Elsewhere in *JAMA Network Open*, Topazian and colleagues\(^1\) report the striking finding that more than 1 in 5 US adults believe that harassing or threatening public health officials because of business closures during the COVID-19 pandemic is justified. Specifically, the authors analyzed 2 waves of a nationally representative panel survey of US adults, in November 2020 and July to August 2021, and found increases in the share of adults who endorsed harassments and threats for public health workers, with 25% of respondents justifying harassing and 21% justifying threatening such officials. This important study not only documents the overall prevalence of these concerning beliefs, but it goes deeper to identify particular groups who are more likely to endorse either of these beliefs at 1 or more of the time points: men, those with lower income and education, Hispanic people, younger people, and those with less trust in science. Surprisingly, given persistent partisan differences in other types of pandemic attitudes and beliefs even very early in the pandemic, Republicans were no more likely to endorse holding these beliefs than were Democrats in November 2020. However, a partisan gap emerged in 2021: 34% of Republicans believed harassment of public health officials was justified in 2021, compared with a still sizable 19% of Democrats. Furthermore, the authors detected growth in reporting these views in 2021 among groups with higher education and more trust in science—findings the authors suggest may be because of the public’s “pandemic fatigue” with restrictions but could also reflect changes in perceived norms, such that respondents felt less social desirability bias in reporting their beliefs endorsing harassment as the pandemic went on.

To be sure, readers might respond that these estimates are measures only of beliefs, not of behaviors; after all, these are study participants’ top-of-head perceptions when asked to respond to a survey on a topic they may not have considered before. Are these responses meaningful? Unfortunately, data from other sources strongly suggest these beliefs endorsing the permissibility of harassment translated to actions taken. In fact, the focal article of the May 2022 issue of the *American Journal of Public Health* quantified actual reported experiences of harassment and threats among workers at local health departments (LHDs) in 2020.\(^2\) Ward and colleagues\(^2\) found that of 583 LHDs that responded to their survey, 335 departments (57%) reported at least 1 instance of harassment targeting leadership or staff, ranging from social media backlash, broadcast of personal information, threatening messages, demonstrations, and vandalism. These experiences of harassment are consequential: they contribute to public health workers leaving the workforce\(^3\) and facing significant mental health challenges.\(^4\) A recent large-scale study of the national public health workforce (44,732 participants) conducted between September 2021 and January 2022 found that 56% of public health workers reported at least one symptom of posttraumatic stress disorder; 22% reported their mental health as fair or poor; 41% of public health executives reported being bullied, threatened, or harassed; and 32% said they are considering leaving their positions.\(^4\)

It is important to contextualize these findings within broader trends in public attitudes about public health and about politics. First, the practice of public health, particularly the work of governmental public health officials, has always been political.\(^5\) However, for the most part, their efforts have been relatively invisible to the public. In fact, a truism in the field of public health is that when public health is effective, it is invisible. The COVID-19 pandemic rendered public health extremely visible, and as a consequence, public health as a field and public health workers became more visibly political. Indeed, the survey conducted by Topazian and colleagues\(^1\) suggests a
conflation between public health workers and politicians, since they found that the vast majority of respondents who justified harassment and threats toward public health officials in 2020 justified the same for politicians. This key finding echoes broader trends: in the 2022 book *Radical American Partisanship*, political scientists Nathan Kalmoe and Lilliana Mason use extensive survey data (more than a dozen nationally representative surveys) to document an increase from 2017 to 2021 in the public’s willingness to endorse political violence, including support for threats of violence against political leaders and members of the opposite political party. Notably, just as Topazian and colleagues observed similar levels of reporting of violent beliefs toward public health officials across the political spectrum in 2020, so too do Kalmoe and Mason: they found that rates of violent views toward the opposing party were similar for Republicans and Democrats through 2020, after which a partisan difference emerges, with Republicans reporting more support for violence. These data collectively suggest that the endorsement of violence against public health officials is a symptom of a broader illness in contemporary US politics, with potentially grave consequences.

What can be done? Given the threat to the public’s health posed by a depleted and demoralized workforce, investment in the workforce and in strategies to neutralize antagonism among the public are needed. For the latter, one positive finding that Kalmoe and Mason report is that messages communicated by political party leaders denouncing violence can reduce support for such violence among the public, particularly among those who have strong attachment to their partisan group. Their work suggests that if party leaders were to strongly endorse antiviolence and support for public health workers, this could have promise in mitigating these views. In a recent commentary, Michael Fraser, the chief executive officer of the Association of State and Territorial Health Officials, similarly endorsed the promise of a communication strategy to “remind all Americans about the importance of our collective good” to help mitigate antagonistic attitudes. Investment in communication research is critical to assess which of many possible messaging approaches can best neutralize negativity and bolster support for public health, and as Topazian and colleagues note, these communication and engagement strategies should be nuanced and tailored to different subgroups.

More tangibly, however, direct and immediate investment in the public health workforce is critical. Ward and colleagues describe a range of needed resources for the public health workforce, including funding, bolstered staffing, worker safety protections, better reporting of violence, and legal support for workers. Social science research affirms that no one silver bullet will reduce the hostility of political discourse at the moment, whether about politics in general nor public health in particular. However, the price of inaction and hopelessness is too high. The evidence provided by Topazian and colleagues should activate all readers to consider the many ways in which they can advocate for more investment in public health, including advocacy for investment in the training and education of future public health professionals, supporting increased resource allocation to protect the safety and mental health of the current workforce, and individual acts of outreach to support and thank public health workers in our communities—all of which could better protect those workers on whom our collective health and well-being depend.
REFERENCES