

community forums, as well as educate, organize, and advocate. These activities also develop student competencies in advocacy and community organizing, better preparing graduates for effective participation in the social justice movements that have long driven public health advances.

Challenge the Status Quo to Effect Change

SPPH have struggled to find the right balance between taking action to improve health and protecting their professional status. Too often, public health professionals are constrained by the many silos that limit their capacity to bring together the expertise, coalitions, and political power needed to overcome harmful policies. To meet emerging challenges, SPPH can model an alternative approach by working across disciplinary, sectoral, and other borders to respond to attacks on public health. SPPH can convene experts from different sectors (e.g., housing, education, criminal justice, community development, environmental science) and

activists from social justice movements who are fighting to improve health conditions. SPPH can become the crucible for interdisciplinary analysis and action to protect public health. Improvements in population health have often been led by individuals with the backbone and skills to stand up to and overcome special interests. Public health faculty need to model these attributes for their students, even if it may jeopardize federal or corporate funding or the approval of established authorities.

CONCLUSIONS

In closing, we suggest three essential changes in SPPH. First, schools must recognize that evidence alone will not win over the public or policymakers; effective professionals also need to tell stories that connect to people's deeply held values and beliefs. Second, SPPH may need to let go of the academic timetables, professional jargon, and disciplinary silos that impede their being credible partners with advocates, communities, and social movements, historically

the most effective actors in changing harmful policies. Finally, if SPPH want to be judged by their impact on health, they must fully engage in the political processes that shape health and disease.

The policies enacted and proposed by President Trump and certain congressional leaders could jeopardize the public health successes of recent decades and exacerbate previous increases in premature mortality and persistent health inequalities.⁷ To contribute to the effort to avoid those outcomes, SPPH must embrace the task of preparing public health professionals who are ready, willing, and able to take on these challenges. By preparing their students to apply the new CEPH competencies, which are fairly generic as proposed, to the concrete realities facing public health in the United States today, SPPH can ready the workforce to meet these challenges. The precautionary principle, that basic tenet of public health practice, suggests that the time to act is now. **AJPH**

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Ideologically Motivated Violence: A Public Health Approach to Prevention

Early on June 12, 2016, an armed man walked into a nightclub in Orlando, Florida, and began shooting. Two minutes into the rampage, he called 9-1-1, pledged allegiance to ISIS, and told the dispatcher, "You have to tell America to stop bombing Syria and Iraq. They are killing a lot of innocent people. What am I to do here when my people are getting killed over there?" He killed 49 people before being shot dead by police. His actions seemed driven by

a toxic confluence of social isolation, romantic troubles, access to weapons, bigotry, and, perhaps, mental illness and radical religious beliefs.

Multiple killings in US cities including Orlando; Charleston, South Carolina; Portland, Oregon; San Bernardino, California; Colorado Springs, Colorado; and elsewhere have been driven, at least in part, by ideological extremism. These heinous acts, in concert with other social forces, have prompted large

investments by the US Department of Homeland Security,

State Department, and law enforcement to understand and prevent ideologically motivated violence (IMV). Dubbed "countering violent extremism" (CVE) under the Obama

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administration, some programs have included public health experts—bringing expertise derived from partly analogous previous work preventing gang violence, suicide, and domestic abuse—and mental health practitioners with expertise on how to detect and prevent violence among “at-risk” individuals.¹

A PUBLIC HEALTH APPROACH

It is intriguing to consider what counterterrorism programs might look like if IMV were considered to be a public health as well as a law enforcement problem. Terrorism has important population-level health effects, and so do potential responses to the threat of terrorism.^{2,3} Could a public health approach to preventing IMV complement or improve current community-based law enforcement approaches? What opportunities for collaboration might arise if public health professionals were to become involved in contemporary CVE programs?

We recently participated in a workshop, “Exploring the Use of Health Approaches in Community-Level Strategies to Countering Violent Extremism and Radicalization,” hosted by the National Academies of Sciences, Engineering, and Medicine’s Forum on Medical and Public Health Preparedness for Disasters and Emergencies. With attendees from law enforcement, intelligence, homeland security, and the public and mental health communities, the group’s rich discussion addressed myriad medical, legal, ethical, and practical issues.⁴ We came away with two lessons that might be

particularly helpful in guiding public health professionals, or others, contemplating whether or how to become involved in CVE programs today.

NO CLINICALLY USEFUL RISK FACTOR

First, clinically useful risk factors marking individuals as being on a predictable path toward carrying out an act of IMV do not exist. Despite considerable research, no constellation of factors predicts with acceptable accuracy that a member of the general public (i.e., someone not already a member of an extremist group) will commit IMV. Factors such as being young, male, religious, disagreeing with US foreign policy, or having a history of mental illness or petty crime are simply too common, even in combination, to be of practical value.

Public health practitioners know that for events occurring at very low rates, even a highly sensitive and specific test will generate impossibly large numbers of false-positive results. One speaker at the workshop noted:

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 9900 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, more than 3.2 million people would 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.^{4(p93)}

Unfortunately, ill-advised attempts to predict which individuals will carry out acts of IMV pose more than merely statistical challenges. Some recently proposed “risk factors” for committing IMV are so general (e.g., country of origin, legal residency status) that pursuing them as a programmatic focus is likely to cause population-level harm. Public health has recognized that stigmatization, and Islamophobia in particular, carry significant health costs.^{5,6}

FUNDING AND FOCUS

This raises a second lesson from the workshop: CVE programs with conceptual origins in and continued funding by law enforcement and homeland security face particular barriers to success. Namely, some Muslim American communities view such initiatives as law enforcement cloaked in community service.

Because of this perception, the community leaders whose cooperation is needed for these programs to succeed sometimes avoid them, even if they are sympathetic to their aims in private, because public association might erode their community’s trust. For example, during the formative evaluation of a CVE program in Boston, Massachusetts, after visiting 45 organizations and interviewing more than 50 stakeholders, the evaluator reported “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.”^{4(p82)}

These concerns are understandable. After all, “CVE” has sometimes described programs developed by law enforcement and focused primarily on threats from “radical Islamists,” despite epidemiological data showing that 43% of recent acts of IMV in the United States have come from far-right extremists, 21% from the far left, and 15% from Islamic extremists.^{4(p11)} And concerns about stigmatization in these programs have undoubtedly been heightened by the recent US political climate, marked by vitriolic rhetoric and Islamophobia, and exacerbated by proposals under consideration by the Trump administration to focus future CVE programs exclusively on “radical Islamic extremism.”⁷

Well-meaning health professionals might hope CVE programs, regardless of how they are funded or focused, can provide resources for disadvantaged individuals and communities. But as trusted community leaders, with knowledge of the damaging effects of social stigmatization and Islamophobia,^{5,6} health care and public health professionals should avoid participating in programs that are focused solely on countering extremist violence among Muslims. Although such programs might have political appeal, they are neither evidence-based nor aligned with the reality of the various sources of IMV in the United States today. As a result, at best, such programs will not work; at worst, they could backfire by exacerbating stigmatization and inequities, which may themselves drive violent behavior.

In sum, the threat of IMV in the United States is real and perhaps increasing; it spans the political, religious, and ideological spectrum; and it has serious individual and population-level

health effects. It therefore deserves the attention of health care and public health professionals, because we might encounter patients and communities fearful of being targeted by violence, and we might be able to put a useful public health lens on approaches to preventing IMV. But a public health approach to preventing IMV would have to be evidence-based. As such, it would recognize that programs focused on identifying “at-risk” individuals from a single ethnic or religious community can result in stigmatization and be counterproductive, even

dangerous. In those instances, our professional responsibility is not merely to avoid becoming involved in such efforts, but also to speak out against misguided programs that will harm the health and well-being of the patients and communities we serve. **AJPH**

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Princess Diana and Reduced Traffic Deaths in France and the United States

This summer marks the 20th anniversary of the death of Princess Diana, who died at age 36 years of a ruptured pulmonary vein and a massive intrathoracic hemorrhage from a traffic crash in Paris, France, on August 31, 1997. The horrific event led to extraordinary public grief, as well as inquests highlighting how her limousine chauffeur was three times over the legal alcohol limit for drinking and driving. Additional factors included excessive speeding, the failure to wear seatbelts, and harassment by paparazzi; there were also alleged conspiracies, none of which was subsequently proven. The French Supreme Court ultimately upheld the official report and concluded that her death was caused by the chauffeur driving at excessive speed while under the influence of alcohol. The need for traffic safety went undisputed.¹

Jacques Chirac, the president of France at the time of these events, was sensitive to the tragedy. Moreover, the event

had added personal salience because he had been injured himself in a traffic crash years earlier. Chirac did not directly emphasize the death of Princess Diana beyond condolences (a natural omission given the political traps of discussing foreign nationals or criticizing people after death), but he understood the shifts of sentiments nationwide. For example, Chirac made no mention of traffic safety when elected in 1995, before Diana’s death, whereas he declared traffic safety as one of his three top goals during his 2002 reelection. Traffic safety depends on countless people, as well as political support for reinforced attention and empowered authorities.²

Years have passed, and traffic mortality in France now displays a remarkable trend compared with the United States. During the decades preceding Princess Diana’s death, the two countries tracked nearly parallel overlapping patterns of reductions in traffic fatalities (Figure 1).^{3,4} In the two

decades following her death, however, a further 30% reduction per decade occurred in France compared with a 15% reduction per decade in the United States. The absolute difference equates to 242 076 additional deaths in the United States during the subsequent years (and an additional 5 million surviving with major injuries). Diverse authorities and commentators have speculated on how these savings in France were motivated partially by the death of Princess Diana.^{5–7}

The implications for pedestrians are particularly impressive. In the United States, the number of pedestrian deaths decreased

modestly, by 1% per decade (5449 in 1996 vs 5376 in 2015). For France, the number of pedestrian deaths decreased substantially, by 28% per decade (987 in 1996 vs 463 in 2015). By 2015, the risk of death for pedestrians was twice as high in the United States as in France (16.7 vs 7.2 per million population annually), equal to an absolute excess of 3062 Americans. The World Health Organization suggests that the savings in lives for France could be explained by both initiation of new policies and reinforcement of old policies.⁸ Of course, the savings may be a coincidence unrelated to the death of Princess Diana: policy changes occurring after the event are not necessarily caused by the event despite being informed by the event.⁹

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