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Evaluating the Safe Spaces Program: Using a Community-based Public Health Approach to Prevent Violent Extremism

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PROJECT PURPOSE AND METHODS

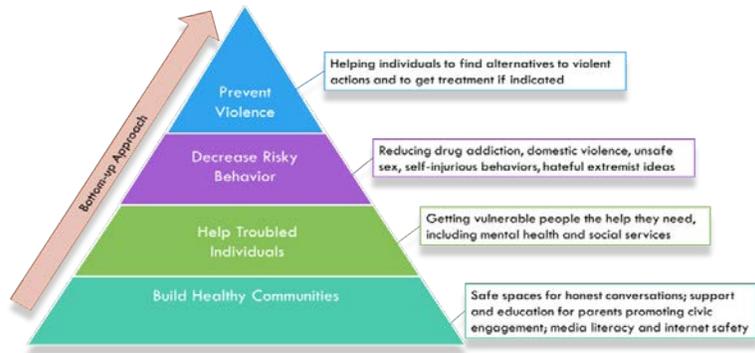
This study evaluated the Muslim Public Affairs Council's (MPAC) Safe Spaces Program which uses a community-led public health approach to prevent violent extremism. This was a three-year, multi-site, mixed methods research study. First, the UIC team conducted three focus groups with eight participants each from a mosque, service organization, and school, to solicit feedback regarding Safe Spaces content in relation to community needs. Second, a program design lab was convened by the UIC team and MPAC staff to help redesign Safe Spaces based on the focus group findings. Third, using the finalized toolkit, MPAC implemented Safe Spaces and the UIC team conducted process evaluations in nine community sites.

The original intention was to evaluate the impact of Safe Spaces in each site with quantitative surveys and statistical analysis. However, of the nine sites that received MPAC training and technical assistance, only four sites attempted to implement any prevention program activities. Of those four sites, three did not continue prevention programming specifically related to what was taught in the Safe Spaces training, and only one site continued prevention programming and formed a community response team (CRT) to carry out intervention activities. Five sites did not implement any prevention activities or intervention activities. Thus, the study was modified to focus on implementation barriers, facilitators, and recommendations through follow-up qualitative interviews.

BACKGROUND

The Safe Spaces Model. The Safe Spaces Program aimed to strengthen community resilience and promote a healthy environment by empowering communities with practical and effective tools. MPAC advocates a bottom-up approach based on the Prevention and Intervention (PI) model. The model incorporated both prevention and intervention components.

Prevention. Prevention is a proactive community-wide effort to build healthy communities through activities that address potential problems



before they escalate. The Safe Spaces Toolkit recommended four focus areas for prevention.

First, **Honest Conversations** encourage communities to create an open and productive environment in communal spaces such as mosques, service agencies, and organization. Second, **Civic Engagement** can help to develop a set of knowledge and skills for individuals to become more informed and effective members of their community. Third, **Parental Support** fosters positive youth development by increasing parental involvement and support to help facilitate discussion of difficult topics with their children. Fourth, **Media Literacy** raises awareness among parents and youth about the various kinds of messages on the internet, including teaching media literacy and cyber safety.

Intervention. Intervention is the adoption of a Community Response Team (CRT) comprised of multi-disciplinary experts that addresses troubled individuals, potentially harmful behaviors, and violence. The Safe Spaces Toolkit recommended four focus areas for intervention. First, develop a CRT to assess persons of concern and to form relationships with education, mental health, law enforcement, and social services agencies. Second, assess situations when notified of a troubled individual, potentially harmful behavior, or threat of violence, to determine the level of distress, harm, and threat. If the situation does not readily appear to be high risk, the CRT should analyze their findings to determine if an intervention is needed. Third, offer interventions that integrate practices from crisis intervention and threat

assessment when needed. Fourth, refer for continued care if a specific situation is beyond the capacity of the CRT and if they decide that the troubled individual needs further care.

RESULTS

PROGRAM MODIFICATION AND COMMUNITY CAPACITY

Obtaining Community Feedback on the Model. UIC researchers conducted three focus groups at different settings (i.e. mosque, school, and community center) to gather community feedback that was used to modify the Safe Spaces model. The feedback focused on program content issues including: some inconsistent language and unclear key terms (e.g. community response team vs. crisis inquiry team; Islamophobia term causing confusion if program focused on outsiders or insiders), preference for a public health approach, loss of focus without the violence prevention emphasis, perceived need to focus on helping youth and families, and lack of clarity on who in the community is vulnerable. A community member stated, *“I think it's very important to identify an objective before we get sucked into this general concept of safe spaces...what is the goal and objectives that we are trying to achieve.”* Another community member asked, *“How do you know what are important signs to look for?”*

Identifying Possible Implementation Challenges. In the focus groups, community members also identified a number of concerns regarding how to implement Safe Spaces. These included: How can mosques get people in the community involved who do not usually attend? How can mosques start a new program with limited human and material resources? How can mosques find the local partners, including mental health professionals, to help support the program? A community member said, *“There are a lot of parents who don't know what's going on, don't even come to parent-teacher conferences. We need to bring them in... you get the same volunteers over and over. How do we get those involved?”*

Revising the Manual and Engagement Packages. Following feedback from the focus groups, the UIC researchers and MPAC staff convened a Program Design Lab (PDL). The PDL was conducted for 2 days via Skype followed by regular calls and emails. The PDL drew upon the focus group findings and made modifications to the Safe Spaces model. The modifications included removing ‘Ejection’ from the PIE model (Prevention, Intervention, Ejection) to no longer support removing a person from their organization. Second was moving to a public health framework that focuses on improving personal, familial, and social factors to create safer, healthier, and more resilient communities. Third was removing “risk factor” language that focused on individual risk factors related to moving toward ideological extremism and instead added language on prevention at the community level.

Training the Trainer. To facilitate implementation and to address these challenges, MPAC hired a Safe Spaces Coordinator who was trained over 20 hours to deliver the toolkit. Training included background readings and discussions on key concepts and methods underlying the Safe Spaces Model, co-developing a script to coincide with the toolkit to be used during the trainings, and session practice runs with MPAC staff and UIC researchers providing feedback.

COMMUNITY BUY-IN, SITE TRAINING, AND TECHNICAL ASSISTANCE ISSUES

Site Recruitment and Opposition from Leadership. Following program modification, MPAC recruited community sites and explained the purpose and procedures of the training, and explained their obligations of implementing Safe Spaces. There were challenges to recruit sites and the training was turned down by many sites. Responses included: leaders were interested but the Board said no; not having enough resources to implement, and; not having translators for non-English speakers. Additionally, due to the political climate, there was a lot of pushback from communities who did not want Countering Violent Extremism (CVE) training in their institution. Even though there was a shift from CVE to public health, since the initial framing was a violence prevention program, there was widespread, vocal opposition to anything associated with CVE. Responses included: concerns about civil liberties; only focusing on the Muslim community, and; Muslim terrorism.

Conducting Safe Spaces Training. The nine community sites that initially agreed to participate then invited community members who were site administrators and security personnel, psychiatrist or psychologist, social workers, educators, and religious leader, to participate in the training. MPAC then conducted a Safe Spaces training at each site using a mixed pedagogical approach that combined standard “classroom” teaching (i.e. lecturing and presentations) with tabletop exercises that were intended to be more “real world”.

Providing Technical Assistance. After each initial training, MPAC offered ongoing post-training technical assistance to implementation sites free of charge. Each site received immediate follow-up technical assistance and the contact information of the Safe Spaces Coordinator’s if they needed assistance with prevention activities, forming the CRT, or building relations with local and federal law enforcement.

ASSESSMENT OF SAFE SPACES TRAINING AND TECHNICAL ASSISTANCE

Community Priorities. UIC researchers conducted observations during the trainings and follow-up interviews with the leaders and found that violent extremism was not seen as a major concern in the involved communities. Community members expressed far more concerns about mental health, substance abuse, youth leaving their religion, marital and family problems, the generation gap between youth and elders, as well as more immediate concerns, like dealing with a disruptive congregant during prayer, when a team doesn't have time to convene. During the Safe Spaces training, a community member stated, *“There are misconceptions about youth thoughts; having identity issues, questions about mental health, drinking, premarital relations, parents say the youth are crazy- need psycho-education.”* Another community member commented, *“What is important is irate congregants, people who talk nonsense during prayer, who are disruptive, someone who was off their medication it's an immediate concern.”*

Satisfaction with Safe Spaces Training. Immediate feedback from community members following the training showed some areas where the training was successful. Community members thought the discussion of prevention activities could be useful for their site; they had the opportunity to ask questions and share their experiences; and the facilitator provided clarifications and corrected misunderstandings. During follow up interviews, some leaders also expressed that they were satisfied with the technical assistance provided. A community leader remarked, *“The topics involved were definitely relevant to our community as well, so I think that it did bring up a lot of emotion and engagement.”* Another community leader said, *“MPAC gave us the layout of the land, and what we had to do, if we needed more trainings we would have asked for it.”* However, even though some sites thought the information received during the training was useful, there were still too many barriers to get Safe Spaces running at these sites.

Negative Feedback on Training. The community members who attended the Safe Spaces training also had some negative feedback that included: the training being too long for a single session; the facilitator lacked knowledge on some of the topics presented; prevention activities were not tangible things that could be implemented, and; there was a disconnect between the prevention activities on community strengthening and the intervention tabletop exercise on violent threat assessment. This resulted in changing the table top exercise mid-way through the site trainings from a Threat Assessment to a Crisis Intervention focused on the mental health needs of a community member. One community leader explained, *“You need to be clearer...It needs to be more specific, more substantive than putting a team together. Didn’t really give tools, skill building, that wasn’t part of the training.”* A different leader commented, *“The 11 key questions to assess threat seem too focused on violence. It doesn’t address broader needs of community, when all the prevention is focused on other issues that aren’t violence.”*

COMMUNITY IMPLEMENTATION ISSUES

Engagement in Training. Many sites had a low turnout and a “revolving door” of participants who did not attend the full training. Some sites were not adequately aware of the need for a long-term commitment following the initial training. Additionally, the program was not backed by some of the imams and/or elders at some of the sites. One leader explained, *“The training was helpful and informative, but there was some confusion about what people’s responsibilities would be moving forward. They didn’t realize it was a long-term initiative.”*

Lack of Resources. Getting the Safe Spaces Program running at each site was problematic due to a limited number of volunteers who lacked time and limited financial resources to run programming. The only site that formed a Community Response Team had funding for a project coordinator and mental health professional who were held accountable for

forming the team. One leader explained, *“The reason it didn’t get off the ground was because we didn’t have people who were able to make the commitment to it.”* Another said, *“We didn’t form a team because there’s only so much we can do. The same people are doing different jobs, don’t want to burn them out.”*

Other Prevention and Intervention Activities. The researchers learned of other activities that sites were conducting apart from Safe Spaces. These included partnering with organizations to bring in outside experts like youth organizations, local law enforcement, and political groups. Some sites also had established committees that provided a range of services, such as social services, youth groups, charity groups, as well as hosting lectures on different topics including social justice, community service, and wellness. One leader explained, *“All of those elements already existed and a lot of the things we’re having, like having open forums and having open conversations with the youth, all of those things we have been doing.”*

Some sites also had their own mental health clinics that were run by psychiatrists in their community. One community leader explained, *“We allow anybody, Muslims, non-Muslims, for any kind of psychological health...there are three board members of the masjid who are also board members of the clinic.”* Another community leader explained, *“At the monthly clinic, we provide counseling and medication management...so the idea was to create a space that was specifically for the Muslim community who might feel kind of hesitant to engage in counseling services or receiving mental health services outside of the Muslim community.”*

CONCLUSIONS

The overall conclusion is that the Safe Spaces program as implemented was not successful, but some aspects showed potential.. Particularly, there was not enough focus on each site’s needs, engagement with leadership, or preparing the site ahead of training. Additionally,

most of the mosques did not prioritize terrorism or violence and there was no collaborative partnership approach to define priorities of the community. Another issue was that the mosques did not have the human and financial resources to take on this type of program or to implement both prevention and intervention activities simultaneously. Finally, a one-time full day training was too long for sustained engagement and did not provide enough breadth for the participants to feel knowledgeable without enhanced support services to provide active and ongoing monitoring.

RECOMMENDATIONS

If there is any possibility for mosques to lead community-led violence prevention, then they will need a different model that better addresses community's needs and capacity building.

First, programs must better address the community's needs, as violent extremism was not regarded as a top priority by any of the implementation sites. Instead, the primary focus should be on the community's concerns and priorities using a collaborative partnership approach so that community members, program designers, and researchers can collaboratively define the priorities that the program addresses, including but not limited to violence prevention. Gathering information on the needs of each community site allows for tailoring the training and understanding concerns, issues for action, and developing goals prior to delivering the training.

Second, there needs to be a clearer program focus and focus on one level of the model at a time. Community sites were expected to implement both prevention and intervention activities, which may be beyond their capacity. Additionally, the removal of terrorism prevention and shifting towards public health created an unclear understanding if the purpose was still violence prevention and resulted in a disconnect between prevention and intervention components of the toolkit. Prevention activities focused on building healthy communities,

whereas the intervention activities focused on forming a team of experts to conduct threat assessments or crisis interventions.

Third, preparing the trainer should be a main priority since a program cannot be effectively implemented by community sites without an effective trainer to deliver the skills and education to the sites. In addition to practice run-throughs with the program developers, there should be multiple mock trainings at pilot community. This will better ensure the trainer is prepared for dealing with community questions and can successfully implement the program in a real-world setting. Additionally, the trainer should be prepared to inform sites about the content and length of the training, commitment required, and send materials in advance so participants attend with background knowledge and will be more likely to attend the full training.

Finally, there needs to be consideration of the human and resource capacities of community sites. The program should incorporate community capacity building to promote the ability of communities to develop, implement, and sustain their own programming. This should include focusing on leadership buy-in so that local institutions are more willing to mobilize resources. Additionally, the program could provide assistance to search for potential funding and staffing, as well as help connect sites with local experts to address a broader range of concerns.

LESSONS LEARNED

Community-based violence prevention programs require: 1) Buy-in from the local community; 2) Appropriate follow-up after the initial training and on-going technical support provided, including webinars, review of plans, and troubleshooting; 3) Resources and capacity building available to the community; 4) Delivery across a range of communities where there is a concern about other types of violence, not only in ethnic and religious minority communities, and; 5) Focus on design, implementation, and program development before metrics.