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Articles

The Community Readiness Model: Evaluating Local Smoke-Free Policy Development

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The purpose of this article is to review the literature on community readiness and assess the utility of the community readiness model (CRM) for understanding and affecting smoke-free policy development and implementation. The CRM evaluates a community's capacity for successfully developing and implementing prevention or treatment interventions. The purposes of evaluating a community's readiness are to: (a) identify the stage of readiness for policy change, and (b) determine stage-specific strategies to advance a community toward policy change.

Keywords: *community readiness; community needs assessment; smoke-free laws; public policy*

INTRODUCTION

Exposure to secondhand smoke (SHS) is the third-leading cause of preventable death, after active smoking and alcohol use (American Cancer Society, 2006). It is estimated there are over 46,000 coronary artery disease and 3,000 lung cancer deaths attributable to SHS annually (California Environmental Protection Agency, 2005; Centers for Disease Control and Prevention [CDC], 2002). Given that SHS exposure is a leading cause of preventable death in the United States, reducing exposure is an essential community and public health objective and a Healthy People 2010 objective (United States Department of Health & Human Services [USDHHS], 2000).

Policies that decrease nonsmokers' exposure to SHS have demonstrated significant positive health effects. Smoke-free policies and laws reduce nonsmokers' exposure to the toxic chemicals in SHS (CDC, 2004; Hahn et al., 2006; Heloma, Jaakkola, Kahkonen, & Reijula, 2001; Mulcahy, Evans, Hammond, Repace, & Byrne, 2005). These same policies have been shown to reduce smoking prevalence and average daily cigarette consumption, in addition to increasing serious quit attempts among smokers (Borland, Owen, & Hocking, 1991;

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Chapman et al., 1999; Evans, Farrelly, & Montgomery, 1999; Fichtenberg & Glantz, 2002; Heloma & Jaakkola, 2003; Moskowitz, Lin, & Hudes, 2000; Trotter, Wakefield, & Borland, 2002).

Enacting smoke-free laws is a major goal of the tobacco-control movement and is considered a high-impact public health intervention (Rabin & Sugarman, 2001; USDHHS, 2006). Public policy efforts to reduce the negative effects of SHS have been initiated at federal, state, and local levels. As of May 2007, 22 states had enacted statewide laws restricting smoking in workplaces, restaurants, and/or bars, with 8 of these states eliminating smoking in virtually all workplaces (Americans for Nonsmokers' Rights, 2007b). There are also more than 2,570 local ordinances across the United States and Washington, D.C., that restrict smoking to some degree in workplaces (Americans for Nonsmokers' Rights, 2007a).

Public policies that affect the environment have been shown to promote lasting change by reinforcing positive behaviors and changing social norms (Aguirre-Molina & Gorman, 1996; Butterfoss, Goodman, & Wandersman, 1996; Mittelmark, Hunt, Heath, & Schmid, 1993). A community that is educated and supportive of smoke-free policy development may encounter multiple benefits, such as decreases in adult and teenage smoking incidence and prevalence rates, in addition to decreases in SHS exposure.

Assessing a community's readiness to implement public policy to improve health outcomes is a critical initial step in policy development. A community needs to be thoroughly examined in an effort to determine its stage of readiness for implementing smoke-free policies. This may be especially true for tobacco-producing communities (Chaloupka, Hahn, & Emery, 2002; Hahn, Toumey, Rayens, & McCoy, 1999). Recognizing the influences both of economic factors and of health-related outcomes associated with tobacco may assist smoke-free advocates in planning and implementing appropriate strategies to advance clean indoor air policy at the local level.

Community can have multiple definitions: a group of people living in a general locality under one government—a neighborhood or town; a group of people having common interests, such as the scientific community or a professional organization; or a group of people who share an identity or similarity, such as a community of interest. For the purposes of policy change, a community is defined as a group of citizens who share geographic and social contexts.

The purpose of this article is to review the literature on community readiness for developing and implementing prevention and treatment interventions with implications for policy change. In addition, the utility of the community readiness model (CRM) for smoke-free policy development and implementation is examined.

METHODOLOGY

A search in MEDLINE, JSTOR (Journal STORage), CINAHL (Cumulative Index to Nursing and Allied Health Literature), ERIC (Educational Resources Information Center), ProQuest, Proceedings, Academic Search Premier, Social Sciences Citation Index, and PubMed yielded 18 articles published between 1995 and 2007 reviewing the community readiness literature. In addition, three dissertations using the model were found in Digital Dissertations or ProQuest Dissertations & Theses. Keywords used in this search included community, community readiness, readiness, readiness to change, stages of change, community needs assessment, and needs assessment.

CRM

The CRM is a guide to assessing a community's capacity for successfully developing and implementing prevention or treatment interventions (Jumper-Thurman & Plested, 2000; Oetting et al., 1995). The model was originally created to advance drug and alcohol abuse prevention programs. Since its inception in 1995 by Oetting et al., the model has been successfully used in a variety of international to local prevention and intervention programs dealing with drug and alcohol abuse (Jumper-Thurman & Plested, 2000; Plested, Jumper-Thurman, Edwards, & Oetting, 1998), and reduction of HIV/AIDS (Kennedy et al., 2004). In addition, the model has been effectively used with social programs such as intimate partner violence prevention (Brackley et al., 2003; Han, 2003), breast cancer education (Lawsin, 2005), and needle exchange programs (Duynstee, 2001).

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Theoretical Development

The CRM is based on a hierarchical approach, asserting that communities advance through a series of stages when developing, implementing, and evaluating prevention or intervention programs (Jumper-Thurman, Plested, Edwards, Helm, & Oetting, 2001). Underlying assumptions of the model are: (a) communities are at different stages of readiness for dealing with a specific problem, (b) stages of readiness can be accurately assessed, (c) communities progress through stages, and (d) stage-specific strategies can be designed to advance communities through the process of change (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000).

Development of the CRM was influenced by two separate yet related research traditions: psychological readiness for change and community development (Plested et al., 1998). Prochaska and DiClemente's psychological readiness for change, also named the transtheoretical model (TTM), is an integrated model of intentional behavior change that describes how individuals modify problem behaviors or acquire new positive behaviors (Velicer, Prochaska, Fava, Norman, & Redding, 1998). There are five stages through which an individual moves: precontemplation, contemplation, preparation, action, and maintenance. Though these stages loosely parallel those of the CRM, the TTM does not reflect the "group processes necessary for a comprehensive model of community readiness" (Engstrom, Jason, Townsend, Pokorny, & Curie, 2002, p. 33).

Community development theories by Rogers and Warren also provided the foundation for the CRM by Oetting et al (1995). Both Rogers' innovative decision-making process (2003) and Warren's social action process (1987) suggest that dynamic interactions occur that can lead to the definition and prioritization of communities' own needs (Oetting et al., 1995). Rogers' five-stage process addresses how individuals or groups adopt novel ideas and practices, and includes the stages of knowledge, persuasion, decision, implementation, and confirmation. Warren's social action approach is similar to Rogers' but is used exclusively for group change. Warren's process of change includes a group's stimulation of interest, initiation of problem definition, legitimization of the problem by leaders, decision to take action, and initiation of actions to correct the problem.

Even though the TTM, innovative decision-making process, and social action process were the foundations for the development of the CRM, they do not address the multidimensional decision-making process required for community change. Further conceptualization was required to accurately address not only a community's psychological readiness for change but also its mechanisms for local problem definition and the decision-making process for taking action (Engstrom et al., 2002).

Assessment of Community Readiness

Merging concepts from the TTM, innovative decision-making process, and social action process, while also using their own field experience, Oetting, Jumper-Thurman, Plested, and Edwards (2001) developed the CRM. The CRM evaluates six primary dimensions to determine a community's overall stage of readiness for change (Slater et al., 2005). Evaluating a community's readiness is used for two discrete yet related purposes: identification of the specific stage of readiness, followed by application of stage-specific strategies to advance a community along the stages of readiness continuum (Slater et al., 2005). Edwards et al. (2000) assert that unless a community is adequately prepared using appropriate strategies, initiation of health-related prevention efforts will likely fail.

The six dimensions of community readiness include: knowledge about the problem or issue, existing efforts to deal with the problem, knowledge of these efforts, leadership, resources, and community climate (see Table 1). Communities vary in their degree of readiness among these dimensions (Edwards et al., 2000; Jumper-Thurman et al., 2001). For example, a community that has effective leadership for enacting a strong smoke-free policy may not yet have the community climate or knowledge to produce such change.

The best way to assess the six dimensions of community readiness is through key-informant interviews. A key informant is a community member who is knowledgeable about the issue, existing programs or efforts aimed at the problem, and community leadership (Plested et al., 1998). A key informant is not necessarily a community leader or decision

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Table 1: Dimensions of Community Readiness

Community's knowledge about the problem or issue
Existing efforts to deal with the problem
Programs
Policies
Activities
Community coalitions
Community's knowledge of existing efforts
Leadership
Appointed leaders
Influential community members
Resources
People
Money
Space
Equipment/supplies
National/state/local advocacy partners
Community climate
Personality or characterization of community
Community attitudes about issue
Obstacles the community will face

SOURCE: Adapted from Jumper-Thurman et al. (2003).

maker, but rather someone who can provide detailed information about the specific community issue (Edwards et al., 2000; Jumper-Thurman et al., 2001). Depending on the problem, authors of the model suggest that six to eight key-informant interviews will provide adequate insight into a community's issue (Jumper-Thurman, Vernon, & Plested, 2007). Informants neither rate a community's readiness nor need to have familiarity with the model; they simply provide explicit information about each specific dimension. Key informants for smoke-free policy development would likely be different than those addressing the issue of HIV/AIDS prevention programs.

Semistructured interviews with key informants are conducted via telephone or in person. Interview questions are specific to the problem addressed while being consistent with the culture and language of the community (Jumper-Thurman, Plested, Edwards, Foley, & Burnside, 2003). Questions assess all six readiness dimensions and lead to the identification of the stage of readiness for change.

Dimension scores are typically determined with an anchored rating scale. Anchored rating scales are descriptive statements that best describe a community's position within each dimension. For the dimension of community leadership, for example, the lowest ranked anchor on the scale might be "leadership resistant to all change efforts," with the highest ranked anchor choice, "leaders support multiple efforts of change and/or even support extending efforts" (Plested, Smitham, Jumper-Thurman, Oetting, & Edwards, 1999).

Cumulative dimension scores are calculated and used to assign the community to one of nine stages of readiness. Edwards et al. (2000) identify the nine stages of readiness: no awareness, denial, vague awareness, preplanning, preparation, initiation, stabilization, confirmation/expansion, and professionalization (see Table 2).

Empirical Data

Development of the CRM has occurred primarily at, or in conjunction with, the Tri-Ethnic Center for Prevention Research at Colorado State University (see Table 3). The initial report by Oetting et al. (1995) detailed the CRM's development, including use of key informants and proposed dimensions and stages of community readiness. Subsequent research has included case studies and qualitative descriptions of the model's use and modifications (Donnermeyer, Plested, Edwards, Oetting, & Littlethunder, 1997; Jumper-Thurman & Plested, 2000; Oetting et al., 2001; Plested et al., 1999). Four additional review articles summarized the process of developing the CRM including lessons learned, roadblocks encountered, and successes achieved within specific communities (Edwards et al., 2000; Jumper-Thurman et al., 2003, 2007; Plested et al., 1998).

Nine studies have examined communities' readiness for prevention and intervention programs using qualitative methods or a case-study approach (see Table 3; Brackley et al., 2003; Donnermeyer et al., 1997; Duynstee, 2001; Han, 2003; Jumper-Thurman et al., 2007; Jumper-Thurman & Plested, 2000; Kennedy et al., 2004; Lawsin, 2005; Oetting et al., 2001; Plested et al., 1999). These studies determined overall readiness scores by interviewing community members. These community assessments were conducted in a variety of international locales and with various cultural and ethnic groups. Plested et al. (1999) added the sixth readiness dimension, "community climate." Minor adjustments have also been made to the model, including changing the dimension of "funding" to "resources" to increase

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Table 2: Stages of Community Readiness

Stage	*Characteristics*	*Goals*
1. No awareness	Issue is not accepted or not recognized as a problem by community members and/or leaders	Raise awareness of the issue/problem
2. Denial	Some recognition by a few members of the community that a problem exists; however, overall community belief is that it is not a local issue to be addressed	Create awareness that a problem exists within community
3. Vague awareness	Some believe there is a local problem to deal with; however, there is little to no immediate motivation to change anything	Bring awareness of problem to a level were it provides motivation to do something within community
4. Preplanning	Clear recognition by some community members and leaders that a local problem exists and action is needed	Bring awareness of concrete ideas that will help community
5. Preparation	Active planning is being done with a focus on details; leadership and coalitions are active and energetic	Gather data, plan strategies, advocate policy preference
6. Initiation	Strategies (including policies) to address problem are initiated; activities and programs are implemented; enthusiasm is present among leaders	Enact policies
7. Stabilization	Policy and/or programs are operating and stable; there is little perceived need for further change by community	Stabilize policies and tie them to existing supportive structures
8. Confirmation/ expansion	Policy and/or programs are viewed as valuable, and community decision makers support expanding or improving efforts	Expand and/or enhance programs and policies
9. Professionalization	Evaluations are obtained and disseminated	Maintain momentum, effectiveness, and evaluation

SOURCE: Edwards et al. (2000); Oetting et al. (2001).

the comprehensiveness of the dimension, and expanding and clarifying readiness stage descriptions (Donnermeyer et al., 1997; Plested et al., 1999).

Two studies used quantitative methods to assess community readiness (Feinberg, Greenberg, & Osgood, 2004; Slater et al., 2005). These studies extended previous work and examined the role of key informants in obtaining readiness data, as well as the relationships between readiness and coalition functioning and media efforts. Feinberg et al. (2004) found that readiness for implementation of prevention programs in 21 communities was strongly correlated with coalition functioning ($r = .82$; $p < .01$) and perceived coalition effectiveness ($r = .78$; $p < .01$). Slater et al. (2005) determined that communities using media interventions had an increase in their "knowledge of the issue" dimension score when compared to communities without the intervention, F (1, 13) = 5.65, $p = .03$. Media interventions were not related to community climate or community leadership dimensions.

Thorton's dissertation (2002) examined the relationships of individual and community characteristics and substance use in eight communities using a secondary analysis of data collected on over 4,000 students. Community readiness was related to drug use by junior-high females, with higher community readiness correlating with lower drug use ($r = -.857$; $p < .01$).

Beebe, Harrison, Sharma, and Hedger (2001) developed and tested a community readiness survey tool to evaluate communities' perceptions of alcohol, tobacco, or other drug problems. The purpose was to assess the psychometric properties of a proposed 89-item eight-dimension survey that was mailed to 15,000 community members. Reported Cronbach alpha coefficients

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Table 3: Empirical Support of Community Readiness Model

Reference	*Purpose*	*Sample*	*Method/Tool*	*Research Question/ Hypotheses*	*Results/Findings*
"Assessing Community Readiness for Prevention" (Oetting et al., 1995)	To review the initial development of the community readiness model by the Tri-Ethnic Center for Prevention	None reported	None reported	None reported	Development of readiness stages, dimensions and anchored rating scales
"Community Readiness and Prevention Programs" (Donnermeyer, Plested, Edwards, Oetting, & Littlethunder, 1997)	To more fully define the concept of community readiness for drug abuse prevention efforts	46 communities	Qualitative	None reported	Readiness levels clustered around the "vague awareness" and "institutional-ization" stages Recommendations given on methods to improve measurement scales
"Readiness for Drug Use Prevention in Rural Minority Communities" (Plested, Smitham, Jumper-Thurman, Oetting, & Edwards, 1999)	To assess Tri-Ethnic Center's model for drug use prevention programs	3 community groups by ethnicity (Mexican American, Native American, Anglo American) 102 communities surveyed Number of key informants not reported	Qualitative Kolmogorov-Smirnov two-sample, two-sided test reported	None reported	Anglo group had higher stages of readiness than two other groups ($p < .05$) Descriptions of readiness stages were clarified "Community climate" dimension added "Funding" dimension revised to "Resources"
"Community Readiness: A Model for Healing in a Rural Alaskan Community" (Jumper-Thurman & Plested, 2000)	To identify one community's stage of readiness and ability to advance to higher stages	One Alaskan village	Case study	None reported	Community progressed from "No awareness" stage to "Pre-Planning" stage due to employment of stage-specific strategies

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Table 3: (continued)

Reference	*Purpose*	*Sample*	*Method/Tool*	*Research Question/ Hypotheses*	*Results/Findings*
"The Community Readiness Survey: Development and Initial Validation" (Beebe, Harrison, Sharma, & Hedger, 2001)	To develop and evaluate a community readiness survey that measures population attitudes toward substance use and prevention efforts	30 communities representing five regions within one state 2 communities per region selected to represent one of three levels of readiness (low, medium, high readiness) 7,151 community member respon- dents —53% response rate	Initial 89-item survey Eight hypothesized readiness dimensions Nine stages of readiness	Validation of hypothesized readiness dimensions Scale development and item reduction Determine construct validity	Five of eight dimensions $\alpha > .6$ Factor analysis yielded a 38-item, six-component model Construct validity partially supported
"A Community's Readiness for Needle Exchange: An Analytic Case Study" (Duynstee, 2001)	To examine the utility of a six-concept model targeted at explicating the process of community readiness for needle exchange	One Northeastern U.S. city 13 in-depth interviews 200+ written documents	Case study	None reported	Identified the components and processes underlying community readiness, specified the relationships among those components, and linked them to community policy formulation relative to a needle exchange program
"Community Readiness and Health Services" (Oetting, Jumper-Thurman, Plested, & Edwards, 2001)	To assess Tri-Ethnic Center's theory for HIV, drug use, and intimate partner violence prevention	Various ethnic groups by issue Number of communities not reported Number of key informants not reported	Qualitative	None reported	Anglo group had higher stages of readiness for drug prevention African American and Anglo groups had higher stages of readiness than other groups for HIV prevention Native American group had higher stages of readiness for intimate partner violence prevention

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Table 3: (continued)

Reference	*Purpose*	*Sample*	*Method/Tool*	*Research Question/ Hypotheses*	*Results/Findings*
"Community Readiness for Prevention: Applying Stage Theory to Multi-Community Interventions" (Engstrom, Jason, Townsend, Pokorny, & Curie, 2002)	To adapt the community readiness theory to a multi-community intervention to reduce youth access to tobacco	11 communities Community is defined as "police department" Number of key informants not reported	Modified and added one dimension to Tri-Ethnic Center's six readiness dimensions	H_1—Communities rated with higher stages of readiness will execute more of tobacco sales enforcement activities than communities rated at lower stages of readiness	H_1—supported $r = .88$; $p < .1$
				H_2—Communities in higher stages of readiness will execute more tobacco possession enforcement activities than communities rated at lower stages of readiness	H_2—not supported $r = .52$; $p > .5$
"An Exploration of the Relationship of Community Readiness for Prevention and Community Characteristics With Adolescent Substance Use in Rural Areas" (Thornton, 2002)	To assess the interrelationship of individual and community level characteristics and substance use	Two rural New York counties with a total of 8 communities 4,201 youths aged 12 to 17 years	Secondary data analysis	Is grade level associated with differences in substance use between males and females?	Age positively correlates with drug use $p < .001$
				Are rural community characteristics associated with adolescent substance use?	Moderate to high associations between substance use and poverty and population density
				Are rural characteristics associated with community readiness for prevention?	Communities with the fewest resources are the least ready for prevention
				Is community readiness for prevention associated with adolescent substance use?	Community readiness had a significant negative correlation with drug use by females

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Table 3: (continued)

Reference	*Purpose*	*Sample*	*Method/Tool*	*Research Question/ Hypotheses*	*Results/Findings*
"Community Readiness to Prevent Intimate Partner Violence in Bexar County, Texas" (Brackley et al., 2003)	To describe how the Tri-Ethnic Center's theory is used for intimate partner violence prevention in one Texas county	One county Four geographically divided subgroups within county	Case study	Determine the county's stage of readiness Identify differences in readiness within the county by geographic location Develop targeted strategies Evaluate results of the project	County in overall "Pre-Planning" stage One of four subgroups found to be in a lower stage of readiness Specific strategies developed and implemented-some more successful than others
"Community Readiness: A Promising Tool for Domestic Violence Prevention Programs in the Korean Community" (Han, 2003)	To explore the Community Readiness Model for a domestic violence prevention program in one Korean community	1 community in Northern California Number of key informants not reported	Case study	Determine the community's stage of readiness	Community in either "Denial" or "Vague awareness" stage
"Readiness, Functioning, and Perceived Effectiveness in Community Prevention Coalitions: A Study of Communities that Care" (Feinberg, Greenberg, & Osgood, 2004)	To examine if community readiness, prevention knowledge, coalition functioning, and barriers are linked to perceived effectiveness of community prevention coalitions	21 communities in one state (rural and urban) 203 key-informant interviews (including community participants, state technical assistance staff and research team)	Five readiness dimensions Objective information obtained Research staff ratings Technical assistant ratings	Is community readiness related to the functioning of a coalition and its perceived effectiveness?	Community readiness and coalition functioning $r = .82$; $p < .01$ Community readiness and perceived coalition effectiveness $r = .78$; $p < .01$
"Evaluation of HIV/AIDS Prevention Resources in Liberia" (Kennedy et al., 2004)	To assess the HIV/AIDS prevention needs, services, and resources in Liberia, including the readiness of local providers to conduct prevention programs	Convenience sample of 12 key informants throughout Liberia	Qualitative Modified Tri-Ethnic Center's six readiness dimensions	None stated	Mean global score of Liberia's readiness = "Vague" awareness

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Table 3: (continued)

Reference	*Purpose*	*Sample*	*Method/Tool*	*Research Question/ Hypotheses*	*Results/Findings*
"Latinas' Participation in Breast Cancer Clinical Trials" (Lawsin, 2005)	To understand the sociocultural factors influencing Latinas' participation in breast cancer control and prevention activities	4 communities (2 rural and 2 urban) Key informant interviews Focus group interviews	Qualitative	What factors influence Latinas' participation in breast cancer prevention and control activities?	Latinas had minimal awareness of breast cancer prevention activities 3 communities were in "Vague awareness" stage and 1 community was in "Pre-planning" stage
"Using Community Readiness Key Informant Assessments in a Randomized Group Prevention Trial" (Slater et al., 2005)	To examine the role of key informants in community readiness assessments	16 communities	Nonequivalent group design	H_1—Communities receiving media training intervention will show greater increases in community readiness scores on the community knowledge dimension	H_1—supported $F(1, 13) = 5.65$, $p = .03$
	To examine the impact of media efforts on public awareness and support for prevention strategies	8 treatment/ 8 control	Pre/post-test evaluation	H_2—Communities receiving media training will show greater increases in readiness scores on the community climate dimension	H_2—marginally supported $F(1, 13) = 4.45$, $p = .06$
		Number of key informants not reported	Tri-Ethnic Center's stages and dimensions	H_3—Communities receiving media training will show greater increases in readiness scores on the leadership dimension	H_3—marginally supported $F(1, 13) = 3.52$, $p = .08$

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Table 3: (continued)

Reference	*Purpose*	*Sample*	*Method/Tool*	*Research Question/ Hypotheses*	*Results/Findings*
"Maintenance of Community Change: Enforcing Youth Access to Tobacco Laws" (Jason, Pokorny, Kunz, & Adams, 2004)	To build upon Engstrom's study and determine if community readiness to participate in tobacco enforcement activities is maintained postintervention	11 communities Community is defined as "police department" Number of key informants not reported	Determined stage of readiness for each community during 3 consecutive years followed by 3 years of data collection regarding tobacco enforcement activities Used seven readiness dimensions from Engstrom's previous study	H_1—Communities that advanced through the most stages of readiness would demonstrate higher levels of tobacco sales enforcement activities than communities that advanced through fewer stages of readiness	H_1-supported $r = .604$; $p < 0.5$
"Advancing HIV/AIDS Prevention Among American Indians Through Capacity Building and the Community Readiness Model" (Jumper-Thurman, Vernon, & Plested, 2007)	To demonstrate the importance of developing strategies consistent with readiness levels for more cost-effective and successful prevention efforts	Native American communities	Three case studies	None stated	The community readiness model is an effective tool for building capacity at various readiness levels

for the eight dimensions ranged from .11 to .85. Factor analysis revealed a 38-item, six-dimension model explaining 52.4% of the variance in community readiness. Further evaluation of the model led the authors to combine two of the six dimensions related to adolescent substance use into one—"perception of adolescent access to alcohol and tobacco."

The CRM has been used in two related studies that assessed communities' readiness to address tobacco-control initiatives and evaluate community intervention strategies, including public policies (Engstrom et al., 2002; Jason, Pokorny, Kunz, & Adams, 2004). Both studies involved the Youth Tobacco Access Project (YTAP), a randomized, multicommunity intervention designed to examine the effectiveness of sales and possession-enforcement activities to reduce youth access to tobacco. Using 11 of the 24 YTAP communities, Engstrom et al. (2002) conducted a one-time cross-sectional evaluation of communities. Jason et al. (2004) conducted additional analyses by examining these same communities 3 years postintervention.

Both studies hypothesized that as communities progress into higher stages of readiness, they would report more enforcement activities. These studies added a seventh readiness dimension, "police department climate," and used local police

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personnel as their key informants (Engstrom et al., 2002; Jason et al., 2004).

Engstrom et al. (2002) reported a strong positive correlation between communities' stages of readiness and the number of compliance checks conducted by police on retail tobacco sales ($r = .97$; $p < .01$). However, there was no significant relationship between community readiness and enforcement of tobacco possession laws. Jason et al. (2004) reported that communities at the highest stages of readiness were more likely to continue conducting sales compliance checks 3 years following the YTAP interventions compared to those at lower stages ($r = .64$; $p < .05$). Although both studies slightly modified the original readiness model, they reported it was appropriate to use and demonstrated that community readiness was related to youth tobacco law enforcement strategies (Engstrom et al., 2002; Jason et al., 2004).

The original model created by Oetting et al. was intended to assess community readiness for drug and alcohol abuse prevention and intervention programs. To date, studies have expanded the use of the model to include other health-related prevention programs, social programs, as well as policy initiatives. Few studies have directly measured a community's readiness for public policy change or evaluated a policy's effectiveness. However, the model appears to be suitable for this purpose, as health policy development is a public health intervention. When first describing development of the model, Oetting et al. (1995) suggested it was designed with the supposition that readiness would be relevant to a wide variety of community-based prevention efforts. Slater et al. (2005) noted the CRM provides a mechanism for community mobilization, a necessary means for health policy change.

THE CRM FOR LOCAL SMOKE-FREE POLICY CHANGE

Improvements in public health can result in the enactment of public policies that affect the social, legal, and economic environments in which members make health-related decisions (Aguirre-Molina & Gorman, 1996; Brownson, Haire-Joshu, & Luke, 2006). Public policy initiatives create lasting changes that influence both the prevention of substance abuse and related risks. Enactment of local policy alters community members' behaviors and re-establishes community norms (Forster et al., 1998; Goodman, Wandersman, Chinman, Imm, & Morrissey, 1996). Readiness is depicted in the model as an antecedent to a community's capacity to change. Policy advocates can use information about a community's readiness when attempting to understand the complex structures and processes that contribute to local policy decision making. This may be especially helpful in tobacco-producing states such as Kentucky, which is a national leader in burley tobacco production, while also having the highest smoking rates and lung cancer incidence and mortality rates (Hopenhayn, Jenkins, & Petrik, 2003; Kentucky Cabinet for Health and Family Services, 2005).

The purposes of a community readiness assessment are to identify a social problem and its extent within the population, devise strategies to address the problem, monitor how strategies are implemented, and evaluate success by determining if both the short- and long-term outcomes have been attained. These constructs may be appropriate when assessing a community's readiness to implement public policy to improve health outcomes (Engstrom et al., 2002; Jason et al., 2004; York, 2006). Communities need to be carefully examined for their current stage of readiness, as well as what strategies would be most effective in advancing their readiness to not only enact but also to maintain and evaluate policy change.

Strategies to Mobilize a Community for Policy Change

Though the model's six dimensions and nine stages of readiness need to be evaluated for their appropriateness to public policy change, studies are also needed to test the strategies used to advance a community's readiness for policy change. For example, leadership development may be a critical strategy for advancing community readiness for policy change. Andranovich and Lovrich (1996) suggest that developing local leadership capabilities can potentiate the local policy process. Leaders not only facilitate the process of policy development but also play a visible role in educating and influencing community members.

In addition to developing strong, effective leadership, coalition formation also promotes

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public policy change. Some type of community organization, prevention partnership, or community coalition is essential to the promotion of public policy initiatives targeted at tobacco or other drug use (Aguirre-Molina & Gorman, 1996; Blaine et al., 1997; Engstrom et al., 2002; Fawcett et al., 1997; Feinberg et al., 2004; Forster et al., 1998; Saxe et al., 1997). Coalitions that include participation by diverse sectors of the community can successfully influence policy change (Butterfoss et al., 1996). In addition, effective coalitions mobilize resources and recruit volunteers from the political, educational, social, religious, business, and health sectors of the community.

Lastly, it may take more time to implement and evaluate the outcomes of public policies than it does to develop and evaluate prevention programs. To advance communities to the later stages of readiness necessary to enact policy change, communities need to organize and coordinate efforts, mobilize resources, develop leadership, and educate elected officials and community members. Communities typically do not progress quickly or in linear fashion through the stages of readiness. Each community responds uniquely to the policy process and the possibility of change. Oetting et al. (1995) state that resistance to change may stall a community's readiness in one stage or even result in a setback, and this should be expected with public policy development.

Specific Strategies to Mobilize a Community for Smoke-Free Policy Change

There are similarities, as well as differences, in advancing a community along the stages of readiness for prevention programs, as compared to developing smoke-free policies. Both interventions are preventive and share similar long-term goals, including a decrease in both the incidence and prevalence of substance use. Additional long-term outcomes specifically related to smoke-free policies include changes in community members' attitudes and beliefs about tobacco use and SHS exposure, as well as an increase in the number of smoking cessation attempts. Fawcett et al. (1997) state that changes in a community's social norms and reductions in smoking prevalence would most likely move slowly after policy enactment. Therefore, communities might anticipate that the stabilization through professionalization stages of readiness may require longitudinal summative evaluation.

In an effort to maintain momentum and measure short-term success, communities can identify initial or intermediate policy outcomes (Pentz, 2000). Ongoing formative evaluation of smoke-free policy development could include measurement of media advocacy, on-going community prevention and education campaigns, the number and comprehensiveness of workplace and school tobacco-free policies, and actual ratification and enactment of local policy.

In addition to sharing goals, smoke-free policies and prevention programs share the involvement of the public health community in combating health-related problems. Whether initiating HIV/AIDS prevention campaigns, drug use treatment interventions, or smoke-free policies, public health officials are critical participants in the process of change (Poland, Boutilier, Tobin, & Badgley, 2000). Health departments can provide community education, assist with media campaigns and public service announcements, participate in forums, and conduct community-wide meetings.

There are strategies that are unique to mobilizing a community to support smoke-free policies. First, policy advocates must anticipate and plan for opposition, including preemption. Preemption removes communities' rights to enact their own laws on a particular issue. The subject of preemption poses a "significant barrier" for local-level tobacco policy implementation (Jacobson & Wasserman, 1999). Smoke-free advocates need to promote local control of smoke-free laws and work to prevent or repeal statewide preemption.

Secondly, Stillman et al. (1999) emphasize that smoke-free advocates often ignore the influence that pro-tobacco efforts have on fighting smoke-free policies. Tobacco companies, hospitality coalitions, restaurant associations, gambling organizations, licensed beverage associations, and smokers' rights groups often campaign actively against smoke-free laws (Dearlove, Bialous & Glantz, 2002; Mandel & Glantz, 2004; Tsoukalas & Glantz, 2003). These groups deliberately promote state preemption laws, indoor ventilation alternatives, and claim that business owners will lose money if comprehensive smoke-free policies are enacted (Americans for

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Table 4: Proposed Dimensions of Community Readiness for Smoke-free Policy Change

Dimension	*Characteristics*
Community's knowledge about the negative health effects of tobacco and SHS	Community awareness of the effects of tobacco use and SHS exposure (medical, financial)
Existing policy efforts	Voluntary smoke-free restaurants and bars Voluntary smoke-free workplaces Youth access ordinances Local enforcement, compliance, and regulation records Comprehensiveness of school tobacco policies
Community's knowledge of existing policy efforts	Visibility of voluntary smoke-free establishment policies
Smoke-free leadership	National and state partners such as the American Lung Association, American Heart Association, American Cancer Society Opinion shapers in community that support smoke-free—hospitals, physicians, dentists, health department, religious leaders, business and labor leaders Major political players—both elected officials and nonelected leaders who support smoke-free policy
Resources for supporting smoke-free efforts	Community coalitions Health department/hospital support Community groups–community foundations, youth-oriented community groups Media
Community climate	Strength of pro and anti-smoke-free sentiment Media's portrayal of existing policy efforts Smoking incidence and prevalence rates Progressive versus conservative environment
Political climate	Preemption Election year Political champions Issue framing Priority of other local policy issues Accessibility to politicians Turf disputes

SOURCE: Adapted by York from Jumper-Thurman et al. (2003).

Nonsmokers' Rights, 2005). Anticipation of opposition efforts, in addition to countering their misinformation with policy makers, media, and coalition members, is an important early strategy in evidence-based smoke-free policy development (Drope & Glantz, 2003; Magzamen & Glantz, 2001).

Another community climate-promotion strategy is to anticipate and prepare for the tactics used by tobacco growers and manufacturers, as well as business owners who rely on tobacco and alcohol sales (Smith, Altman, & Strunk, 2000). These groups will likely claim an economic hardship if smoke-free laws are enacted. Policy advocates need to foresee these challenges and counter with studies describing not only the negative health outcomes and associated costs related to smoking and SHS exposure, but also the growing body of policy outcome studies showing the health and economic benefits of smoke-free laws (Fichtenberg & Glantz, 2002; Hahn et al., 2006; Heloma & Jaakkola, 2003; Pyles, Mullineaux, Okoli, & Hahn, 2007).

Smoke-free advocates should anticipate the need to spend a significant amount of time in the early stages of readiness. According to Donnermeyer et al. (1997), the first four stages "are largely awareness-creating in nature" (p. 80). Policy supporters should not advocate for a vote on any smoke-free law until they have educated and obtained the support of both the public and the elected officials (Americans for Nonsmokers' Rights, 2006).

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FUTURE RESEARCH

The CRM has been used successfully in assessing a community's capacity to implement prevention and treatment programs. Although there is little empirical evidence supporting the use of the model for advancement of public policy, it may be both relevant and appropriate to explore for this very reason. Jason et al. (2004) claim the model could guide the assessment of political climate variations that communities confront over time.

Construct validity of the CRM when used for policy change needs to be examined. Beebe et al. (2001) state in their review of the model that the qualitative methods used to develop and evaluate items on readiness survey tools, as well as proposed readiness dimensions, may not be sufficient. How do the dimensions of community readiness correlate with one another? In relation to policy development, do certain dimensions play a more critical role than others in predicting community readiness? Do the six original readiness dimensions accurately and comprehensively reflect those required for policy change? For instance, does the dimension of "community climate" include a community's size, demographics, political idealism, and social norms? If not, are additional dimensions needed or is there another more appropriate conceptual framework for promoting policy change? Might a seventh readiness dimension, "political climate," be helpful in understanding readiness for policy change? Political climate could be defined as the influence of the political process on policy making and would include both politicians and politics. Themes within this dimension would include the possibility of preemption, effects of elections, political champions, issue framing, other policy issues having precedence, accessibility to elected officials, and turf disputes among elected officials (see Table 4).

Future research also needs to determine what outcomes occur if policy enactment is unsuccessful at the local level. How does the CRM assist policy advocates in reframing the issue, determining the reasons for failure, and planning and implementing new strategies? According to Oetting et al. (1995), communities often vacillate between stages before prevention programs are initiated; does this hold true for local-level policy change too, and, if so, how might the model guide policy advocacy?

Lastly, the model needs to be tested to determine if assessment of community readiness for policy change and stage-specific strategies can produce such long-term public health outcomes as decreases in smoking incidence and prevalence, as well as decreases in smoking and SHS-related mortality and morbidity rates. The definitive success of using the CRM for local smoke-free policy change will be the achievement of both broad and meaningful outcomes.

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