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THE IMPACT OF "DUTY TO WARN" (AND OTHER LEGAL THEORIES) ON COUNTERING VIOLENT EXTREMISM INTERVENTION PROGRAMS

by

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December 2016

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Countering violent extremism (CVE) programs are moving into the realm of intervention, diversion, and deflection. These programs require mental health professionals to conduct assessments, construct treatment plans, and provide the treatment. How can practitioners treat or divert individuals from the path to radicalization but also communicate when an individual remains a threat? An understanding of the laws that facilitate or restrict disclosure of confidential health info, combined with a structure to oversee the process, is critical. Research for this thesis has focused on federal and Maryland state laws pertaining to medical record confidentiality and the duty to warn. This legal analysis has determined that exceptions exist within medical confidentiality laws, enabling mental health practitioners to disclose when a threat exists, and that Maryland's duty-to-warn laws mandate that mental health practitioners have a duty to protect third parties from the actions of patients. Due to the varied disciplines involved in CVE, collaborative group models are suggested to structure the process.

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THE IMPACT OF "DUTY TO WARN" (AND OTHER LEGAL THEORIES) ON COUNTERING VIOLENT EXTREMISM INTERVENTION PROGRAMS

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ABSTRACT

Countering violent extremism (CVE) programs are moving into the realm of intervention, diversion, and deflection. These programs require mental health professionals to conduct assessments, construct treatment plans, and provide the treatment. How can practitioners treat or divert individuals from the path to radicalization but also communicate when an individual remains a threat? An understanding of the laws that facilitate or restrict disclosure of confidential health info, combined with a structure to oversee the process, is critical. Research for this thesis has focused on federal and Maryland state laws pertaining to medical record confidentiality and the duty to warn. This legal analysis has determined that exceptions exist within medical confidentiality laws, enabling mental health practitioners to disclose when a threat exists, and that Maryland's duty-to-warn laws mandate that mental health practitioners have a duty to protect third parties from the actions of patients. Due to the varied disciplines involved in CVE, collaborative group models are suggested to structure the process.

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LIST OF ACRONYMS AND ABBREVIATIONS

ADC	American-Arab Anti-Discrimination Committee
BRAVE	Building Resilience against Violent Extremism
CAC	child advocacy center
CFR	Code of Federal Regulations
CII	collective impact initiative
CPS	child protective services
CRS	Congressional Research Service
CVE	countering violent extremism
DHHS	Department of Health and Human Services
DHS	Department of Homeland Security
DOJ	Department of Justice
EO	Executive Order
FBI	Federal Bureau of Investigation
FCWG	Faith Community Working Group
FISA	Foreign Intelligence Surveillance Act
FISC	Foreign Intelligence Court
HIPPA	Health Insurance Portability and Accountability Act
HVE	homegrown violent extremist
ISH	International Student House
ISIS	Islamic State of Iraq and Syria
JTTF	Joint Terrorism Task Forces
LE	law enforcement
MCM	Montgomery County Model
MCP	Montgomery County Police
MDT	multi-disciplinary team
MOU	memorandum of understanding
NCAC	National Children's Advocacy Center
NGO	non-governmental organization
NIJ	National Institute of Justice
OCR	Office for Civil Rights

PERF	Police Executive Research Forum
PHI	personal health information
SCR	shared responsibility committee
SIP	Strategic Implementation Plan
UC	University of California
WORDE	World Organization for Resource Development and Education

EXECUTIVE SUMMARY

As the threats of homegrown violent extremists have increasingly become a reality, the federal government has created a countering violent extremism (CVE) program to fill the pre-criminal space. Elements of the CVE program are designed to add the missing preventative pieces to traditional methods. The four main parts of the U.S. CVE design are community engagement, education on radicalization, counter narratives, and intervention programs designed to deter or re-direct individuals from a path to radicalization. These parts are the same basic components of the most successful precursor models, namely gang diversion[1] and substance abuse diversion programs.[2]

Law enforcement (LE) plays an integral role in CVE, but the effort also relies heavily on other participants and stakeholders. Mental health practitioners must play a critical role in both the intervention and education segments of CVE by providing essential services, detecting those at risk, and educating others on the radicalization process. While LE and mental health practitioners represent two professions dedicated to helping others, a mutual understanding or cooperation has historically been lacking.[3] This conflict of perceived interests and obligations has slowed meaningful collaboration in the CVE intervention realm.

How can mental health providers treat or divert individuals from the path to radicalization but still share risk assessments and intelligence with LE when patients pose a threat to others? CVE programs involved in intervention and diversion need a mechanism or policy in place that facilitates the notification of LE authorities when a

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[1] James C. Howell, "Gang Prevention: An Overview of Research and Programs, Juvenile Justice Bulletin," *Office of Juvenile Justice and Delinquency Prevention*, 2010, 12, http://eric.ed.gov/?id=ED 518416.

[2] Jason Payne, Max Kwiatkowski, and Joy Wundersitz, *Police Drug Diversion: A Study of Criminal Offending Outcomes*, Research and Public Policy Series, no. 97 (Canberra: Australian Institute of Criminology, 2008), xi.

[3] James R. Corbin, "Confidentiality & the Duty to Warn: Ethical and Legal Implications for the Therapeutic Relationship," The New Social Worker, April 23, 2014, 1, http://www.socialworker.com/ api/content/f6758dd1-7700-3ccb-95ab-96de65ea6fcd/.

diversion practitioner suspects that the client is not responding to diversion efforts or a determination is made that the individual presents a risk to others.

The beginning steps involve an understanding of the legal environment that applies to the effort. Mental health practitioners are bound by federal and state laws that may restrict or facilitate the disclosure of privileged personal health information (PHI).

A. MEDICAL RECORD CONFIDENTIALITY

In reference to medical confidentiality laws, it is imperative that practitioners understand the existence of both the federal Health Insurance Portability and Accountability Act (HIPAA) law and specific state laws. In relation to HIPAA, stakeholders must understand that the HIPPA Privacy Rule only identifies two mandatory disclosures of PHI, to the patient, and to Department of Health and Human Services (DHHS) for auditing purposes. The remaining exceptions provide permissible conditions for mental health practitioners to share information. In terms of CVE, the two applicable exceptions to confidentiality when a mental health practitioner may disclose information are located in paragraphs (j) and (k) of the HIPAA Privacy Rule.[4] Paragraph (J) allows a medical provider (mental health professional) to disclose PHI when it is "necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public."[5] Paragraph (K) presents a broader exception to the federal law in that it allows for the disclosure of PHI to protect national security. The paragraph allows for the disclosure to "authorized federal officials" for the purpose of conducting "lawful intelligence, counter-intelligence, and other national security activities."[6] It is important to note that these exceptions to federal law are permissive and do not require the disclosure of PHI. It is clear, however, that mental health practitioners involved in intervention may, under federal law, disclose otherwise protected information if their client poses a threat of violence.

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[4] U.S. Government, *45 CFR Part 164 Subpart E—Privacy of Individually Identifiable Health Information* (Washington, DC: Government Printing Office, n.d.), 764–765, accessed August 6, 2016, https://www.gpo.gov/fdsys/pkg/CFR-2007-title45-vol1/pdf/CFR-2007-title45-vol1-part164-subpartE.pdf.

[5] Ibid., 764.

[6] Ibid., 765.

Like the Privacy Rule, Maryland state laws on medical record confidentiality are permissive in nature. Maryland law is broader than the federal law in regards with whom PHI may be shared. Maryland law allows for the disclosure of PHI to any government agency conducting authorized actions (as described by law). Practitioners will be challenged when blending state and federal law. Maryland law also allows for the release of information for an investigative process. The law does stipulate that the receiving agency must have written policies in place to protect the information. Many law enforcement (LE) agencies do not have written procedures for the protection and safe storing of PHI. As a result, LE agencies involved in CVE actions must create these types of policies.

Practitioners in Maryland must also understand that they must disclose, or not disclose, PHI in compliance with the law to be immune from civil action.

CVE programs may also use consent to share information. Consent is the easiest and cleanest practice that may address the issue of communication among stakeholders. The process must include a written waiver completed by the client. The waiver must include the length of the consent and under what circumstances it may be revoked. Under Maryland law, the consent process is described under §4-303.[7]

B. DUTY TO WARN AND PROTECT

As with medical confidentiality laws, training on duty to warn and protect laws will be critical for practitioners involved in CVE intervention and diversion. Mental health professionals working with CVE programs should already be well versed on the ethical and legal conditions imposed upon their work. The practitioners may not, however, have experience working with other professionals from other disciplines. They also may not be well versed on the exceptions to confidentiality in relation to the threat presented by radicalized persons.

[7] State of Maryland, *22. Medical Records Act--Duty to Hold Confidential and Duty to Disclose a Medical Record, Health-General Article § § 4-301--4-309, 8-601* (Baltimore, MD: Maryland Department of Mental Health and Hygiene, n.d.), accessed September 12, 2016, http://dhmh.maryland.gov/psych/pdfs/Medicalreports.pdf.

The terms "duty to warn" and "duty to protect" were born of a series of incidents, and subsequent legal maneuvers, in California in the late-1960s and mid-1970s. The events of concern were litigated in the California case of Tarasoff v. Regents of University of California.[8]

As duty to warn and duty to protect laws reside at the state level, practitioners must be aware of the laws of the state where they are practicing. Additionally, many laws are written in a broad manner that does not clearly articulate what is forbidden, mandated, or allowed. Many of these laws, such as Maryland's, allow for discretion. Mental health practitioners must have access to legal experts to assist in deciphering and applying the law, which is especially important when situations are frequently not the same.

Maryland is a mandatory duty-to-protect state. The affirmative nature of the duty may differ from other states in that it provides for options for which a therapist may act and does not specifically dictate which option the therapist must choose. The statute is located in Maryland's Courts and Judicial Proceedings Section §5-609.[9] Section (b) outlines the mandated duty to protect as occurrences when a mental health care provider is aware that a patient is capable of violent behavior against a known victim or group of victims. The statue provides immunity from legal or disciplinary action if the provider for discharge of the duty to warn or protect. Section (b) also describes the manner in which a provider may come to know of the threat posed by a patient as the patient's spoken word, writing, or conduct.[10]

Section (c) (2) provides the options for the discharge of the duty that a provider may take. The statue allows for discretion on the part of the provider to either seek a commitment for the patient, construct a treatment plan to address the potential violence, inform a LE agency of the danger posed by the patient, or warn the intended victim(s). If

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[8] "Tarasoff v. Regents of University of California—17 Cal.3d 425—Thu, 07/01/1976|California Supreme Court Resources," accessed August 28, 2016, http://scocal.stanford.edu/opinion/tarasoff-v-regents-university-california-30278.

[9] "Courts and Judicial Proceedings, Section 5-609," accessed September 10, 2016, http://mgaleg.maryland.gov/webmga/frmStatutesText.aspx?article=gcj&section=5-609&ext=html&session=2015RS&tab=subject5.

[10] Ibid.

the provider decides to provide a warning to LE or the intended victim(s), the stature delineates that the warning must include the nature of the threat, the identity of the patient, and the identity of the intended victim(s). As a result, Maryland's law is both a duty to warn and a duty to protect statute. The law is mandatory in requiring the therapist to take action to protect, but allows discretion in how the provider discharges the duty. The law also states that the actions taken by the provider must be both reasonable and timely.[11]

Mental health practitioners working with CVE programs within the state of Maryland are thus bound by state law to protect third parties from the actions of their clients. The law does, however, provide a certain amount of discretion in how the practitioner addresses the threat. Since CVE programs are collaborative efforts, mental health practitioners may rely on advice and input from other disciplines.

C. CVE STRUCTURE MODELS

The Building Resistance against Violent Extremism (BRAVE) model of CVE is currently operating in Montgomery County, Maryland, and is expected to expand to other jurisdictions.[12]

According to its strategic plan, the BRAVE model in Montgomery County describes itself as a "collective impact initiative" (CII).[13] "Collective Impact is a framework to tackle deeply entrenched and complex social problems. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change."[14] The idea of a CII was first written about in the Stanford Social Innovation Review in 2011. According to the article, five key elements are needed for a

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[11] "Courts and Judicial Proceedings, Section 5-609."

[12] World Organization for Resource Development and Education (WORDE), *The Building Resilience against Violent Extremism (BRAVE) Model—A Collective Impact Initiative That Increases Public Safety and Social Cohesion* (Montgomery Village, MD: World Organization for Resource Development and Education (WORDE), 2016, https://drive.google.com/file/d/0B8ZeOqiUkpq2MUZheTd5eUNKRVk/view?usp=sharing&usp=embed_facebook.

[13] Ibid., 12.

[14] "The Collective Impact Framework | Collaboration for Impact," accessed October 16, 2016, http://www.collaborationforimpact.com/collective-impact/.

successful program: a common agenda, shared measurements systems, mutually reinforcing activities, continuous communication, and a backbone support organization.

Figure 1. Collective Impact Initiative.[15]

CIIs are models that may be applied to organizational structures to ensure that practitioners are working together to achieve a common goal. The BRAVE model is currently the only true community led CVE initiative in existence.

The BRAVE model also calls for the creation of an intervention task force to oversee intervention efforts. While the task force is not currently being used, it is envisioned to work in the same manner as a multi-disciplinary team (MDT).[16] The MDT approach identifies practitioners with critical responsibilities to an issue, and brings those practitioners together to form a team. The practitioners represent agencies that have a stake in the solution of the challenge. The practitioners are brought together as subject matter experts on their aspect or interest in the issue. The goal is to form a team of experts where each expert represents a different discipline for the purpose of

[15] "The Collective Impact Framework | Collaboration for Impact."

[16] World Organization for Resource Development and Education (WORDE), *The Building Resilience against Violent Extremism (BRAVE) Model—A Collective Impact Initiative That Increases Public Safety and Social Cohesion*, 16.

collaborating on complex challenges. One of the assumptions of the effort is that individual practitioners would not benefit from the expertise of team members from different disciplines if the team was not formed. The practitioners represent each of their disciplines and work to collaborate the efforts of their organizations with the partner agencies. The goal is to create a common plan to overcome a challenge and identify the role of each discipline. MDTs have been used in the United Stated for several decades, with a high level of success, in the area of physical and sexual child abuse. The MDT approach was first applied to child sexual abuse in the 1980s by the National Children's Advocacy Center (NCAC) in Huntsville, Alabama.[17] MDTs are currently used in Montgomery County to coordinate child abuse investigations.

CVE programs should use structural models similar to CIIs and MDTs to facilitate the cooperation of stakeholders from different disciplines. A structure similar to a MDT is needed to manage the screening and service plan of persons receiving assistance in intervention programs. MDTs should be led by mental health practitioners who possess the training and experience needed to access and manage treatment properly. The teams should also include legal professionals and LE to manage the balance between successful treatment and public safety.

[17] "National Children's Advocacy Center History," accessed July 11, 2016, http://www.nationalcac.org/table/about/history/.

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This paper is dedicated to all the men and women who have devoted their lives to helping other people. These noble endeavors are frequently undertaken by everyday heroes who are quick to deflect recognition. My classmates are perfect examples. I remain proud and grateful to walk among them and call them friends.

Without the support of my organization, I would not have been able to apply, let alone complete, the Center for Homeland Defense and Security program. I extend special recognition to the following Montgomery County Police professionals:

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Assistant Chief Betsy Davis
Assistant Chief Russel Hamill
Captain Paul Liquorie
Captain Nancy Demme (ret.)
Lieutenant Phillip Raum (ret.)

and

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My parents, Joseph and Ann Marie Ward, instilled within me the importance of pursuing a good education and the desire to choose a career that matters. Without their love and support, I would not be where I am today.

Lastly, I thank my wife, Alanna, for her support and patience over the last 18 months (actually, for the last 23 years). I am a better man because of you, Alanna.

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I. INTRODUCTION

In Colorado, a seemingly normal and bright young girl was raised in a middle class suburb of Denver. The daughter of a Catholic college professor, she took honors courses at the local high school. She did not display troubling behavior, and enjoyed interacting with her friends. She was like any number of other American teenagers.

In her junior year, the girl—Shannon—began wearing traditional Muslim clothing. See Figure 1. On her Facebook page, she changed her name from Shannon to Halima (Arabic for "gentle"). She began frequenting a Christian mega-church while wearing her traditional Muslim clothing.[1]

Figure 1. Shannon Conley.[2]

[1] Jenny Deam, "Colorado Woman's Quest for Jihad Baffles Neighbors," *Latimes.com*, July 25, 2014, http://www.latimes.com/nation/la-na-high-school-jihadi-20140726-story.html.

[2] Source: TheDenverChannel.com Team, "Shannon Conley, Arvada Teen Who Tried to Join ISIS to Wage Jihad, Sentenced to 4 Years in Prison," *7NEWS*, January 24, 2015, http://www.thedenverchannel.com/news/local-news/sentencing-for-shannon-conley-arvada-teen-who-tried-to-join-isis-to-wage-jihad.

Church officials approached the young woman and inquired if she had questions or was interested in joining the church; she replied that she was Muslim and was there to conduct research. Shortly thereafter, the Federal Bureau of Investigation (FBI) was notified and conducted their first interview of Shannon Maureen Conley.[3]

Nothing Conley was doing was illegal; but she was in the process of radicalizing to Islamic extremism. She had been watching DVDs of Anwar al-Awlaki and other jihadists.[4] Conley met an Islamic State (IS) jihadist on-line, and agreed to travel to the Middle East to marry him and join him in waging jihad. She was also apparently pursuing military-style tactical training. Her parents, aware of her plans, were alarmed.

The FBI interviewed Conley eight times over the course of five months. Six of the interviews were conducted with her parents present. Agents pleaded with Conley to abandon her radical views of Islam.[5] The agents also beseeched her parents to dissuade her from committing any crimes or traveling to join a terror group. On April 8, 2014, shortly after the FBI's last conversation with Conley, she was arrested at Denver International Airport, en route to Turkey and then Syria. Conley was charged federally with providing material support to a terrorist group.

In January 2015, a federal judge sentenced Conley to four years in prison after she admitted to trying to travel to Syria to join the IS. The judge who sentenced her stated that he believed she needed psychiatric care, but also noted that she had remained defiant and possibly dangerous. "Added the judge, She has no history in the criminal justice system. She is very young…Teenagers make dumb decisions a lot."[6] At sentencing, Conley claimed that she had been wrong and now understood that Islamic State of Iraq and Syria (ISIS) had corrupted Islam and the Quran. Prosecutors argued for the four-year sentence to dissuade others from taking a similar path.

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[3] TheDenverChannel.com Team, "Shannon Conley, Arvada Teen Who Tried to Join ISIS to Wage Jihad, Sentenced to 4 Years in Prison."

[4] Michael Martinez, Ana Cabrera, and Sara Weisfeldt, "Colorado Woman Gets 4 Years for Wanting to Join ISIS," *CNN*, January 24, 2015, http://www.cnn.com/2015/01/23/us/colorado-woman-isis-sentencing/index.html.

[5] Deam, "Colorado Woman's Quest for Jihad Baffles Neighbors."

[6] Martinez, Cabrera, and Weisfeldt, "Colorado Woman Gets 4 Years for Wanting to Join ISIS."

The greatest irony of the Shannon Conley case is that both her family and the FBI were aware of her activities and took steps to try and convince her from continuing on her path, and it was not enough. It is perfectly legal in the United States to be vulnerable to radicalization to violent extremism, to radicalize, or even to express radical beliefs. For this reason, authorities undertake investigative or prosecutorial activities only once a crime has been committed. The problem is not, in the first instance, that authorities fail to recognize or track would-be terrorists and their plans. Law enforcement (LE) and intelligence communities around the world are aware of individuals who pose a possible danger to society but who have not committed a crime, or at least a crime the government wished to prosecute. French officials, for example, were aware of the suspect brothers who committed the Charlie Hebdo attacks and murders in Paris in 2015. The government conducted surveillance, but the brothers were not observed committing any crimes, so the authorities turned their attention to other potentially violent suspects. It turned out that the brothers were planning mass murder, but they had not revealed any suspicious signs during the course of the government's investigation.[7] Similarly, the homegrown violent extremist (HVE) who committed murder at an Orlando nightclub had twice previously been investigated by the FBI.[8] When the FBI exhausted all plausible investigative efforts, agents had no choice but to let this future killer go. The FBI and other federal LE agencies are restricted in their options in advance of a criminal act by a process that regulates their ability to open formal investigations, and limits the length of the investigation.

As the threats of HVE have increasingly become a reality, the federal government has created a countering violent extremism (CVE) program to fill the pre-criminal space. Elements of the CVE program are designed to add the missing preventative pieces to traditional methods. The four main parts of the U.S. CVE design are community engagement, education on radicalization, counter narratives, and intervention programs

[7] Scott Bronstein, "Cherif and Said Kouachi: Their Path to Terror," *CNN*, January 14, 2015, http://www.cnn.com/2015/01/13/world/kouachi-brothers-radicalization/index.html.

[8] Del Quentin Wilber, "The FBI Investigated the Orlando Mass Shooter for 10 Months—and Found Nothing. Here's Why," *Latimes.com*, July 14, 2016, http://www.latimes.com/nation/la-na-fbi-investigation-mateen-20160712-snap-story.html.

designed to deter or re-direct individuals from a path to radicalization. These parts are the same basic components of the most successful precursor models, namely gang diversion[9] and substance abuse diversion programs.[10]

LE plays an integral role in CVE, but the effort also relies heavily on other participants and stakeholders. Mental health practitioners must play a critical role in both the intervention and education segments of CVE by providing essential services, detecting those at risk, and educating others on the radicalization process. While LE and mental health practitioners represent two professions dedicated to helping others, a mutual understanding or cooperation has historically been lacking.[11] LE is frequently a profession charged with gathering information, and the field of mental health is generally a profession ethically and legally bound to protect the confidentiality of its patients. This conflict of perceived interests and obligations has slowed meaningful collaboration in the CVE intervention realm.

A. RESEARCH QUESTION

How can mental health providers treat or divert individuals from the path to radicalization but still share risk assessments and intelligence with LE when patients pose a threat to others? CVE programs involved in intervention and diversion need a mechanism or policy in place that facilitates the notification of LE authorities when a diversion practitioner suspects that the client is not responding to diversion efforts or a determination is made that the individual presents a risk to others. What should such a policy comprise?

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[9] James C. Howell, "Gang Prevention: An Overview of Research and Programs. Juvenile Justice Bulletin," *Office of Juvenile Justice and Delinquency Prevention*, 2010, 12, http://eric.ed.gov/?id=ED518416.

[10] Jason Payne, Max Kwiatkowski, and Joy Wundersitz, *Police Drug Diversion: A Study of Criminal Offending Outcomes*, Research and Public Policy Series, no. 97 (Canberra: Australian Institute of Criminology, 2008), xi.

[11] James R. Corbin, "Confidentiality & the Duty to Warn: Ethical and Legal Implications for the Therapeutic Relationship," The New Social Worker, 1, April 23, 2014, http://www.socialworker.com/api/content/f6758dd1-7700-3ccb-95ab-96de65ea6fcd/

B. PROBLEM STATEMENT

The United States has adopted CVE as a preventative aspect of its counterterrorism strategy. In 2011, the U.S. government issued a report titled, *Empowering Local Partners to Prevent Violent Extremism in the United States*.[12] The report documents the government's position that traditional efforts, including diplomatic relations, military action, intelligence gathering and analysis, and investigative and prosecutorial processes, were deemed insufficient in preventing and deterring HVEs in the homeland.[13] CVE programs are focused on building trusting relationships between the government and the communities they serve, training practitioners and community members on radicalization and terrorism, countering the narratives of violent jihad, providing an deflection or diversion application to redirect individuals at-risk or engaged in the radicalization process, and providing an intervention element to assist individuals who may be at risk for radicalization.[14]

1. Intervention, Deflection, and Diversion

George Washington University Professor Dr. Lorenzo Vidino divides the categories of radicalization into two parts. According to Vidino:

> Cognitive radicalization is the process through which an individual adopts ideas that are severely at odds with those of the mainstream, refutes the legitimacy of the existing social order, and seeks to replace it with a new structure based on a completely different belief system. Violent radicalization occurs when an individual takes the additional step of using violence to further the views derived from cognitive radicalization.[15]

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[12] Executive Office of the President of the United States, *Empowering Local Partners to Prevent Violent Extremism in the United States* (Washington, DC: Executive Office of the President of the United States, 2011), https://www.whitehouse.gov/sites/default/files/empowering_local_partners.pdf.

[13] Ibid., 2.

[14] Executive Office of the President of the United States, *Strategic Implementation Plan for Empowering Local Partners to Prevent Violent Extremism in the United States* (Washington, DC: Executive Office of the President of the United States, 2011), https://www.whitehouse.gov/sites/default/files/sip-final.pdf.

[15] Lorenzo Vidino and James Brandon, *Countering Radicalization in Europe* (London: International Centre for the Study of Radicalization and Political Violence, 2012), 9–10.

Vidino's assertion describes the difference between an individual who is radicalized and an individual who is radicalized and involved in illegal or violent activities.

Intervention programs are designed to provide services for individuals who are vulnerable to radicalization; these people might be immigrants who are having a hard time adjusting to a new culture, or teenagers experiencing social difficulties. Deflection and diversion programs are designed for individuals involved in the radicalization process. Diversion programs are designed to be in lieu of incarceration after or during a prosecution. Deflection programs are used "when a law enforcement agency is aware of the subject but instead of prosecution or before a crime is committed, the individual is referred to an intervention program."[16]

According to the strategic plan issued by the World Organization for Resource Development and Education (WORDE) for the Building Resilience Against Violent Extremism model of CVE:

> Both diversion and deflection programs attempt to divert or channel offenders away from the justice system by providing intense wrap-around services, including counseling, mentoring, case management, and community service opportunities. Such programs are often conducted in partnership with police departments, courts, district attorneys, or non-governmental agencies in lieu of incarceration or prosecution and often require reporting compliance to the referring agency.[17]

For the purpose of this thesis, collectively, all three are referred to as "intervention." "Intervention efforts are typically provided by trained, experienced, and licensed mental health practitioners. These experts include social workers, clinicians,

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[16] World Organization for Resource Development and Education (WORDE), *The Building Resilience against Violent Extremism (BRAVE) Model—A Collective Impact Initiative That Increases Public Safety and Social Cohesion* (Montgomery Village, MD: World Organization for Resource Development and Education (WORDE), 2016, 19, https://drive.google.com/file/d/0B8ZeOqiUkpq2MUZheTd5eUNKRVk/view?usp=sharing&usp=embed_facebook.

[17] Ibid.

therapists, psychiatrists, and psychologists. (Referrals for intervention also come from the community and government.)"[18]

Clinicians and therapists involved in intervention efforts are bound by ethical and legal obligations to maintain the confidentiality of the persons they are treating.[19] As a result, legal restrictions may be in place prohibiting or mandating the notification of LE. On the other hand, a situation may emerge in which the therapists may be assessing a client who has been referred for intervention without recognizing clues that may indicate that the client poses a risk to the rest of society. In such a scenario, communication between diversion and intervention practitioners and LE sources may be crucial.

2. Medical Record Confidentiality

Practitioners may be affected and limited in their ability to disclose client or patient information by federal HIPAA laws and state statutes directed towards medical record confidentiality.[20] HIPAA and state laws were created to protect patients' privacy rights, but they also provide for exceptions to fulfill crucial LE and public health functions. Some of the exceptions to confidentiality and privacy laws include responses

[18] The community referrals may come from "bystanders," defined as individuals who are close, or in contact with, an individual who is at risk or engaged in a radicalization process. See Thomas Schillinger, "Bystander Effect and Religious Group Affiliation: Terrorism and the Diffusion of Responsibility" (PhD diss., Walden University, 2014), http://scholarworks.waldenu.edu/dissertations/126/.Bystanders may be family members, friends, co-workers, religious associates, or neighbors. When bystanders make a referral to a CVE for diversion, the presence and identity of the individual referred may, or may not, be known to government authorities. Mechanisms and processes may not be in place to facilitate notification of LE when the referred individual presents a threat. Examples of intervention referrals originating from government sources are court referrals, juvenile justice systems referrals, referrals from LE (i.e., a referral from a school resource officer), referrals from Health and Human Services agencies, referrals from schools, and referrals directly from terrorism investigative agencies, such as the FBI and the FBI's Joint Terrorism Task Forces (JTTF).Typically, in cases where the referral originates from an investigative agency, an investigation has been conducted and a determination has been made that no charges or prosecution will take place at the time of the referral. This finding does not ensure that the target of the investigation does not pose a risk, that the investigation will not continue, or that charges will not be placed in the future.

[19] Corbin, "Confidentiality & the Duty to Warn: Ethical and Legal Implications for the Therapeutic Relationship."

[20] "When Does the Privacy Rule Allow Covered Entities to Disclose Protected Health Information to Law Enforcement Officials?," accessed September 19, 2015, http://www.hhs.gov/ocr/privacy/hipaa/faq/disclosures_for_law_enforcement_purposes/505.html.

to court orders, mandated reporting of sexual or physical abuse, and notification of when a patient dies.[21]

Various federal laws define the government's role and responsibilities in regards to national security (i.e., the National Security Act and the Patriot Act). These laws define terms and delineate the circumstances in which a practitioner may report behavior that endangers national security.[22] For example, Section 215 of the PATRIOT Act describes the process through which the federal government may require practitioners to provide the FBI with evidence of national intelligence, counter-intelligence, or national security implications.[23]

3. Confidentiality versus Public Peril

State laws inspired by the 1974 and 1976 Tarasoff vs. Regents case in California affect clinicians and their duty to warn or protect when they are treating a client who poses a risk to others.[24] It is from the Tarasoff case that the terms "duty to warn" and "duty to protect" originate.[25] Tarasoff was the first case to explore the balance between a patient's right to confidentiality and a therapist's obligation to warn third parties of potential danger posed by the client.[26] The requirement, which has been adopted and applied by most states, requires that psychotherapists with information that a client they are treating poses a threat to someone else make reasonable efforts to communicate with

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[21] "When Does the Privacy Rule Allow Covered Entities to Disclose Protected Health Information to Law Enforcement Officials?."

[22] F. Sensenbrenner, "H.R.2048—114th Congress (2015–2016): USA FREEDOM Act of 2015," June 2, 2015, https://www.congress.gov/bill/114th-congress/house-bill/2048/text.

[23] "National Security and Medical Information," accessed March 26, 2016, https://www.eff.org/issues/national-security-and-medical-information.

[24] Tarasoff v. Regents of the University of California, 17 Cal. 3d 425 (1976).

[25] Steven Granich, "Duty to Warn, Duty to Protect," *SocialWorker.com*, accessed February 27, 2016, http://www.socialworker.com/api/content/a89ea5ac-f455-31d0-b88f-d814ca06299f/.

[26] Damon Muir Walcott, Pat Cerundolo, and James C. Beck, "Current Analysis of the Tarasoff Duty: An Evolution towards the Limitation of the Duty to Protect," *Behavioral Sciences & the Law* 19, no. 3 (June 2001): 325–43, doi:10.1002/bsl.444.

and warn the victim and a LE agency.[27] Since duty to warn and protect laws reside at the state level, each state has a unique law that applies the duty differently.

C. HYPOTHESIS

CVE intervention, deflection, and diversion programs need mental health practitioners to conduct an assessment, construct a treatment plan, and provide treatment. The effort needs to be coordinated among professionals from various fields. Relationships and communication between the professionals are critical. The solution includes an understanding of the laws that facilitate or restrict disclosure of confidential health information combined with structured teams to oversee the process.

In Montgomery County, Maryland, detectives assigned to the County Police Department's Special Victim Investigative Division Child Abuse Units work hand in hand with social workers from the County's Child Protective Services division. The detectives and social workers conduct joint investigations into the reports of physical and sexual child abuse. In some cases, where the victim is younger, the specially trained social workers conduct the interview of the victim. The social workers and detectives are also part of a larger team of practitioners who all have an interest in the investigation and coordination of services to the victims and their families. The larger team includes specially trained medical personnel (pediatrician and nurse), prosecutors from the state's attorney's office, and lawyers from the county attorney's office. The team meets once a week (as needed) to collaborate on cases that need special attention. The meetings, called "multi-d's," are the formal collaborative efforts of an entire multi-disciplinary team. Members, who have identified an issue, or problem, call the meeting to bring together the collective expertise of the members to solve any issues. During the meeting, members work together to identify issues and create solutions. Over the years, the members of the teams have developed a strong working relationship, which has led to an understanding and appreciation for the roles of the other members of the team.

[27] Bonnie R. Benitez, "Confidentiality and Its Exceptions (including the U.S. Patriot Act)," *The Therapist* 16, no. 4 (2004): 32–36.

Collaborative efforts designed to address complex issues frequently organize into structures that have proven to overcome challenges. CIIs and multi-disciplinary teams (MDTs) are two examples of such structures. Each model was designed to bring together practitioners from different disciplines to accomplish a shared goal. The structures facilitate a mutual understanding of roles and ensure communication and cooperation between the different elements of the group, thus ensuring a higher probability of success. CIIs are best deployed at the organization level, and MDTs are best utilized at the sub-group level. CVE programs should analyze the concepts inherent in both programs. CVE programs may benefit from the structure of a CII. Smaller working groups, such as those managing and facilitating intervention efforts, should operate as a MDT. The collaborative group and the tenets of the structure should then be used to ensure proper training on laws and policies applicable to the overall missions of the program.

Although the response to child abuse and radicalization are different, it is possible to apply methods that have proven successful to CVE. CIIs and MDTs may be used to identify and solidify roles, create trusting partnerships, study policy, and manage the screening and creation of treatment plans for clients in CVE intervention programs. The use of a MDT to oversee efforts would ensure that all members of the team were educated on the laws that apply to the effort, and that proper communication between team members occurred. The strength of the model lies in the melting together of different disciplines that all have a role in the effort.

Once practitioners have formed into CIIs and MDTs, the identification and execution of roles and responsibilities may begin. Legal experts may begin determining the path forward and policies may be constructed. As the effort progresses and additional issues arise, a team of experts would already exist to analyze and address the issues.

D. LITERATURE REVIEW

The U.S. CVE program was designed to apply to local levels of government with the support of the federal government. The main goal of the program is to "prevent violent extremists and their supporters from inspiring, radicalizing, financing, or

recruiting individuals or groups in the United States to commit acts of violence."[28] In locations where CVE programs exist, not all aspects of the program have been implemented. As a result, a fair amount of research has been conducted on CVE in general, but little current research is available on CVE programs presently in place, and specifically, no research on CVE intervention or diversion programs. The lack of metrics associated with measuring the success of CVE programs, and the need for continuous studies on CVE efforts have been raised by researchers.[29]

As threats against the homeland develop, the response to those threats evolves. As a result, the landscape is constantly changing. This literature review is divided into the following categories:

- The U.S. CVE program
- Current CVE models
- National security laws and confidentiality
- The multidisciplinary approach

1. U.S. CVE Program

The 2011 federal government report titled, *Empowering Local Partners to Prevent Violent Extremism in the United States*, defines violent extremists as "individuals who support or commit ideologically-motivated violence to further political goals."[30] The report identifies the central goal of CVE as "prevent[ing] violent extremists and their supporters from inspiring, radicalizing, financing, or recruiting individuals or groups in the United States to commit acts of violence."[31]

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[28] Executive Office of the President of the United States, *Empowering Local Partners to Prevent Violent Extremism in the United States*.

[29] NaureenChowdhury Fink, Peter Romaniuk, and RafiaBarakat, *Evaluating Countering Violent Extremism Programming: Practice and Progress* (New York: Center on Global Counterterrorism Cooperation, 2013), http://globalcenter.org/wp-content/uploads/2013/07/Fink_Romaniuk_Barakat_EVALUATING-CVE-PROGRAMMING_20132.pdf.

[30] Executive Office of the President of the United States, *Empowering Local Partners to Prevent Violent Extremism in the United States*, 1.

[31] Ibid., 3.

Several months later, the federal government issued a second report, titled, *The Strategic Implementation Plan (SIP) for Empowering Local Partners to Prevent Violent Extremism in the United States*.[32] The SIP identified a three-part strategy to implement CVE programs as increasing support for local communities, expanding governmental knowledge, and providing counter-narratives.[33] These two reports provide a roadmap of the federal government's intent for its CVE program. These types of reports issued directly by the federal government are primary sources; the remaining, secondary literature, provides an analysis and evaluation of the plans.

Many of the sources that provide an analysis of the federal CVE program have come to similar conclusions and have identified similar criticisms, or areas of interest in which lie opportunities for improvement. The fact that different experts who represent a variety of organizations have drawn the same conclusions may lend a certain amount of credibility to the findings. For example, a report issued by the federal Congressional Research Service (CRS) and a report issued by the Heritage Foundation both recognized that the federal government had not selected a lead agency for the implementation and management of CVE, and that it was an area of concern that needed to be addressed.[34] In this case, both a federal agency and a non-governmental organization (NGO) arrived at the same conclusion in regards to CVE. Since then, the federal government has consolidated many of its efforts under the Department of Homeland Security (DHS). Other federal agencies, such as the FBI and the U.S. Attorney's Office, are still involved in different areas.

Virtually all the research on CVE identifies problem areas within the model and its implementation: a lack of funding, an absence of a lead agency, the lack of a clear definition for CVE, hurdles associated with community engagement and trust, the

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[32] Executive Office of the President of the United States, *Strategic Implementation Plan for Empowering Local Partners to Prevent Violent Extremism in the United States*, 2011.

[33] Ibid.

[34] Jerome P. Bjelopera, *Countering Violent Extremism in the United States* (CRS Report No. R42553) (Washington, DC: Congressional Research Service, 2012), http://digital.library.unt.edu/ark:/67531/metadc87235/m1/1/high_res_d/R42553_2012May31.pdf; David Inserra, "Revisiting Efforts to Counter Violent Extremism: Leadership Needed," *The Heritage Foundation*, April 20, 2015, http://www.heritage.org/research/reports/2015/04/revisiting-efforts-to-counter-violent-extremism-leadership-needed.

stigmatization of the Muslim community, a lack of effort aimed at other populations vulnerable to radicalization, and a lack of empirical research to provide policy makers with information for decision making.

Since September 11, 2001, the United States has experienced acts of violence committed by individuals who have been radicalized to violent extremism. According to a report issued by the CRS, an estimated 63 homegrown violent jihadist plots or attacks have occurred in the United States between September 11, 2001 and 2013.[35]

Many of the individuals who committed these acts were considered HVEs who had undergone a radicalization process. According to Bjelopera, "'homegrown' is the term that describes terrorist activity or plots perpetrated within the United States or abroad by American citizens, legal permanent residents, or visitors radicalized largely within the United States."[36]

In this context, radicalization refers to the process in which an individual acquires and internalizes extremist or jihadist beliefs.[37] Experts agree that the process of radicalization may contain some similarities for some individuals, but that currently no solid pattern exists since it is an individualized event. The process may be affected by outside influences, such as intermediaries, social networks, the Internet, or contact with others in prison.[38] Even though the radicalization process is unique to each individual, case studies are beneficial to identifying markers displayed by other individuals in the process of radicalizing.

"The term 'jihadist'," notes Bjelopera, "describes radicalized individuals using Islam as an ideological and/or religious justification for their belief in the establishment of a global caliphate, or jurisdiction government by a Muslim civil and religious leader

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[35] Jerome Bjelopera, A*merican Jihadist: Terrorism Combating a Complex Threat* (CRS Report No. R41416) (Washington, DC: Congressional Research Service, 2013), 1, https://www.fas.org/sgp/crs/terror/R41416.pdf.

[36] Ibid.

[37] Ibid.

[38] Ibid., 2.

known as a caliph."[39] The federal government defines violent extremists as "individuals who support or commit ideologically-motivated violence to further political goals."[40] Examples of terror acts committed by homegrown individuals who had radicalized to extremist violence include the Fort Hood shooting and the Boston Marathon bombing.[41]

Historically, the government's response to terrorist acts committed or planned on U.S. soil has involved traditional LE and intelligence activities. These activities include gathering and analyzing information, traditional investigative techniques, and prosecutions. These efforts are conducted by LE and intelligence agencies at the federal, state, and local levels. According to a 2010 report by the RAND Corporation:

> Traditional law enforcement, in which authorities attempt to identify and apprehend a perpetrator after a crime has been committed, is inadequate to deal with terrorists who are determined to cause many deaths and great destruction and who may not care whether they themselves survive. Public safety demands a more preventative approach, intervention before an attack occurs.[42]

In October 2016, the U.S. government released an updated SIP, which addresses many of the broad criticisms of the CVE program.[43] The 2016 SIP re-enforces the goals of CVE programs, and states, "The overall goal of the Strategy and United States Government efforts to implement it remains unchanged: to prevent violent extremists and their supporters from inspiring, radicalizing, financing, or recruiting individuals or groups

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[39] Ibid., 1.

[40] Executive Office of the President of the United States, *Empowering Local Partners to Prevent Violent Extremism in the United States*, 1.

[41] For more information on these events, please refer to Joseph Lieberman and Susan Collins, *A Ticking Time Bomb Counterterrorism Lessons from the U.S. Government's Failure to Prevent the Fort Hood Attack* (Washington, DC: U.S. Senate Committee on Homeland Security and Governmental Affairs, 2011), http://fas.org/irp/congress/2011_rpt/hsgac-hood.pdf; "Boston Marathon Bombings," accessed July 8, 2015, http://www.boston.com/news/local/massachusetts/specials/boston_marathon_bombing/.

[42] Brian Michael Jenkins, *Would-Be Warriors: Incidents of Jihadist Terrorist Radicalization in the United States since September 11, 2001*(Santa Monica, CA: RAND, 2010), viii, http://www.rand.org/content/dam/rand/pubs/occasional_papers/2010/RAND_OP292.pdf.

[43] Executive Office of the President of the United States, *Strategic Implementation Plan for Empowering Local Partners to Prevent Violent Extremism in the United States* (Washington, DC: Executive Office of the President of the United States, 2016), https://www.whitehouse.gov/sites/default/files/docs/2016_strategic_implementation_plan_empowering_local_partners_prev.pdf.

in the United States to commit acts of violence."[44] The current SIP also recognizes that no single path to radicalization is followed and the phenomenon is not exclusive to any one population, religion, or cause. The introduction to the current SIP also provides clarity to the term "stakeholder" in relation to CVE programs. The document describes stakeholders as persons who have an "expressed or identified role" in CVE and may include LE, members of the public, NGOs, researchers, members of the education field, mental health practitioners, and efforts provided by private-sector experts.[45]

The new SIP addresses previous criticism of the federal CVE model's lack of a lead agency by assigning a DHS task force as the lead government agency in coordinating research and the dissemination of information. "Its work is organized into four lines of effort: Research and Analysis; Engagement and Technical Assistance; Interventions; and Communications and Digital Strategy."[46]

The current SIP identified intervention as one of the four areas of concentration for the DHS task force. The document states that the task force, "will coordinate the development and dissemination of resources describing possible warning signs as well as steps families and friends can take if they believe someone close to them is becoming recruited or radicalized to violence."[47]

Counter-radicalization programs are typically divided into three different types of efforts: prevention (intervention), disengagement (deflection), and de-radicalization (diversion). Prevention involves education and counter-narrative efforts designed to stop the radicalization process before it begins. These efforts may involve an intervention aspect for individuals who have been referred to a program after a determination has been made that the individual may be vulnerable or susceptible to a radicalization process. Disengagement or deflective efforts are designed to provide an "off ramp" for individuals engaged in a radicalization process. De-radicalization or diversion programs are designed

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[44] Ibid., 1.

[45] Executive Office of the President of the United States, *Empowering Local Partners to Prevent Violent Extremism in the United States*, 1.

[46] Ibid., 2.

[47] Ibid., 11.

to lead a radicalized individual to abandon violent or deviant views and return to regular society. A successful outcome of disengagement and de-radicalization activities may include an individual maintaining radical views, but abandoning violent activities.[48] All these activities and phases fall under the general rubric of "intervention."

2. Current CVE Models

Several years after the U.S. government began planning a CVE program, efforts stalled. After the Boston Marathon Bombing and the rise of the IS, interest in the program was renewed.[49] Former Attorney General Eric Holder announced in September 2014 that CVE efforts would be focused on three cites, which were identified as Boston, Los Angeles, and Minneapolis-St. Paul. The "Three City Pilot" effort tasked authorities in those cities with developing local CVE programs targeting IS-related radicalization.[50] The three pilot cites were chosen by the federal government based on their "existing achievements with community engagement."[51] A fourth program was developed in Montgomery County, Maryland, by a NGO in partnership with local government.

A search for literature on the four models yields primary source information released by various stakeholder panels enacted by the local jurisdictions to create and implement the CVE models. For example, Boston and Los Angeles both released documents, referred to as "frameworks," outlining their plans for the creation and implementation of their CVE models.[52] The frameworks clearly describe the intended

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[48] Lorenzo Vidino, *Countering Radicalization in America* (Washington, DC: United States Institute of Peace, 2010), 2, http://dspace.africaportal.org/jspui/bitstream/123456789/31361/1/SP%20262-%20Countering%20%20Radicalization%20in%20America.pdf.

[49] Lorenzo Vidino and Seamus Hughes, *Countering Violent Extremism in America* (Washington, DC: Center for Cyber and Homeland Security: The George Washington University, 2015), https://cchs.gwu.edu/sites/cchs.gwu.edu/files/downloads/CVE%20in%20America%20.pdf.

[50] "Pilot Programs Are Key to Our Countering Violent Extremism Efforts," February 18, 2015, http://www.justice.gov/opa/blog/pilot-programs-are-key-our-countering-violent-extremism-efforts.

[51] Ibid.

[52] U.S. Attorney's Office District of Massachusetts, *A Framework for Prevention and Intervention Strategies: Boston CVE Framework* (Boston: U.S. Attorney's Office District of Massachusetts, 2015), http://www.justice.gov/sites/default/files/usao-ma/pages/attachments/2015/02/18/framework.pdf; Los Angeles Interagency Coordination Group, *Los Angeles Framework for CVE-Full Report* (Los Angeles: Los Angeles Interagency Coordination Group, 2005), http://www.dhs.gov/sites/default/files/publications/Los%20Angeles%20Framework%20for%20CVE-Full%20Report.pdf.

parts of the models and identified their goals. Several fact sheets on the pilot cities' CVE programs were issued by the federal government. The Minneapolis-St. Paul team did not issue a framework document, but a fact sheet does exist.[53] Additionally, numerous articles from media sources are available on the pilot cities programs, but the majority of the information is taken from the releases provided by the programs themselves. The fourth program, located in Montgomery County, Maryland, and known as the Montgomery County Model (MCM), has also released information on its program, which identifies the parts and goals of the program. Recently, the MCM has expanded to other jurisdictions. As a result, the name of the program has changed to Building Resilience Against Violent Extremism (BRAVE). In the summer of 2016, BRAVE released a three-year strategic plan outlining recommendations and future growth.[54]

The MCM of CVE is the first community based and led CVE model in the country. The model was developed by the WORDE, which is a NGO. According to WORDE's director, Dr. Hedieh Mirahmadi, the MCM was designed to be a community-led, public-private partnership rooted in interfaith collaboration.[55] WORDE has partnered with the Montgomery County Police (MCP) Department and the Montgomery County Executive's Office of Community Partnerships. The MCM is tied to the Office of Community Partnerships' Faith Community Working Group (FCWG). The FCWG is composed of faith-based community leaders, the MCP, trauma-informed counselors, youth activists, and violence prevention experts. "The success of the program relies on a trusting relationship among local police, schools, health and human services agencies, and the faith community, whereby persons, who may be radicalized, regardless of the

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[53] United States Attorney's Office, *Minneapolis-St Paul Building Community Resilience Program-Pilot Fact Sheet* (Minneapolis, MN: United States Attorney's Office, 2015), http://www.dhs.gov/sites/default/files/publications/Minneapolis-St%20Paul%20Building%20Community%20Resilience%20Program-Pilot%20Fact%20Sheet.pdf.

[54] World Organization for Resource Development and Education (WORDE), *The Building Resilience against Violent Extremism (BRAVE) Model—A Collective Impact Initiative That Increases Public Safety and Social Cohesion*.

[55] George J. Selim et al., "New Strategies for Countering Homegrown Violent Extremism," *The Washington Institute for Near East Policy*, November 21, 2013, http://www.washingtoninstitute.org/policy-analysis/view/new-strategies-for-countering-homegrown-violent-extremism.

reason, are identified as possibly benefitting from an intervention."[56] The goal of the MCM is to educate the public and governmental organizations on the risk factors associated with violent extremism, and then to refer the appropriate resources to intervene with the at-risk individuals before they progress down a path to radicalized violence.[57]

Studies on the different CVE models are being conducted by such institutions as the National Institute of Justice (NIJ) and the Police Executive Research Forum (PERF), and one study of the Minneapolis/St. Paul model is being conducted by the University of Southern California.[58] It is expected that the studies will provide additional information on the differences between the programs, and assist in identifying any strengths and weaknesses of the different programs.

3. National Security Laws and Confidentiality

Governments in democratic countries have an obligation to protect themselves, their citizens, and their interests. Federal laws, such as the National Intelligence Act and the PATRIOT Act (and since 2015, its successor, the USA FREEDOM Act) spell out the U.S. government's responsibility and authority.[59] The structure of these laws ensures that protective efforts remain balanced with the protection of civil liberties, "The governments of free societies charged with fighting a rising tide of terrorism are thus faced with a democratic dilemma: If they do not fight terrorism with the means available to them, they endanger their citizenry; if they do, they appear to endanger the very freedoms which

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[56] Hedieh Mirahmadi, "An Innovative Approach to Countering Violent Extremism," *The Washington Institute for Near East Policy*, October 9, 2013, http://www.washingtoninstitute.org/policy-analysis/view/an-innovative-approach-to-countering-violent-extremism1.

[57] "The Montgomery County Model," accessed July 27, 2015, http://www.dhs.gov/sites/default/files/publications/Montgomery%20County%20MD%20Community%20Partnership%20Model-WORDE%20Report.pdf.

[58] National Center of Excellence for Risk and Economic Analysis of Terrorism Events (CREATE), *Foreign Fighters: Terrorist Recruitment and Countering Violent Extremism in Minneapolis-St. Paul* (Los Angeles, CA: University of Southern California, 2015), http://securitydebrief.com/wp-content/uploads/2015/04/Foreign-Fighters-Terrorist-Recruitment-and-CVE-in-Minneapolis-St-Paul.pdf.

[59] *National Security Act of 1947*, *50 U.S.C. 401*, 1947, https://www.ncsc.gov/training/resources/nsaact1947.pdf; Lou Ann Wiedemann, "Homeland Security Act, Patriot Act, Freedom of Information Act, and HIM (2010 Update)," *Journal of AHIMA*, November 2010, http://bok.ahima.org/doc?oid=106172.

they are charged to protect."[60] This balance has sometimes been described as a pendulum that swings toward security in times of danger, and then back towards civil liberties and increased freedom during times of peace, "Thus it seems that the democracies are destined to wander to and fro between the poles of too much liberty and too extensive a security effort, walking the fine line between security and freedom."[61] An argument can be made that freedom is not possible under threatening conditions. A counter argument may be made that freedom trumps all. Balancing and ensuring both is the responsibility of the government and the people. Free speech, a free press, courts, and elections are all part of the balancing process. Laws, and granting power to government agencies, provide the counterbalance.

After WWII, and at the beginning of the Cold War, the U.S. government enacted the National Security Act, which called for a major re-organization of the military and intelligence community.[62] The Act defines intelligence as all information that involves threats to the country, its citizens, property, or interests. Intelligence is also defined as anything having to do with the proliferation of weapons of mass destruction, or any other matter affecting U.S. national or homeland security. The use of the term homeland security seems like a newer phenomenon, but it was actually used in this sweeping legislation in 1947. The National Security Act begins to define authority and responsibility in reference to intelligence issues. Executive Orders (EOs) are legal entities that describe how other laws will be applied to various entities within the government.

In addition to the major re-structuring of government, and the creation of the Central Intelligence Agency, the National Security Act laid the groundwork for the government's framework for providing today's national security efforts and a base upon which future laws would be built. EO 12333, issued by President Ronald Reagan, is good

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[60] Benjamin Netanyahu, *Fighting Terrorism: How Democracies Can Defeat Domestic and International Terrorism*, 2001st ed. (New York: Farrar, Straus, and Giroux, 1995), 67.

[61] Netanyahu, *Fighting Terrorism: How Democracies Can Defeat Domestic and International Terrorism*, 99.

[62] "Truman Signs the National Security Act–Jul 26, 1947," accessed August 14, 2016, http://www.history.com/this-day-in-history/truman-signs-the-national-security-act.

example of a legal action building upon the National Security Act.[63] The EO defines and relegates the duty of civilian intelligence and counter-intelligence responsibilities in the homeland to the FBI. The EO also affirms the government's right to collect and use intelligence on U.S. persons, and mandates that the methods be the least intrusive as possible. It also delegates the oversight process to various entities within the government.

In short, the National Security Act and the EO, which clarifies roles and methods, provides the U.S. government with the authority to protect the country, its citizens, and interests by collecting and using intelligence. A separation of powers was developed in which normal intelligence agencies are aimed outside of the United States, and the FBI is relegated with the authority as a civilian LE agency to conduct protective investigations on U.S. soil, although the reach of the FBI extends oversees.

The PATRIOT Act is another example of sweeping legislation in response to a major national security event.[64] The Act was the largest re-organization of this nation's federal government since the National Security Act. The expedited creation of the Act and the scope of its change are both notable. In addition to a large scale re-organization and the creation of the DHS, it is also important to recognize that the Act is aimed directly at terrorism targeting the U.S. homeland. As a result, the Act both focuses and increases the government's ability to collect, use, and store intelligence.

Some of the authority vested in the government by the Act has created controversy. Some of this controversy has bled over into the realm of CVE. Specifically, Section 215 of the Patriot Act has received a significant amount of criticism for the broad power it granted the government in collecting data on U.S. citizens.[65] Much of the debate has surrounded the ability the section granted the National Security Agency to monitor and collect electronic data. The public response to this aspect of the Act has been used by some to fuel discontent in other areas.

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[63] "Executive Order 12333—United States Intelligence Activities," accessed August 15, 2016, http://www.archives.gov/federal-register/codification/executive-order/12333.html.

[64] "What Is the USA Patriot Act: Preserving Life and Liberty," accessed August 20, 2016, https://www.justice.gov/archive/ll/highlights.htm.

[65] "Law Enforcement & National Security Access to Medical Records," July 11, 2013, https://cdt.org/insight/law-enforcement-national-security-access-to-medical-records/.

Some of the literature used for this thesis connects the government's collection of data to confidential personal information in the field of psychotherapy.[66] According to a 2004 article from *The Therapist*, concern has arisen within the field of psychotherapy that the PATRIOT Act, in particular Section 215, grants the government *carte blanche* to collect personal health information (PHI). Expressly, claims have been made that the section allows the FBI to require therapists to turn over "books, records, papers, documents, and other items," while at the same time, prohibiting the therapist from advising the patient that the government was seeking or obtaining the information.[67] These claims are technically true, but not at all a new development. The FBI and other LE agencies have always been able to collect information as part of criminal investigations.

The law has always had checks and balances and provided oversight for the process. Investigators must possess a certain level of proof (probable cause), articulate the proof in a sworn document (search warrant), and receive approval from a judge (oversight) to seize information (or anything else of an evidentiary nature). None of these legal requirements are new, expanded, or out of the ordinary. It should also be noted that the Act does not require mandatory notification of the government by therapists, or anyone else.

One point of possible concern is Section 215, and the collection of information. Section 215 makes changes to the Foreign Intelligence Surveillance Act (FISA), which allows for the FBI director, or designee, to apply for a court order to seize PHI through the Foreign Intelligence Court (FISC).[68] While the FISC provides the same oversight over 4th Amendment search and seizure issues as regular courts and magistrates, it adds a layer of secrecy to the proceedings. The secret nature of the FISC was necessary due to the court's original purpose as an oversight of foreign intelligence investigations. The court serves as a balance of oversight and secrecy to protect the integrity of counter-

[66] Benitez, "Confidentiality and Its Exceptions (Including the U.S. Patriot Act)," 32–36.

[67] "FAQ on Government Access to Medical Records," accessed August 15, 2016, https://www.aclu.org/faq-government-access-medical-records.

[68] "Law Enforcement & National Security Access to Medical Records."

intelligence investigations. The expansion of the use of the FISC for counter-terrorism investigations serves the same purposes. While the oversight remains the same, it is more difficult to shine the light of public oversight to FISC proceedings. "As the law stands now, the federal government has multiple avenues for accessing medical records by citing national security considerations, and gag provisions in the Patriot Act make it difficult to know how this power is being used."[69]

The bottom line is that Section 215 of the Patriot Act expands the use of the FISC to include investigations of domestic terrorism.[70] The use of the court retains the same level of judicial oversight (perhaps more) as other judicial venues used by government investigators to have search and seizure warrants issued. Additionally, the nature of the system has not changed in reference to the ability for the federal government to use Section 215 for a "fishing expedition."[71] The opportunity does not exist. If a CVE practitioner is served with a search and seizure warrant or court order ordering the release of PHI, it is in relation to an investigation of a serious national threat. If the CVE practitioner has not provided the government with the information that was used to open the investigation, and the government developed probable cause from sources not related to the CVE practitioner, the practitioner has no choice but to comply with the warrant.

4. Multi-Disciplinary Teams

For many years, different fields have relied on multidisciplinary efforts to find the best approach to shared goals. MDTs are typically composed of a group of professionals from different fields who share a common purpose, but contribute different areas of expertise to the effort.[72] By this definition, CVE efforts are already a form of MDT. This thesis studies the expansion of the use of the MDT model to improve cooperation and communication with an increased set of practitioners involved in CVE. Since MDTs have existed for several decades and been used in multiple fields, sufficient information exists

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69 "National Security and Medical Information."

70 "Law Enforcement & National Security Access to Medical Records."

71 "FAQ on Government Access to Medical Records."

72 *The Free Dictionary*, s.v. "Multidisciplinary Team," accessed July 11, 2016, http://medical-dictionary.thefreedictionary.com/multidisciplinary+team.

on their history and use. MDTs have previously been successfully used to address complex issues. Some of the areas where MDTs have been applied (such as child abuse investigations) involve many of the same professionals involved in CVE intervention programs.[73] As a result, the focus is on the use of MDT in response to reports of child abuse with comparisons made to the adoption of the use to CVE in an expanded capacity.

The FBI has suggested its own version of an MDT in the form of shared responsibility committees (SCRs).[74] The federal government has been vague in the information released concerning SRCs; however, the public response from certain areas has been swift and strong. Few official sources are available that document the government's intent or use of SRCs, while ample secondary sources exist criticizing the proposed program.[75] Research for this thesis provides an analysis of what is known about the SRCs, a comparison to other MDT processes, and a recommendation on how to move forward.

5. Summary

The threat to the United States represented by HVEs is constantly evolving partly because of the pace of changes in other parts of the world. For example, IS currently is considered one of the greatest terror threats, yet did not exist just several years ago. As conditions around the world change and evolve, the threat in the U.S. homeland continues to transform. The fast pace at which technology progresses affects how terror groups plan, recruit, communicate, and attack.

In response, efforts to counter violent extremism may be advancing faster than studies and research on the policies and programs can be completed. The use of CVE in the United States has been researched for several years, but models of the program have only begun to be implemented as of 2016. Studies of the models have recently been

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[73] "Multidisciplinary Team," accessed July 8, 2016, http://www.nationalcac.org/about/multi-team.html.

[74] Murtaza Hussain and Jenna McLaughlin, "FBI's 'Shared Responsibility Committees' to Identify 'Radicalized' Muslims Raise Alarms," *The Intercept*, April 9, 2016, https://theintercept.com/2016/04/09/fbis-shared-responsibility-committees-to-identify-radicalized-muslims-raises-alarms/.

[75] Julian Hattem, "Key Dem Wants Watchdog to Probe Little-known FBI Program," *The Hill*, April 29, 2016, http://thehill.com/policy/national-security/278223-key-dem-wants-watchdog-to-probe-fbi.

conducted by such groups as the NIJ and PERF. Research on foreign programs is abundant, but is not the focus of this thesis because U.S. laws are different and unique from other countries.

Sufficient information exists to analyze CVE models, intervention or diversion, and to conduct a legal analysis of the laws that affect the topics of confidentiality, duty to warn, and the notification of the proper authorities by CVE practitioners when they determine a threat or possible threat exists.

E. RESEARCH DESIGN

The thesis analyzed the two major legal areas that affect CVE intervention, diversion, and deflection (medical record confidentiality and the duty to warn or protect) and how they facilitate or restrict practitioners from making notification to authorities concerning clients who remain or become a threat. This portion of the thesis takes the form of a legal analysis that determines the meaning of the cases and their respective implications.

The goal of the thesis is to define and explain the space in which diversion and intervention practitioners must operate in terms of the ability and requirements related to their duty to warn, confidentiality, and national security exceptions. The output from the thesis is a set of structural recommendations to facilitate intervention efforts by integrating or leveraging organizational models already in use.

CVE practitioners will need to be knowledgeable in medical confidentiality laws at both the federal and state levels to comply and understand exceptions to the laws. HIPAA's Privacy Rule is analyzed, and Maryland law stands in for state law. Most mental health providers are familiar with the theory of duty to warn. This paper explores the cause for state duty to warn laws and apply the legal theory, and specifically Maryland's laws, to CVE related intervention programs. Since CVE programs are a collaboration of practitioners from various fields, it is useful for all involved to understand the way that medical confidentiality and duty to warn laws impact the operations of CVE intervention programs. The paper then suggests models for

collaboration that may be applied to CVE programs as a whole, and work groups consisting of members from different disciplines.

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II. MEDICAL RECORDS AND THE THEORY OF CONFIDENTIALITY

A. FEDERAL PRIVACY FRAMEWORK

The theory of confidentiality in health care may be traced to the Hippocratic Oath, which states, "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about."[76] For health care practitioners, confidentiality is both an ethical and a legal issue. Confidentiality is essential for the treatment of both physical and mental health issues, but as Benitez reminds us, "Confidentiality is defined as a restriction on the volunteering of information outside of the courtroom setting, not to be confused with the concept of psychotherapist-patient privilege."[77] Privilege is a legal concept that involves special relationships between such practitioners as lawyers and medical professionals and their clients. Privilege has to do with the right of the client to withhold testimony in court by the individual with whom they hold the relationship.[78] According to her article in *The Therapist* titled, "Confidentiality and it Exceptions (Including the U.S. Patriot Act)," Benitez explains the difference between confidentiality and privilege:

> These terms are not synonymous. They apply in different circumstances and are addressed in separate sections of law. The psychotherapist patient privilege affords the holder of the privilege (usually the patient) the right to withhold testimony (your testimony) in a court of law. The psychotherapist-patient privilege arises from the special relationship therapists have with their patients. It is an exception to the general rule that requires testimony from witnesses who are subpoenaed to provide such testimony.[79]

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[76] Ask a Librarian, "Guides: Bioethics: Hippocratic Oath," *Johns Hopkins University*, accessed July 13, 2016, http://guides.library.jhu.edu/c.php?g=202502&p=1335752.

[77] Benitez, "Confidentiality and Its Exceptions (Including the U.S. Patriot Act)," 1.

[78] Ibid.

[79] Ibid.

According to one expert, "Without assurances of confidentiality, patients will be reluctant to divulge sensitive information about their physical and mental health, behavior, and lifestyle that would be vital to the individual's treatment."[80] During testimony before the Congressional Subcommittee on Investigations and Oversight, House Committee on Energy and Commerce, Professor Mark Rothstein of the University Of Louisville School Of Medicine spoke of the importance of confidentiality of medical records by stating:

> The Privacy Rule codifies this crucial requirement for ethical and effective health care. Surveys of patients indicate that many of them, fearful of disclosure of their sensitive health information, currently engage in "defensive practices" by withholding certain information from their health care providers. Any weakening of privacy protections would undoubtedly increase the use of defensive practices.[81]

In his testimony, Rothstein cited a survey conducted by the California Healthcare Foundation in which two thirds of the public surveyed expressed concern over the privacy and security of their health information.[82]

To ensure the protection of sensitive and private health information, the federal government and states have passed legislation defining the legalities. The laws define the circumstances in which a practitioner may or must disclose confidential information. This chapter analyzes the laws, explains the circumstances, and applies the laws to mental health practitioners working in the realm of CVE.

Federal laws tend to be broad and far-reaching forms of legislation that in many cases define what is allowable at the state and local levels of government. Many federal regulatory laws may be viewed as defining the "bare minimum," which then opens the door for state law to impose stricter requirements. As a result, state laws are frequently

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[80] Mark A. Rothstein, *Testimony of Mark A. Rothstein Subcommittee on Investigations and Oversight, House Committee on Energy and Commerce* (Washington, DC: U.S. Congress, 2013), 1–2, http://docs.house.gov/meetings/IF/IF02/20130426/100769/HHRG-113-IF02-Wstate-RothsteinM-20130426.pdf.

[81] Ibid.

[82] "Consumers and Health Information Technology: A National Survey," April 2010, 2, http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ConsumersHealthInfoTechnologyNationalSurvey.pdf.

more restrictive than federal laws covering the same topic.[83] The negative consequence of the existence of different laws affecting the same topic, but created by different levels of government, is the legal confusion they may create. While this combination of laws affords some practitioners and patients a great deal of confidentiality protection, it also makes for confusion, as standards and strictures change from jurisdiction to jurisdiction. When referring to confidentiality law, most practitioners refer to HIPAA. Rarely are state laws spoken of or cited. When state laws afford exceptions, they must also align with the federal law. For example, Maryland law allows for the sharing of confidential medical information with any state sanctioned representative conducting their official business. This exception must then also align with the Privacy Act exceptions.[84]

1. HIPAA Background

The Health Insurance Portability and Accountability Act, commonly known as HIPAA, is the federal law of the land regulating health care information. As a result, HIPAA, and the accompanying Privacy Rule, represent the bare minimum of legal regulation of PHI. Due to the confusion surrounding the implications of the law, HIPAA has been described as the elephant in the room that may need to be euthanized (or at least better defined and explained to the public and practitioners).[85] The application of the federal law has created a confusing environment in which health care providers must learn to operate. The impact of the law is so confusing that both government and private companies frequently bring in outside experts to conduct training for employees. Even with specialized training, a lot of confusion remains concerning who the law applies to, and what the law requires or allows. It has been asserted that medical entities regulated by federal law may use the existence of the law as an excuse not to make lawful

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[83] John Petrila and Hallie Fador-Towe, *Information Sharing in Criminal Justice—Mental Health Collaborations: Working with HIPAA and Other Privacy Laws* (Lexington, KY: CSG Justice Center, 2010), vii, https://csgjusticecenter.org/wp-content/uploads/2012/12/Information_Sharing_in_Criminal_Justice-Mental_Health_Collaborations-2.pdf.

[84] State of Maryland, *22. Medical Records Act--Duty to Hold Confidential and Duty to Disclose a Medical Record, Health-General Article § § 4-301--4-309, 8-601*(Baltimore, MD: Maryland Department of Mental Health and Hygiene, n.d.), accessed September 12, 2016, http://dhmh.maryland.gov/psych/pdfs/Medicalreports.pdf.

[85] Officer Scott Davis, Crisis Intervention Team, Montgomery County Police.

disclosures of medical information in situations that may warrant the disclosure. The lack of disclosure may be the result of ignorance of what laws dictate, allow, or mandate; or the laws may actually be used as an excuse not to disclose if the disclosure is deemed inconvenient or burdensome.[86]

As with all legislation, HIPAA began as a bill, proposed by U.S. Senators Edward Kennedy and Nancy Kassebaum to address privacy and confidentiality with health care information. Prior to the proposal of the bill, no federal law regulated the confidentiality of PHI.[87] The bill was passed by Congress and signed by President Bill Clinton on August 21, 1996. The new federal law (HIPAA) was also known as Pub. L. No. 104-191.[88] Even though the original intent of the bill, and subsequent law, was to regulate the electronic transfer of private medical information, and to mandate privacy regulations on certain covered entities, HIPAA and the Privacy Rule have "become the de facto legal standard for health privacy issues involving both covered and un-covered entities in the United States."[89]

Title 45 of the Code of Federal Regulations (CFR) provides the regulations and rules that apply to the Department of Health and Human Services (DHHS). Section 160. 103 provides the federal definition of health care as:

> care, the services and supplies related to an individual's health, are all considered health care. Preventative, diagnostic, rehabilitative, maintenance, or palliative care, counseling service, assessment, or procedure with respect to the physical or mental condition or functional

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[86] Rothstein, *Testimony of Mark A. Rothstein Subcommittee on Investigations and Oversight, House Committee on Energy and Commerce*, 4.

[87] Daniel J. Solove, "HIPAA Turns 10: Analyzing the Past, Present and Future Impact," *Journal of AHIMA* 84, no. 4 (April 2013): 22–28.

[88] Rebecca Herold and Kevin Beaver, *The Practical Guide to HIPAA Privacy and Security Compliance*, 2nd ed. (United Kingdom: Taylor & Francis Group, LLC, 2015), 1.

[89] Mark A. Rothstein, "Tarasoff Duties after Newtown," *Journal of Law, Medicine & Ethics* 42 (2014): 107.

status of an individual or that affects the structure or function of the body.[90]

HIPAA defines regulated health information as, "[i]individually identifiable health information transmitted by electronic media, maintained in electronic media, transmitted or maintained in any other form or medium."[91] HIPAA uses this definition to identify what is referred to as PHI under the law. PHI may also be described as any information related to health care that may individually identify the patient, such as any data that relates to an individual's past, present, or future physical or mental health, payment, or provision of care to the individual.[92] PHI covered by HIPAA includes:

- Patient names
- Geographic areas smaller than a state to include street addresses, city or town, county, precinct, or zip code
- Numerical identifiers, such as telephone numbers, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate/license numbers, device identifiers and serial numbers, and elements of dates related to birth, death, admission or discharge, except for the year
- Email addresses
- Vehicle identifiers
- Computer identifiers, such as uniform resource locators and internet provider addresses
- Images and photographs
- Biometric identifiers, such as DNA, fingerprints, and voice prints
- Any other identifying factor unique to the patient[93]

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[90] Cornell University Law, LII/Legal Information Institute, "45 CFR 160.103—Definitions," accessed July 23, 2016, https://www.law.cornell.edu/cfr/text/45/160.103; U.S. Government, *45 CFR Part 160—Subchapter C—Administrative Data Standards and Related Requirements* (Washington, DC: Government Printing Office, n.d.), 698, accessed August 6, 2016, https://www.gpo.gov/fdsys/pkg/CFR-2007-title45-vol1/pdf/CFR-2007-title45-vol1-part160.pdf.

[91] Herold and Beaver, *The Practical Guide to HIPAA Privacy and Security Compliance*, 16.

[92] "Summary of the HIPAA Privacy Rule," May 7, 2008, http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

[93] Herold and Beaver, *The Practical Guide to HIPAA Privacy and Security Compliance*, 16.

HIPAA delegated the DHHS as the arm of the federal government responsible for implementing and enforcing HIPAA and the standards inherent in the law.[94] The original language of the law, located in Sections 261–264, assigned responsibility to the Secretary of DHHS to make public the standards and practices for the exchange and protection of PHI.

Furthermore, the law required that the Secretary of DHHS issue the regulations mandating the accomplishment of the law if Congress failed to do so within three years after the law was passed. DHHS released a proposed set of standards to the public for comment in November 1999. In 2002, DHHS released the Standards for Privacy of Individual Identifiable Health Information, which is commonly referred to as the Privacy Rule.[95] DHHS also assigned oversight and enforcement responsibilities to its Office for Civil Rights (OCR).[96]

2. The Privacy Rule

The Privacy Rule creates the national standards for the protection of PHI. The main goal of the Privacy Rule is to balance the confidentiality of an individual's PHI with society's needs. When crafting the Privacy Rule, DHHS recognized that the disclosure or sharing of otherwise protected PHI was sometimes necessary to accomplish public health goals and other community needs.

> Public health practice often requires the acquisition, use, and exchange of PHI to perform public health activities (e.g., public health surveillance, program evaluation, terrorism preparedness, outbreak investigations, direct health services, and public health research). Such information enables public health authorities to implement mandated activities (e.g., identifying, monitoring, and responding to death, disease, and disability among populations) and accomplish health objectives.[97]

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[94] Herold and Beaver, *The Practical Guide to HIPAA Privacy and Security Compliance*, 6.

[95] "Summary of the HIPAA Privacy Rule."

[96] Ibid.

[97] "HIPAA Privacy Rule and Public Health, Guidance from CDC and the U.S. Department of Health and Human Services*," April 11, 2003, http://www.cdc.gov/mmwr/preview/mmwrhtml/m2e411a1.htm.

The Privacy Rule applies its regulations to organizations it refers to as covered entities, "health plans, health care clearing houses, and any health care provider who transmits any health care information electronically."[98] Due to the sometimes ambiguous nature of laws and the manner in which they are written, whether an agency, or an individual, qualifies as a covered entity remains vague. Many practitioners have taken the stance that they are covered entities and conduct their business within the guidelines of the Privacy Rule. According to a report sponsored by the federal Bureau of Justice Assistance titled, *Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws*, "HIPAA's restrictions on sharing health information are often misunderstood, which has resulted in practitioners' misapplying the law to be far more restrictive than the actual regulatory language requires."[99]

In general, the Privacy Rule provides for the following areas:

- Gives patients increased control over their own health information
- Describes the confines related to the use, maintenance, and disclosure of health records
- Sets protective measures that most health-care providers must follow to protect the confidentiality of PHI
- Enforces violations of the Privacy Rule with civil and criminal penalties which are enforced by the DHHSOCR
- Balances individual privacy with the good of the public
- Allows patients to make decisions on how their own PHI may be used
- Allows patients the opportunity to learn if a covered entity has disclosed their PHI
- Limits PHI disclosure to the amount minimally reasonable to accomplish the purpose of the disclosure
- In most cases, allows the patient the right to have copies of their own medical records and the ability to request corrections

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[98] "Summary of the HIPAA Privacy Rule."

[99] Petrila and Fador-Towe, *Information Sharing in Criminal Justice—Mental Health Collaborations: Working with HIPAA and Other Privacy Laws*, viii.

- Allows individuals to control the use and disclosure of their PHI[100]

When deciphering the meaning inherent in the Privacy Rule, one of the first steps involves determining who is a covered entity, or who is regulated by the Rule. At first look, it seems that the entities covered are any health plan, health care clearing house, or any health care provider who transmits PHI electronically.[101] As noted previously, both behavioral and physical health care providers are covered entities. The law does not differentiate between organizations that provide general care and specialty health care providers or facilities. Correctional facility health care is covered.[102]

As important as determining who or what may be covered is determining who or what is not covered. LE agencies and officers are not covered entities. "The HIPAA Privacy Rule broadly defines law enforcement as 'any government official at any level of government authorized to either investigate or prosecute a violation of the law."[103] As a result, LE is not bound by the regulations when asked to provide PHI to others, unless the LE officer originally gained the information from another entity covered by the regulations.[104] For example, if a LE official obtains PHI as the result of an exception, the PHI may not be further shared unless the subsequent recipient also falls under an exception. Courts and judicial systems are also not covered by HIPAA or the Privacy Rule due to the responsibility they hold in sentencing or monitoring the treatment of persons in the system. This exclusion also takes into account the court's role in overseeing treatment and compliance with its rulings.[105] "Correctional institutions are not considered 'covered entities' under HIPAA unless they classify themselves as such."[106]

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[100] "HIPAA Privacy Rule and Public Health, Guidance from CDC and the U.S. Department of Health and Human Services*."

[101] Herold and Beaver, *The Practical Guide to HIPAA Privacy and Security Compliance*, 12.

[102] Petrila and Fador-Towe, *Information Sharing in Criminal Justice—Mental Health Collaborations: Working with HIPAA and Other Privacy Laws*, 11.

[103] "Law Enforcement Access," accessed August 15, 2016, https://www.eff.org/issues/law-enforcement-access.

[104] Petrila and Fador-Towe, *Information Sharing in Criminal Justice—Mental Health Collaborations: Working with HIPAA and Other Privacy Laws*, 5.

[105] Ibid., 8–10.

[106] Ibid., 11.

These instances may be an example of the institution applying the boundaries of the law in an over-reaching manner due to a lack of understanding of the law, or because it is easier to be classified as a covered entity and then not have to face civil liability for releasing PHI even if the disclosure is allowable under the language of the law.

The Privacy Rule also identifies what it describes as hybrid entities; covered entities that perform functions that are both covered and not covered.[107] A hybrid entity may separate its functions so that the Privacy Rule only applies to those functions that align with covered entities. The remaining functions would not fall under the regulation of the Rule.[108] The onus for determining which components are covered falls upon the entity. The portions of the hybrid entity must then function as standalone covered entities and must treat the non-covered components as it would outside business associates in terms of abiding to the Privacy Rule.[109]

The Privacy Rule mandates some affirmative duties on covered entities. These duties represent standards that must be adopted by any covered entity. The Privacy Rule requires that covered entities:[110]

- Notify individuals of their privacy rights as afforded by the Privacy Act, and of how any of their PHI may be used or disclosed
- Create and implement internal policies and procedures for the safekeeping of PHI (including physical security procedures)
- Train employees on the policies and procedures
- Assign employees to manage the enactment of privacy policies and who will handle related complaints
- Include appropriate privacy regulations in contracts with business partners
- Entities must accommodate clients' rights

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[107] U.S. Government, *45 CFR Part 164 Subpart A—General Provisions* (Washington, DC: Government Printing Office, n.d.), accessed August 6, 2016, https://www.gpo.gov/fdsys/pkg/CFR-2007-title45-vol1/pdf/CFR-2007-title45-vol1-part164-subpartA.pdf.

[108] "HIPAA Privacy Rule and Public Health, Guidance from CDC and the U.S. Department of Health and Human Services*."

[109] U.S. Government, *45 CFR Part 164 Subpart A—General Provisions*, 733.

[110] "HIPAA Privacy Rule and Public Health, Guidance from CDC and the U.S. Department of Health and Human Services*."

The Privacy Rule defines the term disclosure as, "the release, transfer, provision of, access to or divulging in any other manner of information outside the entity holding the information."[111] The Privacy Rule mandates the disclosure of PHI in only two circumstances, to the individual owner of the PHI (patient), and when required by the Secretary of DHHS when the agency needs to determine if a covered entity is complying with the regulations set forth in the Rule.[112]

The Privacy Rule also delineates when it is may be permissible for a covered entity to disclose PHI. It is important to note that these exceptions are not required, but that the Rule allows for the disclosures under certain situations. The most obvious and broad exception is the use of consent by the owner of the PHI to disclose or use the information. When the use of the PHI is not for the purposes of treatment, billing, or otherwise permitted by the Privacy Rule, a covered entity must obtain written permission from the individuals to disclose their PHI.[113] This option may apply in cases where the individual is referred to the covered entity by a court, such as community supervision or when the court allows a supervising agent, such as a parole or probation agent, the ability to obtain medical records to ensure compliance with a court mandate for the individual. Courts may make a condition of an individual's release from custody or a treatment order that the individual grant consent for providers to release the individual's PHI to ensure compliance.[114]

It is also acceptable for covered entities to disclose de-identified PHI. The Rule does not place any restrictions on the use of, or disclosure of de-identified PHI. The Rule clearly defines de-identified PHI as "aggregate statistical data or data stripped of

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[111] U.S. Government, *45 CFR Part 160—Subchapter C—Administrative Data Standards and Related Requirements*, 697.

[112] U.S. Government, *45 CFR Part 164 Subpart E—Privacy of Individually Identifiable Health Information* (Washington, DC: Government Printing Office, n.d.), 746, accessed August 6, 2016, https://www.gpo.gov/fdsys/pkg/CFR-2007-title45-vol1/pdf/CFR-2007-title45-vol1-part164-subpartE.pdf.

[113] "Summary of the HIPAA Privacy Rule."

[114] Petrila and Fador-Towe, *Information Sharing in Criminal Justice—Mental Health Collaborations: Working with HIPAA and Other Privacy Laws*, 8.

individual identifiers."[115] Title 45 CFR Part 164 Subpart E §164. 514 defines the process for creating de-identified PHI and provides a list of identifiers that must be removed from PHI to qualify as de-identified.[116] The process of de-identifying PHI to remove the protections on the information provided by the Privacy Rule may be referred to as a "Safe Harbor" method. The process requires the removal of 18 identifiers from the PHI. The identifiers include information, such as names, numerical identifiers, images, and biometric information.[117] The remaining information must not be capable of being used to identify the subject.[118]

Federal Title 45 CFR Part 164 Subpart E §164. 512 is titled "Uses and disclosures for which an authorization or opportunity to agree or object is not required."[119] As the title indicates, this section of the Privacy rule allows for the disclosure of PHI without the owner's consent.[120] The Rule allows for the disclosure of PHI under certain conditions, but the Rule does not mandate or require the disclosure. The disclosure may, however, be mandatory under other law, such as state laws (see exception [a] or [c]). The exceptions listed in the section include:[121]

a) Uses and disclosures required by law

b) Standard uses and disclosures for public health activities

c) Disclosures concerning the victims of abuse, neglect, or domestic violence

d) Disclosures for health oversight activities

e) Disclosures for judicial and administrative proceedings

f) Disclosures for law enforcement purposes

g) Uses and disclosures in relation to medical examiners and coroners

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115 "HIPAA Privacy Rule and Public Health, Guidance from CDC and the U.S. Department of Health and Human Services*."

116 U.S. Government, *45 CFR Part 164 Subpart E—Privacy of Individually Identifiable Health Information*, 766–770.

117 "HIPAA Privacy Rule and Public Health, Guidance from CDC and the U.S. Department of Health and Human Services*."

118 Ibid.

119 U.S. Government, *45 CFR Part 164 Subpart E—Privacy of Individually Identifiable Health Information*, 757–766.

120 Ibid.

121 Ibid.

h) Cadaveric organ, eye, or tissue donation

i) Research purposes

j) Disclosures to avert serious threats to health and safety

k) Specialized government functions

The aforementioned letters also correspond with the paragraph sections in the Rule. This section focuses on paragraphs (j) and (k).

§164. 512 paragraph (j) provides perhaps some of the most applicable guidance when considering the Privacy Rule in connection with the relationship between mental health practitioners and LE. The section reads as follows:

> (j) Standard: Uses and disclosures to avert a serious threat to health or safety–
>
> > (1) Permitted disclosures. A covered entity may, consistent with applicable law and standards to ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the disclosure:
> >
> > (i)
> >
> > > (A) Is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public; and
> > > (B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or
> >
> > (ii) Is necessary for law enforcement authorities to identify or apprehend an individual
> >
> > > (A) Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim.[122]

The section goes on to state that the use and disclosure of the PHI referenced in (j) (1) (ii) (A) is not permitted if the information is discovered by the covered entity during treatment in which the covered entity is determining the likelihood for the individual to

[122] U.S. Government, *45 CFR Part 164 Subpart E—Privacy of Individually Identifiable Health Information*, 764.

commit the crime, or during counseling or therapy, or if the information is in relation to the reason for which the individual sought the treatment. In other words, if the covered entity is a therapist and is attempting to determine the likelihood of their patient committing a crime, the situation would not satisfy the exception. The section would also not be applicable if the propensity for the individual to commit the crime was the reason that the individual sought treatment.

More broadly, paragraph (k), which addresses specialized government functions, focuses specifically on a national security exception to the Privacy Rule. Section (2) of the paragraph reads:

> National security and intelligence activities. A covered entity may disclose protected health information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act (50 U.S. C. 401, et seq.) and implementing authority (e. g. Executive Order 12333).[123]

Once again, it is important to note that even these "national security disclosures are permissive rather than mandatory under HIPAA (your doctor can say no), but the language—particularly the disclosures to agencies—is amazingly broad."[124]

B. MARYLAND HEALTH CARE LAWS

Since each state has its own companion laws to the federal medical privacy law, this thesis uses Maryland's health care laws as the example of state law. Maryland's health care laws are similar to HIPAA and the Privacy Rule. For example, Maryland's law allows for the disclosure of PHI under certain circumstances, which are similar to the Privacy Rule exceptions. Like the federal exceptions, the disclosures under these circumstances are permissible and not mandatory.

Maryland law relating to health records may be found in the State Code Article titled Health-General under sections §4-301 through §4-309. Section §4-301 provides definitions, including that the statute applies to both physical and mental health care

[123] U.S. Government, *45 CFR Part 164 Subpart E—Privacy of Individually Identifiable Health Information*, 765.

[124] "National Security and Medical Information."

providers. The statue also defines health care providers as anyone licensed, certified, or authorized by the state to perform their duties. The section also defines medical records to include "any oral, written, or other transmission in any form or medium of information" that may be entered into a patient's file, identifies the patient, and relates to the care of the patient.[125]

Section §4-302 has to do with confidentiality and the general disclosure of medical records. The section mandates that health care providers maintain the confidentiality of medical records and sets the authority for the release of the records in accordance with the section or by other law.

Section §4-303 allows for the disclosure of medical records upon the request of the owner of the records (patient). The section outlines the consensual process and requires certain information regarding the authority to be in writing. The written authority is to include the period of time for which the authorization to release the records is valid (not to exceed one year). The one exception to the time limit is for cases in which the patient was referred for treatment by a criminal justice entity, such as a court. In these cases, the length of release authority extends until 30 days following the final disposition of the case.[126] The section of the Code titled "Disclosures without authorization of person in interest" (§4-305) is a state law similar in structure to the exceptions provided in the federal Privacy Rule. This section also allows for disclosures, which are permissive, and not mandatory. The first line of the section reads, "This section may not be construed to impose an obligation on a health care provider to disclose a medical record."[127] Sub-section 3 allows for the disclosure of medical records "to a government agency performing its lawful duties as authorized by an act of the Maryland General Assembly or the United States Congress."[128] The sub-section notes that further restrictions will follow in a subsequent sub-section related to the disclosure of mental health records. The

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[125] State of Maryland, *22. Medical Records Act--Duty to Hold Confidential and Duty to Disclose a Medical Record, Health-General Article § § 4-301--4-309, 8-601.*

[126] Ibid.

[127] Ibid.

[128] Ibid.

section, otherwise, permits the release of medical records by a provider to other government agencies in Maryland or federal government agencies by the provider without the authorization of the patient. Sub-section 6 goes on to authorize (permissive and not mandatory) the release of medical records if the provider "makes a professional determination that immediate disclosure is necessary to provide for the emergency health care needs of a patient." What is of note concerning this area of the law is that it provides no interpretation of circumstances, and leaves the decision up to the provider.[129]

Section §4-306, titled "Disclosures without authorization of person of interest—Investigations," is similar to the Privacy Rule's 45 CFR Part 164 Subpart E §164. 512 paragraph (f) in that it addresses compulsory disclosures in response to legal processes to include action needed to satisfy a subpoena, search warrant, or court order. These occasions involve a mandatory release of otherwise protected information in response to a legal order.

The second part of §4-306 involves permitted disclosures without the consent or authorization of the patient. Sub-section (b) (1) reads as follows:

> (b) Permitted Disclosures, --A health care provider shall disclose a medical record without the authorization of a person of interest:
>
> > (1) To a State or local government, or to a member of a multidisciplinary team assisting the unit, for the purposes of investigation or treatment in a case of suspected abuse or neglect of a child or adult, subject to the following conditions:
> >
> > > (i) The health care provider shall disclose only the medical record of a person who is being assessed in an investigation or to whom services are being provided in with Title 5, Subtitle 7, or Title 14, Subtitle 3 of the Family Law Article;
> > >
> > > (ii) The health care provider shall disclose only the information in the medical record that will, in the professional judgment of the provider, contribute to the:
> > >
> > > 1. Assessment of risk;

[129] Maureen O'Brien, "HIPAA vs. Probable Cause—Bridging the Communication Gap" (PowerPoint, Practitioner Legal Training, Montgomery County, Maryland, June 23, 2016).

2. Development of a service plan;
3. Implementation of a safety plan; or
4. Investigation of the suspected case of abuse or neglect; and

(iii) the medical record may be disclosed as provided in §§ 1-201, 1-202, 1-204, and 1-205 of the Human Services Article.[130]

Section 7 of paragraph (b) permits health care providers to release protected information to grand juries, prosecution agencies, LE agencies, or their agents in furtherance of a prosecution or investigation. The section of the law does, however, require that the receiving agency has written procedures in place designed to protect and safely store and use the information.

Section §4-307 is the area of Maryland law that discusses the release of mental health records. Maryland duty to protect laws are discussed in a later chapter of this thesis. The statute separates mental health medical records from the personal notes of the provider. Personal notes are defined as "the work product or personal property of a mental health provider."[131] Personal notes must be kept separate from records, and may not include information concerning diagnosis or treatment.

Paragraph (j) of the section addresses disclosures in relation to the health, safety, or protection of others. (j) (1) 2. (ii) connects directly with Maryland's duty to protect provision's Courts and Judicial Proceedings Article Section §5-609, which is discussed in the duty to warn chapter of this thesis.

Section §4-308 absolves a health care provider from "any cause of action" for either disclosing or not disclosing a medical record if that action was taken in compliance with the law.

C. ANALYSIS OF MEDICAL RECORDS AND CONFIDENTIALITY LAWS AND CVE

Federal and state medical privacy laws protect patient's PHI from disclosure. Patients have a need to feel that their private information is safe. Medical practitioners

[130] State of Maryland, *22. Medical Records Act--Duty to Hold Confidential and Duty to Disclose a Medical Record, Health-General Article § § 4-301--4-309, 8-601.*

[131] Ibid.

need their patients to disclose full details of their patient's condition to diagnose accurately and create treatment plans. As evidenced by the Hippocratic Oath, medical practitioners operate under strict ethical and legal mandates to protect their patient's PHI from outside entities, including government. However, even laws designed to keep personal information private have exceptions built in to balance the individual's right to privacy with the welfare of the public. CVE practitioners involved in intervention programs will be on the razor's edge of this balance.

As CVE intervention and diversion programs very much involve a mental health and medical component, which is balanced with the public safety component, a clear understanding of applicable laws is vital. CVE programs must balance confidentiality with the protection of the public.

CVE programs include partnerships with NGOs and public agencies with multiple functions. The balance of applying privacy laws in an environment including multiple agencies with varying functions presents a challenge. CVE programs also represent what the Privacy Rule refers to as hybrid entities. As such, it is the responsibility of the program to decide which portions of the structure are bound by the Privacy Rule, and separate the different components of the program to comply with the law.

In terms of disclosure of PHI, the Privacy Rule only mandates two circumstances of an affirmative obligation to disclose PHI. One instance involves open access of PHI to the patients themselves, and the other involves releasing PHI to DHHS for the purpose of auditing compliance with the law. Federal and state laws require that CVE intervention programs properly record and store medical information related to their clients. Both sets of laws dictate the requirements of record retention and storage. Clients receiving services from CVE programs have the right to review their medical records under the law. CVE programs are also required to explain the law to their clients. Programs must also be prepared to release medical records to DHHS in the event of an audit to ensure that the federal law is being followed.

One of the easiest ways to disclose PHI is with the patient's consent. The Privacy Rule requires written permission from the owner of the PHI. Some CVE programs might

use written consent when a client enters the program that would be in conjunction with an explanation of the rights afforded to the patient under the Privacy Rule and applicable state laws. It would also involve information on how the patient could revoke the consent. In cases where a patient is referred to a CVE program by a court system, consent on the part of the patient may be included in the referral if the court orders participation in the program.

One of the interesting exceptions to confidentiality in the Privacy Rule involves the sharing of de-identified PHI. The Privacy Rule provides clear instruction on what constitutes de-identified PHI. According to the Privacy Rule, there are no restrictions on the use of de-identified PHI. The Privacy Rule refers to the use of de-identified PHI as the "safe harbor" use. It is possible that CVE practitioners may use de-identified PHI to discuss otherwise restricted information concerning clients with other practitioners. In such cases, where other options are not available, it may be possible for mental health practitioners to discuss particular details concerning a client if all information that identifies the patient is removed from the discussion. Under these circumstances, the practitioner would be responsible for ensuring that the discussion did not include any details that could be used to identify the patient.

The most applicable portion of the Privacy Rule that has an impact on the ability of CVE practitioners to communicate details of potentially violent clients falls under the section describing the permissible exceptions to the Rule. The Rule begins explaining the exceptions by stating that they are restricted by the application of other laws or ethical standards. In other words, the exceptions exist when not restricted by other laws. The exceptions are required to balance the need for confidentiality with the obligation to protect other persons or the public.

Of the sections describing allowable exceptions to confidentiality, the section discussing government functions is most applicable to situations likely to be encountered in a CVE environment. The Rule allows for the disclosure of PHI without the patient's consent for certain government functions, including intelligence and national security functions. When other avenues permitting disclosure are exhausted, this section may allow practitioners to disclose information concerning clients who pose a risk to others by

violent means. Similar to other laws discussed, this section of the Privacy Act is broad and leaves much open to discretion and interpretation; however, the language makes it clear that the federal government's authority to conduct intelligence and national security investigations is an exception to the Rule. It is important to remember that this exception is permissive and not mandatory, but the language of the Privacy Act leaves open the possibility for CVE practitioners to disclose PHI to the federal government in cases where the client poses a risk to others or the national interest.

Maryland state law applying to the confidentiality of medical records is similar, and in many ways, mirrors the federal law. As with the federal law, Maryland state law begins by defining what and who are covered by the law. Based on Maryland's legal definitions, CVE practitioners administering mental health services, including therapists and counselors, would be covered by the law. Maryland's law also covers the use of consent by the patient as a means to use or disseminate medical information.

Likewise, the section of Maryland law addressing disclosure without the authorization of the "person of interest," is similar to the Privacy Rule. One broad difference is that Maryland law permits the disclosure of medical record information to government agencies "performing their lawful duties." As with other aspects of both federal and state law, the exception is permissible and not mandatory unless required by other laws.

Maryland separates mental health records into a separate section of the law. Similar to the minimally reasonable standard of the Privacy Rule, Maryland law mandates that mental health information released must only be relevant to the purpose of the disclosure. Maryland health confidentiality law refers to the legal section covering mental health records when referring to disclosure.

Based on both federal and Maryland state law on the use and disclosure of PHI, it appears that the laws provide broad guidance on exceptions allowing for disclosure. In some circumstances, these conditions and what they mean may present confusing circumstances for practitioners.

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III. THE DUTY TO WARN AND PROTECT

Like other medical health professionals, mental health professionals have an ethical and legal obligation to protect their patient's confidentiality. As with other health disciplines, this obligation is designed to facilitate a trusting relationship. While the protection of patient privacy is critical, and mandated by law, exceptions are built into the law. Some of the exceptions are permissive in nature, and some are obligatory. The exceptions, especially the mandated exceptions, are designed to balance confidentiality with the prevention of danger to the public. A legal requirement for mental health practitioners to warn or protect a third party from the actions of their patient is one such mandatory exception in many states.

The most simple definition of the term duty to warn is that social workers, therapists, or another mental health workers have an ethical and legal obligation to warn a third party of a potential danger presented by the therapists' client.[132] The term duty to protect implies that the therapists have a larger obligation to take additional steps to protect a third party from their patients when they have reason to believe that the patients pose a violent threat to the third party. "The general rational on which such laws are predicated holds that certain individual rights must give way to the greater good of society or to the rights of a more vulnerable individual (e.g., in child abuse or child custody cases)."[133] In terms of a state licensed therapist's duty to warn or protect, the legislation only resides at the state level. No federal law mandates a duty to warn or protect.

In his article, "Confidentiality and the Duty to Warn: Ethical and Legal Implications for the Therapeutic Relationship," James Corbin speaks of the nature of confidentiality and the friction it may cause between the field of mental health and other

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[132] Granich, "Duty to Warn, Duty to Protect."

[133] Gerald Koocher and Patricia Keith-Spiegel, "'What Should I Do?' - 39 Ethical Dilemmas Involving Confidentiality Educational," Continuing Ed Courses, March 9, 2015, 11, http://www.continuingedcourses.net/active/courses/course049.php.

disciplines, such as elements of our legal system.[134] Corbin concedes that outsiders may perceive mental health as an unreliable science and that mental health practitioners may view laws and the legal system as foreign and contrary to the aims of their profession.[135] Corbin describes the unavoidable intersection of the two worlds. As a result, the importance of cross training and knowledge of both systems is important to practitioners in both fields.[136]

Scholars David Wexler and Bruce Winick coined the term "therapeutic justice" to describe a problem-solving process used to bring the two fields closer together.[137]

> Therapeutic jurisprudence describes the problem-solving process between two systems—a study on the impact of the system of law on mental health, as well as the impact of the social sciences on law.[138]
>
> The mental health system and our nation's criminal justice systems (as well as civil court systems) depend on the expertise and knowledge base from each respective discipline, as well as the prudence of those specialists who have combined expertise, in attempts to address and solve problems. Both fields inform the practice of one another.[139]

The theory of duty to warn or protect is one issue that is frequently a point of contention between practitioners of mental health and the legal system.

Mental health practitioners are bound by the same legal and ethical rules as other health professionals. The American Psychiatric Association published "The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry," which outlines the ethical code of mental health professionals.

Section 4 of the code states, "A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and

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[134] Corbin, "Confidentiality & the Duty to Warn: Ethical and Legal Implications for the Therapeutic Relationship."

[135] Ibid.

[136] Ibid.

[137] David B. Wexler, "Two Decades of Therapeutic Jurisprudence," *Touro L. Rev.* 24 (2008): 17.

[138] Corbin, "Confidentiality & the Duty to Warn: Ethical and Legal Implications for the Therapeutic Relationship."

[139] Ibid.

privacy within the constraints of the law."[140] The section also describes how mental health records must be protected with a high level of care and that a psychiatrist may only release the records with the permission of the patient or "under proper legal compulsion."[141] As important as the theory of confidentiality is to health care as a whole, the issue is magnified in the realm of mental health care. "The confidential relationship between mental health professionals and their clients has long stood as the cornerstone of the helping relationship."[142]

The need for confidentiality in psychotherapy has been described as a "cornerstone" upon which therapist and client relationships are built.[143] Confidentiality is usually described as the restriction placed upon the disclosure of information by the mental health provider outside of courtroom settings, where the practitioner's testimony is demanded. "Confidentiality refers to a general standard of professional conduct that obliges a professional not to discuss information about a client with anyone"[144] As with regular health care, a difference exists between confidentiality and privilege in the realm of mental health care. Privilege refers to the legal immunity that certain specific types of relationships, such as therapist/client relationships, enjoy from testifying in court.[145] As noted in the chapter on HIPAA, this thesis does not delve into the concept of privilege, and instead focuses on the issues surrounding the theory of confidentiality.

The confidential relationships between psychotherapists and their clients are considered sacrosanct for very good reasons. When establishing a healing or helping relationship with a therapist, trust in an essential element. If potential patients believe that

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[140] American Psychiatric Association, *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* (Arlington County, VA: American Psychiatric Association, 2013), 2, https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/principles-medical-ethics.pdf; "Confidentiality and Privilege in Maryland," accessed August 27, 2016, http://mdpsych.org/resources/confidentiality-and-privilege-in-maryland/.

[141] Ibid., 2; Ibid., 6–7.

[142] Koocher and Keith-Spiegel, "'What Should I Do?' - 39 Ethical Dilemmas Involving Confidentiality Educational," 2.

[143] Benitez, "Confidentiality and Its Exceptions (Including the US Patriot Act)," 32–36.

[144] Koocher and Keith-Spiegel, "'What Should I Do?' - 39 Ethical Dilemmas Involving Confidentiality Educational," 8.

[145] Ibid., 9.

professionals will disclose the personal experiences that they share during therapy, many persons needing treatment may choose not to seek help. The successful treatment of ailments requires that patients fully disclose their symptoms for the provider to diagnose the illness successfully and construct a treatment regimen. An argument for the protection of confidentiality recognizes that patients who do not trust the confidential nature of the relationship they have with their therapist may not fully disclose information needed to diagnose and treat their conditions.[146]

Since duty-to-warn or -protect statutes, and subsequent interpretations by the judicial branches, exist at the state level, the laws and their application between states vary greatly. As shown in Figure 2, the states may be divided into the following three categories: states that mandate a duty to warn or protect, states that have permissive laws that allow therapists to warn or protect third parties, and states that have not enacted legislation concerning any duty to warn or protect.[147] Each of these three categories presents therapists with certain obstacles that must be overcome for the therapist to treat their patients successfully and follow legal guidance.

[146] Rothstein, *Testimony of Mark A. Rothstein Subcommittee on Investigations and Oversight, House Committee on Energy and Commerce*, 1–2.

[147] Rebecca Johnson, Persad Govind, and Dominic Sisti, "The Tarasoff Rule: The Implications of Interstate Variation and Gaps in Professional Training," *Journal of American Academy of Psychiatry and the Law Online* 42, no. 4 (December 1, 2014): 469–477, http://www.jaapl.org/content/42/4/469.long.

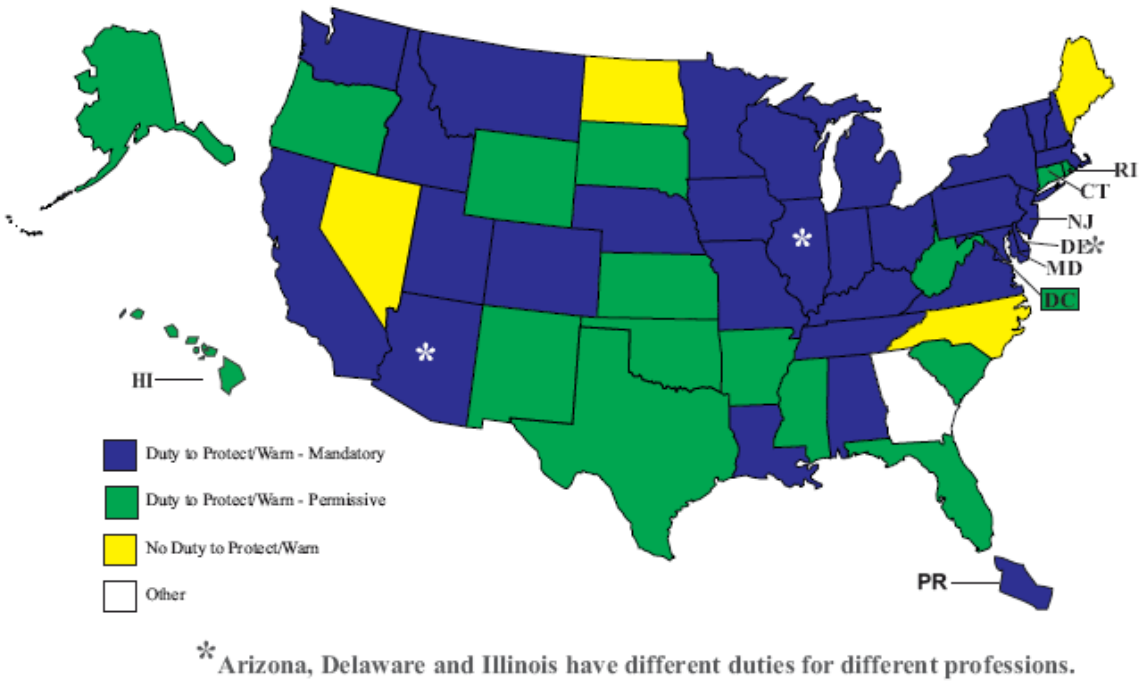

Figure 2. State Duty to Warn/Protect Laws.[148]

In states with mandatory statutes, therapists must regulate the trusting relationship with their patients and also make a determination on whether patient disclosures rise to the level to which the law mandates a duty to warn or protect. In determining whether the therapists must discharge the duty to warn or protect, the therapists must evaluate the level of risk posed by their client and decide if it rises to the level required by that state's specific guidance. Different states also make other requirements affected by the imminence of the potential threat, and whether the indented victim is known.[149]

Therapists who work in states with permissive statutes face even more challenging decisions.

> Therapists in states with permissive statutes have several legally acceptable options when a patient makes a violent threat against an identifiable victim: continue therapy as planned without issuing any

[148] Source: "Mental Health Professionals' Duty to Warn," September 28, 2015, http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx.

[149] Johnson, Govind, and Sisti, "The Tarasoff Rule: The Implications of Interstate Variation and Gaps in Professional Training," 469–477.

> warning, change the therapy to contain the threat and protect the potential victim, warn law enforcement, warn the victim, warn the victim and law enforcement, or determine if there are grounds for civil commitment based on the patient's dangerousness to others.[150]

In states with permissive legislation and law interpretations, the first two options present several legal and moral complications. If the therapist does not warn or notify the proper authorities and a third person becomes a victim, the therapist may be legally responsible since most states with permissive laws only cover the therapist from liability when a warning is made. Many of these state laws do not cover the therapist from liability when confidentiality is not breached, when valid reasons to warn, and then a third party victim is created. From a therapeutic standpoint, moral and treatment considerations may prevent the therapist from making a permissive notification, even when discharging a permissive duty to warn may be the safest course of action. "This moral basis serves as the foundation for legal duties to protect, which specify cases where legal requirements of clinician-patient confidentiality are removed to allow a clinician to try and avert harm to an identifiable victim."[151]

The third type of jurisdiction involves states with no statutory law or legal guidance. These states create a more challenging environment for therapists than the two previous categories. Without an affirmative duty to warn or protect, or a legal permissive ability to breach confidentiality, therapists in these states are in a very precarious position. If therapists breach confidentiality, they may be open to civil litigation. If the therapists fail to warn a potential victim, they may also be open to civil litigation. These two possibilities are in addition to the complexities involved in treating patients with violent potential, and preventing them from victimizing others.

A. TARASOFF—THE ORIGIN OF DUTY TO WARN

The terms "duty to warn" and "duty to protect" were born of a series of incidents, and subsequent legal maneuvers, in California in the late-1960s and mid-1070s. The

[150] Johnson, Govind, and Sisti, "The Tarasoff Rule: The Implications of Interstate Variation and Gaps in Professional Training," 469—477.

[151] Ibid.

events of concern were litigated in the California case of Tarasoff v. Regents of University of California.[152] The case involves the murder of a woman at the University of California (UC) Berkeley by a student who had been under psychiatric care. This seminal case was the first to use the terms "duty to warn" and "duty to protect" in legal jurisprudence. It is also the forerunner of all current duty-to-warn and -protect state laws. As a result, the topic of duty to warn or protect is frequently referred to as relating to Tarasoff, even though the Tarasoff case only directly applied to the state of California.

The details are compelling. Tatiana Tarasoff, also known as Tanya, was born in China to Russian parents, as shown in Figure 3. The family then moved to Brazil until relocating to Berkeley, California, in 1963.[153]

Figure 3. Tatiana Tarasoff.[154]

Prosenjit Poddar, seen in Figure 4, was raised in a small village in northern India and was a member of the Harijan (untouchable) caste. Poddar graduated from the Indian Institute of Technology in 1961 and relocated to Berkeley in 1967 as a graduate student

[152] "Tarasoff v. Regents of University of California—17 Cal. 3d 425—Thu, 07/01/1976|California Supreme Court Resources," accessed August 28, 2016, http://scocal.stanford.edu/opinion/tarasoff-v-regents-university-california-30278.

[153] Rothstein, "Tarasoff Duties after Newtown," 104–9.

[154] Source: "Duty to Warn," accessed September 4, 2016, https://courses2.cit.cornell.edu/sociallaw/student_projects/DutytoWarn.html.

studying naval architecture. Poddar lived in the International Student House (ISH) at UC Berkeley.[155]

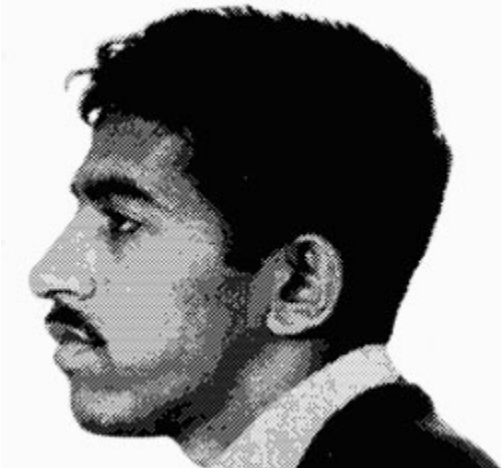

Figure 4. Prosenjit Poddar.[156]

It has been reported that Poddar experienced a hard time transitioning from his home culture to American culture. This challenge was probably made more complicated by his being born into, and raised, in the Harijan caste. It was noted that Poddar, who had previously attended all-male schools, was especially challenged by the cultural differences in terms of relationships with women.[157]

In 1968, Tarasoff and Poddar met at the ISH while Tarasoff was attending folk dancing classes. On New Year's Eve, Tarasoff kissed Poddar, which led him to believe that she was interested in him romantically. When Poddar pursued Tarasoff, she declined his advances. Poddar became infatuated with Tarasoff. When Poddar learned that Tarasoff was engaged in sexual relationships with other men, his mental condition began to decline. Poddar began missing classes and work, and began spending time alone in his

[155] Rothstein, "Tarasoff Duties after Newtown," 104–9.

[156] Source: Cornell University Law, "Duty to Warn."

[157] Rothstein, "Tarasoff Duties after Newtown," 104–9.

room. In the summer of 1969, Tarasoff left to spend the summer in Brazil. While she was gone, a friend of Poddar's encouraged him to seek treatment.[158]

Poddar sought help at Cowell Memorial Hospital at UC Berkeley. During treatment under the supervision of Dr. Lawrence Moore, Poddar disclosed that he was going to kill a woman named Tatiana. Case law indicates that the intended victim was "readily identifiable" by Moore.[159] Moore diagnosed Poddar with paranoid schizophrenia and consulted with colleagues. Believing that Poddar presented a danger to himself and others, Moore contacted the UC Berkeley police and asked that they take Poddar into custody. Moore further advised that he would commit Poddar. Campus police officers detained Poddar in his room. During the encounter, the police officers determined that Poddar appeared rational, instructed him to stay away from Tatiana, and did not transport him for commitment. Moore's supervisor instructed that all therapy notes be destroyed and instructed that no further attempts to commit Poddar be attempted. Poddar stopped participating in treatment.[160]

Upon her return to Berkeley, Tarasoff was open concerning her romantic escapades in Brazil. Upon learning of Tarasoff's involvement with other men, Poddar's mental state continued to deteriorate. On October 27, 1969, Poddar armed himself with a pellet gun and a knife, and went to Tarasoff's residence. Poddar chased Tarasoff into the back yard and fatally stabbed her 17 times. Poddar then went back inside and called the police, who responded and arrested him.[161]

Poddar was initially charged with murder, and was convicted of second-degree murder in spite of his defense of insanity. Poddar appealed, and a California Court of Appeals lowered the initial conviction to manslaughter. A new trial was ordered when it

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[158] Rothstein, "Tarasoff Duties after Newtown," 104–9.

[159] "Tarasoff v. Regents of University of California—17 Cal. 3d 425—Thu, 07/01/1976|California Supreme Court Resources."

[160] Walcott, Cerundolo, and Beck, "Current Analysis of the Tarasoff Duty: An Evolution towards the Limitation of the Duty to Protect," *Behavioral Sciences & the Law*, 325–43.

[161] Filmore Buckner and Marvin Firestone, "'Where the Public Peril Begins': 25 Years after Tarasoff," *Berkmand Klein Center for Internet & Society at Harvard University* (2000): 5, https://cyber.law.harvard.edu/torts01/syllabus/readings/buckner.html.

was determined that the judge in the first case failed to provide adequate instructions to the jury concerning the issue of diminished capacity. Poddar was never re-tried, and California ultimately allowed him to leave the United States and return to India.[162]

Tarasoff's parents later brought a civil suit against the University of California for wrongful death. The initial case was dismissed, and the Tarasoffs appealed. The California Court of Appeals affirmed the lower court's decision and found in favor of the defendants, that is, the university. The case was appealed again in front of the California Supreme Court. This time, the court agreed with the Tarasoffs and determined that the defendants should have warned Tatiana of the risk. In doing so, the California Supreme Court applied the legal theory of "duty to warn" to the therapists.[163]

Due to the controversial nature of the court's first opinion, and in an unusual maneuver, the California Supreme Court agreed to take a second look at its Tarasoff decision.[164] As unusual as it was for the California Supreme Court to agree to a rehearing of the case, it became even more unusual when the second decision expanded on the decision of Tarasoff 1. The decision in Tarasoff 2 expanded the duty to warn in decision of Tarasoff 1 to the "duty to protect." The case decisions are sometimes referred to as Tarasoff 1 and Tarasoff 2.[165]

Tarasoff 2 looked at all the causes for action claimed by the plaintiffs (Tarasoffs), and decided to focus on one, the "Failure to warn on a dangerous patient."[166] The defendants in the case contended that they had "no duty of care to Tatiana or her parents and that in the absence of such duty, they were free to act in careless disregard of Tatiana's life and safety."[167]

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[162] Rothstein, "Tarasoff Duties after Newtown," 104–9.

[163] Ibid.

[164] Ibid.

[165] Johnson, Govind, and Sisti, "The Tarasoff Rule: The Implications of Interstate Variation and Gaps in Professional Training," 469–47.

[166] "Tarasoff v. Regents of University of California—17 Cal. 3d 425—Thu, 07/01/1976|California Supreme Court Resources."

[167] Ibid.

In its analysis, the court determined that the most important consideration in terms of a failure to warn on behalf of the defendants was the issue of foreseeability. According to the opinion provided by Judge Tobriner in the case, "As a general principle, a 'defendant owes a duty of [17 Cal. 3d 435] care to all persons who are foreseeably endangered by his conduct, with respect to all risks which make the conduct unreasonably dangerous.'"[168] The court further noted that historically, affirmative action had been required if the defendant had a "special relationship" with either the individual posing a danger, or the intended victim. The relationship between a therapist and a patient qualified as a special relationship, which left the issue of whether therapists should have foreseen their client's future action.[169]

The defense counter-argued that therapists cannot predict whether a patient will act violently in the future with any degree of accuracy, and, in fact, practitioners likely would over-report their concerns.[170]

> In support of this argument amicus representing the American Psychiatric Association and other professional societies cites numerous articles which indicate that therapists, in the present state of the art, are unable reliably to predict violent acts; their forecasts, amicus claims, tend consistently to over-predict violence, and indeed are more often wrong.[171]

The court determined that making diagnoses is a central function of psychiatrists and psychologists, and in doing so, these practitioners do routinely make predictions. According to the court's decision, "Thus the judgment of the therapist in diagnosing emotional disorders and in predicting whether a patient presents a serious danger of violence is comparable to the judgment which doctors and professionals must regularly render under accepted rules of responsibility."[172] The court did recognize the difficulty inherent in the process of predicting behavior, and noted that a perfect performance on

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[168] "Tarasoff v. Regents of University of California—17 Cal. 3d 425—Thu, 07/01/1976|California Supreme Court Resources," 4.

[169] "Tarasoff v. Regents of University of California—17 Cal. 3d 425—Thu, 07/01/1976|California Supreme Court Resources."

[170] Ibid.

[171] Ibid.

[172] Ibid.

the part of therapists was not expected or necessary. The actions of a therapist in making predictions must only be reasonable in the context of the circumstances and as comparable to others in the field. The court also pointed out that the defendants in the Tarasoff case did accurately predict Poddar's violent behavior and the threat he posed, but failed to warn or protect the victim.

The significant conclusion of the court's decision was the determination that once a therapist does determine that a patient poses a threat to another (or should have determined based on the reasonableness of the circumstances and common practice), the therapist is responsible to act upon a duty to protect the threatened party.[173] This expansion of the duty to warn to a duty to protect increases the affirmative action that a therapist must take to protect a third party by imposing duties in addition to a warning. The court opined that the risk of predicting false warnings was overshadowed and made reasonable by the potential for the saving of lives and protecting third parties from danger.

In regards to the crucial nature involved in protecting confidential communications between therapists and their patients, the court acknowledged the importance of confidentiality and the role it plays in the successful treatment of patients, but weighed the interest of the confidentiality against the welfare of the public and the need to protect the public from future acts of violence.[174]

In providing the majority decision for the case, Judge Tobriner authored the now famous lines, "We conclude that the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins."[175]

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[173] "Tarasoff v. Regents of University of California—17 Cal.3d 425—Thu, 07/01/1976|California Supreme Court Resources."

[174] Ibid.

[175] Ibid.

B. MARYLAND DUTY TO WARN AND PROTECT LAW

Maryland is a mandatory duty-to-protect state. The affirmative nature of the duty may differ from other states in that it provides for options in which a therapist may act and does not specifically dictate which option the therapist must choose. The statute is located in Maryland's Courts and Judicial Proceedings Section §5-60.[176]

Section (a) of the statue defines to whom the law applies. Mental health care providers who must be licensed in the state are covered by the law. Definitions of who must be licensed are provided in the Health Occupations Statute under Section §17-101.[177] Licensing requirements for social workers may be found under the Health Occupations Statute under Title 19-Social Workers Subtitle 3-Licensing Title §19-301.[178]

Section §5-609 defines a mental health care provider as, "a mental health care provider licensed under the Health Occupations Article or any facility, corporation, partnership, association, or other entity that provides treatment or services to individuals who have mental disorders."[179]

Section (b) outlines the mandated duty to protect as occurrences when a mental health care provider is aware that a patient is capable of violent behavior against a known victim or group of victims. The statue provides immunity from legal or disciplinary action of the provider for discharge of the duty to warn or protect. Section (b) also describes the manner in which a provider may come to know of the threat posed by a patient as the patient's spoken word, writing, or conduct.[180]

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176 "Courts and Judicial Proceedings, Section 5-609," accessed September 10, 2016, http://mgaleg.maryland.gov/webmga/frmStatutesText.aspx?article=gcj&section=5-609&ext=html&session=2015RS&tab=subject5.

177 "2015 Maryland Code :: Health Occupations :: Title 17—Professional Counselors and Therapists :: Subtitle 1—Definitions; General Provisions :: § 17-101—Definitions," accessed September 10, 2016, http://law.justia.com/codes/maryland/2015/article-gho/title-17/subtitle-1/section-17-101/.

178 "2015 Maryland Code :: Health Occupations :: Title 19—Social Workers :: Subtitle 3—Licensing :: § 19-301—License Required; Exceptions; Practice without License," accessed September 10, 2016, http://law.justia.com/codes/maryland/2015/article-gho/title-19/subtitle-3/section-19-301/.

179 "Courts and Judicial Proceedings, Section 5-609."

180 Ibid.

Section (c) (2) provides the options for the discharge of the duty that a provider may take. The statue allows for discretion on the part of the provider either to seek commitment of the patient, construct a treatment plan to address the potential violence, inform a LE agency of the danger posed by the patient, or warn the intended victim(s). If the provider decides to provide a warning to LE or the intended victim(s), the stature delineates that the warning must include the nature of the threat, identity of the patient, and the identity of the intended victim(s). As a result, Maryland's law is both a duty to warn and a duty to protect statute. The law is mandatory in requiring the therapist to take action to protect, but allows discretion in how the provider discharges the duty. The law also states that the actions taken by the provider must be both reasonable and timely.[181]

C. ANALYSIS AND APPLICATION TO CVE

Confidentiality is a vital component of the therapist/patient relationship. Without the trusting relationship created by the existence of confidentiality, patients in need of treatment may not seek it, patients may not disclose all information needed for the mental health worker to diagnose and treat the patient properly, and patients may stop treatment (as was seen with Poddar). The reasons for the confidentiality and trust are also a benefit to society when they facilitate the successful diagnosis and treatment of the mental health patient.

This balance of trust with the responsibility to protect others from their patient's potential violent acts creates a precarious responsibility for therapists. The element of risk lies inherent in both the treatment of the patient and the protection of the public. When treating patients vulnerable to radicalization, engaged in radicalization, or radicalized, the threat of danger to others and the risk to the patient are always present.

A therapist must first diagnose a patient before administering treatment. In cases where the patient has indicated a threat to others, the therapist must determine if the threat is viable. A determination of whether the patient intends to carry out the threat, or is just venting frustration must be made. The therapist must determine if the patient has the means to carry out the threat. For example, a patient threatening to kill his wife with

[181] "Courts and Judicial Proceedings, Section 5-609."

whom he resides may be more credible than a threat to kill an ex-girlfriend who resides on another continent.

Many state laws, such as Maryland's, require that the threat posed by the patient be imminent, but provide no definition of what that means. The therapist must determine the imminence of their patient's threat to another. Without guidance on what constitutes imminent, practitioners are left to their own devices to make the determination.

As a result, mental health providers are responsible for treating patients suffering from mental health disorders, successfully diagnosing the disorder, creating a treatment plan, enacting the plan, monitoring the progress and adjusting as necessary, and being wary of danger the patient may pose to others. In the situations when the patient poses a danger, the practitioners must understand the boundaries of the law in the state in which they are practicing, determine if the threat is imminent, and then determine what to do. Risk assessment is a constant element in all phases of the therapist's role.

Maryland's duty to protect law applies to CVE practitioners providing therapy to referred clients. As licensed social workers or therapists, CVE practitioners are working in an environment rife with risk, and are bound by the duty to protect others. As such, when licensed mental health providers working in the CVE field in Maryland are treating patients, they must determine if the patient poses a threat to others. The threat may be communicated in words, writing, or other action.

Even though Maryland's law mandates an affirmative action on the part of the provider, the law allows for discretion on the part of the provider in the form of options which may be applied. In Maryland, providers are not mandated to warn the victim, although they may elect to do so. Maryland's law allows for the provider to address the threat by having the patient civilly committed for further treatment, establishing a more robust treatment plan, or making notification to the appropriate LE agency and the potential victim.

Maryland's duty to protect only applies to future crimes, and does not apply to crimes that have already been committed. The law also indicates that the victim, or victims, must be identifiable.[182]

The decision by a therapist to breach confidentiality remains a challenging issue. Identifying risk, and determining the seriousness or level of risk remains critical. A possibility exists that therapists, who are ethically and morally bound to protect the confidentiality of their patients, may be more inclined to try and treat patients as their choice of options, when in fact, the more appropriate response might have been to warn the victim and alert LE of the danger. While discretion is important in both mental health care and LE, some practitioners may elect to take what they believe is the safer ethical route and treat the patient as their response to discharging their protective duty.

The fields of mental health and LE are frequently misunderstood in general, and practitioners in both fields frequently do not possess an adequate understanding or appreciation of the other field. Corbin, Wexler, and Winick point out the conflict between the two professions while highlighting the importance of cooperation.[183] Mental health and LE will always overlap. The theory of therapeutic justice seeks to educate practitioners in both fields on the work of the other, and bring the two disciplines closer together. Both fields possess the same super-ordinate goal of helping others, but a lack of understanding or cooperation may block the efforts of one field instead of creating a complimentary union.

Practitioners in both fields are motivated and bound by ethical and moral values. Both fields are also impacted by laws that regulate or permit actions taken in pursuit of the specific field's goals, while still under the shadow of the broad goal of helping others. Therapists focus on their patients, and LE may focus on victims. The victims are sometimes the therapists' patients, and at other times, victims may be created by these patients. In terms of confidentiality and treatment of their patients, therapists are bound by both ethical and legal means. It is therefore important for LE professionals to

[182] Beth Tabachnick, "Maryland Duty to Protect/Warn" (PowerPoint, CVE Practitioner Confidentiality Training, Montgomery County, Maryland, 2016).

[183] Wexler, "Two Decades of Therapeutic Jurisprudence," 17.

understand the role of the therapist and the benefit to society of the successful treatment provided by the therapist. The therapist, on the other hand, must understand that at some point, the protection of society may outweigh the individual patient. In short, a balance must exist between the obligation the therapists have to their clients and the safety of the public. As noted by the second Tarasoff decision, the balance must always tip in favor of public safety as a whole. The protected privilege, should in fact, end where the public peril begins.

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IV. MULTI-DISCIPLINARY APPROACH

CVE programs are designed to operate as collaborative entities. The models bring together various entities and experts who may not normally work together. The models are designed to apply all the correct resources deemed necessary to achieve the goals of the program. This approach does, however, create challenges for organizing, managing, and ensuring the entities complement each other, remain focused on the goal, and collaborate effectively. Two of the main groups involved in CVE are represented by LE and mental health practitioners. As referenced earlier, conflict and cooperation between the two groups have previously existed in various venues. CVE adds additional ingredients to the pot by including additional resources and disciplines. Fortunately, collaborative models have been used successfully in other areas.

As the FBI has prepared to refer individuals to CVE programs for intervention, the agency has begun referring to the intervention practitioners as a MDT. The definition fits, but as shall be seen, the method and application as used by the FBI may not be appropriate.

For many years, different fields have relied on multidiscipline efforts to find the best approach to a super-ordinate goal. MDTs are sometimes also referred to as interdisciplinary teams, but the two are actually somewhat different, and the definition sometimes depends on the discipline in which it is used. MDTs have historically been used in the fields of private industry, health care, special education, and for child abuse investigations.

MDTs are typically composed of a group of professionals from different fields who share a common goal, but contribute different areas of expertise to the effort. In the field of medicine, interdisciplinary teams may be defined as, “a group of healthcare professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient,” as opposed to a MDT defined as, “a team of professionals including representatives of different disciplines who coordinate the contributions of each

profession, which are not considered to overlap, in order to improve patient care."[184] In the United States, MDTs have been used in hospitals for more than 50 years.[185]

The MDT approach identifies practitioners with critical responsibilities to an issue, and brings those practitioners together to form a team. The practitioners represent agencies that have a stake in the solution of the challenge. The practitioners are brought together as subject matter experts on their aspect or interest in the issue. The goal is to form a team of experts where each expert represents a different discipline for the purpose of collaborating on complex challenges. One of the assumptions of the effort is that individual practitioners would not benefit from the expertise of team members from different disciplines if the team was not formed. The practitioners represent each of their disciplines and work to collaborate the efforts of their organizations with the partner agencies. The goal is to create a common plan to overcome a challenge and identify the role of each discipline.

MDTs have been used in the United Stated for several decades, with a high level of success, in the area of physical and sexual child abuse. The MDT approach was first applied to child sexual abuse in the 1980s by the National Children's Advocacy Center (NCAC) in Huntsville, Alabama. At the time, social services providers, members of the criminal justice system, and LE officers were not effectively working together to address child sexual abuse issues. Members of these different disciplines pursued the same super-ordinate goal of protecting children, but the services provided were different, and what others were doing was not clear, or the mission of other practitioners was not really known either. A district attorney and now former Congressman from Alabama, Bud Cramer, recognized the lack of coordination, and assisted in forming MDTs with the various disciplines. Cramer organized representatives from the fields of child protective services (CPS), LE, medical and mental health practitioners, and attorneys and formed the first MDT for assisting child victims. The formation of the MDT also created the first child advocacy center (CAC), which evolved into a coordinated center where all aspects

[184] *The Free Dictionary*, "Multidisciplinary Team."

[185] Mark Ellis, *Forming a Multidisciplinary Team to Investigate Child Abuse* (Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 2000), 4, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2518713.

involved with the response to sexual crimes committed against children, as shown in Figure 5, could be addressed.[186]

Figure 5. NCAC Organizational Chart.[187]

According to the NCAC:

> This innovative model recognized that in order for the United States to effectively respond to this issue that a unique public-private partnership was essential, and that the various agencies and departments responsible

[186] "National Children's Advocacy Center History," accessed July 11, 2016, http://www.nationalcac.org/table/about/history/.

[187] Source: National CAC, "Multidisciplinary Team."

> for the protection of children must be united in a collaborative effort to respond with the recognition that no one agency by itself could assure the protection of children.[188]

This new approach was received with a certain amount of uncertainly by members of the different involved groups. Eventually, members of the MDT grew to appreciate the strength of the team. A greater understanding of different roles and an appreciation for the collaborative approach became obvious. Since that time, the CAC model of MDT has spread to over 950 CACs in the United States and to over 25 other countries.[189]

The investigation and response to the report of child abuse is a complicated and complex endeavor that necessitates the involvement of numerous different professionals from various different disciplines. The members of each area represent different, but aligned, missions with the same goal of protecting and assisting the victim.

LE is obviously tasked with the investigation of reported child abuse crimes. CPS social workers also investigate the reports of abuse and neglect, and frequently do so in conjunction with LE. Interviewing children in general, and especially children who may be the victims of horrible crimes, requires a very specialized skill set. CPS social workers, who are typically specially trained to conduct interviews with children, often conduct the interviews on behalf of LE. In the world of LE, it is rare that a professional from another field is relied upon so heavily to contribute such an important part of an investigation. As a result, a strong relationship between the LE and CPS workers is more than essential.

Medical and mental health professionals are brought into the equation to provide treatment, but are also used to gather both physical and testimonial evidence. In jurisdictions with CACs, specially trained pediatricians and nurses work in the Center to assess, treat, and document injuries and evidence in conjunction with their evaluation of the victim. In other jurisdictions, the victims are brought to a hospital where the attending physician may, or may not, have experience in treating the victims of child abuse, or sexual abuse.

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[188] National CAC, "Multidisciplinary Team."

[189] Ibid.

Prosecutors and government attorneys representing children also have a place in the response to child abuse. In many jurisdictions, when responding to crimes of a serious nature, prosecutors are frequently involved in the investigation. When dealing with the unique and fragile nature of child abuse investigations, prosecutors are frequently involved to assess the value of evidence and provide guidance. Other government attorneys are also involved in other legal areas involving children, such as custody and civil court proceedings.

When addressing matters representing a high level of seriousness, such as child abuse, teamwork is essential. To accomplish overall goals, the creation or formation of a team is very important. In addition to coordinating the various roles of team members, well-functioning child abuse MDTs frequently move into the arenas of group decision making, policy evaluation and recommendations, and coordinated strategies to apply to individual cases.[190]

Some of the recognized benefits to child abuse MDTs include:

- Leaner and more efficient use of scarce resources
- Better decisions made by groups with pertinent and multifaceted experience
- Better investigative, prosecutorial, and treatment outcomes
- Better understanding of roles and responsibilities leading to increased positive outcomes
- A higher level of community respect
- Lower levels of burnout and turnover among team members
- Lower amount of exposure to multiple agencies by victims[191]

Once the importance of the use of MDTs in child abuse investigations has been accepted, the next step involves the creation and maintenance of a team. Critical steps to forming a MDT include:

- Identifying and recruiting members

[190] Ellis, *Forming a Multidisciplinary Team to Investigate Child Abuse*.

[191] Ibid., 4.

- Creating and writing a mission statement
- Creating and writing policies and protocols
- Evaluating the impact of laws on the group's mission
- Establishing and maintain relationships
- Evaluation[192]

In Montgomery County, the MDT design is used for child abuse investigations and treatment plans. Any member of the team has the authority to call a MDT meeting to present issues related to a case for the team to discuss with the intent of producing a collective agreement on a path forward.

The model brings together representatives from the County's DHHS' child welfare services, police department, State's Attorney's Office, County Attorney's Office, and the Primary Care Coalition of Montgomery County. The team is a public private partnership. According to the Montgomery County memorandum of understanding and operational agreement for the Tree House Child Assessment Center of Montgomery County, Maryland:

> This agreement is set forth to enable the Montgomery County Multidisciplinary Team to pursue the well-established process of the interdisciplinary approach to cases of child maltreatment which includes, but is not limited to the following:
>
> A. Sharing information and resources to enhance each step of the case intervention process.
>
> B. Responding effectively and efficiently to all child protection issues of mutual concern.
>
> C. Ensuring that victims and their families receive community-based services in a timely fashion in order to reduce the stress on the family system.
>
> D. Providing an environment to allow each discipline to bring the training, experience and resources to the table to address child maltreatment and case management.

[192] Ellis, *Forming a Multidisciplinary Team to Investigate Child Abuse*.

E. Monitoring collaborative case management and service provision to ensure quality of treatment to support healthy outcomes.

F. Enhancing communication between and among all MDT operations.

G. Providing opportunity for feedback on Tree House and MDT operations.

H. Conducting peer reviews for all Tree House staff.[193]

The negative consequences of the failure of teamwork and cooperation among disciplines involved in the investigation and response to child abuse involve the continuation of child victimization and the possible failure to detect cases of child abuse. In 1995, a New York State commission investigating the failure to prevent the death of a child victim determined that part of the blame was due to, "an appalling lack of communication and coordination among the agencies investigating reports of possible abuse."[194] In response, the commission recommended the creation of legislation facilitating the sharing of information among MDT members.

The number of reports of child abuse and neglect has increased over the last several decades. The increase in cases has tested the limits of practitioners and agencies tasked with investigation and treatment. According to a report issued by the U.S. Department of Justice (DOJ), attention to these cases has assisted in focusing attention on the problem, but has also led to a spectrum of accusations varying from government overreach to government inaction.[195]

A. APPLICATION TO CVE

When comparing the collaborative efforts of CVE programs with CACs, many structural and goal similarities appear. In Montgomery County, the MDT structure already exists, and many of the partners are the same as those involved in the county's

[193] Montgomery County, *Montgomery County Memorandum of Understanding and Operational Agreement for the Tree House Child Assessment Center of Montgomery County, Maryland* (Montgomery County, MD: 2013).

[194] Ellis, *Forming a Multidisciplinary Team to Investigate Child Abuse*, 2.

[195] Ibid., 3.

CVE program. Child abuse and radicalization are both complex issues that require collaborative solutions. In Maryland, the law was amended to allow for the communication between partners on child abuse MDTs.[196] Other states have created or altered existing law for the same purpose. According to the Department of Criminal Justice Services for the Commonwealth of Virginia, "MDT members can share information. When the 2004 General Assembly made the above-referenced changes to section 63. 2-1503 (K) regarding the purpose and composition of child abuse and neglect MDTs, the specifically included language allowing team members to share information."[197]

According to its strategic plan, the BRAVE model in place in Montgomery County describes itself as a CII.[198] "Collective impact is a framework to tackle deeply entrenched and complex social problems. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change."[199] The idea of a CII was first written about in the Stanford Social Innovation Review in 2011. According to the article, five key elements are needed for a successful program: a common agenda, shared measurements systems, mutually reinforcing activities, continuous communication, and a backbone support organization. See Figure 6.

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196 State of Maryland, *22. Medical Records Act--Duty to Hold Confidential and Duty to Disclose a Medical Record, Health-General Article § § 4-301--4-309, 8-601*.

197 Virginia Department of Criminal Justice Services, *Information Sharing and the Multidisciplinary Child Abuse Team* (Richmond, VA: Department of Criminal Justice Services, 2005), 2, https://www.dcjs.virginia.gov/juvenile/resources/infoSharing.pdf.

198 World Organization for Resource Development and Education (WORDE), *The Building Resilience against Violent Extremism (BRAVE) Model—A Collective Impact Initiative That Increases Public Safety and Social Cohesion*, 12.

199 "The Collective Impact Framework | Collaboration for Impact," accessed October 16, 2016, http://www.collaborationforimpact.com/collective-impact/.

Figure 6. Collective Impact Initiative.[200]

CIIs are models that may be applied to organizational structures to ensure that practitioners are working together to achieve a common goal. The BRAVE model is currently the only true community led CVE initiative in existence.

B. THE FBI'S SHARED RESPONSIBILITY COMMITTEES

In the spring of 2016, media sources began reporting that the FBI had created SRCs that were being used as MDTs to control and facilitate the actions of CVE practitioners involved in intervention efforts with individuals referred by the FBI. One source, *The Intercept*, claimed to have a copy of a letter issued by the FBI to CVE members of SRCs. According to reports, and the letter itself, the FBI was seeking to create voluntary SRCs within CVE programs to define the boundaries and rules regarding individuals referred from the FBI.[201]

According to The Intercept, George Washington University Professor Seamus Hughes advised:

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[200] Source: "The Collective Impact Framework | Collaboration for Impact."

[201] Cora Currier and Murtaza Hussain, "Letter Details FBI Plan for Secretive Anti-Radicalization Committees," *The Intercept*, April 28, 2016, https://theintercept.com/2016/04/28/letter-details-fbi-plan-for-secretive-anti-radicalization-committees/.

> if implemented transparently, the SRCs could offer the promise of an "off ramp" for people on the road to radicalization or arrest. 'We haven't provided families with any tools to help them. Parents are taking passports away, bringing their kids to local imams, but these are ad hoc approaches set up to fail with no support system in place. Law enforcement is given very few options besides arrest. There are a lot of attacks on heavy-handed counter-terrorism approaches, like the informants and agent provocateurs, but that's the status quo now until we have other options.[202]

According to the letter, the FBI defines SRCs as, "multi-disciplinary groups voluntarily formed in local communities."[203] The letter outlines how the FBI may refer "potentially violent extremists for intervention so long as the SRC operates within the FBI's rules."[204] The FBI has not confirmed the existence of the letter and has been accused of implementing the SRC program in secrecy. The FBI has admitted that the SRC program is a limited "pilot" program but has not confirmed where the program is being used.[205]

According to the letter and media sources, the primary goal of the SRC is disengagement where the, "social and psychological process whereby an individual's commitment to violence as a solution to a grievance is reduced to such an extent that he/she is no longer at risk of using violence as a solution to a grievance."[206] The letter claims that the FBI's goal in referring individuals to SRCs is not to alter political or religious beliefs.

Some of the main points of the letter include the following:[207]

- The FBI is not part of the SRC.
- Once the FBI refers an individual, the SRC will decide if appropriate treatment may be applied.

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[202] Hussain and McLaughlin, "FBI's 'Shared Responsibility Committees' to Identify 'Radicalized' Muslims Raise Alarms."

[203] "FBI-SRC-Letter," April 28, 2016, https://www.documentcloud.org/documents/2815794-FBI-SRC-Letter.html.

[204] Ibid.

[205] Currier and Hussain, "Letter Details FBI Plan for Secretive Anti-Radicalization Committees."

[206] "FBI-SRC-Letter."

[207] Ibid.

- The SRC will then be responsible for designing and implementing a treatment plan.
- A referral will not preclude the FBI from conducting an investigation of the referred subject; however, the FBI will not use the SRC to gather intelligence.
- The FBI will not share investigative details with the SRC.
- Any investigation or prosecution may be conducted without notifying the SRC.
- Once a referral has been made, members of the SRC may share confidential PHI in accordance with applicable law.
- SRC members will sign confidentiality agreements, which forbid members from discussing the FBI referrals with anyone outside of the SRC or FBI, to include other LE members.
- The onus is placed on SRC members to reasonable ensure any information passed back to the FBI is accurate.
- The FBI reserves the right to stop making referrals to the SRC.
- The SRC may share best practices with other SRCs.
- SRC members may not seek outside consultation with other experts on the treatment of referred individuals without the written consent of the FBI.
- The FBI will not disclose the identities of the SRC members unless legally required to do so (represents another form of risk for CVE practitioners).
- SRC members will be required to sign federal form FC-857 for instances when they are exposed to sensitive, although unclassified, information.
- The FBI and DOJ will provide yearly training to SRC members on the handling of sensitive information and materials.
- The SRC will share all information on the referred individuals who pose a threat of violence to any other individual, group, or the public in a manner consistent with applicable laws.
- The SRC will notify the FBI when a referred individual is not responding to treatment.
- SRC may notify the FBI of the progression of treatment.

- Any information shared with the FBI may then be passed on to other LE, members of the U.S. intelligence community, or representatives of foreign governments.
- Financial and civil liability resides with the SRC members who are required to provide their own insurance and legal representation when needed.
- The letter of agreement makes no promise of funding.

Referrals made by the federal government of potentially radicalized individuals to SRCs would most likely represent a small but critical portion of treatment by CVE programs. The FBI certainly has an obligation to protect the integrity of its responsibilities. The manner the FBI has moved forward with SRCs and the construct of the agreement letter, however, do raise some concerns. For example, one of the main tenets of the CVE program is community outreach. Relationships between community and government, like all relationships, are based on trust. A semi-secret implementation of a program with such important consequences does not help this effort. According to the Muslim Public Affairs Council:

> This lack of transparency is harmful to the very goal the FBI is trying to achieve. Any individual who is being counseled by his/her imam, social worker, or therapist, will wonder if these individuals are working with the FBI—an entity that could very well arrest him/her and does not have any actual concern for his/her well-being.[208]

The letter also appears to move the lion's share of risk onto SRCs. This level of risk does not create an atmosphere where the most qualified practitioners would be most willing to partake in risky work that carries such an important role. The contents of the letter also do not create a trusting relationship between the FBI and the various public and private partners engaged in CVE endeavors. The letter also gives the FBI the appearance of hypocrisy. On one hand, the letter claims that the FBI will not use the SRC to gather intelligence, and then goes on to strictly set the rules mandating a one-way flow of information from the SCR to the FBI. Once again, the FBI has a responsibility to conduct

[208] Muslim Public Affairs Council, "The Problem with the FBI's 'Shared Responsibility Committees,'" *Muslim Public Affairs Council*, March 31, 2016, http://www.2fwww.mpac.org/policy-analysis/the-problem-with-the-fbis-shared-responsibility-committees.php.

its business, but the approach taken as outlined in the letter does not create a trusting and inclusive relationship.

The FBI will possess a lot of information concerning its referrals, which it understandably will not be able to share. However, successful treatment of referred persons also requires CVE practitioners be informed of certain information concerning an individual for whom they will creating and implementing a treatment plan. The fact the FBI may continue, or begin, a criminal investigation of a referred individual without the SRC's knowledge is understandable; however, the FBI's lack of presence on the SRC is not. The bottom line in regards to the letter and the role of the FBI and SRC members is that it appears that the FBI wants its cake, and to eat it as well, and to deny any cake to anybody else.

Much of the criticism of the FBI's SRC program has come from civil liberty and watch dog agencies, such as the American-Arab Anti-Discrimination Committee (ADC) and the Muslim Public Affairs Council.[209] The ADC has demanded that the FBI cancel the program.[210] One of the main accusations is that the program is a front for the expansion of FBI informant networks. Unfortunately for the FBI and CVE programs, this accusation is easy to make. The appearance that the FBI is using professionals and communities to expand surveillance of specific communities may validate existing claims that CVE programs stigmatize and unfairly target certain portions of communities. This phenomenon also runs contrary to community engagement theories.

The FBIs reference to CVE practitioners as an MDT may be technically accurate, but the FBI's approach violates the spirit of MDTs. MDTs include all relevant practitioners who work together to solve problems by combining the expertise of all. By not including itself in the MDT, the FBI is excluding its expertise, and probably some information held that would be better served shared.

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[209] "ADC Demands Cancellation of 'Shared Responsibility Committees' FBI Informant Program," March 25, 2016, http://www.adc.org/2016/03/adc-demands-cancellation-of-shared-responsibility-committees-fbi-informant-program/; Muslim Public Affairs Council, "The Problem with the FBI's 'Shared Responsibility Committees.'"

[210] "ADC Demands Cancellation of 'Shared Responsibility Committees' FBI Informant Program."

For all its good intentions, the design and roll out of the FBI SRC plan may do more harm than good. The FBI may be in a hurry to refer individuals to CVE programs, but not having the proper partners and relationships in place prior to kick off is never advisable. The result may be distrust or an undermining of what the CVE program could do to build relationships, help others, and protect the country.

V. RECOMMENDATIONS AND CONCLUSION

A number of common and repeated themes are inherent in the topic of this thesis. The issues of risk and threats to the community, community trust, delegation of roles, investigative restrictions, and importance of intelligence remain as challenges that must be addressed.

One of the most important elements of a successful CVE program will involve assembling the right team and establishing relationships between the stakeholders. This researcher would refer to the definition in the newest SIP and re-iterate that this group involves the public, LE, mental health practitioners, government leaders, attorneys, educators, NGOs, and private entities. Each element must not only understand its own role, but the roles of others for the effort to succeed. The importance of the relationship with the public was discussed previously. Two of the most important groups that need to establish strong working relationships include the mental health practitioners and LE. The theory of therapeutic jurisprudence, as proposed by Wexler and Winick may help to explain the difference between the two fields, and the important relations between the two. Frequently, practitioners of each discipline do not understand the role of the other. As a result, the two fields tend to work independent of each other and view the other with suspicion. The truth is that both fields share basic values and missions. To gain the best results, practitioners from both fields need to depend on the expertise of the other to achieve a better result. Both disciplines must develop a true collaborative and understanding relationship for the best results to occur. Fortunately, this relationship occurs in other areas, such as drug and gang diversion programs and in CACs.

For CVE intervention programs to operate successfully, stakeholders (using the same definition from the current SIP) must understand the law. The three areas of law (both federal and state) that have the greatest impact on CVE intervention programs include medical record confidentiality laws, national security laws, and duty to warn or protect laws. An analysis of the federal national security laws reveals that the impact of the Patriot Act's Section 215 represents a smaller change than is expressed in literature. It is critical that stakeholders receive comprehensive training on these laws. As noted

earlier, many segments of government and the private sector frequently hire outside experts to train their employees on such topics. The training should be provided to all stakeholders. It is important that stakeholders to whom the laws may not directly apply, such as LE, understand the legal environment in which their partners must work. It is also important that the training be specific to the state in which the program is operating, and any neighboring states with which the program may overlap.

A. CVE INTERVENTION PROGRAM ORGANIZATION

CVE programs should study and apply the tenets of collaborative models, such as CIIs and MDTs. CVE programs, in general, may benefit from a CII structure. For more information on the BRAVE model, refer to its strategic plan.[211]

CVE intervention programs should be managed and run by a MDT comprised of the applicable professionals. Since the goal of an intervention program is provided by mental health professionals, the MDT should be led by an experienced mental health practitioner. The MDT would be tasked with screening and assigning patients for treatment. The team would then monitor progress and oversee the application of resources to the treatment plan. Once assigned to other professionals within the program, the MDT would stand back and monitor based on the advice of the treating professional.

The MDT would also consist of LE and legal experts. The goal of the team would be to address any issues and make suggestions on plans to address the issues. The creation of the team, similar to MDTs used for child abuse investigations, would facilitate a cooperative working environment on the appropriate practitioners who would bring relevant experience to the effort. It is possible that states hosting CVE programs should study existing laws facilitating information sharing among MDT members engaged in responding to child abuse. In states that have created or altered laws to facilitate the sharing of otherwise protected information in these situations; similar laws may be needed for CVE intervention programs.

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[211] World Organization for Resource Development and Education (WORDE), *The Building Resilience against Violent Extremism (BRAVE) Model—A Collective Impact Initiative That Increases Public Safety and Social Cohesion*.

The MDT would also monitor and respond to training needs for members of the program, allied partners, and the public. The MDT would also be responsible for the application of HIPAA and state medical law requirements.

Public and private entities involved in CVE, and specifically intervention, should consider the creation of a memorandum of understanding (MOU) between involved organizations. A MOU would describe roles and set rules prior to establishing a group effort. The MOU would benefit by setting rules and expectations prior to any disagreements. If a CVE program is going to accept referrals from the federal government, they may consider including the FBI and the U.S. Attorney's Office in the MOU. Another option would be for the CVE itself to create a contract with the FBI (similar to a reverse SRC letter) to take the burden off of the FBI and stimulate a more fair perception of the process. The contract between the CVE program and the FBI would still acknowledge the responsibility the federal government has to protect the country, and balance the need for information with existing laws and regulations. The danger to the relationship between the federal government, local governments, and community led groups is the federal government's tendency to use funding to ensure it gets what it wants. The federal government should limit itself to coordinating research and providing advice, collating research, funding, referrals, and traditional investigative efforts. The federal government should also stay focused on its correct assessment that local governments are better positioned to create community relationships and understand the needs at the local level. The expertise to put the elements of CVE into practice resides at the local level.

B. MEDICAL CONFIDENTIALITY

In relation to medical confidentiality laws, it is imperative that practitioners understand the existence of both the federal HIPAA law and specific state laws. In relation to HIPAA, stakeholders must understand that the Privacy Rule only identifies two mandatory disclosures of PHI, to the patient, and to DHHS for auditing purposes. The remaining exceptions provide permissible conditions for mental health practitioners

to share information. Relationships must be in place prior to the treatment of clients so that stakeholders understand the law and know who needs access to information.

CVE programs must also determine if they constitute a hybrid entity and identify the part of the program that must operate under medical record laws. The program will then be responsible for segregating the portions of the program so that PHI remains secure.

Programs involved in intervention and diversion efforts must then be prepared to notify their clients of the laws, and the impact of the laws on their treatment and confidential information. CVE programs will be responsible for creating and implementing policies and procedures to ensure the protection of PHI and training their employees. These programs are also responsible for designating employees to be responsible and accountable for the requirements.

Programs will most likely advise clients of their privacy rights afforded by the Privacy Rule when they are first registered. It is an opportune time to ask the client for consent to share their PHI, and explain under what circumstances this sharing may be done. Consent is the easiest and cleanest practice that may address the issue of communication among stakeholders. The process must include a written waiver completed by the client. The waiver must include the length of the consent and under what circumstances it may be revoked. Under Maryland law, the consent process is described under §4-303.[212]

CVE practitioners may also consider the use of de-identified PHI used in a "safe harbor" method of sharing when consulting with other stakeholders as long as the information does not identify the client. It is a limited use of PHI, but one that may be considered when other options are not available.

Like the Privacy Rule, Maryland state laws on medical record confidentiality are permissive in nature. Maryland law is broader than the federal law in regards to whom PHI may be shared. Maryland law allows for the disclosure of PHI to any government

[212] State of Maryland, *22. Medical Records Act--Duty to Hold Confidential and Duty to Disclose a Medical Record, Health-General Article § § 4-301--4-309, 8-601.*

agency conducting authorized actions (as described by law). Practitioners will be challenged when blending state and federal law. Maryland law also allows for the release of information for an investigative process. The law does stipulate that the receiving agency must have written policies in place to protect the information. Many LE agencies do not have written procedures for the protection and safe storing of PHI. As a result, LE agencies involved in CVE actions must create these types of policies.

Practitioners in Maryland must also understand that they must disclose, or not disclose, PHI in compliance with the law to be immune from civil action.

C. DUTY TO WARN AND PROTECT

As with medical confidentiality laws, training on duty to warn and protect laws will be critical for mental health practitioners involved in CVE intervention and diversion.

CVE intervention programs will be run and performed by mental health professionals. These experts should already be well versed on the ethical and legal conditions imposed upon their work. The practitioners may not, however, have experience working with other professionals from other disciplines. They also may not be well versed on the exceptions to confidentiality in relation to the threat presented by radicalized persons.

Since duty to warn and duty to protect laws reside at the state level, practitioners must be aware of the laws of the state where they are practicing. Additionally, many laws are written in a broad manner that does not clearly articulate what is forbidden, mandated, or allowed. Many of these laws, such as Maryland's, allow for discretion. Mental health practitioners must have access to legal experts to assist in deciphering and applying the law, which is especially important when situations are frequently not the same.

Mental health professionals have an obligation to their clients. Due to the special relationship between mental health professionals and their clients, they may also have a legal obligation to protect third parties from the actions of their clients. This balance of

confidentiality needed to provide mental health treatment successfully must be balanced with any threat to the public.

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