

Addressing violent extremism as public health policy and practice

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ABSTRACT

Addressing violent extremism could potentially benefit from new initiatives that extend beyond criminal justice and are a part of public health policy and practice. This claim is based on knowledge from prior countering violent extremism (CVE) research and on immersion with communities, practitioners, and policymakers. This knowledge indicates that to date law enforcement-centered initiatives have not generated targeted evidence-based prevention or intervention initiatives, and they have had the unintended consequence of provoking community resistance. The Center for Disease Control's Ten Essential Public Health Services is proposed as a new conceptual framework for a public health approach to addressing violent extremism which aims for policy and practice shifts. The public health approach offers opportunities for multi-purpose programming, avoiding stigma, and leveraging existing public health resources. Such shifts are illustrated by discussing the CVE program being further developed in Los Angeles, California, based in part upon the public health model.

ARTICLE HISTORY

Received 2 June 2016
Accepted 2 June 2016

KEYWORDS

CVE; public health; prevention

Introduction

Violent extremism and how to best address it is not only a top national security priority (The White House, 2011), but the rise and reach of ISIS, and the 2015 and 2016 terrorist attacks in San Bernadino, California, Brussels, & Orlando, Florida have caused concerns to rise rapidly to the forefront in many US communities (Yuccas, 2015). Violent extremism refers to, 'advocating, engaging in, preparing, or otherwise supporting ideologically motivated or justified violence to further social, economic or political objectives' (USAID, 2011).

Beginning in 2011, the Obama administration began a new national security policy initiative which has been referred to as countering violent extremism (CVE). CVE is defined as the 'use of non-coercive means to dissuade individuals or groups from mobilizing towards violence and to mitigate recruitment, support, facilitation or engagement in ideologically motivated terrorism by non-state actors in furtherance of political objectives' (Khan, 2015). This policy initiative is outlined in the White House's Strategic

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Implementation Plan (SIP) (The White House, 2011) and culminated in the February 2015 White House Summit on Countering Violent Extremism (The White House, 2015).

To date CVE has been predominately conducted by law enforcement and informed by criminal justice frameworks. This paper reviews some of the achievements, challenges, and limitations of CVE approaches to date, and proposes a new conceptual framework for extending beyond criminal justice and framing CVE as a part of public health policy and practice.

First-wave CVE

In support of the SIP, law enforcement agencies in Los Angeles, Minneapolis, and Boston have conducted engagement and partnering with communities incorporating a community policing strategy (Department of Justice [DOJ], 2015; Weine, 2015b). Community policing develops collaborative partnerships between law enforcement and impacted communities with an emphasis upon proactive joint problem solving so as to build trust and cooperation and address the immediate conditions that give rise to public safety issues. This approach, referred to as first-wave CVE, is regarded as completely necessary in terms of establishing relationships, sharing information, and building trust (Silk, 2012). However, its drawbacks have also become apparent as documented through research (Schanzer, Kurzman, Toliver, & Miller, 2016)

We have been conducting community-based research on CVE involving qualitative interviews and observations, both in Los Angeles and Minneapolis (Weine, 2013a, 2013b). A frequently heard comment in our research interviews from community members impacted by violent extremism and law enforcement-driven responses is that there is hardly anything filling the space between a person at risk of crossing the line into terrorist activity and being investigated by the Federal Bureau of Investigations, which in the US is the law enforcement agency charged with policing terrorism (Montgomery & Koumpilova, 2016). Community members report that if one sees something suspicious or communications that suggest a risk for ideological violence, there often are not clear pathways to get advice from trusted persons in their community. They add that there are not enough programs and practitioners where the potential bystander can find others who can help them to interpret and problem solve and put a stop to activities before they become crimes. Many people report fearing calling law enforcement and as a result too often nobody gets called.

A frequently heard comment from law enforcement in our research about this first wave of CVE activities is that there are not enough community persons or programs championing CVE (Weine & Braniff, 2015). To the contrary, CVE in the US has engendered considerable grass roots opposition, especially following the 2015 White House CVE Summit (The White House, 2015) when our research noted a surge in pushback (Weine, 2015a). While law enforcement expounds engagement, many community members often speak from a position of preferring 'disengagement' from CVE, claiming that it is a government program which conducts illegal surveillance activity by the government and stigmatizes Muslims Americans (Weine, 2015a).

Second-wave CVE

As Peter Romaniuk noted, 'Community engagement on CVE can yield negative unintended consequences' (Romaniuk, 2015, p. 16). For example, a key unintended

consequence of the first wave of CVE activities that emerged in both the US and UK was the stigmatization of Muslim communities. Some CVE programs were having the effect of constructing Muslims as a 'suspect community' whereas, 'They were being viewed in a homogeneous and unified in a way that other ethnic/religious communities are not' (Thomas, 2008, pp. 4–5). According to Romaniuk, for CVE to succeed it requires a second wave of new initiatives characterized by, 'integrative, broad-based state–civil society relationships in which governments and NGOs engage broadly and partner strategically' (Romaniuk, 2015, p. 16). Increasingly, we found that many in both communities and law enforcement were realizing that the first wave of engagement and partnerships initiatives were just starting points and that what was especially needed were second-wave CVE activities that were less potentially stigmatizing, outcomes oriented, theoretically grounded, and feasible.

In the US, there is a call for these second-wave CVE activities to be focused more specifically on the prevention and intervention components of CVE. Prevention activities of CVE refer to programs, policies, and interventions that promote inclusion of individuals and communities at risk and engage them to diminish exposure to the causes and promoters of violence as well as reduce the progression to violence. Additionally, these strategies increase their access to support and resources promoting individual and community well-being. From the perspective of public health, this can be thought of as primary prevention, which aims to prevent disease or injury before it ever occurs (O'Connell, Boat, & Warner, 2009). Intervention activities of CVE refer to programs, policies, and interventions that serve youth and adults who are believed to be at risk of committing a violent act but are still in the pre-criminal space. This can be thought of as either or secondary prevention, which aims to reduce the impact of a disease or injury that has already occurred, or tertiary prevention which aims to soften the impact of an ongoing illness or injury that has lasting effects.

Both prevention and intervention programs need the participation of community actors. Law enforcement is constitutionally forbidden from getting involved in matters of religion and the so-called battle of ideas regarding ideology and does not have sufficient legitimacy in addressing community members, especially youth. Community-led initiatives to address violent extremism, such as the Muslim Public Affairs Council's Safe Spaces, exemplify what is needed (Muslim Public Affairs Council [MPAC], 2014). When conducting second-wave prevention and intervention CVE activities, communities do not just need a seat at the table, which we found is the mantra of engagement, rather according to community advocates, they need to build their own tables and then under certain circumstances invite law enforcement to take a seat (Weine & Braniff, 2015).

Another matter of concern identified in our research is that violent extremism often is not in the top tier of needs typically identified by community members (Weine, 2015a). Thus, policies and programs are being called upon to not only address violent extremism, but also to address the stated priorities of communities regarding promoting and protecting their well-being and health. This includes addressing a range of problems linked to youth development, for example, drugs, suicide, mental health, gangs, trafficking, hate crimes, domestic violence, and education. In the US, examples of such more broadly conceived community programs can be found in the Montgomery County Model, Life after Hate, as well as Safe Spaces (LAH, 2009; MPAC, 2014; World Organization for Resource Development and Education [WORDE], 2015). Each of these programs embeds addressing violent extremism alongside other issues of targeted violence and other threats to

community well-being. However, understandably with this broader range of issues comes the concern that CVE initiatives could potentially lose their focus and become so diffuse as to diminish their potential effectiveness. Whether or not this is true has yet to be evaluated, but should be.

CVE has been commonly perceived by civil rights organizations and some community members as being a government program that is taking away people's freedoms, as documented in our research interviews (Weine, 2015a). Part of the problem has been that CVE policymakers and practitioners do not presently have adequate ways of framing their mission more broadly. Consequently, they are vulnerable to attacks from community and civil liberties advocates who see in CVE nothing beneficial and only harm to their communities (Osman, 2013). Community members have reported that they do not want their relationship with government to become even more securitized, or do not want to become more stigmatized as a suspect community. They protest CVE efforts because they regard them as a law enforcement-driven activity.

Merely calling CVE by different terms will not remedy the perceived problems. What is needed to more fully develop second-wave CVE is an entirely different way to frame programs addressing the prevention of violent extremism and violent acts it promotes. This can be done by drawing upon public health approaches.

Public health

CVE community programs need not be framed by criminal justice, which has been the dominant approach thus far, but instead could be framed through a public health framework. According to the World Health Organization,

public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease. (World Health Organization [WHO], 2016)

Though often associated with preventing epidemics and the spread of disease, public health concerns also include protecting against environmental hazards, preventing injuries, promoting and encouraging healthy behaviors and environments, responding to disasters and assisting communities in recovery, and assuring the quality and accessibility of health services (Atrash & Carpentier, 2012; Powell, Hanfling, & Gostin, 2012). Public health involves diverse disciplines relevant to CVE such as psychiatry, psychology, sociology, communications, education, and public policy. Public health professionals carry out their work through many relevant approaches too, including developing and implementing community-based programs, administering services, conducting research and evaluation, and recommending policies. All these characteristics make public health a potential framework for understanding the multiple aspects of violent extremism (vs. just looking at it from a single perspective). Despite some prior calls for greater public health involvement in CVE (Bhui, Hicks, Lashley, & Jones, 2012), and a growing movement in the US which frames violence prevention and intervention from a public health point of view (Ritter, 2009), public health has heretofore not played a significant role in the program planning or discourse on CVE.

Generally policies and practices in public health, especially those undertaken at the level of community, are effective if there is an adequate definition of the problem and the identified causes of the problem vis a vis a specific target population that then guides the prevention and intervention planning. Preventive interventions then are conceived as being linked to a very precise understanding of risk and protective factors, which are targeted for change. These may include social, familial, personal, organizational, and structural factors. The more specific the factors identified, the more can be achieved. In the CVE field, what is presently lacking is an evidence base that points clearly to risk and protective factors which could drive public health program planning. Our prior research among Somali Americans identified risk and protective factors through ethnographic research (Weine & Ahmed, 2012). Our findings described how risk could be understood not just individually, but as a property of the community and family. We looked at risk from the vantage point of the opportunity structure which is defined as opportunities for behavior that are provided by a given social context. We identified a total of 37 risk factors which were present at the levels of global, state societal, community, and family and youth. However, it is important to note that there has yet to be a statistical evaluation of these factors from this earlier study.

One risk factor that emerged from our findings and was cited by community members is lack of access to social and mental health services. Another risk factor is the possible overlap between radicalization to violence and mental health/psychosocial troubles (Bhui, Everitt, & Jones, 2014). The latter risk has been given new attention in several recent studies. For example, Paul Gill found that 32% of lone wolves were diagnosed with mental illness, and Pete Simi, Anton Weenik, and Mark Hamm have demonstrated similar findings in other groups (Corner & Gill, 2015; Hamm & Spaaij, 2015; Simi, 2015; Weenink, 2015). Taken together, these risk factors would argue for a prevention strategy that aimed to promote earlier identification of persons with mental health problems, decrease stigma around mental health help seeking, facilitate access to mental health services, and also offer a diversion program for persons with mental health problems who are heading toward criminality, but have not yet committed a crime, such as has been done in juvenile justice (Weine & Ellis, 2015).

Framing CVE community programming as a public health intervention might also allow prevention and intervention programs to access new resources, as part of public health programs. Community safety is vital to public health as well as law enforcement. It could also help in terms of embedding programs in existing structures that are integrated into community life (e.g. community organizing and strengthening), rather than to add new structures that either are or just appear to be a part of the security apparatus. One example is the UK's notion of safeguarding, which refers to efforts to promote and protect the health of children and adults, and is recognized as a responsibility of public health and mental health practitioners (HM Group, 2015).

Moving CVE into a public health framework is different from finding roles for public health as a profession. Each community and jurisdiction should find its own leadership as it develops and CVE initiatives may come from faith-based, civic engagement, mental health, social services or other sectors – not necessarily from public health. But public health as a framework is often applied by other sectors with or without actual public health professional involvement.

Table 1. U.S. CDC Ten Essential Public Health Services.

CDC states that public health policies and practices should:

- 1 Monitor health status to identify and solve community health problems
 - 2 Diagnose and investigate health problems and health hazards in the community
 - 3 Inform, educate, and empower people about health issues
 - 4 Mobilize community partnerships and action to identify and solve health problems
 - 5 Develop policies and plans that support individual and community health efforts
 - 6 Enforce laws and regulations that protect health and ensure safety
 - 7 Link people to needed personal health services and assure the provision of health care when otherwise unavailable
 - 8 Assure competent public and personal health care workforce
 - 9 Evaluate effectiveness, accessibility, and quality of personal and population-based health services
 - 10 Research for new insights and innovative solutions to health problems
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The public health framework also uses theory (mostly socio-behavioral) to help researchers better understand the nature of the health issues being studied, and is essential to the development of programs and evaluations. Some examples of socio-behavioral theories that have been used in violence prevention research include opportunity structure theory, which refers to the fact that the opportunities available to individuals in a society or institution are shaped by the social organization and structure of that entity (Cloward & Ohlin, 2013); resilience theory, which examines an individual's or group's ability to adapt to stress and adversity (Yates & Masten, 2004); and socio-ecological models which look at the interrelations between individuals and their environments and conceptualize that environment at multiple levels (Bronfenbrenner, 1988; Stokols, 1992, 1996; Stokols, Lejano, & Hipp, 2013).

As a framework for rethinking CVE in terms of public health, we turn to the US Center for Disease Control and Prevention (CDC) 'Ten Essential Public Health Services' which describe the public health responsibilities that all communities should undertake (CDC, 2010) (see Table 1).

These were initially developed in as part of President Clinton's 1994 healthcare reform efforts, so as to explain what public health is and link its performance to outcomes. It was followed up by multiple first of their kind research efforts that measured how well agencies were providing these public health services. Our hope is that the 'Ten Essential Public Health Services' could help the CVE field move in a similar direction.

Addressing violent extremism as public health

In this section, we will explain how the Ten Essential Public Health Services can be used to guide specific tasks with respect to addressing violence extremism. We will do so by drawing from our experiences conducting a US Department of Homeland Security-funded evaluation of the CVE initiative in the greater metropolitan Los Angeles area (ICG, 2015). This effort first involved a formative evaluation in which the 'Ten Essential Public Health Services' policy and practice framework was applied to addressing violent extremism. The ongoing discussions of the formative evaluation with primary stakeholders helped us to elaborate in practical terms how the Ten Essential Public Health Services could facilitate the further development of CVE as a part of public health policy and practice, in Los Angeles or beyond. This is illustrated in Table 2 and further explained in the summaries below.

Table 2. Public health functions and addressing violent extremism activities.

Essential public health functions	Public health questions that can drive activities	Addressing violent extremism activities (select examples)
1. Understand health issues at the state and community levels	What is going on in our communities with respect to health?	Conduct assessments to see if local resources match CVE needs
2. Identify and respond to health problems or threats	Are we prepared to respond to health threats?	Share information on newly emerging threats
3. Keep people informed about health issues and healthy choices	How do we keep our communities informed about health?	Convene workshops and trainings for professionals in relevant settings
4. Engage people and organizations in health issues	How well do we really get people and organizations engaged in health?	Develop a coalition of partners to help sectors integrate CVE into existing activities
5. Plan and implement sound health policies	How effective are we in planning and setting health policies?	Directly involve public health and mental health policymakers in CVE policymaking
6. Enforce public health laws and regulations	When we enforce health regulations are we up-to-date, technically, competent, fair and effective?	Review, evaluate, revise CVE related law and policies to guard against civil liberties violations
7. Make sure people receive the medical care they need	Are people receiving the medical care they need?	Provide access to a culturally competent system of care for interventions
8. Maintain a competent public health and medical workforce	Do we have a competent public health staff?	Design and evaluate trainings for public health staff on VE
9. Evaluate and improve programs	Are our programs doing any good?	Conduct evaluations to show if programs work and to direct resource allocation for prevention and intervention
10. Support innovation and identify and use best practices	Are we discovering new ways to get the job done?	Conduct research to identify innovative ways of conducting prevention or intervention

(1) *Monitoring health.* Policymakers, practitioners, and community members have called for accurate and timely assessments of the risks, assets, and resources in communities with respect to violent extremism. They complained that much of the available information has been undisclosed because of security concerns, and called for greater transparency and access to information. Violent extremism risk and protective factors may overlap with factors in other areas of public health concern, such as those in community health, resilience, and violence prevention. According to the Public Health Agency of Canada, many of the determinants of health overlap with posited risk factors for violent extremism, including income and social status, social support networks, education, employment/working conditions, social environments, coping skills, healthy child development, health services, and culture (Public Health Agency of Canada, 2012). Many of the protective factors posited to mitigate against violent extremism could be the same factors that allow communities to withstand stresses and sustain healthy behaviors in the face of adversity, such as social cohesion, economic stability, and access to health care. Perceived discrimination, social isolation, and trust in government are often measured in public health surveillance surveys. Therefore, CVE efforts might find relevant data in these health surveillance surveys while, as research improves to understand the relevant risk and protective factors for violent extremism these surveys will become more useful to CVE programming. Other activities under this function, aside from assessing health status, might include conducting a resource assessment to see if existing resources fit the local CVE issues, building connections between CVE and other community and population-level data collection efforts, and creating mechanisms to share data across health and social service agencies and programs.

(2) *Diagnosing and investigating.* A significant consensus of policymakers and practitioners have called for developing community-based capacities that proactively address those vulnerable to violent extremism in the pre-criminal space through mental health and psychosocial programming, rather than waiting for them to cross the line, or involving them in sting operations that take them in a direction where they never would have dreamed of going. These capacity-building efforts target the period before persons are radicalized though still may have sympathetic opinions toward violent extremist ideas or groups without being directly involved. Public health activities under this function could include timely gathering and sharing of information on newly emerging violent extremism issues in communities and participating on committees addressing violent extremism and related issues. Even more fundamental would be accurately diagnosing violent extremism in the first place, including coming up with definitions and behavioral criteria that are measurable.

(3) *Informing, educating and empowering.* In environments where rumor and misinformation often prevail, a top priority should be educating the public about how addressing violent extremism is part of building healthy communities. A public health approach that addresses violent extremism within the wider reaches of violence prevention provides an opportunity for engaging community members, reaching a broader audience, normalizing the concern, and destigmatizing high-risk populations. Empowering communities through participatory planning of CVE programs and supporting them to assume responsibility for their efforts are needed to build successful programs. Public health educational expertise can contribute to trainings, workshops, and resource development to professionals who work in relevant settings. Conducting media campaigns that raise the visibility of the issue as one for communities to address may be relevant. Equally important is using communications sciences to make sure messages do not stigmatize (Glik, 2007).

(4) *Mobilizing community partnerships.* An emerging consensus is that an intervention program for violent extremism should involve a core group which develops and partners with a broader network of mental health, public health, and education professionals, and other community advocates so as to facilitate help seeking and referrals and to insure that services are relevant to the population needs. Community partnerships in public health, at their best, are more than simply bringing representative voices to the table. They recognize the breadth of stakeholders contributing to community health from social and health services to private business and media. They entail an integrated approach with active, bi-directional communications between the government agencies and the community partners engaged in collaborative action. Partnerships strengthen the way that non-governmental and community organizations and government (e.g. local public health departments) work together to identify strategies and resources, helping sectors integrate CVE into their activities, and working as teams to develop an integrated prevention and intervention plan, clear roles, and responsibilities for each stakeholder. From the public health perspective, enhancing organizational partnerships extends beyond increasing and enhancing the linkages and collaborations between government and non-governmental organizations; a public health approach encompasses improving partnerships between NGOs in the community irrespective of governmental involvement. Public health professionals can also teach community leaders how to develop and sustain collaborations and to obtain additional resources from external funders and grants.

(5) *Developing policies.* The building of programs to address violent extremism requires revisions to the policy framework that move violent extremism reduction programs away exclusive dependence on law enforcement and closer to mental health, education, youth development and other human services. This requires direct involvement of policymakers from these other sectors, who heretofore have not played significant roles in CVE policymaking.

(6) *Enforcing laws that protect.* New intervention programs must operate within the law, which for example, prohibits law enforcement and other government agencies from getting involved in religion and ideology, and instead is focused on relevant behaviors, not identity. Public health practitioners can review laws and policies for their impact on discrimination as well as advocate against such practices, and for protecting civil liberties and diminishing stigmatization.

(7) *Linking to/providing care.* An intervention program should intend to, as part of its charge, identifying those who need or want mental health care and social services, and finding ways to refer them to service providers. Public health can provide guidance on the systematic issues well known to impede or facilitate access to mental health and social services. For instance, intervention programs should identify and address barriers to utilization such as stigma, cost, cultural and language competency, transportation, and child care. They can also address funding by assisting community services in seeking funding, notifying them of funding opportunities, and even funding some programs.

(8) *Assuring competent workforce.* The existing public health, mental health, social service, and education workforce is not adequately trained in matters of violent extremism or even violence reduction more generally. Thus it is necessary to design appropriate initial and ongoing training and supervision to upgrade their capacities and skills. This also calls for evaluation that feeds back into quality improvement and thus ensures ongoing learning and developing leaders and practitioners in the field.

(9) *Evaluating.* Rigorous evaluation of programming is a staple of public health and evaluating extant and future programs that are intended to prevent violent extremism or modify suspected risk factors for violence is just as critical. The US Department of Homeland Security has funded a program evaluation of the Los Angeles initiative which is being conducted with public health strategies, and local policymakers and practitioners are currently collaborating to design an intervention capacities that are fully evaluable by having measureable outcomes. However, having measureable outcomes depends on specification of the risk or protective factors that need to be changed: thus for example, regarding protective factors, increasing referrals to and utilization of mental health services for at-risk people would be evaluable. This can be achieved through building a logic model based upon socio-behavioral theory that shows the intended relationships between inputs, activities, outputs, and outcomes for the newly developed targeted program. This logic model can be used by the evaluators and interveners to create measures and hypotheses for the future CVE intervention study. Public health evaluators can also assist by conducting trainings on program evaluation, distributing program evaluation results to practitioners locally and nationally, and emphasizing the critical value of evaluation in all programs. Evaluation should be part of a quality improvement cycle and, as lessons accumulate, should be provided to policymakers responsible for allocating resources.

(10) *Researching.* Current program development and evaluation are drawing upon prior and ongoing research on violent extremism and CVE. One example is research which

demonstrated a high rate of psychosocial problems and mental health issues in some violent extremists (Corner & Gill, 2015; Hamm & Spaaij, 2015; Simi, 2015; Weenink, 2015). Another example is the research on risk assessment models (Douglas & Skeem, 2005; Reddy et al., 2001; Skeem & Monahan, 2011). Public health programs often include leadership and contributions from multiple academic partners. Partnering between practitioners and academics is common in public health departments where their work is viewed as the application of public health sciences. In time, health services research questions should be asked of CVE programs, given that CVE programs will likely include service provision. This could help to further frame the CVE research focuses on service provision and its outcomes. Thus at the community level this entails developing research methods to assess the degree to which such services are available, the quality of those services, and the levels at which at risk populations use them.

Conclusions

Addressing violent extremism requires significant new initiatives that extend beyond criminal justice and are a part of public health policy and practice. The Ten Essential Public Health Services is proposed as a conceptual framework for a public health approach to addressing violent extremism.

A public health approach creates opportunities for multi-purpose programming, where for example, addressing violent extremism can become part of a broader platform for addressing other youth well-being concerns, such as involving identity, mental health, and gender violence. Also, a public health approach may be able to avoid the stigma associated with criminal justice engagement perceived as identifying a suspect community. Lastly, a public health approach may open up other approaches to organizing and funding CVE programs, by leveraging existing public health resources.

Further progress in accomplishing this policy and paradigm shift toward public health will require additional efforts. First, addressing violent extremism should be grounded in solid theory, which should include that of public health. Second, addressing violent extremism needs policymaker and practitioner champions not just from law enforcement but also from public health as well as mental health, education, youth advocacy, and faith communities. Finally, evaluations of initiatives to address violent extremism and scientific investigations of violent extremism should use cutting edge public health scientific approaches or their equivalent.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was supported by the Science and Technology Directorate and by Department of Homeland Security, Cooperative Agreement 2015-ST-108-FRG006.

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