Welcome, everyone, to the National Criminal Justice Training Center's webinar, in participation with the Center for Court Innovation. Our topic today is the second webinar in a three-part series. Today's webinar is an Introduction to Evidence-Based Practices in Corrections, What Works in Changing Offender Behaviors and Protecting Victims.

Presenting today's webinar is Dr. Anjali Nandi and Rebecca Thomforde Hauser. My name is Greg Brown, and I will be your moderator for today's webinar. The victim-centered approaches to community supervision training and technical assistance program provides program support and specialized training and technical assistance to active Improving Criminal Justice Response, and Stop Violence Against Women program grantees, to develop community corrections, strategies that enhance probation and parole officers response to sexual assault, domestic violence, dating violence, and stalking.

Topics are focused on, but are not limited to, harm reduction strategies, implementing trauma informed approaches within respective jurisdictions, increasing leadership abilities to improve multidisciplinary responses, and coordinated community response team development, safety planning for victims, and effective policies and procedures. This project was supported by Grant Number 2017-TA-AX-K068, awarded by the Office of Violence Against Women, US Department of Justice. The opinions findings and conclusions and recommendations expressed in this program are those of the authors, and do not necessarily reflect the views of the Department of Justice, Office of Violence Against Women.

Poll questions may be asked during the webinar so we can better understand the audience and provide the most useful information to you. And actually, we're going to start off with a poll question. So with the first poll question, here we go. We would love to know more about who's on the call, and to get a better sense of which types of agencies are represented. Those include victim services or victim advocates, probation or community corrections, law enforcement, child advocacy center employees, social workers or mental health professionals and other.

Looks like there's a nice group-- nice mix. We've got victim services, about 27%, probation and community corrections, about 28%, law enforcement's represented, child advocacy workers are represented, so it's a really nice mix. This webinar is a three-part series focused on the enhancement of victim-centered probation responses. Today's topic is based on practices that work in changing offender behavior while still protecting victims.

Over the next 90 minutes it is our goal to help you first, explain the science behind evidence-based based practices and corrections. Second, list static and dynamic risk factors that drive criminal conduct. Third, identify successful strategies that professions can employ in their interactions with offenders. And then, fourth, describe successful domestic violence intervention practices.

With that, it's my pleasure to introduce our presenters for today's webinar. First, Dr. Anjali Nandi is an instructor with the National Criminal Justice Training Center of Fox Valley Technical College. She is also the Chief Probation Officer for the 20th Judicial District of the State of Colorado. Additionally, Dr. Nandi a published author, having co-authored nine books.

Rebecca Hauser is the Associate Director of Domestic Violence Programs for the Center of Court Innovation, a partner with NCJTC on this grant project. She assists jurisdictions nationally and in New York state, to plan and implement domestic violence courts. She also has co-authored several articles relating to the topic of domestic violence. With that, I'll now turn the time over to Dr. Anjali Nandi, who will be our first speaker today. Anjali, the time is yours.

Thank you so much, Greg. So you all have mentioned-- or all of you have heard Greg mention the term evidence-based practices. But before we define what those are, I wanted to start by talking a little bit about why this is important. So if you've been noticing trends in our criminal justice world, crime rates have gradually been reducing and yet incarceration rates have continued to increase.

Oftentimes, interestingly enough, the states with low incarceration rates actually have the highest reduction in crime, as well, which is a surprising number. Right? One would think that if we're incarcerating a ton of people, surely crime rates should reduce. But that's not what's happening.

Unfortunately, there's an over-reliance on incarceration and imprisonment as a strategy, and that strategy is just not working. And sometimes recidivism rates are as high as 60%. So if we are faced with high recidivism rates, we need to focus on certain practices that reliably reduce recidivism. So what we're going to talk about today is that there are certain practices that can be implemented, some over a longer period of time, some really quickly, that can reliably reduce recidivism anywhere from 10% to 20% based on some conservative research, all the way up to even 30% and 40% recidivism reduction rates.

So that's really what we're going to focus on today. We'll cover eight evidence-based principles. And you may have seen this graphic before. But what this does is combines these eight guiding principles. And the way the graphic works is it starts at the bottom. So it starts with something called risk need, where we're assessing risk, and then moving all the way up to engaging support in the community. And then what wraps this whole thing together is measuring practices and providing feedback.

But through today we'll just be stepping through-- really quickly stepping through all of these eight pieces. And at the place that I'm going to start is starting with risk. There is a particular principle called a risk principle. And what the risk principle does, is it states that when people are low-risk-- and by risk, I mean risk for recidivism, meaning

committing crime again or getting involved in the system again. When people are low-risk, ideally we provide them low supervision and minimal services.

So low supervision-- we're watching them a lot less. When people are higher risk, that's when we provide them a more intensive or close supervision. So that seems to make more sense. Right? Low-risk, low supervision. High-risk, high supervision. Except we run into a little bit of trouble when we have a low-risk person who we really want to invest in.

Why not give them everything we've got? Why not hook them up with all kinds of services, all kinds of supervision, just to make sure that they never come back into the system? And that would be something that oftentimes we would consider. Right? Why not provide a low-risk person a lot of stuff? Surely, that would make them better.

And what we're finding in the research is actually, we tend to make low-risk people worse when we over-supervise them or when we over-service them. And this is because when you take a low-risk person, there are certain things that make them low-risk, things like stable employment or pro-social relationships or things in the community that they're engaged with. And when we over-supervise or over-program them, we take them away from these very things that make them low-risk, and then we expose them to people who are higher risk. And so they learn new definitions for crime, new ways of doing things that are antisocial.

So the risk principle essentially says, make sure that we're matching level of supervision and service with level of risk. So I'm going to take a step back for just a second and step away from criminal justice, and talk about something that's probably really easy to relate with, which is health. And let's take cardiac health, in particular.

When you're thinking of cardiac health, there are certain things that will predict whether somebody is going to have cardiac trouble or not. So if you take a second to be thinking about it, there are certain things like stress, level of stress in my life, that might predict problems with cardiac health, exercise, smoking and genetics. So if we just take these four things-- and there are probably several other things, but if we just take these four things, you'll notice that one of them is different from the other three.

And the thing that's different is genetics. So genetics is different from exercise and smoking and stress because, for the most part, potentially I have control over smoking and stress and exercise. But I cannot change my genetics. So genetics becomes what we call a static predictor. Static, meaning it's not moving. It's not changing. It's a static predictor.

It still predicts really strongly, but it doesn't change. It's not something that I have control over versus what's dynamic, meaning I can change or I can make some-- I have some control over. That's about cardiac health. Let's step back and talk a little bit about criminal justice.

So there are many things that predict risk. There are certain static predictors that increase the likelihood or increase the likelihood that I will recidivate, and certain dynamic factors. These static factors-- the two strongest static predictors of future criminal behavior among adults is age at first arrest, meaning the younger I was when I first was arrested or got into the system, the higher the likelihood is that I'll continue an antisocial pattern.

So age at first arrest, and then number of priors. So those are my two strongest static predictors. The dynamic predictors, the things that can change, are also called needs or criminogenic needs. Criminogenic means related to crime, so criminogenic needs.

So we talked about the risk principle. Let's talk about the need principle. What the need principle says is that there are certain needs that predict whether somebody is going to recidivate stronger than a whole bunch of other needs that people have. And these, if we attend to these very things, they will get us our biggest bang for our buck in terms of reducing recidivism.

So on this slide you see eight needs that have been prioritized, and I'll talk about that in a second. But you may not be seeing some things that you thought would have been very important. Very commonly when I'm talking about these with folks they will say things like, well, surely self-esteem is a really important need. And while it is, it's very important for an individual, having high or low self-esteem doesn't predict future antisocial behavior.

So I can support somebody's self-esteem. But if I don't address these central eight needs, I've essentially not impacted that antisocial activity. And so I have essentially created somebody who is continuing with crime, but feeling really good about themselves. Right? Because I've attended to self-esteem, but not attended to the very things that drive criminal behavior.

So these central eight pieces drive criminal behavior. And we've organized them based on what the research is telling us. What are the things that really are predictive with higher risk people, and then what are the next things that usually are present that we also have to address? So you'll see the organization in terms of top four and next four.

The top four issues, I'll cover each one of them individually, are more intrinsic, internal to the person. The next four issues-- substance use, dysfunctional family, employment, leisure and recreation or what they're doing with their spare time-- those are the next four, and in some ways are more tangible and a little external to the individual.

Without going too deep into what those top four mean, which I'll do next, I just want to check in and do a poll with you all. Do you think it's easier as providers, as practitioners-- no matter what your job description is, do you think it's easier to address top four issues or next four issues? And as all of you can see by the poll results, most of you,

85% of you say it's the next four that's easier. And you are absolutely right.

So we have research that demonstrates that when certain needs are present we are more or less likely to attend to them. And here's what this research says-- that when somebody we're talking with-- when a client, a probationer, whoever it is-- when they're talking with us about a family issue or a substance use issue, we're likely to continue that discussion. We even engage in employment or education kinds of conversation.

But when they mention a big four issue, whether it's peers or attitude or anti-social behavior, anti-social cognition, any of those, we're very unlikely to engage in that conversation. And for me personally, I find those conversations a lot harder. And therefore, it's a lot easier for me to have a conversation about relapse or a conversation about how to find a job, and way more difficult to have a conversation about how somebody is thinking.

Let's delve into these top four just a little bit further. So one of the big four is called anti-social behavior. And what this means-- even though this sounds like something that's a static factor, what it means is the ability to manage a high-risk situation without engaging in criminal behavior. If that sounded way too complicated, let's make it really simple and talk about managing stress.

So, for me, when I get very stressed it's very difficult for me to manage my stress without engaging in unhelpful behavior like eating fried food and chocolate. That leaning towards managing something difficult with an unhelpful behavior is what we're talking about. So for our clients, for example, for some of them it's very hard to be in a high-risk situation and manage it without engaging in alcohol or drugs or without engaging in violence or without engaging in intimidation. And so that would be examples of anti-social behavior.

Usually, people who score high on this scale have the young age of entry into crime. They often have different kinds of crimes that they've committed. We call that versatility. And ideally, what we're trying to do here is to notice and develop new behaviors, and develop new skills for managing high-risk situations.

Second of the top four is an anti-social personality pattern. This is different from having an anti-social personality disorder. This is just a pattern of certain negative behaviors or certain negative ways of thinking and functioning. Low impulse control-- somebody who gets angry really easily, isn't able to problem-solve, has a hard time with empathy, has a Teflon-like character, you know, nothing sticks, kind of callous. And so when you see this, these are the areas to attend to.

The third is the big four is anti-social cognition. And what this is thinking that is supportive of anti-social behavior, so either values or attitudes or just rationalizations that you'll hear. And the clients that you're talking with, you'll catch it. You'll hear them make statements that you will recognize as problematic. It's almost like their statements reveal a moral compass that's a little bit off from what the rest of society is.

So those are three of the big four. And then the last one is anti-social peers. And anti-social peers could be two different things. It could be associating with folks who are anti-social or it could be not having anyone in my life who is pro-social. But everybody around me really supports crime. And so, in order to attend to that, I have to build up a pro-social support or help the client build this pro-social support.

So those were the top four, the big four. And, of course, the next four that we talked about include attending to substance use, education, employment, leisure, recreation, and engagement with a dysfunctional family system. I'm not saying that the next four are less important.

Ideally, what we're doing is assessing the individual in front of us, assessing risk. How risky is this person to commit another crime? And then, what are their needs? What do I do with this individual? What do I prioritize?

And, yes, next four issues are important. But if I have top four issues then I cannot ignore them. Unfortunately, we sometimes do that. We ignore the top four issues. We just focus on the next four, and then wonder why our recidivism rates are so high.

So when we're thinking about planning for an individual-- when we're thinking about what do I focus on-- there's so many things going on. What do I focus on? Here are some things to think about. This is in no particular order, so I don't want you to read this as the most important thing is highest criminogenic need. That's not the case.

These are just seven things to be thinking about, and you prioritize it based on your client. So you might want to focus on the highest criminogenic need, and that could be substance abuse. It could be one of the next four issues or it could be one of the top four issues. And all of the top four or least three of the top four are intrinsic, meaning internal to the person.

Or maybe you start where the client is motivated to change. Maybe you start with stability factors, which we haven't talked about yet. But stability factors are things like housing, things like do they have access to transportation or food, do they have medical issues. Those are things that really get in people's ways. They're not going to have a conversation with you about their anti-social thinking if they're so hungry or if they're not sure where they're going to sleep that night.

So we do need to focus on stability factors. Unfortunately, though, sometimes we tend to only focus on stability factors. We get people stable and then we think they're fine. And then we dismiss the rest of the criminogenic need, which unfortunately does not contribute to recidivism reduction.

The first possibility is you can focus on strengths or protective factors. Protective factors that those factors that buffer people from committing future crime. So in adults, the two strongest protective factors are engagement with

some kind of employment or engagement at school, whichever, and then having a positive pro-social intimate other, a support of some kind that's positive and pro-social. So those are the two strongest protective factors for adults.

You may want to focus on something that's connected to a non-criminogenic need that's really important to the individual or you might want to focus on something that's related to trauma. So there might be a place where trauma is really impacting their behavior. And, therefore, if you start there it really eases some of the rest of the negative behaviors that the client might be engaged in. So being trauma-informed is extremely helpful.

So we've talked about risk, we've talked about need. So the risk principle-- low-risk, low supervision and services. High-risk, high supervision and services. Don't mix low-risk and high-risk. Need-- attend to whatever the top criminogenic needs are. Yes, attend to stability factors, but the criminogenic need will tell you what kind of services to provide.

So if I have somebody who's top criminogenic need is anti-social cognition, let me put them in a cognitive behavioral treatment group, not a group focused purely on substance or relapse prevention, for example, if that's not the client's highest criminogenic need.

So then the third principle that we're going to talk about is something called responsivity. And responsivity is how does this particular individual respond to all these different services. We know how they respond based on having ongoing and effective conversations with people.

Effective conversations have two things going on. They have really strong structure and very strong relationship. So if those two things are present, then we're able to build on that. And the next building block is focusing on cognitive behavioral techniques. And by cognitive behavioral techniques, I mean increasing the awareness of people's thoughts, and getting some kind of agency around their ability to manage their thinking and combat some of that anti-social thinking.

So other factors regarding the response to principle are learning styles, it could be brain health-- so does the person have a traumatic brain injury and, therefore, I have to focus on certain things or help them with some organization or make some accommodations for them? What stage of change are they in? That should dictate how fast I might move with them.

Some of the more obvious responsivity pieces are gender, ethnicity, language, and making sure that I'm matching the modality and the treatment provider to where the client is going to be most successful. In some of the research that looks at what helps practitioners be most successful with our court ordered non-voluntary criminal justice clients, four things routinely rise to the top. So we call these four successful strategies. And these are

strategies that can be employed at any time in conversations with people.

One is to really model collaborative problem solving. If I have to lay out a continuum of problem solving, on the one end it could be, gosh, that sounds like a really tough problem. Good luck with that, and moving on. Right? That's one of the ways that I could potentially address it. And then the other way I could address that is fixing it for the person. So those are two ends of the continuum, the problem solving continuum.

And, ideally, I do neither of those. Ideally, when I'm problem solving I'm actually helping the clients learn how to problem solve. And that starts with helping the client define what the problem is and what they have control over. Unfortunately, many times when I'm going through this with clients they will frequently define the problem as something external. So what is the problem? The problem is-- it's your fault, it's the system's fault, it's the cop's fault, it's my partner's fault, it's my probation officers fault.

So oftentimes, problem solving starts with a really clear identification of the problem with what I have control over. So we call that an internal locus of control. So collaboratively problem solving helps people learn how do I correctly define a problem, how do I then go about figuring out what my options are, how do I brainstorm that, how do I evaluate what my options are, and then how do I pick something that would most likely get me to what my goal is. So that's the collaborative problem solving approach. And it seems to be very helpful modeling that for our clients to help reduce recidivism.

The second successful strategy is pro-social modeling and pro-social reinforcement, meaning we as practitioners, we model pro-social behavior. And we model that in so many different ways-- simple ways like being on time. More tricky ways-- being respectful, not escalating conversations. So there are a lot of different ways in which our clients are watching us and taking a lead from us, and then also, reinforcing pro-social behavior.

So an example of that is whenever we see a client engaging in some kind of pro-social behavior, making sure that we're reinforcing it, we're praising it, we're supporting it. Thank you, client, for being on time. It's really helpful for active and be able to start this appointment on time. Or I appreciate you just took responsibility for what happened. That's really helpful. So just noticing any positive or pro-social behavior.

Then also, attending to whether it's a parole officer, a probation officer, whoever you are, whatever practitioner relationship, and the client relationship, so attending to the practitioner-client relationship. Oftentimes, when we talk about relationships, people say, well, what are we talking about? Are we talking about needing to be the person's friend? And that's not the case, at all.

Relationships are predicated upon a couple of different things. One is empathy, and empathy is being able to understand what the other person is saying, and conveying that understanding. But understanding does not make

it OK, meaning just because I understand it doesn't make your behavior OK. You're still accountable. I still have to put in whatever the consequences are that I need to put in. But I do understand, and I can see your perspective. I can see how hard this was for you or whatever that understanding sounds like.

So when I said relationship was predicated on a couple of things, one is empathy, and of course, empathy with boundaries. And the second piece is structure and clarity of goal. So we are really clear about what we're working towards. Where are we going here? We're very goal-oriented, but, of course, flexible about how we get there. So empathy and structure, those are the two pieces that really support a strong working alliance or a strong positive relationship.

And then the fourth successful strategy is frequent role clarification. And role clarification has to do with being clear about expectations, being clear about what the client can expect from me, what I can expect from the client. Being clear about what the negotiables are, what the non-negotiables are. So that's role clarification.

So an example of that might be noticing when a client does something right, that coincides with our expectation. So when they do something that fits into our expectation, it's really important to reinforce that. So frequent role clarification is not talking about the rules every single day. It's about noticing when people are abiding by the rules and commenting on that, praising that behavior.

So those are four successful strategies that help with recidivism reduction. And then there are lots of different interventions. These are strategies or entire interventions that people can use. But before I go down this road, I just want to remind folks that we have research that tells us how to-- or what predicts behavior change and positive outcome in the long run. And intervention predicts only 15% of long-term behavior change.

Interestingly enough, the biggest piece that predicts long-term behavior change is the client themselves, and that's 40%. So the client has 40% of this outcome already in the bag, and it's their internal and external factors. So how amenable the client is to services, what their social support might be, those kinds of things. All of that contribute about 40%. So that's the client.

But then, the next strongest predictor of long-term term successful outcome is relationship, and that's 30%. So 30% of our outcome with the client is predicted by the strong supportive relationship. The next 15% is what the client thinks will happen. The research calls it anticipatory set, but it's sort of like a placebo effect. If I think it's going to be good, it will be good. So that's 15% of the outcome.

And then the final 15% is the actual intervention. So I'm not saying interventions aren't important. They absolutely are. It's just if I don't have relationship, then we're really starting from ground zero. So successful interventions-- these interventions that you have up on your slides-- they all have research support in terms of supporting

behavior change or addressing whatever the issue is.

So CBT is an evidence-based practice, an evidence-based treatment modality for a variety of different behaviors, definitely criminal justice related for anti-social behaviors, but also mood management, anxiety, depression, and addiction, as well. So lots of different areas that CBT is successful with. EMDR, Eye Movement Desensitization and Reprocessing, you may be familiar with. It's a trauma resolution technique.

I won't read out the rest. But these are all different ways, different successful interventions. And there are so many more, I couldn't fit all of them on the slide. So there are quite a few. And then we've talked about interventions, but there are other things just to consider, other things that really help us have a successful not just conversation, but a successful program where overall we're aligned with recidivism reduction, and we're aligned with evidence-based practices. And so I'll end my piece just by talking about these important considerations.

One technique or strategy of working and facilitating long-term behavior change is called motivational interviewing. And many of you have probably heard about motivational interviewing. But the research is really clearly showing us that when we use certain techniques, certain motivational interviewing techniques, we are more likely to facilitate change and support a person make intrinsically motivated change, than if we sort of tell people what to do. So motivational interviewing is extremely helpful.

There's research that says gender specific programming is extremely helpful, particularly for women. And this has to do with being trauma informed. So that brings up the next piece, making sure that we're trauma informed. And trauma informed just means having a lens that we can look through that tells us that some of the client's behaviors are not because they are anti-social or manipulating, but there's really a trauma reason why they're responding in that particular way.

And then the fourth piece, of course, is frequent reassessment. I'm going to leave you with that, and I'm going to hand it over, I think, to Greg to introduce Rebecca.

Thanks, Anjali, for your insights and expertise. It will now be our pleasure to turn the rest of the webinar over to Rebecca. As a reminder, that will be a question and answer period at the end of the webinar. So feel free to enter questions you may have your Anjali or Rebecca into the Q&A box. Rebecca, the time is now yours.

Thank you. Hi, everyone. I'm Rebecca from the Center for Court Innovation. It's so nice doing these webinars with Anjali because she sets up the research framework for us to think about, and how we can apply that information to domestic violence cases. So I love doing these when she tees it up for me.

So we're going to transition and think about some of the things that Anjali was talking about in terms of risk needs responsivity, what are domestic violence specific risk and needs, and what does responsibility mean in the context

of abusive partner programming. I think nationally, most folks are used to some kind of sentence for a DV defendant or domestic violence defendant that would include probation and a program. And so we wanted to spend some time talking about what are some best practices around that, and what's happening nationally to incorporate this research that Anjali was talking about.

So when we're thinking about domestic violence risk specifically, one person may come to mind for some of you. And that's Dr. Jackie Campbell. And we'll get to this a little bit later, but I want to put this out there so that it's in our mind as we're thinking about finding the risk with domestic violence litigants, is that her research found that victims rarely overestimate the level of risk they face, but often underestimate it.

And her research focused on women who were killed or almost killed by their male intimate partners, so it was very gendered research. And what she found-- it's really important for us when we are working either with the victim tangentially, as many probation officers are or when we're working directly with the person who has caused that harm to the defendant or the probationer, it highlights the importance of listening well, of gathering information about these risks and needs, and thinking about and collaborating with victim advocates so that we're really sure that we're understanding correctly that level of risk that these DV victims may be facing or that the DV defendant may be placing on victims.

So Anjali talked about those central criminogenic factors, that central eight. I want to spend some time talking about the research that has been done that's looking at domestic violence defendants, specifically. And what they've found is that not only did domestic violence defendants have some of these central eight criminogenic factors, but they also have domestic violence specific risk factors that are important for us to understand.

We'll be talking about these a little bit more in the next webinar. And at the end of this one, Greg will talk about that a little bit more. But I want to highlight this now because it's really important to think about. When we're thinking about domestic violence probationers or defendants, we need to be thinking about both recidivism-- so is this defendant or probationer in front of me someone who's at increased risk for committing a domestic violence crime and/or is this victim someone who's at increased risk of being killed by their intimate partner. And that's that lethality factor.

So there are two different things. We're going to walk through them now just so you can understand those a little bit more. But in your coordinated community response, some folks are going to be thinking about recidivism. That would be probation in the courts. Right? They're concerned about is this person going to commit another general crime or domestic violence related crime, and how can we use some of these best practices that Anjali talked about to reduce that risk.

And then victim advocates and folks who are working directly with the victim or their survivor-- they're concerned about this lethality. Is this victim someone who is at increased risk of being killed by their intimate partner? And how can we safety plan with them around that? So domestic violence risk factors-- these are the ones that are associated with an increased risk of lethality. And this is coming, as I said, primarily from Dr. Jackie Campbell's research.

She looked at thousands of women who, again, had been killed or almost killed by their intimate partner. Jackie Campbell was an ER nurse, and she was seeing a lot of really, really almost fatal cases coming into the ER. And so she was concerned, is there a way that the medical profession can respond more quickly or start gathering more information so that as victims of domestic violence come in, they can somehow assess their level of lethality.

And so what she found is that these factors here are ones that are at increased risk of lethality. She has since done more research, and is continuing to do research on other types of intimate partner violence, LGBTQ, and when the male is the victim and a female is the perpetrator. And so she's working gather more information about this. But the statistics here and the information is really about male perpetrators or defendants and female victims. I wanted to just be clear about that.

But what she found is, again, some of these are those general criminogenic factors, so drug and alcohol abuse. But some things are different. Abuse during pregnancy, child abuse threats-- a child that is not the biological child of the defendant over the respondent, that's kind of a tricky one. But it does make sense, right? In domestic violence cases, often there's jealousy or the accusations that the victim is cheating on the defendant. And so if that victim has had a child with someone else, either prior to the relationship or during this relationship, that actually increases her risk of being killed by her intimate partner.

Oftentimes that child is more bonded towards the mother. Oftentimes that child could interfere or try and intervene during an incident. And the defendant often sees that child as a threat or a reminder that the victim has been with someone else.

Stalking is really important. Those folks who were killed by their intimate partner had been stalked by their partner in the year prior to the homicide. And so stalking is something that we really want to look at. Again, it's something harder for us to gather. It's a pattern of behaviors.

And so when we add probation officers or whomever, making sure that we're gathering that information or understanding if stalking it's part of that-- stalking is part of the pattern of behaviors in this domestic violence relationship. TK Logan, who's a researcher on civil protective orders and domestic violence, she found that civil protective orders for the most part do what they're supposed to do to protect that victim, except where stalking is part of the pattern of domestic violence.

Those were the orders that were most often violated. And so, again, when we're thinking about reducing recidivism or safety planning for victims, stalking is something that we want to be thinking about. Avoidance of arrest, and then victim belief that the defendant or respondent is able or capable of killing him or her-- and that gets back to what Jackie Campbell was talking about before. Really, if a victim is saying this person is going to kill me, I know what their plan is, those types of things, that's where we really want to be thinking about how we can do some intensive safety planning or if we're working with that defendant, really thinking about compliance monitoring and supervision.

Again, some more factors that Dr. Jackie Campbell found is an increase in physical violence over the past year, the respondent or defendant owning a gun, using or threatening the use of a lethal weapon. And then here's one that's really important, as well, for us who are working in the criminal or the civil legal systems. Separation within the past year. That's often the time that folks are engaging in our systems.

They may be wanting to get an official divorce. They may be coming in to get a civil protective order. There might have been some arrest that initially caused some type of separation. But then there was a decision made by the victim to separate.

So a separation within the past year is a lethality factor for the first 12 months of that separation. What Dr. Jackie Campbell found is that after that initial year, separation actually becomes a safety factor. So it's something for us to think about, whether we're working with a or during this first year of separation, what types of supervision, what kind of support can we give this defendant and respondent to transition into the separation, and then what kind of safety planning do we want to do with that victim survivor if that's who we're working with?

Unemployment-- again, that's something that we already talked about as a general criminogenic risk factor. Strangulation-- strangulation is huge. Maybe many of you have been trained on this, in particular. But strangulation, it does not require much force to strangle someone. Oftentimes, victims are saying he put his hands on my throat, he choked me out, those types of things. It doesn't take very long for someone to put that pressure on the carotid artery and to have someone pass out, and then within a few seconds of release the person comes back again and may not remember exactly what has happened.

So it's really important if strangulation is part, again, of these domestic violence dynamics, that we highlight that and share that with folks who are doing the safety planning with the victims, and/or doing the supervision with the defendant.

Jealousy-- again, that's kind of like a extreme jealousy and controlling behaviors. Under there, this is where Jackie Campbell puts destruction of property, pet abuse, is under that jealousy and controlling behaviors where she puts

those things. So those are some of the lethality factors.

Then I want to switch gears and talk about the recidivism factor. So, again, this is specific to domestic violence re-offense. Dr. Kirk Williams did a lot of research on this in Colorado, and he has continued to research this and has developed some tools, that we'll talk about in the next webinar, to look at domestic violence recidivism factors. And you'll see there's a lot of overlap, again, with the general criminogenic risk and needs, as well as with the lethality factors.

So having a prior DV-related incident or a violation of an order of protection, violence towards other family members, suicidal or homicidal, so threats of suicide-- you'll see here, again, access to firearms and/or use of weapons, the obsession with the victim. And again, Kirk Williams quantifies what that means, goes into some more details if you were to use his risk assessment tool.

The victim's fear of re-assault-- again, that should sound familiar to you now. Attitudes that condone DV-- so that's that anti-social thinking, having anti-social peers. Right? The idea of, it's OK. My partner deserved it or it's OK to hit my partner if they do X, Y or Z. Again, the recent separation, and then this final one I think is really interesting for us-- a failure to complete a mandated batterer program. So, again, that's showing that someone is not able or willing to comply with a court order. And that indicates that they might be more willing to commit another crime while under our supervision.

So when we're thinking about what this means for us in our work, I think this quote from Jackie Campbell's research, right? The majority of victims or perpetrators or both had contact with our systems, right, either through our criminal justice system, victim advocates, health care agencies in the year prior to the homicide. And this really indicates it's an opportunity for prevention if we can identify those folks who are most at risk, and intervene, but do that safety planning.

So it's a call to us to think about where we are identifying risk, who's identifying risk in our system, how that information is being shared, how it's informing decisions around supervision and programming. Right? Thinking about, again, this is the risk, but then moving into the needs and the responsivity. How can we respond to both the risks and the needs of DV defendants so that we can reduce both the recidivism and the lethality?

So this is a summary. Remember, we heard this from Anjali, right, the risk principle is saying who to treat. Right? The need principle is what we need to treat, those criminogenic needs. And then the responsibility principle is how to treat it. And as Anjali said as she was wrapping up, there's a lot of research on the effectiveness of cognitive behavioral approaches. If they target multiple criminogenic needs, those are most effective in reducing recidivism.

And so the role of risk needs assessment then, right, we want to gain information about the risk of re-arrest and

future domestic violence. We want to understand that DV defendant or the offender's specific array of needs, and we want to match that with appropriate-- in the context, I think, of domestic violence, most often it would be some kind of cognitive behavioral based program. And so what we're going to move into programming in a minute.

This is an overview. This is like, a little teaser for the next webinar. We're going to be going into really great detail around risk assessments for both lethality and recidivism. So these are the tools most often used. And they're used in different ways, in some ways to inform those decisions around what kind of programming or the length of programming might be most appropriate given the risks and needs of, and the responsivity concerns of that specific defendant or probationer with whom we're working.

And then the lethality assessments are really how can we tailor specific and immediate safety planning to address and minimize the lethality risk for that victim. And so we're going to be talking about those in our next webinar. So where do abusive partner intervention programs fit in? As I said, most all of you-- I should have put in a poll question. Right? But I would assume that in your community or in your neighboring community, there is some kind of abusive partner intervention program or a batterer intervention program. So I wanted to talk a little bit about that, and how that fits into this kind of risk needs responsivity that we've been talking about.

So we know that batterer programs or as we're calling them-- our office calls them abusive partner intervention programs, they started in the late '70s, kind of responding to this lack of appropriate programming or sentencing options in DV cases. They were initially created to be one prong in a coordinated community response. They weren't ever created-- or at the beginning, they were not created to be acting in isolation.

Our office did a study over 10 years now-- 10 years ago now, when we were looking at domestic violence courts around the country. We asked about batterer intervention programs. And you can see back then, there were over 2,000. It's really hard to gauge how many there are. Some have standardization or certification processes in some states, and that's easier to kind of figure out how many there are.

Many abusive partner intervention programs are required by statute. If there is a DV offense and that person is found guilty or pleads guilty to that crime, they have to take-- they have to do some kind of abusive partner intervention programming. And back in 2004, about 80% of participants were court ordered. I think we're seeing a movement now to have more community based programs that are not-- that the referrals are coming from other community agencies. And many more family courts or our civil court system are now referring child protection services, often run their own programs or child welfare. So that stat might change if we were to look at it again.

So simultaneous developments-- add batterer intervention programs we're proliferating around the country. There was an increased funding for victim services. There was a rise in pro-arrest policies, and more aggressive prosecution strategies. There's been a greater use of protection orders. And many times, in that protection order

someone can be ordered to a batterer intervention program.

Probation often, as I said, it's either a condition of probation or is a condition of their sentence that they do probation and a program. And then more and more courts are following up on compliance with the programming Anjali mentioned evidence-based best practices of drug courts. More and more domestic violence courts that you know are being used to respond specifically to domestic violence cases. And there is a much more coordinated effort, when those courts are in communities, to understand and order abusive partner intervention programs.

So some of the key goals, right, to-- this is what we found when we were doing our research back in 2007, to reduce recidivism. Right? We want to reduce the violence. Other folks are looking at doing that through rehabilitating. Can we change those thoughts, beliefs, and attitudes, and decision making that Anjali was talking about that? And deterrence-- what kind of supervision through the courts or probation can be utilized to ensure or help support that reduction of violence?

And then programs nationally are really looking at seeing their role as holding that offender accountable. Right? They're serving as a relevant sanction when jail is not an option. And then if you're thinking about accountability, you're looking at did the person complete the program, and then how do we leverage other types of sanctions if the person is non-compliant with the program. OK.

So just a reminder about cognitive behavioral therapy. Again, this is used most commonly just with general-- to address a variety of criminogenic needs. And more and more, abusive partner intervention programs are thinking about how can we apply these principles of cognitive behavioral therapy that have been shown to reduce recidivism in the general population, with the goals of abusive partner programming, which are really to increase victim safety, hold that individual accountable. Right? So really focusing on the present, addressing those thinking errors that Anjali was talking about, and thinking about how can we provide supportive role modeling and skill building around restructuring the responses to certain incidents. Right? So focusing on decision making, focusing on the lack of empathy, and addressing as many of those criminal granite needs as possible.

I want to just talk for the next few minutes, before we open it up for Q&A, about what's happening nationally with abusive partner intervention and engagement. As I said, there's this national movement towards risk needs responsivity in programming, so thinking about giving programs as much information as possible when you're making the referral. But programs themselves are really thinking about how can they themselves have a more comprehensive assessment that's really looking at these risks and needs, and then providing-- responding to those with appropriate programming.

More and more abusive partner intervention programs are thinking about how can we separate folks by risk level, since that's such a key component of evidence-based best practice. And then, how can we support programs to

identify a curriculum, have the training that they need, and to be able to support those facilitators so that they can be-- that there's really that fidelity to the model, and really good programming and facilitation. And then, thinking about, as I said, how we can apply those cognitive behavioral principles to abusive partner intervention programming.

When we're thinking about risk needs responsivity, a lot of abusive partner intervention programs are thinking about trauma and adverse childhood experiences. In some ways, trauma is a risk factor and a responsivity factor in domestic violence cases. So if a defendant or probationer is coming in and has experienced a lot of childhood trauma, it may impact their ability to engage or respond to cognitive behavioral approaches or programming. And this is in no way to minimize the abuse and the impact of their violence on their intimate partner.

It's a way for us to better understand this person in a holistic way, so that we can figure out in addition to abusive partner intervention programming what else might need to be in place to support this person's change. And in what ways can abusive partner intervention programs address childhood trauma in a way that says, we see that you experienced these traumas as a child. Now let's look about at how you are you know traumatizing your children or your partner in the same way.

And I'm sure you've all heard about the research around adverse childhood experiences. I won't spend too much time with it, but you can see here there's an assessment that you can-- that is often done. Abusive partner intervention programs are often including that now in their intake assessment, and then are often use this also to talk about the impact of abuse on children. So you can see here, the more of these factors that you have as a child, the more risk and adverse experience-- or adverse symptoms you have as an adult.

And they've expanded it to look at more diverse communities. The original study was done primarily a white middle class folks. And so they expanded the study and realized that witnessing violence, feeling discrimination, living in an unsafe neighborhoods, experiencing bullying or living in foster care also increased these negative outcomes for you, as an adult, which can be health outcomes but it can also indicate an increased risk for being and becoming a perpetrator of domestic violence.

So when we're thinking about responsibility and thinking about trauma informed strategies, Anjali talked about that a little bit. Again, thinking about that motivational interviewing as a trauma informed way, shifting the language from why did you do that to what brought you here, kind of what is happening in your life. What's going on in your brain? What are your thinking-- what are your thoughts and your beliefs that are leading to this type of behavior? And how can we engage with you on building up your strengths and addressing your trauma so that you can be a better partner in the future?

Thinking about having this kind of person-centered approach-- some abusive partner intervention programs are actually incorporating mindfulness. Again, these aren't-- when you think about an abusive partner intervention program, the goal isn't to say, oh, your problem is that you're stressed out. So go take five deep breaths before you have a conversation with your partner. That's not what we're talking about.

We're just talking about ways to integrate the research that's been effective with other types of populations, and saying we need to slow this process down so that you are able to really identify those thoughts, feelings and beliefs that are supporting your mind with behavior. And if we can break those down and think about healthier ways to respond and communicate with your partner, we hope that that would have more lasting change. And again, encouraging facilitators to really understand and recognize the effects of trauma, creating a safe environment and building trust in those abusive partner intervention programs.

Another responsivity factor that programs are really looking at is incorporating culture, and really valuing the culture of the probationers or the people in that program and having facilitators that reflect that culture. And so there are some examples here. Accountable Choices in Michigan is a program. What they do is they invite past participants to help revise the curriculum. They bring in pizza and they kind of just go through everything. And that's making sure that they are reflecting the needs and the culture of the folks in their community.

Caminar Latino is a community-based organization in Atlanta, Georgia area where they have created a curriculum for Latino men designed by Latino psychologists. And they also have comprehensive programming for the whole family. So they not only have a program for men, they have supportive services for women. And they also have programming and supportive services for children.

Men Stopping Violence in Georgia they really have been looking at ways to incorporate and reflect the culture and the values of the African-American community in Georgia. They do a lot of exercises on intersectionality, on historical trauma, in systemic trauma. And they have an African-American culturally specific group.

What they also do-- and this gets to Anjali's point about helping to support probationers or defendants having pro-social peer groups, is that Men Stopping Violence-- one of the components of their program is to-- that the men in the group have to bring in a peer at some point during the program. And that, again, is really to help support this change process. Right?

Because a lot of men might be coming into a program and being like, oh, wow. Yeah, I want to think differently. I want to act differently. And then they're going back out into their community, in their peer groups, where that type of behavior might not be acceptable or even safe. And so what they've been doing there is really each of the men have to bring in a peer. And it's really powerful to have the peer, someone from their own community, come into the class with them. And there are certain exercises they do around that. They also have the men engage in some

kind of community project around stopping intimate partner violence.

Wica Agli, based out of Minnesota but does a lot of work in South Dakota-- they incorporate traditional native teachings into their curriculum. They host cultural camps for team building. It's really interesting. They have a whole thing on horse therapy for abusive partners. And it gets, again, to this idea of creating pro-social bonding, caring and increasing those empathy skills for horses that have been traumatized. And it's amazing to see the changes in the way that those men relate to the horses, and then the team building and kind of the positive vulnerability that the men in the group have, and then how they apply that to ending domestic violence and coercive control in their relationships.

So those are just some examples there. Anjali talked about-- I don't think she used the word hope, but she was talking about this collaborative goal setting. In an abusive partner intervention program, some of them are thinking about goal setting as a way to create hope. There is a lot of research now on the importance of building hope in folks who are defendants or engaged in criminal activity.

If they don't feel like they have access to pathways to achieve their goals, that can negatively impact them. And it's been really interesting, this research by Holiday in 2018 out of Baltimore. It found that-- it was research on men in abusive partner intervention programs in Baltimore. And they found that no hope for the future was the greatest contributor to intimate partner violence perpetration when they were looking at kind of concept mapping for African-American men in Baltimore.

Additionally, *Hope Rising,* there's a new book out about the science of hope. And it shows that there's been more than 2,000 studies on the psychology of hope and the importance of thinking about hope as the single best predictor of well-being. And so, again, we don't want to minimize the impact of the violence and the coercive control that is happening in intimate partner violence. But programs are thinking about really incorporating all of these tools to see if they can create some lasting change in abusive partners or people who have caused harm.

So, again, what's happening on the national level-- collaboration is really important. And what's great for those of you who are OVW grantees-- I said this on the last webinar and I'll say it again. The benefit of having an OVW grant is that it encourages this really deep collaboration and thinking about who are the partners.

If we're thinking about risk needs responsibility in the context of domestic violence, who needs to be at the table? Who's doing what? What are our programs doing? How can advocates and programs work together to really think through some of these issues around victim safety or victim centered programming?

Thinking about kind of expanding this idea of accountability, right, we want to focus on that personal accountability, the person who's caused harm in their intimate partner relationship. We also want to hold ourselves

accountable. Are we doing the best that we can to address the needs of this defendant or respondent or probationer, so that we are setting them up and giving them the support and the programming and the accountability that they need to make non-violent choices in their future relationships?

And, at the same time, are we-- everything that we're doing in the program, is it tied back to victim safety, not losing the fact that we want to be victim centered in our work? Many programs, as I said, are working collaboratively with their community based victim advocates, and thinking about how can the program do safe outreach to victims to give them information about what's happening in the class, what the goals of the class are or aren't, so that the victim or a partner or ex-partner isn't getting a false information about the programming, and then thinking about multiple pathways for accountability. Right?

Many folks are getting referred from our criminal and civil legal systems. But thinking about how can we have programming that's just available and is something that folks can be referred to-- whether it's from their faith leaders, whether it's from their workplace, whether it's a collaboration with mental health and substance abuse treatment, right, so that there's kind of no wrong door in getting referred to programming, abusive partner intervention programming.

And we talked about this last time, as well, but the importance of really thinking about what's happening in your system. Doing that strategic planning to think about, all right, if we want to really think about risk needs responsivity, doing that system mapping and figure out how each player is incorporating these things into their information gathering and their decision-making process, and then figuring out where there are gaps.

Again, just as a summary, thinking about that comprehensive assessment, thinking about how we can apply some of these principles of cognitive behavioral therapy into programming without losing sight of the coercive control, thinking about how we can support programs so that they have good curricula, good facilitators, and ongoing training, and thinking about programming that addresses not only the coercive control but other needs or responsivity factors that are directly correlated to the intimate partner violence.

And then, where possible, how can we separate by risk level? In the next presentation we'll talk about some examples from Colorado and other places, where they're really looking to use risk assessment to have different lengths of programming, different types of programming, and supervision based on that level of domestic violence risk.

Our office, the Center for Court Innovation, not only is fortunate enough to collaborate with Fox Valley on this project, but we also are the Office on Violence Against Women funded tech training and technical assistance provider on abusive partner accountability engagement. We are hosting some webinars of our own. And we have some training coming up that was just OVW approved. And we'll be sending out some information about that.

But we're really looking at collaborative responses that are holistic and trauma-informed, and that we're really creating those system wide responses. And so we have a wide range of partners on that, practitioners, and researchers, and court staff. And so we're really excited about that project. And it dovetails nicely with the work that Fox Valley is doing around victim-centered probation responses.

On our website we have a lot of information about abusive partner intervention programming. We have a national clearinghouse for, as I said, we're doing some training institutes and some webinars there. And we also have some documents on our website.

So a couple of questions came in during the presentation, and they all had to do with juveniles. So the first one to both Rebecca and Anjali is-- and I'm going to summarize it. It's a long question. Are we missing the mark with adolescents and the proper placement or having resources available to them when we're identifying some of the at-risk behaviors that you all talked about or information from the aces with respect to where they-- with respect to their risk to engage in delinquent behavior, as well as domestic violence or intimate partner violence? So I'll turn it over to the two of you to provide an answer.

This is Rebecca. Do you want to start?

Sure. Yeah. I meant to mention this. New York City has-- so one of the things in New York City we found was that the adult domestic violence courts were kind of missing the mark on teen dating violence cases. It was until recently, if you were 16 or over you could be tried as an adult in our criminal court system. So teen dating violence cases, ages 6 to 19 let's just say, we're being heard in our adult domestic violence courts.

And so we actually carved out and created teen dating violence courts in the boroughs of New York because we were exactly missing the mark. We were sending them to programming with adult men, which the research shows is not a good idea. A lot of times, these teens-- you know, this was maybe the first time they'd done something. And then they're in a 26-week program with men who'd had a long history of being abusive.

And so we actually created a free 12-week program that really focused on the cognitive-- it was kind of at the cognitive skill level, and took in teen adolescent brain development. It was really looking at healthy relationships. And then it was thinking about a lot of the other factors that were going into place.

With these teens, a lot of them were homeless. A lot of them already had children with the victims, so they were also going through our family court. So we tried to connect them with free civil legal services that were for teens. As I said, this programming really kind of looked more at healthy relationships, skill building, and addressing some of those other criminogenic needs to see if we could stop that cycle of violence earlier, so that we were not seeing

these folks again as grown men or women in our system.

Yeah. I think, Rebecca, you're right on. And I'm going to answer this question and also another question that one of our participants asked about assessment. So just as Rebecca was saying, that sometimes we're missing the mark with our younger offenders. And research indicates that they have a few additional, and some different risk and need factors.

And so there was a question about are there specific instruments or assessment tools that are more targeted towards young offenders. And that is true. There are some risk assessment tools. So I'll rattle them off, but also, this information is also available online.

There are several tools. One of them is called the YLSCMI, the Youth Level of Services Case Management Inventory. It's an evidence-based actuarial risk tool. It parallels something called the LSI on the adult side. There's the SAVRY, which is Structured Assessment of Violence Among-- for Violence Risk Among Youth, so Structured Assessment of Violence Risk for Youth, S-A-V-R-Y, also evidence-based. And it's created based on theory and research.

There's the YASI, which is the Youth Assessment and Screening Interview. It's a promising tool, so it hasn't reached sort of evidence-based criteria, but it is promising, also actuarial. And then there's what we call the Ohio Youth Assessment System, also a promising tool. It hasn't reached evidence-based status, but it's showing really promising results in the data. So these are some assessment tools that might be helpful to you all, and better target what the risks and needs are for our youth.

Thanks, Anjali and Rebecca. You guys actually did a nice job of answering-- at least partially answering several questions. Unfortunately, this is going to have to conclude our question and answer period for today's webinar. We want to thank our presenters again for their time and expertise today. Thank you for attending, and have a wonderful day. Thank you, all.