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The Fast Track Program for Children at Risk: Preventing Antisocial Behavior.
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Chapter 1

Setting the Context for Youth Violence Prevention

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It was 1989. The media was starting to report stories of teenagers who committed gruesome murders. School shootings were on the rise. On September 26, 1988, at a school in Greenwood, South Carolina, a teenage boy shot and killed an 8-year-old girl and wounded eight other children with a 9-round .22 caliber pistol. He then shot a teacher who tried to stop him and entered a third-grade classroom, wounding six more students before he was restrained. On December 16, 1988, in Virginia Beach, Virginia, a 15-year-old boy opened fire at school, wounding a teacher who fell to the ground. He then stood over her and killed her point blank. On January 17, 1989, in Stockton, California, when Patrick Edward Purdy's mother refused to give him money for drugs, he went to Cleveland School and shot over 100 rounds into the schoolyard, killing 5 students and wounding 30 more before taking his own life. On July 18, 1990, the *New York Times* carried a front-page headline, "Number of Killings Soars in Big Cities Across U.S." Two weeks later, the U.S. Senate Judiciary Committee released a report stating that the number of murders in the United States would reach an all-time high that year.

It was in this context that the National Institute of Mental Health (NIMH) realized that it needed to take quick and decisive action to address the growing concerns about rising levels of youth violence in the United States. As the lead U.S. federal agency for research on mental disorders, NIMH focused on preventing conduct disorder (CD)—the mental illness associated with youth aggression and violence. It convened meetings of experts and called for proposals to create new, innovative approaches to the prevention of CD. A group of psychologists from four

different universities, calling themselves the Conduct Problems Prevention Research Group (CPPRG), responded to the call with a proposal to create a new school- and family-based intervention program, called Fast Track. The goal was to implement Fast Track in four different U.S. communities and to evaluate its impact on young children with the most rigorous scientific method available, a randomized controlled trial. That proposal was approved, beginning a 29-year project illustrating the ways in which university-based developmental science can be used to address a complex, real-world problem. This book tells that story.

RISE IN YOUTH CRIME IN THE 1980s

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Hard data verified the fact that crime in America was indeed rising in the 1980s, especially youth crime, and in particular, violent youth crime. The overall violent crime rate in the United States increased by 470% between 1960 and 1991, the year that the Fast Track randomized trial began. In addition, more and more of these crimes were being perpetrated by teenagers under the age of 18. In the period between 1980 and 1993, the rate of victim-reported violent crimes by youth increased by 49%. During the same period, the arrest rate for violent crime by children ages 10–17 increased by 68%, as shown in Figure 1.1.

Multiple factors contributed to this rise in youth crime. Albert Blumstein (1995) and other notable criminologists argued that the rise in crime was attributable to a growing crack cocaine drug trade in which urban teenagers were being recruited as drug-runners and participants. This explanation was consistent with the data, which showed the most dramatic rises in violent crime occurring among teenagers. Although murder rates by adults over the age of 24 did not change over this time, there were dramatic increases in murders committed by teenagers ages 15–18. In fact, during the short period between 1985 and 1992, the murder arrest rate among teenagers increased by over 200%, while the murder arrest rate for adults over age 30 actually declined. There was indeed a frightening problem developing with teenage violence.

At this same time, there was a sharp increase in guns being brought onto the campuses of public schools. According to a survey at that time by the Harvard School of Public Health, 15% of high school students reported that they had carried a handgun on their person in the past 30 days, and 4% reported that they had taken a handgun to school in the past year. The public school was becoming a more dangerous place.

Fueled by these statistics and sensationalized media reports, the Centers for Disease Control and Prevention (CDC) listed "Violence and Abusive Behavior" as one of 22 public health priority areas in its 1990 report of targets for Healthy People 2000 (Public Health Service,

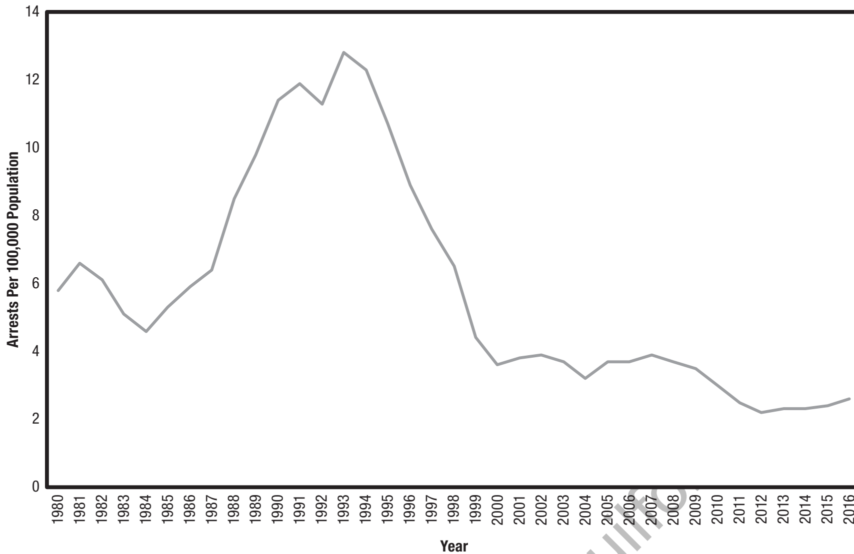

FIGURE 1.1. Violent crime offenses: Arrests of persons ages 10–17 per 100,000 persons ages 10–17 in the resident population. The Violent Crime Index includes the offenses of murder and nonnegligent manslaughter, rape, robbery, and aggravated assault. From OJJDP Statistical Briefing Book (n.d.). Data source: Arrest estimates developed by the Bureau of Justice Statistics and disseminated through its online "Arrest Data Analysis Tool."

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1990). In 1992, a landmark issue of the prestigious scientific publication *Journal of the American Medical Association* was devoted to violent behavior, which it declared to be "a major public health problem" (Marwick, 1992, p. 2993). A year later, the CDC established the Division of Violence Prevention, one of three divisions within the newly created National Center for Injury Prevention and Control, and it publicly called the problem of violence an "epidemic" in its report, "The Prevention of Youth Violence: A Framework for Community Action." Attention was focusing on the subset of chronically aggressive teenagers.

Scholars at that time began to focus on the fact that a relatively small number of youth accounted for a large proportion of the teen crimes being committed. For example, in a long-term study of children born in Philadelphia in 1945, a select group (7%) was responsible for over half of the adolescent crimes committed (Tracy, Wolfgang, & Figlio, 1990). The adolescents most likely to commit multiple crimes were those who, as children, displayed frequent behavior problems. In fact, in a long-term study of adolescent delinquency, Robins (1978) found that approximately half of children of early school age (ages 6 or 7) who displayed frequent

problem behaviors went on to engage in adolescent crime. These two findings led researchers to conclude that efforts to prevent serious adolescent crime might need to start in early elementary school and focus on children displaying early signs of aggressive behaviors.

THE COST OF A CHRONIC CRIMINAL

In addition to the physical danger violent adolescents represented to others, there was mounting evidence that youth who committed violent crimes cost society a great deal of money. Aside from the costs for medical and emotional treatment needed by victims and their families, the violent teenagers themselves incurred costs for adjudication, incarceration, and treatment. In addition, these youth were often costly to society in other ways, including unemployment or underemployment (income taxes that they would not pay) and need for welfare or other forms of public assistance. Mark Cohen, an economist at Vanderbilt University, first reported in 1988 that the actual cost of crime was larger than anyone had assumed. He has since estimated the lifetime total cost to society of the average chronic criminal to be more than $4.2 million (Cohen & Piquero, 2009).

In the late 1980s, public interest in understanding the cost–benefit ratios for social programs was emerging. The high cost of chronic criminals set a high bar for the amount of money that might be spent on prevention efforts and still yield a positive financial return on investments, if the expenses associated with chronic patterns of violent crime were averted or reduced. Emerging longitudinal research was suggesting that the very large lifetime costs of chronic violent crime were mostly the result of the actions of children who started their antisocial behavior early in life and continued it throughout most of their lives. By the late 1980s it was also clear that it was possible to identify a pattern of early childhood misconduct that predicted with about 50% accuracy those children who would commit a disproportionate amount of juvenile violence and other crimes and continue to do so well into adulthood at an enormous cost to society. By the late 1980s all of these facts were known to the federal agencies concerned with youth violence.

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THE CALL FOR A SOLUTION

The CDC report called for innovation in prevention and treatment that would require cooperation and integration across public health, health care, mental health, criminal justice, social service, education, and other

relevant sectors. In 1990, NIMH focused a spotlight on the underlying mental health problems associated with CD, characterized by an early-starting pattern of persistent aggression, and allocated funds for research examining the causes and for testing prevention programs aimed at reducing chronically aggressive and antisocial behavior by children.

The NIMH perspective was that children who were at high risk for displaying serious CD might be identified early, before their patterns of behavior became intractable. If effective preventive intervention plans could be developed to address the causes of their emergent pattern of antisocial behavior, future aggression and criminal activity might be averted or substantially reduced. The Fast Track prevention program was based on this model, in the hope that early preventive efforts with the child, the family, and the school could alter the developmental pathway toward serious CD.

While rare, this was not the first time that large-scale efforts to prevent serious adolescent crime and violence had been attempted. In 1935, little was known about the developmental features of aggression and violence, but Richard Cabot, a Boston physician, combined the legal clout of the Boston courts with the clinical wisdom of the Judge Baker Guidance Center to begin the Cambridge–Somerville Youth Study. The study became the largest attempt to date to prevent delinquency in children. Cabot was skeptical about the ability of the human services profession, especially social work, to undo damage resulting from poverty and the stress of the Great Depression, work that he likened to "attacking a granite fortress with a pea shooter" (1931, p. 8). In contrast, he had hope that the provision of preventive intervention might shape the development of vulnerable children in more positive directions.

Drawing on ongoing research on delinquency by William Healy and Augusta Bronner (1948) and the longitudinal studies of Sheldon and Eleanor Glueck (1930), the Cambridge–Somerville Youth Study program was a community-based effort to prevent delinquency. In all, 506 boys ages 5–13 in the local community signed up for the program. Cabot began a randomized controlled trial in 1939, which enrolled children for 5 years. The children assigned to the intervention received family counseling twice a month, individual tutoring, medical and psychological therapy, and a group-based summer camp program, and they were connected with a number of social service agencies. The control group received only an initial assessment.

During the first several years, the intervention team was pleased with its program. It seemed that children had benefited. But the optimism waned as the children grew older. In 1978, Joan McCord followed up with the boys who had participated in the Cambridge–Somerville Youth

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Study. The findings were startling. On the measures collected, including criminal record, alcoholism, mental illness, age at death, health problems, and job status, not only was there no evidence of improvement in the intervention group, but that group was significantly worse off than the control group on several indicators. The program had no positive effect on juvenile and adult arrest rates measured by official or unofficial records. There were no differences between the two groups in the number of serious crimes committed, the age at which a first crime was committed, or the age of desistance from crime. A larger proportion of criminals from the treatment group went on to commit additional crimes than their counterparts in the control group. Boys who had been assigned to the intervention group were more likely than controls to have received serious psychiatric diagnoses, such as schizophrenia. Boys assigned to the intervention group were more likely to die at younger ages than boys in the control group. This news deflated the clinical community and became ammunition for those skeptics who favored the early detection, rounding up, and incarceration of delinquent children.

A generation passed and a second attempt, called the St. Louis Experiment, was led by Ronald Feldman, a social work professor at Washington University (Feldman, Caplinger, & Wodarski, 1983). In 1970, he and his colleagues developed a group-based therapeutic intervention to prevent antisocial behavior in boys. He randomly assigned 263 early adolescent high-risk boys and 438 early adolescent low-risk boys to a 24-session peer-group intervention administered through local community centers. Feldman's experimental design cleverly varied the groups in several ways, in order to evaluate the impact of therapy group composition (e.g., high-risk boys only, low-risk boys only, or mixed groups), group leader experience, and therapeutic approach (e.g., traditional, behavioral, or minimal). The "traditional social work" intervention group used guided group interaction and group dynamics focused on problem behaviors to elicit insight and commitment to change. The behavioral groups were highly structured attempts to apply group contingencies and systematic reinforcement to improve group behavior. Minimal intervention control groups met, but without a therapeutic goal. Unfortunately, the interventions examined in this effort also proved to be ineffective. Data from direct observations of boys' behavior, self-reports of deviant behavior, and therapist ratings all indicated a disappointingly low impact on boys' outcomes (Feldman et al., 1983). But several interaction effects suggested some ways that future interventions might need to be structured. High-risk boys who were placed in groups together, had inexperienced therapists, and who received process-oriented guidance became increasingly antisocial over time. In contrast, boys in groups run by experienced therapists and following a behavior change agenda fared better.

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In addition, when deviant boys were placed with nondeviant peers, their outcomes were more favorable. These findings pointed to the conclusion that high-risk early adolescent boys could be positively affected by being matched with nondeviant peers, with an experienced therapist, using behavior change principles (Feldman et al., 1983).

DESTINY VERSUS DEVELOPMENTAL ORIENTATIONS

As the crime curve for adolescents continued to rise through the first half of the 1990s, John Dilulio, a political scientist, and James Fox, a sociologist, began to write about a phenomena they described as "super predators." Using the metaphor of wolf packs to describe violent teenagers in a 1995 issue of *The Weekly Standard,* Dilulio predicted that tens of thousands of severely impoverished juvenile super predators were on the near horizon of American culture. This prediction was based (mistakenly, as the findings of the Fast Track study later demonstrate) on an assumption that the 7% of children who account for half of all juvenile crime fit a super-predator profile and could not be deflected from a life of violence. During this same period, the media coverage of juvenile crime framed as part of the super-predator threat led to increasing initiatives to treat juvenile offenders as adults and to focus on incarceration efforts as opposed to treatment alternatives. Incidents such as those mentioned at the outset of this chapter and even more dramatic tragedies such as the Columbine massacre in 1999 resulted in zero tolerance for weapons legislation, making it mandatory to suspend or expel offending youth from schools (Krisberg, 2005). This movement toward getting "tough on crime" led to laws such as "three strikes and you're out" that would keep recidivists in prison for the rest of their lives. The deterministic idea that youth showing early problems were hopeless was fueled by books such as *The Bell Curve* (Herrnstein & Murray, 1994). These authors offered the criticism that "much of public policy toward the disadvantaged starts from the premise that interventions can make up for genetic or environmental disadvantages, and that premise is overly optimistic" (p. 550).

At the same time that these restrictive and nonmalleable orientations toward aggressive children were emerging in the media and reflected in some policies, extensive research was accumulating from the 1970s and 1980s, leading to rapid advancements in the understanding of the developmental processes associated with CD and adolescent delinquency. More detail on this research is described in the following chapter. By the late 1980s and early 1990s, consensus was emerging among researchers that CD rates might be reduced effectively with preventive interventions,

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with the potential to prevent or substantially reduce later adolescent and adult crime and violence.

It was becoming clear that chronic violence most often emerged when children grew up in high-risk communities and experienced multiple, sequential adversities, including a harsh home life, unstable supports, peer rejection, and academic difficulties. Emerging research suggested that the risk for chronic violence accumulated over time—and the outcomes of at-risk youth might be changed with the right kind of early supports. Longitudinal research conducted by the Oregon Social Learning Center (Patterson, Reid, & Dishion, 1992) had begun to identify a set of specific developmental processes that distinguished children who exhibited antisocial behavior early in childhood and escalated in later adolescence from youth who engaged in delinquency only later, in adolescence.

As described in the following chapter, these developmental studies provided a foundation for the design of the Fast Track program, which was based on the premise that prevention efforts need to begin in childhood, focusing on children with early-starting aggressive behaviors and targeting risk and protective factors identified in developmental research. Fast Track was also supported by a set of short-term prevention and treatment studies that documented how constructed interventions that were grounded in developmental theory could improve parenting and reduce child aggression and promote early competencies.

An important model was provided by the Montreal Prevention Experiment (McCord, Tremblay, Vitaro, & Desmarais-Gervais, 1994). Eighty-four aggressive boys between the ages of 7 and 9 were identified from Montreal schools serving low socioeconomic status (SES), French-speaking families. Half of these boys (n = 43) were given an intervention involving 20 sessions of parent training and prosocial skill training across a 2-year period. Rates of self-reported thefts were lower for the intervention group than the control group when youth were evaluated at 10–12 years of age, and self-reported delinquency was similarly significantly lower for intervention youth at 11–15 years of age. However, a report followed the participants into early adulthood (until age 28) and effects on personal violence were no longer significant at that point in time (Vitaro, Brendgen, Giguère, & Tremblay, 2013). One possible implication from these initially promising findings was that a more sustained intervention might have yielded stronger effects.

The substantial research base on the development of CD, along with the short-term benefits associated with small-scale interventions testing parenting or school-based interventions, provided a strong foundation for a more ambitious effort at large-scale prevention. Whereas most interventions targeted a specific factor in the development of the

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problem, the Montreal Prevention Experiment provided an example of a multicomponent approach. These studies were somewhat encouraging but fell short of providing long-term documentation that prevention of youth violence was possible. As a group, these studies suggested that what was really needed was a large test of a multicomponent, long-term intervention with children who were at high risk for the most serious forms of CD. This was the goal of Fast Track.

In the following chapter, we describe the developmental and intervention research that informed the design of Fast Track in more detail. In subsequent chapters, we describe details of the intervention program and empirical findings about its impact. At the conclusion of this volume, we return to some of the issues raised in this first chapter and discuss the lessons learned from this large and extensive prevention trial.

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