

A Public-Health Approach to Countering Violent Extremism

by Michael Garcia

April 3, 2019

The recent horrific attack on two mosques in New Zealand has again prompted criticism that the United States and the international community fail to address violence committed by far-right extremists as energetically as that of al-Qaeda or ISIS assailants. While we unequivocally should focus on both kinds of violence, a more effective strategy may be to concentrate on the factors that draw individuals to any violence-inspiring ideology in the first place. An approach to countering violent extremism (CVE) that employs practitioners across multiple disciplines to identify and mitigate such risk factors would eliminate the arbitrary nature of focusing on one form of violent extremism or another.

In other words, we need to apply public-health policies and practices to CVE.

The U.S. Centers for Disease Control and Prevention (CDC) already views a public-health approach—a collective action by mental health, substance-abuse, psychological, and law enforcement practitioners—as a way to address violence in general. Researchers and practitioners recently examined how this idea could be applied to CVE. They crosswalk how CDC's essential public-health functions could be translated into CVE and how multi-sector and non-discriminatory techniques would foster a holistic approach.

While the reports resulting from these projects provide great frameworks and general recommendations, they do not detail *how* to implement such an approach from a policymaker's standpoint. That is why my team and I at the National Governors Association are using one of 26 U.S. Department of Homeland Security CVE grants to create a practical guide detailing how a state can adopt public-health policies and practices for CVE, with primary, secondary and tertiary prevention efforts.

Our framework differs from previous CVE efforts in at least three ways.

First, it calls for a multi-disciplinary, *state-led* strategy that fosters coordination between state and local agencies, nonprofits and federal resources. Previous initiatives have been driven primarily from either the local government or federal level, or a combination of both. Yet, a recent study by the RAND Corporation found that some particularly vulnerable individuals or communities did not want to engage with the local entities because they didn't trust the federal authorities involved. The state could act as a buffer to mitigate this challenge, while also mobilizing financial, political and human resources available at the state level that may not be available in local communities.

Terminology Matters

Second, we've adopted the term "preventing targeted violence," or PTV, to describe our work rather than countering violent extremism. Critics might think this is just CVE in sheep's clothing, but the terminology matters. Using "preventing" rather than "countering" suggests proactive action that mitigates risk factors rather than often-fraught and not always successful efforts to counter an ideology. Furthermore, using the term "targeted violence" rather than "violent extremism" increases the emphasis on violence over ideology and includes any form of premeditated violence committed against innocent populations for a specific political or ideological reason.

Lastly, a prevention model — as opposed to a countering paradigm — aligns with a public-health approach because it requires the inclusion of multiple disciplines such as social services, behavioral health services (which includes mental health and substance abuse specialists), schools and employers. This allows for the delineation of appropriate roles and responsibilities among stakeholders, which is critical to illustrating that the problem is not solely a law-enforcement issue. Elevating non-security-related functions to prevent targeted violence could then allow states and localities to sustain these programs through non-law enforcement mechanisms (e.g., non-law enforcement federal and foundation grants).

With this framing, states can implement tangible and feasible primary, secondary and tertiary prevention efforts.

In the public-health world, primary prevention efforts include an array of activities aimed at preventing disease before it occurs, such as risk mitigation and resiliency strategies. For PTV, states would need to inform local stakeholders — mayors, social-service providers, public-health staff, educators, chiefs of police and so forth — about how

frequently or infrequently targeted violence occurs, and has occurred, in the state. This ensures stakeholders are aware of *all* forms of targeted violence and helps dispel misconceptions that only al-Qaeda or ISIS-inspired individuals commit acts of targeted violence.

Then, states need to convey the root causes of targeted violence to policymakers and practitioners, based on solid research and data, to illuminate why this is more than a law-enforcement issue.

Risk Factors

The RAND Corporation recently analyzed reports and studies that examined the potential risk factors associated with “ideologically motivated violence.” The research identified four major categories:

1. **Individual risk factors** such as anger or hostility toward others, psychological/personality disturbances, alcohol/substance misuse and violent or suicidal behaviors.
2. **Relationship risk factors** such as fractured family structures, family history of violence or suicide, current relationship/marital turmoil, intimate partner violence and financial and work stress.
3. **Community risk factors** such as poverty, poor education systems, limited economic opportunities, high crime levels and inadequate social services.
4. **Societal risk factors** such as economic inequality, stigma regarding mental distress and help-seeking, and discrimination.

If these risk factors look familiar, it’s because they are associated with various types of violent and non-violent behavior. The FBI’s Behavioral Analysis Unit listed similar risk factors in “Making Prevention Reality,” which examined reasons that may lead someone to commit acts of targeted violence.

Of course, merely possessing some or many of these risk factors does not mean an individual is certain to commit a violent act. Further, we must ensure that a PTV approach protects the civil rights, civil liberties and privacy of vulnerable individuals who exhibit these factors.

Realizing that these risk factors cross-cut various forms of violence, states could engage programs where practitioners are already actively involved and coordinating activities (such as crisis response, suicide prevention, and/or school safety efforts), and support the addition of targeted violence to their program portfolio.

Bolstering Prevention Capacity

Secondary prevention efforts typically refer to actions directed at a specific population that is susceptible to a disease or is in the early stages of experiencing a disease. For PTV, this means helping those who may be prone to risk factors or may already be experiencing or exhibiting a few of the risk factors but are not fully on the road to committing violence. States could help local governments support institutions, professionals, and social programs involved with these populations by bolstering existing prevention capacities with measures such as:

- Ensuring programs are not only tailored to youth, but are also available for adults.
- Destigmatizing seeking out mental-health services through public service announcements and campaigns.
- Creating or adopting a “mental-health first aid kit” template for human resources staff and teachers.
- Establishing an anonymous mechanism for the public to report concerns and problems with government services, to encourage vulnerable individuals and groups to provide feedback.
- Promoting social and government services in predominant languages other than English, as needed, to enhance responsiveness to the whole population.

Tertiary prevention, in public health, involves curing an individual of a disease and/or ensuring the person does not relapse. In this case, we are not talking about “curing” someone of an ideology. Rather, this involves providing tailored services to an individual who is exhibiting several risk factors or someone who has already committed an act of targeted violence and may be in prison or about to be released.

One primary role for states in tertiary prevention is to ensure connectivity among local and state referral systems. For instance, in many small towns, 911 is the first number people call, even if it is a non-law enforcement issue, because it is the only 24/7 line available to reach someone. States could provide information on state (and where feasible, local) services to which law enforcement can redirect a caller.

This is no easy task, as there may be local regulations and policies on call handling and transfers related to liability, not to mention the fact that callers may not want to talk to anyone else. Further, law enforcement may be concerned about redirecting potentially violent individuals to a service, which is why establishing trust and confidence among stakeholders is key to this whole framework.

Similarly, states could work with suicide hotlines, school safety lines and other intervention-type reporting mechanisms to ensure they are fully briefed on issues of targeted violence and how it could be handled most effectively. This would include clarifying liability concerns, helping establish guidance when law enforcement should be involved, and informing them of services offered by the state.

Drawing on Experience

Lastly, states could provide lessons learned and guidance for local entities considering creating teams that assess an individual's risk factors.

In brief, these multi-disciplinary services teams would assess an individual with risk factors and develop an intervention plan that connects and/or provides the individual with appropriate services (e.g., substance abuse disorder services, financial and employment assistance, anger management, therapy, etc.). States have begun offering recommendations on how these teams should be assembled and their roles and responsibilities, with states such as Arkansas, Indiana and Nebraska providing this type of guidance in recent school safety reports.

The public-health approach to PTV is not just theory. It is already occurring.

Illinois established the Targeted Violence Prevention Program to promote policies and practices for preventing targeted violence by developing training for practitioners from multiple disciplines on how they can expand and coordinate health and human services to assist vulnerable people. In California, the governor's office established a program on

preventing violent extremism that includes a grant initiative to assist locally led prevention and intervention efforts that would struggle without additional resources and guidance. Colorado is partnering with the Colorado Resilience Collaborative, which provides clinical consultations for organizations and individuals, to develop strategies that prevent identity-based violence.

This framework is not a panacea to eliminate the risk of attacks like those in New Zealand. Nothing ever will. But a public-health approach that focuses multiple disciplines on reducing specific risk factors may be a good way to start curbing the spread of this vexing plague.

IMAGE: A man in a Pulse memorial t-shirt pauses near the nightclub on June 17, 2016 in Orlando, Florida. Five days earlier, Omar Mir Seddique Mateen had killed 49 people and wounded 53 others at the popular gay nightclub. (Photo by Spencer Platt/Getty Images)