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Tapping the Power of Community

Building Assets to Strengthen Substance Abuse Prevention

PREVENTION PROGRAMS HAVE BECOME almost ubiquitous in U.S. communities. For example, the average U.S. public school now offers 14 prevention activities, with 90% of schools providing students with information on tobacco, alcohol, other drugs, violence, accidents, health, or risky sexual behavior. The most widespread program, Drug Abuse Resistance Education (DARE), operates in 48% of the elementary schools in the United States.[1]

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Furthermore, it is difficult for program-based interventions to effectively address the multiple influences in community on young people's alcohol, tobacco, and other drug (ATOD) use. A growing body of research points to the need to *build the capacity of communities* to support young people's healthy development as an integral part of society's ATOD prevention efforts.

Search Institute's extensive research and applied learning on developmental assets and asset-building communities offers a promising approach to community building that has significant potential to complement, strengthen, and expand substance use prevention efforts through community-building strategies that unleash public commitment, passion, and capacity.

This article examines the relationship between developmental assets and substance use. Then it highlights the realities, challenges, and emerging directions of current ATOD prevention efforts, which lead to the opportunity to blend existing prevention efforts with community-building approaches suggested by developmental assets.

Developmental Assets and Substance Abuse

Search Institute's framework of developmental assets identifies 40 scientifically based experiences, relationships, opportunities, skills, and character traits that form a foundation for healthy development (Display 1).[2]

Grounded in the scientific literature on prevention, resilience, youth development, and protective factors, the framework is conceptually aligned with a number of recent syntheses of research on adolescent development, including those of the National Research Council and Institute of Medicine,[3] Child Trends,[4] the working group on positive youth development within the Society for Research on Adolescence,[5] and the American Academy of Political and Social

DISPLAY 1

Search Institute's Framework of Developmental Assets (Ages 12 to 18)

This publication presents research on developmental assets, which are positive factors in young people, families, communities, schools, and other settings that have been found to be important in promoting young people's healthy development. Further details on developmental assets are available at www.search-institute.org/assets.

External Assets

SUPPORT

1. **Family support**—Family life provides high levels of love and support.
2. **Positive family communication**—Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents.
3. **Other adult relationships**—Young person receives support from three or more nonparent adults.
4. **Caring neighborhood**—Young person experiences caring neighbors.
5. **Caring school climate**—School provides a caring, encouraging environment.
6. **Parent involvement in schooling**—Parent(s) are actively involved in helping young person succeed in school.

EMPOWERMENT

7. **Community values youth**—Young person perceives that adults in the community value youth.
8. **Youth as resources**—Young people are given useful roles in the community.
9. **Service to others**—Young person serves in the community one hour or more per week.
10. **Safety**—Young person feels safe at home, at school, and in the neighborhood.

BOUNDARIES AND EXPECTATIONS

11. **Family boundaries**—Family has clear rules and consequences and monitors the young person's whereabouts.
12. **School boundaries**—School provides clear rules and consequences.
13. **Neighborhood boundaries**—Neighbors take responsibility for monitoring young people's behavior.
14. **Adult role models**—Parent(s) and other adults model positive, responsible behavior.
15. **Positive peer influence**—Young person's best friends model responsible behavior.
16. **High expectations**—Both parent(s) and teachers encourage the young person to do well.

CONSTRUCTIVE USE OF TIME

17. **Creative activities**—Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
18. **Youth programs**—Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.
19. **Religious community**—Young person spends one or more hours per week in activities in a religious institution.
20. **Time at home**—Young person is out with friends "with nothing special to do" two or fewer nights per week.

Internal Assets

COMMITMENT TO LEARNING

21. **Achievement motivation**—Young person is motivated to do well in school.
22. **School engagement**—Young person is actively engaged in learning.
23. **Homework**—Young person reports doing at least one hour of homework every school day.
24. **Bonding to school**—Young person cares about her or his school.
25. **Reading for pleasure**—Young person reads for pleasure three or more hours per week.

POSITIVE VALUES

26. **Caring**—Young person places high value on helping other people.
27. **Equality and social justice**—Young person places high value on promoting equality and reducing hunger and poverty.
28. **Integrity**—Young person acts on convictions and stands up for her or his beliefs.
29. **Honesty**—Young person "tells the truth even when it is not easy."
30. **Responsibility**—Young person accepts and takes personal responsibility.
31. **Restraint**—Young person believes it is important not to be sexually active or to use alcohol or other drugs.

SOCIAL COMPETENCIES

32. **Planning and decision making**—Young person knows how to plan ahead and make choices.
33. **Interpersonal competence**—Young person has empathy, sensitivity, and friendship skills.
34. **Cultural competence**—Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. **Resistance skills**—Young person can resist negative peer pressure and dangerous situations.
36. **Peaceful conflict resolution**—Young person seeks to resolve conflict nonviolently.

POSITIVE IDENTITY

37. **Personal power**—Young person feels he or she has control over "things that happen to me."
38. **Self-esteem**—Young person reports having a high self-esteem.
39. **Sense of purpose**—Young person reports that "my life has a purpose."
40. **Positive view of personal future**—Young person is optimistic about her or his personal future.

Science.[6] It is also consistent with and complements the framework of risk and protective factors that is widely used in substance use, violence, delinquency, and other public health research, funding, and implementation.

Extensive research over the past decade has confirmed the power of developmental assets in young people's lives. New analyses of a large, diverse dataset of 217,277 young people in grades 6 through 12 across the United States,[7] as well as a longitudinal study of 370 students in St. Louis Park, Minnesota,[8] add new insight and rigor to the assertion that developmental assets play a powerful role in preventing ATOD onset and use across a wide diversity of young people. Seven key findings are embedded in the following statement: *When they accumulate in young people's lives, developmental assets are powerfully related to lower levels (and delayed onset) of multiple forms of ATOD use and other outcomes, regardless of young people's socioeconomic, family, or racial/ethnic background.*

1. The more assets youth experience, the less likely they are to engage in ATOD use— The developmental assets framework provides a unique tool for understanding the additive power of simultaneously addressing multiple domains and influences in young people's lives. This cumulative or pileup effect is similar to a phenomenon in the research on the co-occurrence or covariance of risk factors wherein young people who are at risk in one area have an increased risk in other areas.[9]

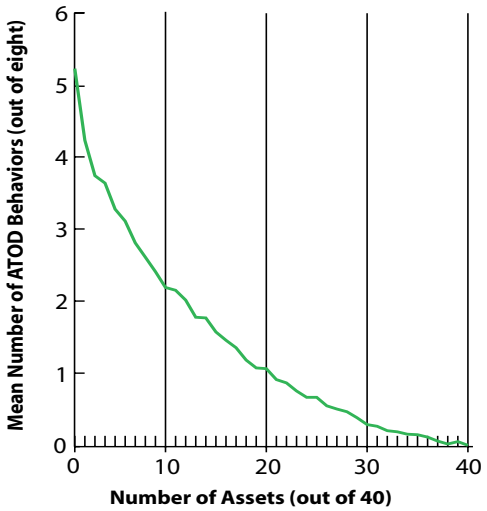
As shown in Figure 1, the more developmental assets young people have, the less likely they are to engage in any form of ATOD use. For example, those young people who experience 6 or fewer of the 40 developmental assets report, on average, engaging in three or more forms of ATOD use (out of eight measured). In contrast, those who experience more than 20 assets engage, on average, in fewer than one of these 8 forms of ATOD use. Thus, the cumulative power of the assets increases the odds that young people will avoid substance use.

It is also important to note that this relationship is not linear. That is, the decrease in ATOD use is much greater when comparing those young people with different but still very low levels of assets than when comparing those with different but relatively high levels of assets. Hence, an increase in two or three assets has a more graphic influence on reducing substance use among low-asset youth (those with 10 or fewer assets) than among high-asset youth (those with 31 or more assets).

FIGURE 1

Number of ATOD Behaviors by Number of Developmental Assets

The more assets young people (grades 6–12) experience, the fewer types of substance abuse they engage in out of the eight forms of ATOD use.*



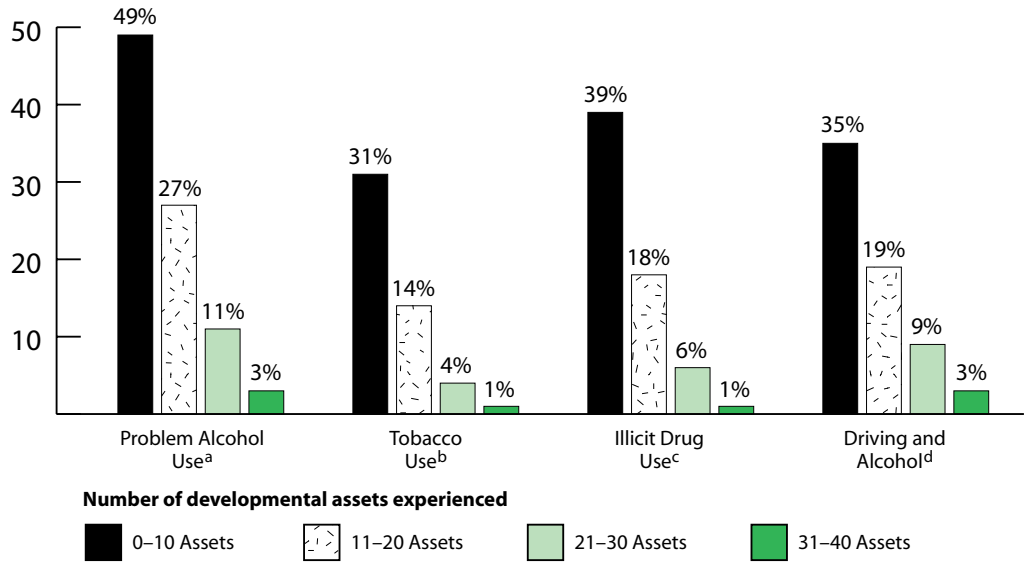
* The eight types of ATOD use are alcohol use; binge drinking; drinking and driving; cigarette use; smokeless tobacco use; marijuana; inhalants; and other illicit drugs.
SOURCE: Search Institute's 1999–2000 aggregate dataset of 217,277 6th- to 12th-grade youth.

At the same time, adding developmental assets reduces reported ATOD use *along the entire continuum* of developmental assets. Figure 2 divides young people into four groups based on the number of developmental assets they report (0–10, 11–20, 21–30, and 31–40). Although the largest decreases in absolute percentages occur when comparing 0–10 assets with 11–20 assets, each move up from one asset quartile to the next brings substantial and meaningful change.

This relationship between asset levels and ATOD use holds true not only in cross-sectional samples but also in longitudinal studies. In the longitudinal study of 370 students in St. Louis Park, Minnesota, for example, students reporting an increase in assets between middle school and

FIGURE 2

Percentage Reporting High-Risk ATOD Use by Asset Level



[a] Has used alcohol 3 or more times in the last 30 days or got drunk once or more in the last 2 weeks.

[b] Smokes 1 or more cigarettes every day or used chewing tobacco frequently.

[c] Used illicit drugs (cocaine, LSD, PCP or angel dust, heroin, marijuana, and amphetamines) 3 or more times in the past 12 months.

[d] Has driven after drinking or ridden with a drinking driver 3 or more times in the past 12 months.

SOURCE: Search Institute's 1999–2000 aggregate dataset of 217,277 6th- to 12th-grade youth.

high school showed a significant decrease in ATOD use, whereas those students reporting a decrease in assets showed a significant increase in ATOD use.

2. Developmental assets play a role in reducing all types of ATOD use—The correlation between higher levels of developmental assets and lower ATOD use applies to many types of ATOD use. Table 1 shows the increased level of risk for different kinds of ATOD use, based on levels of developmental assets. In every case, those young people with very low asset levels (0–10) are from 2.4 to 4.4 times more likely to engage in overall ATOD use than those who have 21 or more developmental assets.

3. Developmental assets "work" across diverse samples of young people—Table 1 also shows that the relationship between assets and ATOD use is reflected across a wide diversity of young people. In other words, having higher levels of developmental assets increases the odds of preventing substance use among young people from different racial/ethnic backgrounds, both genders, low and higher socioeconomic status, grade in school, and type of community. These patterns have also been found in all regions of the United States, in several Canadian communities, and in all types of cities, including rural counties, suburban towns, and urban centers.

4. Having more developmental assets delays ATOD onset—The vast majority of people who develop serious ATOD use problems begin using substances during adolescence, usually starting with alcohol and/or tobacco, "gateway drugs" that increase the likelihood of using illicit drugs.[10] It is also clear that the earlier people initiate drug use, the greater their risk for later abuse.[11] Thus, delaying onset of any ATOD use in early adolescence is a critical prevention strategy that consistently surfaces in the scientific literature.

Increasing developmental assets appears to play an important role in delaying onset of ATOD use. The longitudinal sample of 370 students in St. Louis Park, Minnesota, shows that young people who abstain from ATOD into high school have significantly more developmental assets than those who initiate use. We compared those 6th to 8th graders who reported no ATOD use in 1997 (abstainers) with those who had started

using (about 1 out of 4 in the sample). Those who continued to abstain in high school were significantly higher on their overall level of assets in both 1997 and 2001 than those who began using.

The difference was particularly evident in the asset categories of support and boundaries and expectations. In other words, those young people who consistently experienced more of these two categories of external assets in middle school were less likely than those who did not experience these assets to initiate some kind of ATOD use.

In addition, the group of youth who continued to abstain reported significantly higher levels of assets in most categories as well as higher educational achievement and higher overall thriving. These findings suggest that higher levels of assets protect young people from the onset of ATOD use during high school.

5. Developmental assets make more difference in ATOD use than demographic factors—The findings on the power of developmental assets in delaying ATOD onset and reducing ATOD use take on more significance when we see that low levels of developmental

TABLE 1

Risk of Engaging in ATOD Use by Levels of Developmental Assets Reported for Diverse Groups of Young People

This table shows the risk ratios for whether young people with different demographic characteristics will engage in four high-risk ATOD behavior patterns. These numbers show the increased risk for engaging in each ATOD use pattern when comparing those youth with 21 or more assets to those with 10 or fewer assets within each population shown. For example, African American youth with 0 to 10 developmental assets are 5.1 times more likely to engage in problem alcohol use than African American youth with 21 to 40 assets. *This chart does not show the percentages of youth in each population who engage in each pattern of ATOD use. Rather, it shows their increased risk of engagement based on their level of developmental assets.*

	Increased Risk of High-Risk ATOD Behavior Patterns When Comparing Youth With 0–10 Assets to Those With 21–40 Assets				
	Overall ATOD Use[a]	Specific ATOD Use Patterns			
		Problem Alcohol Use[b]	Driving and Alcohol[c]	Illicit Drug Use[d]	Tobacco Use[e]
All	**3.3**	5.5	4.8	9.4	9.6
Race/Ethnicity					
African American	**2.8**	5.1	3.3	6.1	7.3
American Indian	**2.6**	4.2	3.6	6.7	5.9
Asian American	**3.6**	6.2	6.5	15.2	12.4
Latino/Latina	**2.4**	3.6	3.3	7.4	7.9
White	**3.4**	5.8	5.2	10.0	9.8
Multiracial	**3.0**	4.7	3.8	7.1	7.8
Gender					
Female	**3.6**	6.0	5.0	10.7	10.9
Male	**3.0**	4.9	4.7	8.3	8.2
Socioeconomic Status (SES)					
Low SES[f]	**2.5**	4.2	3.4	6.0	5.4
Not-Low SES	**3.3**	5.5	4.8	9.4	9.4
Grade in School					
6–8	**4.4**	9.9	4.6	19.3	9.3
9–12	**2.5**	4.1	4.4	6.2	17.4
Type of Community					
Rural	**3.3**	5.6	4.7	10.8	8.8
Suburban	**3.3**	5.6	5.1	9.2	10.1
Urban	**3.3**	4.9	4.8	7.9	9.9

[a] Overall ATOD Use is the sum of the four high-risk behavior patterns (b–e below).
[b] Has used alcohol 3 or more times in the last 30 days or got drunk once or more in the last 2 weeks.
[c] Has driven after drinking or ridden with a drinking driver 3 or more times in the past 12 months.
[d] Used illicit drugs (cocaine, LSD, PCP or angel dust, heroin, marijuana, and amphetamines) 3 or more times in the past 12 months.
[e] Smokes 1 or more cigarettes every day or uses chewing tobacco frequently.
[f] Low SES was defined as single-parent household and low maternal education (< high school degree).

SOURCE: Search Institute's 1999–2000 aggregate dataset of 217,277 6th- to 12th-grade youth.

assets are a better predictor of ATOD use than the demographic factors that the public and policy makers typically view as placing young people at risk: living in poverty and/or being from a single-parent family.[12]

As shown in Table 2, young people with a low socioeconomic status[13] are, as would be expected,[14] 1.3 to 1.4 times more likely to engage in overall ATOD use than those young people with higher socioeconomic status. By comparison, young people with few assets (0–10) are at least three times as likely to engage in ATOD use compared to those with 21–40 assets. The difference is even greater for several of the individual types of substance use.

6. Developmental assets also play a role in other positive youth outcomes—It is important to note, too, that the relationship between assets and healthy outcomes for young people extends beyond ATOD use. Search Institute research shows similar relationships between a wide range of high-risk behaviors (including problems in school, violence, antisocial behavior, gambling, eating disorders, and depression).

Furthermore, young people with more assets are consistently more likely to be successful in school, be leaders, value diversity, resist danger, maintain good health, and other indicators of thriving. In each of these areas, the more assets young people have, the better. This consistent pattern points to the value of broad, asset-building approaches that contribute to a wide range of positive outcomes for young people.

7. Some categories of assets play a particularly important role in ATOD prevention—Virtually all categories of assets are associated with reduced ATOD use among adolescents. However, the category of assets that is consistently most strongly related to lower levels of ATOD use is boundaries and expectations, which focuses on the limits, expectations, and role modeling from family, peers, school, neighborhood, and other settings.[15]

The number of assets also matters within the category, suggesting the importance of consistency in boundaries and expectations across socializing systems, including family, peers, school, and neighborhood. For example, 59% of young people who report experiencing none of the six boundaries-and-expectations assets engage in problem alcohol use. Only 4% of those who experience all six of these assets engage in problem alcohol use, however. In comparison an average of 23% of youth engage in problem alcohol use in the total sample. Similar patterns hold true for other forms of ATOD use.

TABLE 2

Comparing the Magnitude of Association Between Demographic Risk Factors and Asset Depletion in ATOD Use

	Overall ATOD Use[e]	Problem Alcohol Use	Driving and Alcohol	Illicit Drug Use	Tobacco Use
Living with a single parent[a]	1.3	1.3	1.4	1.7	1.6
Low maternal education[b]	1.3	1.4	1.6	1.6	1.7
Low socioeconomic status[c]	1.4	1.5	1.8	2.0	2.0
Low asset level[d]	3.3	5.5	4.8	9.4	9.6

[a] Young person reports living alone with mom or dad or living only part-time with mom or dad.
[b] Young person reports that mother has only some high school education.
[c] Young person reports both (a) living in a single-parent family and (b) low maternal education.
[d] Comparison between youth with 0–10 assets and youth with 21–40 developmental assets.
[e] Overall ATOD use: alcohol use, cigarette use, smokeless tobacco use, driving while drinking, marijuana use, inhalant use, binge drinking, and other illicit drug use.

SOURCE: Search Institute's 1999–2000 aggregate dataset of 217,277 6th- to 12th-grade youth.

Comparing Assets and Protective Factors

Because of recurrent questions about the relationship between developmental assets and protective factors, it is important to address the similarities and distinctions.[16] As research in resilience has evolved, the term "protective factors" has taken on a number of different definitions. Along with others,[17] we define protective factors as only operating under conditions of risk. This conceptualization is akin to an air bag: Air bags are defined by what they do when a crash occurs. Assets are seen more generally as promoting positive development *regardless of the risk context*. That is, developmental assets are important for high-, mid-, *and* low-risk youth.

Furthermore, assets denote factors that are useful not only for preventing risk behaviors but also for promoting thriving. Hence, assets represent a broader area of development than protective factors.

Given the conceptual and practical overlaps between these terms, a growing number of program implementers and evaluators have woven them together based on local priorities and funding needs in ways that work for their specific efforts in their communities.

The State of Current Prevention Efforts

Throughout the 1990s, Search Institute's work on developmental assets and asset-building communities emphasized positive youth development and community engagement much more than it did prevention or risk reduction (though both themes were consistently addressed in Search Institute's presentations of developmental assets). That emphasis largely emerged as a counterbalance to the often-exclusive focus on risk reduction and problem prevention that dominated youth policy and practice in the last two decades of the 20th century.

Since that time, however, positive youth development, other strength-based approaches, and community-building themes have gained increasing acceptance, scientific rigor, and credibility. Thus, it is important to weave together these complementary approaches, recognizing the creative (and healthy) tensions between building assets and reducing risks, between formal and informal strategies, and between proven practices and innovations that open the door for improved practices in the future. To understand the value of this integration, it is first important to highlight key strengths and challenges in the field of prevention.

Effective prevention programs—Most ATOD prevention programs are designed to develop skills, competencies, and related factors that are known either to delay the onset of ATOD use or reduce use. As these programmatic efforts have become more sophisticated during the past 20 years, evidence is emerging that these science-based programs—when delivered well and comprehensively—can reduce ATOD use both in the short term and, under some conditions, with lasting benefits to society.[18]

A growing national emphasis has been on documenting, disseminating, and implementing a variety of "science-based practices"[19] and "scientifically defensible principles"[20] that have been documented to have an impact. For example, a recent special issue of *American Psychologist* on prevention for children and adolescents identified the following nine principles of effective prevention programs:

- *Comprehensive,* using multiple strategies to address critical domains in young people's lives (family, peers, community);
- *Varied teaching methods* that both raise awareness and build skills;
- *Sufficient dosage* to produce and maintain the desired effects;
- *Theory driven,* based on accurate information and research;
- *Positive relationships* with both adults and peers;
- *Appropriately timed* in light of developmental needs and to be early enough to have a preventive impact;
- *Socioculturally relevant* by being tailored to community and cultural norms;
- *Outcome evaluation* that documents results relative to stated goals and objectives; and
- *Well-trained staff* who are appropriately trained in program implementation.[21]

Addressing multiple influences—Underlying principles such as these is a growing body of research that points to the importance of comprehensive, multifaceted interventions that address broad environmental issues, rather than only programs that focus on the individual level through building social skills and/or shaping young people's beliefs and attitudes. In addition, these studies of effective programs note that school-based strategies account for only some of the variation in program effectiveness, suggesting that other factors beyond the school clearly influence program effectiveness.[22]

Put another way, school- and program-based prevention approaches can only directly impact a few of the factors that are known to influence young people's use of alcohol, tobacco, and other drugs. A major federal publication, for example, recommends that comprehensive substance abuse prevention efforts address six domains of

influence: individual, family, peer group, school, community, and society.[23] Within each of these domains, multiple dynamics and strategies play a role, including parental involvement in school-based programs; parenting skills; family bonding; peer norms; neighborhood engagement; community-wide social norms; community awareness; engagement in service to others; and consistent media messages.

The complexity—and importance—of addressing multiple influences is generally seen as a key reason that, despite this broad implementation, DARE, by itself, has not been effective in preventing substance use. However, recent efforts to combine the traditional DARE curriculum with other strategies that engage parents and community have shown promise.[24]

Because of the vital role that multiple influences play in ATOD prevention, the need for *community-level interventions* that "combine individual and environmental change strategies to prevent dysfunction and promote well-being"[25] has emerged.

A six-year longitudinal study of Project STAR (Students Taught Awareness and Resistance, also known as the Midwest Prevention Project) concluded that prevalence rates for cigarette and marijuana use significantly decreased among participating adolescents. This project combines school-based skill-building programs with parent education, mass media, and both school and community policy changes.[26]

Project Northland combined school-based programs with parental involvement, peer leadership, and community-wide task forces to change peer norms to support prosocial behaviors and thwart substance use.[27] Of 24 school districts and communities in this experimental/control group design, intervention communities showed reduced alcohol, tobacco, and marijuana use by 8th-grade students.[28]

These two projects stand as illustrative exemplars of community-based interventions within the ATOD prevention field. They are well designed, guided by trained experts, and expensive. In addition to school-based programs, each influences several community dynamics known to inform ATOD use.

Building community collaborations—A key feature of ATOD prevention efforts that emerged in the 1990s was an emphasis on building effective cross-sector collaborations or identifying and reducing community-level risk factors (availability of ATOD, norms regarding ATOD use, poverty, neighborhood disorganization, and family dysfunction).[29] These approaches typically involve efforts to coordinate policy, enforcement, and public education about the dangers of drug use.

For example, Communities That Care (CTC) is a widely used planning process for building community collaborations targeted at reducing risk behaviors and increasing protective factors.[30] Rooted in the science of risk and protective factors, CTC helps communities plan, implement, and evaluate prevention programs related to youth development and the reduction of problems such as substance abuse, delinquency, teen pregnancy, school dropout, and violence.[31]

Persistent Challenges in ATOD Prevention

Although an increasing number of effective programs are available for use in schools and other settings, there is a growing awareness of the gap between effectively *designed and studied* programs and effectively *implemented* programs.[32] For example, a study of 104 schools in 12 states found that many are adopting research-based curricula according to the U.S. Department of Education's Principles of Effectiveness, but only 19% were implementing the curricula with fidelity. Researchers found that lack of teacher training, lack of materials for all classes, and lack of student exposure to the whole curriculum were common quality problems.[33]

Another study found that only 64% of middle schools with substance use prevention programs met at least four of the seven recommendations from the Centers for Disease Control and Prevention for effective school-based tobacco prevention programs,[34] and only 4% met all seven recommendations.[35] As Morrissey and colleagues write, "Even though those in the field of prevention practice often feel that their efforts are paying off, outcome studies frequently show minimum effects."[36]

Thus, although there have been great advances in understanding of ATOD use and prevention, it is clear that prevention programs are necessary,

but not sufficient, to substantially reduce overall ATOD use among adolescents for the long term. As a recent analysis concluded, "Despite the growing achievements in prevention theory, research, and practice, considerable progress is still needed if significant numbers of children are to experience tangible benefits in their lives."[37] Major challenges remain in moving from well-designed, well-tested programs to broad and measurable impact, including:

- The persistent gap between the science and practice of prevention;
- Costs associated with model-based programs;
- The need to balance fidelity in replication with adaptation to ensure that the program fits local needs, resources, culture, and other realities;
- The common marginalization of school-based prevention in that it tends to operate as distinct from the school's overall mission and operation—and thus is always vulnerable in the face of other priorities that are seen as more central; [38] and
- A lack of sustained public and institutional will to invest financially, institutionally, and personally in prevention initiatives.[39]

The Potential for Asset-Building Community

Ongoing efforts are needed to strengthen model programs and their effective dissemination and utilization. However, a growing number of researchers and practitioners are questioning whether this solution *alone* is adequate. "The general stance from scientists and policymakers has been that if we produce more science and disseminate it to the community, then the practitioners will be more effective," writes Wandersman. While acknowledging the importance of this traditional approach, he also calls for "community-centered models [that] begin with the community and ask what it needs in terms of scientific information and capacity building to produce effective interventions."[40]

The developmental assets framework sets the stage for an integration of insights from ATOD prevention, community building,[41] and youth development[42] with potential to address some of the challenges facing the field of prevention. Rather than emphasizing program development and replication, asset-building communities seek to achieve four targets (which may be accomplished in part through programs):

1. *Vertical accumulation of assets,* in which each young person experiences more and more developmental assets in her or his life;
2. *Horizontal accumulation,* in which youth experience these resources in multiple contexts, including families, schools, neighborhoods, faith communities, after-school programs, parks, playgrounds, workplaces, retail centers, and other places children and adolescents spend time;

Although there have been great advances in understanding ATOD use and prevention, it is clear that prevention programs are necessary, but not sufficient, to substantially reduce overall ATOD use among adolescents for the long term.

3. *Chronological accumulation,* in which these asset-building experiences are renewed and reinforced repeatedly across time; and
4. *Developmental breadth,* which focuses on intentionally extending the reach of asset-building energy to *all* children and adolescents, not only those judged to be "at risk."

In the decade since Search Institute launched its national Healthy Communities • Healthy Youth initiative, hundreds of towns, cities, and counties across the United States and Canada have launched grassroots asset-building initiatives designed to strengthen community life for young people based on the developmental assets framework. Conceived more as grassroots movements than centrally guided programs or models, these initiatives have adopted, adapted, and developed a wide range of strategies and approaches to asset building.[43] In addition, many communities have combined their asset-building work with other initiatives and related frameworks in ways that respond to local needs, priorities, and funding parameters.

Search Institute has informally learned from many of these communities about the dynamics, challenges, and strategies they use to build devel-

opmental assets. In addition, preliminary findings from a series of case studies yield more systematic learning about the process and dynamics of community building for asset building.[44]

A Framework for Asset-Based Community Building

In addition to being grounded in research on community building and social change,[45] the asset-building approach developed by Search Institute has been operationalized in a "community-centered model" that can lead to what Wandersman calls "'best practice' as process rather than as packaged interventions."[46] Put another way, it is a strategy aimed at building community capacity, which Chaskin, Brown, Venkatesh, and Vidal define as "the interaction of human capital, organizational resources, and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well-being of that community."[47] In this case, the particular focus is on building the capacity of individuals, organizations, and networks to contribute to all of the community's young people's accumulation of many developmental assets in multiple contexts and across time.

Creating asset-building community is conceived less as a program implemented and managed by professionals and more as a mobilization of public will, power, capacity, and commitment.

Based on experiences in asset-building communities to date combined with emerging knowledge on community-centered prevention efforts, we hypothesize the preliminary model shown in Figure 3 as a way of understanding the role of community capacity building in order to increase the accumulation of assets in young people's lives.

a. Cultivate Community Readiness, Energy, and Commitment—Creating asset-building community is conceived less as a program implemented and managed by professionals and more as a mobilization of public will, power, capacity, and commitment, creating a normative culture in which all residents are expected to contribute to young people's healthy development. Thus, a strong focus is on stimulating community passion, commitment, and capacity not only for strengthening formal prevention programs but also for uniting the whole community in supporting and contributing to all young people's healthy development.[48] Components of creating this ethos of sustained commitment include:

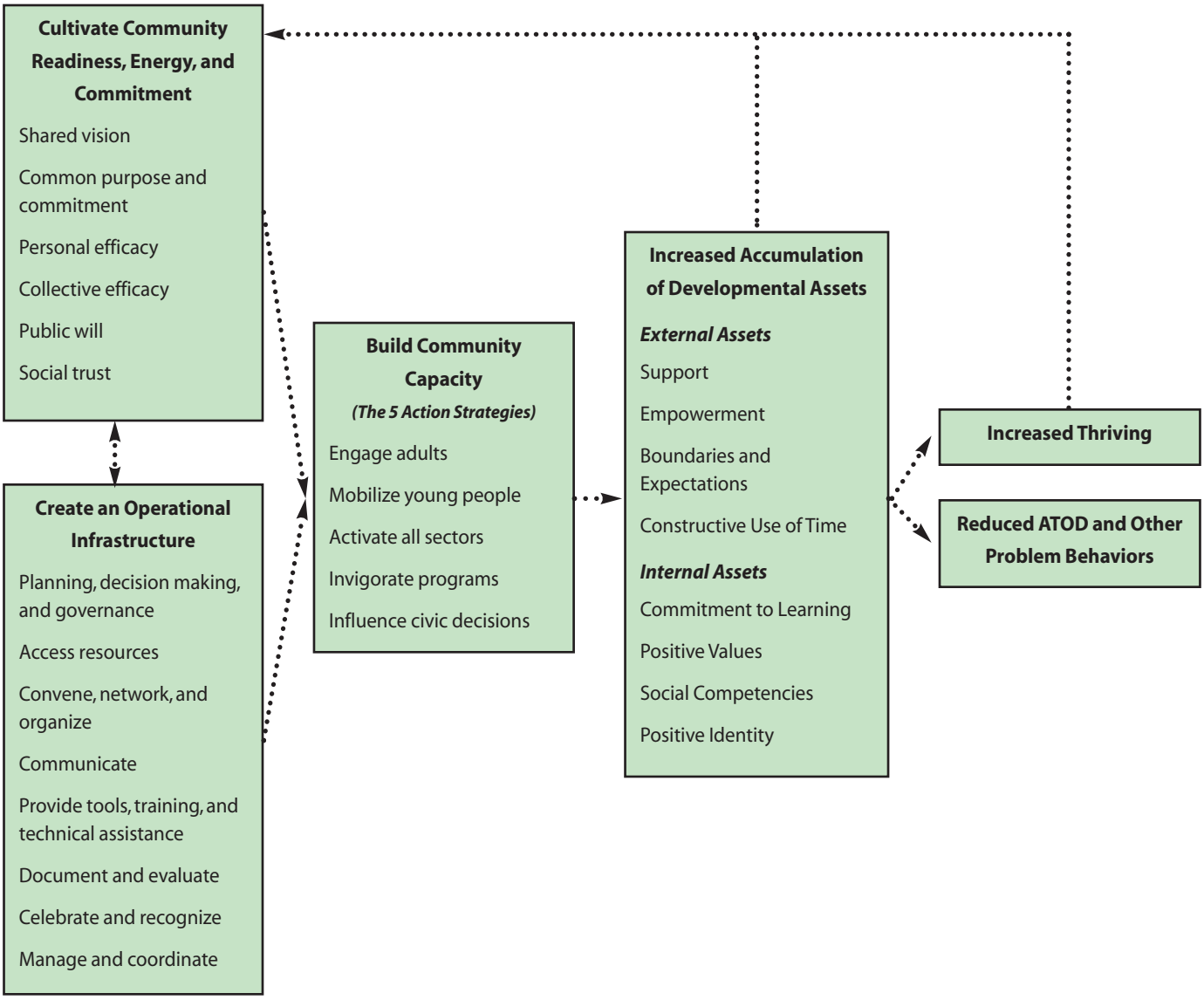
- *A shared vision* that unites multiple sectors, systems, policies, and leaders across political, ideological, religious, economic, and/or racial/ethnic differences.
- *Common purpose and commitment* that allow for collaboration and synergy across different initiatives and agendas in the community.
- *Personal efficacy* in which young people, residents, parents, and nonparents recognize their own capacity and power to contribute to young people's healthy development and community life.
- *Collective efficacy* in which people, organizations, and networks recognize and act upon their shared strengths and capacities to work together for common goals.
- *Public will* for investing individually and collectively in young people's lives and the policies, programs, and practices that support their healthy development.
- *Social trust* that comes from being in relationship with others and recognizing commonalities and mutual respect, even in the midst of ideological, cultural, or economic differences.

b. Create an Operational Infrastructure—A great deal has been written about community coalitions to support prevention efforts. The formal asset-building infrastructure in a community (the initiative, coalition, or organization) plays the vital role of linking, promoting, and supporting asset-building efforts in the community. It typically includes the following kind of core functions:

- *Planning, decision making, and governance* that guide both the maintenance issues of the infrastructure and the missional priorities of building community capacity.
- *Access resources* (financial, personnel, skills, etc.) needed to support the core functions

FIGURE 3

A Preliminary Model of Asset-Based Community Capacity Building



and capacity-building efforts.

- *Convene, network, and organize* committed "champions" who have the passion to spread the word and help make the vision a reality. Create opportunities for these champions to learn from, support, and inspire each other.
- *Communicate* broadly to the community to inspire and support engagement by distributing information, making presentations, and tapping the media to raise awareness about asset building and local efforts.
- *Provide tools, training, and technical assistance* that increase capacity of individuals and organizations to engage in, deepen, and sustain their asset-building efforts.
- In addition to *formal documentation, assessment, and evaluation,* a community initiative can examine community life through the asset lens to identify how well a community ensures youth access to multiple opportunities across the age span.
- *Celebrate and recognize* asset-building efforts and progress in the community.
- *Manage and coordinate* schedules, budgets, and other administrative tasks, as needed.

c. Build Community Capacity—Search Institute has identified five action strategies that begin to name the domains of capacity within

community that need to be tapped in order to create asset-rich communities as part of ATOD prevention efforts. These strategies are:

- *Engage adults* from all walks of life to develop sustained, strength-building relationships with children and adolescents, both within families and in neighborhoods.
- *Mobilize young people* to use their power as asset builders and change agents, tapping the power of peer influence in substance abuse and in healthy development.
- *Activate all sectors* of the community—such as schools, congregations, youth organizations, businesses, human services, and health-care organizations—to create an asset-building culture and to contribute fully to young people's development.

Asset-building approaches point toward opportunities for community-centered practices that have the potential to "blend and braid" science-based principles with asset-based community building.

- *Invigorate, expand, and enhance programs* to become more asset rich and to be available to and accessed by all children and youth. In addition to suggesting specific components to address within prevention programs,[49] the asset framework offers a tool for reflecting on current practices to determine how they can be strengthened.
- *Influence decision makers and opinion leaders* to leverage financial, media, and policy resources in support of this positive transformation of communities and society. In addition to the emphasis in prevention on developing public standards and limits that guide young people, this strategy involves providing a lens for decision making in the media, foundations, and public policy.

Community as Source of Life-Giving Nutrients

Building developmental assets through community-centered approaches is not a substitute for risk-reduction, protection-focused programs or initiatives that have been shown to contribute to reduced ATOD use among young people. Nor does it eliminate the complexity and messiness of community building and community collaboration. It does not do away with the need for accountability to determine that investments are being made wisely. And it still takes considerable investment in time, energy, long-term commitment, and financial resources to expand engagement and impact beyond a core of committed leaders.

However, asset-building approaches do point toward opportunities for community-centered practices that have the potential to "blend and braid" science-based principles with asset-based community building. They offer additional strategies, tools, insights, and capacities that can be woven together within communities around a shared and sustained commitment to young people's healthy development.

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Notes

[1] Gottfredson, G. D., & Gottfredson, D. C. (2001). What schools do to prevent delinquency and promote safe environments. *Journal of Educational and Psychological Consultation, 12,* 313–344.

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[7] This aggregate dataset includes 217,277 6th- to 12th-grade students in 318 U.S. communities in 33 states who were surveyed during the 1999–2000 school year using the *Search Institute Profiles of Student Life: Attitudes and Behaviors* survey.

[8] The longitudinal study sample consists of 370 6th- to 12th-grade students in St. Louis Park, Minnesota, who were surveyed three times (fall 1997, fall 1998, and fall 2001) using the *Search Institute Profiles of Student Life: Attitudes and Behaviors* survey. Youth were in grades 6, 7, and 8 in fall 1997 when the first survey administration was conducted, then in grades 10, 11, and 12 for the second administration.

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[12] It is important to note that the literature on ATOD use points to a wide range of risk factors that, similar to the cumulative power of developmental assets, also cumulate to create greater and greater risk. Typical cumulative risk formulations include numerous risk factors, such as parental substance use, single parenthood, low maternal education, poverty, being a victim of family violence, parental mental illness, foster-home experience, and other experiences and stresses.

[13] The SES measure was created by identifying youth who reported that they lived in a single-parent home and had a mother who did not receive a high school degree, which is a widely used proxy measure of socioeconomic status. See Entwistle, D. R., & Astone, N. M. (1994). Some practical guidelines for measuring youth's race/ethnicity and socioeconomic status. *Child Development, 65,* 1521–1540.

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[15] Cross-sectional regression analyses examining the unique and independent contribution of each asset category to the prediction of ATOD use (a sum score of eight possible ATOD behaviors) indicate that five of the eight asset categories were all significantly related (at $p = .001$) to ATOD use: boundaries and expectations (ß = -.30); constructive use of time (ß = -.16); commitment to learning (ß = -.13); positive values (ß = -.10); and social competencies (ß = -.10). Longitudinal analyses predicting ATOD use in 2001 from asset category scores in 1997 indicated that boundaries and expectations (ß = -.19**) and support (ß = -.16) were the only statistically significant asset categories.

[16] A more complete discussion of this issue will be published in Sesma, A., Jr., Mannes, M., & Scales, P. C. (in press). Positive adaptation, resilience, and the developmental asset framework. In S. Goldstein & R. Brooks (Eds.), *Handbook of resilience in children.* New York: Kluwer Academic/Plenum Publishers.

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[48] This process is often stimulated by surveying young people to gain a portrait of their developmental assets, engagement in multiple risk behaviors, including substance use, and thriving using the *Search Institute Profiles of Student Life: Attitudes and Behaviors* survey. For more information, see www.search-institute.org/surveys/ab.html.

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