A Drop-Out Prevention Program for High-Risk Inner-City Youth

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Inner-city youth are at high risk for dropping out of high school. Within this article, risk factors associated with dropout and strategies for effective prevention and intervention are reviewed. An example of a school-based drop-out prevention program is highlighted. The FUTURES Program is a school-based drop-out prevention program designed to address the needs of high-risk youth through smaller classes, character development, career preparation, case management/mentoring, positive incentives, and access to mental health services. Components of the program are described in detail and data evaluating the effectiveness of the program are presented. Directions for the future development of programs and conducting research to prevent dropout by inner-city youth are discussed.

Keywords: *drop-out prevention; inner-city youth; school-based prevention*

Studies indicate that a significant percentage of adolescents at much earlier ages are engaging in behavior that endangers their physical health or well-being (Adger & DeAngelis, 1994). Dryfoos (1997) estimates that approximately one out of three adolescents ages 14 to

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17 is at "high risk," with high risk defined as having "low probabilities of gaining an education, getting a job, effectively parenting, or being able to participate in the political process" (pp. 18-19). Although adolescents in general are a high-risk group, youth living in the inner-city communities may be especially vulnerable to these outcomes. Studies have documented that inner-city youth experience high levels of life stress, poverty, and exposure to violence (Duncan, 1991; Farrington, 1987; Garbarino, Dubrown, Kostelny, & Pardo, 1992; Weist, Acosta, & Youngstrom, 2001). These stressors can negatively affect healthy adolescent development, and are associated with higher rates of emotional and behavioral problems and psychopathology (Farrington, 1987; Tolan & Henry, 1996). The literature on high-risk youth indicates that youth living in inner-city communities exhibit elevated levels of teen pregnancy, involvement in drug dealing, substance abuse, juvenile delinquency, and chronic and serious health problems (Adger & DeAngelis, 1994; Feigelman, Stanton, & Ricardo, 1993; Hernandez, 1993; Rhodes & Jason, 1990; Taylor, 1987; Tolan & Gorman-Smith, 1997; Weist, Paskewitz, Jackson, & Jones, 1998). When combined, these risk factors may contribute to poor school functioning and ultimately to school dropout.

DROP-OUT STATISTICS AND ASSOCIATED FACTORS

The U.S. Department of Education (2000) reported that as of October 1999, 3.8 million young adults were not enrolled in school and had not earned their high school diplomas. Of the 34.1 million young adults (ages 16-24) in the United States in 1999, these youth accounted for 11.2%. There are severe economic implications from dropping out of high school, both on an individual and a national level. Specifically, the economic impact of school dropout is reflected in both short- and long-term loss of career options and earning potential. On the average, high school graduates earn U.S.$6,415 more per year than high school dropouts (Bureau of the Census, 1994). Over their lifetime, high school dropouts can expect to earn U.S.$200,000 less than the students who graduated from high school (Edmondson & White, 1998). Not only are dropouts being paid less, they also are at increased risk

for unemployment. In fact, Edmondson and White (1998) estimate that the unemployment rate is 4 times greater for high school dropouts than for graduates.

The development and implementation of drop-out prevention initiatives should be guided by research identifying factors that are associated with dropout (Kronick & Hargs, 1998; Skromme, Van-Allen, & Bensen, 1998). Factors shown to be associated with increased likelihood of school dropout include prior grade failure, underachievement, low self-esteem, frequent confrontation and nonacceptance by teachers and peers, poor school attendance, low level of interest and involvement in school and extracurricular activities, unstable family life, pregnancy, substance abuse, and history of disruptive behavior (Brooks-Gunn, Guo, & Furstenberg, 1993; Centers for Disease Control and Prevention, 1994; Edmondson & White, 1998; Horowitz, 1992; Malloy, 1997; Weist, Randall, & Tashman, 2000).

DROP-OUT PREVENTION PROGRAMS

With so many youth at risk of dropping out of school in the inner-city communities, it is a public health challenge to intervene quickly and effectively. Numerous programs and strategies have developed over the past decade to address these issues with youth and to prevent students from dropping out. For example, Barr and Parrett (2001) suggest that effective programs are characterized by three main components: positive school climate; customized curriculum and instructional program; and promotion of personal, social, and emotional growth. Furthermore, Lunenburg (2000) outlined several different strategies that may assist in drop-out prevention: modifying the instructional environment, strengthening school membership, developing school board policies, and mentoring. Sanders and Sanders (1998) emphasize the importance of collaboration in drop-out prevention arguing that for a program to be successful, parents, teachers, school counselors, and community members must form solid partnerships. Other strategies that have found some success in reducing drop-out rates involve creating alternative high schools (Karl & Karl, 2000; Weller et al., 1999), developing tutorial and counseling programs

(Edmondson & White, 1998), and creating career academies (Kemple & Snipes, 2000).

THE MARYLAND'S TOMORROW PROGRAM

One program that includes many of the components associated with effective drop-out prevention is the Maryland's Tomorrow Program for at-risk high school students. Begun in 1988, the program is designed to reduce high school dropout and increase successful postgraduation transitions into postsecondary education or employment. The program is founded on the ideal of a strong collaboration between the school system, the employment training system, and the business community (Office of Employment Development, 2001a). The Maryland's Tomorrow Program in Baltimore City is entitled the "FUTURES Program." The FUTURES Program is a collaborative drop-out prevention effort involving six high schools in the Baltimore City Public School System. In the sections that follow, the components of the FUTURES Program and evaluation/outcomes data will be presented as an example of a successful drop-out prevention initiative.

The sites enroll approximately 60 ninth graders each year who have been identified as being at high risk for dropping out of school. Students are eligible for the program if they meet any of the following criteria: (a) failure of at least one grade in elementary or middle school, (b) attendance rates less than 85% in the seventh grade, or absent for 20 days or more in the first quarter of the eight grade, or (c) scores at least one grade level behind in either math or reading on a standardized test of basic skills (K. Owings, personal communication, September 25, 2001). Many enrollees exhibit more than one of the indicators. The FUTURES Program is a 5-year, comprehensive program beginning the summer before ninth grade and ending the year after graduation from high school. The Program includes the following five components: "basic skills enhancement," "work experience," "motivation and leadership development," "student support," and "transition services" (Office of Employment Development, 2001a).

As part of the program, there is a paid 4-week "transition to high school" program. In the summer, students are introduced to the school and the FUTURES Program. The summer allows students to become oriented with the program, staff, and school in a more casual and less threatening atmosphere (Office of Employment Development, 2001b). They attend classes throughout the summer program targeted at improving math, writing, reading, and computer skills and are given the opportunity to take statewide functional tests that are required for graduation. With the assistance of advocates, students participate in a number of activities, including life skills, career development, and cultural enrichment workshops; field trips; and daily recreational time. A mental health clinician also is available to the students during the summer program. The clinician assists FUTURES staff with daily activities, conducts educational workshops, and completes mental health screenings for all students. The screenings assist in the identification of students who are in need of more intensive services during the school year. In addition, the clinician is able to identify areas of unmet needs and to make referrals to community resources.

During the regular school year, FUTURES students attend smaller classes; receive extra support from trained advocates, counselors, and teachers; earn incentives for positive achievement; and participate in cultural enrichment, character development, and career preparation activities (Office of Employment Development, 2001b). In the first year of the program, ninth-grade students attend smaller classes taught by trained teachers. The teachers are Baltimore City Public School System teachers who have an interest, desire, and commitment to work with high-risk students. The teachers are given special training in educational computer activities and receive teaching materials, support, and guidance from the FUTURES Program. The ninth-grade team of FUTURES teachers meets regularly with advocates and the clinician to discuss students' progress and to develop plans for individualized intervention. After the ninth-grade year, the students may still have classes with FUTURES teachers for their main subjects; however, these students are integrated into the large school environment.

One of the most important components within the FUTURES Program is the use of advocates. Advocates serve in a case management

role. In the fall of the student's freshman year, youth are assigned an advocate who will remain with them throughout their enrollment in the program. Advocates perform numerous tasks, including encouraging attendance and academic improvement, monitoring attendance, assisting the student with negotiating problems with teachers and peers, arranging tutoring, promoting participation in school and extracurricular activities, encouraging family involvement, offering counseling and support, exploring personal goals and career options, and conducting life skills workshops. In addition, a transition advocate works with the students to help them learn about college and career options and discover their own career-related strengths and interests. The transition advocate helps seniors develop postsecondary plans (e.g., college, job, training program, military) and is available to assist all students with finding part-time employment after the school day and planning for college and career choices (Office of Employment Development, 2001b).

All FUTURES students have access to a school-based mental health clinician. The clinician is responsible for completing assessment measures and individual mental health intakes on all youth in the program, providing therapeutic intervention to referred students (e.g., individual, family, group), and consulting with advocates, teachers, and other school staff. Students are referred for services by FUTURES advocates, teachers, school staff, families, health providers, peers, or through self-referral. Participation in the mental health treatment component is voluntary. Any involvement in clinical sessions requires written parental or guardian consent and student verbal assent for services. FUTURES clinicians have the luxury to work with a smaller number of students within the larger school setting. They are able to integrate into the day-to-day activities of the program, thereby demystifying youth's beliefs about who clinicians are and what mental health services may represent. This likely reduces the stigma that contributes to adolescents not seeking services (Flaherty, Weist, & Warner, 1996). In addition, mental health clinicians are able to coordinate and collaborate treatment with the advocates, teachers, and families, thus increasing intervention continuity and cohesiveness. Intervention strategies used by FUTURES mental health clinicians include enhancing strengths, encouraging involvement in extracurricular

activities and with caring adults, helping develop better problem-solving abilities, coping skills and conflict resolution skills, and helping develop a positive, goal-oriented view of their future.

School-based mental health services provided in the FUTURES Program are representative of the movement in the field toward service provision utilizing an Expanded School Mental Health Framework (Weist, 1997). These services are designed to augment services typically offered in the school setting and are intended to reach youth that might otherwise not receive any mental health services. Services are usually contracted through universities, hospitals, or community mental health centers to provide services within the school building to regular and special education students. Within this framework, mental health services are provided by clinicians with at least a master's degree in the fields of social work, counseling, psychology, or related health professions.

EVALUATION FINDINGS

The FUTURES Program has achieved success in obtaining drop-out rates lower than the average drop-out rates for their respective schools. For the 1998-1999 school year, whereas the FUTURES Program reported a 6.28% drop-out rate, the total Baltimore City School System reported a drop-out rate of 10.98%. Similarly, in the 1999-2000 school year, whereas the FUTURES Program reported a 5.12% drop-out rate, the total Baltimore City Public School System drop-out rate was 8.14% (Office of Employment Development, 2001c). These figures are remarkable in that not only did the FUTURES Program achieve lower drop-out rates than the school at large, but it did so with a sample of youth at high risk for school dropout. The program also has achieved high rates of employment and post–secondary education enrollment on graduation. In the 1999-2000 school year, 85.2% of the FUTURES Program graduates were in college, vocational school, or employed. More specifically, 27% of the graduates were attending college or vocational school, 8.2% were employed and attending college or vocational school, and 49.2% were employed (Office of Employment Development, 2001d).

The mental health services provided through the FUTURES Program were utilized at a high volume. In a Baltimore Mental Health Systems (2001) summary of services provided by FUTURES clinicians across the six program sites in a 6-month period between July 1, 2000 and December 31, 2000, 459 students received services. More specifically, clinicians provided 967 individual sessions, 162 group sessions, 123 family contacts, 50 educational workshops, and 265 crisis sessions. In addition, clinicians provided more than 300 hours of consultation to teachers, FUTURES staff, school staff, health suite staff, and other service providers/agencies involved with students.

The impact of mental health services on psychosocial functioning was assessed. An evaluation was conducted to compare student psychosocial functioning at the beginning and at the end of the school year. Participants included 270 ninth-grade students (132 males, 138 females) enrolled in FUTURES during the 1999-2000 school year. Students were divided into two groups: treatment group and nontreatment group. Students who had been seen four or more times by the mental health clinician in any combination of individual, family, or group sessions were considered to have received mental health services ($N = 106$). The first wave of data collection (pretest) occurred in October 1999, and the second wave (posttest) in May 2000.

The Youth Self-Report (YSR) (Achenbach, 1991) was administered to assess a broad range of social, emotional, and behavioral concerns. The YSR is a commonly used measure that has good reliability and validity (Achenbach, Howell, & McConaughy, 1995; McConaughy & Achenbach, 1994) and is sensitive to measuring change over time (Achenbach, 1991). Furthermore, it has been found to be an effective measure in prior studies evaluating inner-city youth (Weist & Baker-Sinclair, 1997; Weist et al., 1998). The YSR yields *T* scores on three main scales (Total Behavior, Internalizing, and Externalizing) and eight subscales (Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, and Aggressive Behavior). *T* scores have a mean of 50 and a standard deviation of 10. *T* scores greater than 67 are considered clinically significant (Achenbach, 1991).

Repeated measures MANOVAs and ANOVAs were used to examine changes in self-report ratings from pre- to posttest. Table 1 pres-

ents the means and standard deviations for the YSR at pre- and posttest for the treatment and nontreatment groups. Significant MANOVAs for the effect of Time were found on the measures of overall psychopathology (i.e., externalizing and internalizing behaviors combined), $F(1, 177) = 9.22$, $p < .001$, and internalizing behaviors, $F(1, 178) = 18.84$, $p < .001$. Significant MANOVAs for the effect of Group (i.e., treatment vs. nontreatment) were found on the measures of overall psychopathology, $F(1, 177) = 3.36$, $p < .05$, and externalizing behaviors, $F(1, 185) = 7.6$, $p < .05$. There were no significant Group × Time interaction effects for overall psychopathology, internalizing behaviors, or externalizing behaviors.

The main effects for Time revealed that across the course of the year, students showed symptomatic improvement, regardless of their treatment status. In examining the main Group effect, it was found that the treatment group reported significantly greater emotional and behavioral problems than the nontreatment group at both points in time.

DISCUSSION

The FUTURES Program is an example of successful collaborative partnership involving the business community, employment training system, and mental health and public school systems. It targets high-risk inner-city youth designed to decrease drop-out rates and improve successful post–high school transition to college, vocational programs, and employment. Overall, the program's components fit with recognized best practices in drop-out prevention (Barr & Parrett, 2001; Edmondson & White, 1998; National Dropout Prevention Center/Network, 2000). Key components of the program include mentoring, attendance monitoring, smaller classes, tutoring, life skills training, leadership development, career preparation and work experience, incentives for positive achievement, family involvement, and counseling. The program focuses extensively on increasing students' developmental assets and enhancing resiliency (Barr & Parrett, 2001; Malloy, 1997). Perhaps the most powerful component of the program is the fostering of close relationships with positive adults. Advocates,

TABLE 1
Youth Self-Report Means and Standard Deviations

	*Treatment (*n = *106)*		*Nontreatment (*n = *165)*	
Scale/Subscales	*Pre*	*Post*	*Pre*	*Post*
Overall problems	57.52 (9.8)	55.02 (9.67)	53.68 (10.08)	51.92 (11.37)
Externalizing problems	58.65 (9.74)	57.76 (10.2)	54.96 (10.34)	53.82 (11.57)
Delinquent behavior	61.89 (8.19)	61.15 (7.5)	59.1 (7.85)	59.36 (8.43)
Aggressive behavior	57.92 (8.08)	57.66 (8.07)	55.76 (7.53)	55.28 (7.32)
Internalizing problems	54.21 (9.72)	50.18 (11.31)	52.02 (9.96)	48.27 (14.31)
Somatic complaints	58.18 (10.15)	56.94 (8.26)	57.26 (7.14)	56.2 (7.36)
Anxiety/depression	54.95 (6.24)	53.26 (5.18)	53.18 (6.33)	53.39 (6.00)
Withdrawn	55.89 (6.51)	55.02 (5.63)	55.89 (6.80)	55.16 (6.52)
Thought problems	58.4 (8.56)	56.55 (8.58)	56.29 (7.59)	54.55 (7.27)
Attention problems	55.01 (6.48)	54.09 (5.14)	53.12 (5.50)	53.19 (5.01)
Social problems	56.6 (7.11)	55.92 (6.55)	55.14 (6.34)	54.82 (6.67)

Numbers in parentheses denote standard deviation.

teachers, and mental health clinicians work closely with the students over a 5-year period developing close personal relationships with students. Because of their closeness to students, they are able to help students cope with day-to-day issues and build problem-solving skills for the future. The clinical literature documents that warm supportive relationships with positive adults promote adolescent resiliency (Resnick et al., 1997). Although the program's primary focus is on academics, it also recognizes the importance of addressing psychosocial concerns, exposing youth to cultural enrichment activities, and providing work experience and developing career paths. Youth are encouraged by all FUTURES staff to recognize their strengths and to develop both short- and long-term personal goals. Teachers, advocates, and counselors work with the youth to help instill hope and expose them to more positive options for their futures.

Evaluation findings have shown that the FUTURES Program helps reduce drop-out rates. It is striking that the programs have lower rates of dropout than the schools that they are housed in, as the youth were identified for the program based on their high-risk status. In addition to reduced drop-out rates, students also report high rates of

postgraduation successful transitions to work, college, and vocational programs. These findings strongly support the impact and success of the program.

To further evaluate the program, we took advantage of group administrations of a measure of emotional and behavioral problems to all ninth-grade FUTURES students in the fall and again in the spring. Ninth-grade students who received mental health services were compared to the other FUTURES students. At the fall assessment, the treatment group was found to have greater symptomatology than students in the nontreatment group. This suggests that the appropriate students were referred for counseling. Although the treatment group showed declines in self-reported emotional and behavioral problems from the fall to spring assessment, so did students receiving three or fewer sessions of mental health counseling. Thus, the evaluation was unable to document improvement of more intensively treated students compared to those who received less intensive or no treatment. This may be due to a number of factors, including (a) the cutoff of four or more sessions may not be the best cutoff for determining treatment versus nontreatment groups (e.g., students receiving one to three sessions of care could well have benefited from it), (b) all students in the FUTURES Program receive some level of supportive and case management services, making services between our "treatment" and "nontreatment" groups less distinguishable, (c) there may be a natural tendency for students to show improvement from the fall assessment (when there is more stress about the school year) to the spring assessment (when the school year is almost over and the weather is nicer), (d) data on confounding factors such as receipt of mental health services from other mental health providers, types of service provision (e.g., family, group, individual, etc.) and lengths of session were not available and, hence, were not included in the analysis plan, and (e) findings were limited to self-report, with data from multiple informants (e.g., teachers, parents, clinicians) yielding a more complete picture of the needs of the youth served and of the mental health treatment effects. These limitations notwithstanding, our attempt to acquire additional evaluation data was informative to our program planning and clinical efforts, and has taught us lessons on factors that

are critical for consideration in improving the utility of existing data sources (see Hawkins, Mathews, & Hamdan, 1999).

High school dropout is a serious concern that has negative economic and psychosocial consequences. The effects of dropout extend far beyond schools, affecting families and communities. Drop-out rates are alarmingly high in inner-city communities, with estimates as high as 25% (National Center for Education Statistics, 1997). Reaching out to help youth at risk of dropping out of school is a public health challenge that needs to be given high priority (Elmen & Offer, 1993). Partnerships involving educational systems, the business community, the employment training system, and expanded school mental health programs create the opportunities for the development of intensive and comprehensive approaches to drop-out prevention. Our goal in this article was to present an example of one such partnership, presenting challenges and opportunities that are being confronted within it.

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