Countering Violent Extremism Through Public Health Practice: Proceedings of a Workshop

DETAILS

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Proceedings of a Workshop

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Forum on Medical and Public Health Preparedness for Disasters and Emergencies

Board on Health Sciences Policy

Health and Medicine Division

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This Proceedings of a Workshop was reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published Proceedings of a Workshop as sound as possible and to ensure that the Proceedings of a Workshop meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the process. We wish to thank the following individuals for their review of this Proceedings of a Workshop:

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Although the reviewers listed above have provided many constructive comments and suggestions, they did not see the final draft of the Proceedings of a Workshop before its release. The review of this Proceedings of a Workshop was overseen by **BRUCE ALTEVOGT,** Pfizer Inc. He was responsible for making certain that an independent examination of this Proceedings of a Workshop was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this Proceedings of a Workshop rests entirely with the rapporteurs and the institution.

CONTENTS

ACRONYMS AND ABBREVIATIONS

APA	American Psychological Association
BRAVE	Building Resilience Against Violent Extremism
CAMP	Case Assessment Management Program
CDC	Centers for Disease Control and Prevention
CRSS	Crisis Response Support Section
CVE	countering violent extremism
DHS	U.S. Department of Homeland Security
DMH	U.S. Department of Mental Health
DOJ	U.S. Department of Justice
EADR	Empirical Assessment of Domestic Radicalization
EMS	emergency medical services
EPREP	Emergency Preparedness Research, Evaluation, and Practice
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
ICCPR	International Covenant on Civil and Political Rights
ISIL	Islamic State of Iraq and the Levant
JRIC	Joint Regional Intelligence Center
JTTF	Joint Terrorism Task Force
LAPD	Los Angeles Police Department
MCD	Major Crimes Division
MEU	Mental Evaluation Unit
NGO	nongovernmental organization
NIJ	National Institute of Justice
PEACE	Promoting Engagement, Acceptance, and Community Empowerment
RENEW	Recognizing Extremist Network Early Warnings
RFP	request for proposal

ROC	receiver operating characteristic
SAMHSA	Substance Abuse and Mental Health Services Administration
SAR	suspicious activity report
SMART	System-Wide Mental Assessment Response Team
START	Study of Terrorism and Responses to Terrorism
USAID	U.S. Agency for International Development
WORDE	World Organization for Resource Development and Education

1
Introduction and Overview[1]

WORKSHOP OBJECTIVES

Countering violent extremism (CVE)[2] consists of various prevention and intervention approaches to increase the resilience of communities and individuals to radicalization toward violent extremism, to provide nonviolent avenues for expressing grievances, and to educate communities about the threat of recruitment and radicalization to violence. To explore the application of health approaches in community-level strategies to countering violent extremism and radicalization, the National Academies of Sciences, Engineering, and Medicine held a 2-day public workshop called *Health Approaches in Community-Level Strategies to Countering Violent Extremism and Radicalization*. The workshop, held in Washington, DC, on September 7 and 8, 2016, convened speakers with expertise spanning the domains of health care, mental and behavioral health, public health, homeland security, law enforcement, education, civil rights, and countering violent extremism. Topics explored included

- The evolving threat of violent extremism and radicalization within communities across America;
- Traditional approaches to countering domestic violent extremism and radicalization;
- Applying health-centered approaches (e.g., public health, health care, mental and behavioral health) to countering violent extremism and radicalization; and
- Opportunities for cross-sector and interdisciplinary collaboration and learning among domestic and international stakeholders and organizations (e.g., community and/or faith-based groups, law enforcement, justice system, public health, health care, mental and behavioral health) for countering violent extremism and radicalization.

[1] The planning committee's role was limited to planning the workshop, and this Proceedings of a Workshop was prepared by the rapporteurs as a factual account of what occurred at the workshop. Statements, recommendations, and opinions expressed are those of individual presenters and participants and have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine. They should not be construed as reflecting any group consensus.

[2] Many participants noted that a common language and set of definitions is a challenge faced by the field of CVE, but for the sake of clarity, these proceedings will use the terms *countering violent extremism*, *violent extremism*, and *extremist violence*.

BOX 1-1
Workshop Objectives[a]

1. The evolving threat of violent extremism and radicalization within communities across America
2. Traditional approaches to countering domestic violent extremism and radicalization
3. Consideration of health-centered approaches (e.g., public health, health care, mental and behavioral health) to countering violent extremism and radicalization
4. Opportunities for cross-sectoral and interdisciplinary collaboration and learning among domestic and international stakeholders and organizations (e.g., community and/or faith-based, law enforcement, justice system, public health, health care, mental and behavioral health) for countering violent extremism and radicalization

[a] The full workshop statement of task can be found in Appendix B.

COUNTERING VIOLENT EXTREMISM

George Selim, director of the Office for Community Partnerships, U.S. Department of Homeland Security (DHS), and CVE Task Force, described the emergence of CVE. He stated that in the period immediately after the events of 9/11, the primary focus was on law enforcement and military-led counterterrorism interventions. In 2006 and 2007, tactics expanded to include prevention strategies directed toward identifying and curtailing the process of radicalization that many foreign and domestic organizations use to attract and deploy individuals to commit terrorist acts, Selim explained. By 2010 and 2011, the U.S. government began to codify policy on CVE. Peter Romaniuk, associate professor in the department of political science at John Jay College of Criminal Justice, The City University of New York, proffered that the shift from counterterrorism to CVE reflected evolving, empirical developments in our understanding of violent extremism and radicalization.

People who radicalize may espouse extreme beliefs or opinions and attempt to significantly change the essential qualities of their society and government (Australian Government, 2016). The process is relatively uncommon, affecting only a small percentage of people in any given community. Likewise, a small number of people who become radicalized may go on to commit acts of violence to achieve their goals; this behavior is also referred to as *violent extremism*. Romaniuk interpreted the term *violent extremism* as being a relatively new addition to the lexicon, reflecting a shift in focus away from the deeply politicized term *terrorism*, and toward the processes at play in radicalization to violent extremism. Georges Benjamin, executive director of the American Public Health Association, talked about violent extremism, which has been defined as "the beliefs and actions of people who support or use violence to achieve ideological, religious, or political goals" (Australian Government, 2016). Michael Jensen, senior researcher, National Consortium for the Study of Terrorism and Responses to Terrorism (START), University of Maryland, defined violent extremism as "beliefs that justify the use of violence for obtaining a political or social goal." Just as there are varying definitions of violent extremism, there is not yet consensus on how to define CVE. However,

Romaniuk commended the following definition for its focus on prevention by dissuasion rather than coercion:

> CVE is the use of noncoercive means to dissuade individuals or groups from mobilizing towards violence and to mitigate recruitment, support, facilitation, or engagement in ideologically motivated terrorism by nonstate actors in furtherance of political objectives. (Khan, 2015)

Broadly, CVE is aimed at recognizing individuals who have become radicalized—or those who are vulnerable to radicalization—and intervening to prevent them from perpetrating acts of violent extremism. CVE differs functionally from counterterrorism in its focus on cross-disciplinary, community-based, resiliency-building efforts that interrupt the process of radicalization toward acts of violent extremism. Romaniuk remarked that CVE has few, if any, direct precedents to inform the field.[1]

In the United States, violence linked to Islamic extremist beliefs tends to receive the most public attention and be perceived as the strongest threat. However, violent extremism is not limited to Islamic extremism; far-right, far-left, and single issue ideologies are also prevalent among those individuals who commit such violence. Irfan Saeed, director of the Office of Countering Violent Extremism, Bureau of Counterterrorism and Countering Violent Extremism, U.S. Department of State, explained that the government of the United States was founded on radical and extremist thoughts, and individuals with these beliefs are absolutely protected by the Constitution. Only when the line is crossed into violence can the government justifiably intervene. Several participants strongly cautioned against conflating extremism (or extremist beliefs) with violent extremism. For example, as Jalon Arthur, director of Innovation and Development, Cure Violence, School of Public Health, University of Illinois at Chicago, commented: "You can have ideas that are viewed as extreme and you can have ideas that are associated with radicals without violence even being a part of the equation. The fact that most extremists do not act on it is evidence of that."

A major component of the CVE enterprise is identifying and intervening with individuals who are radicalized and likely to commit violence to achieve their views but who have not yet committed any crime. Thus, a key challenge is the public perception that certain communities are being "profiled" and subject to discrimination and victimization through CVE programming. Michael German, Brennan Center for Justice, New York University Law School, criticized CVE programming that is predicated on the false, invalidated assumption that bad ideas necessarily or exclusively lead to violence. He emphasized that it is very difficult to predict who will engage in violence, and that people with bad ideas are not the only ones who commit violence. Thus, he argued that there is a flawed, unscientific premise incorporated into the indicators of potential violence or potential radicalization, which are often characterized in terms of race, national origin, and ideology. In that vein, Laura Runnels, facilitator and engagement strategist at LARC, LLC, noted that there is tension to be resolved between CVE efforts aimed at protecting and preserving the society at large, and the fear that certain groups will continue to be marginalized and oppressed by the government. Addressing these challenges, she said, will require multidisciplinary, cross-sectoral approaches that strive to include, engage with, and empower

[1] With the exception of certain types of analogous violence prevention efforts and approaches within the domain of public health, particularly those that target gangs.

communities. Furthermore, CVE programs that are implemented must include evidence-based approaches that are centered on empirically established protective and risk factors.

PUBLIC HEALTH AND CVE

Borrowing a concept from the public health arena, Matthew Wynia, director of the Center for Bioethics and Humanities at the University of Colorado framed CVE as a complex adaptive challenge; given the number of factors at play, one approach or intervention will not solve the problem. Instead, interventions may have an incremental positive effect coupled with some negative externalities. George Selim commented on the potentially negative connotations attached to prevention or intervention, pointing out that the overall spirit of CVE policy is not just to prevent or intervene with coercive measures. Instead, the U.S. government's national strategy seeks to empower local partners and to invest in communities across the country to help them build and cultivate their own strategies shaped by local perspectives to enhance individual and community resilience.

Kiersten Stewart, director of public policy and advocacy at Futures Without Violence, called for embedding the prevention of violent extremism within a broader public health approach to violence. She argued that repositioning CVE within a public health framework provides the tools to do the requisite type of prevention-focused analyses, the first step of which is to clearly define the problem and the goals of the planned policies or actions. Examining push-and-pull factors from a public health perspective involves looking at individuals, societal and community influences, as well as the entire social ecology. She encouraged turning away from a focus on the rationale for violence and concentrating on preventing the acts of violence, suggesting that public health approaches can also add value to the CVE space by providing tools and mechanisms for understanding violence and what motivates it. She argued that placing violent extremism in the context of violence prevention—not in political or religious ideology—will strengthen efforts to prevent violence and better maintain CVE programmatic integrity.

While many panelists and participants argued that using public health in CVE was potentially dangerous, and raised many civil liberties, ethical, and legal concerns for health professionals and researchers, other participants and panelists in the workshop explored how models, strategies, and lessons learned from public health could strengthen and support the CVE enterprise.

David Phillippi, program coordinator for Parents for Peace, differentiated between legal responsibility and ethical responsibility. He asked how those issues apply to organizations outside the medical profession that do not necessarily have the same professional or legal responsibilities but that adhere to similar ethical responsibilities in trying to interact with families and friends who are concerned about loved ones. Furthermore, he asked whether those legal and ethical responsibilities differ when working with a third party (friend or family member) rather than working with the individual directly. He advised that considering any CVE approach or framework should consider how it will affect the small independent organizations that will implement programs. He suggested developing a roadmap for creating viable civically and ethically legally responsible CVE programs for nongovernmental organizations (NGOs). Reddick also highlighted the need for clear guidelines about ethical issues so when such situations do arise, a framework exists and is ready to use.

TOPICS HIGHLIGHTED DURING PRESENTATIONS AND DISCUSSIONS[2]

Throughout the 2-day workshop, many themes where highlighted by speakers and participants:

- **An individual's progression to extremism is complex, and there is no evidence to predict when or how an individual will act on violent impulses.** Michael Jensen said that researchers are trying to identify a shared set of characteristics or a specific pathway that individuals take to become violent extremists, but ultimately researchers should conclude that such shared characteristics do not exist. Some researchers, said Mark Stainbrook, found shared motivations behind violent behavior, but, as Mike German points out, there is no evidence to predict when or how an individual will act on violent impulses.
- **Gaps in research about CVE programs are negatively affecting best practices.** Many presenters, like Peter Romaniuk, said it was difficult to determine whether programs were effective because they did not always participate in an evaluation or assessment of their efforts. To support the continued development and refinement of evidence-based policy may require continued assessment of methods and programs.
- **Fitting practical solutions to CVE is often difficult with current political realities.** Rebecca Skellett noted that it is difficult to tread the line between achieving good outcomes and addressing political caveats imposed on work in the CVE arena. In fact, many programs have found preventing violent extremism works much more effectively when steps are taken to strengthen and improve communities instead of targeting CVE in a group or in an individual, as Alejandro Beutel and Mehreen Farooq described in their presentations.
- **The unintended consequences of earlier CVE practices have hindered efforts to address violent extremism.** Many presenters, like Romaniuk and John Hick, lamented past attempts to curb violent extremism because they often resulted in groups and individuals feeling isolated and associating CVE with bigotry and profiling.
- **Approaching violent extremism as a public health issue offers intriguing opportunities.** Many speakers, like Jihad Turk and Michael Downing, believed that the best way to prevent individuals from radicalizing to violence was to build strong, healthy, welcoming, and resilient communities that are hostile to violent extremist ideologies. Georges Benjamin, David Eisenman, and Leesa Lin discussed public health models of prevention that could be effective at doing this.
- **Health professionals face a set of practical and ethical challenges when working in CVE roles.** Hick, Lin, and Wynia also discussed some identified issues that have historically complicated the health professional's role, such as patient threat

[2] This list is the rapporteurs' highlights of main topics and recurring themes from the presentations, discussions, and summary remarks by the meeting facilitator, speakers, and participants. Items on this list should not be construed as reflecting any consensus of the workshop participants or any endorsement by the National Academies of Sciences, Engineering, and Medicine or the Forum.

assessments and being obligated to report to law enforcement. Screening programs and other population-level strategies were also debated.

PROCEEDINGS STRUCTURE

This report will account for the presentations and discussions had at the September workshop in Washington, DC. It is organized to first present an introduction to our current understanding of the roots and sources of violent extremism in Chapter 2. It then discusses some of the contemporary approaches to curtail extreme violence in Chapter 3. Chapter 4 explores the challenges and unintended consequences of initial CVE actions as well as some of the opportunities our better understanding has afforded us. Chapter 5 applies health and public health models and approaches to CVE objectives. Finally, Chapter 6 suggests how CVE initiatives might move forward.

2
Understanding Violent Extremism

Highlights of Main Points Made by Individual Speakers[a]

- The best CVE policies should reflect an empirical understanding of the causes of radicalization and its consequences, but representative, systematic data on those phenomena is currently lacking (Jensen).
- From the law enforcement perspective, there is no "silver bullet" or profile of someone who will perpetrate violent extremism but there are certain observable consistencies like a lack of identity, lack of attachment, and lack of societal inclusion (Downing).
- No single shared motivator for violent extremism has been found, but the sum of several could provide a strong foundation for understanding (Stainbrook).

[a] This list is the *rapporteurs'* summary of the main points made by individual speakers and participants, and it does not reflect any consensus among workshop participants.

Many participants proposed that to better understand violent extremism, it is necessary to examine the shared characteristics of individuals who exhibit violent extremism. In this chapter, speakers discuss the origins of violent extremism and the challenges surrounding collecting empirical data about violent extremists. Several speakers noted that the progression to radicalization is complex, often connected to personal as well as societal grievances, and that there is no single profile for a violent extremist. However, an expectation remains that if some shared characteristics of violent extremists can be identified more preemptive steps can be taken to protect those individuals from progressing any further.

RADICALIZATION AND VIOLENT EXTREMISM: CHARACTERISTICS AND EMPIRICAL DATA

The Empirically Assessing Domestic Radicalization (EADR) Project

Michael Jensen, senior researcher at START, University of Maryland, provided a data-informed look at extremism in the United States. He emphasized that the best CVE policies should reflect an empirical understanding of the causes of radicalization and its consequences, but that representative, systematic data on those phenomena is currently lacking. This gap led to the development of the Empirical Assessment of Domestic Radicalization (EADR) project, a multiple-methods research project housed at START (see Box 2-1). Its quantitative cross-sectional dataset (Profiles of Individual Radicalization in the United States or PIRUS) contains information on a random representative sample of 1,473 individuals who radicalized, to either

nonviolent extremist behaviors or violent extremist behaviors, in the United States. The qualitative component of the project is drawn from the life-course narratives of 110 individuals who became radicalized in the United States.

Jensen outlined the three objectives of the EADR project. First, it is designed to provide policy makers, CVE practitioners, intelligence analysts, law enforcement officers, researchers, and the public with representative data on extremism in the United States, including information on key radicalization mechanisms and processes. Second, it aims to provide analyses using rigorous methods that help to better understand how radicalization in the United States works, how it has changed over time, and how it may evolve in the future. Its third objective is to produce empirically derived policy recommendations for counterterrorism and CVE.

BOX 2-1
Empirical Assessment of Domestic Radicalization (EADR) Project Variables

Jensen explained that the EADR project captures a wide range of data in order to examine the complex issue from multiple angles. Variables include

- Identification variables: number ID, name and aliases
- Plot and consequences: activity description, location of plot, date of exposure, violent or nonviolent, criminal charges
- Group information: group name(s), role in group, name of group leader, group dynamics
- Demographics: ethnicity, age, gender, marital status, religious background, citizenship
- Radicalization details: ideologies, recruitment, role of the Internet and media, event influence
- Socioeconomic status: education level, finances and employment, military background
- Personal details: abuse and psychological concerns, family and relationships, drug and alcohol use, social life, previous criminal activity, mindset prior to radicalization
- Foreign fighter information: pretravel behaviors, group preference, activities in the conflict zone, return information, plot involvement

SOURCE: Jensen presentation, September 7, 2016.

Jensen discussed five findings from the EADR project with relevance to CVE.

Extremism in the United States Spans Diverse Ideologies

Extremism in the United States is ideologically diverse, encompassing the far right (e.g., antigovernment, white supremacists), the far left (e.g., social justice, animal rights, environmental protection), single-issue ideologies, and Islamist. Figure 2-1 represents exposure date by ideology over time between 1965 and 2013 in the United States.

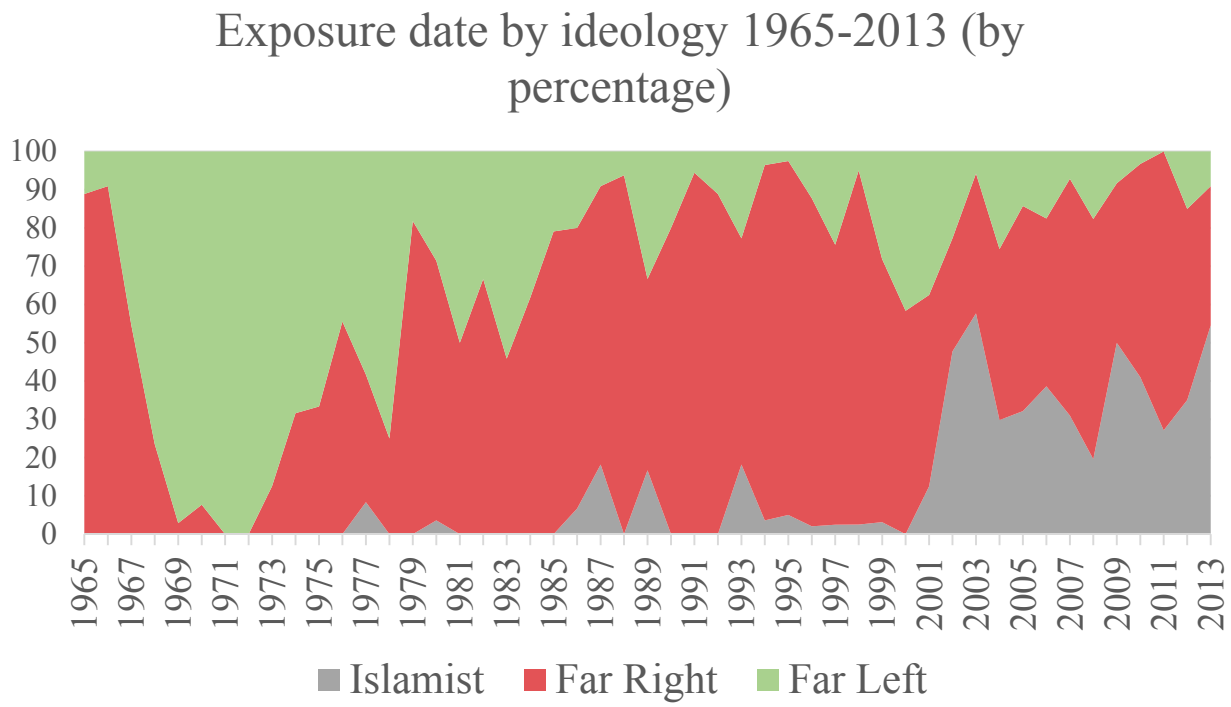

FIGURE 2-1 Radicalization over time by various ideologies.
SOURCE: Jensen presentation, An Empirical Assessment of Domestic Radicalization, September 7, 2016.

Jensen explained that in the mid-1970s, there was a substantial upturn in the activity of extremists ascribing to far-right ideologies, and that group remains the majority in the present day. After the events of 9/11, there was a spike in the activity of Islamist extremists; however, the group still remains proportionally much smaller than far-right extremists. He noted that the ideological distribution in the PIRUS database also spans the spectrum of extremism:

- 43 percent far right
- 21 percent far left
- 21 percent single issue
- 15 percent Islamist

Jensen contended that the problem faced today, despite what is portrayed in national media, is much broader than the issue of Islamist extremists, asserting: "So far our efforts in the CVE and counterterrorism realm have been disproportionately focused on one end of the spectrum, and there is a lot more going on that we need to pay attention to." Warner Anderson, assistant professor in military and emergency medicine at the Uniformed Services University of the Health Sciences remarked that from a public health perspective, violent extremism should be considered in context of a national epidemic of violence. However, he expressed concern that interventions in the CVE space are drifting from where the evidence base recognizes the threat, which is in far-right wing and white supremacists' groups, and into terrorism motivated by Islamic ideology.

Important Differences Across Ideologies

Jensen reported that there are important differences within and across the ideological spectrum that should inform the design of CVE programs and policies. For example, analysis of the database reveals broad variation along multiple demographic variables. Individuals on the far right (with an average age 38 years) are much older than individuals on the far left (28 years) as well as Islamists (30 years). Thus, intervention programs tailored toward young people may not be appropriate in all situations. Gender distribution in the database is also diverse. A quarter of active individuals on the far left are women, while the percentages of women active on the far right and among Islamists are 5 percent and 4 percent, respectively.

Counter to the assumption that most individuals motivated to commit violent extremism come from economically disadvantaged backgrounds and have little education, Jensen reported that most individuals across ideologies in the database have at least some college experience (far right, 45 percent; far left, 75 percent; Islamists, 59 percent). Nearly 30 percent of those motivated by far-right ideology have military experience, compared with 11 percent of far-left cases and 10 percent of Islamist cases. Engagement in previous criminal activity prior to radicalizing is also common among all three groups, although it is more common on the far right, with 63 percent of cases having engaged in criminal behaviors before they adopted extreme views (compared with 51 percent of far-left cases and 40 percent of Islamist cases).

Jensen explained that the variable of radicalization duration captures the length of time from first evidence of exposure to radical beliefs to the time that an individual engages in extremist behaviors. He reported that individuals with far-right ideologies tend to have a longer window of 5 or more years, versus 1–5 years for both far-left and Islamist cases (both of the latter groups generally tend to skew closer to the 1-year window). Competition between extremist groups or cells is quite common on the far right, occurring in 50 percent of cases compared with 35 percent on the far left and 14 percent among Islamists.

Current Extremists Progression: Alone and Quick to Radicalize

Jensen suggested that because of increased online activity, extremists are acting alone more frequently and becoming radicalized more quickly than they did in the past. He defined *lone actors* as individuals who are not affiliated with a formal extremist group or small cell; at most they might operate with just one other person. He reported that analysis of lone-actor behavior over time in the database reveals a sharp increase since about 2008. However, he emphasized that the label *lone actor* may be a misnomer. Although lone actors may be acting alone operationally, most are deeply embedded in strong social networks and thus are not alone in a practical sense. Online networks can mobilize behavior in a very real and expedited way, he explained, and true lone actors—those who have no interaction with anyone else with extreme views—are the outliers, not the norm (see Figure 2-2).

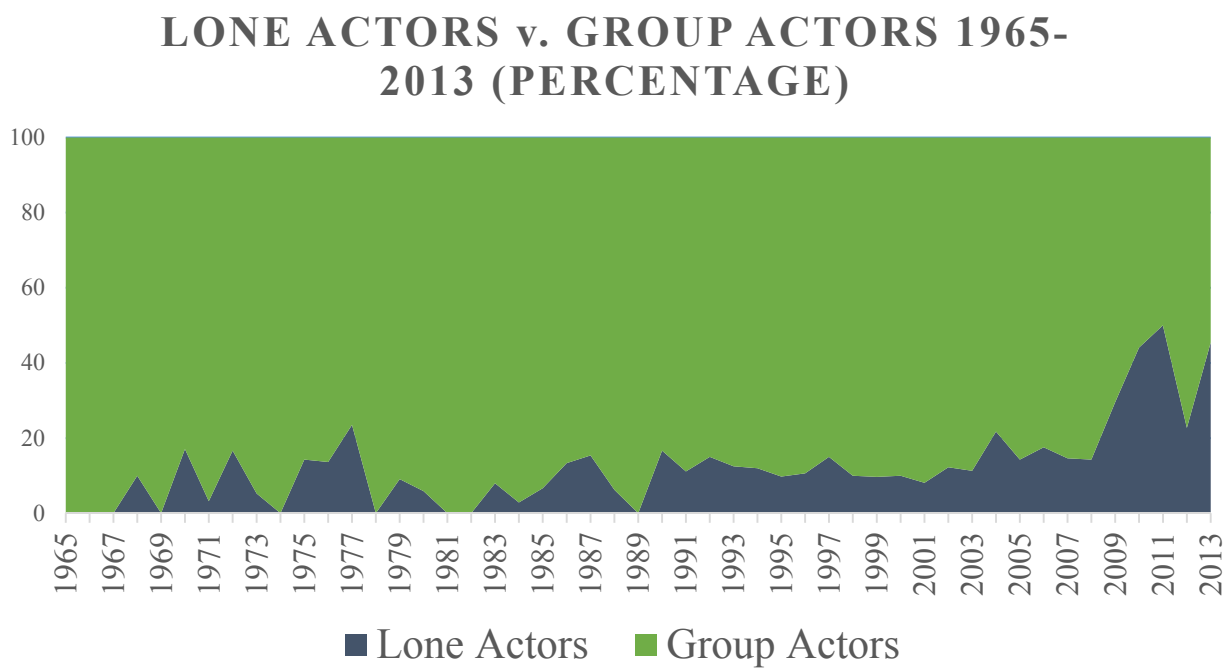

FIGURE 2-2 Lone actors versus group actors over time (1965–2013).
SOURCE: Jensen presentation, An Empirical Assessment of Domestic Radicalization, September 7, 2016.

The analysis also evaluated radicalization duration and online activity for the subset of individuals who attempted to (or did) leave the United States to join foreign conflicts. Jensen reported a steep increase in those individuals' use of social media and the Internet, coupled with a drop-off in radicalization duration from an average of around 16 months in the early 2000s to around 9 months by 2014. He suggested that windows of opportunity for intervention do exist, but they are shrinking, so acting quickly to intervene is crucial.

Shared Characteristics of Individuals Who Commit Violent Extremism

Jensen explained that most individuals who hold extreme views do not engage in violence, but those who do often share a set of key characteristics. He reported that some of START's data has generated a set of significant differences and strong predictors of the likelihood of engaging in an act of political violence. One of the strongest predictors, regardless of model and using different controls, was engagement in criminal activity prior to radicalizing, especially a history of juvenile criminal behaviors. Individuals with a criminal history were 1.5 times more likely to engage in violence after radicalizing than those without a history of criminal activity. Furthermore, individuals that adhered to far right or Islamist ideologies were 2–3 times more likely to be violent or attempt violence than those on the far left, or those that are motivated by idiosyncratic single issues. Individuals who were embedded in radical social networks were 2.5 times more likely to engage in politically violent acts based on database analysis.

Jensen added that individuals in the database with either a clinical diagnosis of mental illness or whose friends or family members believed them to suffer from mental illness were twice as likely to engage in political violence. Conversely, individuals in the database who had a

stable employment history were two times less likely to engage in violence, which he flagged as a promising development. However, he noted that the relationship between mental illness and violence is complex and confounded by multiple factors (such as substance abuse or trauma), so further research is needed to identify the primary drivers of violent behavior.

Radicalization Is Complex

Finally, Jensen emphasized that the pathway to radicalization is incredibly complex and unique: "There is no profile of an extremist; there is no set of three or five warning indicators that we can give to a law enforcement officer or to a school administrator." To help disentangle some of those complexities, Jensen described an in-depth analysis of 56 people who radicalized in the United States. The analysis found that certain conditions seem to be particularly important or even necessary in the CVE space, said Jensen. First, almost every individual had a sense of community victimization, feeling deeply that they were members of communities being targeted and victimized. Secondly, most individuals underwent a fundamental radical shift in their cognitive frames: the way they perceive the world, the way they process information (especially disconfirming evidence), and how they process things that challenge their views. Furthermore, he suggested that many pathways to radicalization begin with emotional vulnerabilities that are often brought on by traumatic experience (e.g., the death of a loved one, childhood abuse). Because of the traumatizing event or events, the individual develops a need for identity that is fulfilled by extremist narratives or causes. Also very common were cognitive biases (groupthink, in-group/out-group bias, and perceptions of threat), especially among individuals embedded in radical social networks. Jensen observed that such isolated networks may serve as a breeding ground for further engraining those cognitive biases and making them increasingly difficult to overcome.

THE HYPOTHESIZED ROOT CAUSES OF VIOLENT EXTREMISM

Transforming Grievances into Violent Action

Multiple panelists explored the constellation of personal and societal factors that can drive an individual's progression from personal grievances, to radicalization, and eventually to violent extremism.

Michael Downing, deputy chief of the Counter-Terrorism and Special Operations Bureau at the Los Angeles Police Department (LAPD), commented that from the law enforcement perspective, there is no "silver bullet" or profile of someone who will perpetrate violent extremism. However, he suggested that there are certain observable consistencies, including lack of identity, vulnerabilities, lack of attachment, and lack of societal inclusion. From the public health perspective, Arthur pointed to similar factors at play—oppression, discrimination, and disconnection—that seem to contribute to individuals around the world being radicalized toward other violent groups, such as gangs and cartels.

Stewart cited a study that examined the individual "pull" factors that increase susceptibility to recruitment to violent extremist groups, noting that the motivations tend to be extremely personal in nature: experiencing or witnessing torture, death of a relative or friend at the hands of the security forces or a foreign power, unfair trials, loss of property, humiliation, or even something as simple as refusal of a personal loan. She noted that these "pull" factors were

connected to broad systemic forces: lack of socioeconomic opportunities, marginalization and discrimination, poor governance, violations of human rights and the rule of law, prolonged and unresolved conflicts, and radicalization in prisons.

Mark Stainbrook, assistant chief of the San Diego Harbor Police and senior fellow at the Potomac Institute, presented a list of 10 motivating factors for joining a gang or a terrorist group, derived from his academic research as well as his personal experience with individuals involved. He noted that, in most cases, no single element is the sole factor. Rather, it is typically the sum of several motivators that tips the scale. Nine of the motivators Stainbrook presented were shared between gang members and members of terrorist groups: camaraderie, identity, family or social network, family disruption, excitement or thrill, social pressure, protection, racism and discrimination, and satisfying material needs. He explained that the only motivating factor that seems exclusive to people who join terrorist groups, as opposed to those who join gangs, is ideological and/or religious justification. He stated,

> The main difference is someone who has radicalized can now point to the ideological and/or religious justification for their participation in the group as it serves their vision of the greater good. This is extremely dangerous as it can justify high levels of violence, due to moral and theological imperatives.

Citing work by Hafez and Mullins (2015), Stainbrook called for a shift from thinking about radicalization as a linear process to thinking of it as a set of puzzle pieces that, taken together, provide a strong foundation for motivating homegrown violent extremism (see Figure 2-3).

FIGURE 2-3 Homegrown violent extremism.
SOURCES: Stainbrook presentation, September 7, 2016; radicalization model based on Hafez and Mullins, 2015.

Gender Violence and Childhood Trauma

Stewart's group, Futures Without Violence, is a national nonprofit organization dedicated to preventing and ending violence against women, children, and youth, and it seeks to analyze violence through public health and social justice lenses. The group's work around CVE arose out of its efforts to address violence against women and girls internationally, which exposed linkages between violent extremism globally and its relationship to gender.[1]

Stewart cited work by Valerie Hudson (2012) that examined data from more than 100 countries, finding that after controlling all other factors (e.g., religiosity and poverty), the presence of gender-based violence was the best predictor of state instability. She suggested that domestic, gendered violence may be what attracts terrorists toward the Islamic State, because the Islamic State of Iraq and the Levant's (ISIL's)[2] practices include sexual slavery and a fidelity to

[1] April 2016 Open Square Roundtable on CVE and Gender, https://www.futureswithoutviolence.org (accessed November 8, 2016).
[2] To be consistent with the Director of National Intelligence all references to Daesh or ISIS have been changed to ISIL.

traditional gender norms, which can be used as recruiting tools for young men, with reassertion of male control as a compelling narrative.[3]

She explained that domestic violence can be a red flag for violent extremism because it demonstrates that the person believes it is acceptable to use violence to exert control through instilling fear and is willing to do so. She emphasized this point using the examples of recent mass killers who had histories of domestic violence and grievances against women. Omar Mateen, for example, carried out the 2016 mass shooting at a gay club in Orlando, killing 49 people and wounding 53. He had an extensive history of domestic violence, or as Stewart characterized it, domestic terrorism: taking his wife's paychecks from her; confining her to the house; and beating her regularly for not living up to the standards of Islam. Mohamed Lahouaiej Bouhlel (who killed 80 people in Nice in 2016) and Robert Lewis Dear (Colorado Planned Parenthood shooter in 2015) had similar histories of domestic violence and sexual assault.

Stewart reported that an analysis of Federal Bureau of Investigation (FBI) data on mass shootings from 2009 to 2015 found that in the majority of mass shootings, defined as killing four or more people, there were cases of domestic violence present in some form.[4] While there is no proven explanation for this correlation, she suggested that there are striking parallels between the factors that drive the two phenomena: power and control through fear and violence.

Growing up as a witness to domestic violence is a major contributor to child trauma, which in turn is a major contributor to youth and adult violence, according to Stewart. She outlined some of the consistent drivers of violent behavior identified in the document on youth violence prevention in the United States released by the Centers for Disease Control and Prevention (CDC).[5] On the individual level, she highlighted prior exposure to violence, in particular, as contributing to impulsiveness, substance abuse, and perpetration of violence, which in turn feeds the cycle of violence.

According to the Adverse Childhood Experiences Study on toxic stress,[6] she explained, exposure to violence in childhood affects the architecture of the brain and body. The ability to react to life stressors becomes compromised, such that perceptions of threat and danger are heightened. A person's response to such stressors, whether it is walking away or drawing a gun, is also partially shaped by childhood exposures. From a policy standpoint, she suggested that because a person's biology actually changes based on exposures to violence and trauma in childhood, more attention needs to be paid to childhood experiences of abuse and trauma, and more resources devoted to developing healthy coping.

Edward Pieczenik, licensed clinical social worker at the University of California, Davis, Extension Division, referred to additional research establishing that there are brain changes caused by exposure to violence. A type of hyperarousal can cause a person to cognitively misperceive the world, particularly in the presence of charismatic authority figures promoting propaganda. He suggested that there might be a direct—although not causal—association between such brain changes and violent or extremist behavior. He posited that emotional

[3] Sexual violence perpetrated against boys and young men is a taboo that also needs to be addressed, according to Stewart.

[4] Such as an abuser who kills his wife or girlfriend, other family members, and/or neighbors or law enforcement officials attempting to help.

[5] This document is available at http://www.cdc.gov/violenceprevention/youthviolence/opportunities-for-action.html (accessed November 8, 2016).

[6] Through the work of Dr. Jack Shonkoff (director of the Center on the Developing Child at Harvard University) and many others. Data and resources available at http://www.cdc.gov/violenceprevention/acestudy/index.html (accessed November 8, 2016).

regulation and executive function deficits might make certain people more vulnerable in this regard.

Stewart reported that through life history interviews with violent white supremacist groups, the START research team found:

- Forty-five percent reported being the victim of childhood physical abuse.
- Twenty-one percent reported being the victim of childhood sexual abuse.
- Fifty-seven percent reported experiencing mental problems, as diagnosed by a medical practitioner, either preceding or during their extremist involvement.
- Seventy-two percent reported having problems with alcohol and/or illegal drugs.

While high levels of exposure to trauma in childhood may indeed be related to committing violence later in life, Heidi Ellis, director of the Refugee Trauma and Resilience Center and associate professor of psychology at Harvard Medical School, noted that there are many other potentially significant factors that contribute to the overall burden of adversity that some children face. In her experience with refugee youth and families, Ellis has observed a wide range of developmental trajectories among children who have experienced similar types of adversities. Some are resilient and emerge with good mental health and high levels of community engagement. Others struggle with mental illness, or become involved with gangs, and a small number engage in violent extremism or travel abroad to join foreign terrorist organizations. Her work within the refugee resettlement community focuses on finding the right levers to pull to help nudge someone toward a healthier trajectory. A common thread that has emerged is the importance of social bonds. Feeling connected and a sense of belonging to one's country of resettlement helps to mitigate violent extremist views.

Bob Griss, director of health care policy at the Institute of Social Medicine and Community Health, suggested that technology has made it easier for populations not to assimilate, particularly among refugee and immigrant communities who would have been less isolated and more connected to their physical communities in the past. Technology has made it possible to be part of any virtual community and adopt any value system, he noted, which can be problematic from a standard public health or community perspective. Yolanda Rondon, attorney with the American-Arab Anti-Discrimination Committee, pointed out that embracing one's cultural heritage does not make one more or less prone to assimilating into American society, which is founded on a diversity of cultures. Rebecca Skellett, Strong Cities Network manager at the Institute for Strategic Dialogue, noted that given the increasing number of individuals who engage in extremist groups online, issues around policing and restriction of the Internet will be subject to debate among CVE practitioners, governments, and Internet service providers.

3
Contemporary Approaches to Countering Violent Extremism

Highlights of Main Points Made by Individual Speakers[a]

- Overall CVE programs skew toward policy development and implementation phases but not assessment and evaluation of their efforts (Romaniuk).
- It can be difficult to tread the line between achieving good outcomes for people through CVE interventions and addressing the serious political caveats imposed on any work in such a sensitive area (Skellett).
- It is impossible to conclude that any single intervention has stopped somebody from committing an act of violent extremism. However, by using intermediary outcomes, such as intake assessments and postprogram evaluations, it is possible to determine if a program has helped to decrease potential risk factors of radicalization while also increasing protective factors (Farooq).
- The pillar of prevention should be the core of building a healthy community—even if the activities that strengthen it are not specifically labeled as CVE or carried out by entities exclusively devoted to CVE (Silyan-Saba).
- To inoculate against violent extremism, develop healthy, resilient, strong communities where it is hard for violent extremism to take root (Downing).

[a] This list is the rapporteurs' summary of the main points made by individual speakers and participants, and it does not reflect any consensus among workshop participants.

Several organizations were invited to the workshop to present their approaches to countering violent extremism. Speakers and workshop participants discussed policy and practical frameworks that are currently used to disrupt an individuals' progression from radicalization to violent extremism. The strategies presented identified shared challenges such as how the gaps in research affect best practices and the trial of fitting practical solutions into political realities.

COMPARATIVE EVALUATION OF FIRST- AND SECOND-WAVE CVE PROGRAMS

Romaniuk explained that the Global Center on Cooperative Security has had a work stream on CVE and evaluation since 2012; one of its outputs was the 2015 report *Does CVE Work?: Lessons Learned from the Global Effort to Counter Violent Extremism*.[1] The report

[1] Available at http://www.globalcenter.org/publications/does-cve-work-lessons-learned-from-the-global-effort-to-counter-violent-extremism (accessed November 8, 2016).

compares different types of CVE programs using a basic typology of CVE measures to examine variance in scope, causal mechanism, implementing agents, and activities undertaken. The scope of CVE measures may be directed at an entire population at the macrolevel; it may be targeted toward communities at the mesolevel; or it may be geared toward vulnerable individuals at the microlevel. CVE spans a wide range of activities, including traditional overseas development work, domestic crime and gang prevention programs, sports programs, and maternal support programs.

The 2015 report also examined the policy process underlying the development and implementation of CVE and generated a basic four-step policy cycle for how CVE ought to be addressed (see Figure 3-1).

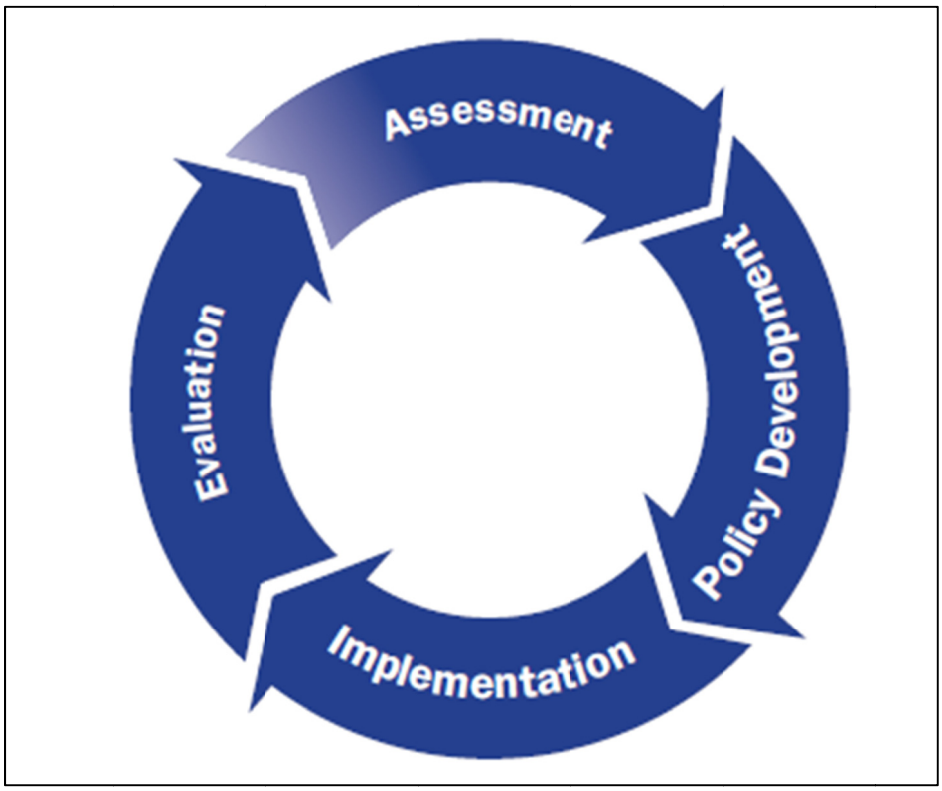

FIGURE 3-1 The CVE policy cycle.
SOURCE: Romaniuk presentation, September 7, 2016.

The first step is assessment; Romaniuk noted that because there is no universally accepted theory of terrorism (a highly contextual phenomenon), the first step in undertaking CVE should be to assess and define the problem. The policy development phase was designed to facilitate the development of a proportional response considered to be effective against the defined problem. The implementation phase should aim to tactically achieve the defined objectives, followed by an evaluation phase to determine whether it had the desired effect.

Romaniuk explained that in developing the report, he and his team found that the field of CVE skewed toward policy development and implementation but not the assessment and evaluation of those efforts. Evidence-based policy will require researching and strengthening the assessment and the evaluation phases, he advised. Romaniuk outlined the substantive lessons

learned from the efforts. The research demonstrated that evaluating CVE programs is both feasible and valuable, particularly if the program implementer or sponsor invests resources and effort in undertaking robust evaluations. While there was not a clear evidence base for developing and implementing CVE policy, there is clear guidance about what should *not* be done, with past evaluations highlighting missteps and unintended consequences in engaging programs at the community level.

The first best practice is to know your audience and to understand how a CVE program might be received in the community in which it is implemented. For example, the intended beneficiaries of CVE programs may not have a nuanced understanding of the shift from counterterrorism to CVE and thus may be predisposed to experiencing CVE programs as a sometimes unwelcome imposition. However, Romaniuk cautioned that governments have varying levels of expertise in terms of engaging at the community level. To help address this, he suggested that "states should use soft power softly."

The second suggestion is to avoid stigmatization. The first rollout of CVE programs around the world had a stigmatizing effect, especially in Muslim communities, because informing a community that it will be the beneficiary of—or subject to—a CVE program implies that it is vulnerable to violent extremism. This may be at odds with the community's self-perception and can be quite offensive, as evidenced by program evaluations. Many people who were asked to implement CVE programs also felt that stigmatizing effect as well. School teachers, for example, were reluctant to stigmatize their students and compromise their own relationships with them.

Thirdly, clear messaging is critical. From a community perspective, it can be difficult to disaggregate traditional counterterrorism and CVE, explained Romaniuk. This issue arose in the United Kingdom among Muslim communities who were identified as being the beneficiaries of "prevent" programming[1] but felt that they were being subjected to "pursue" measures.

While working on a project aimed at preventing abuse of the nonprofit sector for the purpose of terrorist financing, Romaniuk noted the delicate nature of the relationship between state and civil society stakeholders. On one hand, governments tend to be suspicious of the vulnerability of nonprofits to be abused for terrorist financing; on the other hand, those same governments are looking for trusted partners to engage and help deliver the CVE message. Often a community will be the recipient of mixed messaging, interpreting the government as saying that the community is vulnerable to terrorist financing, but at the same time it is a trusted partner for the purpose of CVE.

The final suggestions were to engage broadly and partner strategically. He reported that the evaluation research included much discussion of what constitutes a community leader and the best broker for the government. He noted the importance of considering, without cynicism, what prospective partners have to gain from engaging in CVE. Some communities may have mixed motives in this regard: being the beneficiary of a CVE program implicitly advertises suspected vulnerability and may have other negative repercussions, but it may also result in financial resources. Finding trusted partners requires thinking through the difficulty of identifying these individuals and entities and creating the kinds of relationships that are fruitful.

Romaniuk explained that the evaluations of the first wave of CVE programming highlighted the need for a "do no harm" style of approach, which was then integrated into the

[1] The Counter-Terrorism and Security Act 2015 in the United Kingdom specified a duty authorities have to prevent people from being drawn into terrorism. Program information about the duty guidance can be found at https://www.gov.uk/government/publications/prevent-duty-guidance (accessed January 17, 2017).

second wave of programs. He commended the second wave of CVE programming as being, on the whole, better targeted and less likely to stigmatize and cause offense on the macrolevel because of better communication strategies. On the mesolevel, second-wave programs also tend to be more focused on behavioral radicalization. That is, they are more focused on identifying and assisting individuals with "bad ideas" and who are committed to acting upon them, rather than toward people who might be cognitively radicalized but do not have the intent to act. Intervention programs on the microlevel, he noted, have also yielded better results.

APPROACHES TO COUNTERING RADICALIZATION: INTERNATIONAL AND DOMESTIC PERSPECTIVES

Strong Cities Network

The Strong Cities Network is a network of cities around the world working to synthesize best practices among initiatives to address community polarization and counter violent extremism.[2,3] Rebecca Skellett explained that the network aims to support cities and other local authorities on an international basis and to enhance local approaches to prevent violent extremism by facilitating information sharing, mutual learning, and creation of new and innovative local practices. The network's key tenets are to connect, inform, empower, build, innovate, and represent. Skellett noted that member cities take a wide range of approaches. Some approaches are targeted at raising community awareness of available resources; others include active prevention in their scope, such as exploring different mechanisms by which to receive referrals; still others are very targeted in terms of understanding how best to engage individuals deemed to be at risk.

Skellett drew on her experiences with the Strong Cities Network and as a practitioner with the Prevent program in the United Kingdom to draft a list of key decisions to be considered when working with individuals at risk of radicalization. She noted it can be difficult to tread the line between achieving good outcomes for people through CVE interventions and addressing the serious political caveats imposed on any work in such a sensitive arena.

She presented the following questions for consideration:

1. Should group interventions or individual interventions be used?
2. Is it more important to address an individual's ideology or an individual's identity (and the vulnerabilities related to each)? She emphasized that this should be a critical prioritization, and it is the subject of diverse opinions globally and locally.
3. Should the focus be on deradicalization, disengagement, or mainstreaming? She noted that the former two options are the most commonly discussed and employed, but she suggested that the newer mainstreaming option should be considered. The mainstreaming approach to radicalization would involve integrating it into all public services, coupled with a baseline awareness of the need for cooperation.
4. Should the schemes be mandatory or voluntary?
5. Should the approach involve working with criminals or working only with individuals who are not in the criminal space?

[2] Program information available at http://strongcitiesnetwork.org (accessed November 8, 2016).
[3] Sixty members from 34 countries (and growing) led by a steering committee of 25 city members, of which 8 are in the United States.

6. Is it beneficial or not to involve former extremists who can share their experiences and exit stories, with the aim of dissuading others from taking a similar path?
7. Should efforts be led nationally with federal structures, or led locally by organic grassroots programs? If a locally led approach is adopted, how should programs be selected?
8. Should efforts involve a single agency or multiple agencies? Should prison and probation approaches be used?
9. To achieve sustainable outcomes for individuals, is it better to use impartial "active listening" approaches or judgement-based approaches?
10. Should the approach encompass all types of extremist ideologies or just a single one?

Skellett observed that the breadth of individualized risk factors for radicalization, coupled with country-specific priorities and values, has given rise to a similarly broad range of approaches and interventions for countering radicalization across the world. Table 3-1 provides a taxonomy of counterradicalization intervention approaches.

TABLE 3-1 Range of Counterradicalization Intervention Approaches

Intervention approach	Examples
Diversionary tactics	London Tigers, United Kingdom
Psychological disengagement	CPRLV, Montreal Center, Canada
Realignment of interests and integration	Aarhus model, Denmark
Family-led models	Hayat, East Germany
Nationally directed models	Channel Programme United Kingdom, Danish Security and Intelligence model
Socioeconomic models	Italy, Saudi Arabia
Disruption models	Mumbai Police Force, India (and many others)
Punitive models	Medellin, Columbia (FARC peace deals)
Community models	Active Change Foundation, United Kingdom
Religious-led models	Committee for Dialogue, Yemen
Models led by exited/former extremists	EXIT-Germany, ExitUSA, Life After Hate

NOTE: CPRLV = Center for the Prevention of Radicalization Leading to Violence; FARC = Revolutionary Armed Forces of Colombia;
SOURCE: Skellett presentation, September 7, 2016.

Skellett explained that diversionary tactics may not address violent extremism directly; they aim to imbue people with a sense of identity, self, and comradery that they might otherwise seek by joining an organization that favors violence. For a decade, the London Tigers group, based in the United Kingdom, has used such diversionary strategies to engage former and current gang members and engender a sense of brotherhood through sport. She explained that based on this work, the group recently expanded into the realm of CVE by taking referrals from the United Kingdom's national CVE structure (the Prevent and Channel programs), with a new focus on how to build a sense of identity that encompasses both religion and a sense of national heritage.

She referred to the Montreal Center in Canada as having an approach to CVE centered on psychological disengagement from a very public health-oriented perspective, with a focus on individuals in the medium risk (previolence) space. The Aarhus Model in Denmark uses an approach focused on realignment of interests and improved integration among individuals who have returned from abroad, according to Skellett. She noted that the intervention aims at capacity

building, casework support, and advising critical aftercare centers at the municipal level. Both the Channel program in the United Kingdom and Hayat in Germany are counterradicalization initiatives that address ideology and identity as equally important issues. Channel uses a multiagency joint referral model that has a national infrastructure that is adapted and delivered locally. Channel includes a panel of experts from the local community (such as social workers, or people who know the individual who has been referred) who work together to discuss risks and appropriate next steps. She noted that Channel is a voluntary intervention process that requires participants' consent to participate. Skellet went on to explain that Hayat focuses specifically on Al-Qaeda and ISIL narratives and ideologies, and it relies on counselors to act as bridges between institutions, individuals at risk, and their families. Hayat has two different channels for referral, a government hotline and a community hotline, both of which offer first-line assessments. She explained that the use of two avenues of referral is predicated on the value of a double-edged approach that can facilitate people who are comfortable contacting a government authority as well as people who are more comfortable contacting a community structure.

Other counterradicalization initiatives take the approach of socioeconomic and monetary dissuasion, she noted. Saudi Arabia's Counseling program, for example, is founded on the idea that an individual must be able to satisfy basic needs in order to foster a sense of belonging. She explained that the program provides employment, transportation, funds, and housing for families who are recruited and then holds the beneficiaries financially and socially accountable. Saudi Arabia claims an 80–90 percent success rate for the program (as of 2008, 3,000 people had passed through the program).[4] She noted that Italy has begun a program to explore culture mechanisms of assimilation. Starting in September 2016, more than 500,000 18-year-old citizens of the European Union who living in Italy (regardless of ethnicity or religion) became eligible to receive vouchers valued at more than $500 each, which allow recipients to visit museums for free and go to concerts and movies for reduced prices.

Responding to a question about why the United States may not be as far along in the CVE space as other countries, Skellett said that the U.S. governance structures, with each state having a large degree of autonomy, are very different than those in many countries. This creates a host of challenges for CVE that are not faced by countries where programs operate on a national level, she remarked. Civil liberties and the balance of beliefs are also critical differentiating components that should be carefully considered, she suggested. In Europe, for example, there are more restrictions on freedoms of expression, particularly with respect to language that incites hate and violence.

Skellett outlined some broad observations about the approaches employed by the range of CVE models. She observed that consensual programs can work most effectively, and locally led programs have more credibility; however, earning community trust and buy-in is never easily achieved. Furthermore, it is becoming more commonplace for programs to be positioned within existing support structures and services that tackle ideology as a secondary issue. Regardless of the type of CVE approach, she advised that consistent and long-term support for individuals and families is critical.

Skellett said that engaging former extremists and survivors in CVE efforts can help other community members to better understand and discuss issues around radicalization. As an

[4] Aliya Saeed, psychiatrist, Vanguard Medical, disagreed with characterizing the Saudi Arabia program as deradicalization, given that it is a country that carries out public beheadings and amputations.

example, she referred to the Against Violent Extremism Network,[5] which features several survivors and former extremists who tell their stories with humility and compassion; it aims to promote the idea that radicalization is a fairly common social process by which people can be exploited and manipulated toward something that provides them a sense of significance.

Tailored individual programs should address social and personal needs, according to Skellett. She described how the Institute for Strategic Dialogue in London has created a mechanism for delivering one-to-one interventions online,[6] which moderates many of the risks that are associated with directly motivated individual interventions, such as tarnishing personal reputations or labelling people.

The Building Resilience Against Violent Extremism (BRAVE) Program

Mehreen Farooq, senior fellow at the World Organization for Resource Development and Education (WORDE),[7] explained that WORDE uses a research-informed foundation for promoting understanding between communities to mitigate social and political conflict. She described WORDE's establishment of the International Cultural Center in Montgomery County, Maryland, in 2011. The Build Resilience Against Violent Extremism (BRAVE) model was developed to engage residents in a wide variety of initiatives, premised on principles of social integration theory, that aim to promote pluralism and social cohesion. According to Farooq, research suggests that if appropriate care is not taken, bringing disparate communities together can actually reinforce the differences between groups, which can further fuel misconceptions of "the other" and increase intergroup tensions. To successfully bridge the intergroup divide in ways that create lasting change, she suggested participants must be of equal status and be brought together in a friendly environment to work toward common goals and foster a sense of interdependence.

Farooq described how WORDE has developed an innovative four-part collective impact initiative for the prevention and intervention of violent extremism, by effectively leveraging the robust partnerships with diverse communities that were developed over the years in Montgomery County. Unlike other CVE programs that may only engage one faith or ethnic community, this model involves more than 300 different faith-based organizations and community service providers. Adopting this type of holistic approach avoids stigmatizing any single faith community, she explained.

The first component of the initiative is to identify and engage a wide range of stakeholders, who can form an early warning network of trusted adults. She remarked that by bringing these diverse stakeholders together, the program fosters trust between diverse communities. This in turn has increased participants' willingness to tackle issues of shared concern in a collaborative way, such as addressing bullying-related issues or finding ways to integrate faith leaders in emergency management and disaster relief. Consequently, she contended that the WORDE model has changed the face of community organizing and even community policing: rather than law enforcement reaching out to communities on an individualized or targeted basis,[8] the police department now engages civil society as a whole.

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[5] Information available at http://www.againstviolentextremism.org (accessed November 8, 2016).
[6] Information available at http://www.strategicdialogue.org (accessed November 8, 2016).
[7] Information available at http://www.worde.org (accessed November 8, 2016).
[8] For example, Montgomery County previously had an African-American liaison officer and a person responsible specifically for outreach to the Middle Eastern community.

The second component of the initiative is to educate stakeholders about the range of public safety threats, including the risk factors for radicalization and recruitment to violent extremism. She explained that to date, hundreds of local law enforcement officers, teachers, and faith community members have already received training. A special peer gatekeeper training program for youth has also been developed to promote help-seeking behaviors. According to Farooq, the aim of this program is to educate youth that just as it is important to look out for peers who might be suffering from depression, drug abuse, or suicidal ideation, it is equally important to recognize when a peer may be vulnerable to recruitment to violent extremism.

The third component of the initiative ensures that stakeholders are connected with public and private resources that can provide counseling and other social safety services for vulnerable individuals, she explained. The fourth component is to have the program work with trained professionals situated within a culturally competent trauma-informed network to provide counseling, mentoring, mental health services, and other direct services to troubled individuals before they choose a path of violence. She remarked that the initiative has established its own social service agency to assist traditionally underserved populations.

A 2-year mixed-methods evaluation funded by the National Institute of Justice (NIJ) found that the approach has had a positive effect in Montgomery County,[9] explained Farooq. Specifically, the programs were found to be effective in 12 out of 14 CVE-specific measures. She reported that the evaluation found that program participants felt welcome, felt they were part of something bigger than themselves, and felt like the programs made people feel useful and cultivated a sense of purpose in their lives. It provided participants with a safe space of acceptance, free of any peer pressure, where they could learn about other cultures and make lasting friendships. In evaluating the youth gatekeeper trainings, she reported that the NIJ study and WORDE's own assessment data indicate that participants felt that they had increased communication skills, had strengthened conflict transformation skills, and had gained help-seeking behaviors for themselves and their peers. She noted that participants also had greater trust in local law enforcement, who were now perceived as a resource to help address potential conflict in communities. An overview of lessons learned are noted in Box 3-1.

She posited that the initiative addresses many of the potential psychosocial risk factors associated with radicalization. Farooq explained that the key question is how to determine if the initiative has managed to prevent violent extremist acts. Yet, it is impossible to conclude that any single intervention has stopped somebody from committing an act of violent extremism. However, she noted that by using intake assessments and end-line evaluations (i.e., intermediary outcomes), it is possible to determine if a program has helped to decrease certain potential risk factors of radicalization while also increasing protective factors.

[9] While not mentioned at the workshop, researchers at the University of Illinois at Chicago have expressed dissenting opinions to Congress regarding the limitations of the evaluation of the BRAVE model. See: https://www.brennancenter.org/sites/default/files/Nguyen%20Krueger%20WORDE%20final%20%284%29.pdf (accessed February 1, 2017).

BOX 3-1
Implementing the BRAVE Program: Lessons Learned

Farooq outlined a set of lessons learned in implementing the Montgomery County BRAVE program.

- The model relies heavily on having an effective backbone organization to anchor the public–private collaboration. Most NGOs do not have the institutional capacity nor the bandwidth to assume this responsibility.[a]
- A holistic violence prevention framework requires establishing a multidisciplinary advisory council with representatives from public agencies, community service providers, and violence prevention experts.
- There remains a pervasive fear and apprehension surrounding CVE that needs to be continuously addressed.
- There is a delicate balance between governmental support and local community empowerment in CVE programming. Civil society must retain the ownership of the agenda, and it should be allowed to define the contours of the CVE space.

[a] In Montgomery County, WORDE realized that scaling and replicating the program across the United States would require partnering with a larger organization, such as the University of Maryland with the Center for Health and Homeland Security that has the absorptive capacity to carry the program forward.
SOURCE: Farooq presentation, September 7, 2016.

Safe Spaces Initiative

Alejandro Beutel, a researcher on countering violent extremism for the National Consortium for the Study of Terrorism and Responses to Terrorism (START) at the University of Maryland, talked about his experiences in helping to develop the Safe Spaces initiative in 2014 while he was working with the nonprofit Muslim Public Affairs Council.[10] He described how the initiative was sourced and developed in order to strengthen American Muslim communities and address issues of sustainability for the future of Islam in America. He explained that Safe Spaces was initially motivated by the policy paper *Building Bridges to Strengthen America* (Beutel, 2009), which attempted to parse out the issues of violence—that is, unlawful criminal behaviors—and extremism, which is generally construed as lawful, if distasteful, views related to violence and politics in society. The paper's position held that communities and government agencies in societies need to work together, but there needs to be a division of labor: civil society should address the extremism that may facilitate violence in some cases; law enforcement and government should address the criminal activity. He explained that the Safe Spaces initiative enters into that larger strategy by working to find ways to implement such a division of labor.

[10] Information available at http://www.mpac.org/safespaces (accessed November 8, 2016).

Beutel emphasized that the Safe Spaces initiative focuses on preventive rather than predictive efforts.[11] He characterized the concept of prevention in this context as essentially about building healthy communities: community capacity building, public health, strengthening families, strengthening individual's identities, civic empowerment, and educating young people to be savvy consumers of information. The aim is to create inclusive, strong, welcoming environments that are not CVE specific, but CVE relevant, he clarified. He suggested that making healthy communities the initiative's primary objective effectively diffuses benefits into a host of other psychosocial and public safety issues, including CVE.

Beutel pointed out that even the strongest, healthiest communities will always have some individuals who require some form of intervention. For that reason, the Safe Spaces' model incorporates multidisciplinary teams that include social workers, mental health professionals, religious workers, and spokespeople for defusing rumors and resolving misunderstandings. He described how the concept of the intervention team was adapted from methods used to prevent mass shootings in schools, workplaces, and public spaces. This strategy is grounded in empirical work that suggests that potential behavioral and facilitating factors can overlap between a school shooter and a lone actor terrorist. He noted that the initiative also encourages communities to obtain legal counsel for the purposes of protection, awareness of legal rights, and mitigation of potential legal liabilities.[12]

Implementing the Safe Spaces model is context specific and dependent on the communities' needs and capabilities, explained Beutel. In the initial phase, a Safe Spaces' coordinator reaches out to the local community and performs a baseline assessment of its needs, capabilities, and opportunities for enhancement. Baseline training is modified appropriately before being implemented in the community, supplemented by follow-up booster training and 2-year-long complementary evaluations. He remarked that two of the biggest barriers to entry for many communities are the lack of capacity and the inability to facilitate the best evaluation possible through consistent data-gathering methods.

Beutel reiterated that in order to gain better traction in communities, Safe Spaces does not explicitly situate itself within a CVE framework. This also allows for the initiative to be better aligned with public health framing and for the training that the initiative provides to serve multiple functions. He explained that the move away from CVE framing arose out of feedback—and in some cases, pushback—from community members who associate CVE with government overreach, or who do not feel that CVE-framed programs are relevant to the issues they face on a daily basis, such as anti-Muslim bigotry, identity crises, and violent gangs.

The Approach to CVE in Los Angeles

Haroon Azar, the regional director of the Office of Community Partnerships-Los Angeles, U.S. Department of Homeland Security, and Joumana Silyan-Saba, director of the Mayor's Office of Public Safety, City of Los Angeles, provided an overview of some of the policy underpinnings and strategic objectives of the approach taken at the local government level

[11] Beutel clarified that predictive efforts concentrate on determining the accuracy of whether or not an individual will commit an act of violence. Preventive measures focus on two different strands: developing a rapid and context-specific analysis of a potential threat posed by an individual; and connecting the person of concern to protective resources that will mitigate his or her context-specific issues moving him or her along a pathway into violent action.

[12] For example, those that surround material support for ideologically motivated violence, HIPAA laws, FERPA (when dealing with students), the 1974 Privacy Act, and Tarasoff laws at the state-to-state level.

to CVE in Los Angeles, California. In 2011, the federal government released an interagency national strategy, *Empowering Local Partners to Prevent Violent Extremism in the United States* (The White House, 2011), which advocated an approach to CVE that concentrates on local activities entrenched within communities. Silyan-Saba reflected that over the years, challenges and lessons learned through activities in Los Angeles have spurred evolution on multiple fronts for approaching these complex CVE-related issues, such as redefining the core concepts of radicalization and counterradicalization and shifting activities toward the social domain and away from the traditional law enforcement counterterrorism lens. Azar described how this collaborative work led to the formalization of a three-pronged framework for codifying CVE activities: prevention, intervention, and interdiction.

Silyan-Saba likened CVE efforts in the social domain to a spectrum or continuum of services, with pillars representing preventative actions, intervention activities, and law enforcement that operate separately but collectively providing a holistic strategy. She suggested that one end of the spectrum, the pillar of prevention, should be the core of building a healthy community—even if the activities that strengthen it are not specifically labelled as CVE or carried out by entities exclusively devoted to CVE. According to Azar, the prevention pillar of the framework is aimed at creating environments that are hostile to violent extremist ideologies or other types of bad actors seeking to penetrate, influence, and recruit members of the community.

Moving into the intervention space of the continuum, Silyan-Saba remarked, reveals many layers to contend with in terms of what the interventions mean, what they look like, and how they address the multiple needs to be met. Azar commented that the intervention component was the least developed at the initial stage, but the approach has since changed direction to encourage participation from entities and institutions in other spheres: public health, mental health, and the social services. Silyan-Saba reported that three groups (the Operational Development Committee, the Community Advisory Committee, and the Interagency Coordination group) comprising multidisciplinary expertise have been convened by the Los Angeles mayor's office and regional DHS office to bolster the intervention pillar. Silyan-Saba provided an overview of each of those group's mandates. The Operational Development Committee is focused on the operational concerns, examining how to build capacity within existing operations and create multiple referral processes to enable individuals and communities to access the services they need. She clarified that in terms of operational structure, the group is examining how to deal with violence in general as well as how to carve out a nuanced approach to violent extremism. The Community Advisory Committee is tasked with developing a conceptual and practical understanding of how to build a network of services (rather than a single program) to support and meet the needs of individuals and communities, she explained. The Interagency Coordination group is investigating how to meet the community's needs as a way of expanding the CVE space beyond law enforcement parameters and into the social domain. She noted that this transition will require meaningful dialogue and shared learning about how to support the work already being done in communities and to inform how communities are engaged going forward.

Silyan-Saba emphasized that this network of services, interventions, and activities needs to be carried out by community-based organizations operating at a grassroots level, not by government or government entities. To that end, a community advisory group of local expertise was convened to ensure that genuine community-led interventions are being put into place within the network. She argued that the government's role should be to support those community-led

prevention efforts and interventions. However, she noted that there has not been any CVE-designated funding for Los Angeles to date; everything they have achieved has been driven by recognition of need and by sincere interest in understanding how to best meet the community's needs.

Jihad Turk, the president and dean of the Islamic Graduate School at Bayan Claremont University, presented another approach to CVE taking place in Los Angeles County. He explained that mental health training is part of the education provided to students at his graduate seminary, who will go on to become religious leaders serving Muslim communities across the United States. Topics of study include basic counseling methods and means of identifying young people who are at risk, whom they can then refer to mental health professionals. The aim is to provide those students with an understanding of the CVE space and of the intersection of government relations, civic engagement, and law enforcement.

A common grievance among many ISIL recruits, according to Turk, is a sense that America is at war with Islam; this is often coupled with an ill-adjusted attitude or identity. He suggested that this attitude may also be shared by other community members who are refugees from war-torn areas, or are from ethnic or racial backgrounds that are not well integrated into society. Addressing this issue of identity formation, argued Turk, is important for the community. He posited that part of the mandate of the American Muslim community and leadership is to help young people become well-adjusted in their American Muslim identity, and "to have an identity that is not in conflict with itself." He suggested that it would be helpful to have that idea reinforced by the government, law enforcement, and the population at large.

Turk went on to say that given the history and missteps of the past, the landscape of engagement with the Muslim community is a treacherous one, but he expressed confidence that progress could be made. He commended the trajectory that he has seen in the government approach: "some transition, some humility, some admissions of missteps." He was also hopeful that the high-profile nature of violent extremism, and specifically violence associated with the Islamic faith, would translate into government funding for CVE. He also called for health efforts to play a central role in helping serve the needs of the entire community and address issues of violence. He concluded that building more resilient and healthy communities will require backing away from this securitized relationship with the Muslim community and allow for all Americans of diverse backgrounds and faiths to work together.

Azar remarked that the change to a mental health and public health approach was also a response to direct community feedback about a standalone CVE intervention program and the community's concerns about stigmatization, funding, responsibility, and legal and privacy issues. This motivated the decision to make the Department of Mental Health (DMH) in Los Angeles County the initial focus. He noted DMH's resources are underused by the community both inside and outside of the CVE realm; for example, the DMH reported that they have a $100,000 per annum grant for promoting interfaith community awareness, but no Muslim organizations have taken advantage of that funding in the previous 10 years. He expressed confidence that through cross sector inclusion and convening powers within the CVE space, there will be more resources available to increase the capacity of social service organizations and assist them in finding potential funding opportunities.

Azar reported that despite the strength of efforts in the interdiction pillar, to date those activities have not resulted in a perceptible reduction of threats or of recruitment efforts. However, he noted that the change toward the public health lens has yielded other measurable results. He described a recent exercise that was designed to help build out the precriminal

intervention space by assessing the current capability and capacity for dealing with a person who professes an extremist ideology but who has not engaged in criminal activity.[13] Multiple partners participated and observed, including community members, mental health and social services professionals, the U.S. Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), civil rights organizations,[14] the FBI, local law enforcement, DHS, and others. Azar judged the exercise as very successful in exposing the complexity of developing effective and appropriate interventions in this precriminal space. By sharing perspectives, the participants in the exercise identified both commonalities and gaps to be filled. According to Azar, the exercise generated new partnerships with community-based organizations for trainings, and it resulted in the provision of new community awareness briefings.

Downing offered a law enforcement perspective on the citywide three-pillar framework for approaching CVE in Los Angeles. He explained that the approach to counterterrorism adopted by the LAPD can be distilled to the following equation: "operational capability plus motivation equals terrorism." Operational capability refers to elements such as recruitment, funding, preoperational planning, and execution of plans. He noted that the department works to diminish these types of operational capabilities in cooperation with federal partners, including the Joint Terrorism Task Force and the Joint Regional Intelligence Center. Work on the motivation piece focuses on community outreach and engagement, and efforts are strengthened by partnerships with NGOs, communities, and the federal government, among many others. Downing commented:

> The approach there is not to create an inoculation against violent extremism, but to develop a prescription for healthy, resilient, strong communities where we build hostility towards [violent extremism] so it is harder to take root in communities.

He suggested that the prevention component is relatively strong, owing in large part to enhanced community-oriented policing strategies that incorporate a nuanced understanding of the context, history, and motivations of diasporas and other communities. He described the objectives of community-oriented policing: teaching problem-solving skills, encouraging civic engagement, and focusing on women's groups and youth. As an example of a current LAPD initiative in this space, he referred to the Counter-Terrorism and Special Operations Bureau liaison program, which is staffed by people from the community who match the people being served in terms of ethnicity, culture, religion, and language. He explained that the department leverages interfaith engagement as a strength for employing innovative techniques to educate the community about hate and violent extremism, with the aim of trying to stop bigotry before it starts. He reported that a group of Muslim community members serve as part of an advisory board that meets regularly. Social media and the arts are also used as catalysts for discussion about the issues of bigotry, hatred, prejudice, and discrimination.

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[13] Held under the Regional Steering Committee in partnership with the Los Angeles County DMH, the Los Angeles Office of the Mayor, the University of Illinois at Chicago, and the University of California, Los Angeles, School of Public Health.

[14] Rondon emphasized the importance of ensuring that the civil rights organizations observing the process are actually credible, owing to concerns about cherry picking particular organizations based on their particular viewpoints.

Downing remarked that the intervention component is very complex. To illustrate, he looked back on the gang violence that pervaded Los Angeles in the 1980s and 1990s, when the number of homicides in the city exceeded 1,100 per year, 80 percent of which were gang related. The LAPD famously declared war on the gangs, implementing operation plans with names like "Operation Hammer" and "Operation Battle Plans." He reflected that this strategy was founded on the mistaken idea that they could arrest their way out of the problem, which was not only ineffective but ultimately did more harm than good as made evident by the community's lack of trust in the department. Downing described how the LAPD began looking for ways to balance its efforts. They considered the need to arrest the leaders and other people actively recruiting young people, executing drive-by shootings, and committing mass murder. However, they started also looking for opportunities on the other end of the spectrum: intervention, deflection, diversion, building "off-ramps on the road to violence," encouraging character development, and supporting job placement. They employed "interventionists," credible voices who have experiences that allow them to empathize and connect with community members. Downing believes that because LAPD is striking the appropriate balance between arrests and other interventions, the number of homicides in Los Angeles dropped to 250–300 per year between 2004 and 2016, with less than 50 percent of those being gang related.

Downing provided an overview of a new intervention model called Recognizing Extremist Network Early Warnings (RENEW), a collaboration among the LAPD, the Los Angeles County DMH, the Los Angeles Sheriff's Department, and the FBI.[15] The RENEW model was adapted from a structure that already existed in the LAPD, called the Crisis Response Support Section (part of the Medical Evaluation Unit). Comprising 115 police officers and 50 clinicians from DMH, the structure was designed to address Los Angeles' large homeless population, many of whom were suffering from mental illness. Downing noted that building on an infrastructure already in place has expedited the RENEW program's design and implementation.

Downing outlined the procedural plan for how the steering committee envisions the RENEW program (see Figure 3-2).

[15] As of September 2016 the program had not yet been implemented.

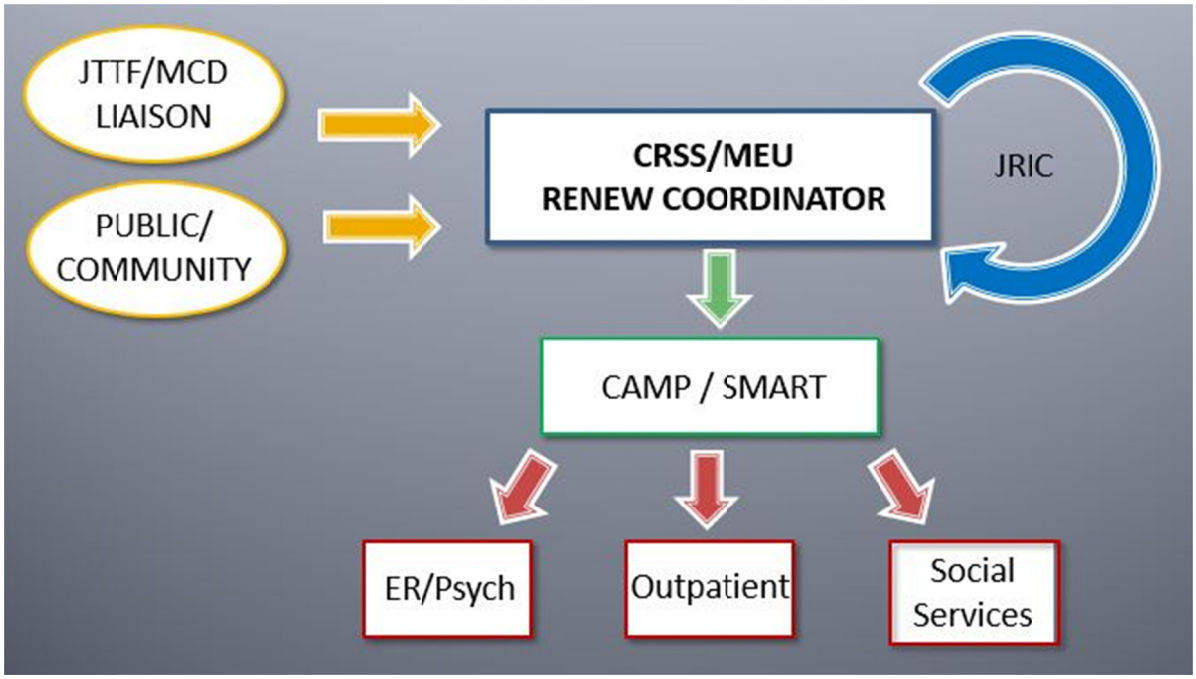

FIGURE 3-2 RENEW program process.
NOTE: CAMP = Case Assessment Management Program; CRSS = Crisis Response Support Section; JRIC = Joint Regional Intelligence Center; JTTF = Joint Terrorism Task Force; MCD = Major Crimes Division; MEU = Mental Evaluation Unit; SMART = System-Wide Mental Assessment Response Team.
SOURCE: Downing presentation, September 7, 2016.

The RENEW coordinator is positioned within LAPD's Mental Evaluation Unit (MEU) in the Crisis Response Support Section (CRSS). The RENEW process is initiated when the Joint Terrorism Task Force (JTTF)/Major Crimes Division (MCD) liaison notifies the RENEW coordinator that they would like the program to consider an encountered subject. Any calls from the public about individuals in the community who may benefit from RENEW assessment are also referred to the RENEW coordinator.

Once a referral is received, the coordinator contacts the Joint Regional Intelligence Center (JRIC), where a full workup on the subject is compiled. The JRIC subject workup provides comprehensive information about the individual, including social media analysis, criminal records, probation and warrants, weapons, travel details, financial records, and any other information deemed to be relevant.

The workup is provided to the RENEW coordinator, who chooses whether to forward it either to the Case Assessment Management Program (CAMP) or to the System-Wide Mental Assessment Response Team (SMART). CAMP is a joint LAPD-DMH program that tracks incidents created by individuals who may be suffering from mental illness. SMART is another joint LAPD-DMH program that responds to situations and provides crisis intervention.

The CAMP or SMART team assesses the individual and, depending on the circumstances, suggests one of the following three options:

- Immediate action required: The subject is a threat to him- or herself or others and needs to be placed on a 5150 hold for evaluation.

- Outpatient therapy suggested: While the subject is not an immediate danger, he or she is exhibiting signs of mental illness that are best served through an outpatient therapy program.
- Subject would benefit from social services: In this instance, there may be no mental illness, but the subject may be isolated and would respond positively to integration with community or social services such as a mentorship, cross-cultural programs, or advice about other resources available to him or her.

Next, the RENEW coordinator resubmits the updated package and provides feedback to the JTTF. Downing emphasized that these are criminal cases that were opened because there was reasonable suspicion to believe that a crime was about to take place. Such cases remain open until it has been determined that the person has been successfully integrated.

Downing emphasized that the policy does not allow profiling of people, only criminal behaviors. He explained that another LAPD program, the Suspicious Activity Report (SAR) program, has been used to institutionalize an ideological shift from profiling people to profiling behaviors. SARs are used to document any reported or observed activity, or any criminal act or attempted criminal act, which an officer believes may reveal a nexus to foreign or domestic violent extremism. He noted that SAR reports are audited by the inspector general on a yearly basis to provide the community a sense of fairness, honesty, authenticity, and transparency. He explained that the LAPD is trying to create a culture of first preventers rather than first responders in counterterrorism. Downing clarified that the LAPD provides training on constitutional policing and on suspicious activity reporting for officers, command staff, and communities. He explained that all such policies remain in place with the DMH with regard to the information they provide in the criminal space. The JTTF receives feedback regarding whether individuals have accepted help and whether they are progressing in terms of the referral, outpatient, or social service work.

4
The Challenges and Opportunities of CVE

Highlights of Main Points Made by Individual Speakers[a]

- We need to broaden the focus of CVE beyond religion, ideology, or motivation and embed the effort into violence prevention more generally (Stewart).
- If CVE programming determines vulnerability in terms of racial background, ethnicity, national origin, or ideology, then "suspect" communities are identified as precriminal (German).
- In many diaspora communities, there are widespread and deeply held concerns that CVE policies are mechanisms for profiling and discrimination (Hick).
- If there are injustices driving the belief systems that cause people to become violent, it could be argued that CVE efforts are only focused on preventing people from getting violent about the injustices and not about actually addressing those injustices (Wynia).
- Groups around the country are seeking to refine the concept and reshape the scope of prevention, how various sectors should be involved, and what prevention should look like on a community-based level (Selim).

[a] This list is the rapporteurs' summary of the main points made by individual speakers and participants, and does not reflect any consensus among workshop participants.

As discussed in the last chapter, many of the contemporary approaches to curtail violent extremism lack evidence of success, which can undermine their efforts. Many programs have resulted in profiling, discrimination, and resentment in the individuals they were meant to help, and, sometimes, programs have been shown to increase an individual's sense of isolation and inspire violent behavior. A public health approach could address and mitigate many of these issues, but because of past behavior key stakeholders are often reluctant to participate in activities that are sponsored by counterterrorism organizations. This chapter explores (1) how the complicated objectives of CVE and unintended consequences of earlier practices have hindered efforts to address violent extremism, and (2) the opportunities presented by approaching violent extremism as a public health issue.

PERCEPTIONS OF CVE

Given that violent extremism is a relatively low-base-rate issue in terms of number of deaths, Runnels asked the workshop participants what else CVE was intended to prevent and to preserve. David Reddick, chief strategy officer and co-founder of the Bio-Defense Network, suggested focusing on preventing future potential deaths by looking at what steps can be taken to meet and resolve the concerns of people who are vulnerable to violent extremism. Muhammad

Babar, physician with the Muslim Americans for Compassion, remarked that CVE approaches should aim not only to prevent future incidents, but to build a society to preserve American values for the entire nation, including Muslim Americans. In that vein, Downing commented that the key question is how to create an environment that is hostile to prejudice, bigotry, and racism:

> not an inoculation to prevent violent extremism, but rather a prescription to build healthy resilient communities where people feel like they're part of the process, they have a voice, they're American, and this is their home. I think that's what we're trying to preserve.

Stewart argued for the need to broaden the focus beyond religion, ideology, or motivation and to embed the CVE effort into violence prevention more generally. German concurred that the task at hand should be countering violence irrespective of extremism and the ideology. Turk warned that given the high-profile nature of violent extremism, and the political will and consequent funding it attracts, a shift in focus from violent extremism to violence more broadly construed will be a complicated path to navigate. He suggested that it would require strategies for placing attention on issues of violent extremism and positive outcomes of the program (e.g., benefiting the society as whole with a focus on mental health in resilient communities and finding ways to prevent factors that lead people to violence).

Saeed outlined the U.S. Department of State's joint strategy with U.S. Agency for International Development (USAID) for approaching CVE on the international level, which focuses on adapting to the constantly evolving threat of violent extremism (see Box 4-1). He emphasized that the concepts of prevention and intervention are crucial to the State Department's adaptive approach to countering and preventing violent extremism. USAID's strength of good governance enables them to play a larger role in the prevention space, albeit not necessarily directly targeting violent extremism, but rather by aiming to leverage USAID's capacity for good governance to help prevent people from embarking on the pathway to violent extremism. Broadly, the strategy is designed to address the entire life cycle of violent extremism. To better disrupt and intervene in that cycle, the strategy focuses not only on the reactive side (investigation, arrest, and prosecution), but also on understanding how a person becomes motivated to commit violent extremism.

BOX 4-1
Key Components of the U.S. Department of State/USAID CVE Approach

1. Prevention efforts are employed to preempt people from becoming violent extremists by examining the environment that breeds it.
2. Pursue research to better understand the global and localized drivers of violent extremism. Previous research focused on presumptive drivers such as poverty and unemployment, but subsequent research has expanded the focus to other potential drivers, such as the shared characteristics of middle-class individuals who join terrorist groups.
3. Intervention strategies include "off-ramps" and alternatives to prosecution.
4. Rehabilitation and reintegration efforts are geared toward individuals who travel internationally to foreign conflict; comprehensive strategies must be in place to reintegrate them into society upon their return.
5. Strategic messaging will not stop the radicalization of violence, but it can be used to amplify messages about the previous four components via social media and traditional media. The U.S. Department of State also has a new Global Engagement Center that is involved in both messaging and working to empower partners to develop their own messages. He noted that the best messaging, in terms of credibility, resonance, and reach, will come from people local to areas of foreign conflict.

SOURCE: Saeed presentation, September 7, 2016.

THE UNINTENDED CONSEQUENCES OF WORKING IN A PRECRIMINAL SPACE

One of the differences between CVE and traditional counterterrorism efforts is that CVE is designed to work in the "precriminal space," according to Romaniuk. Susan Szmania, senior advisor for the Office for Community Partnerships, Science and Technology Directorate, DHS, warned that our thoughts are not good predictors of our actions, calling the "precriminality" concept critically important in understanding violent extremism in the CVE space. German contended that an important problem is situated in the premise of CVE programming: the notion that bad ideas are a precursor state to committing violence, which empirical studies discount.

German cautioned about the consequences of adopting language that is used in a different sphere and has a very different meaning. For example, if CVE programming determines vulnerability in terms of racial background, ethnicity, national origin, or ideology, then "suspect" communities are identified as precriminal, which he suggested is tantamount to criminalizing them. If discrimination is one of the drivers of violence, then declaring someone or some communities to be precriminal could have the counterintuitive effect of increasing their risk of committing criminal acts. As a result, he argued, no such program should disproportionately target any particular community, since that would be both counterintuitive and counterproductive.

Rajeev Ramchand, senior behavioral scientist at RAND Corporation, contributed that in the realm of suicide prevention work, there are no interventions in place to screen people for (or

prevent) *thoughts* of killing oneself, because of the difficulty in distinguishing between those who are thinking about killing themselves and those who go on to kill themselves. He noted parallel issues in the CVE space—whether individuals should be screened for extremist thoughts, and how to distinguish between those who have extremist thoughts and those who act violently on them—and suggested that there are lessons to be gleaned from public health in considering these ethically challenging issues.

Wynia posed a hypothetical scenario to illustrate the potential moral, policy, and programmatic hazards at play after a person is identified as precriminal. If a law enforcement or FBI officer is investigating a person and genuinely believes that person will commit violence, but has not done so yet, then what is the next step? He suggested that the officer faces a moral dilemma: either to let the person go and see what happens, or create an environment to entrap the person in a situation that warrants arrest. Furthermore, if it is simply not possible to predict who will go from holding extremist beliefs to acting violently on those extremist beliefs, then he questioned where that leaves the policy community in terms of options.

With respect to the "diagnostics" for radicalization, German noted that when a person receives a mental health evaluation, there is a strict and scientifically established diagnostic procedure. However, this is not the case when it comes to determining whether a person has become radicalized in a dangerous way. The mixture of those approaches is a cause for concern, he warned, because it entails pathologizing characteristics that are not scientifically validated and extend into the realm of political beliefs. He cautioned that the early warning signs and indicators used by CVE programs for this purpose may also be problematic. For example, he challenged the argument that an individual who professed belief that the United States is at war with Islam was unreasonable, because, as he put it, "It is certainly true that the U.S. is at war with Muslims and with multiple Muslim countries." German worried about civil liberty violations if such a belief is taken to be an indicator of mental illness and potential dangerousness within a CVE approach. He argued that at its core, CVE is really about suppressing dissent, particularly within the Muslim community, and specifically about suppressing dissent against U.S. foreign policy. He argued that there is an existing body of good research that challenges the conventional premises underlying CVE approaches and how they affect impacted communities that should be reviewed. He expressed dissatisfaction that neither the people conducting that research nor anyone from the impacted communities were present on the workshop panels. He suggested that meaningful engagement with critics is crucial in the CVE space moving forward.

Violent Extremism, Political Violence, and Civil Liberties

German remarked that for the past 30 years the field of counterterrorism research has been struggling with many of the issues raised in the workshop. He emphasized that the body of relevant research has been ignored because it does not provide the answers that CVE practitioners are seeking: How to establish the profile of a violent extremist; how to predict violent extremism, and how to define the preterrorist state. Instead, he observed, this research suggests that there are no simple answers to those questions. This narrow focus on ideology, he contended, comes at the expense of exploring the other critical dimensions. He argued that a narrow focus ultimately pathologizes the political viewpoint of people who align themselves with political ideologies that are deemed inappropriate, when in fact, there is no mental illness underpinning their views and that young men going to conflict (for example, when there is an invasion from a hated enemy on the border, as is the case in Somalia) is a part of human life. He

emphasized that focusing on people who watch the "wrong" video or read the "wrong" book blinds the CVE enterprise to the enormity of the political situation and impedes said politics from entering the discussion. He noted that this is not a new development, since governments have historically labelled their opponents or anyone who challenges the status quo as "radicals" and have sought to suppress them through police practices.

German explained that existing research looks at political violence in context. He reported that in empirical studies seeking to understand terrorists' motivations, there are references to drones, Guantanamo, and torture policies—none of which are included on lists of risk factors for violent extremism or addressed by CVE programs. He posited that this is because the government wants to construe such violence as a problem of a bad ideology rather than conceding its political nature. Furthermore, he suggested that the political nature of so-called extremist violence is the only reason that it is distinguished from the other types of violence that are far more prevalent, such as police violence and state violence, saying "You are allowed to be very violent in this society. You just have to be with the right club." He clarified that he is not calling for violent extremism to be reframed as political violence. He argued that the objective should be to counter violence irrespective of extremism and ideology, by looking at it in context and trying to resolve violence writ large, whether it is state violence, police violence, or criminal violence.

Griss cautioned against using the public health framework to address violence.[1] He characterized it as a type of subterfuge aimed at diverting resources from the public health sector where it can be used to address real public health concerns and shifting it to the military and to law enforcement. He suggested that many people are comfortable with the public health approach in part because it is easy to ignore such concerns, and to focus instead on the individual predictors of violent behavior and how soft power can be wielded to achieve objectives. He contended that the hidden agenda in this CVE framework is to ignore the politics around antiterrorism.

Reflecting on the differences between CVE in the United States and other countries, Skellett observed that unlike the national-level programs implemented in other countries, the U.S. governance structures are completely different in that each state has a large degree of autonomy, which in itself creates a host of challenges in the CVE space. Civil liberties and the balance of beliefs are also critical differentiating components that need to be carefully considered, she argued. In Europe, for example, she noted that there are more restrictions on freedoms of expression, particularly with respect to language that incites hate and violence. Skellett reported feeling like she could not talk about all violent extremism ideologies in the United States in the same way that she can across Europe. She cast as hypocritical the fact that the list of foreign terrorist organizations in the United States does not feature domestic white supremacists or extreme right-wing groups. She explained that this causes her to refrain from speaking openly about ongoing neo-Nazi movements because she fears that it has been accepted as a right of freedom of speech in the United States in a way that has not been condoned elsewhere in the world. Paul Turner, senior conflict advisor at Creative Associates International, commented that there are separate and distinct strands of CVE approaches in place around the world; assuming that there are commonalities among different types of violent extremism, he

[1] Griss noted that public health approaches to violence prevention have a well-established and successful history. More information about this history can be found at https://www.cdc.gov/violenceprevention/pub/history0fviolence.html (accessed January 17, 2017).

suggested that there should be platforms for networking where practitioners can share lessons learned and best practices on the ground while also embracing differences in approaches.

Based on her experience, Skellett disagreed with the contention that the public sector is discriminatory in the sense of encouraging stereotypes and discrimination; rather, she suggested, the public-sector spirit is to safeguard strategies that stretch the mark and speak up against injustices. She called for a distinction between using the term *radicalization* to describe normal social movements used as a force of the good, as opposed to violent radicalization. She suggested that people are often recruited and encouraged to use violent means to achieve aims on behalf of leaders who are hiding their true intentions; thus, policies should be put into place to protect those people. She urged all areas of public service to maintain their focus on the individuals affected by violent extremism and how to make a positive impact on their lives.

Griss suggested that a neglected issue has been the role of radicalized social movements in driving social change, in strengthening democracy, and in changing the power structure for the better. He argued that it is a mistake to construe radicalization itself as the problem, when in fact it is an essential ingredient in rethinking the assumptions of power and legitimacy. He expressed concern about CVE programming because of how similar approaches have been used in the past against public health advocates like Martin Luther King, Jr., against the Black Panthers, and against the Native Americans in North Dakota challenging the pipeline:

> Unless we recognize that pathologizing radicalization is itself part of the propagandistic role that we are seeing supported by the government and the police and the military, this is a very dangerous movement that has undermined democracy in the United States in the past and probably even more so now.

Social Injustices and Earned Mistrust

In many diaspora (and particularly Muslim) communities, there are widespread and deeply held concerns that CVE policies are a mechanism for profiling and discrimination, according to John Hick, deputy chief emergency medical services (EMS) medical director, medical director for Emergency Preparedness, Hennepin County Medical Center, and other participants. Rondon argued that CVE must address the problem of people feeling alienated because they are being targeted and victimized, not in a sense, but in actuality. She called for law enforcement accountability and oversight with hate crime enforcement policies, as well as investment into education and infrastructure. Jensen also suggested that counternarratives and programs should be put in place to address such feelings of community victimization, but warned that because of common biasing mechanisms, certain audiences may not be responsive to the message.

Turk noted that violent extremism is much less of a concern for most Muslim families and community leaders than other issues, such as gangs, but that the Muslim community often feels victimized by certain targeted CVE strategies. He observed that this has created a sense of mistrust among Muslim communities toward law enforcement: “Whether it is counterterrorism or the securitization of the relationship between the Muslim community and government, it has stigmatized the Muslim community.”

W. Craig Vanderwagen, retired rear admiral, U.S. Public Health Service, and co-founder and director of East West Protection, LLC, commented that the complex issue of violence in society commonly revolves around issues of social injustice that engender anger within

communities. Whether that anger takes an ideological or some other form, he suggested, violence is a product of many of these social inequities and social injustices. He argued that criminalizing or "medicalizing" violence is inevitably reductive; while it may be useful in constructing specific interventions and dealing with certain individuals, it does not contribute to resolving the problem's complexities at the macrolevel or mesolevel. He urged practitioners to devise a paradigm for approaching CVE more holistically, and to validate such a holistic approach.

Griss suggested exploring the potential for applying the restorative justice model, which has programs at the school level and at the prison level but has wider implications for society as social movements are trying to address real dysfunctions at the national and global level.[2] He suggested that this would improve the effectiveness of CVE work, and mitigate the tendency to pathologize so-called terrorist behavior. Griss argued that it is counterproductive to use the counterterrorism framework to try to create healthier and more just communities. He suggested that applying a restorative justice model to CVE may be more appropriate than the antiterrorism frameworks, because it recognizes the legitimacy of individuals' and groups' respective and overlapping grievances. He explained that the restorative justice approach involves providing a platform for dialogue—not only within small groups (such as a school anti-bullying program), but within neighborhoods, within the broader criminal justice program, and nationwide. For a given problem, the strategy creates opportunities to address and legitimatize different grievances, to validate the contribution of different perspectives, and through that process, to resolve it by restoring justice.[3] He argued that the participants in the workshop had ignored the primary sources of violence: the military and the police, both of whom he suggested have been given carte blanche in many contexts. He contended that this underlies much of the behavior that has been labeled as terrorism, and urged CVE practitioners to inspect this critical blind spot.

Wynia suggested that if there are injustices driving the belief systems that cause people to become violent, some may argue that instead of addressing the injustices, CVE efforts are only focused on trying to prevent people from getting violent about them. He asked how it may be possible to ensure protection of speech and continue to value radicalization and radical speech, while also discouraging violent extremism. Brette Steele, acting deputy director of the Countering Violent Extremism Task Force at the U.S. Department of Justice (DOJ), emphasized that maintaining a clear distinction between extremism and violent extremism needs to remain at the core of CVE work, though she noted that no single program will ever be able to address every grievance. The root causes of these grievances should be addressed through a range of efforts and different programs.

Wynia suggested that a broader approach would also focus on the reasons for mistrust and how to address it. He considered restorative justice to be a tool for achieving improved trust or, as an example, for proving the trustworthiness of the prior offending organization. He characterized community mistrust as beyond mere political polarization, but as arising out of earned mistrust of a variety of different entities. He noted that this has been an issue that the medical system has dealt with over the past decade in investigating the drivers of health and health care disparities, many of which have been related to policy decisions that created adverse health outcomes and mistrust within minority communities. He described how the medical profession has struggled to find ways to address the legitimate mistrust that has gained momentum over decades: "not mistrust that comes from misunderstandings, but mistrust that

[2] More information about this model is available at http://restorativejustice.org (accessed November 8, 2016).
[3] He noted that using the term *restoring* when justice did not exist before is somewhat of a misnomer, but it is at least providing an opportunity to collectively create conditions for justice.

comes from understanding." He suggested that the CVE arena will have to struggle similarly to prove its trustworthiness, after having deservedly lost that trust.

Saeed observed that partner governments around the world have contributed to the senses of grievance and anger that are potential drivers of violent extremism; for example, the International Covenant on Civil and Political Rights (ICCPR) has been signed by multiple countries that do not necessarily abide by it.[4] He reported that to address this, the U.S. Department of State has sought to increase diplomatic engagement with governments that have been too overzealous in their CVE efforts by encouraging them to adopt CVE programming that builds in a rights-respecting component as its driving mechanism in law enforcement and government responses. The U.S. Department of State and USAID, he argued, should push partner governments around the world to adhere to the ICCPR and to consider whether their rule-of-law initiatives are essential to their CVE programs.

Ellis suggested that the field of CVE is at a unique juncture where it can be shaped to fit the needs of the country and its communities. Ellis echoed Selim's point about the importance of empowering local partners and strengthening communities from within. She related a procedural lesson learned from her experience in working with refugee youth as a clinical psychologist:

> You don't do this research on a community and to a community and then decide what to do with the answers. You have to partner in a really genuine fashion with the communities that you're trying to serve. If you don't have an equal partnership where they have voice, where they can shape the questions, where they can interpret the answers with you, and where they can use the information to build a program that's relevant to them, then don't do the work.

Shifting the Bell Curve: Addressing Social Determinants and Engaging Communities

Brett Kubicek, manager, Research and Academic Relations at Public Safety Canada, observed that the shift to the second wave of CVE programming ushered in an expanded focus on context, unintended consequences, and stigma. He suggested that potentially instructive lessons could be drawn from the literature on social determinants of health to contextualize violence and its link to community resilience, as well as to inform CVE programming, implementation, outreach, measurement, evaluation, and accountability.

In the context of social determinants, Leesa Lin, senior program manager with the Emergency Preparedness Research, Evaluation, and Practice (EPREP) Program, Division of Policy Translation and Leadership Development, Harvard T.H. Chan School of Public Health, emphasized that people are the products of their environments. She observed that violence should be construed as a symptom to be addressed, rather than a driving cause, because progress will depend on addressing the root causes of violence. She suggested investing at the community level in building trust, education, and improving environmental circumstances to help to shift the bell curve, but she expressed concern that currently those areas do not get enough attention or sufficient funding to warrant investing in the programs that produce the greatest outcomes. In that vein, Benjamin commented that from a societal perspective, more attention needs to be paid and resources devoted to factors that put individuals at high risk for a range of violent activities:

[4]Available at http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx (accessed November 8, 2016).

improving early childhood education, broadening access to mental health services, preventing domestic violence, limiting access to firearms, and strengthening economic empowerment.

Leana Wen, health commissioner of Baltimore, Maryland, noted that there may be a disconnection between people working outside the public health sphere and the understanding of root causes that may lead to radicalization and eventual violence. To explain, she remarked that frontline practitioners treating a patient for gunshot wounds do not have time to investigate root causes and determine whether the person was a victim of trauma earlier in life. Even if that were established, she said, at that point it would be too late to intervene. Furthermore, she noted that the disparities present in the communities in Baltimore City, for example, make it difficult (and even disingenuous) to address root causes such as healthy nutrition, for example, with parents who live in a food desert. She highlighted the need to call out and address the disparities that are in and of themselves the root causes of so many problems.

Rondon agreed that CVE does not address the root factors that drive violent behavior; she suggested that people are feeling alienated because they are actually being targeted and victimized by CVE programming. She emphasized that law enforcement accountability and oversight must be addressed with hate crime enforcement policies, coupled with investments in education and infrastructure. She also suggested improving access, particularly for Arab and Muslim communities, to mental health resources that are not linked to CVE and do not require a person to profess to being a criminal or at risk of criminality.

Multiple participants highlighted the need to bring more community stakeholders and credible voices to the table. Rondon suggested that CVE programs are developed and implemented without input from key stakeholders and credible voices who are only asked for input after the fact, when they should have been involved in the planning stages. Farooq also commented that the CVE space should bring more stakeholders to the table, particularly people who have been involved in developing and implementing evidence-based CVE programs. Farooq suggested that this is one reason the conversation constantly circles back to semantic concerns about what to call CVE, rather than focusing on actions to take. She contended that people who have implemented CVE programs would be able to describe the practical challenges that they and their communities have faced. Based on her experience, she observed that the communities being served do not need to be convinced of the need for action; they already recognize it and should be allowed to play a driving role defining what that specific threat is and how to address it. To that end, she cautioned against generalizing and recommended allowing communities to define what the threat of violent extremism means to them, because it will always differ based on geography and demography. She pointed out that community building is not rocket science; rather, it is about drawing on basic principles of community mobilization and development from the international development field, and applying them to the challenge of violent extremism. Hick commented that the polarization that surrounds these types of discussions in the CVE space is difficult to surmount:

> Even efforts to promote community equity wind up being tainted with optics from different perspectives, and make it hard to accomplish anything in the value of the common good, regardless of whether that applies to the whole population or not.

STRENGTHENING RESILIENCE AT THE INDIVIDUAL AND COMMUNITY LEVELS

Ellis characterized individual resilience as a process that can be built within an individual, rather than a binary attribute that a person has or does not have. Identifying factors that interfere with that process (e.g., mental illness, trauma, or a sense of disconnection) and addressing them can promote more resilient trajectories at the individual level. She suggested widening the lens of the prevention component of CVE to encompass early-stage interventions to prevent future negative outcomes. According to Ellis, resilient communities are those in which everyone feels like they belong and feels they have a meaningful voice, with communal social bonds among and within different subsets of the community and at different levels of government. Annie Miller, associate professor at University of Denver/Metropolitan State University of Denver, suggested that public health can lend a useful lens for examining community-level perceptions of safety, and offer ways to enhance them with effective mechanisms.

Multiple participants emphasized the importance of educating communities about the warning signs that an individual may be at risk of radicalization that may lead to violent extremism. They suggested that to effectively intervene with individuals who are vulnerable to radicalization and may be on the pathway to violence, recognizing the warning signs must be coupled with a network of appropriate referral channels for seeking help and accessing services for remediation. Key challenges highlighted were the stigmatization that can surround seeking help and some community members' reluctance and apprehension about engaging with traditional avenues of referral through law enforcement or government agencies.

Selim reported that over the previous 24 months, there had been roughly 100 cases inspired by ISIL, in which the U.S. government or federal law enforcement agencies interdicted in some way—either in attempted attacks in the United States or in attempts to travel abroad. He pointed to a single predictor as a common theme: in the overwhelming majority of those cases, someone in the person's social or family sphere realized that something was amiss but did not know what to do or where to go (anecdotally, this may be attributable to trepidation in contacting law enforcement for a range of different reasons). According to Selim, this bolsters the need for integrating a public health approach in developing CVE-related programs to help destigmatize the issue of wanting or needing to seek help, as well as having the resources and ability to access advice and services.

Wynia noted that in recent years, public health has moved away from negative framing (i.e., preventing bad outcomes) and toward encouraging better outcomes like health and well-being. He questioned whether there has been an analogous shift in the CVE space. Ellis located a similar shift surrounding the issue of preventing violence. There is a grey area surrounding the best way to intervene with a youth who has not actually committed violence, but his or her family, teachers, and peers recognize intuitively that something is wrong. It can be problematic if turning to law enforcement to help prevent violence is the only option in such cases, because law enforcement have a different mandate than other disciplines that operate in the constructive space of helping the youth to reconnect with the community and foster a sense of belonging. She suggested that prevention approaches should shift in focus from the prevention of violent acts to exploring options for reengaging youth who are embarking on a trajectory that could lead to violence.

PARTNERING TO SUPPORT CVE

Wynia remarked that while the discipline of CVE is still young, it is far from stagnant, with multiple innovative approaches already being implemented in the field. He argued, however, that a novel public health approach is urgently needed. He drew parallels between the origin stories of public health and CVE: both are fields that arose out of eras in which heroic interventions for very challenging problems became common. Although these aggressive interventions made intuitive sense, he explained, people began to question their efficacy and began to recognize them as counterproductive, giving rise to retrospective examination about how to prevent those bad outcomes from occurring. He remarked that in both CVE and public health, this triggered the emergence of new fields focusing on different types of approaches (e.g., those that focus on root causes, on prevention, population-based approaches, or environmental and restorative justice approaches). However, he noted, both CVE and public health have faced similar difficulties in distinguishing themselves from existing approaches, in defining the appropriate language, and in implementing approaches that do not alienate the very people they are designed to help—these challenges may be new to CVE, but they have been perennial challenges in public health for more than 100 years, he observed. He continued, suggesting there is much these sectors can learn from each other, emphasizing that this avenue for reciprocal learning and spreading of ideas represents a crucial opportunity to strengthen both fields. Selim remarked that the director of the FBI, the Secretary of Homeland Security, and the attorney general have all stated that the current threat of radicalization, recruitment, and the influence of foreign terrorist organizations to inspire an act of domestic terrorism is not a problem that "we are going to arrest our way out of." Similarly, he reported, law enforcement professionals have acknowledged the new state of threat from both foreign and domestic influence on communities in the United States and are calling for the integration of more holistic, adaptive approaches.

Selim continued, noting that conversations around the country are seeking to refine the concept and reshape the scope of prevention, how various sectors should be involved, and what prevention should look like on a community-based level. He suggested that the federal government has an important role to play in promoting and facilitating these conversations and catalyzing continued engagement toward a multidisciplinary comprehensive approach to CVE. Selim remarked that given the potentially negative perceptions related to the prevention of radicalization toward extreme violence, the overall spirit of the U.S. government's national CVE strategy is not just to prevent or intervene, but to build and strengthen communities from the ground up. He reported that many U.S. cities have cultivated and invested in their own CVE strategies, shaped by local perspectives and contexts, to enhance community resilience and empower local partners. He said:

> The intent and spirit of our [CVE] policy and all our programs is to invest, is to build, is to engage, and not to have some type of coercive measure, but really to provide solutions in a way that is constructive.

Legal and Ethical Responsibilities of the Nonmedical Practitioners

Hick reflected on the legal and ethical obligations of parents who have children that may be venturing into risky or threatening territory, given that once the parents broach the legal boundary they risk losing their children to the criminal justice system. He noted that similar concerns apply to the ethical obligations of religious or community leaders and community members who may be intimidated into not speaking up about activities within their community that they consider potentially dangerous because of concerns they have about garnering unwanted attention and the risk of legal action. However, he was optimistic that there is the space and opportunity to develop applicable ethical frameworks to establish expectations and counterbalance some of the legal obligations.

Role of the Media

Dan Hanfling, contributing scholar from the Johns Hopkins University Center for Health Security, raised the issue of media ethics and the role media can play in perpetuating stereotypes and exposing risks in vulnerable communities, especially in the age of the 24-hour news cycle and pervasive social media networks. David Eisenman, professor of medicine and public health at the David Geffen School of Medicine, University of California, Los Angeles (UCLA), UCLA Fielding School of Public Health, and director of the UCLA Center for Public Health and Disasters, expressed similar concerns about how the media can incite problems, but he suggested there could be opportunities to leverage the media in advantageous ways and to reinforce positive behaviors. He proposed that storytelling might be a way to inject characters with new traits and new behaviors into television programs and other types of media. Having stigmatized groups shown playing less-stigmatized and more respectable roles, he suggested, could counter stereotypes and provide those groups with a voice.

Funding and Resources

Harlan Dolgin, president and cofounder of the Bio-Defense Network, pointed to the challenge of how to convince funders to support CVE programming, given that the payoff will be at least 15 to 20 years in the future. Lin suggested that to better quantify the return on investment, research should be marketed in a better way to get the right people to pay attention. Neil Rainford, public health advisor with the Prevention Practice and Translation Branch, Division of Violence Prevention, within the National Center for Injury Prevention and Control at CDC, commented that the source of resources matters not only to communities, in terms of trusting the outcomes or intentions of those resources, but in the sense that resources can come in many different nonfinancial forms, such as people and capabilities. He suggested framing all resource conversations in the context of building sustainable programs, noting that resources provide an opportunity to develop solutions and strategies that can potentially solve multiple problems or issues. He also highlighted the need to diversify resources so programs and strategies are supported by multiple funding streams. With respect to government resources he suggested that communities can feel exploited when researchers supported by the government appear to take data and depart after three-to-five-year project cycles are completed, but the issues that plague the community do not get resolved.

German warned that with the funding currently available for CVE, people may be tempted to shoehorn other types of programming into the CVE space, when in fact they are programs for law enforcement, the FBI, or DHS. Anderson also remarked on the need for caution in using science as part of an effort to prevent dissent versus using it to help to prevent violence, a distinction that can sometimes be lost because of groupthink and the availability of funding.

Performance Assessment and Measurement

Wynia asked about how to measure the success of CVE programs in terms of the types of outcomes, measurements, or proximal measures that should be used. Steele noted that assessing outcomes will require better understanding of risk and protective factors, assessment strategies, and identifying opportunities for prevention programs by evaluating preventive efforts at the primary, secondary, and tertiary levels.[5]

Wynia suggested that teaching people how to measure performance is critical, and that there are many pitfalls in performance assessment. For instance, the best outcomes might not be the easiest to measure, leading to a false sense of security because measured outcomes are looking good, while unmeasured (but more important) outcomes might be poor. A related issue he highlighted is the propensity to "game" the system. In situations where resources and other meaningful impacts are contingent on better or worse performance, he cautioned that people will inevitably finesse that measure. He suggested that there is an entire panoply of issues related to evaluation, and especially high-stakes evaluation, that warrant careful attention. Anderson raised the similar issue of how monitoring, evaluation, and measures of effectiveness can be subject to manipulation. He noted that because of those concerns, USAID switched to a policy of using independent agencies to perform their measures of effectiveness. He suggested that CVE policy makers should budget to include an independent evaluation, rather than the agency evaluating itself. Miller suggested that the element of protection may be missing in discussions about measuring and evaluating community resilience and other work carried on in the CVE environment.

Wynia commented that despite the challenges facing evaluators (such as publication bias and the lack of a shared measure set), there are positive developments afoot. For example, DOJ now requires many of its funded projects to share data in a common database, and the DHS is thought to be moving in that direction; the use of independent evaluators has gained positive momentum as well. He explained that the public health concept of community-based participatory research could be a useful model for working with communities to determine which outcomes matter to them and which measures would be appropriate, meaningful, and salient for both communities and policy makers. He asked whether any such efforts were underway in CVE. Steele reported that similar efforts are underway in the CVE realm, with several researchers employing those methods. She observed that because CVE is built around the concept of collaborative problem solving, community-based participatory research can serve as an excellent vehicle for implementing that strategy.

[5] Here, the terms *primary*, *secondary*, and *tertiary* refer to the timing of prevention efforts. More information can be found on page 15 of the World Health Organization's *World Report on Violence and Health*, available here: http://www.who.int/violence_injury_prevention/violence/world_report/en (accessed February 10, 2017).

5
Applying Public Health Models and Approaches to Countering Violent Extremism

Highlights of Main Points Made by Individual Speakers[a]

- Public health prevention models for CVE could address the broad range of political, social, economic, and historical forces or grievances that can create and reinforce the conditions for violent extremism (Eisenman).
- Instead of only looking at what individuals are doing at a specific instance, recognize the policies and circumstances that lead to the behavior and address those (Wen).
- Even the most well-intentioned and best thought-out efforts and interventions can fail if they are not supported by local community champions who can leverage their own credibility and encourage others to understand that CVE is a health issue worth engaging (Arthur).
- Because a small number of people do pose a threat that warrants reporting, health professionals are tasked with striking a delicate balance between their social responsibilities and their duties of care (Wynia).
- Health professionals' poor ability to accurately detect credible threats is a critical concern particularly when the determination is used as justification for breaching civil liberties (Wynia).

[a] This list is the rapporteurs' summary of the main points made by individual speakers and participants, and does not reflect any consensus among workshop participants.

Chapter 5 focuses on how elements of the existing health and public health frameworks can be applied to strengthen and support CVE programs. By incorporating lessons learned in analogous programming that combat other types of violence, health and public health practitioners could promote community resilience, encourage community engagement, and help to gather evidence about the risk and protective factors that underpin radicalization toward violence. The evaluation of these programs, an essential component of public health models, is also discussed, as are the set of practical and ethical challenges health professionals face when working in CVE roles.

THE PUBLIC HEALTH APPROACH TO ADDRESSING THREATS

Eisenman noted that more than 2,500 federal, state, and local agencies constitute the backbone of the U.S. public health system and bear the legal responsibility for assuring the delivery of essential public health functions. The public health profession incorporates both health care delivery systems and academic public health sciences; however, he pointed out that

there are multiple other sectors that contribute to the public health system and to population health (see Figure 5-1).

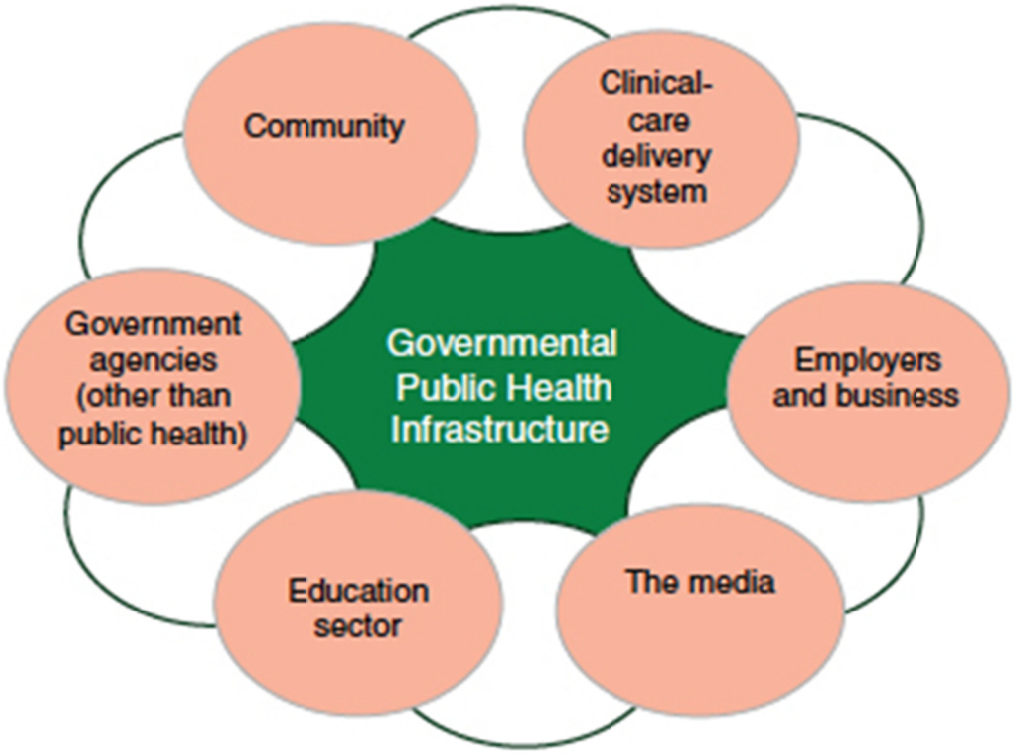

FIGURE 5-1 The intersectoral public health system.
SOURCE: Eisenman presentation, September 8, 2016.

Steps in Implementing a Public Health Approach to Violence Prevention

In their respective presentations, Georges Benjamin and Leesa Lin detailed CDC's four key steps for implementing a public health approach to address health threats, including violence prevention[1]:

1. Define the problem using reliable data: "who," "what," "when," and "how."
2. Identify risk and protective factors using scientific research methods: what factors protect people or put them at risk?
3. Develop and test prevention strategies using evaluation.
4. Assure widespread adoption using additional evaluation, training, and/or technical assistance.

Step 1: Define the Problem Using Reliable Data: "Who," "What," "When," and "How"

[1] Source: Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control, Division of Violence Prevention. For more information on the Public Health approach see http://www.cdc.gov/violenceprevention/overview/publichealthapproach.html (accessed November 8, 2016).

Benjamin explained that the first step is to use data to define and monitor all facets of the problem at hand. This includes understanding who is at risk, what they are at risk of, when the problem is more likely to occur, and where it is likely to occur. Gaining clarity about the problem and how to address it also provides the necessary groundwork for putting measures into place for monitoring interventions, he explained.

Step 2: Identify Risk and Protective Factors Using Scientific Research Methods

The second step, according to Benjamin, is to identify the risk factors and protective factors at the individual, community, and broad societal levels that contribute to making certain communities more susceptible than others to experience a health threat. Such factors include issues such as the availability of firearms, religiosity, and level of wealth. He explained that the public health approach focuses heavily on exploring how these factors coalesce around particular problems.

Step 3: Develop and Test Prevention Strategies: Four-Tiered Model of Public Health Prevention

Benjamin stated that the third step is to apply knowledge gained about the problem, as well as its risk and protective factors, toward developing hypotheses about potentially effective interventions and putting programs into place. He noted that actually measuring and evaluating the efficacy of public health programs tends to be erratic. In many cases, a program is implemented and associated with a desirable health outcome; the program is then championed as effective without the benefit of a formal evaluation to determine whether or not the outcome was actually caused by chance. This highlights the importance of incorporating evaluation measures to assess success in preventing or mitigating health threats, he argued. He explained, however, that regardless of whether the program's success has been empirically validated, if it is ostensibly successful and contributing to positive momentum, then the next goal is to work toward prevention of the problem. Eisenman contended that it would be fair to construe all public health activities as preventative. Furthermore, he suggested that it would be more apt to frame the entire CVE enterprise as the prevention of violent extremism, not countering it.

To explain how the public health sector implements the task of prevention, both Eisenman and Benjamin explored the multitiered public health model, which encompasses multiple levels of prevention (see Figure 5-2).

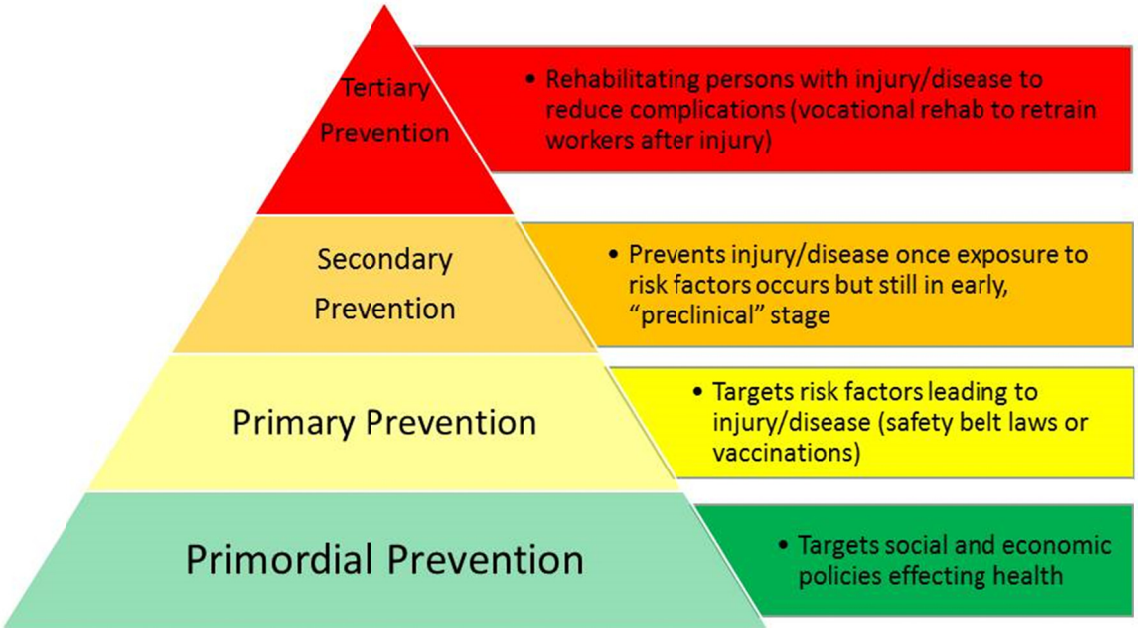

FIGURE 5-2 Tiered model of public health prevention.
SOURCE: Eisenman presentation, September 8, 2016.

Primordial prevention strategies are situated furthest upstream, noted Benjamin. Eisenman explained that the primordial prevention level is not always included in the public health model (some of which have only three tiers of prevention), but suggested that it warrants more attention. For example, by blocking American tobacco companies from introducing tobacco products into developing countries, public health advocates were successfully able to prevent the introduction of new risk factors for disease into those countries. He explained that in subsequent years, primordial prevention has come to be associated with changes in the country or changes in macrolevel social and political policies to prevent disease. Lin described primordial prevention as addressing fundamental health determinants at the system level.

Benjamin explained that the goal of the next tier, primary prevention, is to avert a health threat by addressing its root causes before they result in a disease or injury. Primary prevention efforts are upstream strategies aimed at reducing exposures to hazards, altering risky behaviors, and increasing resistance to disease or injury should exposure occur. He cited several examples of primary prevention strategies, including preventing exposure to secondhand smoke, building sidewalks to encourage and enable walking to promote cardiovascular health, promoting the use of seat belts or bicycle helmets, and vaccinating against pneumococcal pneumonia to protect individuals and strengthen herd immunity. He suggested that another primary prevention strategy with particular relevance to the CVE space—and violence prevention more broadly—is geared toward preventing early childhood trauma, which he described as a predictor of impulse control problems and future violent tendencies.

The goal of secondary prevention is to reduce the effect of a disease or injury that has already occurred, said Benjamin. This process may involve strategies for detecting and treating a disease or injury as soon as possible to halt or slow its progression, encouraging personal strategies to prevent reinjury or recurrence, and implementing programs to return people to their

original health and ability to function. Secondary strategies include, for example, tobacco cessation support for a person with coronary artery disease, mammograms and colonoscopies for detecting and treating early-stage malignancies, and treatment with antibiotics for pneumococcal pneumonia infection. In the context of violence prevention, he suggested that secondary prevention strategies might involve engaging with youth who are gang members without a history of violence. Intervening at that point may reduce their elevated risk of violent behavior as they enter adulthood and possibly become more involved with gang activities.

Benjamin described tertiary prevention strategies as concentrated on reducing the effect of an ongoing illness or injury that has lasting effects, as well as preventing its recurrence. He explained that tertiary prevention is accomplished by helping a person to manage a chronic disease and disability, such as by using medications to control hypertension in a stroke patient or providing rehabilitative therapy to a person who has had a myocardial infarction. Eisenman contributed the example of vocational rehabilitation to help retrain workers after they recover from an injury. According to Benjamin, the goal of tertiary prevention is to improve the person's ability to function, quality of life, and life expectancy. Intervening with an individual who has been a victim of violence to prevent retaliation is another form of tertiary prevention, because engaging with the victim can help to break the cycle of violence that can escalate from relatively minor injury to retaliatory serious injury or death, Benjamin noted.

Step 4: Assure Widespread Adoption Using Additional Evaluation, Training and/or Technical Assistance

After effective strategies have been identified, the fourth step is to assure their widespread adoption by disseminating and implementing them broadly. Benjamin highlighted the four *E*s of prevention: education, environment, enforcement, and evaluation. He suggested that education efforts should cast a wide net and cover individuals at risk, policy makers, and the public at large. Environmental efforts should aim to make the environment as safe as possible for individuals (e.g., providing home safety inspections for older people who have fallen and broken their hips). Benjamin emphasized that solutions must "go viral" with improved efforts to disseminate best practices that can be customized for specific environments.

Applying the Tiered Model of Public Health Prevention to CVE

Benjamin emphasized that the relationships between the four categories of prevention activities are complex, context dependent, and not always easily delineated. However, he suggested that understanding where a given program fits into the spectrum of prevention strategies is an important step in building a system for CVE. Both Benjamin and Eisenman explored how public health's four-tiered model of prevention can help to map out strategies for preventing extremist violence. Eisenman noted that most activities within existing CVE programs would fall under some level of the public health prevention model (see Figure 5-3).

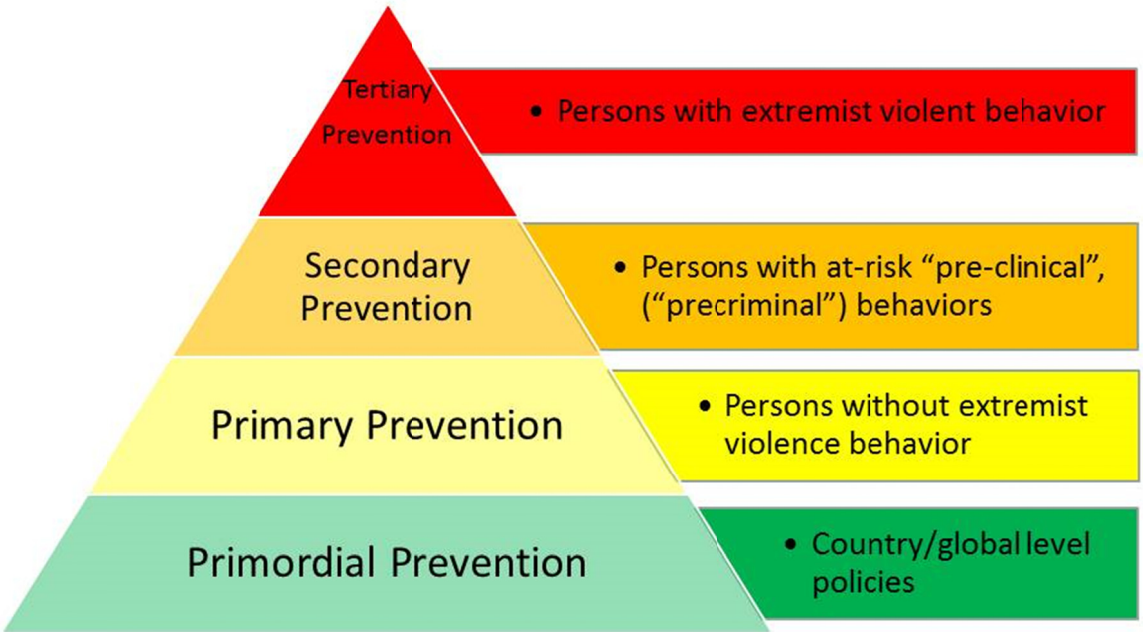

FIGURE 5-3 Applying the four-tiered model of public health prevention to prevention of extremist violence.
SOURCE: Eisenman presentation, September 8, 2016.

Eisenman suggested that primordial prevention for CVE could address the broad range of political, social, economic, and historical forces or grievances that can create and reinforce the conditions for violent extremism (e.g., Western foreign policy, wars in the Middle East, and the global distribution of wealth). He noted that while primordial prevention strategies are not generally on the forefront of the public health approach, there are advocates in the field who are active in attempting to address the social determinants of risk by promoting policies that improve human rights and reduce inequalities on both national and global levels. He noted that many such activities may not be CVE specific, but are CVE relevant.[1]

Universal prevention strategies, according to Eisenman, frame violent extremism as a problem for all communities, and such strategies are predicated on the assumption that all communities have opportunities for violence prevention. In the CVE space, he noted, primary prevention is concerned with targeting the majority of the population who have not engaged in problematic behaviors associated with violent extremism. Eisenman explained that such activities can include community programs and counternarrative media campaigns to reduce risk factors and strengthen protective factors for individuals, families, and communities. These activities may either be CVE relevant or CVE specific, he noted. Benjamin suggested that programs in the primary prevention category could be broadly construed as community-level strategies that mitigate modifiable risks, such as limiting the availability of extremist media and reducing social isolation and exclusion. He contended that this can be done sensitively without

[1] More information and definitions of these terms can be found in *Does CVE work?: Lessons learned from the global effort to counter violent extremism* report, which can be found at http://www.globalcenter.org/wp-content/uploads/2015/09/Does-CVE-Work_2015.pdf (accessed January 17, 2017).

stigmatizing or profiling individuals but by using data-driven methods to identify individuals at risk, a process that will require ongoing scientific research.

Eisenman explained that secondary prevention targets a subset of the population who are considered to be at risk for violent behaviors. He likened secondary strategies for detecting the behavioral changes in individuals that precede violent acts to strategies for detecting and addressing the preclinical changes that occur before a disease manifests.[2,3] Examples of CVE-specific and CVE-relevant program activities include targeted violence threat assessment programs, "off-ramps," and interventions for people at risk before they commit violence. Benjamin similarly described secondary prevention strategies as directed at individuals who have some characteristics that put them at an elevated risk for violent extremism (e.g., exposure to extremist ideologies or proximity to a radical social network).

Tertiary prevention strategies, according to Benjamin, are directed at individuals who have already adopted extremist ideologies or are in contact with violent extremists, but are not engaged in planning or carrying out acts of violence, in order to divert them away from the path to violence. Eisenman explained that tertiary prevention activities, such as deradicalization programs, can help to manage and rehabilitate people who have already manifested criminal intent and violent extremist behaviors; these activities are generally housed in CVE-specific programs.

Lin suggested adopting a fifth tier—quaternary prevention—that would include actions taken to oversee the civil liberty and ethical issues intrinsic in all levels of prevention, in order to ensure that people are not overtreated for behaviors that are not a risk (see Figure 5-4).

[2] He noted such behaviors are often referred to as *precriminal*, but clarified that it is not a public health term and its use may be counterproductive and perpetuate stigmas.

[3] For example, the Los Angeles Targeted Violence Threat Assessment Program is a secondary prevention program for people who have been identified with precursor behaviors but who have not yet committed a violent extremist act.

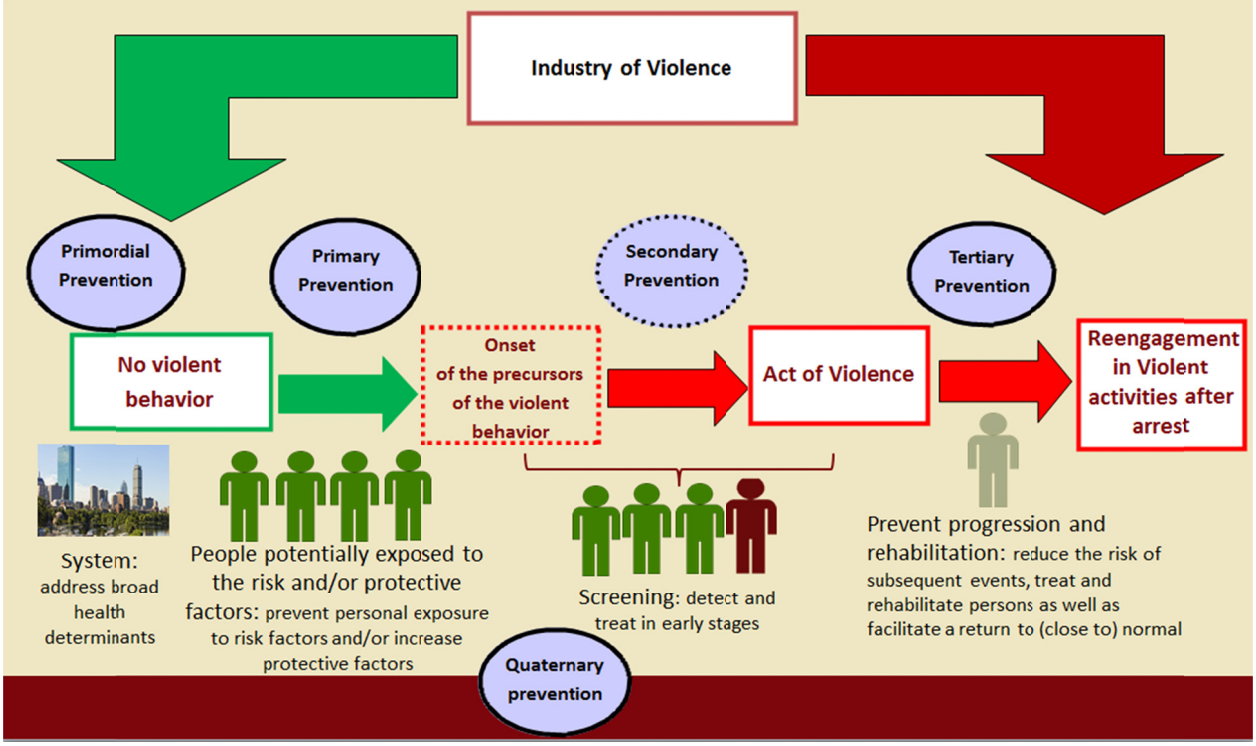

FIGURE 5-4 Levels of prevention in public health.
SOURCE: Lin presentation, September 8, 2016.

Woodie Kessel, senior scholar at the Koop Institute, cautioned against assuming there is one most efficient strategy for prevention, arguing that all levels of prevention will require promotion, attention, investment, and consideration.

Applying CDC's "10 Essential Functions of Public Health" to CVE

Eisenman introduced CDC's 10 Essential Functions of Public Health in order to provide guidance about how the public health approach, system, and workforce can contribute to preventing extremist violence. He explained that these 10 essential functions are widely accepted as forming the foundation for all public health activities, and presented a figure (see Table 5-1) detailing how each of the 10 essential functions can be applied to prevent violent extremism (Weine et al., 2016).

TABLE 5-1 CDC 10 Essential Public Health Functions and CVE

Essential Public Health Function	Activity Applied to CVE
1. Monitor health status to identify and solve community health problems	• Assess if local resources match CVE needs • Connect CVE with community/population data collection • Create mechanisms for data sharing across programs
2. Diagnose and investigate health problems and health hazards in the community	• Gather and share information on emerging threats • Participate on committees addressing CVE • Develop measurable definition of CVE
3. Inform, educate, and empower people about health issues	• Address CVE within wider reach of violence prevention • Convene trainings for professionals in relevant settings • Inform communications to avoid stigmatization
4. Mobilize community partnerships and action to identify and solve health problems	• Develop a coalition to help sectors integrate CVE into existing activities • Assistance to improve program planning • Assistance to improve collaboration, obtain funding
5. Develop policies and plans that support individual and community health efforts	• Directly involve public health and mental health in CVE policy making
6. Enforce laws and regulations that protect health and ensure safety	• Review, evaluate, and advocate for CVE related law and policies to guard against civil liberties violations and stigmatization
7. Link people to personal health services, and assure the provision of health care when unavailable	• Provide access to a culturally competent system of care for interventions • Provide guidance on reducing utilization barriers
8. Assure competent public and personal health care workforce	• Design and evaluate trainings for public health, mental health, social services, education staff on violent extremism
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services	• Evaluate which/why programs work to direct resource allocation
10. Research new insights and innovative solutions to health problems	• Partner between practitioners and academics • Health services research • Implementation and dissemination research

SOURCES: Eisenman presentation, September 8, 2016; Weine et al., 2016.

Eisenman explained that the first two functions fall under the auspices of public health assessments; in the CVE realm, this involves applying public health data to help understand CVE needs. He reiterated Benjamin's contention that data is the foundation of the public health enterprise, pointing to the usefulness of using relevant information from population-level public health surveillance surveys to inform CVE activities, particularly as research continues to improve understanding of the relevant risk and protective factors for violent extremism. For example, he suggested that many of the protective factors that are posited to mitigate against

violent extremism—such as social cohesion and access to health care—could be the same factors that allow communities to withstand stresses and sustain healthy behaviors in the face of adversity. He noted that perceived discrimination and trust in government are often measured in public health surveillance surveys. Eisenman suggested that public health could also contribute by codifying definitions of violent extremism that lend themselves to prevention programs with a clear connection to health and well-being.

Functions 3, 4, and 5 in Table 5-1 pertain to the core public health function of developing policies and plans for health, according to Eisenman. Activities include informing and empowering communities, mobilizing partnerships, and developing policies and plans. He proposed that CVE could be addressed within the wider context of violence prevention generally, with the public health sector serving as convener and helping to assemble community sectors and agencies around CVE, as well as providing technical assistance on program planning and grant funding. Furthermore, he suggested that public health could contribute to policy making and program development, thereby helping to shift CVE away from its dependence on law enforcement and closer to the mental health education, youth development, and other human services sectors.

Eisenman explained that functions 6 through 10 represent the public health core functions of ensuring the populations' universal access to a culturally competent health system, for both general health and prevention. These functions include enforcing health and safety laws and regulations, linking people to needed health services, assuring a competent health workforce exists, researching and evaluating programs, and advocating for CVE-related laws and policies that guard against civil liberties violations and stigmatization.

Protective Factors and Interventions: Scope and Subjectivity

Wynia asked whether the types of interventions under consideration play an important role. If someone is inaccurately predicted to be on the path to violent behavior, he questioned whether it matters which interventions are available in terms of making that judgment. Steele replied that it depends on the scope of the program and the nature of the intervention. If the scope of the program is violence prevention writ large, for example, and the type of intervention is social services, then those services may help an individual to better adjust and could potentially prevent that individual from going on to commit violent extremism. Even if the individual goes on to join a gang, she remarked, it is still positive value for that individual if violent behavior is averted. She contended that when it is a positive intervention in terms of social services, the risk of a false positive may be mitigated, and suggested that the key is to implement an iterative process to determine the right scope of programs, find positive opportunities for intervention, and improve the specificity of intervention tools.

Interventions that practitioners may view as positive and free of risk may not be perceived or experienced as such by the person who receives it, Wynia pointed out. For instance, a practitioner might think that there is no harm in engaging with a person who seems to be on the path to violence and referring the person to counselling. However, if the consequences of that counseling referral are loss of employment and social standing in the community, then that was neither a risk-free nor an inevitably beneficial intervention. Wynia explained that as a practitioner, he tends to categorize public health interventions as binary: either positive or negative. Positive interventions are those that promote health; negative interventions are ones

that prevent the spread of disease. He suggested that there may be a grey area in between where; depending on the person's perspective, an intervention may be positive or negative. He noted that this type of subjectivity seems particularly common in the CVE arena. Steele suggested that integrating health approaches into CVE efforts could bring valuable lessons about how to mitigate that type of stigma, as well as offer guidance about tailoring interventions to reduce the potential for stigma.

In discussing protective factors and the scope of interventions, Wynia noted that much discussion has centered on moving the bell curve by looking at populations and the social determinants of peoples' choices and behaviors. He asked about the appropriate balance between a focus on shifting the bell curve, and a parallel focus on identifying and intervening with people on the path to violence. Steele remarked that CVE is a challenge faced by the whole of society, which thus requires "whole of society" approaches. She suggested that the partners involved in improving and amplifying protective factors may be different than the partners involved in the more narrowly focused interventions. She reported that discussions with partners in the education sector have focused on what type of work can be done to improve protective factors, to deliver positive messages, and to foster a sense of inclusion in schools. She suggested that these are the types of interventions that are more likely to have broad public support, because they are ones in which a range of partners can add value. As a caveat, she noted that those types of interventions should not be implemented to the exclusion of other types of efforts that may have more difficulty in garnering public support.

Public Health Approach to Building Community Resilience

Eisenman called for the public health sector to help promote the concept of community resilience in the context of violent extremism.[4] He defined community resilience from the perspective of public health as "the capacity of the community as a whole to prepare for, respond to, and recover from adverse events and unanticipated crises that threaten the health of all," and suggested that it could be reframed in a way that is pinned toward achieving CVE-specific outcomes. He introduced a public health theory about how to build community resilience after a disaster, and suggested that a similar theory could be effective in the CVE arena (see Figure 5-5).

[4] He noted that several national policies now incorporate community resilience: Federal Emergency Management Agency's (FEMA's) National Disaster Recovery Framework; National Health Security Strategy of the United States (2009); Public Health Preparedness Capabilities; and FEMA ESF #14: Long-term community recovery.

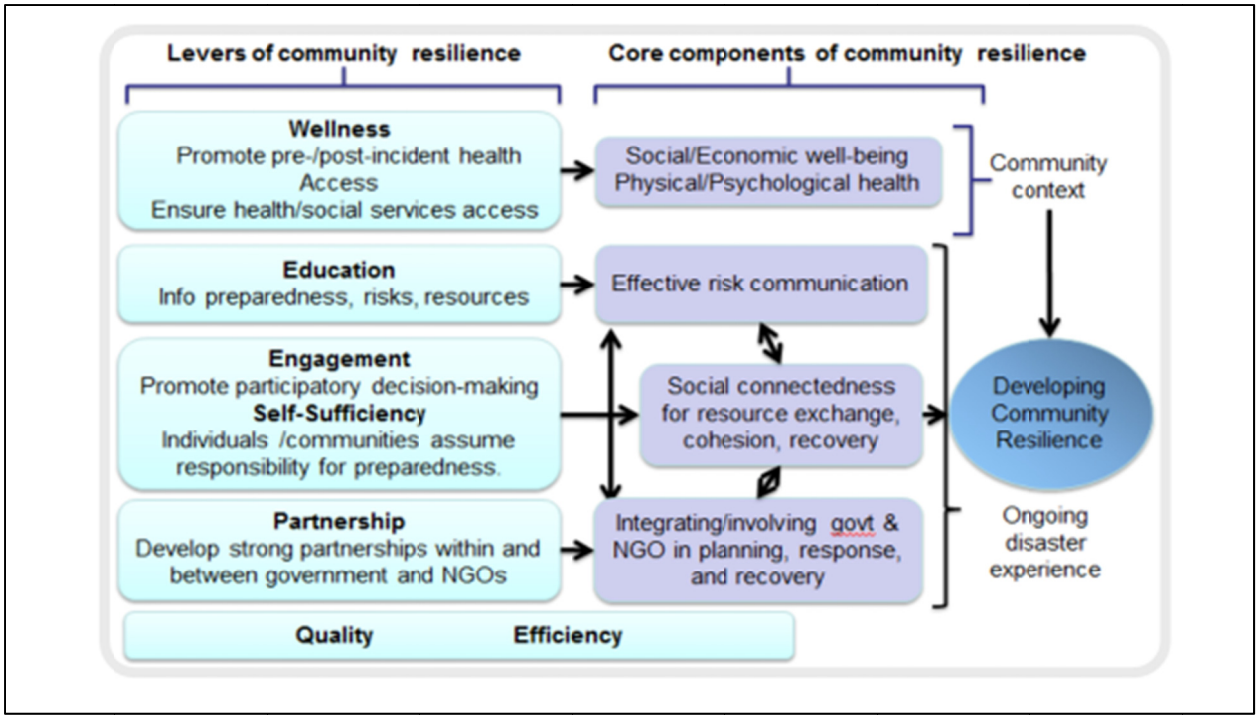

FIGURE 5-5 Theory of community resilience.
SOURCE: Eisenman presentation, September 8, 2016.

According to Eisenman, the theory posits that factors contributing to community resilience include wellness, access, education, engagement, self-sufficiency, partnership, quality, and efficiency. These factors serve as levers to bolster the core components of community resilience within society.

Hick observed, from a practical standpoint, that there is ample room for improvement. He offered the example of overwhelming meningococcemic disease: by the time the disease is eventually recognized and diagnosed in the emergency department, the patient will have a high risk of death even with the best treatment possible. But in the early stages, there is nothing a physician can do to recognize that it is different from any other viral illness, so the only strategy is to vaccinate. Applying the disease analogy to CVE, he suggested there are circumstances in which primordial and primary strategies must provide thrust and "inoculate" the community with culturally competent and specific values. Hick said:

> I can tell my kids hate is not a Christian value, and you can tell your kids, if you're Muslim, that hate is not a Muslim value. How do we continue to build that into the system? Movement of small shifts in the population may make a difference.

Wynia asked whether there may be any potential drawbacks or disadvantages linked to efforts to promote resilience. He went on to say that the only place he had encountered negative feedback about such efforts was in clinical care settings; the perception among the doctors and nurses was that it was an effort to prolong their ability to work. He questioned whether securitizing or medicalizing these types of community-based interventions would run the risk of

a similar response from the public that resilience is being used as a tactic to control political beliefs under the banner of a healthy community. Steele emphasized that resilience is not intended to be about belief system control, but about channeling resilience to nonviolent action. She suggested that there are ways to reduce the risk of violence while still giving a voice to those grievances.

Working on Violence as a Public Health Issue: Reflections from a Practitioner in the Field

Wen introduced the concept "hurt people hurt people" as framing her work in addressing violence from a public health perspective. For example, she reported that among the people currently incarcerated in Baltimore City, 40 percent have mental illness and 80 percent use illegal substances; nationwide, only 11 percent of addicts can get the help they need. She remarked:

> We continue to treat addiction as a moral failing when in fact it is a disease…. Whose fault is it when individuals with addiction end up leaving jail without having their addiction treated in the first place, and then end up in the cycle once more because they do not have employment or because they do not have housing? Whose responsibility is that to break that cycle? We see that as our responsibility in public health to start that conversation, but with the help of everybody else…. We must dig deeper and not just see that person in front of us as the perpetrator of violence.

Wen related a formative experience that informed her understanding of violence as a public health issue. While she was working as an emergency room physician, a teenage patient was admitted with gunshot wounds to the abdomen and chest; health care providers in the room recognized him as having been admitted multiple times with various violence-related injuries over the course of the previous year: a gunshot wound to the arm, a hand fracture from punching someone, and a head injury received in a fight. She characterized him as a powerful exemplar of being caught in a cycle of violence, a cycle in which the perpetrators of violence are often the victim of violence as well. Wen cautioned against looking at what individuals are doing in a single instance without recognizing the policies and circumstances that led to the behavior, such as discriminatory policies in policing, mass incarceration, incarceration of people who have addictions, and treating addiction as a crime and not as a disease.

Wen offered three messages based on her experience working on violence through a public health lens. First, she urged the group to dig deeper and to look beyond individuals as the perpetrators of violence, and to recognize that they are the victims of deep trauma. She explained that in Baltimore City, an ambitious program is in place to train every front-line worker in the city (including social workers, doctors, police officers, and teachers) on trauma-informed care in order to strengthen their abilities to understand, respond to, and treat the impacts of trauma. More than 1,200 people have been trained so far, and the next step is to train every individual in the city who will somehow be in touch with a child to recognize and understand the effects of trauma.

Her second message highlighted the need to invest earlier. In Baltimore, the City Health Department houses the Office of Youth Violence Prevention, predicated on the idea that

investing in early childhood is the best way to prevent violence. She described a program in Baltimore City called "Vision for Baltimore," which was founded in 2016 to achieve one basic goal: to provide glasses to every child in the city who needs them by screening all students in Baltimore City public schools between 2016 and 2019.[5] Less than 20 percent of children who are screened as needing glasses actually have them, leaving up to 10,000 children in the city with uncorrected vision. She emphasized that the simple investment in a child's glasses can potentially be a violence prevention strategy: it may prevent a child from being labelled disruptive and losing traction in school to the point that he or she engages in a cycle that ultimately leads to violence. She stated that investing in children as early as possible is crucial. A program called Baltimore for Healthy Babies, founded in 2009, has thus far resulted in a 28 percent reduction in infant mortality and a 36 percent reduction in teen birth rates. Nurses, social workers, and case workers visiting homes to teach about safe sleep practices and other child rearing practices not only improves a child's educational outcomes, but also reduces the likelihood of the child being involved in violent activities later on in life.[6]

Wen listed her third point as being at the core of public health: looking at the cost of doing nothing. In a sense, she noted, the face of public health is one that does not exist because it saves lives without recognition—from the prevention of food-borne illnesses, to interventions that help mediate conflicts or improve a child's educational outcomes, to intervening in the pathway to violence. She urged everyone involved in public health to talk about the cost of inaction, particularly in high-risk communities.

She explained that the Baltimore Safe Streets program,[7] based on the national Cure Violence program, continues to face funding problems on a yearly basis, despite former gang members and criminals making efforts to stop conflict (mediating nearly 700 conflicts in the previous year) and to give back to their communities. She cited a forthcoming study from Johns Hopkins University that found the Baltimore Safe Streets program to be more effective than any other public health intervention in the previous 10 years, at a cost of just $1.7 million per year, which is dwarfed by the millions of dollars it saves in Medicaid, disability, unemployment, and incarceration. The program is so effective because it is implemented by individuals who have literally walked in the shoes of the people they are helping. Similarly, needle exchange programs have been in place in the city for more than 20 years, reducing the percentage of individuals living with HIV from IV drug use from 64 percent in 2000 to 8 percent in 2014. She posited that its success is driven by the fact that people working on the program are people who are themselves in recovery or living with HIV or hepatitis.

Cure Violence Program: Promoting Local Credible Messengers

Jalon Arthur, director of Innovation and Development for the Cure Violence program, School of Public Health, University of Illinois at Chicago, explained that the national Cure Violence program[8] is an evidence-informed health approach that views and treats violence in all its forms as an infectious health issue, because violence is the leading cause of death in the

[5] Program information available at http://health.baltimorecity.gov/VisionForBaltimore (accessed November 8, 2016).
[6] Program information available at http://healthybabiesbaltimore.com (accessed November 8, 2016).
[7] Program information available at http://health.baltimorecity.gov/safestreets (accessed November 8, 2016).
[8] Program information available at http://cureviolence.org (accessed November 8, 2016).

communities and populations the program serves. He pointed out that like other infectious diseases, violence is not distributed equally: there are epicenters in communities, places like Chicago, Honduras, and Syria. He remarked that violence spreads through exposure, with violence begetting violence: whether it is acts of violence in the home, in the street, in war, or acts of violent extremism.

Many people in communities do not want to see their loved ones or their peers become radicalized, but at the same time, they do not want to see their loved ones or their peers arrested or imprisoned, explained Arthur. Thus, there may be a host of missed opportunities to effectively interrupt the process of radicalization because many people will simply not engage with law enforcement for fear of imprisonment of themselves, loved ones, or peers. In many cases, there is information that is under the radar of the CVE space but known by someone at the community level who does not know how to respond to it.

Credible messengers at the community level can take advantage of their own powerful networks to facilitate a system for efficient detection and response, Arthur emphasized. Empowering community members to serve as a bridge providing critical services for vulnerable people is a critical piece of what Cure Violence and other health approaches can offer, he said. In a community that has a network of credible messengers who are promoting the process of radicalization, it is crucial to empower another smaller credible group within that community to push in the opposite direction away from radicalization.

Training individuals and community groups to recognize people at risk is critical, he explained. A common thread among those who become radicalized is that somebody close to them notices that something is "off" or wrong. By educating a community through the Cure Violence program, or other health-based violence prevention approaches, and by using a pool of credible messengers, a community is able to detect and interrupt this radicalization process. This can provide a trusted and respected alternative to contacting law enforcement. This has been effective in Cure Violence programs within communities where daily shootings used to take place, but have now gone 1–2 years without a single shooting or a homicide. This is an average of a 40–70 percent decrease in violence, according to five independent evaluations, Arthur explained.

Another component of the Cure Violence program is the convening of trusted stakeholders in community forums, town hall meetings, and conferences to strategize and put forth solutions on how to address an epidemic of violence. Arthur explained that these venues offer opportunities to air grievances, share and challenge ideas, exchange perspectives, and present peaceful alternatives. Trusted community insiders can meet without judgement (in the absence of law enforcement), serving as a powerful vehicle for encouraging positive recruitment and allowing people who feel alienated to become part of a bigger group dynamic. He suggested that in the CVE space, given the right trusted messengers, similar approaches could provide platforms for deradicalization.

In regards to CVE, Arthur observed some recurring narratives and concerns that warrant consideration. One is that with a low incidence of violent extremism, many communities are reluctant to buy into CVE efforts at the expense of other issues pervading their communities. Another common concern is that the government has a vested interest in vulnerable communities only to the extent to which the threats—either real or imagined—pose to the larger society. The takeaway for some people at the community level is that whole communities are permitted to suffer through tragedies and more traditional forms of violence, as long as the problems are

contained within that community and do not escalate to what would be considered violent extremism.

He urged that these sentiments should be taken into consideration and warned that programs perceived to be government led can often be counterproductive and lack community-level buy-in, without which the program will not work. He emphasized that even the most well-intentioned and best thought-out efforts and interventions can fail if they are not supported by local community champions who can leverage their own credibility and encourage others to understand that it is a health issue worth engaging.

PUBLIC HEALTH MODELS FOR EVALUATING CVE PROGRAMS

Evaluating Community-Led Interventions

Ramchand remarked that there is a tradition in public health to begin working toward prevention immediately when a crisis emerges, even before the mechanisms that underlie the outcomes are fully understood.[9] Ramchand explained that this tradition holds in the CVE domain: while experts continue to do the important work of investigating the factors that lead certain individuals to violent extremism, community-led organizations and programs are already on the front line implementing interventions to prevent it. However, he emphasized that because little is known about the actual efficacy of the CVE interventions, it is now critically important to scientifically assess and evaluate those programs. He contended that given the resource-constrained environments for funders, assessment and evaluation can be used to guide decisions about which programs should be sustained with funding. Evaluations of how different interventions and activities are working can also inform the science of understanding the potential trajectories of violent extremism, he suggested. A further benefit he highlighted is that instilling a culture of evaluation within those community-led organizations allows them to take ownership of identifying and initiating their own program changes and improvements as needed.

Developing a Tool Kit to Aid Community-Based Organizations: Getting to Outcomes

RAND was commissioned by DHS in 2011 to develop a tool kit to aid community-based programs in evaluating their own CVE programs, explained Ramchand. As an initial step, the researchers turned to an existing resource called *Getting to Outcomes*, an evidence-based approach to evaluation that has been used to aid many community-based organizations in the public health sphere in assessing their own programs. RAND adapted the model to create a similar tool kit for community-based programs seeking to prevent suicide. He noted that there are parallels between suicide prevention programs and CVE programs. For example, the outcomes the programs are seeking to prevent are significant but also very rare, low-base-rate events with high levels of false positives. He observed that this can deter organizations from evaluating their programs, which hinders their ability to adjust and improve. To create a model for evidence-based program evaluation that would be applicable to a diversity of program types,

[9] For example, the Gay Men's Health Crisis was formed in New York City before the HIV virus was identified.

RAND reviewed a corpus of relevant research, drawing on 166 peer-reviewed evaluation studies of suicide prevention programs.

Ramchand explained that the next step was to apply this work toward building a five-step tool kit for CVE program evaluation:

- Step 1: Identify your program's components, and build a logic model.
- Step 2: Design an evaluation.
- Step 3: Select evaluation measures.
- Step 4: Analyze evaluation data.
- Step 5: Use evaluation data to improve the program.

He focused on the formative research that was carried out to understand the activities and outcomes common to U.S.-based CVE programs in order to develop the CVE-focused content for steps 1 and 3. The first step involves programs identifying core competencies and organizing those components in a logic model; he noted that effective evaluations require all of the components of a program to be well specified.

Ramchand detailed how after programs create their own logic model, they are linked to appropriate evaluation measures and available validated metrics that program managers can use to assess and measure the programs' outcomes (step 3 in RAND's five-step tool kit).

To identify the activities, outcomes, and metrics relevant to the CVE space, Ramchand reported that the researchers performed a literature review of prior assessments of CVE programs' effects and limitations. A systematic search of 200 CVE assessment publications produced only seven studies that assessed CVE outcomes and demonstrated the potential effectiveness of those programs. However, he noted that the scientific rigor of those studies was extremely limited compared to other academic disciplines (e.g., lack of control group, lack of empirically validated metrics). A survey was also carried out to identify activities and outcomes common to U.S.-based CVE programs. He reported that researchers were able to carry out successful interviews with 28 of 94 CVE programs contacted (33 percent response rate; program focus: 46 percent Islamic extremism, 54 percent other forms of extremism).

Reasons for Lack of CVE Program Evaluations

To tailor the tool kit for CVE, Ramchand explained, program administrators were asked specifically about evaluation activities and why such activities were not pursued. He reported that the most common reasons cited for the lack of evaluations were lack of resources and administrator uncertainty about data. Regarding the former, Ramchand explained that administrators responded that they did not have enough resources to follow up with participants or conduct surveys, that they had few (if any) staff who are familiar with evaluation, and that they prefer to devote scarce resources to program administration.

Ramchand noted that administrators' uncertainty and confusion about data revealed multiple concerns: they were worried about appearing intrusive in asking for structured feedback from people who participated in the program; they perceived available data options as uninformative (especially with respect to the Likert scale); and they felt uncertain about the most appropriate metrics for their programs. Furthermore, administrators reported struggling with how to measure and demonstrate the counterfactual—the number of extremist acts the program had

prevented. Ramchand suggested that employing proximal outcomes can resolve this issue, allowing administrators to focus on their programs' near-term objectives.

Shaping the CVE Tool Kit

Based on the information gleaned from the literature review and survey, Ramchand noted that the researchers returned to the logic model framework to create a tool kit that was designed to effectively address the barriers identified. He explained that to identify relevant outcomes, programs must clearly specify the audience their activities are targeting. That is, different activities may be geared toward targeting the subset of individuals at risk of committing violent extremism, versus those targeting the families, communities, and institutions that influence or interact with individuals at risk of committing violent extremism.

Once a target audience is specified, the tool kit helps guide programs into considering their likely program objectives. He observed that programs targeting individuals are generally focused on the following outcomes:

- Countering violent extremist opinions and ideology,
- Improving psychological well-being and addressing moral concerns,
- Enhancing positive social networks,
- Reducing political grievances, and
- Improving social and economic integration.

In contrast, he observed that programs targeting the communities surrounding individuals at risk of extremism are generally focused on the following objectives:

- Help community members understand and identify violent extremism and its risk factors.
- Build community capacity to identify and engage with those at risk.
- Build the capacity of positive, influential members to credibly counter violent extremist ideologies.
- Create environments that accept minority groups.
- Promote policies that address political grievances.
- Strengthen capacity to curtail violent extremism.

He explained that identifying their objectives helps guide programs as they customize their logic model. They are then consequently provided with the appropriate available metrics that they can use to assess whether the program is stimulating the intended types of change. Furthermore, he noted that the tool kit provides comprehensive guidance for all five steps of the tool kit, including how to design an evaluation, analyze evaluation data, and use evaluation data to improve programs. The aim, according to Ramchand, is to create an ethos of continuous and ongoing evaluation within programs. Feedback from administrators who piloted the tool kit suggested that cultivating this ethos is crucial, because community organizations will not use the tool kit without active efforts to educate them about the value of evaluation.

Applying a Public Health Approach to the Evaluation of CVE

Lin traced the development of a pilot evaluation program for preventing violent extremism in the greater Boston area. She noted that the project's timeline allowed for independent external evaluators to become involved in a formative evaluation capacity before the pilot was implemented, which informed the program's design.

Lin reported that more than 50 stakeholders from 45 organizations took part in the initial interview process.[10] Two interviewers visited each interviewee's workplace, which were primarily community-based organizations, to gain contextual information about the communities they serve, the programs in place, and the interpersonal relationships at play. Ultimately, the researchers conducted more than 24 hours of interviews and collected approximately 2,000 statements. She emphasized how important it is for evaluators to ensure transparency and timely communication in order to foster trust among interviewees.

The next step, according to Lin, was to identify challenges faced in the design and implementation of violent extremism prevention programs based on the stakeholders' feedback and a thorough review of available literature. The principal challenge they identified concerned the name and scope of the programs; she explained that the controversial history associated with the term *CVE* was discouraging stakeholders' participation. She estimated that 98 percent of interviewees stated bluntly that they would not take part in a program with the CVE label because it would risk undermining the trust and relationships they had worked to build with the communities they serve. Furthermore, she noted a lack of support for any violence prevention program that is too narrow in scope, as in focusing only on a particular subset of the population.

The second challenge Lin's team identified is the lack of a clear, agreed-upon definition for violent extremism and of clear outcomes across CVE programming, according to Lin. To illustrate, she cited the *National Strategy on Empowering Local Partners to Prevent Violent Extremi*sm (The White House, 2011), which defines violent extremists as "individuals who support or commit violent extremism to further political goals." She reported that in trying to use that definition as guidance for defining the outcomes of the pilot evaluation program, the researchers realized that the definition fails to specify what type(s) of ideologies are being referred to, what type of violence is being targeted (for example, whether it should include bullying or verbal discrimination), and what is meant by "support" (for instance, the types of social media interactions that constitute support).

Limited evidence regarding the risk factors for violent extremism emerged as the third challenge, she noted. She explained that this challenge in particular limits the application of secondary prevention strategies that are typically used in the public health sector—namely, screening people in order to detect and treat conditions at an early stage. Thus, the limited evidence available about risk factors obstructs secondary efforts to detect and intervene with people who have the propensity for violent extremist behavior. Essentially, this involves screening people in the precriminal space, because population-level screening for violent extremists is not currently feasible.

Lin explained that without the ability to screen as a secondary prevention strategy, the researchers developed a theory of change that spans the primary, tertiary, and quaternary domains. She detailed how in Boston the theory is informed by feedback from stakeholders

[10] Types of agencies (n = 45): academia (20 percent) and health care and mental/behavioral health (16 percent), which she noted are not mutually exclusive; community-based organizations (40 percent); and government agencies (including law enforcement and schools) (24 percent).

about how to define the program's success, which falls into three broad categories. The first category, building trust and earning social support, addresses the stakeholders' need to be listened to and have their opinions validated, their desire to prevent profiling, and their suggestion to expand community policing. She explained that the second component is designed to address the second category, fostering civic engagement and cultural awareness. Such activities include the provision of safe spaces for encouraging civic conversation and open forums for nonmainstream discussions, increasing diversity in the system (that is, government, social service providers, and schools) and improving cultural sensitivity, as well as developing counternarratives against violence and discrimination. The third category, according to Lin, comprises activities to treat the root causes of violence and violent extremists by improving conditions to the extent that people can reach their full potentials; this includes investing in school system and education initiatives, expanding youth programs and services, addressing housing issues, and nurturing healthy and safe neighborhoods.

Looking forward, Lin reported that in August 2016, the Massachusetts Executive Office of Health and Human Services issued a request for proposals (RFP) for the Promoting Engagement, Acceptance, and Community Empowerment (PEACE) Project to be implemented in Boston. Its goals are to prevent violence (and prevent people from joining organizations that promote, plan, or engage in violence) as well as to promote resilience by strengthening protective factors. She commended the organizers for incorporating stakeholder feedback that was shared with them by the researchers of the evaluation pilot program. Specifically, the most recent RFP for the PEACE project focuses on primary (rather than secondary) prevention and completely excludes concepts such as CVE, radicalization, ideology, and risk factors. She explained that instead, the RFP pinpoints specific results and provides clear definitions of violence and violent extremism as "an act that violates state or federal law and causes physical harm to a person, or property and is motivated by hate and/or the intention of domestic terrorism." She noted that the pilot program has offered its resources for technical support should the PEACE project choose to have an evaluation component of its program.

Evaluating the Capacity of the Mental Health Sector to Support the CVE Enterprise

Stevan Weine is a professor of psychiatry, the director of the International Center on Responses to Catastrophes, and the director of Global Health Research Training at the Center for Global Health, University of Illinois at Chicago. He remarked that many new community-based initiatives to address violent extremism are seeking to engage the mental health sector. He described efforts to incorporate the mental health sector into activities to address both violent extremism and violence writ large within the Los Angeles CVE framework. Because a very large proportion of lone actors who commit violence have mental health and psychosocial problems that necessitate mental health intervention, Weine noted, it is a challenge to find the sufficient organizational capacity and professional expertise to conduct mental health interventions of the scope needed for CVE. According to Weine, there is not yet a credible consensus model to implement and support this work in a way that protects civil rights and civil liberties.

Project Eval LA, a collaboration with UCLA, is a partner of the Los Angeles Region Intervention Steering Committee,[11] and it has prepared a forthcoming formative evaluation report

[11] As discussed by Joumana Silyan-Saba earlier in the report, the LA Regional Steering Committee is convened and coordinated by the Los Angeles Mayor's Office in partnership with the DHS LA Regional Office. It has used a joint

assessing intervention efforts in Los Angeles.[12] Weine shared some of the preliminary findings of the report.

Los Angeles CVE Intervention Services Flow Chart

Weine presented the services flow chart created by the steering committee, which is subdivided into the three domains of community, assessment, and treatment (see Figure 5-6).

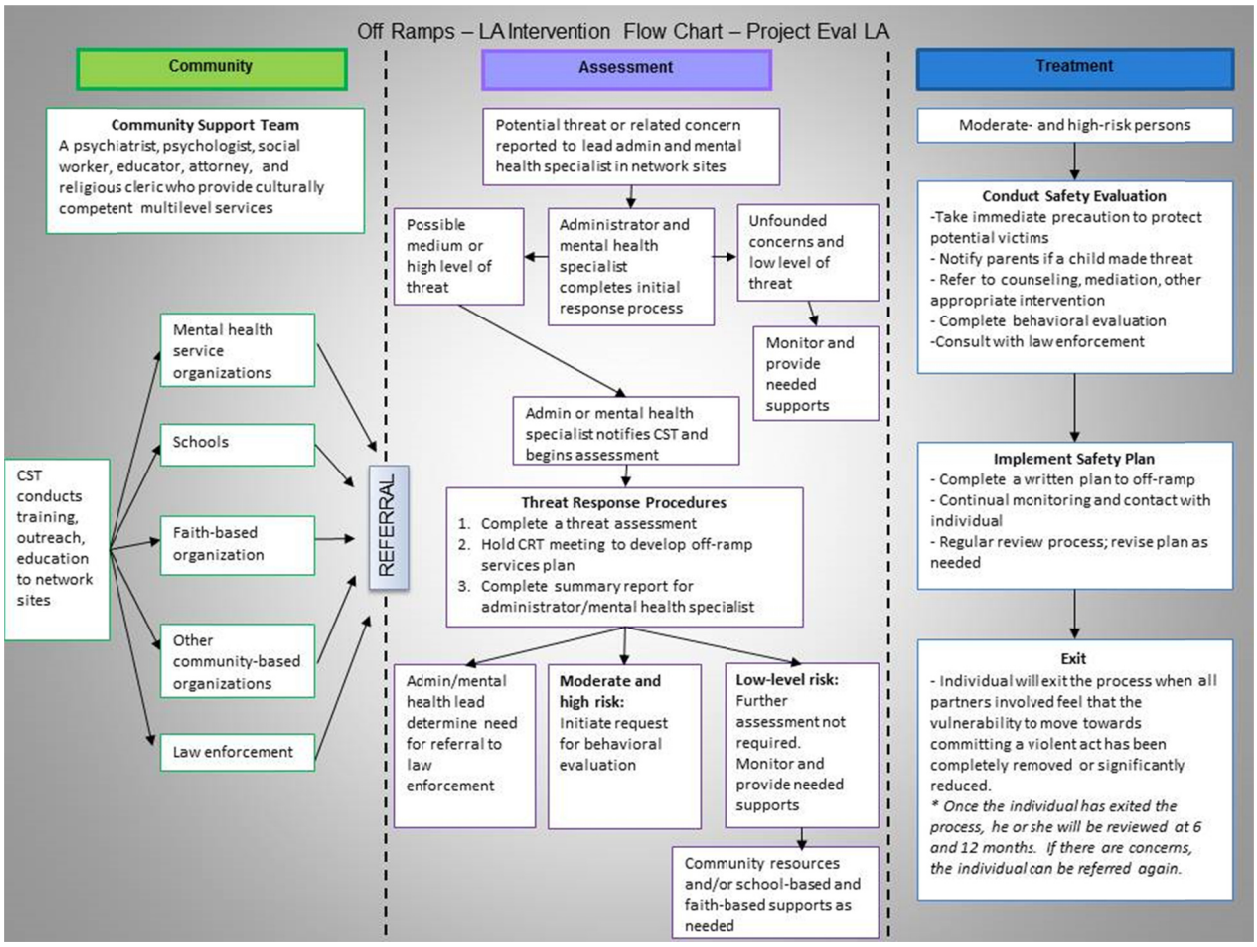

FIGURE 5-6 Los Angeles CVE intervention services flow chart.
SOURCE: Weine presentation, September 8, 2016.

Weine explained that the services flowchart draws heavily on a threat assessment framework used by the School Threat Assessment Response Team program;[13] it is not based on

public health and mental health approach to help augment the Los Angeles CVE framework by building logic models, a services flow chart, evaluation tools, training plans, and other types of supporting materials needed to implement a program.

[12] He explained that such reports are commissioned to ensure that a given program is well formed, is well developed, has clear goals and objectives, has clear outcomes and outputs, has a hypothesized process based on sound theory, and is evaluable.

[13] Run by the LA County Department of Mental Health Emergency Operations Bureau.

radicalization theory but on a pattern of communications and behaviors that people exhibit prior to committing violent extremism. He explained that within the community domain, a community support team composed of multidisciplinary professionals accepts referrals from a wide range of organizations, conducts threat-assessment training, and forges links with a broad network of professionals or paraprofessionals from various organizations. In the assessment domain, a community-based professional (for example, a school or workplace psychologist) conducts the first level of assessment to determine if there is a credible problem that warrants referral to the community support team for further threat assessment and behavioral assessment, or if other types of care or support are appropriate. In the treatment domain, Weine explained, people who have been screened as having a medium to high level of threat, based on established criteria,[14] receive a thorough threat assessment, a behavioral assessment, and a safety plan, all of which are implemented by the community support team. People referred for care receive ongoing case management, law enforcement referral (if needed), social support services, mental health services, a follow-up plan, and a plan for eventual exit from the program as appropriate.

Tabletop Exercise to Assess Mental Health Capacity

According to Weine, the steering committee has grappled with whether the program should be a targeted violence program that incorporates school violence, workplace violence, and hate crimes, rather than focusing exclusively on violent extremism. To explore this possibility, he reported that the steering committee has plans underway to work with LA County DMH to expand the school violence program into a broader violence prevention program that includes expertise on violent extremism.[15]

As part of that process, a pair of tabletop exercises were conducted in July 2016 to assess the performance of the DMH in a CVE situation by using two simulated scenarios of violent extremism. During the exercise, teams of multidisciplinary partners discussed decisions such as determining the veracity of the threat, which types of services to recommend, whether law enforcement should be involved, and how to deal with the community.

Weine reported that the tabletop exercise revealed an instructive panoply of existing capacities and gaps in capacity. It identified 23 existing capacities: for instance, multidisciplinary teams were well established and proficient in working with community members and professionals from multiple disciplines, and the evaluation teams were able to conduct thorough threat and behavioral assessments and cooperate effectively to plan assessments and treatments. However, Weine noted that twice as many gaps (46) were identified as capacities. These included the cultural competency of care regarding Muslim Americans, use of measures and tools, how to make referrals and dispositions, activation and coordination with community leaders and organizations, and monitoring and responding to media.

According to Weine, the exercise revealed that mental health and public health services can make key contributions to targeted violence reduction. Instead of focusing on a very small number of people who may potentially commit acts of violent extremism, the focus with targeted

[14] In a given year, he reported that the department receives between 3,000 and 4,000 referrals for assessment; around 100 people considered to be medium or high risk are screened.

[15] He noted that the DMH is the only organization in Los Angeles with the capacity and professional expertise to perform this type of intervention work on the large scale required (10 million people in 188 cities within Los Angeles County).

violence reduction is on a larger number of people, organizations, and providers involved in violence prevention.

Finally, Weine suggested that tabletop exercises can be an effective way to jumpstart the implementation of targeted violence reduction programs through engagement with the mental health sector, by fostering trust among disparate stakeholders and community partners,[16] and by exposing capacities and gaps to be addressed.

THE ROLE OF HEALTH PROFESSIONALS IN CVE: LEGAL AND ETHICAL ISSUES

Participants discussed the landscape of health professional ethics within the CVE space, focusing on the roles and responsibilities of health professionals with respect to threat assessment and obligatory reporting. Runnels observed that there seems to be a tension between what it means to be a health practitioner involved with CVE and what it means to be someone who does research in these areas, in terms of ethical issues, legal concerns, and the pressures to build an evidence base and actually take action by implementing programs and measures.

Legal Reporting Obligations for Health Professionals

Wynia noted that incidents of extremist violence often spawn legislative attempts to mandate health providers to report on individuals they believe to be dangerous, citing the wave of bills passed in California, New York, and Tennessee in the wake of the 2012 Sandy Hook massacre.[17] Hick observed that there are difficult questions to answer with respect to the specific role of health professionals in reporting suspicious issues, such as whether and when to engage law enforcement. He explained that legal requirements regarding whether the duty to warn and the duty to protect are obligations for providers vary by state (Figure 5-7). In states where both types of reporting are obligatory, if a health provider witnesses any specific threat or thinks there is the probability of a violent occurrence, then it must be reported to the relevant responsible public enforcement agency and the person at risk must be informed.

[16] Weine reported that during the exercise, the strongest critics of CVE were impressed at the sensitive way in which law enforcement, mental health professionals, and others were able to parse the evidence, make determinations, and share (or not share) information.

[17] New York requires mental health professionals to report anyone who "is likely to engage in conduct that would result in serious harm to self or others" to the state's Division of Criminal Justice Services, which then alerts the local authorities to revoke the person's firearms license and confiscate his or her weapons. California mandates a 5-year firearms ban for anyone who communicates a violent threat against a "reasonably identifiable victim" to a licensed psychotherapist. Tennessee requires in-state mental health professionals to report "threatening patients" to local law enforcement, which was passed "in response to mass shootings."

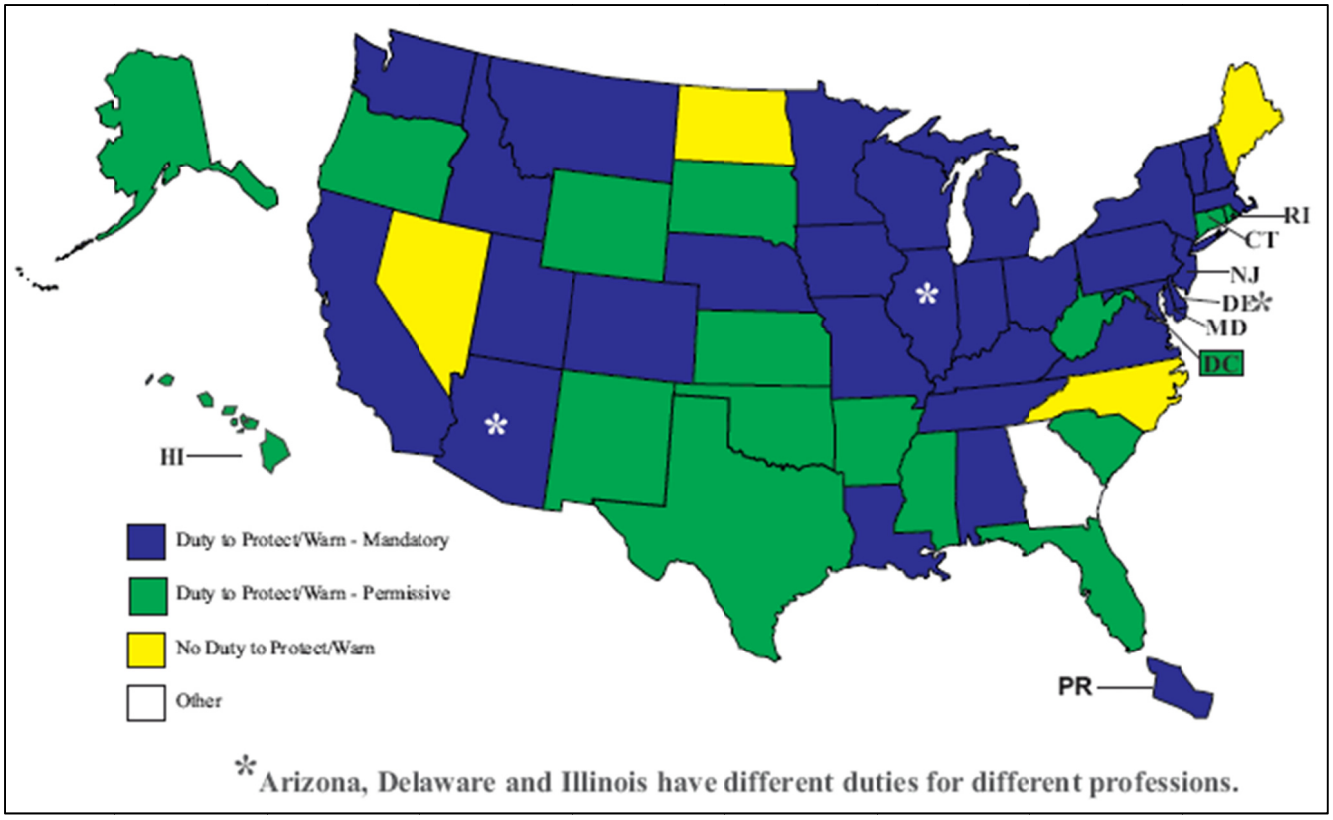

FIGURE 5-7 Reporting obligations nationwide.
NOTE: Green: permitted to report; blue: obligated to report; yellow: no obligation to report.
SOURCES: Hick presentation, September 8, 2016; available at http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx (accessed November 8, 2016).

Hick explained that the 1976 case *Tarasoff v. Regents of the University of California* served as the catalyst for many of the laws concerning the duty to warn and the duty to protect. The case involved a student in California who reported to his psychologist that he was going to kill his female peer. The psychologist reported the claim to law enforcement, but the psychologist did not inform the student that was at risk and her family. He killed the woman when she returned to campus after a study abroad program; her family sued and won a judgment in the case. In the years since, Hick noted that most states have implemented Tarasoff-like laws that oblige health professionals to report specific and probable threats made by their patients. He continued that in many states, medical providers must report any gunshot wound unless law enforcement is already involved, as well as any cases of suspected domestic violence, child abuse, or child neglect. Wynia noted that there are further legal criteria that can be used to breach personal liberties in certain circumstances. For example, HIPAA allows for disclosure to law enforcement with a warrant, including provisions for "intelligence and national security activities" to assure "proper execution of a military mission," and to "provide protective services to the President."

Potential Consequences of Obligatory Reporting for Individuals and Communities

Wynia highlighted the tension between the dual loyalties both inherent and pervasive in health care. Because a small number of people do pose a threat that warrants reporting, health professionals are tasked with striking a delicate balance between their social responsibilities and their duties of care. He emphasized that legislatively mandated reporting inevitably leads to overreporting and false positives, because providers are concerned about the severe consequences of failure to report a patient who goes on to commit violence. However, he pointed out that a false positive report can have a similarly devastating effect on the lives, families, and careers of patients who are reported and then found not to be a threat. Obligatory reporting can also compromise the therapeutic process, according to Wynia, which often requires verbalizing hostile impulses in presumed confidence.

Taking a step back, Wynia observed that there is historical precedence for the practice of requesting (or requiring) health professionals to serve as agents of the state in pursuit of social policy aims under the pretext of protecting the community. He provided several examples to illustrate. The 19th century diagnosis of *drapetomania* was applied to slaves who made "unreasonable" repetitious attempts to escape. California's Prop 187, which was never actually implemented, required physicians to report patients seeking care without appropriate documentation of legal immigration status. In Pakistan, a fake hepatitis B vaccination campaign was designed to gather intelligence on Osama bin Laden; as a result, Pakistan is now home to 60 percent of the world's polio cases after trust in the vaccination enterprise was decimated. In 2013 in New Mexico, at least three people were brought into the hospital under suspicion after routine traffic stops and subjected to rectal exams, colonoscopies, and CAT scans—none of which resulted in any evidence of criminal activity.

Wynia reiterated that missteps and overreach in this arena can be catastrophic for patients, referring to the U.S. Supreme Court case of *Buck v. Bell* (1927), which justified the forced sterilization of Carrie Buck. In his decision, Justice Oliver Wendell Holmes stated:

> We have seen more than once that the law may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices…in order to prevent our being swamped with incompetence…. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough.

The issue persists today, noted Wynia, who is member of a panel for the American Psychological Association (APA) that is considering how to respond to the *Hoffman Report*, which showed that key leadership and staff at the APA colluded in the coercive interrogations program during the Bush administration, which included aspects of research on how best to torture people.

Hick remarked that making a report that turns out to be false can have severe and unintended consequences not only for the individual, but for the cultural community at large. Hick cited the example of an EMS crew being called to transport a woman who was ill from an apartment complex in Minneapolis in which the majority of residents were Somali. The crew

noticed large amounts of electronic supplies, metal cylinders, and other initially suspicious items; they reported it to their supervisor and then to the police. Ultimately it was determined that a man living in the apartment was a radio control vehicle enthusiast. The situation was resolved, but according to Hick, it undermined relations between the EMS and other residents of the apartment complex (e.g., instead of allowing crews to enter to their apartments, residents would bring the family member needing care down to the lobby). He remarked that although the incident was well intentioned, it created a major trust problem. He suggested that while failing to report a threat that comes to fruition in a terrorist attack can have severe consequences, there needs to be appropriate care taken in reporting suspicious activity.

Hick further noted that suspected child neglect can sometimes require a nuanced understanding of cultural context because it can expose the discrepancies between Western medicine and medical traditions of immigrant communities. He explained that providers are protected from legal repercussions if the report is in good faith, but that does not mitigate potential cultural backlash. For example, reporting can result in the state taking protective custody of children who are considered to be at risk based on Western medical criteria but whose parents decline further diagnostics or interventions. He commented that this can severely destabilize the immigrant community's trust in providers (which has happened in both the Hmong and Somali communities in Minneapolis).

Wynia remarked that despite the tenets of the Hippocratic Oath, in which protecting patients' privacy and confidentiality is a key principle, upholding confidentiality is not an absolute value for health professionals. He emphasized that there are no absolute values in biomedical ethics. He explained that the most common means of analyzing ethical problems in medicine is called principalism, which involves balancing all the relevant principles to optimize the overall outcome while conceding that not every principle will be optimized. In the realm of ethics, remarked Wynia, the key criteria in determining when it is ethically justifiable to breach confidentiality include credible threat, significant harm, the presence of an identifiable third party, and the likelihood that the warning will be effective.

Practical and Ethical Challenges in Individual Threat Assessment: Health Approach Perspective

Can Health Professionals Predict Violent Behavior?

Health professionals' poor ability to accurately detect a credible threat is a critical concern, according to Wynia, particularly when the determination is used as justification for breaching civil liberties. He cited data from the 1970s suggesting that physicians are no better than chance at predicting whether an individual will become violent. That said, he conceded that the best possible study design to examine that capability would be completely unethical because it would require tracking individuals who are predicted to be dangerous while letting them roam free. However, he noted that a 1967 U.S. Supreme Court decision (*Baxtrom v. Herold*) released 967 "criminally insane" patients from prison because they were not receiving therapy for their mental illnesses, despite being evaluated annually for dangerousness.[18] The patients were tracked for 4 years after their release, and only 2.2 percent (n = 21) were returned to prison for any

[18] In addition, they had spent more time in prison than they would have had they been convicted of their original crime rather than being judged criminally insane.

criminal act (error rate ~97 percent). A subsequent study (Lidz et al., 1993) revealed these types of predictions of violence have poor differential ability, reported Wynia. Of 357 patients who were tracked in the study, 53 percent of the individuals whose psychiatrists predicted they might commit violence did so within 6 months; however, 36 percent of patients predicted not to be violent actually did commit violence.

Wynia reflected that although practitioners and studies do have a very difficult time accurately predicting individuals who are going to commit violence, it is not impossible. He pointed to the human instinct that makes us feel that it is possible to tell when a person you observe is potentially dangerous. Benjamin commented that individual threat assessment is contingent on a clinician's ability to be astute in the difficult task of "connecting the dots" to recognize that an individual is in the spectrum of threat. He observed that further upstream, public health focuses on risk assessment by astute citizens who "see something and say something." Both approaches need to be further refined. Miller raised the issue of how exposure to vicarious trauma may lower the threshold for health care providers' perception of individual-level and community-level threats. Stewart suggested that the poor ability to predict violence may be attributable to the wrong questions being asked or, perhaps, because it is not predictable at all, despite how counterintuitive that may seem.

Hick explained that the types of credible or probable direct threats for which providers are routinely vigilant are different than the suspicious activities they are asked to report with respect to the threat of violent extremism. CVE threats also have a slightly different threshold. Hick noted that in other contexts, providers are given anticipatory guidance (e.g., questions about suicide risk or domestic violence) that is based on known risks and relatively well-established community-wide interventions with known efficacy. In the CVE space, he explained, it is very difficult to select the appropriate interventions and to select the population at risk. He suggested that by the time an individual's behavior raises red flags that are sufficient for a health care provider to act from legal and other obligatory standpoints, there are often concerns over whether the evidence is sufficient to mandate an assessment or to place restrictions on that person. He expressed doubt that there is much scope for health care providers (from a recognition and treatment standpoint) to do more than perform the types of mental health threat assessments that are already standard practice, without giving rise to significant ethical concerns.

Hick noted that a common criticism leveled against threat assessment is that certain factors can be more heavily weighed and thus prone to subjective bias, but he remarked that this is also a problem with most psychological assessments. He contended that many nonmental health providers have an instinctive feeling about patients that factors into risk assessment; even though there are some criteria they consider when performing assessments, it is by no means a rigid proscriptive set of criteria.

Threat Assessment Methodology and Expertise

Weine observed that the threat assessment field grapples with the issue of whether the people being targeted in CVE interventions are the same people who go on to commit violence, and if efforts should be targeted on a specific subset of people. He advised that there must be a way to differentiate between a person with an overt and potentially modifiable emotional disturbance who is also considering violent behavior, and a person who is a committed criminal who has just not acted violently yet; only the former person would be responsive to CVE-type case management or treatment.

Runnels noted that public health tends to focus its efforts on the broader community, and questioned what the implications of an individual risk assessment strategy would be when dealing with larger populations. Lin explored the issue of population-level screening for violent extremism in her presentation. She explained that a screening program is only as good as the predictive ability of the risk factors on which the population being screened is based. It is also heavily dependent on the prevalence of what is being screened for, so screening is not usually feasible for rare outcomes. The key question in considering a screening test for violent extremism, she explained, is to determine how likely it is that a person with a positive test result is actually a violent extremist. She described the following thought experiment to illustrate the answer.

As of 2016, the United States population was 323 million, including a presumed 10,000 violent extremists. If there were an extremely powerful hypothetical screening test that could pick up 99 percent of violent extremists when screened, then screening the population would identify 9,900 violent extremists (true positives) and miss 100 of them (false negatives). If the hypothetical test also had a 99 percent specificity, then the test would correctly identify more than 320 million people as innocent (true negatives). However, it also means that more than 3.2 million people will be incorrectly labeled as being violent extremists despite being innocent, which is an extremely high number of false positives. In statistical terms, the positive predictive value of this very powerful hypothetical screening test is just 0.3056 percent.[19]

Thus, Lin concluded that population-level screening for violent extremism is not possible at the current stage. She clarified that no screening test with 99 percent sensitivity or specificity actually exists; generally, these types of tests have specificity of between 70 percent and 80 percent.

Wynia noted that individual threat assessment does not typically employ population-level strategies because they do yield such high numbers of false positives. Instead, they target a very rich sample of individuals in clinics and emergency departments who have a high probability of violence prior to screening, which makes testing that sample worthwhile. Wynia stated that a specificity level of 70–80 percent is acceptable in a sample where the probability of disease is high: "If we start with 9 out of 10 people who are going to be doing something bad anyways, then having a 70 percent test is good enough."

Hick commented that Bayes' Theorem is also relevant: when testing a high-probability population for the presence of a disease, the performance of that test is likely to be much better and much more predictive; if the test is applied to everyone in the population regardless of risk, then the performance of the test becomes significantly worse and results in a tremendously higher number of false positives. He emphasized that deciding who should be screened is incredibly important, regardless of the performance characteristics of the test. Lin remarked that this type of testing is only one indicator that factors into clinical judgment and not its sole basis. She highlighted the importance of differentiating between assessment tools and diagnostic tests: assessment tools attempt to predict a future outcome (as in suicide assessment). Diagnostic tests confirm or determine the presence of a condition. Beyond clinical decisions, she argued, the focus should be on ethical issues as well as understanding the limitations of these tests in order to improve them.

[19] Positive predictive value (PPV) = 9,900 true positives/true positives (9,900) + false positives (3,229,900) = 0.003056 (0.3056 percent).

Wynia remarked that typical types of nondichotomous clinical testing (e.g., predictions about the likelihood of a heart attack or of losing a limb due to diabetes) operate on a receiver operating characteristic (ROC) curve, which requires determining what counts as positive and what does not. Moreover, the same will be true of threat assessments; what "score" on a threat assessment should count as a positive or negative result? He explained that the task of threat assessment in the CVE arena becomes even more complex because unlike most medical testing, the intervention of doing the assessment itself can end up affecting the person's subsequent behaviors (he likened this to a kind of Hawthorne effect). He noted that there are analogues in medicine: it is possible, for example, that after telling a patient that he or she is on a path toward diabetes based on the hemoglobin A1C test, the patient suddenly changes his or her behavior. Even though the hemoglobin A1C test actually is predictive of progression to diabetes, some people get that information and change their behavior as a result. For any test that is a predictor of future activities over which the individual has a choice, he explained, it is more challenging to calculate things like an ROC curve, positive predictive value, or sensitivity/specificity (he noted that these are commonly used terms in public health and medicine, but they are difficult to apply to behavioral issues).

Eisenman clarified that there are other tests outside of the domain of the threat assessment approach, which itself is not supported by a huge body of evidence. However, the school-targeted threat assessment approach is considered the best practice based on the models built out at Virginia Tech. He explained that the approach is not dichotomous in the "no violence" versus "yes violence" sense; rather, at the barest minimum, it categorizes individuals as low, medium, and high risk. Furthermore, he noted that medium-risk and high-risk individuals generally are not lost to follow-up because almost all of them continue to receive ongoing follow-up services. In that sense, he argued, the school-targeted threat assessment approach is not strictly a test but actually a complex intervention.

Weine cautioned against lumping together the psychiatric and psychological assessment of suicide and homicide with the practice of threat assessment. He suggested that while the average clinical mental health professional does have a poor ability to predict violent behavior, the emerging discipline of threat assessment is an entirely different, highly specialized discipline beyond the realm of the average emergency room physician's or outpatient clinician's expertise. He remarked: "Nobody is trying to take health professionals and turn them into proxy for law enforcement to do investigations. This would be a serious error, ethical and otherwise." He noted that that there is a body of specialized knowledge and practice that is being applied to the task of training to assess threats. However, he emphasized that threat assessment is not a "witch hunt" or designed to encourage people to report on each other to "drum up cases." Rather, he explained that the aim is to create resources within institutions so when people do make threats, somebody with the appropriate expertise is assessing them.

Ramchand remarked that although discussions of screening protocols and their predictive power are important, there is also a need for more discussion about how to intervene with people who screen positive. In suicide prevention, he noted, an effective and low-cost intervention (that has been replicated) is to send a letter to people after they have been discharged from outpatient clinics that says "You may do fine, that's great, but if you're not, we're here for you, and you should come back." He argued that if such low-cost interventions might help even a small percentage of individuals they reach, then that should supersede concerns about the false positive rate.

Cultural Relativism: Implications for Mental Health and Threat Assessment

Hick described how the Minneapolis, Minnesota, area is home to more than 25,000 Somali immigrants (representing one-third of the U.S. Somali population), many of whom maintain very close ties to their homeland. Assimilation-related issues are very common in the community,[20] and they are complicated by longstanding and targeted efforts by Al-Shabaab and other organizations to recruit community members to enter conflicts abroad.[21] Hick noted the widespread belief that Somali youth in Minneapolis are susceptible to radical messages and are at potential risk of committing violent extremism. He further stated that the vulnerabilities that drive certain individuals into such ideologies are not necessarily predictable on the basis of sociodemographics or various types of anticipatory guidance for health providers.

To illustrate, he described how the perception of mental health and disease is very different among the Somali population than among other populations. While stigma surrounding mental health issues still persists in the United States, he explained that mental health is immensely more stigmatizing in Somalia, and persons are usually categorized in strictly binary ways: crazy or sane. A person deemed crazy will often suffer social indignities, and their family will also be ostracized from fear of a genetic component of the mental condition. Yet, because of the amount of psychological trauma, physical trauma, and abuse that they have endured, he reported that more than one-third of Somalis have diagnosable mental health conditions. Many of their mental health conditions manifest in physical ways, such as chronic abdominal pain and headaches and make them more difficult to conceal from others. He explained that to find out what is actually going on with a Somali patient requires setting aside at least 30 minutes and saying, "Tell me the news." For Somali patients, the "news" covers everything that is happening in the community and its impact on their personal physical and emotional health. Because providers' time constraints make such lengthy visits infeasible, Hick explained that providers have established a specific Somali clinic staffed by Somali liaisons that are available to devote adequate time and then liaise about what they learned with a team that includes medical professionals, allowing for more sensitive detection of mental health issues, as well as assessment for potential risk.

Ongoing trust issues and concerns about profiling have proven challenging. Hick noted that progress is very slow, and a single high-profile incident can be a huge setback. However, he suggested that there may be an opportunity to use funding directed to CVE—regardless of ideological or procedural concerns—to promote community-wide equity of access to chronically underresourced mental health services.

[20] He noted the important benefits to be derived from immigrants maintaining their cultural identities, but that it should be balanced with efforts to ensure that they are accepted (and feel like) members of the community.
[21] He reported that in 2015, six people were arrested and indicted for planning to go and join ISIL, and were in various stages of prosecution as of September 2016. Another Somali who left Minneapolis in 2007 has been linked to continuing ongoing aggressive recruitment efforts on the Internet.

6
Ways Forward in CVE

This workshop acknowledged many challenges in countering violent extremism, but it also identified potential solutions by applying public health and medical health practices. Wynia drew an analogy likening the relationship between the current CVE endeavors and traditional counterterrorism to the relationship between public health and traditional medical care. CVE and public health have origins of "heroic" interventions that many feel were too often ineffective and counterproductive. He explained that, just as the resources available to CVE remain modest compared to those available to more traditional counterterrorism tools (i.e., military and law enforcement), public health also remains underresourced compared to traditional medical care. Furthermore, he suggested that when public health approaches are poorly implemented, like community engagement efforts in CVE, they can yield negative unintended consequences. He contended that the focus in the CVE sphere on "conditions in society that may create an environment in which individuals can become more easily radicalized" is a direct analogue to public health work on social determinants of health, with both arenas facing challenges in defining and delimiting their respective fields and in defining their foundational concepts and objectives. Finally, he cautioned that hubris in using the tools of public health has led to the worst ethical failures in the history of medicine, which underscores the consequences of using positive versus negative approaches to public health.

Wynia outlined a set of five potentially useful lessons from public health and medicine that could contribute to CVE efforts. The first is to move upstream, because prevention is more efficient and effective the further upstream to the event you can go. However, he noted that this gives rise to ethical dilemmas about performing interventions on people at incrementally lower risks of committing violent acts. His second lesson is not to underestimate the social determinants and the role of such socioenvironmental factors as very strong drivers of individual behaviors. He remarked that this may be at odds with the prevailing tendency in medicine, and in society in general, to construe individuals' behaviors as though they always reflect voluntary, rational choices, uninfluenced by the environments in which they live. The third lesson he offered is to seek small shifts in large populations, rather than large shifts in small populations; he argued that there are tremendous benefits in moving a bell-shaped distribution curve of behavior even slightly. Fourth, he recommended using a clear "conceptual model" that can guide decisions about resource allocation and the development and evaluation of interventions, as well as forcing careful consideration about the assumptions that underlie them. Finally, he warned that utilitarian thinking can backfire. He suggested that in some cases—and perhaps in many various facets of CVE—the best way to achieve an objective is not to aim at it directly: "Nudges might work better than mandates."

Based on her observations during the workshop, Runnels offered the following set of challenges and needs pertaining to health approaches to CVE:

- Weigh the benefits, challenges, and drawbacks of applying public health, mental health, and health care models to the prevention of extremist violence.
- Explore what it means for public services to be engaged in the CVE space.

- Learn how to use data appropriately, without segmenting and targeting specific populations.
- Foster effective and inclusive partnerships that engage the relevant stakeholders from multiple domains (e.g., community members, community-based organizations, law enforcement, policy makers, health providers, nonclinical providers, public health expertise), and mitigate "turf" issues moving forward.
- Maintain ethical standards at all levels and between all levels of program design and implementation.
- Address the issues of fear and mistrust, including the negative perspective of government as a tool of oppression and marginalization.
- Consider the lack of an evidence base for the threat of violence motivated by extremist ideology.

While many challenges involved in CVE remain, this workshop demonstrated that there is also a great deal of interest in continuing to modify and improve these efforts so they will help communities to become more resilient as they provide nonviolent avenues for individuals to express their grievances. Many of the speakers and participants at this workshop expressed their belief that a public health approach to countering violent extremism would give communities strategies for how to engage and educate at-risk individuals. Furthermore, it was suggested that studying and establishing best practices could result in stronger, healthier, and safer communities that also counter extreme violent behavior.

References

Australian Government. 2016. *Living safely together*. https://www.livingsafetogether.gov.au/informationadvice/Pages/what-is-radicalisation/what-is-radicalisation.aspx (accessed November 8, 2016).

Beutel, A. J. 2009. *Building bridges to strengthen America: Forging an effective counterterrorism enterprise between Muslim Americans and law enforcement*. Washington, DC: Muslim Public Affairs Council. http://www.mpac.org/assets/docs/publications/building-bridges/MPAC-Building-Bridges--Complete_Unabridged_Paper.pdf (accessed November 8, 2016).

Hafez, M., and C. Mullins. 2015. The radicalization puzzle: A theoretical synthesis of empirical approaches to homegrown extremism. *Studies in Conflict and Terrorism* 38:958–975.

Hudson, V. M., B. Ballif-Spanvill, M. Caprioli, and C. Emmett. 2012. *Sex and world peace*. New York: Columbia University Press.

Khan, H. 2015. Why countering extremism fails: Washington's top-down approach to prevention is flawed. *Foreign Affairs*, February 8.

Lidz, C. W., E. P. Mulvey, and W. Gardner. 1993. The accuracy of predictions of violence to others. *JAMA* 269(8):1007–1011.

Romaniuk, P. 2015. *Does CVE work?: Lessons learned from the global effort to counter violent extremism*. Goshen, Indiana: Global Center on Cooperative Security.

Weine, S., D. P. Eisenman, J. Kinsler, D. C. Glik, and C. Polutnik. 2016. Addressing violent extremism as public health policy and practice. *Behavioral Sciences of Terrorism and Political Aggression* 1–14. http://www.tandfonline.com/doi/abs/10.1080/19434472.2016.1198413?journalCode=rirt20 (accessed November 8, 2016).

The White House. 2011. Empowering local partners to prevent violent extremism in the United States. https://www.whitehouse.gov/sites/default/files/empowering_local_partners.pdf (accessed November 8, 2016).

Appendix A

Workshop Agenda

Forum on Medical and Public Health Preparedness for Catastrophic Events

Health Approaches in Community-Level Strategies to
Countering Violent Extremism and Radicalization: A Workshop

September 7–8, 2016

AGENDA

Location: Auditorium—National Academy of Sciences Building
2101 Constitution Avenue, NW, Washington, DC 20418

WORKSHOP OBJECTIVES

1. Review the evolving threat of ideologically motivated violence and radicalization within communities across America.
2. Discuss the root causes of vulnerability to recruitment to ideologically motivated violence and radicalization.
3. Review relevant conceptual models in health (e.g., public health, health care, mental and behavioral health), and discuss their applicability to countering ideologically motivated violence and radicalization.
4. Explore cross-sector and interdisciplinary emerging and novel policy and practice frameworks and issues in countering ideologically motivated violence.

Note: Breakfast will not be served. Boxed lunches will be provided.

8:30 am	**WELCOME AND OVERVIEW OF THE DAY** *Matthew Wynia (workshop chair), director, Center for Bioethics and Humanities, University of Colorado*
8:35 am	**PANEL KEYNOTE: BRIDGING HEALTH AND COUNTERING IDEOLOGICALLY MOTIVATED VIOLENCE APPROACHES** *Moderator: Matthew Wynia (workshop chair), director, Center for Bioethics and Humanities, University of Colorado* *George Selim, director, Office for Community Partnerships, U.S. Department of Homeland Security and White House Countering Violent Extremism Task Force* *Heidi Ellis, director, Refugee Trauma and Resilience Center; associate professor of psychology, Harvard Medical School*

9:15 am	**PANEL SESSION I: IDEOLOGICALLY MOTIVATED VIOLENCE: WHAT IS IT? IS IT EVOLVING? HOW HAVE WE APPROACHED IT?** • Objective 1: Develop a shared language; describe ideologically motivated violence and radicalization. • Objective 2: Review traditional approaches and challenges at the local and national levels. • Objective 3: Understand the history and characteristics of radicalization. *Session Chair: Susan Szmania, senior advisor, Office for Community Partnerships, Science and Technology Directorate, U.S. Department of Homeland Security* *Speaker: Irfan Saeed, director, Office of Countering Violent Extremism, Bureau of Counterterrorism and Countering Violent Extremism, U.S. Department of State* *Speaker: Michael Jensen, senior researcher, National Consortium for the Study of Terrorism and Responses to Terrorism (START), University of Maryland* *Speaker: Mark Stainbrook, assistant chief, San Diego Harbor Police; senior fellow, Potomac Institute* *Speaker: Peter Romaniuk, associate professor, Department of Political Science, John Jay College of Criminal Justice, The City University of New York*
10:45 am	**BREAK/NETWORKING**
11:15 am	**FACILITATED DISCUSSION** *Facilitator: Laura Runnels, LAR Consulting*
11:45 am	**LUNCH/NETWORKING**
12:45 pm	**PANEL SESSION II: RETHINKING THE ROOTS OF RADICALIZATION TOWARD IDEOLOGICALLY MOTIVATED VIOLENCE** • Objective 1: Explore root causes driving violence and how these might be different from the traditional perception of causes. • Objective 2: Discuss the value or implications of rethinking the sources of violent extremism. *Session Chair: Louise A. Flavahan, program officer, Forum on Global Violence Prevention, Board on Global Health, National Academies of Sciences, Engineering, and Medicine* *Speaker: Leana Wen, health commissioner, Baltimore City* *Speaker: Jalon Arthur, director, Innovation and Development, Cure Violence, School of Public Health, University of Illinois at Chicago* *Speaker: Kiersten Stewart, director, public policy and advocacy, Futures Without Violence*

1:30 pm	**FACILITATED DISCUSSION** *Facilitator: Laura Runnels, LAR Consulting*
2:00 pm	**PANEL SESSION III: CONTEMPORARY APPROACHES TO COUNTERING IDEOLOGICALLY-MOTIVATED VIOLENCE (PART 1)** • Objective 1: Explore and examine cross-sector and interdisciplinary emerging or novel policy and practice frameworks and issues in countering ideologically motivated violence. • Objective 2: Discuss possible barriers and facilitators to applying nontraditional approaches to countering ideologically motivated violence in the United States. *Session Chair: Joumana Silyan-Saba, director, City of Los Angeles, Mayor's Office of Public Safety; adjunct assistant professor, California State University, Dominguez Hills* **LOS ANGELES: A CASE STUDY** *Speaker: Haroon Azar, regional director, Office of Community Partnerships—Los Angeles, U.S. Department of Homeland Security* *Speaker: Joumana Silyan-Saba, director, City of Los Angeles, Mayor's Office of Public Safety; adjunct assistant professor, California State University, Dominguez Hills* *Speaker: Michael Downing, deputy chief, Counterterrorism and Special Operations Bureau, Los Angeles Police Department* *Speaker: Jihad Turk, president and dean, Islamic Graduate School, Bayan Claremont University*
3:00 pm	**FACILITATED DISCUSSION** *Facilitator: Laura Runnels, LAR Consulting*
3:30 pm	**BREAK/NETWORKING**

4:00 pm	**PANEL SESSION III: CONTEMPORARY APPROACHES TO COUNTERING IDEOLOGICALLY MOTIVATED VIOLENCE (PART 2)** • Objective 1: Explore and examine cross-sector and interdisciplinary emerging or novel policy and practice frameworks and issues in countering ideologically motivated violence. • Objective 2: Discuss possible barriers and facilitators to applying nontraditional approaches to countering ideologically motivated violence in the United States. *Session Chair: Joumana Silyan-Saba, director, City of Los Angeles, Mayor's Office of Public Safety; adjunct assistant professor, California State University, Dominguez Hills* **Contemporary Approaches** *Speaker: Hedieh Mirahmadi, president, World Organization for Resource Development and Education* *Speaker: Alejandro Beutel, researcher, countering violent extremism, National Consortium for the Study of Terrorism and Responses to Terrorism (START), University of Maryland* *Speaker: Rebecca Skellett, Strong Cities Network manager, Institute for Strategic Dialogue*
4:45 pm	**FACILITATED DISCUSSION** *Facilitator: Laura Runnels, LAR Consulting*
5:20 pm	**RECAP AND REVIEW OF DAY 2 SESSIONS AND OBJECTIVES** *Matthew Wynia (workshop chair), director, Center for Bioethics and Humanities, University of Colorado*
5:30 pm	**ADJOURN DAY 1**

September 8, 2016

8:30 am	**WELCOME AND OVERVIEW OF THE DAY** *Matthew Wynia (workshop chair), director, Center for Bioethics and Humanities, University of Colorado*
8:45 am	**KEYNOTE: MODELS OF THOUGHT IN HEALTH AND APPLICATIONS TO COUNTERING IDEOLOGICALLY MOTIVATED VIOLENCE AND RADICALIZATION** *Georges Benjamin, executive director, American Public Health Association*

9:00 am	**PANEL SESSION IV: APPLYING HEALTH MODELS AND APPROACHES TO COUNTERING IDEOLOGICALLY MOTIVATED VIOLENCE** • Objective 1: Review relevant conceptual models in health, health care, and behavioral health. • Objective 2: Examine applicability of conceptual models in health to countering ideologically motivated violence. • Objective 3: Discuss possible areas of confusion and adverse outcomes from health approaches to countering ideologically motivated violence. *Session Chair: Dan Hanfling, chair, Forum on Medical and Public Health Preparedness for Catastrophic Events; contributing scholar, University of Pittsburgh Medical Center Center for Health Security* *Speaker: John Hick, deputy chief EMS medical director, medical director for Emergency Preparedness, Hennepin County Medical Center* *Speaker: David Eisenman, professor of medicine and public health, David Geffen School of Medicine, UCLA, and UCLA Fielding School of Public Health, director UCLA Center for Public Health and Disasters* *Speaker: Leesa Lin, senior program manager, Emergency Preparedness Research, Evaluation and Practice (EPREP) Program, Division of Policy Translation and Leadership Development, Harvard T.H. Chan School of Public Health* *Speaker: Stevan Weine, professor of psychiatry, director, International Center on Responses to Catastrophes; director, Global Health Research Training, Center for Global Health, University of Illinois at Chicago* *Speaker: Rajeev Ramchand, senior behavioral scientist, RAND Corporation* *Speaker: Matthew Wynia (workshop chair), director, Center for Bioethics and Humanities, University of Colorado*
10:45 am	**BREAK/NETWORKING**
11:00 am	**FACILITATED DISCUSSION** *Facilitator: Laura Runnels, LAR Consulting*
11:45 am	**LUNCH/NETWORKING**
1:00 pm	**SESSION V: A PATH FORWARD** • Objective 1: Discuss important action items and next steps to leveraging health concepts and approaches to countering ideologically motivated violence, gaps in necessary knowledge, and the challenges or barriers involved. *Speaker: Warner Anderson, assistant professor, Military and Emergency Medicine, Uniformed Services University of the Health Sciences; formerly director, International Health Division, Office of Assistant Secretary of Defense*

	FACILITATED DISCUSSION (PART 1) *Facilitator: Laura Runnels, LAR Consulting*
2:00 pm	**BREAK/NETWORKING**
2:30 pm	**FACILITATED DISCUSSION (PART 2)** *Facilitator: Laura Runnels, LAR Consulting*
4:00 pm	**CLOSING REMARKS** *Brette Steele, acting deputy director, White House Countering Violent Extremism Task Force, U.S. Department of Justice* *Matthew Wynia (workshop chair), director, Center for Bioethics and Humanities, University of Colorado*
4:30 pm	**ADJOURN DAY 2**

Appendix B

Workshop Statement of Task

An ad hoc committee will organize a 2-day public workshop in Washington, DC. Through this workshop, the committee will convene a panel of individuals with expertise in health care, behavioral health, public health, homeland security, law enforcement, and countering violent extremism to discuss and examine applying health-centered approaches (e.g., public health, health care, mental and behavioral health) in community-level strategies to countering violent extremism (CVE) and radicalization. Countering violent extremism (CVE) consists of various prevention and intervention approaches to increase the resilience of communities to violent extremist recruitment narratives, provide nonviolent avenues for expressing grievances, educate communities about the threat of online recruitment and radicalization to violence, and other innovative community-based approaches.

Specific topics that may be explored in this workshop include

- The evolving threat of violent extremism and radicalization within communities across America
- Traditional approaches to countering domestic violent extremism and radicalization
- Consideration of health-centered approaches (e.g., public health, health care, mental and behavioral health) to countering violent extremism and radicalization
- Opportunities for cross-sectoral and interdisciplinary collaboration and learning among domestic and international stakeholders and organizations (e.g., community and/or faith-based, law enforcement, justice system, public health, health care, mental and behavioral health) for countering violent extremism and radicalization

The committee will develop the agenda for the workshop session, select and invite speakers and discussants, and moderate the discussions. A workshop summary will be prepared by designated rapporteurs in accordance with institutional guidelines, based on the presentations and discussions held during the workshop.

Appendix C

Biographical Sketches of Workshop Speakers and Moderators

Warner Anderson, M.D., left U.S. government civil service in 2014 to become medical director at JICGlobal, LLC. Dr. Anderson oversees health-related curriculum development, instructor standards and practice, and clinical integration and innovation. He is also Assistant Professor of Military and Emergency Medicine at the Uniform Services University of Health Sciences. Prior to joining JICGlobal, Dr. Anderson was a senior leader at the Office of the Assistant Secretary of Defense for Health Affairs, developing the Military Health System's capacity and capabilities in global health engagement. As Director of International Health, he led the Medical Stability Operations Working Group and the Global Health Engagement Working Group, identifying gaps in DoD capabilities; and oversaw development of the Medical Stability Operations Course and the Defense Medical Language Initiative. As a Special Forces-qualified colonel in the U.S. Army Reserve, Dr. Anderson was mobilized to active duty immediately after the September 11, 2001, terrorist attacks. He remained on active duty for nearly 7 years, as Associate Dean of the Joint Special Operations Medical Training Center and Deputy Commander of the Special Operations Medical Group, a command in the U.S. Army John F. Kennedy Special Warfare Center and Schools. Here, he oversaw training of 3,000 special operations medics, and refresher training for 600 qualified advanced practice medics and medical officers yearly. During active duty, Dr. Anderson deployed twice to Iraq. During the invasion, he was assigned to Civil Affairs, and was the Chief of Public Health for the Coalition Provisional Authority, leading reestablishment of public health and other health services for the reconstruction of Iraq. In April 2003 his team's convoy was ambushed and all members seriously or critically injured, including Dr. Anderson. He killed the attacker and performed immediate care on fellow team members before attending to himself, actions that won a Bronze Star Medial with Valor Device, a Purple Heart Medal, and Combat Action Badge. Upon redeployment, he received a second Bronze Star Medal. In 2006, Dr. Anderson again deployed to Iraq, this time as Command Surgeon for the Iraq Counter Terrorist Force (ICTF) and the Iraqi Special Operations Forces (ISOF). He developed curriculum for ICTF and ISOF medics, leading the "train the trainer" program, and served as senior combat medic on several high-risk hostage rescue and high-value target missions. Again, upon redeployment, Dr. Anderson was awarded a third Bronze Star Medal. Prior to mobilization for the Global War on Terror, Dr. Anderson was Chief of Emergency Medicine and Urgent Care at two major regional hospitals, and was EMS Medical Director for city, county, and Navajo Reservation jurisdictions, as well as Indian Health Service chief flight medical officer for the Navajo Reservation. In these positions, he was responsible for the continuing education and quality assurance of EMS in a region the size of Connecticut. Dr. Anderson served on the State of New Mexico EMS Board's Standards of Practice Committee, and was New Mexico EMS Medical Director of the Year. Dr. Anderson has published several peer-reviewed articles on cross-cultural health communication.

Jalon Arthur, M.S., has dedicated 14 years of humble program service with Cure Violence, an evidence-informed health approach scientifically proven to reduce violence. During his tenure, Mr. Arthur has passionately served in several program roles and played an instrumental role in

replicating the Cure Violence model (South Africa, New York, New Orleans, Chicago, Puerto Rico, etc.). Mr. Arthur also formerly led Cure Violence's training and technical assistance efforts. As an individual who formerly engaged in violence, his commitment toward the preservation of life and transformation of highest-risk youth is heartfelt, and he views his work as a divine calling. Additionally, Mr. Arthur has played a lead role in securing support services (mindfulness, trauma, counseling, etc.) for staff and high-risk youth to further aid their growth and development as future leaders. Currently, Mr. Arthur serves as Director of Innovation and Development tasked with adapting the Cure Violence health approach to address multiple forms of violence (violence against women and children, youth violence, prison violence, violent extremism, trauma, etc.), and to use technology to further enhance reductions in violence in Cure Violence communities across the globe.

Haroon Azar, J.D., is the DHS Regional Director for Strategic Engagement in Los Angeles. Partnering with the City of Los Angeles in November 2011, DHS established the first office of its kind in the nation. Mr. Azar's primary responsibility is strengthening the department's relationships with state and local law enforcement, government officials, faith-based organizations and community groups, academic institutions, and the private sector. His office partners with both government and nongovernment entities locally to advance DHS's risk mitigation mission. Previously, Mr. Azar worked as Deputy Director and Senior Policy Analyst for the Middle East, Africa, and South Asia in the Office of International Affairs at DHS headquarters in Washington, DC. His portfolio included providing the secretary and other senior leadership with policy counsel and management of international affairs related to homeland security. Additionally, Mr. Azar was responsible for negotiating bilateral and multilateral security agreements with international partners focusing on improving immigration policy, visa security, aviation security, border security, supply chain management, and countering violent extremism efforts. Mr. Azar received a J.D. from the UCLA School of Law where he focused on the intersection of national security and international law.

Georges C. Benjamin, M.D., MACP, FACEP(E), FNAPA, Hon FRSPH, Hon FFPH, is well-known as a health leader, practitioner, and administrator. Dr. Benjamin has served as the executive director of the American Public Health Association, the nation's oldest and largest organization of public health professionals, since December 2002. He is a former Secretary of Health for the state of Maryland. Dr. Benjamin is a graduate of the Illinois Institute of Technology and the University of Illinois College of Medicine. He is board certified in internal medicine, a Master of the American College of Physicians, a fellow of the National Academy of Public Administration, and a fellow emeritus of the American College of Emergency Physicians. He serves on several nonprofit boards such as Research!America, the University of Maryland Medical System, and the Reagan-Udall Foundation. He is a member of the National Academy of Medicine. In April 2016 President Obama appointed Dr. Benjamin to the National Infrastructure Advisory Council, a council that advises the president on how best to assure the security of the nation's critical infrastructure.

Alejandro J. Beutel, M.P.P., is a researcher for Countering Violent Extremism at the National Consortium for the Study of Terrorism and Responses to Terrorism (START). Prior to START, Mr. Beutel was the Policy and Research Engagement Fellow at the Institute for Social Policy and Understanding (ISPU), an applied research think tank specializing in the study and promotion of

evidence-based development strategies for positive civic, social, and political engagement outcomes for American Muslim communities. He was also an independent research consultant to several nonprofit organizations, private corporations, and think tanks. At ISPU, he was co-principal investigator and project manager of the "Islamophobia: A Threat to All" study, a research initiative that empirically analyzed anti-Muslim bigotry in the United States and provided actionable solutions to effectively combat it. As a consultant, Mr. Beutel authored several publications, including most recently, "Safe Spaces Initiative" a community-based tool kit to combat extremism and violence, published by the Muslim Public Affairs Council. Mr. Beutel graduated from the University of Maryland, College Park, in 2013 with an M.P.P. He also has a B.S. in International Relations and Diplomacy from Seton Hall University in South Orange, New Jersey.

Michael Downing, LinCT, PNGEP, SMIP PERF, is the Commanding Officer, Counter-Terrorism and Special Operations Bureau where he leads five operational divisions: Major Crimes, Emergency Services, Metropolitan, Air Support, and Emergency Operations; dealing with intelligence, investigations, tactical response, and emergency preparedness. Deputy Chief Downing is also Chair of the Executive Board of the Los Angeles Joint Regional Intelligence Center and Vice Chair of the DOJ Criminal Intelligence Coordinating Council. Deputy Chief Downing has testified before congressional subcommittees relative to intelligence, homeland security, information sharing, and prison radicalization. Chief Downing served as a member of the DHS Advisory Council working group on developing a national strategy for countering violent extremism. In October 2009, Deputy Chief Downing was appointed as the Interim Police Chief for the LAPD until the permanent police chief was appointed in November 2009. Deputy Chief Downing has also worked with DOJ and the U.S. Department of State, traveling throughout Africa, India, Kenya, Poland, South America, and Turkey in an effort to transition large national police organizations into democratic civilian policing models and overlay counterterrorism enterprises on top of cities. Deputy Chief Downing attended the University of Southern California where he received a bachelor of science degree in Business Administration in 1982, POST Command College 1997, the FBI's Leadership in Counter-Terrorism (LinCT) in 2008, Post Naval Graduate Executive Program in 2009, and the Senior Management Institute for Police at Boston (SMIP PERF) in 2012. He is a senior fellow at the George Washington University Homeland Security Institute.

David Eisenman, M.D., M.S.H.S., is an Associate Professor in the UCLA Division of General Internal Medicine and Health Services Research. He directs UCLA's Center for Public Health and Disasters. Prior to coming to UCLA, he was the Associate Director of the Bellevue/New York University (NYU) Program for Survivors of Torture and Assistant Professor of Medicine at the NYU School of Medicine. He holds appointments in the UCLA School of Public Health and the RAND Corporation. Dr. Eisenman holds an M.D. from the Albert Einstein College of Medicine, an M.S.H.S. from the UCLA School of Public Health, and a B.A. from the University of Pennsylvania.

B. Heidi Ellis, Ph.D., is an Associate Professor in Psychology and Psychiatry at Harvard Medical School and Boston Children's Hospital Boston, and a licensed clinical psychologist. She is also the Director of the Refugee Trauma and Resilience Center at Boston Children's Hospital, a partner in the National Child Traumatic Stress Network. Dr. Ellis's primary focus is on

understanding and promoting refugee youth mental health and adjustment, with a particular emphasis on understanding how trauma exposure, violence, and social context affect developmental trajectories. Over the past 14 years she has conducted a Community-Based Participatory Research program with Somali youth; she is currently principal investigator of a multisite, longitudinal research project examining developmental pathways to and away from violence, including openness to violent extremism, gang involvement, and constructive civic engagement. Dr. Ellis was an advisor to the Boston Pilot Project on countering violent extremism, and is currently developing a multidisciplinary model to promote community resilience to violence. She is also co-developer of the nationally recognized trauma treatment model, Trauma Systems Therapy.

Mehreen Farooq, M.A., is Senior Fellow at WORDE. Ms. Farooq's areas of expertise include countering violent extremism, Muslim community engagement, and grass-roots community development. She received her M.A. in International Affairs from American University, focusing on the sociopolitical development of the broader Middle East. She is one of the lead researchers of WORDE's projects to explore the capacity of local civil society organizations to promote peace and counter violent extremism. She has led fieldwork across 80 cities and villages in Afghanistan and Pakistan, and is currently researching the capacity of religious actors in Egypt to counter extremist narratives in Egypt and beyond.

Louise Flavahan, J.D., M.P.H., is currently the Director of the National Academies of Sciences, Engineering, and Medicine's Forum on Global Violence Prevention and a Program Officer with the National Academies' Board on Global Health. Prior to joining the National Academies in 2014, Ms. Flavahan represented the Duke University Sanford School of Public Policy as a Global Health Fellow within their Global Governance and Policy Program in Geneva, Switzerland. While in Geneva, she also completed an internship with the World Trade Organization's Standards and Trade Development Facility. Ms. Flavahan holds both a J.D. and an M.P.H. from Case Western Reserve University and completed her undergraduate studies in English and political science at The Ohio State University.

Dan Hanfling, M.D., is a consultant on emergency preparedness, response, and crisis management. He is a Contributing Scholar at the University of Pittsburgh Medical Center's Center for Health Security, Clinical Professor of Emergency Medicine at George Washington University, and adjunct faculty at the George Mason University School of Public Policy. He currently serves as the co-chair of the National Academies of Sciences, Engineering, and Medicine's Forum on Medical and Public Health Preparedness for Disasters and Emergencies. Dr. Hanfling spent 18 years as principal advisor to the Inova Health System on matters related to emergency preparedness and response. He continues to practice emergency medicine at Inova Fairfax Regional Trauma Center, and is an operational medical director for a regional helicopter EMS service. He was instrumental in founding one of the nation's first health care coalitions, the Northern Virginia Hospital Alliance, created in October 2002. His areas of expertise include biodefense and mass casualty management, catastrophic disaster response planning with particular emphasis on scarce resource allocation, and the nexus between health care system planning and emergency management. In addition to his hospital and EMS clinical responsibilities, he serves as a Medical Team Manager for the Fairfax County based FEMA- and USAID-sanctioned international urban search and rescue team (VATF-1, USA-1), and has

responded to catastrophic disaster events across the globe. Dr. Hanfling received his undergraduate degree in political science from Duke University, including a General Course at the London School of Economics, and completed his medical degree at Brown University. He completed his internship in internal medicine at Brown University and his emergency medicine training at the combined George Washington and Georgetown University residency program. He has been board certified in emergency medicine since 1997.

John L. Hick, M.D., is a faculty emergency physician at Hennepin County Medical Center (HCMC) and an associate professor of emergency medicine at the University of Minnesota. He serves as the associate medical director for Hennepin County emergency medical services and medical director for emergency preparedness at HCMC. He is medical advisor to the Minneapolis/St. Paul Metropolitan Medical Response System. He also serves the Minnesota Department of Health as the medical director for the Office of Emergency Preparedness and medical director for Hospital Bioterrorism Preparedness. He is the founder and past chair of the Minneapolis/St. Paul Metropolitan Hospital Compact, a 29-hospital mutual aid and planning group active since 2002. He is involved at many levels of planning for surge capacity and adjusted standards of care and traveled to Greece to assist in health care system preparations for the 2004 Summer Olympics as part of a 15-member team from CDC and HHS. He is a national speaker on hospital preparedness issues and has published numerous papers dealing with hospital preparedness for contaminated casualties, personal protective equipment, and surge capacity.

Michael Jensen, Ph.D., is a senior researcher at the National Consortium for the Study of Terrorism and Responses to Terrorism (START) at the University of Maryland, where he serves as the data collection manager for the Global Terrorism Database (GTD) and the principal investigator for the Profiles of Individual Radicalization in the United States (PIRUS) project. He holds a Ph.D. in political science from Arizona State University. Prior to joining START, Dr. Jensen was a postdoctoral fellow in the Moynihan Institute of Global Affairs at the Maxwell School of Syracuse University and the Associate Director of the Consortium on Qualitative Research Methods.

Leesa Lin, M.S.P.H., is the senior program manager of the Emergency Preparedness Research, Evaluation, and Practice (EPREP) Program, formerly known as the Harvard Preparedness and Emergency Response Research and Learning Centers (Harvard PERRC/PERLC) at the Harvard T.H. Chan School of Public Health. She has extensive experience working with domestic and international partners, including the World Health Organization, U.S. CDC, China CDC, and Europe CDC, as well as DHS. Harvard EPREP is currently leading the evaluation of the Boston Countering Violent Extremism pilot program. Specialized in public health emergency preparedness, global health, communication science, program evaluation, and social and behavioral sciences, Ms. Lin's work has centered around the assessment of emergency risk communications, public health systems' emergency preparedness capabilities and capacity, needs for vulnerable and at-risk populations, and assessment of population's knowledge, attitudes, and practices (KAP) during the preparedness for and response to actual public health emergencies ranging from earthquakes, outbreaks, and pandemics to water crises, snow emergencies, and volcano eruptions. More recently, she has applied public health program evaluation methods to initiatives that counter extreme violence perpetrated in the name of an

ideology. Ms. Lin holds an M.S.P.H. in Global Health and Population from the Harvard School of Public Health and a B.A. in Psychology from the University of British Columbia.

Cynthia Lum, Ph.D., is an associate professor in the Department of Criminology, Law, and Society, and Director of the Center for Evidence-Based Crime Policy at George Mason University. She researches primarily in the area of policing, security, and evidence-based crime policy. Her works in this area have included evaluations of policing interventions and police technology, understanding the translation and receptivity of research in policing, and assessing security efforts of federal agencies. With Drs. Christopher Koper and Cody Telep she developed the Evidence-Based Policing Matrix and its associated demonstration projects, which are translation tools designed to help police practitioners incorporate research into their strategic and tactical portfolio. She is a member of the Research Advisory Committee of the International Association of Chiefs of Police, the International Advisory Committee of the Scottish Institute for Police Research, the Board of Trustees for the Pretrial Justice Institute, and a Fulbright Specialist. She is the North American editor for *Policing: A Journal of Policy and Practice* (Oxford), and the founding editor of *Translational Criminology Magazine* and the Springer Series on Translational Criminology. Dr. Lum holds a Ph.D. in criminology and criminal justice from the University of Maryland, College Park.

Rajeev Ramchand, Ph.D., is a senior behavioral scientist at the RAND Corporation. His research focuses on the prevalence, prevention, and treatment of mental health and substance use disorders in adolescents, service members and veterans, and minority populations. He has specific interest in the epidemiology of suicide and its prevention, and was lead author of *The War Within: Preventing Suicide in the U.S. Military* (2011, RAND). He is interested in applying novel approaches in the collection and analysis of survey data, and he formerly served as associate director of the RAND Center for Military Health Policy Research. Dr. Ramchand co-led RAND's 2014 study on military caregivers, Hidden Heroes; he is currently working on studies examining disparities in mental health conditions among minority subgroups in the U.S. military and evaluating the types and quality of services provided on suicide crisis hotlines in California. His research has been published in such journals as the *American Journal of Public Health*, *Journal of Consulting and Clinical Psychology*, *AIDS and Behavior*, *Journal of Trauma*, and *Journal of Traumatic Stress*. He received his B.A. in economics from the University of Chicago and his Ph.D. in psychiatric epidemiology from the Johns Hopkins Bloomberg School of Public Health.

Peter Romaniuk, Ph.D., is associate professor of Political Science at the John Jay College of Criminal Justice, the City University of New York, and is a Senior Fellow at the Global Center on Cooperative Security (www.globalcenter.org). His recent work with the Global Center includes the reports *Does CVE Work?: Lessons Learned from the Global Effort to Counter Violent Extremism* and *Preventing Violent Extremism in Burkina Faso: Toward National Resilience Amid Regional Insecurity* (with Augustin Loada). His book, *Multilateral Counter-terrorism: The Global Politics of Cooperation and Contestation*, was published by Routledge in 2010, and his articles have appeared in the *RUSI Journal*, *Review of International Studies*, the *International Studies Encyclopedia*, and the *CPA Journal*. He holds a B.A. (Hons) and LLB (Hons) from the University of Adelaide, South Australia, and an A.M. and a Ph.D. in Political Science from Brown University.

Laura Runnels, M.P.H., is a strategist and facilitator with LARC, a Washington, DC-based consulting firm. She was born on a mountaintop in Tennessee, raised in a small-town in Mississippi, and educated in California, Connecticut, and Missouri. She has more 12 years of experience providing capacity building assistance, training, and coaching to local, state, and federal clients. She is known for designing and facilitating highly collaborative, efficient, and productive meetings, workshops, and trainings. As a strategist, she guides individuals, organizations, and coalitions through technical and adaptive challenges. Ms. Runnels holds an M.P.H. from Saint Louis University and completed her undergraduate studies at Yale University.

Irfan Saeed, J.D., is the director for Countering Violent Extremism (CVE), Bureau of Counterterrorism and Countering Violent Extremism, at the U.S. Department of State. Mr. Saeed manages an office that leads strategy and policy formulation for international CVE efforts of the United States. Previously, Mr. Saeed served in the U.S. Embassy in Islamabad, Pakistan, where he developed the Community Engagement Office, the first of its kind in U.S. embassies worldwide, to use traditional public diplomacy tools to counter violent extremism in Pakistan. Prior to joining the U.S. Department of State, Mr. Saeed was a senior policy advisor at DHS, Office for Civil Rights and Civil Liberties, where he developed and coordinated activities relating to countering violent extremism. Prior to joining DHS, Mr. Saeed worked as a criminal prosecutor, at the state and federal levels. Mr. Saeed worked as an Assistant U.S. Attorney, DOJ, in the Eastern District of Louisiana, as well as an Assistant District Attorney, in New Orleans, Louisiana. He served as the Resident Legal Advisor at U.S. embassies in Kyrgyzstan and Uzbekistan.

George Selim, M.P.A., serves as the director in the Office for Community Partnerships at DHS and director of the CVE Task Force. Before joining the Task Force, Mr. Selim served for 4 years as the director for community partnerships on the White House's National Security Staff, where he focused on building public–private partnerships to address homeland security priorities. Previously, he served as a senior policy advisor in DHS's Office for Civil Rights and Civil Liberties.

Joumana Silyan-Saba, M.A., is an adjunct assistant professor teaching Bridging Cultural Conflicts and Public Policy Conflict courses in the Negotiation, Conflict Resolution, and Peacebuilding (NCRP) program at California State University, Dominguez Hills (CSUDH). Professor Silyan-Saba commenced teaching at CSUDH in 2006, and prior to that she was a teaching assistant for courses that included Research Design, Labor Dispute, Capstone, Final Examination, and Independent Studies. In her professional life, Professor Silyan-Saba is a senior policy analyst for the City of Los Angeles Human Relations Commission (City HRC). She works directly with communities to promote healthy intergroup relations and create collaborative templates to encourage civic engagement. Her efforts include working with faith and civic leaders, civil rights organizations, policy makers, and academic institutions to bridge divides and address social justice concerns. Within the government structures, her focus includes working with local, state, and federal agencies to provide technical assistance and recommendations aimed to improve community-government relations and expand community engagement concepts. Through her work with City HRC, Professor Silyan-Saba has designed and implemented training curricula in conflict management, cultural fluency and human relations,

and she has presented on panels covering related topics. Previously, Professor Silyan-Saba was Program Director for Community and Intergroup Conflicts at the Asian Pacific American Dispute Resolution Center. She managed all mediation and conciliation direct services, as well as community programs, training, and outreach. Professor Silyan-Saba obtained her M.A in Negotiation and Conflict Management at CSUDH, and her B.S. in Criminal Justice–Law Enforcement with a minor in Business Administration Human Resources Management at California State University, Long Beach.

Rebecca Skellett, manages the Strong Cities Network (SCN) at the Institute for Strategic Dialogue (ISD). ISD is a London-based "think and do tank" that has pioneered policy and operational responses to the rising challenges of violent extremism and intercommunal conflict. SCN is the first global network of mayors, municipal-level policy makers, and practitioners united in building social cohesion and community resilience to counter violent extremism in all its forms. SCN recognizes that cities are uniquely positioned to safeguard their citizens from polarization and radicalization through partnerships with local communities. Previously, Rebecca worked on the front line of the UK government's Prevent Strategy, working as a practitioner across several London boroughs. This role has seen her conduct extensive work with institutions, ideologies, and individuals including the management of case work via the United Kingdom's Channel program, a referral mechanism for individuals at risk of radicalization. During her time as a Prevent practitioner, Rebecca worked with more than 200 institutions, trained 4,000 staff, and worked with more than 2,000 young people building resilience to extremist narratives. She is also a member of the UK Department for Education's Expert Advisory Panel for Extremism.

Mark G. Stainbrook, M.P.A., is the second-in-command of the San Diego Harbor Police Department (HPD), which is the premier police presence on the San Diego Bay, the San Diego International Airport, and on all tidelands around the Bay. The department is composed of 170 employees and has jurisdiction in the five member cities of the Port District, which include San Diego, Chula Vista, Coronado, Imperial Beach, and National City. Mr. Stainbrook retired as a lieutenant from the LAPD, where he served in a variety of assignments including patrol, gangs, internal affairs, intelligence and counterterrorism. Mr. Stainbrook is a graduate of the FBI National Academy in Quantico, Virginia. In his second career, Mr. Stainbrook is a Lieutenant Colonel in the U.S. Marine Corps Reserve with 30 years of military service. He was most recently assigned to Security Battalion, Camp Pendleton, California. His personal awards include the Navy-Marine Corps Medal for heroism, as well as the Army Commendation Medal and the Navy Achievement Medal. While serving in Iraq in April 2003, Mr. Stainbrook was tasked to reconstitute Iraqi police units in Baghdad. His experiences were chronicled in the article "Seven Days in Baghdad" (*Police Magazine*, December 2003). Mr. Stainbrook was extensively interviewed and quoted during Operation Iraqi Freedom by CNN, *Good Morning America*, *Inside Edition*, *The Washington Post*, and the BBC. He graduated with honors from California State University Long Beach with a M.P.P. His master's thesis, "Attitudes of American-Muslims Towards Law Enforcement: A Comparison of Before and After September 11, 2001," was the catalyst for his selection to a Fulbright Police Fellowship. During his Fulbright, Mr. Stainbrook was a visiting fellow at Leeds University in the Religious and Theology Department, and was also seconded to the West Yorkshire Police Force. He studied and worked in local West Yorkshire Muslim communities for 6 months, including the suburbs of Beeston, where the "7/7 London bombers" resided. He has worked with the U.S. Department of State in India, Kenya,

and Nepal to train their police forces on counterterrorism, criminal intelligence, and community policing methods. Mr. Stainbrook has authored several law enforcement articles in *Police Chief Magazine*, including "Learning from the Lessons of the 2008 Mumbai Terrorist Attacks" and "Policing with Muslim Communities in the Age of Terrorism." Mr. Stainbrook joined the Potomac Institute for Policy Studies as a Senior Fellow in June 2016.

Brette Steele, J.D., serves as acting deputy director of the CVE Task Force at DOJ. From 2013 to 2016, Ms. Steele served as senior counsel to the Deputy Attorney General and coordinated DOJ's efforts to build community resilience against violent extremism. She also chaired the DOJ Arab- and Muslim-American Engagement Advisory Committee and vice chaired the Attorney General's Advisory Committee on the Employment of People with Disabilities. Before joining the Office of the Deputy Attorney General, she coordinated departmental CVE policy through the Office of Legal Policy. Ms. Steele graduated with a B.A. from University of California, Berkeley, and a J.D. from the UCLA School of Law.

Kiersten Stewart, M.A., is director of Public Policy for Futures Without Violence and leads the organization's Washington, DC, office. Previously she was the chief of staff to U.S. Representative Maurice Hinchey (D-NY). She received her M.A. from the University of Pennsylvania and her B.S. from Northwestern University.

Susan Szmania, Ph.D., is a senior researcher at the University of Maryland's National Consortium for the Study of Terrorism and Responses to Terrorism (START) with a specialization in CVE. She is currently on an intergovernmental personnel agreement assignment to DHS, where she is a Senior Advisor in the Office for Community Partnerships. In this capacity, she also serves as the Chief of the Research and Analysis line of effort for the interagency CVE Task Force, established in January 2016, to synchronize federal CVE activities. Prior to her work at START and DHS, Dr. Szmania served at U.S. embassies in Spain and Sweden, where she developed and implemented CVE programs. She received her Ph.D. from The University of Texas with a focus on conflict resolution and restorative justice.

Jihad Turk, M.A., the president of Bayan Claremont Islamic Graduate School and former Imam and director of Religious Affairs at the Islamic Center of Southern California, has dedicated the past decade to improving the relations between the Muslim community and other faith traditions in Southern California. Having been born to a Muslim-Palestinian father and a Christian-American mother in Phoenix, Arizona, Mr. Turk spent his college years traveling the Muslim world and exploring his roots and the Islamic tradition. He spent time in both the Islamic University of Medina where he studied Arabic and Islamic Studies and to Iran where he studied Farsi at the University of Tehran and in Qum. He completed his undergraduate study at the University of California, Berkeley, where he received his B.A. degree in History and Arabic. Mr. Turk completed his master's degree at The University of Texas at Austin in Arabic and Islamic law and jurisprudence, and he has taught Islamic Studies and Arabic as adjunct faculty for many years at UCLA. In 2010, having served for 7 years as the Imam and religious director at the largest and oldest mosque in the Los Angeles area, the Islamic Center of Southern California, Mr. Turk went on to found the nation's first accredited Islamic seminary, Bayan Claremont. Mr. Turk has co-founded the Muslim–Christian Consultative Group composed of major Southern California Muslim leaders and the judicatory representatives of mainline protestant

denominations as well as the Catholic archdiocese. This group pairs up mosques and churches nationally. He has organized many interfaith events including an annual interfaith 9/11 memorial held at the Islamic Center and has led several interfaith trips to the Holy Land. Mr. Turk has been consulted by the White House and has traveled around the world (France, Indonesia, Morocco, and Qatar) for the U.S. Department of State to speak to Muslim communities abroad and represent the American Muslim community. Mr. Turk is a member of the U.S Indonesia Society, an NGO that aims to strengthen ties between the United States and Indonesia. Mr. Turk was profiled on the front page of the *Los Angeles Times*, regularly appears on NPR and other news outlets, has appeared numerous times on the History Channel, and was featured in a documentary produced by the Annenberg Foundation's www.explore.org about the Abrahamic faiths, titled "Traveling with Jihad." Mr. Turk has received awards for his religious leadership by U.S. Representative Jane Harmon, the Valley Interfaith Council, and the South Coast Interfaith Council, and he has been acknowledged as a Local Hero in 2008 by the World Festival of Sacred Music. Mr. Turk also sits on the board of a Muslim-Jewish peace organization, the ReGeneration, which is developing a model for education that nurtures understanding and peaceful coexistence between Israelis and Palestinians.

Stevan Weine, M.D., is a professor of Psychiatry at the University of Illinois at Chicago College of Medicine, where he is also the director of the International Center on Responses to Catastrophes and the director of Global Health Research Training at the Center for Global Health. For 25 years he has been conducting research both with refugees and migrants in the United States and in postconflict countries, focused on mental health, health, and countering violent extremism. He leads an active, externally funded research program that has been supported by multiple federal, state, university, and foundation grants, from 1998 to the present, all with collaboration from community partners. To date, this includes eight grants from the National Institute of Mental health, two from the National Institute of Child Health and Human Development, three from the Fogarty International enter, four from DHS, two from NIJ, one from FEMA, and one from the Office of Aids Research. Dr. Weine is author of *When History Is a Nightmare: Lives and Memories of Ethnic Cleansing in Bosnia-Herzegovina* (Rutgers, 1999) and *Testimony and Catastrophe: Narrating the Traumas of Political Violence* (Northwestern, 2006).

Leana Wen, M.D., is the Baltimore City health commissioner. An emergency physician and patient and community advocate, she leads the Baltimore City Health Department (BCHD), the oldest health department in the United States, formed in 1793. BCHD is an agency with a $130 million annual budget and 1,000 employees that aims to promote health and improve well-being through education, policy/advocacy, and direct service delivery. BCHD's wide-ranging responsibilities include maternal and child health, youth wellness, school health, senior services, animal control, restaurant inspections, emergency preparedness, sexually transmitted infection/HIV treatment, and acute and chronic disease prevention. Since her appointment by Mayor Stephanie Rawlings-Blake in January 2015, Dr. Wen has been reimagining the role of public health as being critical to all aspects of urban revitalization. Her transformative approach involves engaging hospitals and returning citizens in violence prevention; launching one of the most ambitious opioid overdose prevention programs in the country that is training every resident to save lives; and implementing a citywide youth health and wellness strategy. Following the civil unrest in April 2015, she directed Baltimore's public health recovery efforts,

including ensuring prescription medication access to seniors after the closure of over a dozen pharmacies and developing the Mental Health/Trauma Recovery Plan. Most recently, Dr. Wen has been an attending physician and Director of Patient-Centered Care in the Department of Emergency Medicine at George Washington University (GWU). A professor of Emergency Medicine at the School of Medicine and of Health Policy at the School of Public Health, she codirected GWU's Residency Fellowship in Health Policy, co-led a new national collaboration on health policy and social mission with Kaiser Permanente, and served as founding director of Who's My Doctor, a campaign calling for radical transparency in medicine. The author of the critically acclaimed book *When Doctors Don't Listen: How to Avoid Misdiagnoses and Unnecessary Tests*, Dr. Wen has given six popular TED and TEDMED talks on patient-centered care, public health leadership, and health care reform. Her TED talk on transparency has been viewed nearly 1.5 million times. Dr. Wen received her medical training from Washington University School of Medicine in St. Louis and Brigham & Women's Hospital/Massachusetts General Hospital in Boston, where she was a Clinical Fellow at Harvard Medical School. A Rhodes Scholar, she studied public health and health policy at the University of Oxford, and worked as a community organizer in Los Angeles and St. Louis. She has served as a consultant with the World Health Organization, Brookings Institution, and China Medical Board; an advisor to the Patient-Centered Outcomes Research Institute and the Lown Institute; and as national president of the American Medical Student Association and American Academy of Emergency Medicine-Resident & Student Association. In 2005, she was selected by the U.S. Secretary of Health and Human Services to represent physicians-in-training on the Council on Graduate Medical Education, an advisory commission to Congress. In 2010, she served as chair of the Young Professionals Council, a global leadership network of medical, nursing, and public health professionals. In addition to her extensive scholarship in public health and patient safety, Dr. Wen has conducted health systems research in China, Denmark, D.R. Congo, Nigeria, Rwanda, Singapore, Slovenia, and South Africa. She has published more than 100 articles, including in the *Lancet*, *JAMA*, and *Health Affairs*. She is regularly featured on NPR, CNN, Fox, MSNBC, *The Atlantic*, *USA Today*, the *Baltimore Sun*, *The New York Times*, and *The Washington Post*. Dr. Wen has been honored by the *Daily Record* as 1 of the 100 most influential Marylanders and by the *Baltimore Business Journal*'s "40 under 40." She is the recipient of the Greater Baltimore Committee's Dr. Elijah Saunders Trailblazers Award and the National Association of Health Services Executives Leadership Award.

Matthew Wynia, M.D., M.P.H., is the Director of the University of Colorado's Center for Bioethics and Humanities, on the Anschutz Medical Campus. Dr. Wynia's training is in internal medicine, infectious diseases, public health, and health services research. Prior to moving to Colorado in July 2015, he worked at the American Medical Association (AMA) and the University of Chicago. At the AMA, he was Director of Patient and Physician Engagement for Improving Health Outcomes, and he developed a research institute and training programs focusing on bioethics, professionalism, and policy issues (the AMA Institute for Ethics). He also founded the AMA's Center for Patient Safety. His research has focused on understanding and improving practical management of ethical issues in medicine and public health. He has led projects on a wide variety of issues related to ethics and professionalism, including public health and disaster ethics; understanding and measuring the ethical climate of health care organizations and systems; ethics and quality improvement; communication, team-based care and engaging patients as members of the team; defining physician professionalism; medicine and the

Holocaust (with the U.S. Holocaust Memorial Museum); and inequities in health and health care. He has served on committees, expert panels, and as a reviewer for the Institute of Medicine/National Academy of Medicine, The Joint Commission, federal agencies, the Hastings Center, the American Board of Medical Specialties, and other organizations, and he has delivered more than two dozen named lectures and visiting professorships nationally and internationally. Dr. Wynia is the author of more than 140 published articles, chapters, and essays. His work has appeared in *JAMA*, the *New England Journal of Medicine*, *Annals of Internal Medicine*, *Heath Affairs*, and other leading medical and ethics journals, and he is a contributing editor at the *American Journal of Bioethics*. Dr. Wynia is a past president of the American Society for Bioethics and Humanities, and he has chaired the Ethics Forum of the American Public Health Association and the Ethics Committee of the Society for General Internal Medicine. He has current board certifications in Internal Medicine and Infectious Diseases, and he cares for patients at the University of Colorado Hospital.