Published in final edited form as:

J Early Adolesc. 2013 January 1; 33(1): 131–154. doi:10.1177/0272431612467536.

Project Step-Up: Feasibility of a Comprehensive School Based Prevention Program

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Introduction

Inner-city, low-income Black and Latino youth are at high risk for developing severe behavioral difficulties and dropping out of high school (Angold & Costello, 2001; Vallerand, Fortier, & Guay, 1997). Efforts to assist at-risk youth with behavioral difficulties in their academic pursuits require a multi-pronged focus on both academic and socio-emotional success (Durlak & Weissberg, 2007; Gardner, Ross & Brooks-Gunn, 2008), as well as an emphasis on secondary prevention, defined as “the prevention of clinical illness through the early and asymptomatic detection and remediation of certain diseases and conditions that, if left undetected, would likely become clinically apparent and harmful” (Encyclopedia of Public Health, 2011). Afterschool programs provide an excellent opportunity to target academic and socio-emotional domains coupled with secondary prevention efforts for at-risk youth (Roeser, Eccles, & Sameroff, 2000). However, most afterschool programs focus on middle-school populations, and are either only academic or socio-emotional focused rather than a combination of efforts (Levy & Shepardson, 1992; Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). Moreover, such programs struggle to engage at-risk youth (Lauver & Little, 2005; Byrd & Zhang, 2006; Weiss, Little & Bouffard, 2005).

As a potential intervention, Project Step-Up is an interdisciplinary, secondary prevention afterschool program targeting socio-emotional and academic domains while also providing needed mental health resources for hard-to-engage youth. This paper presents data on participants’ mental health status and sustained participation in the program’s afterschool

youth group, where participation is conceptualized as a component of overall engagement (Staudt, 2007). While evaluating Project Step-Up via a randomized controlled trial (RCT) is beyond the scope of the current paper, preliminary data helps to determine whether Project Step-Up can feasibly engage at-risk youth, which is a necessary first step prior to formal RCT evaluation.

Behavioral Outcomes and School Drop-Out

Elevated rates of poverty, substance abuse, community violence, coupled with scarce youth-centered supportive resources and mental health options, converge to threaten the development and adjustment of inner-city, low-income minority youth (Bell & Jenkins, 1993; Black & Krishnakumar, 1998; Evans, 2004; Gorman-Smith, Tolan, & Henry, 1999), increasing their risk for behavioral difficulties and school drop-out. Given these stressors, it is no surprise that rates of conduct problems among urban, low-income African American and Latino youth can range from 24% to 40% (Tolan & Henry, 1996), more than 4 times the national rate (Angold & Costello, 2001). Behavioral maladjustments are particularly problematic in low-income, inner-city contexts, as they give rise to further disruptive behavioral difficulties (e.g., impaired judgment, poor problem-solving, conflicted interpersonal relationships, unsafe sexual and drug risk behavior), which negatively impact youth safety and well-being (Tolan, Guerra, & Kendall, 1995; Tubman, Gill, Wagner, & Artigues, 2003). Delinquent and antisocial youth are at particularly high risk of dropping out of high school (Cairns, Cairns, & Neckerman, 1989) and continued delinquency (Loeber et al, 2009). However, healthier transitions into adulthood can be maximized if youth are able to access services that enhance individual-level (e.g., motivation to succeed), family-level (e.g., adult support within/outside of the family), and community-level (e.g., work/school opportunities) protective factors (Masten et al., 2004).

Utilizing Existing After School Programs as Prevention Strategies for At-Risk Youth

Schools play an integral role in shaping youths' academic, socio-emotional and behavioral development (Eccles & Roeser, 2009; Zins, Weissberg, Wang, & Walberg, 2004). Schools are also optimal platforms for service delivery, both during and after school (Roeser, Eccles, & Sameroff, 2000). To date, most school-based programs targeting low income, minority youth focus on academic achievement or improving socio-emotional skills, rather than coupling these initiatives with available school-based mental health treatment options. At the same time, there are a number of school-based mental health programs situated in urban elementary, middle, and high schools (Hoagwood & Erwin, 1997) that typically do not take into account academic achievement outcomes. Additionally, school-based programs have focused primarily on secondary and tertiary prevention strategies, targeting already existing behavior problems, or reducing negative impacts of these problems, rather than prevention efforts that aim to avoid the occurrence of such problems before their onset (Walker & Shinn, 2002).

Secondary and tertiary programs focusing on academic support and tutoring, as well as college readiness, career skills training and adult mentors, have been linked to increases in school attendance rates, enrollment in post-secondary education, and high school graduation rates (Hooker & Brand, 2010). Conversely, socio-emotional programs focus primarily on managing emotional regulation, increasing positive interaction with peers and teachers, and targeting aggressive behavior (Wilson, Lipsey & Derzon, 2003). There is building evidence that such programs may increase self-control, peer support, and school connectedness (Asletine, Dupre & Lamlein, 2000). Many of these programs also address behavioral sequelae of common mental health diagnosis, such as conduct disorder and depression among adolescents, but are typically not identified as traditional school-based mental health treatment programs. However, research has manifested associations between youth

development and socio-emotional issues with academic achievement (Gardner, Ross & Brooks-Gunn, 2008), where increasing school productivity and functioning is linked to healthy mental health states (Garcia, Kimmick & Lindgren, 2010). High rates of mental health need and poor academic performance exhibited by urban minority youth necessitate a multipronged focus to promote clinical mental health as well as academic success and positive youth development.

Multipronged initiatives become increasingly important as youth move into high school settings with unaddressed challenges. Yet, there is little information available about high school programs that focus on academic and socio-emotional aspects of youth development, as well as those which include an explicit mental health focus for at-risk students. This is not a new argument, despite its application at the high school level. At the middle school level, some researchers have argued that schools' current mental health services do not fit youths' needs, and schools should connect with other community systems that offer multidisciplinary approaches to counter youth's complex problems effectively (Levy & Shepardson, 1992; Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). They advocate using structured and collaborative school-based programs which support psychological and physical safety, supportive relationships, positive social norms, opportunities for skills building, and integration of family, school and community needs and efforts. Programs that promote mental health goals and healthy development, as well as identify those youth in need of mental health referrals, may be categorized as an alternative use of mental health resources (Frazier, Cappella & Atkins, 2007; Rones & Hoagwood, 2000; Epstein, 2009). Such programs are optimal due to both primary and secondary prevention approaches (Coie et al, 1993).

Barriers to Participation in Comprehensive School-Based Programs

Providing comprehensive school-based programs that target both socio-emotional and academic success, coupled with mental health services, involves unique challenges given the low levels of adolescent utilization of school- and community-based services. Traditional school-based mental health clinics frequently suffer from participation problems, defined for this paper as attendance and program retention. Adolescents can be particularly resistant to traditional school-based mental health treatment, due to an inability to self-identify as requiring treatment (Offer, Ostrov, & Howard, 1981), anticipating stigma from others (Boldero & Fallon, 1995), as well as fears that peers may find out about their psychiatric issues (Cavaleri, Hoagwood, & McKay, 2009). At the same time, adolescent participation is also a challenge for many after school programs (Byrd & Zhang, 2006; Lauver & Little, 2005; Weiss et al., 2005). In fact, Deschenes et al. (2010) have identified "high attendance" in such programs as a meager 44% average rate of attendance. Moreover, keeping youth retained in such programs over the long-term is problematic. Deschenes et al. (2010) indicate that programs with "high retention" have been able to maintain only 50% of youth over a 12 month period.

Urban minority youth residing in low-income, low-resource, and high-crime neighborhoods are often hindered in their participation to such programs due to the challenges present in their communities (Borden, Perkins, Villarruel & Stone, 2005; Villarruel, Montero, Dunbar, & Outlay, 2005). As a result, their participation rates are particularly low compared to other socioeconomic groups (Brown & Evans, 2002). Reasons include lack of interest in the program's activities, no friends participating in the program, a negative opinion of the program, and lack of proximity. Parents or guardians also deter adolescents' participation due to negative opinions of the program and other responsibilities conferred upon their children, (Borden et al., 2005; Perkins et al., 2007; Weiss et al., 2005). Programs targeting urban youth in need of services must incorporate innovative strategies to address the significant challenges to attendance and long-term retention of youth (Dakof, Tejeda &

Liddle, 2001), in addition to being developmentally appropriate and youth-centered (Durlak et al., 2011).

The extant literature on afterschool programs identifies a number of factors which can improve attendance and retention. Adolescents are more likely to participate and remain in afterschool programs when programs: (1) allow youth to spend time with peers in a stimulating learning environment separate from the classroom (Bartko, 2005; Lauver & Little, 2005; Weiss et al., 2005); (2) have accepting program staff whom youth view as caring adults, and are able to control group behavior (Borden et al., 2005; Rhodes, 2004); and (3) outreach to caregivers who influence adolescents' participation via phone calls, school presentations, or home visits in order to build relationships while communicating program benefits (Bartko, 2005).

Overview of Project Step-Up

Project Step-Up is a year-long, multi-component secondary prevention afterschool program based in two inner-city high schools, which predominantly serve urban low-income Black and Latino adolescents. Step-Up intervenes with participating adolescents at multiple ecological levels (individual, school, family) in order to address mental health difficulties, specifically conduct problems, and provide opportunities for increasing youths' social problem-solving and life skills (Alicea, Pardo, Conover, Gopalan, & McKay, 2011). Briefly, Project Step-Up is informed by Social Action Theory (SAT; Ewart, 1991), which posits that youth are embedded in multiple ecological contexts (e.g., home, school, peer groups). In order to create change, services must address youth functioning within each of these contexts. Therefore, components of Project Step-Up incorporate interventions with teachers, family members, and peers resulting in activities such as home visits, parent meetings and connection to community resources. Desired outcomes are addressed within the contexts in which adolescents are embedded. The program is also informed by Asset Theory (Sherraden, 1990), which posits that income support is a necessary but insufficient ingredient for positive youth and family outcomes. Instead, additional assets, such as having a permanent place to live, educational degrees, and personal savings, are linked to personal and family well-being, school performance, and civic engagement, as well as enabling low-income individuals to respond to opportunities in their environment. Project Step-Up operationalizes personal savings and educational opportunities as assets that may ultimately improve individuals' economic and social positions in society. Thus, Project Step-Up provides stipends for attending group sessions and focuses on promoting future planning, educational goal-setting, and behavioral change among youth who might otherwise engage in harmful risk behaviors. Finally, Project Step-Up emphasizes values consistent with positive youth development, encompassing empowerment and development of competencies (Durlak & Weissburg, 2007). Step-Up's theoretical and empirical underpinnings, program goals, and ecological components, as well as case studies of selected program youth, have been previously described in Alicea et al. (2011). As a secondary prevention afterschool program for youth who have been identified by school staff to have both academic and behavioral difficulties, Project Step-Up defies typical categorization due to a combination of academic and socio-emotional focused after-school programming (e.g., academic and life skills curricula) heavily infused with features of traditional mental health treatment (e.g., counseling, family intervention, referrals).

In this paper, we focus on the structured afterschool youth groups, which most resemble other afterschool programs in high schools. These groups are delivered as a series of sessions held throughout the school year once a week for two hours directly following school hours. Each youth can receive up to 44 hours of group sessions throughout the school year. These sessions include youth-centered discussion and activities designed to help participants build, practice and apply life skills (e.g., communication with others, initiating

and maintaining relationships, stress management), handle emotional and behavioral difficulties appropriately, make academic progress, and encourage youth to think about future goals, including post-high school vocational and educational pursuits. Group sessions incorporate many of the features identified in the extant literature on promoting youth engagement in afterschool programs. Groups are facilitated by adult peer leaders, many of whom are from the same communities as youth in the program, and include clinical social work staff who are experienced in working with urban adolescent populations. Sessions provide opportunities for adolescents to engage with their peers, as well as develop additional supportive relationships with prosocial adult staff. Each group session is designed to incorporate stimulating and enjoyable group activities, as well as discussions that promote youth autonomy and independent decision-making. While not the sole component of Project Step-Up, youth board groups represent the primary mode in which youth participate in the program during after school hours.

Step-Up Engagement Strategies

To promote attendance at weekly youth groups as well as overall program retention, Project Step-Up utilizes a number of engagement strategies. To support group attendance, youth receive stipends (\$15) for attending each session, with the possibility of earning up to \$330 for the program year. Academic incentives are also provided to participants for improving and maintaining positive report card grades with each subsequent semester, such that youth earn \$10 for either passing or improving on their grades in academic credit-earning classes each marking period term. Given that Project Step-Up youth reside in low-income, under-resourced communities, these attendance and academic incentives promote consistent attendance and motivate participants who might otherwise seek outside employment or illegal means of earning money. Program retention is further supported by a flexible approach to engagement in order to meet participants' needs, including (but not limited to) text messaging, monthly individual planning and assessment meetings with youth and Project-Step-Up staff, trips and retreats, as well as assistance in securing summer employment (see Alicea et al., 2011 for more detail). As a result, staff are in contact with participants approximately five days per week, during and outside of program hours. This distinguishes Project Step-Up from other secondary prevention programs which typically have weekly contact with participants for an average of 3 hours over the course of approximately 8 weeks (Ackley & Cullen, 2010; Herrera, Grossman, Kauh & McMaken, 2011; Wilder Research, 2007). As a first step in prevention science research (Coie et al., 1993), this paper focuses on the feasibility of Project Step-Up, specifically, (1) did Step-Up actually recruit its target population of youth with mental health needs?; and (2) to what extent are these youth engaged (i.e., attendance, retention) in Project Step-Up's afterschool youth group? First, we present descriptive data regarding youth's mental health needs and clinical cut-off scores before starting the Project Step-Up service year. We hypothesized that youth would manifest greater rates of mental health needs than typically seen in the general population. Next, we present information on average attendance and retention rates in Step-Up for the last two years of service. We hypothesized rates of attendance and retention would exceed those typically seen in afterschool programs. Finally, we explore differences in attendance and retention by demographic and mental health variables, hypothesizing that Black and Hispanic youth with mental health difficulties would be most likely engaged, as they were the target population.

Methods

Participants

Participants who were at risk for dropping out of high school were identified by school administrators and guidance personnel. Criteria for participation in Project Step-Up included

a total grade average of less than 75%, being one year behind in school and/or having insufficient credits to graduate, poor attendance and academic performance, problems with teacher and peer relationships, or problems at home that could hinder academic achievement. Participants included 91 students (age 14 to 18) recruited from two inner-city high schools in a large, urban Northeastern city over a two year period. Students considered eligible were referred by school staff to attend orientation sessions for each cohort. For Cohort 1, the first 46 students (54% of those attending orientation) who returned signed parental consent packets to school guidance staff were enrolled. According to staff, a number of students were unable to be enrolled due to caps on cohort size, although exact counts for these students were not documented. The cohort size was reduced in the second year (to reduce staff burden), such that the first 40 students to return signed consent packets were enrolled in Cohort 2. Five additional students joined Project Step-Up after the first semester, bringing the total number of students enrolled in Cohort 2 to 45 (45% of those attending orientation). Figure 1 illustrates influx and premature termination from Project Step-Up for each cohort (see Figure 1). Participants were considered “active” by semester if they participated in any program activities during that semester (e.g., youth board sessions, one-on-one meetings, trips). For example, although $n = 46$ students were initially enrolled in Cohort 1, only $n = 45$ were considered “active” for the Spring 2008 semester as this student returned the consent packet but never attended any program activities. This number further reduced to $n = 39$ by Fall 2008 due to service refusals and work conflicts.

Screening for referral to additional mental health services was twofold. As part of a school-wide initiative, Cohort 1 participants received a mental health screening (see Pediatric Symptom Checklist in measures section). Those who met the clinical cut-off scores were referred to the school or community-based mental health services. As this school-wide screening was discontinued for Cohort 2, Project Step-Up staff completed initial intake surveys with participants and their caregivers. After all intake surveys were completed, staff identified students in need of additional clinical services and referred them to either school- or community-based mental health services. Approximately 14% (13 out of 91) participants across both cohorts were referred and accepted into school-based mental health services (no data was reported on those referred to community-based services). For those who declined formal services, Step-Up staff met individually with youth and their families in order to address clinical needs until youth felt comfortable seeking formalized services. This was particularly the case for youth in Cohort 2; as capacity for the school-based mental health services became increasingly constrained, Project Step-Up staff reported intensifying individualized contact with youth participants to address ongoing emotional and/or behavioral concerns.

Measures

Demographics—Demographic variables included youth gender, grade level, race/ethnicity (Black, Latino, Other), and age. (See Table 1)

Mental Health Measures—These measures were administered to youth at the start of each service year. Cronbach’s alphas reported were obtained for participants in the present study. During the first year, Cohort 1 youth were administered the Pediatric Symptom Checklist (PSC; Pagano, Cassidy, Little, Murphy, & Jellinek, 2000), which screens for difficulties with attention, hyperactivity, depression, conduct disorder, anxiety, and other forms of social functioning ($\alpha = 0.85$). In the second year, the PSC was discontinued for youth in Cohort 2, and replaced with more differentiated mental health measures to provide a greater clarity of complex clinical issues. As a result, Cohort 2 youth were administered the Children’s Depression Inventory Short Form (CDI-S; Kovacs, 1992; $\alpha = .70$), the Post-Traumatic Stress Disorder Checklist (PCL; Weathers, Litz, Huska, & Keane, 1994; $\alpha = .89$),

and the Problem Oriented Screening Instrument for Teenagers (POSIT; Rahdert, 1991). For the current study, Cohort 2 youth were assessed on the Aggressive/Delinquent behavior subscale of the POSIT ($\alpha = 0.69$).

Attendance—Attendance records for youth group sessions were kept for each participant throughout the duration of the program. Facilitators indicated if the participant attended each session by marking “yes” or “no” on the appropriate session list. For Cohort 1, 25 total sessions were held in both schools (16 in Spring 2008, 9 in Fall 2008). In Cohort 2, 3 introductory sessions were held in Spring 2009 for both schools. In the subsequent Fall 2009 semester, Schools 1 and 2 scheduled 7 and 8 sessions, respectively. In the Spring 2010 semester, schools 1 and 2 scheduled 13 and 14 sessions, respectively.

Program retention—Project Step-Up staff documented reasons for termination from the program over each service year. Reasons included service refusal, work conflicts, transfer to another school, graduated, and moved to another community. Those considered retained completed each program year.

Analyses

Means, standard deviations, and percentage of youth above clinical cutoff levels (e.g., individuals scoring at or above these scores on standardized measures are considered to have clinically significant mental health symptoms) were computed for all mental health measures. As participants in Cohorts 1 and 2 received different mental health measures, results are presented by cohort. Means, standard deviations, and median percentage attendance for youth group sessions were computed among all participants.

Attendance data was subsequently analyzed by separate cohorts and semesters for conceptual and analytic purposes. As a service in development, Project Step-Up activities for Cohort 1 focused on basic curriculum development. Based on challenges demonstrated that first year, services for Cohort 2 included greater systematic outreach to caregivers prior to the emergence of behavioral or academic difficulties, as well as additional behavior management strategies. As a result, such additions may have impacted overall attendance. From an analytical standpoint, separating analyses by cohort and service status by semester allows for a more nuanced view of the data. Consequently, the mean, standard deviation, and median percentage of total sessions attended per semester was computed for “active” participants, as a more representative documentation of participation supplementing more conservative estimates that do not address “active” status by semester. Additionally, percentages of youth retained at the end of each service year by cohort and overall are reported.

Due to the highly skewed nature of attendance rates, associations between attendance rates by demographic and mental health variables were determined using non-parametric spearman’s rank correlations for continuous variables (e.g., age, mental health measures), and Mood’s median tests for categorical variables (which compares medians from two groups using the chi-square test for significance). To explore associations related to retention, analyses included chi-square tests for categorical variables and t-test for continuous variables.

Results

Pre-entry youth mental health status

On average, Cohort 1 youth ($n=33^1$) manifested an average PSC score of 21.30 ($SD = 8.38$), with 15.2% ($n = 5$) of youth scoring at or above the clinical cutoff score of 30 (Pagano et al.,

2000). This number was less than the 20% above this clinical cutoff reported by Pagano et al.(2000) for low, income disadvantaged school-age children (aged 9-14), but slightly higher than the 14% of adolescents (aged 13-18) from a public high school in a small Northeastern city who scored above the clinical cutoff (Gall, Pagano, Desmond, Perrin, & Murphy, 2000). For Cohort 2 ($n = 32^1$), youth manifested an average of 2.28 on the CDI ($SD = 2.30$), with 15.6% ($n = 5$) of youth scoring at or above the clinical cutoff score of 6 (Kovacs, 1992). This number was higher than the 11.2% lifetime prevalence of depressive disorder for adolescents (aged 13-18) in the United States (Merikangas et al., 2010).

On the PCL, Cohort 2 youth ($n = 33^1$) exhibited an average score of 33.27 ($SD = 12.12$), where 42.4% ($n = 14$) of youth scored at or above the diagnostic clinical cutoff score of 30 (Weathers et al., 1994). This number was substantially larger than the 3.7-6.3% rate of PTSD among adolescents nationally (Kilpatrick et al., 2003). Finally, Cohort 2 youth ($n = 32^1$) scored an average of 5.03 on the POSIT Aggressive/Delinquent behavior subscale ($SD = 2.83$), with 43.7% of youth ($n = 14$) scoring at or above the clinical cutoff score of 6 (Rahdert, 1991). This number was comparable to rates of externalizing behavior disorders in low-income urban settings among adolescents (Tolan & Henry, 1996).

Attendance

For the entire sample regardless of “active” status, average percent attendance was 61.46% ($SD = 34.02$), with a median of 73.92%. Unpacking this further, average attendance for Cohort 1 youth regardless of “active” status was 70% ($SD = 31.06$), with a median value of 84.00%. Average attendance for all Cohort 2 youth regardless of “active” status was 52.74% ($SD = 35.02$), with a median value of 56.52%.

Table 2 summarizes percentage of total youth group sessions attended differentiated by Cohort, semester, and school among “active” participants. Cohort 1 median percent attendance values exceeded 80% for both schools and the overall cohort. For Cohort 2, Table 2 indicates that, among “active” participants, median percent attendance values exceeded 76% for both schools and the overall cohort. Taking into account “active” status resulted in greater median participation rates overall. Moreover, these results indicate that average participation rates exceeded the 44% participation rate identified by Deschenes et al. (2010) as indicating “high participation” for out-of-school programs serving middle- and high-school youths in low-income, distressed neighborhoods in six U.S. cities.

Regardless of “active” status, Black ($M = 77.09$, $SD = 27.24$, Median = 88.00) participants manifested significantly greater percentage attendance than Latino ($M = 53.72$, $SD = 33.87$, Median = 64.00) or other race/ethnicity youth ($M = 44.31$, $SD = 35.34$, Median = 52.17) across cohorts ($\chi^2(2) = 13.30$, $p < 0.001$). Taking into account “active status”, analyses indicated Black ($M = 86.20$, $SD = 16.38$, Median = 93.75) and Latino ($M = 70.39$, $SD = 27.15$, Median = 81.25) Cohort 1 youth manifested significantly greater percentage attendance than youth of other race/ethnicities ($M = 15.63$, $SD = 13.26$, Median = 15.63) in Spring 2008 ($\chi^2(2) = 7.97$, $p = .02$). However, Black ($M = 84.54$, $SD = 25.01$, Median = 100.00) youth manifested significantly greater percentage attendance than Latino ($M = 59.26$, $SD = 35.05$, Median = 66.67) or other race/ethnicity youth ($M = 0.00$, $SD = 0.00$, Median = 0.00; $\chi^2(2) = 6.53$, $p = .04$) in Fall 2008. No other significant associations between attendance rates and other demographic and pre-Step-Up mental health variables were found.

¹Sample responding is less than initial cohort size reported due to missing data

Program Retention

Of the 46 participants who enrolled in Step-Up for Cohort 1, 2 participants dropped out due to work conflicts, 5 transferred to different schools, while 5 participants refused further Project Step-Up services (see figure 1). Consequently, 34 out of 46 participants (74%) in Cohort 1 completed the program year. For Cohort 2, 15 participants moved, graduated, or transferred to different schools or programs, while only 4 refused services. At the end of Year 2, 26 out of 45 (58%) of youth were retained at the completion of Project Step-Up service year, with 9 of these participants continuing for a second service year. Across both cohorts regardless of reasons for terminating Step-Up, 60 out of the 91 (66%) youth enrolled over both cohorts were retained at the conclusion of their respective service years. No significant associations for retention by demographic or pre-service mental health variables were found. Overall, these rates exceeded the 50% rate identifying “high retention” in out-of-school programs (Deschenes et al. 2010).

Discussion

As a first step in prevention research science (Coie, 1993), this study presented data on attendance and retention for Project Step-Up, with results suggesting that it is a feasible secondary prevention intervention with the potential to engage at-risk Black and Latino youth for sustained periods of time. Descriptive information regarding youth’ mental health status prior to Step-Up indicates that a substantial proportion of Step-Up youth manifested clinically significant mental health symptoms, generally greater than what is typically reported from national rates. Such data indicate that Project Step-Up was successful in enrolling a substantial number of academically-struggling students with mental health needs. In particular, close to one-half of Step-Up participants in Cohort 2 manifested clinically significant PTSD and aggressive/delinquent behavior symptoms. Additionally, data on attendance and retention illustrate this program’s ability to engage inner-city adolescents considered at risk for mental health difficulties and drop-out, even when using overly conservative analyses disregarding participants’ “active” status. For each program year, Project Step-Up successfully engaged youth at high levels relative to Deschenes et al’s (2010) standard for high attendance and retention in afterschool programs. Differences in attendance by race/ethnicity suggest that engagement strategies may have been particularly effective for Black and, to a lesser extent, Latino youth, compared to youth of other race/ethnicity categories. As a result, our hypothesis that Project Step-Up would be most successful engaging Black and Latino youth is supported.

In combination, these findings indicate that Project Step-Up is a feasible afterschool secondary prevention program, successfully implemented in inner-city high schools for over 2 years. While the target population of Black and Latino youth were successfully engaged, tailoring of program content may be necessary to also engage youth of other races/ethnicities, depending on the demographic compositions of individual school communities. Moreover, lack of statistically significant associations between participation and mental health status also warrant testing with larger sample sizes. Further research is also required to evaluate Project Step-Up with an appropriate comparison group through a randomized controlled trial.

Two limitations are noteworthy. First, we recognize that attendance and retention rates provide only a partial picture of a program’s ability to engage participants. Other incentives, such as the monetary stipends received by participating youth should be further evaluated in relation to attendance and retention rates. It is entirely plausible that some students initiated participation because they knew they would receive a stipend for being present in group sessions (e.g., see Ryan & Deci, 2000 for discussion on external motivation). However, stipends were small in sum relative to the level of time commitment and work involved in

participating in group sessions. For example, youth were involved in developing and leading activities, speaking, organizing trips, writing for newsletters, as well as participating in trips and individual meetings for which no stipends were provided. The considerable time and effort required by these activities far surpassed what could be adequately compensated by the \$15 stipend per session. Moreover, asset theory would suggest that stipends addressed many of the daily basic needs faced by high-risk youth, thus enabling them to focus their time on participating in the program in more meaningful ways.

While an evaluation of the impact of stipends on participation in the Project Step-Up program is outside the scope of this current paper, qualitative data are currently being collected from youth regarding their program experiences. Questions include why youth chose to initiate and continue participation in the program, as well as the extent and impact of monetary compensation offered by the stipends. Anecdotally, preliminary data from focus groups indicate that while stipends were an initial draw to program participation, over time youth were motivated to continue participating in the program because they saw it as a “family” and “therapy.” Additionally, some participants reported increased motivation to participate even after formal stipends were no longer provided, as a result of seeing immediate academic progress. Consequently, future research should tease apart the process by which stipends may initially motivate youth to participate extrinsically, and how, over time, this may shift to internalized forms of motivation based on other non-monetary experiences.

Second, Project Step-Up has operated as a service in constant transition reflecting initial funding requirements and constraints. For example, Cohort 1 youth started in the Spring 2008 semester, resulting in a 3-month interruption in program service during the summer. In addition to youth group disruptions, several staff members left the program over the summer. The program is now operating on an academic year schedule, allowing for consistent continuity of program components.

Nonetheless, promising findings are apparent in terms of this program’s ability to promote participation from adolescents at-risk for mental health difficulties and drop-out. Step-Up’s strengths include its multi-level, alternative mental health and positive youth development approach. In addition, Step-Up provides an alternative model for work with youth evidencing academic, behavioral, and emotional difficulties by specifying processes and skills necessary for service delivery with an extremely “hard to engage” population.

In terms of future directions, curriculum revisions are underway to include more multimedia formats (e.g., music, television, film/movies, music videos, poetry, radio, internet/newspaper articles, etc.), which would allow Step-Up to capitalize on the emerging use of technology in youth-oriented services for promoting greater engagement (e.g., Gelman & Tosone, 2010). Plans to evaluate Project Step-Up using a randomized controlled design are in development, in order to measure the program’s impact on engagement, socio-emotional and mental health, and academic outcomes. Planned future evaluations will examine the extent to which Project Step-Up components provide knowledge and information, bonding with pro-social others (both staff and peers), and skills training (goal-setting, communication problem-solving) to targeted youth. Evaluations will further examine the program’s impact on individual-level skills (critical thinking, communication, self-regulation, coping), as well as internally (self-agency, self-efficacy, global self-worth), and externally-oriented attitudes (future orientation, competency, engagement in school). Moreover, outcome data related to academic behaviors (e.g., attendance, lateness, cutting, disciplinary notices), academic adjustment (e.g., GPA, test scores, credit accrual), mental health and health risk behaviors (e.g., anxiety, depression, PTSD, risk taking behaviors), and relationships (e.g., help-seeking behaviors, development of supportive relationships) will also be collected. Finally, future

research will tease apart the impact of different intervention components and include analyses to illuminate if there are specific subgroups for which Project Step-Up is most beneficial.

Acknowledgments

This project was supported by the Robinhood Foundation. Salary support (only) for this study came from the National Institute of Mental Health (F32MH090614). The content is solely the responsibility of the author and does not necessarily represent the official views of the National Institute of Mental Health or the National Institutes of Health. Dr. Gopalan is an investigator with the Implementation Research Institute (IRI), at the George Warren Brown School of Social Work, Washington University in St. Louis; through an award from the National Institute of Mental Health (R25 MH080916-01A2) and the Department of Veterans Affairs, Health Services Research & Development Service, Quality Enhancement Research Initiative (QUERI)

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Figure 1.

Table 1

Youth demographics

Variables	Cohort 1 (n = 46)		Cohort 2 (n = 45)		Total (n = 91)	
	^a n	^b %	n	^c %	^a n	^d %
Gender						
Male	23	50.00	22	48.89	45	49.45
Female	22	47.83	23	51.11	45	49.45
Ethnicity						
Black	24	52.17	13	28.89	37	40.66
Latino/a	19	41.30	18	40.00	37	40.66
Other (includes Asian, Bi-racial, unknown)	3	6.52	14	31.11	17	18.68
Grade at start of Step-Up						
9th	14	30.43	2	4.44	16	17.58
10th	21	45.65	16	35.56	37	40.66
11th	10	21.74	14	31.11	24	26.37
12th	0	0.00	13	28.89	13	14.29
Youth Age at start of Step-Up (Mean $\pm$ SD)	15.80 $\pm$ 1.14		15.89 $\pm$ 1.11		15.84 $\pm$ 1.12	

^a numbers may not add up to 46 or 91 due to missing data on 1 participant

^b % are out of n = 46 for Cohort 1

^c % are out of n = 45 for Cohort 2

^d % are out of n = 91 for total sample

Table 2
Average Percent and Number of Total Sessions Attended per Step-Up Semester for “Active” Participants

	School 1		School 2		Total	
	%	n	%	n	%	n
COHORT 1						
Spring 2008						
Cohort N	24		21		45	
Average ^a	76.56	12.25	76.19	12.19	76.39	12.22
SD	27.35	4.38	25.28	4.04	26.11	4.18
Median ^a	87.50	14.00	81.25	13.00	87.50	14.00
Fall 2008						
Cohort N	20		19		39	
Average ^b	79.44	7.15	65.50	5.89	72.65	6.54
SD	28.22	2.54	37.39	3.36	33.32	3.00
Median ^b	88.89	8.00	88.89	8.00	88.89	8.00
COHORT 2						
Spring 2009						
Cohort N	23		17		40	
Average ^c	68.12	2.04	68.63	2.06	68.33	2.05
SD	38.24	1.15	39.91	1.20	38.45	1.15
Median ^c	66.67	2.00	100.00	3.00	83.33	2.50
Fall 2009						
Cohort N	24		13		37	
Average ^d	60.12	4.21	81.73	6.54	67.71	5.03
SD	38.83	2.72	19.51	1.56	34.64	2.61
Median ^d	71.43	5.00	87.50	7.00	85.71	6.00
Spring 2010						
Cohort N	18		13		31	

	School 1		School 2		Total	
	%	n	%	n	%	n
Average ^e	70.94	9.22	72.53	10.15	71.61	9.61
SD	24.55	3.19	31.66	4.43	27.26	3.72
Median ^e	76.92	10.00	85.71	12.00	76.92	10.00

^a Out of Total Sessions Attended for Spring 2008 semester

^b Out of Total Sessions Attended for Fall 2008 semester

^c Out of Total Sessions Attended for Spring 2009 semester

^d Out of Total Sessions Attended for Fall 2009 semester

^e Out of Total Sessions Attended for Spring 2010 semester