Violence Intervention Program Toolkit

The Local Public Heath Experience

Two Rivers Public Health Department

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About Two Rivers Public Health Department

Two Rivers Public Health Department (TRPHD) serves seven rural counties in south central Nebraska, including Buffalo, Dawson, Franklin, Gosper, Harlan, Kearney, and Phelps counties. Two Rivers Public Health Department was formed in 2001, when Nebraska passed legislation that led to the formation of local public health districts across the state. The purpose of the legislation was to ensure equitable health and prevention services to all residents in Nebraska, and ensure that a zip code did not dictate health outcomes. Since this legislation, TRPHD has been working to ensure that all residents of our 7 counties have access to care and prevention services to lead healthy and productive lives.

The core of our services at Two Rivers focuses on prevention, including the prevention of chronic diseases, through lifestyle change programs. We also have a disease investigation unit, where we monitor for potential outbreaks in our jurisdiction. TRPHD also works to advance preparedness activities by working with communities, hospitals, and organizations to prepare for and recover from potential disasters through our emergency response programs.

In August of 2017, TRPHD commenced work on a Countering Violent Extremism (CVE) grant in partnership with UNL Public Policy Center and the Nebraska Emergency Management Agency. We intended to pilot the formation of community-wide threat assessment teams in a rural Nebraska setting. The impetus for focusing on a rural setting was the recognition that extremist violence can happen anywhere. In addition, TRPHD found the CVE program to fit with our other prevention based programming, especially in the emergency response and behavioral health service areas.

Two Rivers Public Health Department Jurisdiction

The TRPHD serves a population of approximately 100,000 people in south central Nebraska. The majority of the population is clustered around the I-80 interstate corridor. As a rural jurisdiction, TRPHD helps to bridge access to care issues that are endemic in rural communities. Access to care issues in our jurisdiction include lack of health insurance, language barriers, and unfamiliarity in navigating the healthcare landscape.

TRPHD decided to implement the CVE program in Lexington and Kearney, Nebraska. We focused on these communities as they represented our population centers, and TRPHD wanted to implement the program in a way to positively impact a majority of the TRPHD population.

Branding to Meet Local Violence Prevention Concerns

Early in the process of implementing the Countering Violent Extremism program, TRPHD recognized that the program would need to be rebranded to address local violence concerns. A discussion was held regarding the name of the program and consideration was given to the names CVE, Disrupting the Pathway to Violence and Violence Prevention. In the Lexington and Kearney communities, concerns were raised that the programs was potentially targeting minority groups. In addition, TRPHD wanted to ensure that the program addressed violence broadly, including domestic, sexual, workplace violence, and suicide. TRPHD staff believed that the program would provide the most benefit if it addressed all types of violence that Kearney and Lexington were experiencing. This ensured that the program was tailored to meet local concerns about violence and not be viewed as discriminating against minority populations.

TRPHD initially chose to brand the program as 'Disrupting the Pathway to Violence', and advertised it as a violence prevention program. This allowed the program to align with other public health activities, including emergency preparedness, as they are both preventative based programs that work upstream of natural disasters or mass violence/fatalities. TRPHD was able to link the violence prevention program to our disaster related programming, by making the link that it was prevention based.

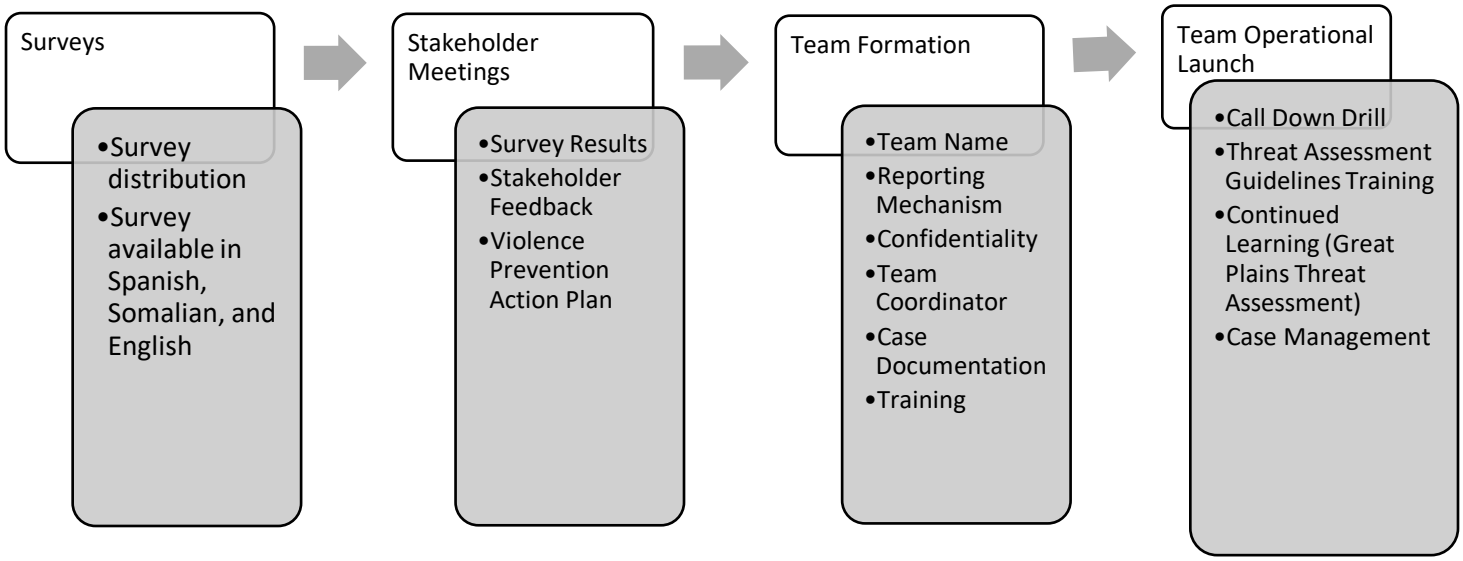
However, halfway through implementing the program, TRPHD staff switched to referring to CVE as a 'Violence Prevention Program'. The previous name, Disrupting the Pathway to Violence, almost required a more technical understanding of the documented pathway towards violent extremism. Framing the program as a violence prevention program allowed the program to broadly address all types of violence that our communities experienced.

Beyond branding the program, TRPHD recognized that we needed to use appropriate language to frame potentially violent offenders. We decided that labeling someone as 'potentially violent' was not justified since no violent act or crime was committed. Instead, TRPHD staff decided to refer to individuals on the pathway to violence as distressed or individuals in a crisis.

Lexington | Violence Prevention Program Implementation

Lexington, Nebraska is located along the I-80 corridor in Nebraska. Lexington is driven by industry, including the Tyson meat packing plant, which is one of the largest employers (~3,000 employees) in a city of 10,000 people. Tyson attracts employees who are refugees and migrants, and as a result, the city has a diverse makeup including Hispanic and Somali residents. While implementing the violence prevention program in Lexington, the health department wanted to ensure that stakeholders and threat assessment team members reflected the diversity of the community.

The following chart diagrams the process the health department used to facilitate the creation of a violence prevention program in Lexington, Nebraska.



Lexington Survey

The health department first issued a baseline survey that was created by the UNL Public Policy Center. The survey was intended to provide information on barriers community members experience in reporting violence. TRPHD found success in issuing the survey at the Tyson meat packing plant during lunch breaks across different shifts. With 3,000 employees, we were able to distribute the survey and provide interpretation through our Community Health Worker. When we were assessing the survey responses, we noticed that the demographics of survey respondents matched the demographics of Lexington.

The survey responses indicated that community members identified trust as the biggest issue when reporting potential violence. This was followed by concerns of personal risk. In Lexington, only 68% of survey respondents indicated they would report violence to the police. This was in contrast to Kearney, where 88% of respondents reported the police as their first reporting source. During the stakeholder meetings in Lexington, it was noted that community members from other countries may have a different or even negative relationship with law enforcement, and are more hesitant to engage local law enforcement as a result. In addition, community members had a strong preference for reporting violence anonymously at 73% of respondents. When discussing this result with stakeholders, they noted that community members with an undocumented status or recent refugees may be afraid of being linked back to a report.

Stakeholder Meetings

Once the survey results were collected, the health department scheduled a series of stakeholder meetings in order to create a community coalition around violence prevention. The stakeholder meetings served two purposes. First, they enabled the health department to engage new, non-traditional partners, including law enforcement. Second, the stakeholder groups were able to help tailor the violence prevention program to community needs.

In the Lexington community, we built a stakeholder coalition that included representatives of law enforcement, state patrol, probation, county attorneys, minority health representatives, crisis centers, behavioral health, schools, and minority leaders. In order to bring a diverse array of agencies to the table, we met with agencies individually to provide education on the program and get buy-in. We also represented at local interagency groups, which helped to promote the program with area non-profits and agencies in the social/behavioral space. It was especially important that our Community Health Worker held one-on-one meetings with stakeholders following the meetings to receive feedback that may not have been discussed.

Following the first stakeholder meeting in Lexington, a few stakeholders were unsure about the intention of the program. A representative of a minority advocacy organization and a leader of the faith meeting both expressed concern about the program. The program coordinator met with each representative individually to receive feedback about the program.

The minority advocate was afraid that a threat assessment team would be used to target minority populations in Lexington. The advocate informed the health department that Hispanic community members, especially those that were

undocumented, would be subject to further harassment from a CVE style program. The advocate was also concerned that reports made to the threat assessment team would be forwarded to ICE. The programs financial support from the Department of Homeland Security was also of concern, as community members felt vulnerable to deportation and workplace raids. In addition, the advocate explained that the word 'Countering Violent Extremism' was linked too heavily to targeting the Muslim community, and the advocate believed that this would further disenfranchise members of the Somali community. The program coordinator believed it was very important to have the minority advocate remain a stakeholder and share this feedback with the team, so that they could build a violence prevention program that was inclusive of these concerns.

In discussing the program with a local pastor, he mentioned his concerns stemmed around the concept of a community-wide threat assessment team. With three culturally distinct populations in Lexington, including the Hispanic and Somali populations, he believed that the mechanism for reporting violence would have to be tailored to each culture. He proposed that three distinct threat assessment teams were formed to handle the unique reporting 'cultures' of each community. This feedback was discussed at the stakeholder meetings and with the technical advisor. However, there were fears that three distinct teams working in one community would divide agencies between each team, allowing some teams to have more preventative resources, creating equability issues.

The intention of the stakeholder meetings was to collect feedback on potential violence in the community, and provide a platform for community members to design a violence prevention program. The health department and UNL Public Policy Center helped to develop an action plan around violence prevention. This action plan was ultimately what powered progress on the formation of the threat assessment teams in Lexington. The action plan created by Lexington stakeholders is excerpted below.

Lexington Stakeholders | Action Plan		
Goal	**Purpose**	**Action Steps**
Violence Prevention Team Formation (Care Coalition)	Multiagency coalition that meets to help manage cases of individuals in crisis. The ultimate goal in managing a case is to provide interventions that help steer individuals away from violence, by surrounding them with support.	The stakeholders discussed nominating individuals/entities to be asked to join a multiagency coalition around violence prevention. Potential representatives that were discussed include: • Tyson Representative • Region 2 Representative • Counselor • High School and Middle School Counselor • Law Enforcement • School Resource Officer • YMCA Representative • Somali Community Representative • Faith Community Representatives • Parent Child Center
		TRPHD will reach out to each agency with an invitation (delivered in person) to join the team during the months of November and December.
		TRPHD will schedule the next meeting to be in mid-January. This will be the first meeting for the care coalition (violence prevention team). The meeting will be held at the Lexington Opportunity Center, with a virtual connection available for anyone who would like to join via webinar.
Education and Outreach	Discussion included utilizing educational materials such as handouts and Train-the-Trainer packets to increase awareness in the community about the new reporting mechanism. The material would also serve to educate the community on the signs of potential violence.	TRPHD will work with the UNL Public Policy Center to prepare the Train the Trainer packets and handouts for educational and outreach activities. This will be available for review to the violence prevention team.
		TRPHD will start schedule outreach and educational events. The stakeholder group discussed the following as potential venues: • Parent Teacher Conferences • Presentation to Faith Leaders

Threat Assessment Team Formation

The health department had noticed continued hesitation from the Lexington community in creating a threat assessment team. However, after a bomb threat was made at a local school, the health department noticed increased participation and attendance to stakeholder meetings, which drove the formation of the threat assessment team.

After three stakeholder meetings, which included the creation of the action plan, the health department then hosted the first meeting for the formation of the threat assessment team. Ahead of the first meeting, the program coordinator met with each agency representative individually. In Lexington, it was really important that stakeholders were engaged individually, and that an invitation was extended to stakeholders and any interested individuals.

During the first meeting, it was crucial we discussed key representatives and agencies that should be involved in the threat assessment team. We referred to the experience of other threat assessment teams on the composition of team members. The Lexington team decided representatives from the following organizations should comprise the ideal team:

- Police
- County Attorney
- Probation
- DHHS Case Worker
- CRISIS Center
- Behavioral Health Rep
- Community Health Worker
- Somali Community Leader
- Hispanic Community Leader
- School Resource Officer
- Faith Community Representative
- Community College Safety Coordinator
- Mental Health Rep

Initially, there were concerns that creating a large threat assessment team would be a disadvantage. Other similar threat assessment teams had between 4-8 members. However, the Lexington team wanted to start with a large group of potential agencies, in order to ensure that all potential resources for an intervention were brought to the table. The team acknowledge that over time, as they handled cases, different agencies/representatives could choose to leave if they desired. This would be natural attrition for the threat assessment team.

A challenge for the health department included ensuring that a representative/leader of the Somali community was an active member of the team. Somali community leaders were very busy, as they serve as liaisons and provide help to schools, police, and other agencies. As a result, the team enlisted the help of a Somali community leader who was unable to serve on the team, but agreed to provide consultations on interventions for Somali community members.

The Community Health Worker (CHW) from the health department also volunteered to be a member of the threat assessment team. The CHW is bi-lingual in Spanish, and is an advocate for issues that affect minority health.

Team Name

During the first few meetings, the team discussed a name. Team members wanted to refrain from being referred to as a threat assessment team. They were afraid individuals utilizing team support would be labeled as a threat. In addition, team members believed that being referred to as a threat assessment team would leave minority populations in Lexington feeling targeted. After debating different names, the team settled on Community Safety Resources Team (CSRT). The team decided the name is more approachable for community members seeking to report.

Reporting Mechanism

In creating a reporting mechanism, CSRT members wanted to ensure that they were presented to the community in a transparent way. Trust of law enforcement is a barrier to reporting in Lexington, and CSRT members believed that could be bridged by being transparent. Therefore, CSRT members decided that each member would be trained to receive reports from the community. CSRT members are also advertised on flyers and brochures with their contact information, agency, and the resources their agencies can provide to individuals in a crisis. The team was very aware that different community members may have a pre-existing relationship or positive experience with a member of the CSRT. For instance, an individual may be more inclined to reach out to behavioral health services when reporting potential violence versus law enforcement based on their previous history with different services.

With team members serving as a report collector, members needed to be trained on bringing cases to the team, and correctly assessing potential cases. The health department facilitated this training by practicing a call-down drill. During the call-down drill, a random member of the team was called, and a mock case was presented.

This tested the ability of the team member ask appropriate questions of the distressed individual, and then report the case to the wider team.

Confidentiality

The CSRT team needed to establish a confidentiality agreement that would allow agencies to share information and collaborate on interventions. The CSRT decided to use a Memorandum Of Understanding (MOU) based on the agreement used by the Lincoln Threat Assessment Team (Lincoln, Nebraska). The MOU sets the standards for confidentiality for the CSRT. It was clearly established that the MOU for CSRT would not supersede any confidentiality obligation that a representative would have through their organization. For example, if a CRISIS Center uses a confidentiality standard that is stricter than the MOU, than the representative is first beholden to the confidentiality agreement of their agency.

Team Operational Launch

The goal of the health department was to help facilitate team formation, and prepare them to be operational. This required that all team members were trained on receiving reports, assessing cases, and case management. In order to ensure that all team members were prepared, the health department and UNL Public Policy Center coordinated to provide a full-day training to all team members.

The training was pivotal for the team members. In order to be considered a team member, it was required that all team members were trained on the same assessment tool (Nebraska Threat Assessment Guidelines) and all members signed the MOU.

Table Top and Call Down Drill

After a series of meetings to train the CSRT, the health department needed to ensure a smooth transition as the team started to receive reports and manage cases.

Table Top Hypothetical Case

During a training conducted by the UNL Public Policy Center, the CSRT members were able to practice assessing hypothetical cases against the Nebraska Threat Assessment Guidelines. This was good practice, and ensured CSRT members were evaluating cases in a standard, consistent way. Stakeholder feedback had included the potential of introducing bias and judgement when assessing cases, and the training introduced an objective process for assessing cases.

Call Down Drill

The health department led a call down drill. A hypothetical case was reported to a team member. The team member was then responsible for informing the CSRT, and following up with either an in-person or virtual meeting to discuss the report of potential violence. In designing the drill, an Standard Operating Procedure was developed for CSRT members to use when receiving reports. This ensured that members are asking appropriate questions to individuals making the reports, and receive consistent screener information.

Program Conclusion

As soon as the CSRT was operational in Lexington, the health department stepped back from facilitating meetings and served to provide material support upon request. A survey was then issued to capture the changes that resulted from the implementation of the program.

Kearney | Violence Prevention Program Implementation

The health department implemented the violence prevention program first in Lexington, which allowed us to replicate the process in Kearney, Nebraska. With a similar process to Lexington, we will focus on the differences between the communities in implementing the program.

Stakeholder

In order to create a community stakeholder group around violence prevention, the coordinator at the health department reached out to agencies via email and phone. In general, the Kearney community was less hesitant in forming the stakeholder group than Lexington. TRPHD attributed this to Kearney's more homogeneous demographic composition, and more trust in local law enforcement (as evidenced in the base-line survey).

Stakeholder Meetings & Momentum

In each community, the health department held three stakeholder meetings. Due to other organizational conflicts, the stakeholder meetings were spaced apart by a matter of months. This caused momentum in the project to stall. In the Lexington community, having a month or two between meetings was helpful, as it allowed the health department coordinator to meet with stakeholders and build project buy-in. As

Lexington was more wary of the project initially, this was important. However, in the Kearney community, where there was more initial support for implementing threat assessment teams, the gap between stakeholder meetings was too long.

Lessons Learned

As this was a new initiative for the health department, we would like to share some lessons learned along the way.

Collaboration & Facilitation

TRPHD recognizes that we have a unique ability to convene diverse stakeholder groups. TRPHD builds a network of partners through other program activities, including our work in chronic disease prevention, emergency response, and disease surveillance. The nature of our programmatic work means that TRPHD staff are out in the communities that we serve on a daily basis. With a track record of convening stakeholder groups and enlisting the support of the community, TRPHD feels that we add value to CVE through our robust partnership network.

Community Health Worker Model

TRPHD also has staff with unique skill sets that make them uniquely qualified to deliver prevention based services. Health departments go into the community with preventative resources, and help educate and empower the public on topics such as chronic disease prevention. This is often accomplished by utilizing peer educators, including Community Health Workers (CHW). The health department uses CHWs to serve as lay health ambassadors and peer health educators. CHWs are often from the minority populations, and identify with the cultural group which they serve and frequently speak the language of the participants. The use of CHWs in other health work, including diabetes prevention, has helped improve health, reduce health disparities, and enhance health equity. In implementing CVE, TRPHD utilizes the expertise of a CHWs who live in the Lexington community since the early 1990s. Due to the CHWs extensive time in the community, they bring an extensive knowledge of the network and landscape of other preventative based resources that other agencies/organizations offer.

The CHWs work is embedded in the community interacting with individuals one-on-one. In the line of work, CHWs often provide services to individuals in a crisis. CHWs have the potential to connect potential violent offenders with the threat assessment team, allowing the opportunity for an intervention. In helping to form the

threat assessment team, the health department decided to volunteer the CHW to join the team. The health department knew the CHW interacted with a high volume of distressed individuals, and could potentially make recommendations for follow-up to the team. In addition, the CHW would be fluent in the services that the health department has, and provide those services to a distressed individual.

Staffing

TRPHD is a small health department with nine employees and struggled with consistent employee levels and employees that were knowledgeable about the CVE program and implementation. To counter this, TRPHD implemented a cross-training program, with the expectation that all staff would be able to serve as back-ups to carry on the work of the program. This also required all employees to be trained in group facilitation, as a major component of the work involved holding stakeholder meetings.

The cross-training program will be of benefit to the CVE program in the long term. Once the grant has ended, all employees will have served the program, and can continue to promote the program and provide Train the Trainer presentations. This will ensure the continued growth of the violence prevention program in both Lexington and Kearney.

Differentiated Approach

In respect to the fact that we focus on prevention and intervention with other community health problems or health, safety, and wellness. That is of a good marriage to what law enforcement has to offer, because it embraces a whole different model of reducing violent encounters and violent episodes in our communities from the perspective of a preventive/intervention mode. Public health creates coalitions from a different angle than law enforcement, and offers a different lens. It is more palatable when bringing this program to the community from an angle that is not law enforcement. When you bring this to community members, such as ministerial, it seems to create opportunities for involvement from many avenues.

When law enforcement is involved in partnering with health departments, it offers them a chance to be viewed in a different lens. They are not just there to address issues after the problem, but are linked to the health department in prevention/intervention. It showcases law enforcement in a new light. It could increase reporting of potential issues with this kind of model available to our communities.

Public health can also bring a diversity of stakeholders to the table through preventative, safety, and wellness programs. There is an increase in opportunities to intervene and contribute from more linked organizations. When groups are not operating as silos, there are more chances for a community to report to different agencies, and elicit a more holistic response.

Local & Regional Knowledge

From the outset, TRPHD was mindful that the CVE program was potentially contentious. We selected a transparent process of educating the community about the program. We didn't want to engage agencies in secret in the formation of community-wide threat assessment teams, which could potentially disenfranchise the community. We also believed that involving the community in the design of the program enabled us to tailor the program around community needs. To accomplish an inclusive engagement process, we held a series of stakeholder meetings that were publicly advertised in both the Lexington and Kearney community. We also presented the program on local radio and TV, and utilized social media. These efforts ensured that the community was well-informed about the program, and helped to ease concerns associated with the program.

Conclusion

The CVE program was a valuable lesson in community engagement. It brought many different local community wide groups together for meetings and broad based discussions. The topics that were discussed were very heart felt if the groups present had the underlying trust in the motives and direction that the program was going. The basic tenants of trust, transparency, and competency cannot be undervalued. The networks forged during the process of creating a violence prevention program will endure across other activities of the health department. We are now more connected to our communities.