduce risk factors. Specifically, STPC was successful in professionalizing positive youth-led after-school programs, blocking new liquor licenses, and working with the local city government to develop neighborhood preservation strategies such as limiting alcohol availability and alcohol advertising.

2.1 Why Community-Level Change Is Necessary for Adolescent Health

The focus on community-level change is critical because it shifts the prevention focus from the individual instead to their ecodevelopmental contexts (family, school, neighborhood, policy, society), which have repeatedly found to be highly influential on health, development, and overall well-being (Bronfenbrenner, 1986; Minkler & Wallerstein, 2011). Adolescent alcohol use is shaped by multiple facets of the community, including community alcohol norms of disapproval/permissiveness, alcohol availability, alcohol regulation, alcohol advertising, knowledge of risks of alcohol use, and adult role models of alcohol use. Adolescents in low-income communities (see Chap. 1 for description of community economic context) have even less infrastructure to support the continuance of adolescent positive youth development or involvement in prevention activities. Adolescents living in low-income neighborhoods are typically exposed to more than the average amount of ecological stressors, such as noise, traffic, trash, and other hazards. Additionally, lower income neighborhoods are also more likely to have higher access to alcohol, higher rates of public drunkenness, and more availability of alcohol (Pearson, Pearce, & Kingham, 2013; Wandersman & Nation, 1998). Additional research (Castro, Boyer, & Balcazar, 2000) also cites the central role of the normative influence of parents, older family members, and community members as an important consideration of health behaviors for Mexican adolescents. Youth living in impoverished neighborhoods are more

likely to report less familial monitoring of adolescent's out of school time and alcohol norms that contribute to more adolescent alcohol use (Trucco, Colder, Wieczorek, Lengua, & Hawk, 2014). Thus, youth in low-income neighborhoods are more likely to face more risks more often and find that they have less support for continued positive health behaviors (Milam, Furr-Holden, Cooley-Strickland, Bradshaw, & Leaf, 2014). It is this combination of higher access/availability and community alcohol norms that can be destructive for adolescent health.

However, most prevention programs do not include community members or environmental change prevention strategies. In fact, most prevention programs are run by a single community-based organization (CBO), and many agencies act in isolation from each other, and it is this silo-ed effect we attempted to change with STPC (Kania & Kramer, 2011; Merves, Rodgers, Silver, Sclafane, & Bauman, 2015). Too often prevention is fragmented because time and resources are devoted to the same issue by different agencies who have the same goals, but who do not collaborate. Based on STPC's coalition work, we will demonstrate that collaboration can increase agency's potential to reach more people and use their resources more effectively and with greater impact. Furthermore, silo-ed approaches to adolescent alcohol use prevention ultimately contribute to the lack of sustainability of public health change because without a coordinated approach there is not going to be continued support for adolescent involvement in alcohol use prevention.

Thus, for these reasons we argue that community-level change is important and that by bringing multiple sectors of the community to work together on prevention strategies it is much more likely to be effective as compared to one segment of the community. On a very concrete level, bringing together diverse groups to discuss the issue provides broader societal insight into the health issue, each individual or agency has expertise within the perspective of their own group, yet they often have less experience or exposure to alternative viewpoints. Understanding resources outside of one's own agency can help bring a community together to coordinate prevention efforts. STPC created community transformational resilience, by transforming their community to create new protective factors, aligning existing resources, and reducing risk factors, such as alcohol availability and alcohol advertising. Thus, we demonstrate how we applied the Community Readiness Model for Change to understand how community infrastructure changes were achieved through coalition building strategies that linked readiness levels to prevention strategies.

2.2 Community Readiness Model for Change Stages

The Community Readiness Model for Change (Oetting et al., 2001) was originally based on theories of individual behavior change, such as, social action process (Beal, 1964) and innovation decision-making process (Rogers, 1983). Both previous theories are based on five stage process models that begin with awareness of behavior and then describe a process of change that moves through decisions to act and finally to reflections on behavior change (Beal, 1964; Prochaska, DiClemente, & Norcross,

Fig. 2.1 Community readiness model

1992; Rogers, 1983). The stage model for Community Readiness expanded the original five-stage process models for individual change to a nine-stage model for community change (Oetting et al., 2001). The stages describe progressively more receptive levels of (1) current community norms and, (2) appropriate prevention strategies given the current norms. The flow of this public health change process is recognition of the health issue as a problem and the resulting motivation to change the issue. The following are the primary stages that describe representative community norms at each level (see Fig. 2.1)

1. Community Tolerance or No Awareness: "health issue is normal and acceptable"
2. Denial: "belief the health issue does not exist or that change is impossible"
3. Vague Awareness: "recognition of health issue, but no motivation to change"
4. Preplanning: "recognition of health issue and agreement that something needs to be done"
5. Preparation: "active planning to change the health issue"
6. Initiation: "implementation of a program to change the health issue"
7. Institutionalization: "1–2 prevention programs are operating and stable"
8. Confirmation and Expansion: "recognition of limitations and attempts to improve the prevention program"
9. Professionalization: "sophistication, training, and effective valuation of the prevention programs"

Previous research has found that the psychological readiness to change is fundamental to success, because if an individual is pushed to change their behavior before they are ready or aware of need/desire to change their behavior the efforts to create change are most likely to fail (Oetting et al., 2001; Prochaska et al., 1992). This may

be due to resistance to change, denial about the need to change, or lack of sufficient skills to sustain the behavior change. Thus, the Community Readiness model applied models of individual level behavior change to a community-level public health change approach. As such, the model is based on first understanding community norms around the health issue and then working to move the needle on those norms incrementally by targeting interventions to the existing normative state (Oetting et al., 2001). This model advocates for intervention strategies to be rooted in collaborations with community decision-makers in order to assess readiness, develop strategies to act, and community-led evaluation of prevention efforts. Continuous community-led evaluation is also essential to this process of change as a tool for reflection on results, which can lead to informed modification of prevention strategies.

2.3 Prevention Strategies Linked to Readiness Stage

This model also describes the most appropriate prevention or intervention strategies at each level of community readiness in order to create effective incremental change that will naturally lead to the next stage of community readiness. The intervention strategies that are linked with the first four stages are aimed primarily at raising awareness about adolescent alcohol use as a problem. At *Stages 1 & 2 of tolerance and denial*, the intervention approaches focus more on descriptive community-based examples and rely less on statistics, or do not include statistics at all. Effective strategies include small one-to-one settings, small group discussions/focus groups, home visits, or talking circles (Oetting et al., 2001; Plested et al., 2006). Local anecdotes have been found to be much more effective at communicating with community members, who are often in a state of denial that the issue exists in their own community, this is one reason why statistics, particularly national or large-scale statistics or research are often not as effective in these stages and may even be counter-productive.

During *Stage 3, vague awareness with some recognition of the problem but no motivation to change,* strategies can grow to larger settings that include small group events, newspaper articles, or local survey data (Plested et al., 2006). Targeted one-to-one outreach to community leaders, such as government officials, school officials and parents, may be effective to raise awareness, particularly with those who may be hesitant to admit the existence of adolescent alcohol use in their community. In the early stages, the primary focus is still on increasing awareness about the issue at a local level and introducing the idea that these issues are changeable. At these early stages (1–3) the broader community may not be prepared to receive interventions to create change, because they may deny the problem exists or feel that there is no need to change. Some community members may even feel that change may not be possible because the issue is too big, too long-standing, or because they have accepted that something such as adolescent alcohol use is a normative aspect of development. Once awareness about the local problem of adolescent alcohol use is raised then the community can move to the next *Stage 4, preplanning and taking stock of existing prevention programs*. It is important to acknowledge that not all community members are likely to be at the same stage at the same time; moreover,

it is not necessary that the majority of community members reach Stage 4 in order to begin preplanning. As long as a strong cohort of community leaders and influential community members is ready then preplanning can begin (Plested et al., 2006).

At *Stage 5 and 6, preparation & initiation*, the community is ready to begin gathering and sharing community-specific information, such as local data. The focus during this stage is to develop community-specific strategies that incorporate a broader representation of the community. During the initiation stage some of the appropriate activities include prevention training for professionals and further needs assessment about existing services, effectiveness, and gaps in service (Plested et al., 2006).

Stage 7 and 8, institutionalization, confirmation and expansion, are continuation of these activities at stages 5 and 6, but at a higher level of sophistication and quality. For example, this may be represented by the collaboration with an external evaluation service to develop a comprehensive community database. It may also include formalizing relationships with local business sponsorship in order to diversify funding. These stages can then more easily lead to the institutionalization stage where one or two programs are being implemented on a regular basis. During the final stages comprehensive evaluation plays a more central role in that it should be integrated and used as a key decision-making tool (Oetting et al., 2001). While data at these stages are regularly shared publicly, it is expected that the community climate is open, but always critically questioning the meaning of data trends. The *9th final stage of professionalization* where the results of the prevention efforts have been confirmed, formalized and professionally maintained throughout larger segments of the community.

2.4 Community Readiness and Assessment

A firm understanding of the community's readiness through continual and community-led assessment can aid in building on existing cultural strengths and neighborhood resources. Oetting et al. (2001) propose *six dimensions for assessment, which include existing community efforts, community knowledge of efforts, leadership, community climate, community knowledge about issue, and resources for prevention issue*. A principal way to assess the six dimensions is through key informant interviews (Kelly et al., 2003; Plested et al., 2006). The key informant interviews are best conducted, analyzed, and interpreted by community members, themselves. If the community members are trained in using these protocols and are able to allow the interviewees to share information with minimal bias and validity. This can be a highly challenging task for community members to interview each other. The interview serves as a tool to understand the community level of readiness, and the results can be utilized for community discussion and reflection on existing strengths and resources as building blocks to advance to the next stage of community change.

The ultimate goal of assessment within a Community Readiness Model is to apply the assessment results to the intervention strategy in order to create change in the level of readiness. Thus, the community experts must hold the assessment capacity to use the prevention tools in order for them to continually implement programs and

strategies even if researchers and external funding are not present (Plested, Jumper Thurman, Edwards, & Oetting, 1998). The approach of the Community Readiness Model that encourages community-led research to incorporate research findings as a tool for reflection and improvement is an evidence-based model to establish community leadership, capacity development, and community investment for adolescent health (Plested et al., 2006).

While Community Readiness stages are extremely relevant to intervention work, they are also integral to assessment. In fact, data collection by and with local key respondents is fundamental to determining the readiness level. Knowledge of community readiness stages can help guide the development of appropriate and effective research tools. For example, community members who feel that adolescent alcohol use does not occur in their community may be less likely to participate in surveys on this topic. Community readiness level can also help guide the type of questions included in surveys or interviews so that they are more likely to match the reality of how the issue is perceived by the community at large. By acknowledging the current stage of the community health priorities and current norms on adolescent alcohol use and the associated prevention efforts, research efforts are more likely to be successful and to benefit the community.

The leadership role of community members in assessment is partially derived from the fact that many community-based programs have encountered local community members who perceive outsiders to be out of touch with local issues. Consequently, community members are more likely to be cautious and critical of research lead by outsiders; moreover, they are less likely to cooperate with research activities. The Community Readiness Model recommends that rather than relying on large-scale data, as many prevention projects do, the focus with Community Readiness is to obtain local community data that are personalized and community specific. However, lower income communities often have lower levels of education and less experience and exposure with research; moreover, they often have high levels of distrust of research and researchers. These are challenges that we discuss in the South Tucson Prevention Coalition (STPC) project and we discuss how community-led research strategies changed over time (also see Chap. 9).

2.5 Defining Community and Their Involvement

Community involvement and recognition of community assets is essential to the Community Readiness Model. Community here is defined by where residents experience society and culture, in this manner of definition it can be a professional group or a community of interest (Kelly et al., 2003). Typically cities are considered too large to be a "community"; however, in our project we focus on the entire city as the community, because it is clearly defined by geographic boundaries of 1 mile by 1 mile square. In most large cities, a location of this size might be considered a neighborhood. In many ways the City of South Tucson is a "community of place" in that the residents share a geographic location as a social context for activities (Edwards et al., 2000), and this is one reason why ecological place-based strategies are appropriate for alcohol prevention because it is a socially based health behavior. The identification of key

stakeholders for a specific health issue is one of the first steps in community readiness; it is the key stakeholders that help begin, lead, and sustain the prevention strategies (Donnermeyer, Plested, Edwards, Oetting, & Littlethunder, 1997). The city boundaries helped to limit our definition of key stakeholders. We also included stakeholders who were not only knowledgeable, but also directly affected by adolescent alcohol use, which included youth, parents, CBO leaders, police, local government, and outside agencies with a focus on adolescent prevention.

At a minimum community membership was considered to be residence in the City of South Tucson; however not all residents are eligible to participate in city-level decision-making that primarily takes place through voting for city council members (Donnermeyer et al., 1997). For example, immigrants and adolescents cannot vote; however, there are other ways in which immigrants and teens can effectively participate as active members of their community to influence decision-making. Specifically, relevant and meaningful activities include volunteering, attending council meetings, speaking publicly, and creating/signing petitions (Watts & Flanagan, 2007). Previous to STPC most youth did not actively participate in community decisions or express their views at a community government level. This means it is critical to acknowledge the traditional role of political gatekeepers and the current processes of public decision-making conducted by adults. However, in order to influence significant community change, it is also critical to include youth as equals in the coalition's collaborative work and decision-making.

Creating the community involvement that was necessary for effective prevention of adolescent alcohol use was challenging. In part, because it is not typical for community members to be included as equal members in prevention program planning, grant planning or the development of externally funded strategies. Even when individuals are included, they are often left out of budgeting discussions and decisions for funded projects. It is more likely that community members, especially adolescents, are primarily included through their participation in after-school prevention programs or formal standardized surveys. At times youth may also be asked to help recruit other youth to participate. It is especially uncommon for youth perspectives to be included in the planning or development of health promotion or health intervention programs. Including youth as equals in the planning process is not easy, and there are few guidelines that exist to support the creation of coalitions that include participation of both youth and adults (Ginwright & James, 2002). In service of the practical application of these activities, we describe some of the pitfalls and challenges as the STPC worked to develop inclusivity of youth and adults as equal partners (see Chaps. 8, 10 and 11).

2.6 Readiness Stages of South Tucson Prevention Coalition

The nine stages of readiness and six dimensions of assessment guide our summary and analysis of changes led by STPC over 8 years. The dimensions are described at each stage and then describe how intervention strategies and research strategies were approached at each stage. The six dimensions for assessment of readiness include: existing community efforts, community knowledge of efforts, leadership, community

climate, community knowledge about issues, and resources for prevention. Descriptions of how STPC Phase 1 was in the earlier stages of readiness, and how it focused primarily on youth and youth allies who were ready for in-depth training for alcohol prevention. Quotes from interviews with STPC coalition members are integrated in this chapter and further elaborated on in other chapters. Some of the interviews were conducted during 2007 while the coalition was first coming together (Sofia Blue, Library Associate, Andrea Romero, University Researcher), and some interviews were conducted in 2010–2014 as retrospective interviews (Gloria Hamelitz-Lopez, John Valenzuela Youth Center Executive Director, Michele Orduña, STPC Coordinator, Maricruz Ruiz, STPC Outreach Specialist, Josefina Ahumada, Social Worker). We discuss the transition from Phase 1 to Phase 2 where the coalition came together and how they moved the needle on community alcohol norms through community activities and community-led research. Finally, we discuss how the coalition and community worked to identify and change city-level policy with relevance for alcohol use. This chapter only provides an overview of the changes over time for STPC, the following chapters provide in-depth methods, results, and analysis. Utilizing this model we describe changes in adolescent alcohol use prevention over an 8-year span in one community that moves from Stage 1 to Stage 9 (see Table 2.1). The analysis we provide here and in later chapters is community level based; although, it is important to acknowledge that individuals or certain agencies may have been at different stages of readiness (Plested et al., 2006). There is a significant change over time in readiness level as reflected in the prevention intervention strategies and the integration of research evaluation in community decision-making.

2.6.1 *Early Stages 1–3: Tolerance, Denial, and Vague Awareness*

In the beginning, most community stakeholders could be classified as ***Stage 1 Tolerance or Stage 2 Denial or Stage 3 Vague Awareness***. Gloria Hamelitz-Lopez, who in a post-STPC interview (2010) describes not only tolerance, but normalcy of alcohol and drug use in their community before STPC: "*Drugs (were) a huge issue in our community. They are a big problem. Part of the problem is that it (was) so normal that people are not seeing it as a problem anymore. To see somebody passed out on the sidewalk because they are drunk (was) nothing. It is just the same as seeing a bird on a tree and that is really scary when something that devastating becomes so normal that people are not shocked by it anymore and it is really scary.*" Gloria brings up a good point that when alcoholism is perceived as normal, that is dangerous, because it is hard to find motivation to create change. This is a reminder of why community readiness strategies are effective, because if the community does not perceive adolescent alcohol use as a problem or risky, then they will not be motivated to engage in community change strategies. An example of tolerance is exhibited in this comment in a 2007 community readiness interview with Sofia Blue, librarian: "*It's a good effort to prevent any of those negative things that might happen, but I am also hesitant, because I also think that there is a certain amount, for*

Table 2.1 Community readiness stages linked to intervention and research

Year	Community readiness stage	Intervention activities	Goal of activity	Use of research
2001–2002	Stage 1, 2, 3: Community Tolerance Denial	Unstructured activities mainly aimed at youth in adjudication		None
2002–2003	Stage 3: Vague Awareness	Youth after-school substance use prevention program	Raise awareness among small groups of youth	Beginning of data collection with after-school program youth
2003–2004	Stage 4: Preplanning	Youth after-school substance use prevention program Community building with Youth Safe Haven leaders	Raise awareness with youth Review existing programs	Sharing national data and local data in small groups
2004–2005	Stage 5: Preparation	Planning for Coalition Development Youth Summer Leadership Conference Beginning of Youth-to-Youth (Y2Y) program	Reach out to broader group of key stakeholders in small group discussion	Sharing local data with new partners and at city level
2005–2005	Stage 6: Implementation	STPC and Y2Y regular meetings and community events	Raise awareness with community	Use of existing local data with coalition and presentations to City Council
2006–2006	Stage 6 Implementation	STPC & Y2Y regular meetings and community events organized together New external funding for community engagement	Community level engagement	Use of existing local data with coalition and presentations to City Council
2007–2007	Stage 7: Institutionalization	STPC and Y2Y regular meetings and events Community readiness training for coalition Media campaign radio PSA's led by Y2Y	Raise community awareness Community engagement	Use of existing data with coalition and presentations to City Council. Community Readiness interviews
2008–2008	Stage 7: Institutionalization	STPC and Y2Y regular meetings and events New external funding	Raise community awareness. Community engagement in events	Grant for Youth-led Participatory Action Research Alcohol Mapping
2009–2009	Stage 8: Confirmation and Expansion	STPC and Y2Y regular meetings and events Expansion of activities to neighborhood preservation	Community attempts to improve and change the physical environment. City level policy changes	Community-led research Sharing data with City Council
2010–2010	Stage 8 Confirmation and expansion	STPC and Y2Y regular meetings and events Expansion of activities to prevent new liquor licenses	Community successful efforts to limit alcohol advertising on businesses and prevention of new liquor licenses	Community led research and use of data at local and state-levels

under aged kids, of experimentation that is hard to get around. I think that they tend to be more curious and they are in that weird phase of between being teenagers or kids and adults. They are trying to feel that out, but I think that a lot of the community leaders are making efforts just to be positive about (what to do) and to offer alternatives." Sofia provides another honest example of how tolerance of adolescent experimentation with alcohol can also be a stopping point for engaging community adults in prevention strategies.

However, early focus group data [$N=20$ parents and their 20 adolescents (13–18 years) conducted at a local charter school] collected by Dr. Romero, STPC evaluator, indicated that youth and parents were at a vague awareness stage. Focus group results with youth and parents indicated that they felt substance use was a concern in the local community indicating that they are at Stage 3, Vague Awareness. However, at this time in the community, there were no existing community efforts through structured activities for youth alcohol prevention; there was also little community knowledge of efforts according to youth, parents, youth program leaders, and community-based organization leaders. There was at least one community service program for adjudicated youth, yet there was no structured curriculum. Some CBO (Community-Based Organization) youth leaders felt that initiating new programing would be overwhelming or impossible due to lack of sufficient funding and lack of existing resources for new prevention activities. In fact, the existing youth community organizations felt overextended in terms of staff time with their current programs that primarily focused on youth physical activity, such as basketball, volleyball, and dancing. Each of the CBOs including Project YES, House of Neighborly Service, and John Valenzuela Youth Center also provided tutoring, but they were constantly seeking volunteers to sustain the tutoring programs. It was clear that there were not sufficient existing resources for prevention issues at the community level.

In terms of community climate, there was some acknowledgement about the need for prevention through previously funded programs, such as Weed and Seed, which had strong police leadership, especially by the Police Chief at that time. In fact, Kimberly Sierra-Cajas indicates that the police community involvement was unique "*When I started working in South Tucson I noticed that the police department was heavily involved with the community and interacting with the Safe Havens. From my perspective this was very unusual from other communities, and the police were always sure to be present at the Safe Haven meetings, events, and even leading the effort in some community events.*" However, there were no specific structured programs targeting adolescent alcohol use. Furthermore, according to some community anecdotes, there was pushback from community members to deny issues such as adolescent risky sexual behavior associated with alcohol use because the community rejected previous HIV prevention programs. The variance in different community sectors awareness of adolescent alcohol use is indicated by Sofia Blue, as she comments: "*Well I was thinking that the fire department is at least like ten (highest level of perceiving underage drinking as a problem). But I think that most of the community members not having to face that everyday in their face, its lower (for) church leaders or people in other agencies*." This anecdote suggests that community climate was not receptive to prevention programs with youth and this shaped the next steps

for intervention strategies. Thus, it could be argued that while parents, youth, and some youth program leaders were at a stage of vague awareness, the larger segments of the community were at Stage 1 or Stage 2 in terms of tolerance or denial.

During 2001–2002, there was not coordinated structured intervention or coordinated use of research by community agencies. There was a deep-seated mistrust of university research; however, Dr. Romero was given entrée because she was introduced to CBO leaders by a local South Tucson community member who worked at the university. There was limited community involvement at this stage, when Dr. Romero began by conducting focus groups and then worked with youth and teachers to develop a prevention program. She delivered a pilot version of this program with a pretest and posttest survey that she developed with input from teachers and youth. The results of the data were then shared in small one-to-one settings with CBO leaders. These initial activities helped to begin establishing trust between the CBO leaders and Dr. Romero, because she demonstrated that she followed through with the delivery of the program for youth, she provided the incentives that she promised, and the program was popular and well received by the youth. Additionally, CBO leaders were interested in her positive and culturally based approach to research on youth; they often expressed concern that outsiders viewed South Tucson youth in a negative and stereotyped view that only focused on problems and overlooked the assets of the community. During Stage 1–3, the most effective method of changing the stage of readiness is through small group activities, and the pilot work and one-to-one meetings were factors that helped build relationships that could be built upon in the next stage.

2.6.2 Stage 4: Preplanning

Stage 4 Preplanning is when there is more awareness about the issue and some agreement that something needs to be done. The CBO leaders were now willing to admit to an outsider that there were problems; they saw firsthand how alcohol use and drugs were factors driving youth toward dropping out of school, getting pregnant, or entering the juvenile detention programs. The larger community climate and knowledge about the issue was unchanged at this stage. Thus, there was increased awareness among a small sector of youth and youth program leaders that alcohol and substances were an issue and that something should be done; however, there were still not sufficient resources.

Dr. Romero and the CBO leaders, such as Kimberly Sierra-Cajas and Gloria Hamelitz-Lopez, were willing to participate in gaining new funding to address these issues. However, in terms of community involvement, CBO leaders still saw their role as primarily opening their doors to outsiders to recruit and provide substance use prevention services. Ms. Hamelitz-Lopez put the grant writer at the City of South Tucson in touch with Dr. Romero. At this stage, youth were not involved, and the community had only minimal involvement in grant planning and budget planning. Dr. Romero began to engage in 1–1 meetings with CBO leaders and internal government grant writers about pursuing future funding. At this stage, she shared the national data of relevance to the topics of adolescent alcohol and substance use.

Dr. Romero also shared some of the local data from the focus groups and previous pre-/post-surveys that she had collected in South Tucson. The sharing of data and discussion of results became a more regular aspect of the small meetings, but it was not shared at a community level. There was only intervention in small group settings; yet, the extent of community partners was growing slowly, and the involvement of the local city government representative was a pivotal step toward future changes. All of this initial work was done before Phase 1 of STPC.

2.6.3 Stage 5: Preparation

It was in 2002 that ***Stage 5 Preparation*** began in earnest for STPC Phase 1. Preparation occurs when the community plans strategies based on information gathered and reaches out to a broader audience of stakeholders to work together and to take ownership of the preparations. This stage is indicated by the growth in resources for prevention, growth in community knowledge of the issue among some sectors, and growth in community climate, and development of youth and adult leader capacity for adolescent alcohol prevention. It was during Stage 5 that Dr. Romero and the representative from the City of South Tucson, along with Southern Arizona AIDS Foundation (SAAF), worked on submitting a federal grant. The grant was mainly written and submitted by Dr. Romero with small sections submitted by each partner and requests for budget.

Stage 5 really took off when the federal grant was approved, and prevention programming for integrated substance use/HIV prevention began in earnest. Michele Orduña (retrospective interview) reminds us of the low level of readiness in the community that had been persistent for a long time: "*(this grant) was first of its kind in the City of South Tucson for adults or youth for HIV prevention.*" This grant brought together for the first time the City of South Tucson, a local community-based health promotion agency SAAF, and the three local Youth Safe Havens (John Valenzuela Youth Center, House of Neighborly Service, and Project YES). Each of these groups received a portion of the subcontract to incentivize their participation. The three primary agencies, University of Arizona, Southern Arizona AIDS Foundation, and the City of South Tucson, received comparable funding amounts in order to nurture equitable relationships. However, the three Safe Haven partners received substantially less, and their funding was distributed by the City of South Tucson. The amount given to the Safe Havens was not a large sum, but it was enough to help leverage their participation in recruitment and planning meetings.

Now, there were more resources for prevention; there was funding to support structured community efforts to implement an after-school adolescent prevention program. However, there was still minimal community knowledge of these efforts, leadership was not very involved, and the overall community climate had not seemed to change. In fact, Chap. 4 discusses how the prevention program leaders felt community pressure to not share too much about the content of the program. However, during this time, the group began to meet regularly, including Dr. Romero, Ms. Michele

Orduña (STPC project coordinator), Luis Perales & Patty Valera (SAAF program leaders), and the City of South Tucson grant writer. Yet, the South Tucson community involvement continued to be limited, as Safe Haven Directors were primarily involved in the recruitment of youth and providing meeting space for the program. Chapter 4 provides more background on the development and implementation of STPC Phase 1, the Omeyocan YES (Youth, Empowerment, Sexuality) prevention program. This after-school 72-hour integrated substance use and HIV prevention program was implemented over a 2-year-time period and reached 125 youth in total.

At this stage youth completed quantitative surveys before and after the program was implemented, primarily as a way to evaluate the program outcomes of substance use and risky sexual behaviors. The majority of the measurements were mandated by the federal agency, and no modifications could be made to the federal set of measures. However, Dr. Romero and her research team added their own local measures; these measures were reviewed by the key leaders from the City of South Tucson and the health promoters. However, there was little to no involvement of youth or other community leaders. A thorough description of the program and the evaluation are provided in Chap. 4, but Omeyocan YES evaluator Michele Orduña summarizes: "*(the curriculum) was unique in that it gave the youth the historical context, what cultural things they carry with them, cultural assets and how that plays into mainstream society, and then it went into HIV prevention, substance use, and sexuality, in terms of this is the whole spectrum, you need all the information you can, you need to know the risk factors, or what risky behaviors are, at the end of the day it is your choice, you have to own your body, you need to own your choices. It was interesting in that the teenagers really felt validation, (it) really helped them make better sense of their world, sometimes you know where you come from, but you don't know the historical context of all of it. That really improved their self-esteem, self-worth, and resiliency.*"

However, it was during the final year of the grant that the participating groups really began to transition to a more involved level of participation that led to the next readiness stage, STPC Phase 2. Toward the end of the grant period (2005), the key stakeholders begin to meet regularly again, this time being more inclusive of the Safe Haven leaders. Michele recalls:

> *"What was happening, which is trending now, we were on the right path to begin with, was breaking down those silos, because that was the first time that those six agencies had ever worked together on such a large-scale project, where of course everyone got a piece of the pie, but you had to integrate all those six—and they all had very different missions, visions and agendas—but the fact that we were able to work well together for 3 years, and at the end of those 3 years, there was no reason why we wouldn't continue to work on something together. When we came across Drug-Free Communities grant. CoST became the grantee, the goal of the grant was to create and sustain a coalition for adolescent alcohol prevention environmental strategies. We had a diverse group to begin with, we just had to add on to our working group. We were on the stepping stone to take that next step."*

The group began to call themselves South Tucson Prevention Collaborative. Now, all partners were more involved in decision-making, especially for budget decision-making during the final year of the grant.

In fact, it was their influence that funneled money into a summer youth leadership conference for the Omeyocan YES youth graduates that was pivotal to the creation of the local Youth-to-Youth (Y2Y)-led after-school program. The Y2Y became essential to the progression through the following stages because it was youth-led/adult-guided and housed at a local Safe Haven, John Valenzuela Youth Center. Youth Omeyocan YES graduates met with the South Tucson Prevention Collaborative in order to decide on the criteria for participation in the leadership conference. In the next several chapters (Chaps. 5–7), these transitions are discussed in more detail. Youth participation in these meetings was fundamental to developing trust in the leadership capabilities of the youth and also to the future involvement of youth in the decision-making. Josefina Ahumada, STPC coalition member and Social Worker, describes the change in her retrospective interview: "*One of the most critical outcomes for this project was that youth grew to have a sense of self-worth, sense of empowerment, different perspective on themselves and the role that they could have in the community. So there was this consciousness raising about what they could do, within themselves, as well as the assets within themselves, within their culture, and within the community.*"

It was also during the final year of the grant that Dr. Romero and other key stakeholders began to present their findings to the City of South Tucson City Council. It was assumed that the city representative had been regularly sharing updates and data, but this was not the case, and in fact the city council members were at earlier stages of readiness, such as tolerance, denial, or vague awareness. They were not familiar with the Omeyocan YES program, and in the first presentation to the city council, Dr. Romero and the project coordinator, Ms. Michele Orduña, summarized the study and the findings. This presentation was met with a flurry of questions and suspicions that the participants were not actually from the City of South Tucson. As a result, the research team returned to organize and analyze the zip codes of the participants. Dr. Romero and Ms. Orduña returned to another city council meeting to share the results of the zip code analysis, which demonstrated that approximately 85 % of the participants were from South Tucson. The city council members continued to have quite a lot of questions, and it was clear that there was confusion over what the HIV prevention component of the grant meant. For example, the grant was referred to casually within the city government as the "HIV grant" which the Safe Haven leaders tried regularly to correct because they were concerned that this may lead to assumptions that the youth participants were HIV positive.

Some of the lessons learned from these presentations to the city council that were essential to moving forward is that the city leadership should have been much more integrated, and perhaps one-to-one meetings or small group meetings would have been beneficial to move to the next level of readiness for preplanning or preparation. Another lesson was that effective communication between all stakeholders is a critical component of community-based research. Additionally, it was clear that the City Council did not entirely believe the data and the description from the outsiders of the community who lacked internal city credibility. Most of these suspicions were not specific to the current project, but were derived from the city's previous experiences with researchers and bad experiences with grants, subcontracts, and partners who

were more "smoke and mirrors," or illusion of implementation, rather than actual implementation or provision of services to community members. Unfortunately, it is still too common that researchers conduct "helicopter research" where they fly in and collect data and then leave the community with few benefits from the research. However, it was an important reminder about the need for matching readiness with prevention approaches led by community members instead of outsiders. In many ways, the city council was acting in the best interests of the community, to serve as gatekeepers to ensure that their members benefited from programs. A lesson learned was the importance of including community partners and youth in the presentations about the program. City Council leaders were much more interested in hearing directly from the local youth that they knew in order to confirm their participation and their results.

2.6.4 Stage 6: Implementation

It was exactly these transitions and the lessons learned that lead to ***Stage 6 Implementation*** where the community really took the lead in developing and submitting (through the City of South Tucson) a federal grant for Drug-Free Communities. At this stage, it is clear that there was more community awareness of the lack of existing community efforts, more community knowledge about the issue of adolescent alcohol use, there is more leadership involvement by multiple sectors of the community (Safe Haven leaders, youth, and government), and there are more resources for prevention (such as financial, personnel, staff, space, and equipment.).

At this stage, the intervention was taken over by the community leaders in terms of development, active seeking of grants, receiving funding, and leading the implementation of the project. The executive directors at the local Safe Havens, Kimberly Sierra-Caja, and Gloria Hamelitz-Lopez organized and led meetings to reach consensus on the logic model and budget for the application for a Drug-Free Community grant that would be submitted by the City of South Tucson. These meetings included the City of South Tucson grant writer and Dr. Romero who both worked together to write the grant application. Each participating Safe Haven submitted a written section of the grant describing their agency and their existing activities. The coalition created a logic model that was submitted with the grant, and these community-based activities to raise awareness about adolescent alcohol use were then implemented by community members (see Fig. 2.3). The grant planning meetings were held at the police station, with regular representation from law enforcement officials. The Safe Haven leaders reached out to include all the required representative sectors for a Drug-Free Community (government, law enforcement, media, youth-serving organizations, health professionals, school, state, civic/volunteer group, parents, and youth) (see Table 2.2). Importantly, the group also changed the name of the South Tucson Prevention Collaborative to South Tucson Prevention *Coalition (STPC)* in order to be better aligned with the grant requirements. At this stage, the city was

Table 2.2 South Tucson prevention coalition: Members and organizations that represented drug-free community grant sectors

Member name	Organization	Sector represented
Gerald Porter	City of South Tucson	Local government
Mary Specio	COPE Behavioral Services	Behavioral Health professional
Sixto Molina & Sharon Hayes-Martinez	City of South Tucson Police	Law enforcement
Patty Ruiz	Clear Channel Media	Media
Gloria Hamelitz	John Valenzuela Youth Center	Youth serving organization
Kimberley Sierra-Cajas	House of Neighborly Service	Religious Organization
Andrea J. Romero	University of Arizona	Schools & State
Jan Daley & Jamie Arrieta	Southern Arizona AIDS Foundation	Healthcare Professional
Steven Kreamer	Private Consultant & STPC Coordinator	Civic and Volunteer Groups
Charles Monroe & Paul Lyons	Project YES	Youth-serving Organization
Georgianna Romero	South Tucson Explorers #327	Civic and Volunteer Groups
Mary Alfaro	Mary's Market	Business Community
Carmen Kemery	Wakefield Middle School	Schools
Sister Leonette Kochan	Santa Cruz Catholic School (k-8th)	Schools
Heidi Arranda	Ochoa Middle School	Schools
Patty Mentz	Mission View Elementary School	Schools
Neal Cash	Community Partnership of Southern Arizona	State
Veronica Madueno	Parent	Parent and Volunteer in Native American Youth Program
Stephanie Sierra	Youth and Omeyocan YES graduate	Youth
Matthew Monsisvais	Youth and Omeyocan YES graduate	Youth
Maria Mora	Parent	Parent
Dr. Antonio Estrada, director	Mexican American Studies & Research Center	School & State
Dr. Sally Stevens, director	Southwest Institute for Research on Women	School & State

centrally involved and when the grant was approved, they had several press releases to announce the grant (see Fig. 2.2). This signifies a major shift in the centrality of community involvement.

However, once again during this period of rapid growth and outreach to broader segments of the community, it was clear that community readiness mattered, and not everyone was on the same level. Since the South Tucson Prevention Coalition was still active and regularly meeting, they quickly moved into expanding the coalition to include more sectors of the community. One of the early meetings had up to

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
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ANNOUNCES $100,000 ANTI-DRUG COALITION GRANT FOR_CITY OF SOUTH TUCSON _

(Washington, D.C.) –The Office of National Drug Control Policy today announced that the City of South Tucson will receive a $_100,000_ Drug-Free Communities matching grant for the South Tucson Prevention Collaborative. The grant was one of 176 new grants totaling $17.1 million awarded today to community anti-drug coalitions across the country. The goal of the 711 local coalitions is to work together to prevent and reduce drug, alcohol, and tobacco abuse among youth. Coalitions are comprised of diverse groups of people, including community leaders, parents, youth, teachers, religious and fraternal organizations, health care and business professionals, law enforcement, and the media.

"This is great news for the anti-drug efforts of City of South Tucson and local community." said Mr. Castro, City Manger. "The Drug-Free Communities Program and other drug prevention efforts are important elements of a balanced national drug control strategy. STPC is doing crucial drug prevention work in our community and this additional influx of Federal money will help them expand their efforts and reach more of South Tucson's children."

John Walters, Director of National Drug Control Policy and President Bush's "Drug Czar," said, "As a nation, we have made significant progress in protecting our young people from the dangers of substance abuse, with a 17 percent reduction in drug use over the last three years. This grant will help the dedicated citizens of_City of South Tucson to contribute even more to this effort and will help build on the important progress being made to keep our children healthy and drug-free."

We are pleased to be working with ONDCP to administer the Drug-Free Communities Program," said Charles Curie, Administrator, Substance Abuse and Mental Health Services Administration. "Some of the most important work to reduce drug use comes from our Nation's grass-roots community coalitions. These coalitions, teamed up with our Strategic Prevention Framework Grants to the states, create a powerful force that can continue to drive down the numbers of young people using illicit drugs."

The Drug-Free Communities Program provides grants of up to $500,000 over five years to community organizations that serve as catalysts for citizen participation in local drug prevention efforts. The 176 new grantees were selected from 411 applicants through a

Fig. 2.2 City of South Tucson drug-free community press release

competitive peer review process. To qualify for matching grants, all awardees must have at least a six-month history of working together on substance abuse reduction initiatives, develop a long-term plan to reduce substance abuse, and participate in a national evaluation of the Drug-Free Communities Program.

Created under the Drug-Free Communities Act of 1997, the Drug-Free Communities Program has earned strong bipartisan support from Congress. In December of 2001, Congress passed and the President signed into law a five-year extension of the Drug-Free Communities Act, authorizing $399 million in funds through FY 2007.

In addition to the 176 new grants awarded today, another $54 million will support continuation grants to 535 existing community coalition projects operating in all 50 states, the District of Columbia, and Puerto Rico. Since 1997, eight competitions have awarded $320 million in grants to more than 1000 community anti-drug coalitions. ONDCP administers the Drug-Free Communities Program in conjunction with the Substance Abuse and Mental Health Services Administration.

More information about the Drug-Free Communities Program is available at:
www.whitehousedrugpolicy.gov, and http://drugfreecommunities.samhsa.gov/
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Fig. 2.2 (continued)

30 people, which had grown from a solid 7–10 members. At this early meeting, the goals and mission of the coalition were discussed, and it lead to some honest and open comments by youth and community leaders that was perhaps too early because many of the new members were still at earlier stages of community readiness, such as tolerance, denial, or vague awareness. There were surprised responses and some denial from adults when they heard that youth were drinking alcohol and had access to alcohol in the community, through local stores and at family parties. At this early stage dialogue, procedures and equality among members had not been established, and there was a need to develop trust among members. Chapter 11 describes the process of coalition trust and organization that ultimately led to success with community-led strategies. After some of these initial challenges, the group began to stabilize in membership and developed a specific focus on preventing underage drinking through raising awareness about alcohol norms and alcohol availability.

Michele also describes how the environmental strategies were first hard to organize around: "*When it came to figuring out environmental strategies, that took us years to figure out because the grant we had just finished was all about individual direct service, but environmental strategy was "How do you change the landscape by adding or removing something? How do you impact underage drinking on an environment strategy, not an individual strategy?" CoST was heavy in service agencies, so it was hard to wrap our heads around. There were questions like, Why*

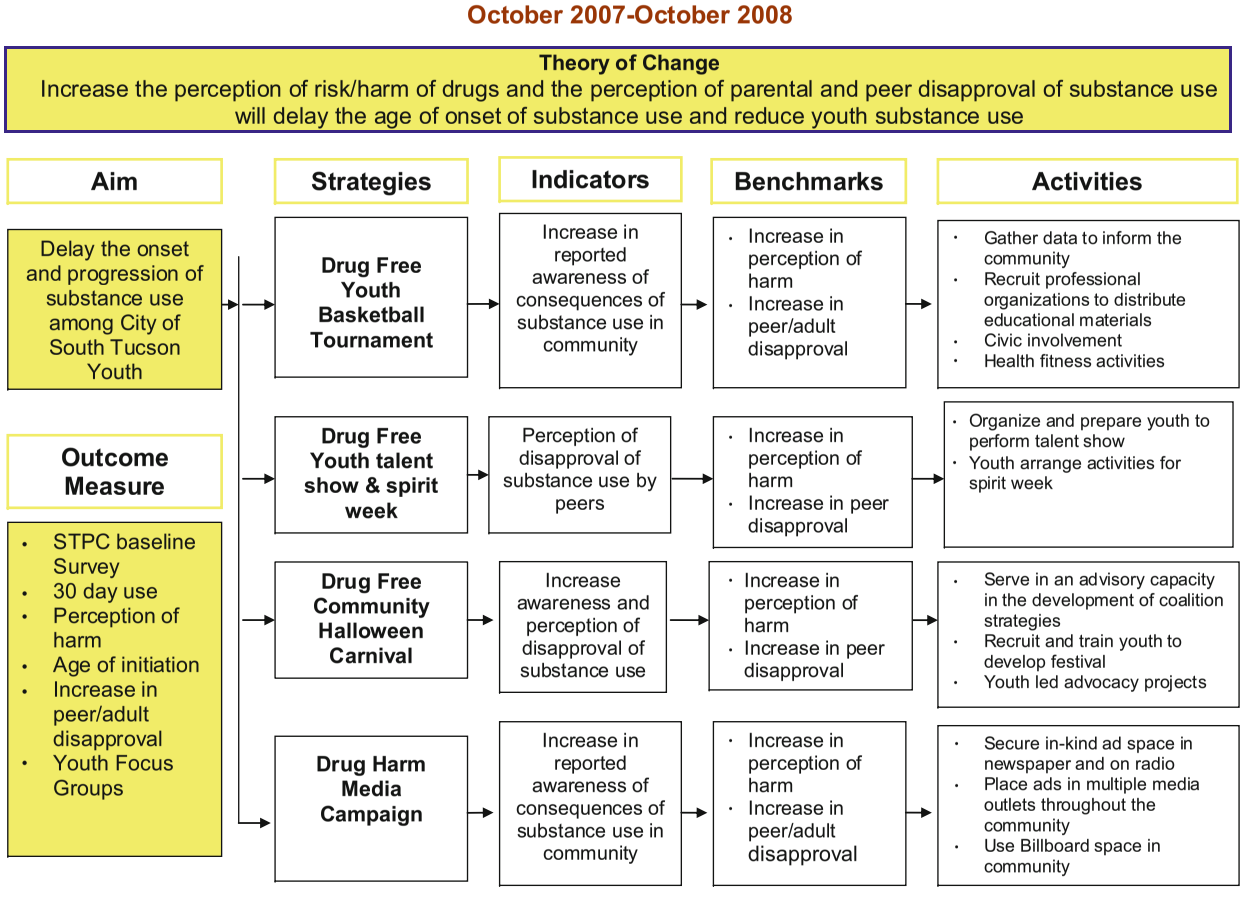

Fig. 2.3 STPC coalition logic model October 2007–2008

can't we initiate this program?" At an early meeting, there was debate about planned activities and the use of anecdotes and the relevance of research findings. The police representatives were eager to host an event where they would show an existing video about a drunk driving accident in the South Tucson community with teenagers that resulted in more than one death. They described the horrific nature of the negative outcomes of drunk driving accidents. They felt that this was something that was important for young people to be made aware of and to remember as a form of prevention. At first, personal anecdotes were favored, and the data shared by Dr. Romero was often dismissed as not relevant to the community, consistent with early stages of community readiness. Dr. Romero disagreed with the proposed video which used a classic "scare tactic" because public health research has shown that this often has a negative effect or only short-term effects on teen's behavior (O'Grady, 2006). This example also demonstrates how often agencies who focus on the same primary goal, youth alcohol prevention, can become silo-ed, separate, and take extremely different approaches to the same issue (Kania & Kramer, 2011). Yet, by working together, they are likely to both benefit from a more comprehensive view of adolescent alcohol use.

STPC agreed to host the police event; almost 30 youth attended and watched the graphic video. Afterward, the youth were shaken by the video partly because some of them knew the youth who were killed in the accident. Due to the unexpected response of the youth, the John Valenzuela Youth Center held small discussion groups afterward to help youth process the information. At the next coalition meeting, there was much reflection about the activity and how to move forward as a group; one lesson learned after this event is that despite disagreements neither the police nor Dr. Romero left the group, and both attended the event because of their dedication to the prevention of alcohol use. It is important to note that each agency has their own unique perspective about underage drinking, and specifically the police noted the serious nature of the police perspective that was focused on saving lives. Michele reminds us that *"Looking at the readiness to change mode, there are baby steps (such as), how ready are we to change (environmental strategies), denial, not recognizing problem, agreeing there is a problem, individuals and different agencies were in different paces/stages. We just took it slow for a couple of years."* Despite relatively slow progress in the first few years of the coalition, the following years between 2007 and 2010 moved rapidly through the higher levels of community readiness and with more consensus than ever before.

2.6.5 Stage 7: Institutionalization

It was during 2007 that the community moved into the ***Stage 7 Institutionalization and Stabilization***. The coalition met regularly with representation from the Safe Havens, City Government, police, food banks, churches, and schools. At this point there was greater community awareness about existing community efforts, more community knowledge about adolescent alcohol use, more resources for

prevention, more leadership and integration of leadership, and an increasingly receptive community climate. Maricruz Ruiz, STPC Outreach Specialist, comments in her retrospective interview, "*Just by existing, the coalition galvanized the community to get involved. They brought lots of light to underage drinking, like with National Night Out events. We shed light on those challenges, and the community came a long way*." Major factors that contributed to this progress through stages were some of the consistent community awareness raising events offered such as (1) National Night Out event in August, which was attended by 600 community members on average; (2) Shining Stars youth award event which was held in April with 8 awards provided to outstanding youth and attended by an average of 50 people including parents, family members, and community leaders; (3) Y2Y activities which were supported with a continual stream of new cohorts of youth who had attended the Voz after-school youth substance use prevention program offered by Southern Arizona AIDS Foundation during this time (Chaps. 6 and 7); (4) New local grants which were awarded to provide public service announcements for health promotion (see Chap. 8) and alcohol mapping (see Chap. 10); (5) STPC retreats which provided expert training in community readiness and assessment. At this time, there was also increasing acceptance and use of community collected data. The evolution toward community-led data collection is described further in Chap. 9.

2.6.6 Stage 8: Confirmation and Expansion

By 2008, STPC entered ***Stage 8 Confirmation and Expansion*** because of youth-led research. Josefina describes how useful the readiness to change model was, but also how the different segments of the community worked to push toward the next level: "*The readiness to change model helped us to take it slow. (The Youth Programs) were beneficial because when youth had access to knowledge and interpretation, they soaked it up, and then they were the ones who started noticing things and they started asking "I don't want to live in a community that does that.*" The coalition received another small local grant to fund youth-led alcohol mapping of their community. The youth worked closely with the city planners, community leaders, and university students to help them plan out and achieve a high quality research collection of community-level data that was translated into a city map by the city planners. Johnny Quevedo, Y2Y youth leader, comments in a retrospective interview "*The research was done by the youth.*" The results of the alcohol-mapping project clearly and tangibly indicated the locations of the current liquor licenses in the city in the context of locations where youth frequented, such as schools and community-based organizations with youth out of school activities. The youth presented their findings in a city town hall with many government employees in attendance; they also presented their findings at the University of Arizona and at a national conference. Josefina: *"We had to keep asking is the community ready for change. We discovered that the readiness came more from the*

youth than the adults." As a result of this highly integrated research and intervention, the community had achieved a significant shift in their understanding of community alcohol norms and alcohol availability. During Stage 8 there was a significant shift to more community-led assessment and utilization of research findings to create change in their community.

2.6.7 Stage 9: Professionalization

This lead to the next ***Stage 9 Professionalization*** and a high level of community ownership that led to the youth–community partnerships to create changes in city policy on issues of alcohol advertising and on new liquor licenses. Josefina describes how: "*The full range of community readiness existed in South Tucson, but with this campaign, that readiness got sparked and whatever pessimism that may have existed got turned around to optimism.*" This required a high level on all dimensions of community readiness and resulted in the success in policy changes. The STPC goal during the professionalization stage was to create policy that would be sustainable that would reach the greatest amount of people, youth as well as children and parents, and other adults in the community for what was truly a "community-level" intervention. Juan "Johnny" Quevedo, Y2Y youth leader, STPC coalition member, notes in a retrospective interview, "*We took things to a whole other level, now that I think about—It makes me really proud. First off, we forced the city council to deny the liquor license for Walgreens. We didn't want more alcohol, we had enough for one square mile city*" Thurman et al. (2003) argues that often political changes within community are reasons why efforts are not sustainable, in part because community members do not work with politicians to consider policy change. However, the success of the coalition building and regularly public reporting was integral to working with the local government agency. Additionally, once the STPC was able to move past the earlier stages of community readiness, which were some of the most challenging, they were able to make great strides through later stages. Their success demonstrates the utility and importance of considering community readiness stages and the need to match intervention and assessment strategies to the appropriate stage. Josefina sums it up "*We went from no awareness, and even pessimism, but with leadership of youth, they stood up and said, "Hey this affects us, and we can make a change." They led the community through this process.*"

2.7 Conclusion

In sum, this chapter demonstrates the utility and relevance of the Community Readiness Model for Change for community level change on the issue of adolescent alcohol prevention. The coalition was able to tackle ecologically based strategies to change community alcohol norms and alcohol related policies (e.g., alcohol

advertising and new liquor licenses) through integrated youth and community partnerships. The goal of this chapter was to provide an overview of community changes as demonstrated and by the Community Readiness Model for Change. The theoretical structure behind the coalition building infrastructure demonstrates how communities may begin their own process of working toward community transformation for adolescent health. The Community Readiness Model was helpful to increase consciousness among coalition members about the diversity of perception of health issues and the complex dynamics of relationships within the community (Thurman et al., 2003). Moreover, it provides structure and insight into the importance of consensus in coalition decision-making that is much more likely to lead to collective action which will result in institutionalization and professionalization, the highest stages of community readiness (Plested et al., 2006).

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