Addressing Barriers to Reporting Signs of Radicalization Using a Public Health Approach

Final Report for Grant #EMW-2016-CA-00129

Prepared for the Nebraska Emergency Management Agency by:

University of Nebraska Public Policy Center
215 Centennial Mall South, Suite 401
Lincoln, NE 68588-0228
Phone: 402-472-5678
Fax: 402-472-5679
http://www.ppc.nebraska.edu

Authors

Denise Bulling, PhD
Senior Research Director, University of Nebraska Public Policy Center

Ryan Lowry, MA
Senior Research Specialist, University of Nebraska Public Policy Center

Mario Scalora, PhD
Director, University of Nebraska Public Policy Center

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Project Narrative

The Nebraska Emergency Management Agency (NEMA) applied for and received a grant from the Department of Homeland Security to test public health led community engagement models appropriate for rural or small to mid-sized cities. Engagement centered on identifying barriers to reporting potential signs of targeted violence (including the process of radicalization) and preferred community strategies for addressing these barriers. Of particular interest were barriers that keep peers or family members who receive an initial report from passing that report on to a helping professional. Two engagement strategies were tested. One strategy focused on engagement via community health workers and another on engagement through public schools. Simultaneously we engaged state officials in the project to improve their ability to provide technical assistance to community agencies engaged in the project.

Significant outcomes include the development of two community-based teams trained to receive, review, and manage reports of potential signs of targeted violence including radicalization, and development of a toolkit for use by small and medium size communities when applying a public health approach to targeted violence.

The Nebraska Emergency Management Agency (NEMA) and the University of Nebraska Public Policy Center (UNPPC) led and managed the project. Local public health efforts were led by Two Rivers Public Health Department (TRPHD), which serves seven counties in rural Nebraska. Two communities were chosen as test sites for engagement activities for this project – Lexington, NE and Kearney, NE. These sites were chosen for their convenience and not because they had a significant problem with targeted violence or radicalization.

State agencies were engaged throughout the project via training activities. Attendees included the Lt. Governor, representatives from the Department of Education, Department of Health and Human Services, Emergency Management, Crime Commission, State Patrol and project partners. This created state buy-in and interest in supporting project activities at the local level.

Project partners met regularly to discuss progress and identify emerging roadblocks. One such roadblock was the use of the language around ‘violent extremism’ in Lexington, NE. This small community is quite diverse and sensitive to discussions about extremism. It was determined that framing the project as ‘disrupting the path toward violence’ was a better approach. Later in the project, the communities preferred to shorten this to violence prevention or community safety.

The second half of year one, a survey was distributed to community members in Lexington and Kearney. The survey, developed by UNPPC and administered by TRPHD, was completed by 218 community members and asked about barriers to reporting. The survey was available in English, Spanish, and Somali to reflect the predominant languages spoken in those communities. Preliminary behavioral threat assessment training was completed for Kearney and Lexington stakeholders, and following the training, stakeholders advocated for a community threat assessment approach A series of meetings and workshops were held in both locations focused on discussing barriers to reporting that were highlighted in the survey and identifying additional partners who should be part of the project.

In the first half of year two of the project, Kearney and Lexington continued to explore the idea of forming community threat assessment teams. Stakeholder meetings were held in Lexington to discuss the need for a safe space for reporting, and creating public service announcements, flyers, and brochures on violence prevention. Kearney stakeholders heard from experienced threat assessment teams from Lincoln and Kearney Public Schools about how to form and become a successful team.

In the second half of year two, both Kearney and Lexington formed community threat assessment teams. The Lexington team consists of representatives from local law enforcement, schools, and the non-profit sector. The team was trained in March 2019 by threat assessment experts from UNPPC. The Kearney community team collaborated with UNPPC and a member of the Lincoln Public Schools threat assessment team to mentor their school and community team. The Kearney team was trained in May 2019 by threat assessment experts from UNPPC.

Train-the-trainer materials increasing awareness of warning behaviors associated with targeted violence and the process of radicalization were created by UNPPC and released to TRPHD. These materials were used to train 44 community members in Lexington and Kearney (22 trained in each community). The low number of trainees can be attributed to the late release of the material. This was purposeful because it was not prudent to increase reporting until communities had a trusted mechanism in place to manage these reports.

The barriers to reporting survey was repeated in both communities in the last quarter of the project It was administered by TRPHD and was completed by 235 community members from Kearney and Lexington.

Dissemination of project materials has been facilitated by a project website (http://cve.unl.edu/) and national presentations. Dr. Denise Bulling with UNPPC was invited to speak about the project at the Michigan Homeland Security Conference in May 2018. Representatives from UNPPC, TRPHD, and NEMA were invited to present this project at the National Homeland Security Conference in June 2018.

Going forward, project stakeholders expect to see continued development of local community threat assessment teams, which, over time, will become more proficient at receiving, reviewing, and managing reports of potential signs of radicalization. Additionally, stakeholders expect to see increased use of the toolkit that was developed for this project.

Outputs

The table below summarizes the required output reporting completed throughout the project. It is important to place these outputs into the context of the two communities that took part in this project. These communities were chosen because they are regional hubs for rural areas in Nebraska and are the largest communities in the seven county Two Rivers Public Health Department service area. Neither had known problems with extremism or radicalization. The population of Lexington is approximately 10,000 and Kearney is about 33,000.[1] Local outreach was conducted by health department personnel with support of the UNPPC. Two Rivers currently has a total of eight staff members (including administration) to serve the entire seven county area. State level activities were convened and conducted by the UNPPC in partnership with the Nebraska Emergency Management Agency.

PROJECT OUTPUT	OUTPUT DETAIL	PARTICIPANTS	#
Community Outreach or Engagement	Meeting with representatives of minority advocate agency to discuss feedback from the Lexington stakeholder meeting.	Activists/Advocates	2
	Meeting with faith representative to discuss feedback from the Lexington stakeholder meeting on March 28, 2018.	Faith Leaders/ Religious leaders	1
	The CVE program was introduced to attendees of the Lexington Interagency, a collaborative of health, behavioral, spiritual, and mental health agencies.	Faith Leaders/ Religious Leaders; Social Service Providers	12
	* Multiple TV interviews with local news (NTV News) were conducted that provided Information about the program and the upcoming stakeholder meetings. *Multiple stakeholder meetings were held in Kearney and Lexington to discuss actions/resources for violence prevention in the community and future plans. *Initial meetings were held with Lexington community threat assessment team (Lexington Community Safety Resource Team) to discuss sharing team details to the community as a reporting mechanism, documentation of cases, and finalization of MOUs for team members. *TRPHD presented at Lexington Interagency and highlighted programmatic activities including CVE to an audience of local non-profits. *Training of trainers in recognizing signs of violence was held in Lexington and Kearney. *CVE web page and content was created and hosted by UNPPC.	General Community Audience	61,880
	Nebraska state officials training was held.	Government Representatives (Local, State, Federal, Tribal)	13

[1] Estimates from census.gov Quick facts

PROJECT OUTPUT	OUTPUT DETAIL	PARTICIPANTS	#
	A presentation on CVE and upcoming program activities was provided for the Community Connections meeting (opportunities for interagency collaboration for health, social, and behavioral health workers).	Mental/Behavioral Health Providers; Faith Leaders/Religious Leaders; Social Service Providers	30
	Meeting with agency representative working in minority health/health literacy space to discuss program and engage new potential stakeholder.	Social Service Providers; Other Service providers	1
	*Lexington Team Meeting with Threat Assessment consultation. *Training of trainers in recognizing signs of violence.	Law Enforcement; Local Government Service Providers	34
Convening of Advisory Group/ Community Coalition/ Subject Matter Experts	Kearney Stakeholder Meeting.	Mental/Behavioral Health Providers; Teachers/School Staff/Educators; Police/Law Enforcement; Faith Leaders/Religious Leaders	15
Education/ Training/Skill Development/Workshop	Training workshop held in Lexington, NE for stakeholders.	General Community Audience	11
General Outreach or Engagement	Meeting with Tyson (private business) representatives to discuss the program, and possibility of Train the Trainer events at Tyson.	General Community Audience	2
Outreach Materials	Materials distributed to local markets & community centers, including more education about program.	Business Owners/Entrepreneurs	2
	Materials distributed to social services agencies, including more education about program.	Other Service providers	7
	Materials distributed to local schools, engaged with school therapist/translators.	Teachers/ School Staff / Educators	2
Symposium/ Conference	Presented at the National Homeland Security Conference - Panel Discussion “Addressing Barriers to Reporting Signs of Radicalization in Rural Areas using a Public Health Approach”	Other (Homeland Security Professionals)	35
Website Content	TRPHD website was modified and updated to show that the programs in Lexington and Kearney are in different stages, and to reflect the content need for each community.	Public Health Professionals; General Community Audience	660
		Total Participants	**62,707**

Outcomes

The project outcome indicators table provide a snapshot of project activities. One of the primary outcomes that is not well reflected in the indicator table is the discovery of barriers to reporting potential signs of violence in each of the communities. These results are included in the Appendix and are consistent with research literature on bystander reporting.[2] .

A collaborative process was used to construct the survey questions, identify where and how to administer the survey, and what groups to seek input from to ensure the survey was culturally appropriate. The UNPPC helped ensure the survey questions were constructed based on the latest available research on barriers to reporting and community stakeholders helped refine the questions. Administration of the survey was online, in-person, and by paper. Two Rivers Public Health Department enlisted community health workers to assist with in-person survey administration and had the survey translated to Spanish and Somali. The original plan was to do the survey at the beginning of the project, then saturate the community with awareness material via a community disease outreach model and a school based model prior to a second survey administration. We were not able to saturate the community with awareness as planned because the reporting and responding mechanisms took longer than anticipated to establish in both communities. Our two survey time points did not correspond neatly to any pre-post methodology and did not involve surveying the same community members. Instead, the survey results were used to guide stakeholder discussions throughout the process of establishing a stakeholder driven community response to decrease the barriers to reporting potential signs of violence. The Appendix contains a summary of survey results for each community with data from both time points combined. The survey questionnaire can be accessed as part of the toolkit deliverable available online at http://cve.unl.edu/.

[2] For example: Scalora, M., Bulling, D., DeKraai, M., Hoffman, S. & Avila A. (2014). Barriers to reporting threatening behaviors in a military context, University of Nebraska Public Policy Center, Lincoln, NE.
Hollister, B., & Scalora, M. (2015). Broadening campus threat assessment beyond mass shootings, *Aggression and Violent Behavior, 25(A), 43-53.*

Outcome Indicators	Evaluation Results
1.0: Increased likelihood of referral or self-referral to community-based support services **1.1: Community-led efforts to address and reduce reporting barriers** **1.2: Increased trust from community members in the referral process** **1.3: Increased availability of effective, contextually appropriate, community-based intervention services** **1.4: Community members have increased understanding of warning signs**	• 16 new partnerships related to the project were formed with school systems, non-governmental service providers, local churches, a local cultural center, a cultural liaison of a local large corporate business, a local large business plant, a state level human minority services representative, a community center, county attorneys, a county sheriff's office, and key community leaders. • Area residents learned about the project efforts through multiple local TV news interviews and community meetings with project stakeholders. • Individuals living in Kearney and Lexington completed a baseline and follow-up community survey to understand the barriers to reporting signs of potential violence in their communities. • Information about the project was made available to the public through the main project website (http://cve.unl.edu/) and the TRPHD website (https://www.trphd.org/). • Increased collaboration between partners was observed at the Lexington and Kearney stakeholder meetings throughout the duration of this project. This collaboration led to the formation of community threat assessment teams in both communities.
2.0: Scalable evidence-based public-health approaches to CVE are tested **2.1: Increased understanding of what yields impact with public health approaches to CVE** **2.2: Toolkit disseminated to CVE practitioners**	• The main project website received 1,728 views from 183 unique visits. Further analytics revealed visitors averaged spending 5 min per session visiting our site and visited 4.4 pages per session. The tracking link was broken when the website was updated midway through the project so many of the website statistics were not captured. • Both Lexington and Kearney communities are developing their respective threat assessment teams. These teams will work with a variety of community organizations, public and private business, and key community stakeholders to receive and manage reports of potential threats. Training of trainers in recognizing signs of violence was held with members of these teams. TRPHD representatives have offered to be part of these teams. • A comprehensive CVE toolkit with resources was created for practitioners and made available through the main project website.

Lessons Learned

The project's "lessons learned" group in three areas: State knowledge and implementation, local knowledge and implementation, and roles and readiness.

State knowledge and implementation. Our project included engagement of state agencies to enhance their knowledge and ability to provide technical assistance to community agencies as they engage in activities related to increasing reporting and responding to potential signs of violence. We found an ally with the Lt. Governor who is also the director of homeland security for Nebraska. He was receptive to the role of state government as technical assistance providers and as an implementer of behavioral threat assessment. The state agency/department heads were also receptive to these roles, however, the actual implementation stalled at the state level after training took place because there was no single agency or person charged with moving it forward after the training was complete. Sustaining state knowledge about threat assessment and targeted violence in agencies such as health and human services or education is not likely if it does not become part of the agency's expected role. Continued development of threat assessment capacity at the state level is also at risk due to a lack of formal leadership charged with moving implementation forward. This is due largely to a lack of resources and not because it was deemed unimportant. The lesson learned is that states require additional resources if they are to create and sustain robust internal knowledge and practices that support targeted violence prevention and response mechanisms. Taking a public health approach to violence prevention will not succeed unless state level agencies have the ability to support local practices.

Local knowledge and implementation. There were many successes in implementing a public health approach to targeted violence prevention in local communities. Key to success is enlisting local partners who are interested in applying this approach. Our key implementation partner at the local level was a small public health department that served a multi-county area. Personnel at this agency changed frequently, causing disruption to the project implementation schedule. The reality of working locally in rural areas is that personnel will change and it will take longer than anticipated to implement a project if it is one part of a person's overall job duties. Having a person dedicated to working with stakeholders surrounding violence prevention would be ideal. However, in small departments it will likely not happen that way. We had to adjust ambitious implementation plans to match the pace and availability of local personnel and the pace of community interest and involvement. Rural communities are diverse and public health departments have varying levels of involvement with those diverse communities. We learned that we could not assume that levels of trust were pre-established with all of those communities. Community health workers were closest to individuals in the community and were in the best position of trust. These workers represented a variety of health agencies and medical providers, addressing things like diabetes education or home health service provision. Our project tapped into this group by educating them about potential signs of targeted violence and the process of radicalization. The project did not extend long enough to gauge how this impacted reporting. Public school systems were tagged as leaders in each of the test communities because their personnel were early adopters of the behavioral threat assessment approach. This included local law enforcement serving the schools. The challenge to local law enforcement was to translate this experience to a community setting and to recognize that not all reports of signs of violence go to them initially. Once communities decided to implement community threat assessment teams, they requested and received mentoring from experienced threat assessment / management professionals. This step is crucial in the development of

local capacity. Our plan was to sustain this mentorship through state agency support; however, this was not entirely accomplished. Instead, we relied upon known threat assessment experts associated with the Association of Threat Assessment Professionals to provide mentoring and ongoing education of team members. Without their support, the gains made in local capacity to manage threats would not be sustained. Having content experts available for local training and consultation is essential.

Roles and readiness. Using a public health approach to counter violent extremism, address targeted violence, or prevent violence requires expertise in and commitment to both the process (public health approach) and content area (targeted violence). While public health departments are experts in applying a public health approach, they are not content experts in targeted violence. Conversely, threat assessment professionals (e.g., mental health, law enforcement) are not experts in applying the public health approach. Our project brought these two roles together and asked each to develop some understanding of the other. We discovered that it was essential to provide knowledge and promote awareness of targeted violence concepts as an initial part of our public health approach. The initial design was to saturate communities using a "train the trainer" model after communities developed ways to respond to the barriers to reporting potential signs of violence. It took much longer to develop ways to respond to the barriers than anticipated and required much more education of stakeholders prior to any implementation of public awareness activities. Communities had differing levels of readiness for this project and were at different stages of implementing the project when it ended.

Promising Practices

Our project tested a public health approach that included community engagement via two models: a chronic disease framework using community health workers to engage individuals, and a public health-school partnership to engage youth and families. For the first model, we engaged community health workers in training on signs of violence. They were provided with handouts and information to use with those they served in the community. We were not able to gauge the success of this model quantitatively because the project did not extend long enough for us to link reporting to their work. However, we know that in one community the lead for community health workers is now a part of the community threat assessment team and plays a vital connecting role with different cultural groups in the community. The second approach was with schools. Again, we do not have quantitative data for the same reason. However, school threat assessment team members were leaders in both communities in the formation of community threat assessment teams. They drew on their experience in school teams and helped community stakeholders understand the role of threat assessment and publicizing awareness of reporting in violence prevention. The school approach included building on school teams to educate them about signs of radicalization and violent extremism so they could pass it on to their constituents.

We used surveys to determine barriers to reporting in the communities. The surveys were distributed online, on paper, and given in person at several locations by trusted community public health professionals. They were translated into Spanish and Somali to ensure active participation from different sectors of the community. This tool was most useful as a way to stimulate discussion about community perspectives. It is important to frame the results as a snapshot and not generalizable research results given the methodological limitations. The team did attempt to get participants representative of the general community demography, but the sample was still considered a convenience sample.

The foundational promising practice we used was the community behavioral threat assessment and management team. There is a great deal of literature describing and supporting the use of multi-disciplinary teams to assess and manage threats. However, most of these teams have been implemented in workplace or school settings. Little research is available on the efficacy of such teams in community settings. The use of a community based threat assessment team can been conceptualized as a "team of teams" when there are multiple workplace/school based teams operating in a community. It can also be conceptualized as a single team, serving people who live in a community or defined geographic area. Either way, it is multidisciplinary, representative of the community, and serves as a trusted entity charged with coordinating compassionate interventions that move a person off a path to violence. The community buy-in for this model is dependent upon the way it is marketed and used by the community. Our test communities took longer than anticipated to gain the necessary buy-in from all sectors of the community so the teams were just getting started with their work when the project ended. Therefore, we have no case related data to report. However, in this project we linked new teams with experienced threat assessment professionals who worked through hypothetical cases with the teams prior to the end of the grant. The teams are now receiving reports via their affiliated agency partners and are working together to make their communities safer. Model community threat assessment teams are active in other USA areas including Lincoln, Nebraska and Salem Oregon. The two small, rural test communities in this project viewed formation of such a team as a way to decrease the barriers to reporting because they could assure community members that the intention of the teams was to divert people from violent activities rather than just arrest them. It also helped to have broad representation on the team from groups that could ensure safety, wrap services around the individual or family, and/or monitor or intervene appropriately.

One innovation we used for rural community threat assessment team development was to veer away from rigid models using checklists and forms to determine level of risk. Instead, we drew upon the current research literature and created guidelines that guide rather than dictate risk levels and interventions. This allowed the teams to customize their interventions based on the current context in their communities (e.g., type and level of resources available). It also created space for teams to integrate cultural nuances in their assessment and monitoring strategies. The easy way out is to rely upon checklists, however threat indicators may look very different in the future. Therefore, we opted to teach team members to think critically with the latest research in mind rather than provide a definitive list of indicators and interventions. This approach is in some ways less satisfying to new team members who want a formula for assessing risk but it is more responsive to emerging threats. It is also in line with the model we use in Nebraska to train and sustain school threat assessment teams. Having the community team model mirror the school model creates a common way of thinking about threats and interventions among all teams operating in a community.

Sustainability

The sustainability of community threat assessment teams is highly dependent upon the level of buy-in from the community, the evolution of leadership within the teams and level of reporting in the community. However, it is anticipated that the community teams established during the grant period will continue past the period of performance.

The involvement of the local public health department in furthering grant activities will only partially continue. Without funding, the health department will only be able to provide minimal administrative support for community teams. We anticipate they will continue to feature violence prevention resources on their website and will continue to use handout materials with community health workers.

State-level threat assessment capabilities continue to develop but are dependent upon available time and funding. During the grant period, the state behavioral health authority chose to fund mental health clinician training in violence risk assessment across the state (including one of the test communities). This training was developed in response to the exposure of a state division director to project funded work with the state leaders. The result was over 200 mental health clinicians receiving two days of intensive training in violence risk and threat assessment. Over 60 of those clinicians volunteered to receive additional education to qualify them as members of a newly formed “violence risk assessment cadre” of mental health professionals. This list is being made available statewide to law enforcement and schools.

Another innovation we used was to link the rural threat assessment teams to a sustainable source of training and consultation via the regional chapter of the Association of Threat Assessment Professionals (ATAP). The ATAP Great Plains Chapter is composed of professionals in fields like mental health, law enforcement, education, corporate security, human resources, domestic violence, and the justice system who practice behavioral threat assessment. The cost of membership may be a barrier for some organizations, but it is generally less than the cost of attending a single training session. The Great Plains Chapter of ATAP provides ongoing monthly training often available via video conference making it convenient for rural attendees.

School threat assessment teams in the test communities are supported by training funded by Nebraska Educational Service Units and two Federal Stop School Violence Act grants awarded to the Nebraska Department of Education. Community threat assessment teams will benefit from this because leaders in the school teams are also part of the community teams. Ensuring training models are consistent across systems leads to more sustainable practices.

Deliverables

The following is a list of deliverables, materials created, and other final work products that were produced for the project.

DELIVERABLE	DESCRIPTION	SUBMITTED TO DHS	LINK TO MATERIAL	CAN MATERIAL BE SHARED OUTSIDE DHS
Community Survey	Gather information about barriers to reporting to help inform strategies to address them	Yes as final	http://cve.unl.edu/wp-content/uploads/2019/06/English-Survey-Example-Barriers-to-Reporting.pdf	Yes
Project website	Inclusive website that contains information about the project, resources available, and training materials.	Yes as final	http://cve.unl.edu/	Yes
Interactive CVE Toolkit for rural communities	Provides an overview of targeted violence, outlines key principles and approaches to engage rural communities in targeted violence prevention, and provides resources to learn more about targeted violence	Yes as final	https://indd.adobe.com/view/c38cb886-1f73-429f-a77a-30c9802748d1	Yes
7 different CVE handouts for stakeholders	Information sheets on a variety of subjects related to CVE	Yes as final	http://cve.unl.edu/home/resources/#toolkit	Yes
Training for threat assessment teams	Guidelines and associated training materials for development of community threat assessment team capabilities	Yes as final		No
Training of trainers awareness material	Trainer manual, power point and handouts for increasing community awareness of reporting concerns about violence	Yes as final	http://cve.unl.edu/home/training/#	Yes

Contact Information

Nebraska Emergency Management Agency

Bryan Tuma
2433 NW 24th St
Lincoln, NE 68524-1801
402.471.7421
https://nema.nebraska.gov/

Two Rivers Public Health Department

Jeremy Eschilman
701 4th Ave, Suite 1
Holdrege, NE 68949
888.669.7154
https://www.trphd.org/

University of Nebraska Public Policy Center

Denise Bulling
215 Centennial Mall South, Suite 401
Lincoln, NE 68588-0228
402.472.5678
http://ppc.unl.edu

Appendix – Survey Results

The following appendix is included as a separate attachment to this report:

- Appendix A: Survey Results – A Community Approach to Disrupting the Pathway to Violence
  File name: Appendix_A_Survey_Results_Summary.doc

Appendix A: Survey Results – A Community Approach to Disrupting the Pathway to Violence

Community surveys were administered in Kearney and Lexington, Nebraska to understand barriers to reporting violence. The original intent was to conduct an initial survey in each community, then conduct extensive train-the-trainer training, followed by a follow-up survey in each community to assess the effectiveness of the train-the-trainer training. Unfortunately, there were some methodological challenges that impacted how the survey data was viewed. The train-the-trainer training did not take place until later in the project timeline, and therefore the initial and follow-up surveys could not be used to compare the effectiveness of the training. Additionally, the follow-up surveys were not administered to the same individuals who completed the initial survey, leading to more challenges for data comparison. However, we combined initial and follow-up surveys and compared the two communities. This gives us an important snapshot into how the communities are similar and where they differ.

Demographics

Table 1. Survey Respondent Demographics

Item	Kearney	Lexington	Total
Gender			
Male	39	78	117
Female	189	142	331
Age Range			
18 or younger	1	4	5
19-39	94	117	211
40-60	92	83	175
61 and over	40	15	55
Race/Ethnicity			
Hispanic	27	137	164
Black	1	20	21
Caucasian	184	48	232
Asian	1	1	2
American Indian	2	0	2
Other	7	7	14

In both communities, the majority of the survey respondents were female. However, the distribution between male and female respondents was slightly less skewed in Lexington. The age distribution was also similar in both communities. Kearney respondents were majority Caucasian (83%) while Lexington respondents were majority Hispanic (64%).

Community Comparisons of Survey Data

Survey respondents were asked a series of questions about the barriers to reporting potential signs of violent behavior. They were first asked about their confidence level in recognizing when someone may be considering violence. Overall, the majority of respondents in both communities indicated higher levels of confidence (4 or 5 on a 5-point scale) in recognizing when someone may be considering violence. However, 38% of Lexington respondents indicated they were "very confident" in recognizing when someone may be considering violence, while only 11% of Kearney respondents indicated that same level of confidence. This could be because the Lexington is smaller than Kearney and was slightly ahead of Kearney in the implementation of project activities.

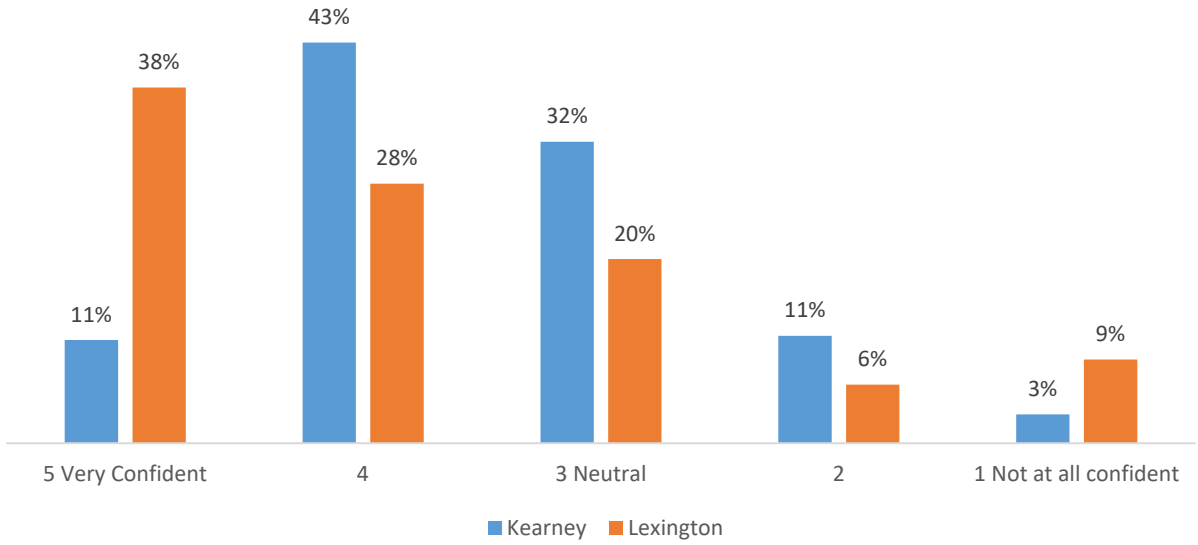

Figure 1. Confidence in recognizing when someone may be considering violence.

Respondents were then asked whether or not they would tell someone if they thought someone might be considering an act of violence. Overwhelmingly, respondents in both communities said they would tell someone (98% of Kearney respondents and 96% of Lexington respondents). Those who said they would not tell someone were asked why they would not. Some of the reasons given for not telling someone include a fear of reprisal or retaliation, not wanting to get involved, not knowing who to tell, not wanting to get in trouble themselves, or accuse someone for the wrong reasons. Those who said they would tell someone were then asked who they would tell. Respondents were able to choose from a list of possible trusted sources they could tell if they felt someone may be considering an act of violence. They were asked to mark all choices that applied. The distribution among trusted sources is similar between Kearney and Lexington. The majority of respondents in both communities said they would tell law enforcement. Local clergy or other religious leaders and public health were low on the list of sources they would tell.

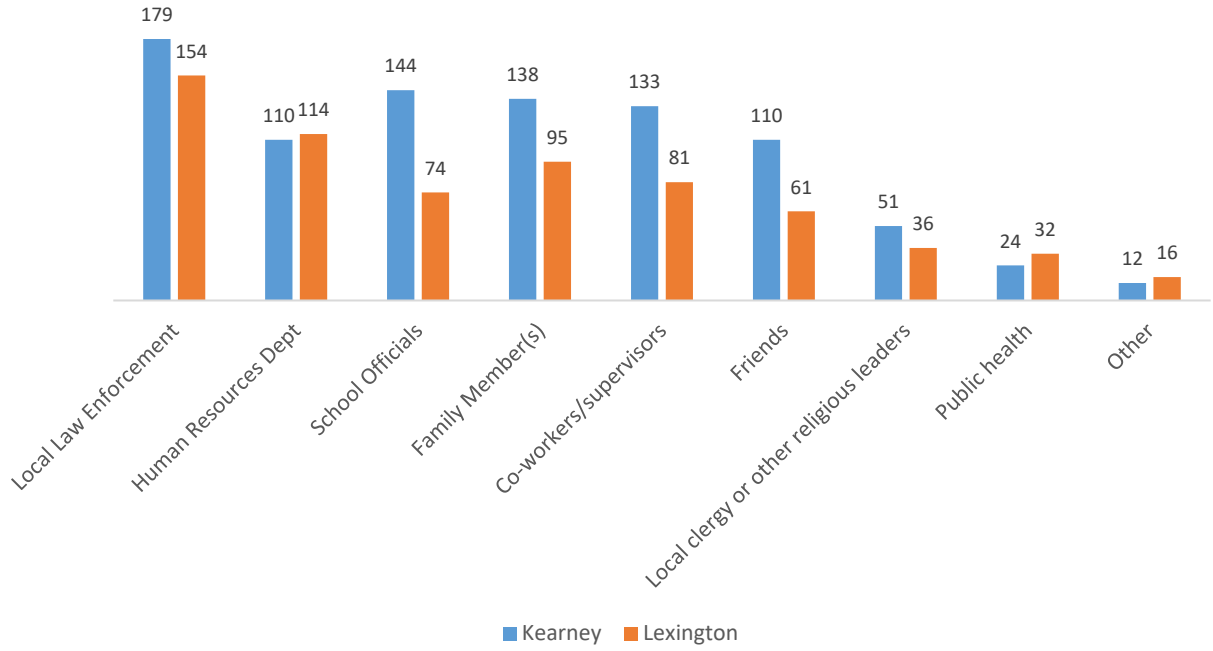

Figure 2. Trusted sources to report potential acts of violence.

When asked how important it was to make reports anonymously, the majority of respondents in both communities indicated it was “very important”. However, the distribution between “very important” and “somewhat important” was much more even in Kearney. There was only a 13 point difference among Kearney respondents, while Lexington respondents had a 55 point difference between the two response options. Lexington respondents place a high level of importance on being able to report anonymously. This could be related to the demographics of respondents because previous studies have shown that individuals who perceive they have less social status, value anonymous reporting the most.

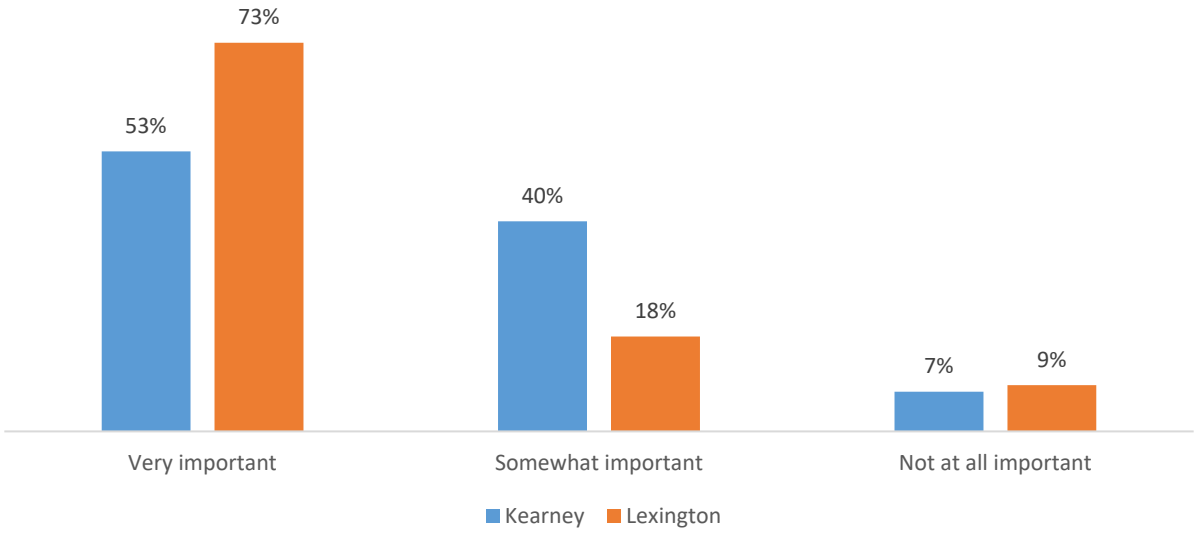

Figure 3: Importance of being able to make reports anonymously.

Survey respondents were then asked about specific barriers to reporting signs of violence in their community. Respondents were given a range of potential barriers and asked to select all that they considered barriers. Kearney respondents indicated that personal risk, not wanting to get involved, and not knowing where to report as the top barriers to reporting. Lexington respondents cited trust, not wanting to get involved, personal risk, and language barriers as the top barriers to reporting.

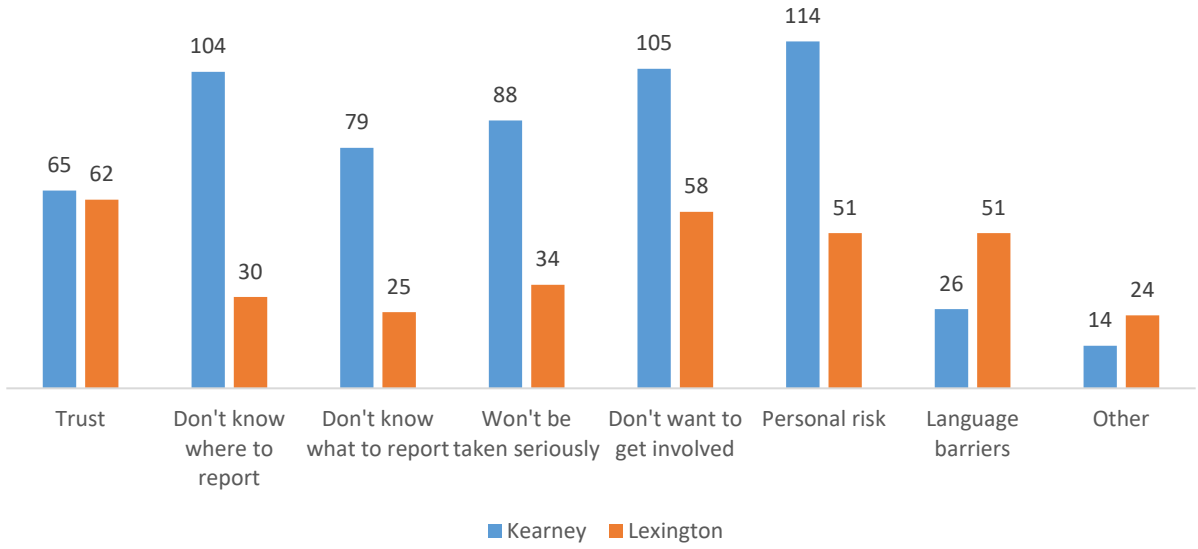

Figure 4: Barriers to reporting signs of violence.

When asked specifically which entities they don't trust, respondents indicated a lack of trust in police or law enforcement, the Department of Health and Human Services, and social workers. Additionally, some respondents stated that the nature of a small town made it difficult to trust that a report that might be made would remain confidential.

Other reasons that respondents cited as barriers include not wanting to make the situation worse for the victim or a fear of retaliation, the concern that nothing will be done even if it is reported, fear of being harassed or deported if the person reporting is an immigrant.

Summary

While there are a number of similarities between the two communities of Kearney and Lexington, Nebraska, it is worth noting several key differences that were highlighted in the responses to the survey. While respondents in both communities reported some level of confidence in recognizing when someone may be considering violence, only 11% of Kearney respondents said they were very confident, whereas 38% of Lexington respondents said they were very confident. There were also differences between the communities when it comes to being able to make reports anonymously. The majority of respondents in both communities said it was very important to be able to report anonymously, but the

gap between it being very important and somewhat important was much greater for Lexington respondents. This may be due to a number of factors including immigration status of the person reporting, trust that the report will remain confidential, or simply not wanting to get involved. These are among the barriers to reporting that were identified through this project. Future work in this area should look at how demographic factors such as race/ethnicity may affect their perceptions of barriers to reporting, or which sources they trusted to make a report.