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STDs

► Drug Abuse and Alcohol Dependence Among Inmates

Stigma

► Rational Choice, Deterrence, and Crime: Sociological Contributions

Sting Operations

► Law of Undercover Policing

Stolen Auto

► Motor Vehicle Theft

Stolen Vehicle

► Motor Vehicle Theft

Stop Now and Plan (SNAP®) Model

Leena Augimeri[1], Margaret Walsh[2], Kathy Levene[2], Karen Sewell[2] and Erin Rajca[2]
[1]Centre for Children Commiting Offenses, Child Development Institute, Toronto, ON, Canada
[2]Child Development Institute, Toronto, ON, Canada

Synonyms

Centre for Children Committing Offences (CCCO); Earlscourt Child and Family Centre (ECFC); Earlscourt Girls Connection (EGC); SNAP®; SNAP® Boys; SNAP® GC; SNAP® Girls; SNAP® ORP; Under 12 Outreach Project (ORP)

Overview

This entry presents a comprehensive summary of the SNAP® (Stop Now and Plan) model including its related programs which are part of a crime prevention strategy for at-risk children under the age of 12. At Child Development Institute (CDI), a multiservice, not-for-profit children's mental health organization, the mandate for two key

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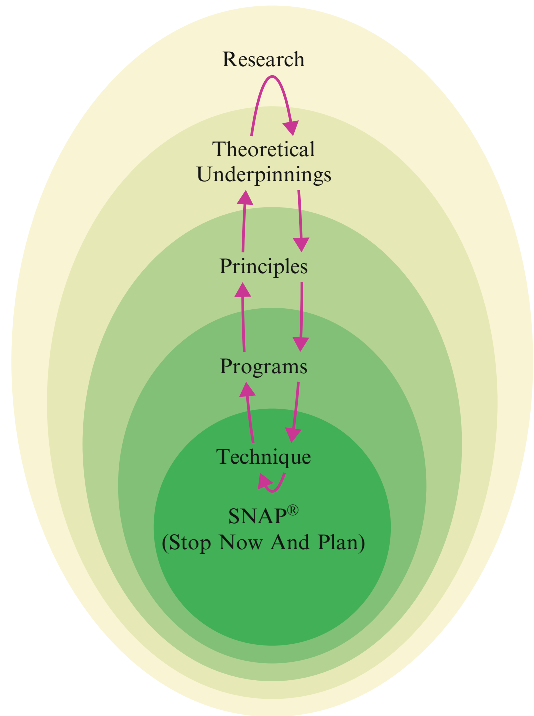
evidence-based clinical programs, SNAP® Boys and SNAP® Girls, and the Centre for Children Committing Offences (CCCO) promotes effective services for these "forgotten" children who have or are at-risk of having police and/or child welfare contact for their disruptive behavior. The comprehensive strategy includes (1) police-community referral protocols; (2) gender-specific risk assessment using Early Assessment Risk Lists (EARLs); and (3) gender-specific interventions, the evidenced-based SNAP® programs (for further details, see Koegl et al. 2008). The overarching goal of SNAP® is to keep high-risk children in school and out of trouble. SNAP® has been found to reduce aggression, delinquency, and antisocial behavior; increase social competency; prevent further and future delinquency; improve academic success by decreasing behavioral issues at school; engage high-risk children and their families in service; increase effective parent management skills; and connect children and parents to community-based resources. Authors discuss key aspects of the SNAP® model including SNAP® principles, theoretical foundation, model framework, and research summary of findings to date.

Fundamentals of SNAP®

Over 27 years, CDI has developed its expertise in responding to children with disruptive behavior problems and their families. In 1985, with the decriminalization of children under the age of 12 in Canada, CDI (with support from the provincial Ministry of Children and Youth Services in Ontario, Canada) developed SNAP® programs in response to the need of mental health services for this age group of high-risk children and families. The SNAP® model is based on a comprehensive framework (Fig. 1, SNAP® Model Framework) for effectively teaching children with serious behavior problems emotion regulation, self-control, and problem-solving skills. Parents also learn SNAP® skills as well as researched cognitive-behavioral parenting techniques. Children and families learn how to stop and think in order to find solutions that "make their problems smaller, not bigger." The



Stop Now and Plan (SNAP®) Model, Fig. 1 SNAP® model framework

SNAP® Model Framework depicts the interconnectedness and relationship of the theoretical underpinnings, principles, programs, and technique and how research plays a role in each of these key areas. The SNAP® programs have been developed with the *technique* as the cornerstone of the program components, have been continuously informed by theory and research, and are delivered through adherence to the SNAP® principles. This dynamic model provides feedback loops which allow for fluidity between the elements to influence and inform ongoing development. The evidence-based SNAP® programs have been adapted to different populations and settings: SNAP® Boys, SNAP® Girls, SNAP® Schools, SNAP® for Children with Asperger Syndrome, SNAP® for Aboriginal Communities, SNAP® Youth Leadership, and SNAP® for Youth in Custody.

Technique

There is robust evidence that early childhood interventions focused on enhancing self-control

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are likely to bring greater return on investments (Moffitt et al. 2011). Further support for this approach is identified in other investigations which highlight that children tend to be good candidates for learning self-control strategies, especially before the age of 10 (Piquero et al. 2010). The SNAP® technique is a cognitive-behavioral emotion regulation, self-control, and problem-solving strategy intended to help children *stop and think before they act* and come up with socially appropriate plans to address their problems – helping to control impulsivity, challenge cognitive distortions, and think about the consequences of their behavior. A key aspect of the SNAP® technique is to help children identify their bodies' physiological responses (*body cues*), thoughts, feelings, and triggers (things that make them feel angry/sad/worried) and help them to make the connection between their body cues, feelings, thoughts, and what they can do to effectively regulate arousal levels and help their bodies calm down (*Stop*), so that they can come up with an effective *Plan*. As discussed in the article, *Rolling Out SNAP® – An Evidence-Based Intervention: A Summary Of Implementation, Evaluation, and Research* (Augimeri et al. 2011a), SNAP® was first developed in the former Earlscourt Child and Family Centre's day treatment classroom for children with behavioral problems in the late 1970s, and the technique underlies the entire foundation of the SNAP® Model Framework (see Fig. 1). This was then formalized with the creation and publication of program manuals (Earlscourt Child and Family Centre 1990a, b, 2001a, b, 2002; Levene 1998) and trademarked in 1998.

As noted in the SNAP® program manuals, there are a number of steps to the SNAP® technique that have been mapped onto the image of a stoplight – red light (*Stop*), yellow light (*Now and*), and green light (*Plan*). These steps are used to teach children to regulate their emotions by helping them to calm down (e.g., by taking deep breaths and/or counting to ten) (*Stop*); replace "hard thoughts with cool thoughts" (coping statements, cognitive restructuring) to help them remain calm (e.g., "this is hard but I can do this") (*Now and*); and generate effective solutions which meet these three criteria: 1. make their problems smaller instead of bigger; 2. make them feel like a winner; and 3. not hurt anyone, anything or themselves (*Plan*).

Programs

The introduction of the first SNAP® program (SNAP® Under 12 Outreach Project, now known as SNAP® Boys) in Toronto in 1985 was designed specifically to address the gap in services when the age of criminal responsibility in Canada was raised from seven to 12 under the *Young Offenders Act* (YOA) in 1984. Prior to the YOA, the *Juvenile Delinquents Act* (JDA) enacted in 1908 prosecuted children as young as 7 years of age. The YOA placed these children under the responsibility of child welfare legislation versus criminal justice; this remained when Canada replaced the YOA with the Youth Criminal Justice Act (YCJA) in 2003.

SNAP® Boys was launched in partnership with Toronto Police Service through provincial funding from the former Ministry of Community and Social Services (today, Ministry of Children and Youth Services). The mandate of SNAP® Boys is to serve children under the age of 12 who are engaging in antisocial behaviors who do not legally fall under the purview of the YCJA. SNAP® Boys is noted as the most fully developed, longest sustained, empirically based multicomponent intervention specifically for "pre-offender" youth under the age of 12 (Howell 2001, 2003). Its sister program, the SNAP® Girls Connection (now known as SNAP® Girls), began in 1996 and is the first reported *gender-specific* intervention for girls under the age of 12 with disruptive behavior problems. Both programs are fully manualized and are in various stages of replication worldwide.

Presenting issues of the children admitted into the SNAP® programs typically include stealing, lying, mischief, vandalism, aggression, assault, bullying, and truancy. A significant number of these children also experience academic difficulties and comorbid mental health symptomology, such as depressive and anxious behaviors or ADHD (Pepler et al. 2004; Walsh et al. 2002).

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Children admitted into the SNAP® clinical programs (SNAP® Boys and SNAP® Girls) have had police contact for their own misbehavior and/or have a score within the clinical range on standardized measures assessing externalizing behavioral issues (aggression, conduct, rule breaking). Primary referral sources include schools, police, child welfare, parents, and other mental health and medical professionals (see Fig. 2).

As noted in the SNAP® Logic Model (Fig. 2), assessment is informed by an ecosystemic approach (also a SNAP® *principle*, see Table 1) that takes into account interventions targeting the child, the family, the school, and the community. The Early Assessment Risk List (EARL-20B for boys or EARL-21G for girls), a structured clinical risk/need assessment device for use with aggressive and delinquent children, is also completed to provide a comprehensive framework for evaluating risk factors known to influence a child's propensity to engage in future antisocial behavior. Informed by the ecosystemic assessment, the risk assessment takes into account multi-informant perspectives (child, parent, teacher, and clinician), identifies the unique treatment needs of children and their families, and assists clinicians with treatment planning in order to mitigate these risks.

The SNAP® clinical programs (SNAP® Boys and SNAP® Girls) offer multifaceted services including core and adjunct components which are available to children and families based on their level of risk and need. In the SNAP® programs, components are goal oriented, skill focused, and developmentally responsive. Integrated into each component are key skill acquisition training techniques (i.e., role-play, modeling, self-talk) and generalization activities (home practice assignments) to transfer learning of the SNAP® technique and SNAP® parenting skills from the clinical environment to real-life settings. Following the ecosystemic and EARL assessments, a treatment plan is tailored to the child and family's strengths, risks, and needs. Children and families typically begin with completing the core components. Core components include:

SNAP® Children's Group – a gender-specific manualized core component that focuses on teaching children emotion regulation, self-control, and problem-solving skills with a special emphasis on challenging cognitive distortions/thinking errors. Examples of topics covered include introduction to SNAP®, peer pressure, dealing with anger, and bullying. Children participate in a 13-week SNAP® group, occurring once a week for 1.5 h.

SNAP® Parent Group – a manualized core component that runs concurrent with the SNAP® children's groups. Parents learn emotion regulation, self-control, and problem-solving skills and effective child management strategies with a special emphasis on challenging cognitive distortions/thinking errors, reducing isolation, and enhancing parent-child relationships. Examples of topics covered include effective communication, positive reinforcement, limit setting and consequences, and family problem solving. Three of the group sessions are joint parent-child sessions where parents and children practice skills together.

Girls Growing Up Healthy (GGUH) – a manualized core component unique to SNAP® Girls, this mother-daughter group focuses on enhancing relationship capacity, healthy relationships, and physical and sexual health. Topics covered include preparing for puberty, deconstructing stereotypes, and planning for the future. Caregivers and daughters meet for 8 weeks, once a week for 2 h.

The following adjunct components are offered based on the child's and family's identified goals, strengths, risks, and continued treatment needs:

Individual Counseling/Mentoring/Community Connections – provides children with individualized support with a SNAP® worker to reinforce and enhance skills learned in the SNAP® children's group and address treatment targets (i.e., social skills, coping ability, cognitive restructuring) and goal attainment. Children can also be matched with volunteers who connect them with structured recreational activities in their community.

Stop Now and Plan Parenting (SNAPP): individualized family counseling – based on our SNAPP Manual, is offered to families who are

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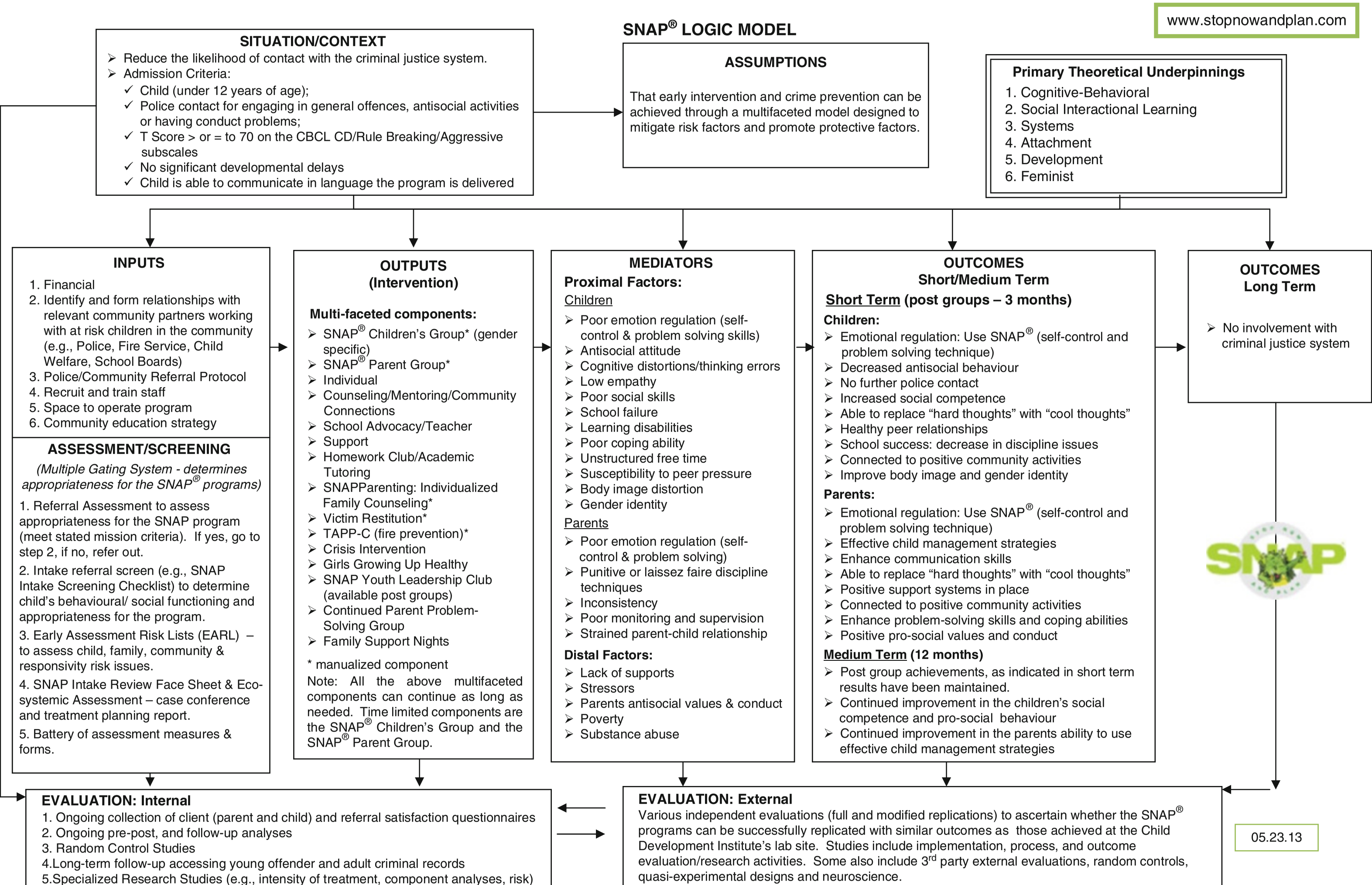

Stop Now and Plan (SNAP®) Model, Fig. 2 SNAP® logic model

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Stop Now and Plan (SNAP®) Model, Table 1 SNAP® principles and indicators

Principle	Indicator
Scientist-practitioner	An interactive science-practice paradigm is sustained by regular cross discipline workgroups to support the high-quality evolution of SNAP® program development, outcomes, and research
Client centered	Services are informed by client personal and cultural narratives and goals, ensuring client responsiveness through growth-oriented engagement and alliances
Gender sensitive	Specific gendered factors which account for differential development, learning styles, and trajectories of boys and girls with conduct problems are integrated throughout SNAP® programs
Ecosystemic	Each client's ecological system (individual, home, school, community) is assessed to identify and inform strengths, needs, and risk and protective factors and to match them with appropriate service components and treatment intensity
Strength and skill based	Specific, consistent use of positive reinforcement, as part of our evidence-based, cognitive-behavioral practice, promotes and strengthens individual capabilities and the acquisition of primary SNAP® skills: emotion regulation, self-control, and problem solving
Continuing services	Continuing needs and commitment to service are regularly and jointly assessed to support and ensure high-risk families, children, and youth are engaged in services
Collaborative	Effective collaborations with appropriate child- and family-oriented services are conducted to ensure service coordination and family support system development during and after SNAP® services
Community responsive	SNAP® programs are adapted to diverse, cultural, and socioeconomic factors that characterize communities in order to be responsive to social determinants of child and family mental health
Accountable service excellence	Combination of high-quality staff development activities that include consistent supervision, training, integrity, and the attainment of accountable standards assessed through a series of well-developed research, evaluation, fidelity, and quality assurance activities fosters overall service excellence

unable to attend the SNAPP parent group, who need additional assistance/practice with parenting skills, or who need parenting support to address barriers to skill acquisition (i.e., mental health, parent cognitive restructuring, attachment).

School advocacy/teacher support – ensures that children receive the best possible education meeting their individual behavioral and learning needs. Teachers of identified clients are contacted at the start of the program to introduce the program skills and offer behavior management support if needed. Parents are supported in advocating for their children within the school system environment.

Crisis intervention – a service available to assist parents and children involved in the SNAP® program in dealing with challenging situations as they arise and/or referral to appropriate crisis services.

TAPP-C (The Arson Prevention Program for Children) – offered to children with fire interest or fire setting as a presenting problem. It involves a fire interest assessment and recommendations, a home safety visit, and education regarding fire by Toronto Fire Services.

Victim restitution – activities that encourage children to apologize to their victim, redress behaviors, and begin to learn how to take responsibility for their actions.

Homework Club/academic tutoring – provides remedial sessions for children functioning below grade level. Weekly 1 hour tutoring sessions with teachers or specially trained volunteers are held in the child's home or community.

SNAP® Youth Leadership Club – a component offered in both the boys' and girls' programs for youth who have completed the core components of the SNAP® program but continue to be high risk. Staff provide group, individual, and family work to prepare at-risk youth for self-sufficiency, increase motivation for school involvement and success, improve their workforce career trajectories, and reduce their involvement with the law.

Parent problem-solving group – a 9-week group component for parents who have

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completed the SNAP® parent group. The focus is on enhancement and refinement of family problem-solving skills in relation to ongoing issues the families are experiencing (i.e., keeping rewarding effective, difficulty with consequencing, school issues, media awareness) while providing continued support.

Long-term connections/continued care – families may continue to be involved in all components of SNAP® as long as there is a need and interest. In addition to previously listed components, this may also include activities such as participation as a peer or parent mentor.

Principles

Nine *principles* with specific indicators have been identified to describe the approach to service delivery and guide SNAP® programming. In addition, the *principles* ensure service and clinical excellence when organizations replicate SNAP® in their communities (sites). These are also used to assist in measuring implementation adherence, fidelity, and integrity of the SNAP® prevention and intervention programs (see Table 1).

SNAP® Theoretical Underpinnings

From the very beginning, the SNAP® model was built on well-known theoretical approaches showing promise in the early 1980s. These included social skills training, cognitive problem solving, self-control and anger management strategies, cognitive self-instruction, family management skills training, and parent training. As noted by Augimeri et al. (2011a), the model continued to evolve as SNAP® scientists and practitioners consulted with the Oregon Social Learning Center (OSLC) in Eugene, Oregon. These consultations helped to strengthen the SNAP® parenting component by adopting aspects of OSLC's Social Interactional Family Therapy's (now known as Social Interactional Learning) approach to working with families (Patterson et al. 2010). The SNAP® model programs have evolved to reflect the contributions of six core treatment theories, including Systems, Social Interactional Learning, Cognitive-Behavioral, Attachment, Feminist and Developmental Theories (see Fig. 2). It is important to note that these theories are not viewed as stand-alone entities, but as interactive in their contributions to the foundation and ongoing development of the SNAP® model programs.

The SNAP® Logic Model (see Fig. 2) also illustrates that the primary targeted outcomes include improved overall child and family functioning with an emphasis on emotion regulation, self-control, and problem solving for both parent/caregiver and child. As Strayhorn (2002) indicates, "self-control difficulties are of central importance for many psychiatric disorders. . .[it] is also a crucial, and often missing, ingredient for success in most treatment programs" (p. 7).

Research

Research on the SNAP® programs has been an integral part of the model's ongoing development since its inception and continues on an ongoing basis. Scientists and clinicians work within a collaborative process (SNAP® *principle: scientist-practitioner*) to inform and update the theoretical approaches of the model, ongoing evaluation, and program development. Rigorous internal and external evaluations of SNAP® programs (e.g., process and outcome evaluation, quasi-experimental designs, random control trials, long-term follow-up – criminal record searches, cost-benefit analyses, third-party external evaluations, and neuroscience) have consistently demonstrated positive treatment effects over time: children improve significantly more than children receiving an attention-only group, delayed treatment, or an alternative treatment with notable effect sizes (moderate to large); treatment gains are maintained at 6, 12, and 18 months; parents report less stress in their interactions with their children and increased confidence in managing their children's behavior; children report improved quality of interaction with parents, less yelling, and more limit setting; children report more positive attitudes and less anxiety and demonstrate more pro-social skills with teachers, peers, and family members. Longitudinal research analysis showed that

91.8 % of the boys and 95 % of the girls had no history of criminal offences by age 14 and approximately 68 % of the children have not had a criminal record by age 19 (Pepler et al. 2010; Augimeri et al. 2007, 2011b). Brain imaging studies conducted by the Hospital for Sick Children in Toronto and the University of Toronto showed that children who responded positively to SNAP® treatment manifest changes in brain systems responsible for cognitive control and self-regulation, and a number of SNAP® families showed an ability to "repair" after engaging in a difficult parent-child interaction (see Granic et al. 2007; Lewis et al. 2008; Woltering et al. 2011).

Designations

As a result of these promising research findings, SNAP® has achieved the highest levels of recognition from independent reviewers who rate evidence-based programs. In 2012, the US Department of Justice, Office of Justice Programs, designated SNAP® as an "effective" crime prevention model (see http://www.crimesolutions.gov/ProgramDetails.aspx?ID=231). In 2011, Public Health Agency of Canada designated SNAP® as a Canadian best practice under their Preventing Violence Stream – Canadian Best Practice Portal (see http://cbpp-pcpe.phac-aspc.gc.ca/intervention/707/view-eng.html; http://cbpp-pcpe.phac-aspc.gc.ca/intervention/706/view-eng.html. In an excerpt outlining effective options for young children with conduct problems, Cipriani (2009) highlighted the SNAP® model as the "best example" of effective early intervention strategies and discussed the program and its successes at length. In 2008, the Canadian *National Crime Prevention Centre* designated SNAP® as a "Model Program" (see www.publicsafety.gc.ca/res/cp/res/2008-pcpp-eng.aspx), in 2012 it was designated as an "Effective Program" by the US Department of Justice's OJJDP (see www.ojjdp.gov/mpg/mpgProgramDetails.aspx?ID=699) because of its robust treatment outcomes, and in 2006 it was given the highest effectiveness designation (Level 1) by the United States' Whitehouse program *Helping America's Youth*, now titled *FindYouthInfo.gov;* (see www.findyouthinfo.gov/ProgramDetails.aspx?pid=699). At the beginning of 2000, a study group on very young offenders led by Drs. David Farrington and Rolf Loeber found the SNAP® program was the "most fully developed intervention to date for child delinquents" (Howell 2001, p. 312).

Current Issues/Controversies

SNAP® Model Replication and Implementation

For a discussion of the program's replication standards and principles, licensing agreements, accreditation, and fidelity frameworks ensuring successful replication of the SNAP® model, see Augimeri et al. 2011b. In this discussion, having a team of dedicated scientists and practitioners was emphasized in order to create an effective, well-established, and recognized program, and it stressed that host organizations need commitment, support, and resources when incubating an evidence-based model program within a community setting.

Five important criteria were identified for the successful implementation and replication of SNAP®: (1) *Adherence* to the model is critical, (2) *restraint from making modifications* is essential, (3) *training and ongoing consultation* is mandatory, (4) *ongoing fidelity/integrity audits* are necessary to ensure the highest possible efficacy, and (5) *selecting the right staff* is paramount to program success.

SNAP® licensing agreements are established with the Child Development Institute. CDI's experience in disseminating SNAP® is that with adequate training and support, this model can be successfully replicated and implemented with strong fidelity in a variety of settings. SNAP® fits in the classroom, in the clinician's office, and at home. The program can be situated in a variety of diverse community settings and real-life community conditions. Currently, there are a number of successful SNAP® implementations in Canada, the United States, and Europe.

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SNAP® Fidelity and Integrity Framework

For successful implementation and replication of evidence-based programs such as SNAP®, training and ongoing consultation activities between the site and its replicators are considered paramount (Augimeri et al. 2011b). As the SNAP® model incorporates a complex therapeutic approach, it requires strict documentation of the services being delivered and records of any integrity activities conducted to ensure successful replication and outcomes. As a result, there is a need to identify all the intricate elements of the various treatment components within the SNAP® model (e.g., SNAP® core groups, individual counseling/mentoring, family counseling) in order to effectively monitor if the delivery of these key elements is done correctly and skillfully, when and where necessary. The SNAP® principle, *accountable service excellence*, highlights the requirement of fidelity practices that include case file audits, consultations, adherence to group manuals, and consistency of facilitation skills. It is essential that the integral pieces of SNAP® related to long-term positive outcomes (e.g., decreased criminal activity) are delivered with appropriate timing, skill, and adherence. Ultimately, SNAP® researchers and facilitators are concerned with delivering an effective program that adequately meets all objectives that were predefined with the clients.

Key Aspects to Ensure a Successful International Implementation

Even though successful SNAP® sites have been established worldwide, we continue to recognize that there are many obstacles to successful implementation. As noted earlier, the implementation of an evidence-based model can be challenging on its own. This is especially true when it is being adopted in another country or culture. As SNAP® implementations continue to reach communities worldwide, the onus is on SNAP® developers to explore creative methods for ensuring successful replications. There are several important factors (e.g., language, culture, travel) that may need to be considered when replicating a "foreign" intervention, even though its core strategies are proven to have universal applicability (e.g., cognitive-behavioral therapy).

Future Directions

A sixth implementation criterion that would greatly contribute to not only the successful implementation of the program, but most importantly, its sustainability, would be the *adoption of community teams for children under 12* (Augimeri et al. 2001a; Goldberg et al. 1999). *Community teams* would be comprised of representatives from child welfare, school personnel, and criminal justice systems such as the police, health, and children's mental health. The *community team* would be responsible for setting up police-community referral protocols, managing and maintaining a centralized referral intake line, conducting comprehensive risk and needs assessments/screenings, and connecting children and families to the appropriate gender-sensitive services to at-risk children and their families. The creation of a government-supported *National Advisory Working Group for Children and Youth Involved in Offending Behaviour* would act as a knowledge-based resource center (similar to CDI's CCCO) dedicated to knowledge transfer activities that would support the dissemination of current research and services tailored to the needs of high-risk children and their families. This national working group would act as an external, unbiased body responsible for monitoring fidelity of implementation and replication, thus ensuring integrity and accountability from those engaged in assessment and/or services.

Conclusion

After numerous decades of working with young children in conflict with the law, their families, and communities, CDI and SNAP® continue to support and advocate on behalf of these "forgotten children." CDI and SNAP® researchers and clinicians remain committed to keeping such children out of the youth justice and adult criminal systems. These vulnerable children deserve our utmost attention and help to develop to their fullest potential.

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Strategies of Policing Terrorism

Simon Perry
Institute of Criminology, Faculty of Law, The Hebrew University, Jerusalem, Israel

Synonyms

Counterterrorism strategies; Internal security strategies

Overview

In the last decade terrorism has become a prominent topic in many areas, including criminology. Since terrorism affects almost every aspect of life, it has become a central priority for the police in Western democracies. American police and even countries that had been prepared to fight terrorism prior to 9/11, such as Great Britain and Germany, began after that date to review their readiness and rethink the role of police in counterterrorism (Weisburd et al. 2009a; Bayley and Weisburd 2009; International Association of Chiefs of Police 2005; Bamford 2004). Howard (2004) argues that police departments should start thinking of themselves as proactive valuable assets in deterring, defeating, and recovering from terrorist attacks. Law enforcement, intelligence, and security agencies are expected to team up, join forces, and work together with other organizations to uncover terrorist networks, foil terrorist attacks, respond to suspicious situations, and serve as first responders (Weisburd et al. 2009a). Yet there is a lack of evidence-based models for this new role of policing terrorism. A Campbell Collaboration (Lum et al. 2006) systematic review of strategies to combat terrorism could only identify seven studies that met minimal methodological requirements. None of these seven studies examined a police intervention. In fact, to date there are only a few descriptions of possible models for strategic and tactical activities of policing terror. Therefore, little is known about what the best antiterrorism strategies and tactics are. Furthermore little is known about how models can be systematically measured and assessed for their effectiveness (Weisburd et al. 2009a).

This entry will attempt to summarize recent developments in the field of counterterrorism. It will introduce and portray principal strategies, tactics, and practices that are presented in the literature and/or that have been widely adopted by practitioners in policing terrorism.

Why Police Bear Primary Responsibility for the Terrorism Threat in Democratic Countries?

Before discussing what these counterterrorism strategies, tactics, and practices are, four principal themes that naturally surface will be discussed: (a) the characteristics of the terrorism threat phenomenon, (b) the complexity of developing and evaluating a counterterrorism model, (c) the tension between preserving democratic principles and counterterrorism, and (d) why the police (according to Bayley and Weisburd 2009) bear primary responsibility for preserving public security in most countries.

The Terrorism Threat

In order to address the threat and develop an effective response to terrorism, one should first define this criminological phenomenon and its goals (Weisburd et al. 2009b). According to