

*Chapter 1*

## PREVENTING VIOLENCE: THE ROLE OF RISK ASSESSMENT AND MANAGEMENT

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Violence, and in particular violence against women and children, is recognized worldwide as a major public health problem. The response of the criminal justice and health care systems to violence relies on two related processes: *risk assessment*, the process of identifying risk and protective factors for violence; and *risk management*, the process of preventing violence by influencing risk and protective factors. The first part of this chapter discusses the nature and goals of violence risk assessment, compares the professional judgement and actuarial approaches to assessing violence risk, and identifies some major limitations of existing procedures for violence risk assessment. The second part of the chapter focuses on violence risk management. It presents general principles that should guide the development of risk management strategies, as well as a comprehensive model of risk management tactics.

*Violence* is the actual, attempted, or threatened physical injury of another person that is deliberate and nonconsensual (Webster, Douglas, Eaves, and Hart, 1997). Violence is a major determinant of physical and psychological well-being. In 1996, the Forty-Ninth World Health Assembly resolved that violence – and, in particular, violence against women and children – is “a leading worldwide public health problem” (Resolution WHA49.25; see Krug et al., 2002, pp. xx-xxi) and urged its member states to take steps to deal with the problem, including the implementation of violence prevention programs.

According to Dahlberg and Krug (2002), the view that “violence can be prevented and its impact reduced...is not an article of faith, but a statement based on evidence” (p. 3). They discuss various prevention programs, noting that their efficacy depends in part upon the systematic identification of risk and protective factors. This is true regardless of whether the

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programs are designed to prevent victimization among people who have never been exposed to violence (i.e., primary or "true" prevention), those who appear to be at elevated risk (i.e., secondary prevention), or those who have already been victimized in the past (i.e., tertiary prevention).

The process of identifying risk and protective factors for violence is sometimes referred to as *violence risk assessment*. Similarly, the process of preventing violence by influencing risk and protective factors is sometimes referred to as *risk management*. Risk assessment and risk management are integral parts of the contemporary criminal justice and public health responses to violence (e.g., Andrews and Bonta, 2003; Kraemer et al., 1997). The goals of this chapter are twofold: first, to discuss the nature and goals of violence risk assessment, as well as the two primary approaches to assessing violence risk; and second, to present some general principles for violence risk management, including a comprehensive model of risk management tactics. The focus of the chapter is on violence in general; several chapters in the rest of this volume focus on risk assessment and management specifically in the context of intimate partner violence.

## VIOLENCE RISK ASSESSMENT

### The Nature of Violence Risk

A risk is a hazard that is incompletely understood and thus whose occurrence can be forecast only with uncertainty (Bernstein, 1996). The hazard we are concerned with in this chapter is violence, and violence clearly is a complex phenomenon. Violent acts can vary greatly with respect to such things as motivations, acquaintanceship with the victim, severity of physical or psychological harm, and so forth. Accordingly, violence risk is multi-faceted and cannot be conceptualized or quantified simply, for example, in terms of the probability that someone will engage in violence. Instead, one must also consider the nature, seriousness, frequency or duration, and imminence of any future violence (Hart, 1998, 2001; Janus and Meehl, 1997; but cf. Kapur, 2000; Kraemer et al., 1997). Also, violence risk is inherently dynamic and contextual (Hart, 1998, 2001; Kapur, 2000). For example, the violence risk posed by patients depends on where they will reside, what kinds of clinical services they will receive, their future motivation to establish a pro-social adjustment, whether they will experience adverse life events, and so forth. In essence, then, violence risk is not a characteristic of the physical world that can be evaluated objectively, but a subjective perception – something that exists not in fact, but in the eye of the beholder. These opinions regarding the nature and degree or quantum of risk in a given case, as well as the selection of risk management strategies and tactics, are based, in turn, on judgments regarding the collective influence of myriad individual things or elements, referred to as *risk factors*.

But what exactly is a risk factor? It is relatively easy to demonstrate using a wide range of research designs that a thing is, on average, correlated with violence. But things that are correlated with violence may be causes, features, concomitants, or even consequences of violence. A risk factor is a correlate that also precedes the occurrence of the hazard and therefore may play a causal role (Kraemer et al., 1997). Demonstrating that something is a risk factor requires longitudinal research or well-substantiated theory. Risk factors may be

further subdivided into three types (Kraemer et al., 1997). *Fixed risk markers* do not change over time in status. *Variable risk markers* change status over time, but these changes do not influence the outcome. *Causal risk factors* change status over time, and these changes influence the outcome. Differentiating among these three types of risk factors also requires longitudinal designs, and, ideally, experimental or quasi-experimental longitudinal designs.

Considerable attention has been devoted to the identification of (putative) risk factors for violence. There have been several excellent summaries of the research literature in recent years (e.g., Litwack and Schlesinger, 1999; Monahan and Steadman, 1994; Otto, 2002; Webster and Douglas, 1999). Unfortunately, there is no good research or theory that helps us to determine the nature of risk factors, ascertain their potency, understand how they are associated with each other, or specify what causal role they may play with respect to violence.

### **The Nature of Assessment**

Assessment is the process of gathering information for use in decision making. The specific assessment procedures used are determined by what is being assessed and the nature of the decisions to be made. In the case of violence risk assessment, we must assess what people have done in the past, how they are functioning currently, and what they might do in the future. The decisions to be made are strategic in nature, including what should be done in clinical and legal settings to cope with or manage the violence risks posed by a person (Hart, 2001; Heilbrun, 1997; Monahan, 1981/1995; Monahan and Steadman, 1994). This means that violence risk assessment can be defined as the process of evaluating individuals to (a) characterize the risk they will commit violence in the future, and (b) develop interventions to manage or reduce that risk (Hart, 2001). Put differently, the task is to understand how and why a person chose to act violently in the past and then to determine what could be done to discourage the person from choosing to act violently in the future. The specific procedures used to gather relevant information typically include interviews with and observations of the person being evaluated; direct psychological or medical testing of the person; careful review of available documentary records; and interviews with collateral informants such as family members, friends, and service providers (Webster et al., 1997).

### **Goals of Violence Risk Assessment**

The ultimate goal of violence risk assessment is violence prevention, or the minimization of the likelihood of and negative consequences stemming from any future violence. But violence risk assessment should achieve a number of goals in addition to the protection of public safety (Hart, 2001): A "good" risk assessment procedure should also yield consistent or replicable results. That is, mental health professionals should reach similar findings when evaluating the same patient at about the same time. It is highly unlikely that inconsistent or unreliable decisions can be of any practical use. Furthermore, a good risk assessment procedure should be prescriptive; it should identify, evaluate, and prioritize the mental health, social service, and criminal justice interventions that could be used to manage a patient's violence risk. Finally, a good risk assessment procedure should be open or transparent. Put another way, we mental health professionals are accountable for the decisions we make, and it

is therefore important for us to make explicit, as much as is possible, the basis for our professional opinions. A transparent risk assessment procedure allows patients and the public a chance to scrutinize our opinions. The transparency should protect mental health professionals when a patient commits violence despite the fact that a good risk assessment was conducted, as it can be demonstrated easily that standard or proper procedures were followed. Transparency should also protect patients and the public by making it obvious when an improper risk assessment is conducted.

It is impossible for any single risk assessment procedure to achieve all these goals with maximum efficiency. Similarly, it is impossible for the various parties interested in violence risk assessment (mental health professionals, hospital administrators, patients, lawyers, judges, victims, etc.) to reach a consensus regarding which procedure is "best" for all purposes and in all contexts (Hart, 2001). Instead, mental health professionals should choose the best procedure or set of procedures for a particular assessment of a particular patient after considering explicitly the legal context of the evaluation.

## APPROACHES TO VIOLENCE RISK ASSESSMENT

Mental health professionals use two basic approaches to reach opinions about violence risk: professional judgment and actuarial decision making (e.g., Menzies, Webster, and Hart, 1995; Monahan, 1981/1995). These terms refer to how information is weighted and combined to reach a final decision, regardless of the information that is considered and how it was collected (Meehl, 1954/1996). The hallmark of professional judgment procedures is that the evaluator exercises some degree of discretion in the decision-making process, although it is also generally the case that evaluators have wide discretion concerning how assessment information is gathered and which information is considered. It comes as no surprise that unstructured clinical judgment is also described as "informal, subjective, [and] impressionistic" (Grove and Meehl, 1996; p. 293). In contrast, the hallmark of the actuarial approach is that, based on the information available to them, evaluators make an ultimate decision according to fixed and explicit rules (Meehl, 1954/1996). It is also generally the case that actuarial decisions are based on specific assessment data, selected because they have been demonstrated empirically to be associated with violence and coded in a pre-determined manner. The actuarial approach also has been described as "mechanical" and "algorithmic" (Grove and Meehl, 1996; p. 293).

### Professional Judgment Procedures

The professional judgment approach comprises at least three different procedures. The first is unstructured professional judgment. This is decision making in the complete absence of structure, a process that could be characterized as "intuitive" or "experiential." Historically, it is the most commonly used procedure for assessing violence risk and therefore is very familiar to mental health professionals, as well as to courts and tribunals. It has the advantage of being highly adaptable and efficient; it is possible to use intuition in any context, with minimal cost in terms of time and other resources. It is also very person-centered,

focusing on the unique aspects of the case at hand, and thus can be of great assistance in planning interventions to manage violence risk. The major problem is that there is little empirical evidence that intuitive decisions are consistent across professionals or, indeed, that they are helpful in preventing violence. As well, intuitive decisions are unimpeachable; it is difficult even for the people who make them to explain how they were made. This means that the credibility of the decision often rests on charismatic authority — that is, the credibility of the person who made the decision. Finally, intuitive decisions tend to be broad or general in scope, so that they become dispositional statements about the patient (“Patient X is a very dangerous person”) rather than a series of speculative statements about what the patient might do in the future assuming various release conditions.

The second professional judgment procedure is sometimes referred to as *anamnestic* risk assessment (e.g., Melton, Petrila, Poythress, and Slobogin, 1997; Otto, 2000). This procedure imposes a limited degree of structure on the assessment as the evaluator must, at a minimum, identify the personal and situational factors that resulted in violence in the past. The assumption here is that a series of events and circumstances, a kind of behavioral chain, led up to the patient’s violent act. The professional’s task, therefore, is to understand the links in this chain and suggest ways in which the chain could be broken. (In this way, anamnestic assessment has much in common with relapse prevention or harm reduction approaches to treating violent offenders.) However, there is no empirical evidence supporting the consistency or usefulness of anamnestic risk assessments. Anamnestic risk assessment also seems to assume that history will repeat itself — that violent people are static over time, so the only thing they are at risk to do in the future is what they have done in the past. Nothing could be further from the truth, of course; there are many different “trajectories” of violence. Some patients or prisoners will escalate in terms of the frequency or severity of violence over time, some change the types of violence they commit, and some will de-escalate or even desist altogether.

The third procedure is *structured professional judgment*. Here, decision making is assisted by guidelines that have been developed to reflect the “state of the discipline” with respect to scientific knowledge and professional practice (Borum, 1996). Such guidelines — sometimes referred to as clinical guidelines, consensus guidelines, or clinical practice parameters — are quite common in medicine, although used less frequently in psychiatric and psychological assessment (Kapp and Mossman, 1996). The guidelines attempt to define the risk being considered; discuss necessary qualifications for conducting an assessment; recommend what information should be considered as part of the evaluation and how it should be gathered; and identify a set of core risk factors that, according to the scientific and professional literature, should be considered as part of any reasonably comprehensive assessment. Structured professional guidelines help to improve the consistency and usefulness of decisions, and certainly improve the transparency of decision making. They may, however, require considerable time or resources to develop and implement. Also, some evaluators dislike this “middle ground” or compromise approach, either because it lacks the freedom of intuitive decision making or because it lacks the objectivity of actuarial procedures.

## Actuarial Procedures

There are at least two types of actuarial decision making. The first is the actuarial use of psychological tests. Classically, psychological tests are structured samples of behavior designed to measure a personal disposition, that is, an attempt to quantify an individual's standing on some trait dimension. Research indicates that some dispositions — such as psychopathy (Hart, 1998), major mental illness (Hodgins, 1992), and impulsivity (Barratt, 1994; Webster and Jackson, 1997) — are associated with violence risk in a meaningful way. On the basis of research results, one can identify cutoff scores on the test that maximize some aspect of predictive accuracy. This procedure has several strengths, most importantly its transparency and the demonstrated consistency and utility of decisions made using tests. One major problem is that the use of psychological tests requires considerable discretion: Mental health professionals must decide which tests are appropriate in a given case, and judgment also may be required in test scoring and interpretation. Another problem is that reliance on a single test does not constitute a comprehensive evaluation and will provide only limited information for use in developing management strategies and tactics. More generally, the actuarial use of psychological tests focuses professional efforts on passive violence prediction rather than violence prevention.

The second type of procedure is the use of actuarial risk assessment instruments. In contrast to psychological tests, actuarial instruments are designed not to measure anything but solely to predict the future. Typically, they are high fidelity, optimized to predict a specific outcome in a specific population over a specific period of time. The items in the scale are selected either rationally (on the basis of theory or experience) or empirically (on the basis of their association with the outcome in test construction research). The items are weighted and combined according to some algorithm to yield a decision. In violence risk assessment, the "decision" generally is the estimated likelihood of future violence (e.g., re-arrest for a crime against persons) over some period of time. Like psychological tests, actuarial instruments have the advantage of transparency and direct empirical support; they also suffer many of the same weaknesses, including the need for discretion in selecting a test, interpreting findings, and the limitations of the test findings for use in planning interventions. There are additional problems with actuarial instruments that estimate the absolute likelihood or probability of recidivism. One is that they require tremendous time and effort to construct and validate. In cases where the time frame of the prediction is long, true cross-validation may require decades. Also, when constructing actuarial tests, there is a classic bandwidth-fidelity trade-off between precision of estimated recidivism rates and generalizability: The same statistical procedures that optimize predictive accuracy in one setting will decrease that test's accuracy in others. Finally, it is easy to accord too much weight to information concerning the estimated likelihood of recidivism provided by actuarial tests. Most actuarial tests of violence risk yield very precise likelihood estimates, proportions with 2 or 3 decimal places, but they do not provide the information necessary to understand the error inherent in these estimates. When one considers the fact that many of these estimates were derived from relatively small construction samples and have not been validated in independent samples, it is clear that the actuarial test results are only pseudo-precise. It is important for any professional who uses actuarial tests to understand and explain to others the limitations of absolute likelihood estimates of recidivism.

## LIMITATIONS COMMON TO PROFESSIONAL JUDGMENT AND ACTUARIAL PROCEDURES

Existing risk assessment procedures tend to suffer from important limitations. One is that they tend to focus on negative characteristics or features — factors associated with increased risk — rather than personal strengths, resources, and protective or “buffer” factors. A comprehensive risk assessment designed to assist in the development of interventions must take into account these positive features. A second problem is that few existing risk assessment procedures are tied to the development of interventions in a systematic or prescriptive manner. This is, in part, because most risk assessment procedures focus on identifying the presence of risk factors, rather than their functional relevance. In any given case, decisions about which interventions to use require evaluators to determine which risk factors are most important and why they are important (i.e., the nature of their causal influence). A third problem is one of quality assurance. Basic research to develop risk assessment procedures is important, but it is naïve to assume that any procedure will function similarly in the field. Evaluative research is required to monitor the implementation of risk assessment procedures and to determine whether they are functioning optimally and what could be done to improve their use.

## VIOLENCE RISK MANAGEMENT

A comprehensive risk management strategy should be developed according to several principles (Hart, 2001; Kropp, Hart, Lyon, and LePard, 2002; see also Andrews and Bonta, 2003). First, the strategy should reflect overall judgments regarding the risks posed by the individual. Second, it should focus on risk management activities or tactics on factors that are relevant in the case at hand, so each relevant risk factor is addressed (i.e., neutralized or contained) by one or more activities. Third, it should be personalized in a way that maximizes its robustness and effectiveness for the individual. Let us discuss each of these principles in turn.

### The Management Strategy Should Reflect Risks Posed

The risk management strategy should reflect both the nature and degree or quantum of risk in the case at hand. With respect to the nature of the risks posed, evaluators must speculate about the types or kinds of violence the individual may perpetrate in the future. The evaluator must ask the question, what exactly is it that I am worried this person might do? The answers are based on an analysis of what the individual has done in the distant and recent past, as well as what the individual is thinking about doing or planning to do at the present time. These descriptions of “possible futures” may be referred to as *scenarios*, short narratives designed to simplify complex issues in a way that facilitates communication and planning (Hart et al., 2003; more generally, see Chermack and Lynham, 2002; Ringland, 1998; Schwartz, 1990; van der Heijden, 1997). The scenarios are not predictions about what will happen, but rather projections about what could happen. Although the number of possible

scenarios is almost limitless, in any given case, only a few distinct scenarios seem plausible, credible, or internally consistent to evaluators in light of theory, research, experience, and the facts of the case (e.g., Chermack and van der Merwe, 2003; Pomerol, 2001).

With respect to the quantum or degree of risk posed by the individual, evaluators should think in both absolute and relative terms. In absolute terms, risk is the probability or likelihood that the person will perpetrate a specific type of violence. Although it is impossible to predict the future with any reasonable degree of scientific or professional certainty, evaluators can meaningfully or plausibly rank-order the different types of violence that a person might commit in terms of the probability or likelihood of occurrence. For example, the likelihood a person will commit sexual homicide is generally much lower than the probability he will commit a non-lethal sexual assault. In relative terms, risk is the level of effort or attention that should be devoted to the management of this person vis-à-vis other people. For example, it may be useful to classify cases as low or routine priority, moderate or elevated priority, and high or urgent priority (e.g., Hart et al., 2003).

It is only after evaluators have identified what types of violence a person might perpetrate and how worried they are the person might do so that they can take rational steps to prevent the violence from occurring.

### **The Management Strategy Should Reflect Relevant Risk Factors**

There are several ways in which a risk factor may be relevant to risk management. First, it may be a *motivator* of violence. A motivator is a risk factor that makes violence an attractive or rewarding option for the person. For example, serious employment problems may lead someone to perceive armed robbery as a viable means of getting money; and relationship problems may lead someone to perceive intimate partner violence as a good way of expressing one's anger or frustration. Second, the factor may be a *disinhibitor* of violence. A disinhibitor is a risk factor that makes the person less likely to be influenced by restraints, prohibitions, or proscriptions against violence, regardless of whether these are intrinsic or extrinsic in nature. For example, alcohol intoxication, extreme anger, or lack of empathy associated with personal disorder may lessen the person's experience of anticipatory anxiety when he considers the possibility of perpetrating armed robbery or intimate partner violence. Finally, even when it is not causally related to violence, a risk factor may play a role as an *impeder* of risk management. An impeder is a risk factor that decreases the effectiveness of the various tactics that are or could be used to prevent future violence. For example, anti-authority attitudes may lead the person to reject the assistance offered by a probation or parole officer; and impulsivity associated with personality disorder may impair the person's ability to make, implement, and revise plans regarding psychological or psychiatric treatment.

But how do evaluators determine which risk factors are relevant in a given case, and how they are relevant? Unfortunately, there is a simple or objective test for measuring relevance. Neither is it possible to use the results of scientific research, as what is true in general may not be true in a specific case. This means that judgments about relevance – like scenarios of future violence – are hypotheses based on scientific theory, scientific research, personal experience, and the facts of the case. Although it is not possible to test directly the scientific validity of these hypotheses, it is possible to evaluate the plausibility or reasonableness of their underlying rationale.

It is sometimes assumed that risk factors are less relevant if they are fixed in nature or if they are "static" or "stable" (i.e., appear to change little or slowly over time). Very few risk factors, however, are truly fixed. Age, criminal history, marital history, and visible tattoos are examples of risk factors that are often characterized as static, yet clearly all of these can and do change over time. Even factors that are truly fixed may change status over time due to new information or re-consideration of old information. For example, a person may decide to disclose personal information, or other people may provide collateral information that had not previously been reported. Even when a factor is truly fixed and unchanged in status, it may change in relevance. A change in the relevance may reflect differences over time in the judgment of the evaluator or in the psychological meaning of the risk factor for the person being evaluated. For example, date of birth may not change, but a person may become more reflective about his lifestyle as he ages, leading to an increase in the perceived costs of perpetrating violence; or chromosomal sex may not change, but a person may develop a gender identity disorder that leads him to become resentful of and angry at people of the opposite sex. For a more detailed discussion of the role of fixed, static, or stable factors in the management of violence risk, see Hart, Douglas, and Webster (2001).

### **The Management Strategy Should be Personalized**

A risk management strategy should be *personalized* for the case at hand. It may be useful to think of risk management in terms of building fence or wall designed to contain the risks posed by an individual (e.g., English, Jones, and Patrick, 2003). Building the fence requires a plan (the risk management strategy) that reflects the lay of the land (the risks posed by the individual). The plan should specify landmarks for placement of the fence (relevant risk factors) as well as the fencing materials to be used (the risk management tactics).

To ensure that a risk management strategy is robust and maximally effective, each relevant risk factor should be targeted by multiple tactics. To continue with the fence metaphor, some parts of a fence are more critical than others, and, in these parts, it may be necessary to place more fence posts or a stronger foundation. Also, a risk management strategy that relies on a number of different professionals working in different agencies and clinics may require coordination activities such as regular interdisciplinary meetings or a detailed policy and procedure document (Kropp et al., 2002). Metaphorically, it may be important for someone to travel the perimeter of the fence, making sure that all the posts remain upright and the fencing material is intact.

### **More on Risk Management Tactics**

Risk management tactics can be divided into four basic categories: monitoring, treatment, supervision, and victim safety planning (Hart et al., 2001; Kropp et al., 2002).

*Monitoring.* Monitoring, or repeated assessment, is always a part of good risk management. The goal of monitoring is to evaluate changes in risk over time so that risk management strategies and tactics can be revised as appropriate. Monitoring services may be delivered by a diverse range of mental health, social service, law enforcement, corrections, and private security professionals. Monitoring, unlike supervision, focuses on surveillance

rather than control or restriction of liberties; it is therefore minimally intrusive. Monitoring tactics may include contacts with the client, as well as with potential victims and other relevant people (e.g., therapists, correctional officers, family members, co-workers) in the form of face-to-face or telephonic meetings. Where appropriate, they may also include field visits (e.g., at home or work), electronic surveillance, polygraphic interviews, drug testing (urine, blood, or hair analysis), and inspection of mail or telecommunications (telephone records, fax logs, e-mail, etc.). Frequent contacts by the client with health care and social service professionals are an excellent form of monitoring; missed appointments with treatment providers are a warning sign that the client's compliance with treatment and supervision may be deteriorating. Plans for monitoring should include specification of the kind and frequency of contacts required (e.g., weekly face-to-face visits, daily phone contacts, monthly assessments). They also should specify any "triggers" or "red flags" that might warn that the individual's risk of violence is imminent or escalating.

*Treatment.* Treatment involves the provision of (re-)habilitative services. The goal of treatment is to improve deficits in the individual's psychosocial adjustment. Treatment services typically are delivered by health care and social service professionals working at inpatient or outpatient clinics or agencies. In many cases, treatment is involuntary, that is, the individual is civilly committed to inpatient or outpatient care under a mental health act; is being treated in a correctional or forensic psychiatric facility; is ordered to attend treatment as a condition of bail, probation, or parole; or is required to attend assessment or treatment as part of an employee assistance program (Kropp et al., 2002). One important form of treatment is directed at mental disorder that is causally related to the individual's history of violence. Although there is as yet no direct evidence that various treatments for mental disorder decrease violence, it is possible — and even likely — that they will have a beneficial impact. Treatments may include individual or group psychotherapy; psychoeducational programs designed to change attitudes toward violence; training programs designed to improve interpersonal, anger management, and vocational skills; psychoactive medications, such as antipsychotics or mood stabilizers; and chemical dependency programs. Another important form of treatment is the reduction of acute life stresses, such as physical illness, interpersonal conflict, unemployment, legal problems, and so forth. Life stress can trigger or exacerbate mental disorder, but it can also lead to transient symptoms of psychopathology even in people who are otherwise mentally healthy. The most effective way to reduce psychological stress is to eliminate the stressor (i.e., stressful circumstance or event). To this end, dispute resolution mechanisms may be helpful. These might include referral to crisis management services or legal counseling and even, when comprehensive assessment indicates it is likely to be helpful for both parties, a recommendation for the individual to participate in arbitration, mediation, or conferencing processes.

*Supervision.* Supervision involves the restriction of the individual's rights or freedoms. The goal of supervision is to make it (more) difficult for the individual to engage in further violence. Supervision services typically are delivered by law enforcement, corrections, legal, and security professionals working in institutions or in the community. An extreme form of supervision is incapacitation; that is, involuntary institutionalization of the individual in a correctional or health care facility. Incapacitation clearly is an effective means of reducing the individual's access to potential victims. It is, however, by no means perfectly effective: The individual may escape or elope from the institution and also may commit violence against staff or other people while institutionalized. Incapacitation also has other disadvantages: It is

expensive; it restricts accessibility to treatment services; and it may promote the development of antisocial attitudes by increasing contact with antisocial peers and by creating a sense of powerlessness or frustration. Community supervision is much more common than institutionalization. Typically, it involves allowing the individual to reside in the community with restrictions on activity, movement, association, and communication. Restrictions on activity may include requirements to attend vocational or educational programs, not to use alcohol or drugs, and so forth. Restrictions on movement may include house arrest, travel bans, "no go" orders (i.e., orders not to visit specific geographic areas), and travel only with identified chaperones. Restrictions on association may include orders not to socialize or communicate with specific people or groups of people who may encourage antisocial acts or with past or potential victims. In general, supervision should be implemented at an intensity commensurate with the risks posed by the individual. This helps to protect the individual's civil rights and also helps to reduce the liability of people involved in providing supervision services.

*Victim safety planning.* Victim safety planning involves improving the victim's dynamic and static security resources, a process sometimes referred to as "target hardening." The goal is to ensure that, if violence recurs — despite all monitoring, treatment, and supervision efforts — any negative impact on the victims' psychological and physical well being is minimized. Victim safety planning services may be delivered by a wide range of social service, human resource, law enforcement, and private security professionals. These services can be delivered regardless of whether the individual is in an institution or the community. Victim safety planning is most relevant in situations that involve "targeted violence," that is, where the identity of the likely victims of any future violence is known. Dynamic security is a function of the social environment. It is provided by people — the victim and others — who can respond rapidly to changing conditions. The ability of these people to respond effectively depends, critically, on the extent to which they have accurate and complete information concerning the risks posed to victims. This means that good victim liaison is the cornerstone of victim safety planning. Counseling with victims to increase their awareness and vigilance may be helpful. Treatment designed to address deficits in adjustment or coping skills that impair the ability of victims to protect themselves (e.g., psychotherapy to relieve anxiety or depression) may be indicated. Training in self-protection should be considered, such as protocols for handling telephone calls and mail or classes in physical self-defense. Finally, information concerning the individual (including a recent photograph), the risks posed to victims, and the steps to be taken if the individual attempts to approach the victims should be provided to people close to the victims and those responsible for their safety. This information will allow law enforcement and private security professionals to develop proper security plans. Static security is a function of the physical environment. It is effective when it improves the ability of victims to monitor their environment and impedes individuals from engaging in violence. The risk management plan should consider whether it is possible to improve the static security where victims live, work, and travel. Visibility can be improved by adding lights, altering gardens or landscapes, and installing video cameras. Access can be restricted by adding or improving door locks and security checkpoints. Alarms can be installed, or victims can be provided with personal alarms. In some cases, it is impossible to ensure the safety of victims in a particular site, and the case management team may recommend extreme measures such as relocation of the victims' residences or workplaces.

## CONCLUSION

Although brief, this chapter hopefully has illustrated both the potential importance and the daunting complexity of violence risk assessment and management. The state of scientific knowledge may be crude or primitive in many respects, yet it is sufficient to offer at least some guidance for professionals, policy makers, and other people who are responsible for preventing violence.

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