


2-28-2018

Pathologizing “Radicalization” and the Erosion of Patient Privacy Rights

Kelly Morgan

Boston College Law School, kelly.morgan@bc.edu

Follow this and additional works at: <http://lawdigitalcommons.bc.edu/bclr>

 Part of the [Health Law and Policy Commons](#), [Law and Psychology Commons](#), [National Security Law Commons](#), and the [Privacy Law Commons](#)

Recommended Citation

Kelly Morgan, *Pathologizing “Radicalization” and the Erosion of Patient Privacy Rights*, 59 B.C.L. Rev. 791 (), <http://lawdigitalcommons.bc.edu/bclr/vol59/iss2/8>

This Notes is brought to you for free and open access by the Law Journals at Digital Commons @ Boston College Law School. It has been accepted for inclusion in Boston College Law Review by an authorized editor of Digital Commons @ Boston College Law School. For more information, please contact nick.szydowski@bc.edu.

PATHOLOGIZING “RADICALIZATION” AND THE EROSION OF PATIENT PRIVACY RIGHTS

Abstract: Countering Violent Extremism (“CVE”) is a counterterrorism strategy ostensibly aimed at preventing “radicalization” through risk assessment and intervention. CVE involves recruitment of helping professionals, including mental health care providers, to monitor their patients for signs of “vulnerability to radicalization,” make referrals to “de-radicalization” programs, and participate in multi-disciplinary intervention teams. Broad national security and public safety exceptions within existing privacy laws allow mental health professionals participating in CVE to make potentially harmful disclosures of private patient information. This Note argues that professional associations representing mental health care providers should develop policies to limit and regulate members’ participation in CVE.

INTRODUCTION

Mahin Khan (“Khan”) is an autistic Muslim eighteen-year-old currently serving an eight-year sentence in Arizona state prison.¹ In July 2016, Khan was charged with plotting to commit terrorism in support of the Taliban and the Islamic State.² Khan first came into contact with the Federal Bureau of Investigation (FBI) when he was fifteen, after he sent a threatening letter to a teacher.³ He subsequently underwent a forty-five day evaluation in an inpatient psychiatric facility, arranged in part by the FBI.⁴ Over the next few years, the FBI met with Khan every few months under the pretense of mentoring him and coordinating his mental health care.⁵ During one of these meetings, authorities

¹ Phil Benson, *Mahin Khan Sentenced to 8 Years in Prison in Tucson Terrorism Case*, AZFAMILY.COM (Nov. 4, 2016), <http://www.azfamily.com/story/33630479/mahin-khan-sentenced-to-8-years-in-prison-in-tucson-terrorism-case> [<https://perma.cc/S2TU-C5U8>]; Murtaza Hussain, *18-Year-Old Arrested on Terrorism Charges Is Mentally “Like a Child,”* INTERCEPT (Aug. 3, 2016), <https://theintercept.com/2016/08/03/18-year-old-arrested-on-terrorism-charges-is-mentally-like-a-child/> [<https://perma.cc/P47C-RFS2>]; Mike Truelsen, *Parents of Tucson Terrorism Suspect Mahin Khan Release Statement; Ask for ‘Understanding,’* NEWS 4 TUCSON (Aug. 4, 2016), <http://www.kvoa.com/story/32501286/parents-of-tucson-terrorism-suspect-mahin-khan-release-statement-ask-for-understanding> [<https://perma.cc/DN6V-5BU4>].

² Hussain, *supra* note 1.

³ *Id.*

⁴ *Id.* It is unclear from news reports how the Federal Bureau of Investigation first became aware of Mahin Khan (“Khan”) and the extent of communications between Khan’s treating mental health care providers and law enforcement officials. *See id.*

⁵ *Id.*; *see* Truelsen, *supra* note 1 (quoting Khan’s parents’ statement indicating that they had cooperated with the FBI for the purpose of helping their son access mental health services).

provided Khan with a cell phone.⁶ Using this phone, Khan allegedly made statements to an undercover informant indicating his willingness to commit terrorism.⁷

Two weeks after Khan turned eighteen, he was charged as an adult with conspiracy to commit terrorism and conspiracy to commit misconduct involving weapons.⁸ At Khan's trial, his parents argued that their son had the mental capacity of a thirteen-year-old and was incapable of formulating the complex plot he was accused of, let alone carrying it out.⁹ Unpersuaded by this argument, an Arizona state court judge sentenced Khan to eight years in prison and lifetime probation.¹⁰

Khan is just one of several mentally ill or developmentally disabled young Muslim men who have been subjects of surveillance and high-profile prosecutions since the September 11, 2001, terrorist attacks ("9/11").¹¹ These cases show a correlation between terrorism-related criminal prosecutions and mental illness or developmental disabilities.¹² Researchers have relied on this correlation in attempting to identify a causal link between behavioral and psychological indicators and terrorism.¹³

⁶ Hussain, *supra* note 1. Khan's parents had refused to buy him a phone, believing he lacked the necessary maturity. *Id.*

⁷ *Id.*

⁸ Press Release, Arizona Attorney General, Mahin Khan Pleads Guilty to Terrorism Charges (Oct. 11, 2016), <https://www.azag.gov/press-release/mahin-khan-pleads-guilty-terrorism-charges> [<https://perma.cc/QX7Y-SEG6>]. While the FBI's investigation began at least four months before Khan turned eighteen, he was not arrested until two weeks after his birthday. Hussain, *supra* note 1.

⁹ Hussain, *supra* note 1; Truelsen, *supra* note 1.

¹⁰ Benson, *supra* note 1. While awaiting his sentencing in Arizona's Maricopa County jail, Khan was reportedly kept in solitary confinement due to attacks by other inmates and the nature of the charges against him. Andrew Blankstein & Eli Panken, *Arizona Terror Suspect Mahin Khan Attacked by Inmates in Jail: Officials*, NBC NEWS (July 16, 2016), <http://www.nbcnews.com/news/us-news/arizona-terror-suspect-mahin-khan-attacked-inmates-prison-officials-n610891> [<https://perma.cc/GJM8-33GU>].

¹¹ See TREVOR AARONSON, *THE TERROR FACTORY: INSIDE THE FBI'S MANUFACTURED WAR ON TERRORISM* 157–58 (2013) (discussing how the lack of oversight of FBI undercover operations results in the targeting of "people who lack the capacity—financial or mental—to commit serious crimes"); HUMAN RIGHTS WATCH & HUMAN RIGHTS INST. AT COLUMBIA LAW SCH., *ILLUSION OF JUSTICE: HUMAN RIGHTS ABUSES IN US TERRORISM PROSECUTIONS* 27–41 (2014) (documenting allegations of terrorism that involved high levels of FBI undercover involvement, including several cases in which individuals targeted by the FBI suffered from mental illness or developmental disabilities); Trevor Aaronson, *The Sting: How the FBI Created a Terrorist*, INTERCEPT (Mar. 16, 2015), <https://theintercept.com/2015/03/16/howthefbicreatedaterrorist/> [<https://perma.cc/8LWL-7A3V>] (describing the prosecution of Sami Osmakac, a mentally ill man arrested for attempting to plant a car bomb provided by undercover FBI informants).

¹² See AARONSON, *supra* note 11; HUMAN RIGHTS WATCH & HUMAN RIGHTS INST. AT COLUMBIA LAW SCH., *supra* note 11.

¹³ See, e.g., Randy Borum, *Psychological Vulnerabilities and Propensities for Involvement in Violent Extremism*, 32 BEHAV. SCI. & L. 286, 287 (2014) (providing an overview of attempts to identify links between mental illness and terrorism and proposing that "mindset" impacts propensity to engage in terrorism); Paul Gill & Emily Corner, *There and Back Again: The Study of Mental Disorder*

Countering Violent Extremism (“CVE”) is a preventive counter-terrorism strategy deployed in the War on Terror.¹⁴ Rather than focusing solely on military responses, governments around the world have incorporated political and social science methods into their national security policies.¹⁵ As a result of this embrace of a multidisciplinary approach to the War on Terror, CVE has expanded worldwide.¹⁶ CVE is based on the assumption that there are identifiable “radicalization” processes through which law-abiding individuals adopt “extreme” ideas that may motivate terrorist activity.¹⁷ CVE is also based on the

and *Terrorist Involvement*, 72 AM. PSYCHOL. 231, 232–36 (2017) (providing a forty-year “history of the study of mental disorders and the terrorist”); Stevan M. Weine & Heidi Ellis, *Mobilize Health Resources to Counter Extremism*, 45 FAM. PRAC. NEWS 17, 17 (2015) (arguing that “psychosocial struggles” are a key factor in “radicalization” processes).

¹⁴ See Kelly A. Berkell, *Off-Ramp Opportunities in Material Support Cases*, 8 HARV. NAT’L SEC. J. 1, 26–28 (2017) (providing an overview of international CVE programs run by governments and non-governmental organizations); Press Release, Department of Homeland Security, Countering Violent Extremism Task Force (Jan. 8, 2016), <https://www.dhs.gov/news/2016/01/08/countering-violent-extremism-task-force> [<https://perma.cc/926G-DMAN>] (announcing the creation of a Countering Violent Extremism (“CVE”) Task Force by the Department of Homeland Security and Department of Justice). This Note uses the term “CVE” to refer to a broad category of programs, practices, and strategies deployed by governments and organizations that involve attempts to prevent “radicalization” through risk assessment and intervention. See Sahar F. Aziz, *Losing the “War of Ideas:” A Critique of Countering Violent Extremism Programs*, 52 TEX. INT’L L. J. 255, 258–61 (2017).

¹⁵ See STEVAN WEINE ET AL., NAT’L CONSORTIUM FOR THE STUDY OF TERRORISM & RESPONSES TO TERRORISM, LESSONS LEARNED FROM MENTAL HEALTH AND EDUCATION: IDENTIFYING BEST PRACTICES FOR ADDRESSING VIOLENT EXTREMISM 4–11 (2015) (demonstrating the ways in which the counter-terrorism field has increasingly drawn on the expertise of mental health professionals); Khaled A. Beydoun, *Between Indigence, Islamophobia, and Erasure: Poor and Muslim in “War on Terror” America*, 104 CAL. L. REV. 1463, 1488 (2016) (discussing how CVE achieves legitimacy through building allegiances between law enforcement and religious and cultural institutions).

¹⁶ See NAT’L COUNTERTERRORISM CTR., COUNTERING VIOLENT EXTREMISM: A GUIDE FOR PRACTITIONERS AND ANALYSTS 9–10 (2014) (discussing CVE in Saudi Arabia and Singapore); Berkell, *supra* note 14; U.N. Sec. Council Counter-Terrorism Comm., Countering Violent Extremism, <https://www.un.org/sc/ctc/focus-areas/countering-violent-extremism/> [<https://perma.cc/P8VD-R8D4>] (discussing the United Nations’ CVE strategy).

¹⁷ See ARUN KUNDNANI, A DECADE LOST: RETHINKING RADICALISATION AND EXTREMISM 9–13 (2015) (explaining the “radicalization” narrative underlying the UK’s CVE program “Prevent”); Amna Akbar, *Policing “Radicalization,”* 3 U.C. IRVINE L. REV. 809, 811 (2013) (explaining how the idea of “[r]adicalization has transformed the landscape of preventive counterterrorism policing”); Aziz, *supra* note 14, at 258–59 (explaining that “stopping so-called ‘radicalization’ of individuals to engage in terrorism is the ultimate goal of CVE”); Berkell, *supra* note 14, at 4 (describing CVE as “a developing set of initiatives that identify and mitigate the factors that lead individuals to embrace and act upon violent ideologies, a process sometimes referred to as radicalization”). The terms “radicalization” and “extremism” are used within this Note to refer to theories and beliefs about ideology and violence, recognizing that these terms have been critiqued for their lack of specificity and perpetuation of stereotypes. See Akbar, *supra*, at 816 (distinguishing between “radicalization” as a “discursive construct” and as an actual singular process); Samuel J. Rascoff, *Establishing Official Islam? The Law and Strategy of Counter-Radicalization*, 64 STAN. L. REV. 125, 137 (2012) (stating that “‘counter-radicalization’ remains almost completely undertheorized”). This Note has quotation marks around these terms to highlight their problematic implications. See Akbar, *supra*, at 816; Rascoff, *supra*.

assumption that there are ways of intervening at early stages of these processes to prevent future acts of terrorism.¹⁸

CVE has two main functions.¹⁹ First, CVE includes a risk assessment function.²⁰ Helping professionals involved in CVE risk assessment are tasked with monitoring individuals in their care for signs of “vulnerability to radicalization.”²¹ Second, CVE includes an intervention function.²² Individuals identified as being “vulnerable to radicalization” are referred to teams of professionals from different disciplines—including mental health workers, teachers, imams, and law enforcement officials—for religious and ideological reprogramming.²³

Although Khan’s arrest does not appear to be directly linked to any official CVE program, his case highlights the dangers of law enforcement interference in mental health treatment.²⁴ CVE is often promoted as a way of provid-

¹⁸ See NAT’L COUNTERTERRORISM CTR., *supra* note 16, at 4 (describing CVE as encompassing “prevention,” “disruption,” and “disengagement” strategies); Sahar F. Aziz, *Policing Terrorists in the Community*, 5 HARV. NAT’L SEC. J. 147, 164 (2014) (describing the purpose of preventive counterterrorism policies as “stop[ping] people from embracing extreme beliefs . . . that might lead to terrorism”); Berkell, *supra* note 14, at 39 (arguing that in some cases, security aims are best achieved through CVE as opposed to criminal prosecutions).

¹⁹ WEINE ET AL., *supra* note 15, at 2; Berkell, *supra* note 14, at 4.

²⁰ John D. Cohen, *The Next Generation of CVE Strategies at Home: Expanding Opportunities for Intervention*, 668 ANNALS AM. ACAD. POL. & SOC. SCI. 118, 120 (2016); Kiran M. Sarma, *Risk Assessment and the Prevention of Radicalization from Nonviolence into Terrorism*, 72 AM. PSYCHOL. 278, 280–81 (2017).

²¹ Akbar, *supra* note 17, at 814–15; Beydoun, *supra* note 15.

²² See DEP’T OF HOMELAND SEC., EXEC. OFFICE OF THE PRESIDENT, STRATEGIC IMPLEMENTATION PLAN FOR EMPOWERING LOCAL PARTNERS TO PREVENT VIOLENT EXTREMISM IN THE UNITED STATES 11 (2016) [hereinafter STRATEGIC IMPLEMENTATION PLAN] (discussing the U.S. CVE intervention prong); Berkell, *supra* note 14, at 37–39 (describing CVE’s risk assessment and intervention functions).

²³ See HM GOVERNMENT, CHANNEL DUTY GUIDANCE PROTECTING VULNERABLE PEOPLE FROM BEING DRAWN INTO TERRORISM, 2015, at 15–18 (UK) [hereinafter CHANNEL DUTY GUIDANCE] (providing guidance to members of the UK’s “Channel panels” and their partners in CVE intervention methods); Rascoff, *supra* note 17, at 142 (explaining that CVE intervention techniques may include “inculcation of ‘mainstream’ religious beliefs”); Cora Currier & Murtaza Hussain, *Letter Details FBI Plan for Secretive Anti-Radicalization Committees*, INTERCEPT (Apr. 28, 2016), <https://theintercept.com/2016/04/28/letter-details-fbi-plan-for-secretive-anti-radicalization-committees/> [<https://perma.cc/94F6-NYFA>] (discussing “Shared Responsibility Committees” which rely on counselors, social workers, religious figures, and other community members to assist the FBI in intervening with those the FBI thinks are in danger of “radicalizing”).

²⁴ See OPEN SOC’Y JUSTICE INITIATIVE, ERODING TRUST: THE UK’S PREVENT COUNTER-EXTREMISM STRATEGY IN HEALTH AND EDUCATION 15–18 (2016) (discussing how CVE has undermined relationships between helping professionals and those to whom they provide care in the UK); Beydoun, *supra* note 15 (describing how CVE policing techniques undermine First and Fourth Amendment rights); Hussain, *supra* note 1 (highlighting the fact that the FBI gained the trust of Khan’s family by helping him access mental health treatment); Alice LoCicero & J. Wesley Boyd, *The Dangers of Countering Violent Extremism (CVE) Programs*, PSYCHOL. TODAY (July 19, 2016), <https://www.psychologytoday.com/blog/almost-addicted/201607/the-dangers-countering-violent-extremism-cve-programs> [<https://perma.cc/BQV9-V2LY>] (calling on psychologists to refuse to participate in CVE due to ethical concerns).

ing “off-ramps” to vulnerable individuals before they ever reach the point of engaging in criminal activity.²⁵ The use of the term “off-ramp” implies that CVE identifies and reroutes individuals on the path towards becoming “extremists,” keeping communities safe and minimizing prosecutions.²⁶ In Khan’s case, however, the integration of mental health treatment and monitoring did not provide an off-ramp.²⁷ Rather, it led to his prosecution, incarceration, and lifetime probation.²⁸

This Note addresses the privacy concerns CVE raises, particularly with respect to individuals like Khan who receive services relating to mental illness or developmental disabilities.²⁹ Part I of this Note discusses the theories underlying CVE and CVE implementation in the United Kingdom and the United States.³⁰ Part II addresses the ways in which information-sharing between mental health professionals and law enforcement under CVE fits within existing health care privacy laws.³¹ Part III argues that professional ethics codes should be adapted to safeguard rights and account for insufficient privacy protections under CVE.³²

I. THE THEORETICAL EVOLUTION AND IMPLEMENTATION OF CVE

CVE gained traction in the United States at the start of the second decade of the War on Terror as a supposedly humane and uncontroversial way of addressing growing concerns about “radicalization” and homegrown terrorism.³³ Today, a wide range governments and organizations promote CVE as an effective, holistic way of addressing many forms of ideologically-motivated violence.³⁴ CVE is also widely criticized, particularly by directly impacted com-

²⁵ STRATEGIC IMPLEMENTATION PLAN, *supra* note 22; Berkell, *supra* note 14.

²⁶ STRATEGIC IMPLEMENTATION PLAN, *supra* note 22.

²⁷ See Hussain, *supra* note 1.

²⁸ See *id.* (describing how the FBI was involved with Khan’s mental health treatment for three years before eventually connecting him with an undercover informant and prosecuting him on terrorism charges); see also Beydoun, *supra* note 15, at 1485 (arguing that Islamophobia is “the cornerstone of CVE” and that CVE threatens Muslim-Americans’ civil liberties).

²⁹ See *infra* notes 33–199 and accompanying text.

³⁰ See *infra* notes 33–88 and accompanying text.

³¹ See *infra* notes 89–160 and accompanying text.

³² See *infra* notes 161–199 and accompanying text.

³³ See FAIZA PATEL & MEGHAN KOUSHIK, BRENNAN CTR. FOR JUSTICE AT N.Y. UNIV. SCH. OF LAW, COUNTERING VIOLENT EXTREMISM 5–6 (2017) (summarizing the Obama administration’s approach to CVE); Aziz, *supra* note 18, at 147, 164 (describing the ways in which community policing principles influence domestic preventive counter-terrorism strategies and how CVE is the “softer ‘hearts and minds’ facet” of counter-terrorism); Berkell, *supra* note 14, at 13–17 (discussing the deployment of CVE in the United States beginning with the White House’s announcement of a CVE domestic policy in 2011); Rascoff, *supra* note 17, at 153–55 (summarizing the use of “engagement” in Muslim communities as a component of domestic counter-terrorism policies).

³⁴ See PATEL & KOUSHIK, *supra* note 33, at 1 (noting, in light of the election of President Donald Trump that CVE has always targeted Muslims); Berkell, *supra* note 14 (discussing international CVE

munities.³⁵ Specifically, critics argue that CVE is based on unsound methodologies and biased assumptions and converts trusted social service providers into “soft surveillance” agents.³⁶ Section A of Part I introduces the theoretical and scientific foundations for CVE.³⁷ Section B discusses how CVE operates in the United Kingdom.³⁸ Section C explains the increasingly important role of CVE in the United States.³⁹

A. Pathologizing “Radicalization”

The term “radicalization” refers to a theorized process through which individuals adopt certain ideologies supposedly associated with terrorism.⁴⁰ Academics have described “radicalization” as “what goes on before the bomb goes off” or “the process . . . that drives ‘unremarkable’ people to become terrorists.”⁴¹ Prior to 9/11, this term generally described the shift from a more moderate to a stricter version of any political ideology.⁴² Following 9/11, however,

programs); The White House Office of the Press Secretary, Remarks by Assistant to the President for Homeland Security and Counterterrorism Lisa O. Monaco (Apr. 16, 2014), <https://obamawhitehouse.archives.gov/the-press-office/2014/04/16/remarks-assistant-president-homeland-security-and-counterterrorism-lisa> [https://perma.cc/M5LC-F9R3] (announcing the Obama administration’s launch of a CVE pilot program in Boston and claiming that CVE does not target any one religious group).

³⁵ See Waqas Mirza, *Fighting Anti-Blackness and Islamophobia*, MUSLIM INTERNATIONALIST (Mar. 27, 2017), <https://www.tnimag.com/articles/fighting-anti-blackness-islamophobia/> [https://perma.cc/YD97-NSGJ] (discussing the work of the Young Muslim Collective, a Minneapolis-Saint Paul-based Muslim-led organization advocating against CVE, which they believe “promot[es] Islamophobia and anti-Blackness and stigmatiz[es] local Somali and Muslim communities”); *What Is “Countering Violent Extremism” (CVE)?*, MUSLIM JUSTICE LEAGUE, <https://www.muslimjusticeleague.org/cve/> [https://perma.cc/32HZ-BG57] (describing the work of a Boston-based Muslim-led organization that advocates against CVE, which the organization claims “has operated to falsely legitimize discrimination against Muslims and dissidents”).

³⁶ See PATEL & KOUSHIK, *supra* note 33 (criticizing the premise and harms caused by CVE and referring to CVE as “soft surveillance”); Mirza, *supra* note 35; *What Is “Countering Violent Extremism” (CVE)?*, *supra* note 35.

³⁷ See *infra* notes 40–57 and accompanying text.

³⁸ See *infra* notes 58–76 and accompanying text.

³⁹ See *infra* notes 77–88 and accompanying text.

⁴⁰ Arun Kundnani, *Radicalisation: The Journey of a Concept*, 54 RACE & CLASS 3, 5 (2012); Rascoff, *supra* note 17, at 140.

⁴¹ Peter R. Neumann, *Introduction*, in THE INT’L CTR. FOR THE STUDY OF RADICALISATION AND POLITICAL VIOLENCE, PERSPECTIVES ON RADICALISATION AND POLITICAL VIOLENCE: PAPERS FROM THE FIRST INTERNATIONAL CONFERENCE ON RADICALISATION AND POLITICAL VIOLENCE 3, 4 (2008); MITCHELL D. SILBER & ARVIN BHATT, N.Y.C. POLICE DEP’T, RADICALIZATION IN THE WEST: THE HOMEGROWN THREAT 2 (2007).

⁴² Kundnani, *supra* note 40, at 7. The September 11, 2001, terrorist attacks by members of the terrorist organization al-Qaeda prompted a fundamental shift in how the United States viewed the threat of terrorism and marked the beginning of the War on Terror. See Aziz, *supra* note 18, at 177–202 (discussing changes in the policing of Muslim communities in the aftermath of 9/11).

“radicalization” came to imply an ideological development associated almost exclusively with Islam.⁴³

This change in how the term “radicalization” was used resulted in a series of studies of the “radicalization” process.⁴⁴ These studies purport to show how this process unfolds and involve differing levels of methodological rigor.⁴⁵ One 2007 study by the New York Police Department’s (NYPD) Intelligence Division analyzed ten completed or thwarted terrorist attacks perpetrated by Muslims in Europe and the United States.⁴⁶ The study concluded that the “radicalization” process includes four phases: pre-radicalization, self-identification, indoctrination, and jihadization.⁴⁷ The study listed several indicators of an individual moving through these phases, including “giving up . . . urban hip-hop gangster clothes,” “growing a beard,” and “becoming involved in social activism and community issues.”⁴⁸

Early studies in the wake of 9/11, including the NYPD’s, primarily relied on secondary data and interviews with individuals convicted of terrorism offenses, with an exclusive focus on Muslim subjects.⁴⁹ Many of these studies

⁴³ Kundnani, *supra* note 40, at 4, 7; see Aziz Z. Huq, *Modeling Terrorist Radicalization*, 2 DUKE F. L. & SOC. CHANGE 39, 41 (2010) (describing the increase in “information about how North American and European states conceptualiz[e] the “radicalization” process” after 9/11); see also Akbar, *supra* note 17, at 824 (explaining how, after 9/11, terms like “radicalization” were integral to the development of expansive law enforcement activities targeting Muslims).

⁴⁴ See, e.g., DAVEED GARTENSTEIN-ROSS & LAURA GROSSMAN, FDD’S CTR. FOR TERRORISM RESEARCH, *HOMEGROWN TERRORISTS IN THE U.S. AND U.K.: AN EMPIRICAL EXAMINATION OF THE RADICALIZATION PROCESS* 27–30 (2009) (analyzing the trajectories of 117 “Islamic homegrown terrorist[s]”); KUNDNANI, *supra* note 17, at 19–21 (summarizing studies that have had the greatest influence on how “radicalization” is conceptualized today); MARK SAGEMAN, *UNDERSTANDING TERROR NETWORKS*, at vii (2004) (analyzing a database of 172 terrorists committed to “global Salafi jihad”); QUINTAN WIKTOROWICZ, *RADICAL ISLAM RISING: MUSLIM EXTREMISM IN THE WEST* 4–5 (2005) (describing a study based on ethnographic fieldwork with the al-Muhajiroun, a designated terrorist organization based in the United Kingdom); Huq, *supra* note 43, at 43–48 (describing early influential state-level studies of “radicalization” in the United States).

⁴⁵ See KUNDNANI, *supra* note 17, at 19–21 (describing the methodological weaknesses in “radicalization” studies); PATEL & KOUSHIK, *supra* note 33, at 9–11 (discussing the “shaky” theoretical basis for CVE); Huq, *supra* note 43, at 46 (discussing how early “radicalization” studies in the United States reflected an “effort to establish the aura of academic credibility via a claim to precision that underlying data cannot support”); Rascoff, *supra* note 17, at 140 (noting that “radicalization” studies “inevitably exhibit the shortcomings of predictive social science applied to limited data sets”).

⁴⁶ SILBER & BHATT, *supra* note 41, at 15; see Huq, *supra* note 43, at 45–46, 57 (describing and critiquing the sampling methods used in the NYPD’s study).

⁴⁷ SILBER & BHATT, *supra* note 41, at 15, 19.

⁴⁸ *Id.* at 31.

⁴⁹ See KUNDNANI, *supra* note 17, at 19–21 (discussing the methodology of the most influential studies of “radicalization”); Beydoun, *supra* note 15, at 1487–88 (noting how, by identifying signs of Islamic piety as indicators of “radicalization,” CVE disproportionately targets “urban-dwelling, recently immigrated, and indigent Muslim American communities”); Sarma, *supra* note 20, at 282 (explaining weaknesses in the evidence base used to identify terrorism risk factors as “due to difficulties accessing samples and data, as well as pragmatic and ethical barriers to conducting research on sensitive topics”).

problematically lacked control groups, tested for correlation instead of causation, were susceptible to hindsight bias, and were never replicated or peer-reviewed.⁵⁰ Due to the methodologies employed, these studies confirmed the belief underpinning initial “radicalization” models that there is something inherent in Islam—specifically conservative or “extremist” interpretations—that leads to violent behavior.⁵¹

In recent years, “radicalization” research has tended to focus on ideological shifts, rather than violence.⁵² Researchers have looked increasingly further back in the theorized “radicalization” process to identify risk factors for the development of allegedly dangerous beliefs, as opposed to dangerous acts.⁵³ In contrast to early studies that focused primarily on small groups of individuals who had actually engaged in violence and produced results overtly equating Islam with violence, more recent studies have identified risk factors that are prevalent across Muslim and non-Muslim populations.⁵⁴

⁵⁰ See KUNDNANI, *supra* note 17, at 19 (discussing the problematic lack of control groups in most “radicalization” studies); ASIM QURESHI, THE ‘SCIENCE’ OF PRE-CRIME: THE SECRET ‘RADICALISATION’ STUDY UNDERPINNING PREVENT 28–33 (2016) (identifying key flaws in the methodology of the study upon which the UK’s CVE risk assessment tool—the ERG22+—was based, including the potential for response bias and the lack of replication assurances of reliability and validity); Huq, *supra* note 43, at 56–60 (discussing the errors in sampling and limited transparency in “radicalization” studies, which hinder peer review and replication); Rascoff, *supra* note 17, at 140 (critiquing studies’ limited sample sizes).

⁵¹ See GARTENSTEIN-ROSS & GROSSMAN, *supra* note 44, at 55 (highlighting the significance of “legalistic” and “ideologically rigid” versions of Islam); KUNDNANI, *supra* note 17, at 11 (“[T]he underlying assumption in radicalization models is usually the same: that some form of religious ideology is a key element in turning a person into a terrorist.”); Huq, *supra* note 43, at 59 (discussing how “radicalization” studies “treat the ‘Muslim’ *a priori* as a source of risk and harm”).

⁵² See KUNDNANI, *supra* note 17, at 26 (describing the shift in focus from “violent extremism” to simply “extremism” in counter-terrorism literature and noting that “[l]ike the concept of radicalisation, the notion of extremism selectively blurs the distinction between belief and violence”); PATEL & KOUHSIK, *supra* note 33, at 9–10 (discussing the problematic conflation of “extremist” beliefs and terrorism in the research underlying CVE).

⁵³ See, e.g., Kamaldeep Bhui et al., *Might Depression, Psychosocial Adversity, and Limited Social Assets Explain Vulnerability to and Resistance Against Violent Radicalisation?*, 9 PLOS ONE 1, 9 (2014) (identifying “radicalization” risk factors such as depression and operationalizing “radicalization” as “sympathies for violent protest and terrorism”); Sarah Lyons-Padilla et al., *Belonging Nowhere: Marginalization & Radicalization Risk Among Muslim Immigrants*, 1 BEHAV. SCI. & POL’Y 1, 5–6 (identifying marginalization as a risk factor, and operationalizing “extremism” as certain interpretations of Islam and belief that members of one’s social circle would support a hypothetical fundamentalist group).

⁵⁴ See Monica Lloyd & Christopher Dean, *The Development of Structured Guidelines for Assessing Risk in Extremist Offenders*, 2 J. THREAT ASSESSMENT & MGMT. 40, 46 (2015) (listing “radicalization” indicators such as “mental health” and “them and us thinking”); see also Huq, *supra* note 43, at 57 (describing how “radicalization” studies treat “facts that are pervasive in the ambient population as indicators of terrorist risk”); Sarma, *supra* note 20, at 282 (describing how research “has identified risk factors that are so broad that they lack discriminatory value”).

The proliferation of “radicalization” studies has produced the scientific and theoretical foundation for CVE.⁵⁵ These studies enable policymakers to direct helping professionals to use a broad array of risk assessment and intervention methods in efforts to prevent people from becoming “violent extremists.”⁵⁶ They also allow lawmakers and academics to claim that such practices are evidence-based and do not target any particular cultural, racial, or religious group.⁵⁷

B. The UK’s “Prevent” Program

A decade-long experiment in the United Kingdom influenced the U.S. implementation of CVE.⁵⁸ After 9/11, the British government instituted a counterterrorism strategy in 2003 called “CONTEST” in response to what was viewed as an “emerging terrorist threat.”⁵⁹ After the 2005 London bombings, CONTEST was revised to address the perceived growing risk of domestic terrorism—terrorism planned and committed within the United Kingdom.⁶⁰ A 2009

⁵⁵ See QURESHI, *supra* note 50, at 6 (explaining how the ERG22+ risk assessment tool is used to train public sector workers in the United Kingdom who are statutorily required to monitor their patients for signs of “vulnerability to radicalization”); Currier & Hussain, *supra* note 23 (stating that the risk factors identified by the National Counterterrorism Center are provided to local law enforcement, education and health professionals who are encouraged to use them to rate patients).

⁵⁶ See QURESHI, *supra* note 50, at 6; Currier & Hussain, *supra* note 23.

⁵⁷ See, e.g., NAT’L CRIMINAL JUSTICE REFERENCE SERV., EVALUATION OF A MULTI-FACETED, U.S. COMMUNITY-BASED, MUSLIM-LED CVE PROGRAM 5 (2016); STRATEGIC IMPLEMENTATION PLAN, *supra* note 22, at 5.

⁵⁸ Rascoff, *supra* note 17, at 148; ‘Countering Violent Extremism,’ a Flawed Approach to Law Enforcement, AM. CIVIL LIBERTIES UNION, <https://aclum.org/our-work/aclum-issues/freedom-of-expression-and-association/countering-violent-extremism-a-flawed-approach-to-law-enforcement/> [<https://perma.cc/EKQ4-2WDM>] [hereinafter *Countering Violent Extremism*]. Although CVE in the United States and the UK’s “Prevent” are independent programs, this Note sometimes uses the term CVE to refer to U.S. and UK attempts to implement predictive counter-terrorism programming. See *Countering Violent Extremism, supra*. CVE has been implemented throughout the United Kingdom, including Great Britain, Scotland, Wales, and Northern Ireland. HM GOVERNMENT, HOME DEPARTMENT, PURSUE PREVENT PROTECT PREPARE: THE UNITED KINGDOM’S STRATEGY FOR COUNTERING INTERNATIONAL TERRORISM, 2009, Cm. 7545, at 63 (UK) [hereinafter PURSUE PREVENT PROTECT PREPARE].

⁵⁹ See HOUSE OF COMMONS, HOME AFFAIRS COMMITTEE, PROJECT CONTEST: THE GOVERNMENT’S COUNTER-TERRORISM STRATEGY, 2008, HC 212 (UK); Nicole Magney, *CONTEST, Prevent, and the Lessons of UK Counterterrorism Policy*, GEO. SECURITY STUD. REV. (May 16, 2016), <http://georgetownsecuritystudiesreview.org/2016/05/16/contest-prevent-and-the-lessons-of-uk-counterterrorism-policy/> [<https://perma.cc/3HDQ-ZXJJ>].

⁶⁰ See PURSUE PREVENT PROTECT PREPARE, *supra* note 58 (discussing CONTEST’s purpose “to reduce the risk to the UK and its interests overseas from international terrorism, so that people can go about their lives freely and with confidence” and its four strands); Huq, *supra* note 43, at 52 (describing how the London bombings resulted in a shift in the UK’s counter-radicalization strategy); Ian Cobain, *London Bombings: The Day the Anti-Terrorism Rules Changed*, GUARDIAN (July 7, 2010), <https://www.theguardian.com/uk/2010/jul/07/london-bombings-anti-terrorism> [<https://perma.cc/B8DQ-FCFU>] (discussing how the political climate following the 2005 London bombings allowed for the emergence of an expansive domestic counter-terrorism policy).

strategy document detailed CONTEST's four strands: "Pursue, Prevent, Protect, and Prepare."⁶¹

The Prevent strand of CONTEST is the UK's CVE program.⁶² Prevent is intended to combat terrorism and "violent extremism."⁶³ It includes both the risk assessment function of CVE and an intervention program called "Channel."⁶⁴ Under Channel, individuals suspected of being "vulnerable to radicalization" are referred to multi-agency panels—including law enforcement, education, and social services.⁶⁵ They are then subjected to a more extensive risk assessment and, if deemed necessary, provided with individualized services and "diversionary activities."⁶⁶ Participation in Channel is not legally compulsory for those who are referred.⁶⁷ The program is criticized, however, for coercing participation, encouraging biased targeting of Muslims, threatening confidentiality, and precipitating entanglements with the criminal justice and family law systems.⁶⁸

⁶¹ PURSUE PREVENT PROTECT PREPARE, *supra* note 58, at 27; Huq, *supra* note 43, at 51.

⁶² Jessie Blackburn & Clive Walker, *Interdiction and Indoctrination: The Counter-Terrorism and Security Act 2015*, 79 MODERN L. REV. 840, 857–58; Huq, *supra* note 43, at 54. Prevent was recently rebranded as Engage based on the "toxicity" of the Prevent policy, but the underlying framework of the program remains unchanged. See *PREVENT Has Ended, Engage Is Its Rebirth*, CAGE (Aug. 25, 2016), <https://cage.ngo/article/prevent-has-ended-engage-is-its-rebirth/> [<https://perma.cc/5E3Q-9PM8>].

⁶³ HM GOVERNMENT, PREVENT STRATEGY, 2011, at 23, 57 (UK); PURSUE PREVENT PROTECT PREPARE, *supra* note 58, at 11. "Violent extremism" is defined as "the active opposition to fundamental British values." HM GOVERNMENT, *supra*, at 34.

⁶⁴ HM GOVERNMENT, *supra* note 63, at 61.

⁶⁵ CHANNEL DUTY GUIDANCE, *supra* note 23, at 7, 12; HM GOVERNMENT, *supra* note 63, at 97.

⁶⁶ CHANNEL DUTY GUIDANCE, *supra* note 23, at 17. The guidance report indicates that training courses are one example of "diversionary activities," and suggests that in some cases, diversionary activities may not be sufficient and one-on-one mentoring may be necessary. *Id.* Other examples of services provided to those referred to the Channel Program include housing, health care, employment, faith guidance, and sports. Alan Travis, *Prevent Strategy to Be Ramped up Despite 'Big Brother' Concerns*, GUARDIAN (Nov. 11, 2016), <https://www.theguardian.com/uk-news/2016/nov/11/prevent-strategy-uk-counter-radicalisation-widened-despite-criticism-concerns> [<https://perma.cc/KF3U-VKRC>].

⁶⁷ CHANNEL DUTY GUIDANCE, *supra* note 23, at 16.

⁶⁸ See OPEN SOC'Y JUSTICE INITIATIVE, *supra* note 24, at 65–106 (documenting cases in which students and patients were discriminated against by helping professionals subject to the Prevent Duty); Homa Khaleeli, *'You Worry They Could Take Your Kids': Is the Prevent Strategy Demonising Muslim Schoolchildren?*, GUARDIAN (Sept. 23, 2015), <https://www.theguardian.com/uk-news/2015/sep/23/prevent-counter-terrorism-strategy-schools-demonising-muslim-children> [<https://perma.cc/FN56-MRNH>] (discussing parents' concerns with the expansion of Prevent); Ben Quinn, *Nursery 'Raised Fears of Radicalisation Over Boy's Cucumber Drawing'*, GUARDIAN (Mar. 11, 2016), <https://www.theguardian.com/uk-news/2016/mar/11/nursery-radicalisation-fears-boys-cucumber-drawing-cooker-bomb> [<https://perma.cc/Y4BX-4T6T>] (discussing the case of a four-year-old Muslim boy whose nursery school threatened to refer him to the Channel program based on a misinterpretation of his pronunciation of cucumber as "cooker bomb").

In 2015, the British government enacted the Counter-Terrorism and Security Act (the “Security Act”), which created a statutory “Prevent Duty.”⁶⁹ This new law requires certain institutions and public employees to monitor those in their care for “vulnerability to radicalization” and make referrals to Channel.⁷⁰ Since Prevent’s inception, and particularly since the Security Act’s passage, numerous Muslims have been referred to Channel as a result of profiling.⁷¹ One such incident involved a fourteen-year-old Muslim high school student who, during his French class, mentioned that certain forms of environmental activism are referred to as eco-terrorism.⁷² As a result, a school official and child protection officer removed the student from class and questioned him about his affiliation with the Islamic State in Iraq and Syria (ISIS), justifying their actions as “reasonable and proportionate” in light of their obligations under the Security Act.⁷³

In addition to impacting the education sector, Prevent significantly affects health professionals and patients.⁷⁴ Some doctors have expressed concerns over not feeling safe to fully explore patients’ needs for fear of initiating a discussion that would reveal the presence of “radicalization” risk factors and require disclosure of confidential patient information.⁷⁵ Health care professionals have also expressed concerns about their inability to genuinely assure patients of confidentiality, their complicity in the marginalization of Muslim populations, and conflicts between their duties under Prevent and their professional ethical responsibilities.⁷⁶

⁶⁹ Counter-Terrorism and Security Act 2015, pt. 5, c. 1–2 (Eng.); Blackburn & Walker, *supra* note 62, at 841.

⁷⁰ QURESHI, *supra* note 50, at 13; Blackburn & Walker, *supra* note 62, at 859–64.

⁷¹ QURESHI, *supra* note 50, at 32–33; Vickie Coppock & Mark McGovern, ‘*Dangerous Minds? Deconstructing Counterterrorism Discourse, Radicalisation and the ‘Psychological Vulnerability’ of Muslim Children and Young People in Britain*, 28 CHILD. & SOC’Y 242, 246 (2014); Miqdaad Versi, *The Latest Prevent Figures Show Why the Strategy Needs an Independent Review*, GUARDIAN (Nov. 10, 2017), <https://www.theguardian.com/commentisfree/2017/nov/10/prevent-strategy-statistics-independent-review-home-office-muslims> [<https://perma.cc/4NDK-4HKE>].

⁷² Vikram Dodd, *School Questioned Muslim Pupil About ISIS After Discussion on Eco-Activism*, GUARDIAN (Sept. 22, 2015), <https://www.theguardian.com/education/2015/sep/22/school-questioned-muslim-pupil-about-isis-after-discussion-on-eco-activism> [<https://perma.cc/EL6B-829A>].

⁷³ *Id.*

⁷⁴ See *As a Doctor, I Refuse to Spy on My Patients*, CAGE (Feb. 12, 2016), <https://cage.ngo/article/doctor-i-refuse-spy-my-patients-0/> [<https://perma.cc/CK6S-RQE5>] (expressing concern at the imposition of the Prevent Duty on health professionals); Clare Gerada, *Prevent Is Stopping GPs Like Me from Doing My Job*, NEW STATESMAN (Nov. 3, 2016), <http://www.newstatesman.com/politics/staggers/2016/11/prevent-stopping-gps-me-doing-my-job> [<https://perma.cc/26PD-8H9Q>] (discussing the negative impacts of Prevent as experienced by a health professional).

⁷⁵ OPEN SOC’Y JUSTICE INITIATIVE, *supra* note 24, at 48–50; Gerada, *supra* note 74.

⁷⁶ OPEN SOC’Y JUSTICE INITIATIVE, *supra* note 24, at 49, 115; ROYAL COLL. OF PSYCHIATRISTS, COUNTER-TERRORISM AND PSYCHIATRY, POSITION STATEMENT PS04/16 4 (2016); Gerada, *supra* note 74.

C. CVE in the United States

In the United States, the Obama administration first adopted an official CVE policy in 2011.⁷⁷ This policy was largely modeled on the UK's Prevent program.⁷⁸ Recognizing some of the criticisms of Prevent, however, the administration promoted CVE in the United States as an equal opportunity program.⁷⁹ That is, it allegedly focused on a wide range of groups from jihadist-inspired terrorists to white supremacists and animal rights activists.⁸⁰ The Obama administration also promised to move forward with CVE while upholding civil rights and liberties and preserving trust between communities, government, and law enforcement.⁸¹

In 2014, the Obama administration announced three CVE pilot programs in Los Angeles, Boston, and Minneapolis-Saint Paul.⁸² Through the U.S. attorney's offices in these cities, CVE funds were awarded to community organizations.⁸³ Building on the perceived success of the pilot program, in 2016, the Obama administration pledged ten million dollars to the federal CVE program and announced the first round of organizations across the country who would receive these funds through individual grants distributed by the Department of

⁷⁷ See generally DEP'T OF HOMELAND SEC., EXEC. OFFICE OF THE PRESIDENT, NATIONAL STRATEGY FOR EMPOWERING LOCAL PARTNERS TO PREVENT VIOLENT EXTREMISM IN THE UNITED STATES (2011) [hereinafter NATIONAL STRATEGY]. The idea of combatting terrorism through engaging with Muslim communities is not new in the United States. See MICHAEL PRICE, BRENNAN CTR. FOR JUSTICE, COMMUNITY OUTREACH OR INTELLIGENCE GATHERING? A CLOSER LOOK AT "COUNTERING VIOLENT EXTREMISM" PROGRAMS 1–2 (2015). Efforts pre-dating CVE were criticized as being a vehicle for intelligence gathering. *Id.*

⁷⁸ PATEL & KOUSHIK, *supra* note 33, at 20; Rascoff, *supra* note 17, at 148; Murtaza Hussain & Jenna McLaughlin, *FBI's "Shared Responsibility Committees" to Identify "Radicalized" Muslims Raise Alarms*, INTERCEPT (Apr. 9, 2016), <https://theintercept.com/2016/04/09/fbis-shared-responsibility-committees-to-identify-radicalized-muslims-raises-alarms/> [<https://perma.cc/LJN7-DLLU>].

⁷⁹ NATIONAL STRATEGY, *supra* note 77, at 7; Berkell, *supra* note 14, at 19.

⁸⁰ OFFICE OF PARTNER ENGAGEMENT, FED. BUREAU OF INVESTIGATION, PREVENTING VIOLENT EXTREMISM IN SCHOOLS 5–6 (Jan. 2016); Berkell, *supra* note 14, at 19; Murtaza Hussain, *Trump's Rhetoric on "Radical Islam" Undermines Counterextremism Programs in U.S.*, INTERCEPT (Feb. 8, 2017), <https://theintercept.com/2017/02/08/trumps-rhetoric-on-radical-islam-undermines-counter-extremism-programs-in-u-s/> [<https://perma.cc/5NFY-9A34>].

⁸¹ NATIONAL STRATEGY, *supra* note 77, at 8.

⁸² The White House Office of the Press Secretary, FACT SHEET: The White House Summit on Countering Violent Extremism (Feb. 18, 2015), <https://www.whitehouse.gov/the-press-office/2015/02/18/fact-sheet-white-house-summit-countering-violent-extremism> [<https://perma.cc/8BEP-HQRC>]. Civil rights groups have hypothesized that Boston, Los Angeles, and Minneapolis-Saint Paul were chosen based on both their sizeable Muslim populations and their existing law enforcement "outreach" programs targeting Muslim communities. See Waqas Mirza, *Boston Finds Muslim Surveillance Program "Flawed and Problematic," but Implements It Anyway*, MUCKROCK (May 13, 2016), <https://www.muckrock.com/news/archives/2016/may/13/boston-cve/> [<https://perma.cc/PY3C-AA6W>].

⁸³ See U.S. DEP'T OF JUSTICE, FY 2016 PERFORMANCE BUDGET: OFFICE OF JUSTICE PROGRAMS 238 (2015) (requesting funding for the CVE pilot program, and explaining how the Department of Justice would work with U.S. Attorney offices to distribute funds to local organizations).

Homeland Security.⁸⁴ Shortly thereafter, President Donald Trump was inaugurated.⁸⁵ Early news reports indicated his administration's plans to transform CVE to a program solely focusing on "Islamic extremism."⁸⁶ Consequently, several organizations announced that they would reject any federal grants for CVE.⁸⁷ The Trump administration ultimately chose to leave the federal CVE grant program in place but declined to issue funding to several of the initial grantees.⁸⁸

II. CVE AND PATIENT CONFIDENTIALITY

For mental health treatment to be effective, patients must be able to trust that the information they share with their providers will not be disclosed without their consent.⁸⁹ For this reason, state and federal law—as well as professional codes of conduct—rigorously protect patient privacy.⁹⁰ CVE compromis-

⁸⁴ Press Release, Department of Homeland Security, DHS Awards Grants to Counter Terrorist Recruitment and Radicalization in the U.S. (June 23, 2016), <https://www.dhs.gov/news/2017/06/23/dhs-awards-grants-counter-terrorist-recruitment-and-radicalization-us> [<https://perma.cc/8EBS-ZSDB>].

⁸⁵ Julia Edwards Ainsley et al., *Exclusive: Trump to Focus Counter-Extremism Program Solely on Islam—Sources*, REUTERS (Feb. 2, 2017), <http://www.reuters.com/article/us-usa-trump-extremists-program-exclusiv-idUSKBN15G5VO> [<https://perma.cc/6F7N-4PCL>]; Hussain, *supra* note 80.

⁸⁶ Ainsley et al., *supra* note 85; Hussain, *supra* note 80.

⁸⁷ Amy B. Wang, *Muslim Nonprofit Groups Are Rejecting Federal Funds Because of Trump*, WASH. POST (Feb. 11, 2017), https://www.washingtonpost.com/news/post-nation/wp/2017/02/11/it-all-came-down-to-principle-muslim-nonprofit-groups-are-rejecting-federal-funds-because-of-trump/?utm_term=.c0532bef31b2 [<https://perma.cc/Z8GX-5F6T>]. One such organization that declined CVE funding was Ka Joog, which serves Somali American youth. Amy Forliti, *Minnesota Somali Group Says Rejecting Federal Grant Was Right*, PBS (Feb. 25, 2017), <https://www.pbs.org/news/hour/nation/minnesota-somali-group-says-rejecting-federal-grant-right> [<https://perma.cc/B4BN-LVWW>]. According to Mohamed Farah, executive director of Ka Joog, the decision was based on President Trump's explicitly anti-Muslim rhetoric, the executive order halting refugee resettlement and banning immigrants from certain Muslim majority countries, and news reports on changes to CVE. *Id.*

⁸⁸ Melania Zanona, *Trump Cuts Funds to Fight Anti-Right Wing Violence*, THE HILL (Aug. 14, 2017), <http://thehill.com/policy/national-security/346552-trump-cut-funds-to-fight-anti-right-wing-violence> [<https://perma.cc/TCX4-ZHVT>]. One organization that the Trump Administration declined to issue CVE funding to was "Life After Hate," a non-profit aimed at rehabilitating white supremacists and neo-Nazis. Debbie Southern, *We Can't Fight Trump-Style Hate with the Surveillance State* (Sept. 19, 2017), <http://inthesetimes.com/article/20531/CVE-surveillance-donald-trump-life-after-hate-islamophobia> [<https://perma.cc/F2QC-UH33>]; Zanona, *supra*.

⁸⁹ See U.S. DEP'T OF HEALTH AND HUMAN SERV., HIPAA PRIVACY RULE AND SHARING INFORMATION RELATED TO MENTAL HEALTH 1 (2017); Len Doyal, *Human Need and the Right of Patients to Privacy*, 14 J. CONTEMP. HEALTH L. & POL'Y 1, 10 (1997); Ellen W. Grabois, *The Liability of Psychotherapists for Breach of Confidentiality*, 12 J. L. & HEALTH 39, 50 (1997).

⁹⁰ See, e.g., 45 C.F.R. § 164.502 (2017); AM. MED. ASS'N, CODE OF MEDICAL ETHICS 47–59 (2016) [hereinafter AMA CODE OF MEDICAL ETHICS]; AM. PSYCHOL. ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT 7–8 (2017) [hereinafter APA ETHICAL PRINCIPLES]; Grabois, *supra* note 89, at 65–80.

es patients' right to privacy in several ways.⁹¹ First, when mental health professionals refer patients deemed "vulnerable to radicalization" to interdisciplinary teams involving law enforcement, they may disclose information obtained in confidential mental health treatment settings.⁹² Second, the interdisciplinary nature of CVE interventions can erode confidentiality protections, particularly when law enforcement officials inject themselves into a patient's mental health treatment.⁹³ As in Khan's case, blurring of mental health and law enforcement roles can result in the criminalization and incarceration of mental health patients.⁹⁴

Part II of this Note explores the legal exceptions that may permit disclosures of private information related to a patient's "vulnerability to radicalization."⁹⁵ Section A discusses the effects of *Tarasoff v. Regents of University of California* on mental health professionals' duty to warn when they suspect a patient may harm another person.⁹⁶ Section B discusses permissible disclosures of private information under the Health Insurance Portability and Accountability Act ("HIPAA") and the Uniting and Strengthening America by Providing Appropriate Tools Required to Obstruct Terrorism Act of 2001 (the "Patriot Act").⁹⁷ Section C compares professional associations' codes of ethical conduct to health care confidentiality laws.⁹⁸

⁹¹ See OPEN SOC'Y JUSTICE INITIATIVE, *supra* note 24, at 48–50 (summarizing how Prevent impacts health professionals' work); Gerada, *supra* note 74 (discussing how Prevent changes how health care professionals interact with their patients); Michael Ward, The Impact of "Duty to Warn" (and Other Legal Theories) on Countering Violent Extremism Intervention Programs 4 (Dec. 2016) (unpublished M.A. thesis, Naval Postgraduate School), https://calhoun.nps.edu/bitstream/handle/10945/51635/16Dec_Ward_Michael.pdf?sequence=1&isAllowed=y [<https://perma.cc/K8L4-XDEH>] (explaining the legal challenges posed by collaboration between mental health professionals and law enforcement in CVE).

⁹² See OPEN SOC'Y JUSTICE INITIATIVE, *supra* note 24, at 50 (discussing reports of British psychologists breaching confidentiality without obtaining consent); PATEL & KOUSHIK, *supra* note 33, at 13 (discussing how Prevent "result[s] in a system of soft surveillance and reporting by entities traditionally bound to confidentiality"); Gerada, *supra* note 74 (identifying patients' fear that they will be reported to authorities by health professionals due to Prevent).

⁹³ See Ward, *supra* note 91, at 10, 43 (explaining that in some cases privacy law will apply differently to different portions of a multi-disciplinary CVE program); see also LoCicero & Boyd, *supra* note 24 (describing CVE as "turning health care professionals into government informants").

⁹⁴ See Hussain, *supra* note 1 (discussing how law enforcement involvement in Khan's mental health treatment led to his prosecution).

⁹⁵ See *infra* notes 99–160 and accompanying text.

⁹⁶ See *infra* notes 99–126 and accompanying text.

⁹⁷ See *infra* notes 127–145 and accompanying text.

⁹⁸ See *infra* notes 146–160 and accompanying text.

A. Tarasoff and the Duty to Warn

Exceptions within confidentiality laws result in an ambiguous legal landscape for mental health professionals participating in CVE.⁹⁹ The duty to warn, commonly referred to as the *Tarasoff* duty, is particularly relevant to mental health professionals who participate in CVE.¹⁰⁰ This duty requires a professional to breach patient confidentiality where a patient is deemed a threat to another person.¹⁰¹

Tarasoff was a 1976 California Supreme Court case following the murder of Tatiana Tarasoff by Prosenjit Poddar, both students at the University of California at Berkeley.¹⁰² Prior to the murder, Poddar received voluntary outpatient mental health services through the university.¹⁰³ When he told his psychologist of his plans to kill someone, the psychologist consulted with colleagues and contacted the campus police.¹⁰⁴ The police questioned Poddar and subsequently released him.¹⁰⁵ After this incident, Poddar stopped seeing his psychologist, and several months later he stabbed Tarasoff to death.¹⁰⁶ Tarasoff's family sued the university, arguing that Poddar's psychologist breached a duty by failing to warn Tarasoff of Poddar's threats.¹⁰⁷ The California Supreme Court ruled in favor of Tarasoff and established that a therapist has a duty to "use reasonable

⁹⁹ See PATEL & KOUSHIK, *supra* note 33, at 24 (highlighting conflicting statements regarding confidentiality obligations); Anne Speckhard, *Alarms Raised Over Safeguarding Professional Ethics in the FBI Proposed "Shared Responsibility Committees" for Addressing Potentially Radicalized Individuals*, INT'L CTR. FOR STUDY OF VIOLENT EXTREMISM (Apr. 29, 2016), <http://www.icsve.org/brief-reports/alarms-raised-over-safeguarding-professional-ethics-in-fbi-proposed-shared-responsibility-committees-addressing-potentially-radicalized-individuals/> [<https://perma.cc/KE9S-EGYL>] (drawing attention to the lack of consensus in what mental health professionals participating in CVE are permitted to disclose); Ward, *supra* note 91, at 47–64 (addressing the lack of legal clarity regarding confidentiality and mental health professionals' participation in CVE).

¹⁰⁰ Justin Snair et al., *Rapporteurs*, in COUNTERING VIOLENT EXTREMISM THROUGH PUBLIC HEALTH PRACTICE: PROCEEDINGS OF A WORKSHOP 70 (2017); Speckhard, *supra* note 99; Ward, *supra* note 91, at 47–64.

¹⁰¹ Ronan Avraham & Joachim Meyer, *The Optimal Scope of Physicians' Duty to Protect Patients' Privacy*, 100 MINN. L. REV. HEADNOTES 30, 39 (2016), http://www.minnesotalawreview.org/wp-content/uploads/2016/02/AvrahamMeyer_PDF1.pdf [<https://perma.cc/ABG9-TM9J>]; see *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 340 (Cal. 1976) (establishing mental health professionals' duty to warn); RESTATEMENT (THIRD) OF TORTS § 41(a), (b)(4) (AM. LAW. INST. 2012) (stating that the relationship between a mental health professional and a patient triggers a mental health professional's duty to third parties).

¹⁰² Douglas Mossman, *Critique of Pure Risk Assessment, or Kant Meets Tarasoff*, 75 U. CIN. L. REV. 523, 532–33 (2006); see *Tarasoff*, 551 P.2d at 339–40.

¹⁰³ *Tarasoff*, 551 P.2d at 339–40; Mossman, *supra* note 102, at 533.

¹⁰⁴ *Tarasoff*, 551 P.2d at 339–40; Mossman, *supra* note 102, at 533.

¹⁰⁵ *Tarasoff*, 551 P.2d at 339–40; Mossman, *supra* note 102, at 533. The three police officers who questioned Poddar believed that he was rational and therefore released him after securing his promise that he would not bother Tarasoff. Mossman, *supra* note 102, at 533.

¹⁰⁶ *Tarasoff*, 551 P.2d at 339; Mossman, *supra* note 102, at 533.

¹⁰⁷ *Tarasoff*, 551 P.2d at 340.

care to protect the intended victim” where a patient “presents a serious danger of violence to another.”¹⁰⁸

Since 1976, nearly all states have followed California in establishing a mental health professional’s duty to warn in certain circumstances.¹⁰⁹ Although the conditions that trigger the duty to warn differ among states, all such laws delicately balance patients’ privacy interests against public safety.¹¹⁰

In regards to CVE, research equating “extremist” ideology with violence skews this delicate balancing of confidentiality and public safety inherent in the *Tarasoff* duty to warn.¹¹¹ In promoting CVE as providing off-ramps to vulnerable individuals before they ever engage in criminal conduct, agencies minimize the harms of CVE.¹¹² While *Tarasoff* acknowledged the potential negative consequences of mental health professionals breaching confidentiality by showing concern for the “damage done [to] the patient,” CVE is framed as a way of helping all parties involved rather than a necessary harm.¹¹³ Further-

¹⁰⁸ *Id.*

¹⁰⁹ See Avraham & Meyer, *supra* note 101, at 39 (noting that twenty-nine states adopted mandatory duty to warn laws and sixteen states and the District of Columbia adopted discretionary duty to warn laws); Griffin Edwards, *Doing Their Duty: An Empirical Analysis of the Unintended Effect of Tarasoff v. Regents on Homicidal Activity*, 57 J. L. & ECON. 321, 325–26 (2014) (noting that about half of all states have a mandatory duty to warn similar to *Tarasoff* and about seventeen percent have a discretionary duty to warn law). In some cases, the duty to warn requires mental health professionals to take action only when a patient articulates a specific threat to do serious harm to a reasonably identifiable victim and only when such a plan is actually feasible and imminent. See, e.g., Mossman, *supra* note 102, at 588 (describing Ohio’s narrow interpretation of the *Tarasoff* duty). In some states this duty is interpreted more broadly to require warnings even when a victim is not identifiable and the harm is not believed to be imminent. See, e.g., Avraham & Meyer, *supra* note 101, at 39–40 (identifying broad interpretations in Nebraska and Michigan).

¹¹⁰ See, e.g., Brady v. Hopper, 570 F. Supp. 1333, 1339 (D. Colo. 1983), *aff’d*, 751 F.2d 329 (10th Cir. 1984) (finding that “[h]uman behavior is simply too unpredictable, and the field of psychotherapy presently too inexact” to impose what would amount to a strict liability duty on psychotherapists for the sake of protecting public safety); Schuster v. Altenberg, 424 N.W.2d 159, 170 (Wis. 1988) (“The concern regarding the preservation of patient trust in the confidentiality of communications is legitimate, yet one which must yield in those limited circumstances where the public interest in safety from violent assault is threatened”).

¹¹¹ See OPEN SOC’Y JUSTICE INITIATIVE, *supra* note 24, at 48 (discussing the Channel program’s blurring of terrorism and non-violent extremism); PATEL & KOUSHIK, *supra* note 33, at 9–10 (discussing the problematic conflation of “extremist” beliefs and terrorism in the research underlying CVE); Speckhard, *supra* note 99 (noting that mental health professionals “may now believe they have blanket national security ‘loopholes’ to report on their clients to the FBI” under CVE).

¹¹² See STRATEGIC IMPLEMENTATION PLAN, *supra* note 22 (describing CVE as providing “alternative pathways or ‘off-ramps’ for individuals who appear to be moving toward violent action but who have not yet engaged in criminal activity”); Press Release, U.S. Dep’t of Homeland Security, Announcing the CVE Grants Program (July 6, 2016), <https://www.dhs.gov/blog/2016/07/06/announcing-cve-grants-program> [<https://perma.cc/HQE6-479D>] [hereinafter CVE Grants Press Release] (promoting CVE as providing off-ramps).

¹¹³ See *Tarasoff*, 551 P.2d at 346 (acknowledging the harms of disclosing a mental health patient’s private information); Berkell, *supra* note 14, at 52 (arguing that “[t]he criminal justice system, and cases involving material support for terrorism in particular, provide opportunities to counter violent extremism with full respect for civil rights and civil liberties”).

more, helping professionals are exposed to public narratives regarding “radicalization” and the threat of homegrown terrorism.¹¹⁴ Consequently, mental health professionals may be overcautious and swayed towards referring their patients to CVE intervention programs at the expense of confidentiality.¹¹⁵

The increased use of actuarial risk assessment tools to predict likelihood of violence may also implicate the ways in which mental health professionals engage with CVE.¹¹⁶ The assumption underlying the *Tarasoff* decision is that—in at least some situations—mental health professionals are able to predict future violence with reasonable certainty.¹¹⁷ In *Tarasoff*, the California Supreme Court suggested that mental health professionals’ can effectively determine whether a patient is likely to harm another person based on their individual experience and education.¹¹⁸ Increasingly, however, mental health professionals use actuarial methods, such as checklists and scoring guides, to conduct assessments of their patients’ likelihood of engaging in acts of violence.¹¹⁹ These actuarial methods of risk assessment are considered beneficial in some settings because they decrease the likelihood of bias and other types of error in risk determinations.¹²⁰ Additionally, in some contexts, actuarial methods are

¹¹⁴ See Mary Brigid Martin, *Perceived Discrimination of Muslims in Health Care*, 9 J. MUSLIM MENTAL HEALTH 2, 58 (2015) (showing that “anti-Muslim discrimination crosses over from society to the health care setting in the United States”).

¹¹⁵ See OPEN SOC’Y JUSTICE INITIATIVE, *supra* note 24, at 43 (quoting a British mental health professional explaining that many of her colleagues comply with Prevent because “the cost of not [referring] would be borne by them whereas the cost of a referral is borne by the referred individual”); Snair et al., *supra* note 100 (discussing how *Tarasoff* may be used to “breach personal liberties” in CVE contexts). *But see* Ward, *supra* note 91, at 62 (cautioning that mental health professionals participating in CVE may be too hesitant to “discharg[e] their protective duty” considering the ethical and legal obligations imposed on them).

¹¹⁶ See Mossman, *supra* note 102, at 528–29 (discussing scientific advances in the field of risk assessment since *Tarasoff* was decided in 1976); Douglas Mossman, *The Imperfection of Protection Through Detection and Intervention*, 30 J. LEGAL MED. 109, 127–28 (2009) (discussing how actuarial methods of risk assessment have advantages over clinical determinations); Sarma, *supra* note 20, at 280 (describing actuarial methods of risk assessment as beneficial given “the objectivity of the decision-making process and the high interrater reliability across evaluators”).

¹¹⁷ See *Tarasoff*, 551 P.2d at 345 (recognizing that, although a therapist cannot predict future violence with absolute certainty in all situations, the defendant in *Tarasoff* accurately predicted that the patient would cause harm, but failed to give sufficient warnings); Mossman, *supra* note 102, at 543–44 (noting that the *Tarasoff* decision suggests that it is possible to distinguish between “those clinical situations in which patients pose ‘a serious danger of violence’ that constitutes a ‘public peril,’ and those situations in which patients pose no such danger”).

¹¹⁸ *Tarasoff*, 551 P.2d at 345; Mossman, *supra* note 116, at 112–13.

¹¹⁹ Mossman, *supra* note 116, at 127–28; see Betsy J. Grey, *Implications of Neuroscience Advances in Tort Law: A General Overview*, 12 IND. HEALTH L. REV. 671, 691–92 (2015) (discussing the ways in which advances in neuroscience methods of risk assessment may also impact the application of the *Tarasoff* duty).

¹²⁰ See, e.g., PRETRIAL JUSTICE INST., PRETRIAL RISK ASSESSMENT: SCIENCE PROVIDES GUIDANCE ON ASSESSING DEFENDANTS 1 (2015) (explaining the advantages of actuarial risk assessment methods over money bond schedules and intuition in deciding which defendants to detain pretrial); Melissa Hamilton, *Public Safety, Individual Liberty, and Suspect Science: Future Dangerousness*

more accurate at predicting violence and less likely to yield false predictions than human judgment.¹²¹

In the context of CVE, however, risk assessment tools are inherently biased due to small and selective sample populations and other methodological flaws in studies underlying CVE.¹²² Additionally, actuarial methods of determining “vulnerability to radicalization” measure a subject’s risk of developing certain “extreme” ideologies, rather than risk of violence.¹²³ For example, Channel’s definition of “extremism” as “the active opposition to fundamental British values” suggests that risk factors predicting whether someone will fit this definition of an “extremist” do not predict whether that person will engage in violent activity.¹²⁴ Considering the misperception that risk factors identified in CVE literature are signs of future violence, mental health professionals using risk assessment tools in their work may believe that such factors trigger the *Tarasoff* duty and thereby permit disclosure of confidential information.¹²⁵ Because CVE does not provide reliable guidance on predicting future violence, however, such disclosures risk harming patients without protecting any overarching public safety interest.¹²⁶

Assessments and Sex Offender Laws, 83 TEMP. L. REV. 697, 698, 712 (2011) (noting the important role that actuarial risk assessment tools play in the context of sex offenses); Eric S. Janus & Robert A. Prentky, *Forensic Risk of Actuarial Risk Assessment with Sex Offenders: Accuracy, Admissibility, and Accountability*, 40 AM. CRIM. L. REV. 1443, 1457–58 (2003) (discussing the ways in which bias impacts clinical dangerousness assessments, as opposed to actuarial methods).

¹²¹ Mossman, *supra* note 116, at 128; J.C. Oleson et al., *Training to See Risk: Measuring the Accuracy of Clinical and Actuarial Risk Assessments Among Federal Probation Officers*, 75 FED. PROB. 52, 52 (2011).

¹²² See QURESHI, *supra* note 50, at 15 (discussing the problems with the ERG 22+ risk assessment tool); Huq, *supra* note 43, at 57 (critiquing the purposive sampling methods and other methodological flaws in *Radicalization in the West*); Sarma, *supra* note 20, at 284 (stating that “actuarial approaches to risk assessment are not appropriate or ethical in the terrorism prevention context”). A risk assessment tool based on studies involving an insufficiently representative sample population—for example, studies focusing solely on one religious group—is likely to produce high levels of false positives. See QURESHI, *supra* note 50, at 32–33; Alice Ross, *Academics Criticize Anti-Radicalisation Strategy in Open Letter*, GUARDIAN (Sept. 28, 2016), <https://www.theguardian.com/uk-news/2016/sep/29/academics-criticise-prevent-anti-radicalisation-strategy-open-letter> [<https://perma.cc/T5G8-CVCC>].

¹²³ PATEL & KOUSSHIK, *supra* note 33, at 9–10; see QURESHI, *supra* note 50, at 28 (discussing methodological flaws with the ERG 22+ study, including that its sample was comprised of individuals convicted of both violent and nonviolent crimes).

¹²⁴ See HM GOVERNMENT, *supra* note 63, at 34.

¹²⁵ See *Tarasoff*, 551 P.2d at 345 (acknowledging the difficult balancing of policy values the *Tarasoff* duty requires of mental health professionals); Ward, *supra* note 91, at 43 (stating that “CVE practitioners involved in intervention programs will be on the razor’s edge of this balance” between confidentiality and public safety).

¹²⁶ See *Tarasoff*, 551 P.2d at 347 (justifying breaches in confidentiality based on the conclusion that “[t]he protective privilege ends where the public peril begins”); KUNDNANI, *supra* note 17, at 19–21 (discussing flaws in the foundational studies underlying “radicalization” theories and CVE, which assumes that ideology is linked to violence); QURESHI, *supra* note 50, at 32–33 (noting the inefficacy of British CVE risk assessment methods, given the high percentage of individuals referred to Channel but determined not to require interventions); *I Refused to Work with PREVENT and Now I’m Afraid of*

B. Medical Records Privacy

Mental health professionals' obligations regarding patient privacy are also governed by HIPAA.¹²⁷ HIPAA was aimed at increasing the efficiency of health care and health insurance systems.¹²⁸ The 2003 HIPAA Privacy Rule governs the privacy of medical records and applies to any entity that electronically transmits health information in connection with certain health care transactions.¹²⁹ HIPAA designates all information that relates to a patient's treatment and has the potential to reveal the patient's identity as protected health information ("PHI").¹³⁰ HIPAA prohibits covered entities from disclosing PHI without a patient's informed consent unless an exception applies.¹³¹

Exceptions to the HIPAA Privacy Rule most relevant to CVE include situations in which disclosure is deemed necessary to protect public safety or ensure national security.¹³² Similar to the *Tarasoff* duty, HIPAA's Privacy Rule permits health professionals to breach confidentiality when a patient presents a danger to others.¹³³ The HIPAA Privacy Rule also contains an exception permitting disclosure of private information to federal officials for national security purposes.¹³⁴

Losing My Children, CAGE (Jan. 6, 2017), <https://cage.ngo/article/i-refused-to-work-with-prevent-and-now-im-afraid-of-losing-my-children/> [<https://perma.cc/AYF7-XK7M>] (discussing one family's struggles as a result of interactions with Prevent).

¹²⁷ See OFFICE FOR CIVIL RIGHTS, U.S. DEP'T OF HEALTH & HUMAN SERVS., SUMMARY OF THE HIPAA PRIVACY RULE 2-3 (2003) [hereinafter HIPAA PRIVACY RULE SUMMARY].

¹²⁸ 45 C.F.R. §§ 160, 164 (2017); Beverly Cohen, *Reconciling the HIPAA Privacy Rule with State Laws Regulating Ex Parte Interviews of Plaintiffs' Treating Physicians: A Guide to Performing HIPAA Preemption Analysis*, 43 HOUS. L. REV. 1091, 1092 (2006).

¹²⁹ See § 160.103 (defining "covered entity" for the purposes of the applicability of HIPAA and the HIPAA Privacy Rule); HIPAA PRIVACY RULE SUMMARY, *supra* note 127, at 2-3 (summarizing the HIPAA Privacy Rule's definition of covered entities); Cohen, *supra* note 128 (noting that HIPAA's covered entity definition includes "most healthcare providers"). The HIPAA Privacy Rule also applies to portions of "hybrid entities" that engage in activities that are and are not covered by HIPAA. See §§ 164.103, .105.

¹³⁰ § 160.103; HIPAA PRIVACY RULE SUMMARY, *supra* note 127, at 3-4; Cohen, *supra* note 128, at 1095-96.

¹³¹ See § 164.502(a) (outlining HIPAA's general rules relating to disclosures of protected health information ("PHI")); § 164.512 (listing situations in which a covered entity may disclose PHI without affording the patient an opportunity to agree or object); HIPAA PRIVACY RULE SUMMARY, *supra* note 127, at 4-9 (summarizing exceptions to the HIPAA Privacy Rule).

¹³² Snair et al., *supra* note 100; see § 164.512(j)(1) (public health/safety exception); § 164.512(k)(2) (national security exception).

¹³³ § 164.512(j); Mark A. Rothstein, *Tarasoff Duties After Newtown*, 42 J. L. MED. & ETHICS 104, 107 (2014); see *Tarasoff*, 551 P.2d at 340. HIPAA also explicitly requires that disclosures comply with "applicable law and standards of ethical conduct." § 164.512(j). Where state law is "contrary to" HIPAA's Privacy Rule, however, HIPAA preempts it. Cohen, *supra* note 128, at 1105.

¹³⁴ § 164.512(k)(2); Ward, *supra* note 91, at 39. While the "threat to health or public safety" exception to the HIPAA Privacy Rule provides heightened protections to individuals receiving mental health services, particularly in relation to involvement with the criminal justice system, the national security exception contains no such protections. See § 164.512(j)(2)-(k)(2).

Mental health professionals participating in CVE may see instances where patients show “vulnerability to radicalization” as permitting disclosures of private information under exceptions to the HIPAA Privacy Rule.¹³⁵ In cases like Khan’s in which the FBI is already monitoring a patient receiving treatment—and there is a clear link between the patient and national security activities—it is even more likely that disclosures will be seen as falling under HIPAA’s public safety or national security exceptions.¹³⁶

The Patriot Act may also govern cases like Khan’s that involve mental health providers and law enforcement.¹³⁷ The Patriot Act authorizes disclosure of any tangible thing, including health records, without a patient’s consent or knowledge for counter-terrorism purposes.¹³⁸ The Patriot Act prohibits disclosure if an investigation is too closely tied to activities protected under the First Amendment, such as political speech or religious practices, but the actual strength of this protection is unclear.¹³⁹ The broad provisions within the Patriot Act permitting disclosure of records related to counter-terrorism investigations therefore suggest that mental health providers may be required to produce records relating to CVE.¹⁴⁰ In such cases, moreover, the patient would not know that their confidentiality was compromised.¹⁴¹

HIPAA and the Patriot Act purport to strike a balance between maintaining confidentiality in health care settings, upholding civil rights, and protecting public safety and national security.¹⁴² CVE distorts this balance in two ways.¹⁴³ First, because CVE is presented as providing an off-ramp that will help subjects avoid, rather than expose them to, involvement with the criminal justice system, health professionals pressured to disclose information may see the potential

¹³⁵ Snair et al., *supra* note 100.

¹³⁶ *See id.* (discussing HIPAA’s confidentiality exceptions in the contexts of ethical challenges facing health professionals participating in CVE); Hussain, *supra* note 1 (describing the FBI’s involvement in Khan’s mental health treatment and prosecution).

¹³⁷ *See* Uniting and Strengthening America by Providing Appropriate Tools Required to Obstruct Terrorism Act of 2001 (the “Patriot Act”), Pub. L. No. 107-56, § 215, 115 Stat. 272, 287–88 (2001) (codified as amended in 50 U.S.C. § 1861) (permitting disclosure of private business records if ordered as part of an investigation related to foreign or domestic terrorism).

¹³⁸ *Id.*; *FAQ on Government Access to Medical Records*, AM. CIVIL LIBERTIES UNION, <https://www.aclu.org/other/faq-government-access-medical-records> [<https://perma.cc/8JY9-L68F>].

¹³⁹ *See* U.S. CONST. amend. I; 50 U.S.C. § 1861 (2012); Kyle Welch, *The PATRIOT Act and Crisis Legislation: The Unintended Consequences of Disaster Lawmaking*, 43 CAP. U. L. REV. 481, 532–33 (2015).

¹⁴⁰ 50 U.S.C. § 1861; NAT’L COUNTERTERRORISM CTR., *supra* note 16, at ii (describing CVE as “help[ing] prevent terrorism and disengag[ing] those already involved in terrorism”).

¹⁴¹ 50 U.S.C. § 1861.

¹⁴² *See id.* (highlighting constitutional limits on the circumstances in which information must be turned over to law enforcement, even if related to an investigation); 8 C.F.R. §§ 164.502, .512 (permitting disclosure of PHI in limited circumstances).

¹⁴³ *See* STRATEGIC IMPLEMENTATION PLAN, *supra* note 22, at 3 (explaining that defending civil rights is in itself a means of CVE); Berkell, *supra* note 14, at 52 (arguing that CVE aims can be accomplished without infringing on individual rights).

harms of such disclosures as minimal.¹⁴⁴ Second, because the research underpinning CVE ties First Amendment protected activities—such as religious practices and political expression—to risk for “radicalization,” the Patriot Act’s safeguarding of these activities may have little meaning in CVE contexts.¹⁴⁵

C. Professional Associations’ Codes of Ethical Conduct

In addition to state and federal laws, professional codes of ethics play an important role in protecting patient privacy and holding mental health professionals accountable.¹⁴⁶ The role of codes of ethics in the War on Terror has received considerable attention since it was discovered that the American Psychological Association (“APA”) structured its Code of Ethics to allow psychologists to participate in torturing terrorism suspects detained at Guantánamo, Abu Ghraib, and other facilities.¹⁴⁷ In response to this controversy, the APA’s Council of Representatives joined other professional associations in voting to adopt anti-torture provisions within its code of ethics.¹⁴⁸ This controver-

¹⁴⁴ See CVE Grants Press Release, *supra* note 112 (describing CVE as providing off-ramps); Stevan M. Weine et al., *Addressing Violent Extremism as Public Health Policy and Practice*, BEHAV. SCI. TERRORISM & POL. AGGRESSION 10 (June 28, 2016), <http://www.tandfonline.com/doi/full/10.1080/19434472.2016.1198413?scroll=top&needAccess=true> [https://perma.cc/CA2H-LCEA] (proposing that by framing CVE as a public health program, it will be possible to address multiple “youth well-being concerns”).

¹⁴⁵ See U.S. CONST. amend. I; 50 U.S.C. § 1861 (prohibiting disclosures of confidential information under the Patriot Act if an investigation is too closely tied to First Amendment-protected activities); PATEL & KUSHIK, *supra* note 33, at 15 (summarizing supposed “terrorism indicators” identified in various studies such as “[f]requent attendance at mosque or prayer group”); Beydoun, *supra* note 15, at 1467 (describing how “CVE policing of indigent Muslim communities . . . endangers . . . their constitutionally protected First Amendment activities”).

¹⁴⁶ APA ETHICAL PRINCIPLES, *supra* note 90, at 3; Jonathan H. Marks, *Doctors as Pawns? Law and Medical Ethics at Guantánamo Bay*, 37 SETON HALL L. REV. 711, 713 (2007).

¹⁴⁷ DAVID HOFFMAN, REPORT TO THE SPECIAL COMMITTEE OF THE BOARD OF DIRECTORS OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION: INDEPENDENT REVIEW RELATING TO APA ETHICS GUIDELINES, NATIONAL SECURITY INTERROGATIONS, AND TORTURE 70 (2015); see Katherine Eban, *The Psychologists Who Taught the C.I.A. How to Torture (and Charged \$180 Million)*, VANITY FAIR (Dec. 10, 2014), <http://www.vanityfair.com/news/daily-news/2014/12/psychologists-cia-torture-report> [https://perma.cc/A7VZ-QXHP]; James Risen, *Outside Psychologists Shielded U.S. Torture Program, Report Finds*, N.Y. TIMES (July 10, 2015), https://www.nytimes.com/2015/07/11/us/psychologists-shielded-us-torture-program-report-finds.html?_r=0 [https://perma.cc/CS2M-RZSX]. During the Bush administration, civil rights advocates discovered that mental health professionals were involved in the War on Terror as behavioral science consultants, and in this role, they “advised interrogators how to ramp up interrogation stressors.” Marks, *supra* note 146, at 714–15. The Hoffman Report, released in 2015, revealed that such actions were due in part to the fact that American Psychological Association (“APA”) officials “colluded with important [Department of Defense (“DoD”)] officials to have APA issue loose, high-level ethical guidelines that did not constrain DoD in any greater fashion than existing DoD interrogation guidelines.” HOFFMAN, *supra*, at 9.

¹⁴⁸ See *No More Torture: World’s Largest Group of Psychologists Bans Role in National Security Interrogations*, DEMOCRACY NOW (Aug. 10, 2015), https://www.democracynow.org/2015/8/10/no_more_torture_world_s_largest [https://perma.cc/GA7K-JECG] (discussing the APA’s new anti-torture measures); *Revision of Ethics Code Standard 3.04*, APA (Jan. 1, 2017), <http://www.apa.org/>

sy demonstrated how codes of ethics can shape mental health professionals' collusion with—or resistance against—abusive counter-terrorism practices.¹⁴⁹

Professional associations have gradually developed extensive lists of ethical standards, which their members are required to learn and follow.¹⁵⁰ Professional associations enforce these codes through licensing and professional sanctions.¹⁵¹ Despite their limited enforceability, however, codes of ethics play a crucial role in establishing clear standards and providing a basis for resistance when mental health professionals are pressured to act in an unethical manner.¹⁵²

Professional codes of conduct generally recognize patients' autonomy and privacy rights.¹⁵³ The codes' exceptions to confidentiality duties, however, do not significantly differ from applicable laws.¹⁵⁴ The APA Code of Ethics, for

ethics/code/standard-304.aspx [https://perma.cc/LFU2-D6AB] (reporting on new amendments to the APA ethics code prohibiting psychologists' involvement in torture); see also Steven H. Miles, *Medical Associations and Accountability for Physician Participation in Torture*, 17 *AMA J. ETHICS* 945, 947 (2015) (advocating that national medical associations follow the lead of the World Medical Association in setting standards against physicians' participation in torture). See generally WORLD MEDICAL ASS'N, *WMA DECLARATION OF TOKYO: GUIDELINES FOR PHYSICIANS CONCERNING TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT IN RELATION TO DETENTION AND IMPRISONMENT* (2016) (prohibiting physicians' participation in torture).

¹⁴⁹ See Marks, *supra* note 146 (explaining the important role of ethics codes where laws are unclear); Eric Merriam, *Legal but Unethical: Interrogation and Military Health Professionals*, 11 *IND. HEALTH L. REV.* 123, 212 (2014) (explaining that, when legal and ethical guidelines conflict, professional associations have a great deal of power in controlling policy).

¹⁵⁰ Merriam, *supra* note 149, at 139–43.

¹⁵¹ APA ETHICAL PRINCIPLES, *supra* note 90, at 2 (noting in introduction to the code of ethics that the APA Ethics Code is intended as a guide, and does not predicate civil liability); Merriam, *supra* note 149, at 142 (discussing the limited ways in which state licensing boards enforce ethical codes).

¹⁵² See Marks, *supra* note 146, at 723 (“In the face of the Administration’s efforts to circumvent international legal protections . . . the voice of professional ethics is especially important.”). See generally Nancy Sherman, *From Nuremburg to Guantánamo: Medical Ethics Then and Now*, 6 *WASH. U. GLOBAL STUD. L. REV.* 609 (2007) (comparing the Nuremburg Trials and the revelations regarding health professionals’ participation in torture in the War on Terror, and describing how both events resulted in heightened interest in the role of medical ethics in contexts of immoral and ambiguous laws).

¹⁵³ See, e.g., *AMA CODE OF MEDICAL ETHICS*, *supra* note 90, at 1–2 (Principles IV, IX) (listing equal access to healthcare and “safeguard[ing] patient confidences and privacy” as foundational ethical values); *APA ETHICAL PRINCIPLES*, *supra* note 90, at 3–4 (including “privacy, confidentiality, and self-determination” in a list of general principles guiding psychologists “toward the very highest ethical ideals of the profession”); *NAT’L ASS’N OF SOCIAL WORKERS, CODE OF ETHICS 5–6* (2017) [hereinafter *NASW CODE OF ETHICS*] (including self-determination within the broad foundational principle of “dignity and worth of the person”).

¹⁵⁴ See, e.g., *AMA CODE OF MEDICAL ETHICS*, *supra* note 90, at 53–54 (Standard 3.2.1) (permitting disclosure of information without a patient’s consent when required by law or when a patient endangers another person); *APA ETHICAL PRINCIPLES*, *supra* note 90, at 8 (Standard 4.05) (permitting disclosure of information without a patient’s consent when required or permitted by law, specifically to protect against harm); *NASW CODE OF ETHICS*, *supra* note 153, at 11–14 (Standard 1.07) (permitting limited disclosures when a patient endangers another person); see also Rothstein, *supra* note 133,

example, states that unauthorized disclosures of confidential information are acceptable where required by law or where permitted by law to “protect . . . others from harm.”¹⁵⁵ The American Medical Association, National Association of Social Workers, and American Psychiatric Association use similar language to articulate the circumstances in which disclosures of confidential information are permissible.¹⁵⁶ While these ethical standards are in some cases narrower than the *Tarasoff* duty, they generally permit disclosures of confidential information where a patient shows signs of dangerousness.¹⁵⁷

Some health care professionals have questioned whether participation in CVE compromises their professional ethics.¹⁵⁸ The exceptions to confidentiality obligations within medical ethics codes that generally mirror the *Tarasoff* duty and the HIPAA Privacy Rule, however, cause the same type of distortion as these laws with regards to “vulnerability to radicalization” (i.e., vulnerability to developing allegedly dangerous ideas) and the risk of actually engaging in violence.¹⁵⁹ Because CVE conflates ideology and violence and is promoted as a way of helping patients access services and avoid criminal involvement, mental health professionals may see confidentiality exceptions within applicable professional codes of conduct as permitting disclosures and referrals to CVE intervention programs.¹⁶⁰

at 106–07 (comparing requirements triggering a mental health professional’s duty to warn or authority to breach confidentiality under *Tarasoff*, HIPAA, and various medical codes of ethical conduct).

¹⁵⁵ APA ETHICAL PRINCIPLES, *supra* note 90, at 8; *see* Rothstein, *supra* note 133, at 106 (noting that while the disclosures provision within the APA’s Ethics Code permits but does not require mental health professionals to warn third parties).

¹⁵⁶ *See* AMA CODE OF MEDICAL ETHICS, *supra* note 90, at 54 (Standard 3.2.1(e)(ii)) (permitting disclosure when a physician believes that “the patient will inflict serious physical harm on an identifiable individual or individuals”); AM. PSYCHIATRIC ASS’N, THE PRINCIPLES OF MEDICAL ETHICS 7 (Standard 4.8) (2013) (permitting disclosure “[w]hen, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant”); NASW CODE OF ETHICS, *supra* note 153, at 11–12 (Standard 1.07) (permitting disclosure only if “necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person”).

¹⁵⁷ *See* AMA CODE OF MEDICAL ETHICS, *supra* note 90, at 54 (Standard 3.2.1(e)(ii)); APA ETHICAL PRINCIPLES, *supra* note 90, at 8; AM. PSYCHIATRIC ASS’N, *supra* note 156; NASW CODE OF ETHICS, *supra* note 153, at 11–12; Rothstein, *supra* note 133, at 106–07 (comparing requirements triggering a mental health professional’s duty to warn under *Tarasoff*, HIPAA, and various medical codes of ethical conduct).

¹⁵⁸ *See* OPEN SOC’Y JUSTICE INITIATIVE, *supra* note 24, at 50 (quoting a British psychologist as stating that the obligations of health professionals under the Prevent program are “ethically hugely problematic”); LoCicero & Boyd, *supra* note 24 (comparing CVE with mental health professionals’ ethical obligation to warn); Speckhard, *supra* note 99 (cautioning that “professionals agreeing to take part in [CVE] must consider carefully existing security, legal and ethical protections”).

¹⁵⁹ *See* PATEL & KOUSHIK, *supra* note 33, at 9–10 (discussing the dangers of CVE’s conflation of ideology and violence); Snair et al., *supra* note 100, at 69–72 (discussing the range of ethical issues facing health professionals participating in CVE); Rothstein, *supra* note 133, at 106–07 (comparing confidentiality exceptions in *Tarasoff*, HIPAA, and ethics codes).

¹⁶⁰ *See* STRATEGIC IMPLEMENTATION PLAN, *supra* note 22 (describing CVE as providing “alternative pathways or ‘off-ramps’”); Weine et al., *supra* note 144, at 1, 10 (arguing that CVE can be a

III. RESPONDING TO INSUFFICIENT LEGAL PROTECTIONS BY REVISING PROFESSIONAL CODES OF CONDUCT

CVE operates in a context lacking sufficient legal or ethical protections to safeguard patient privacy.¹⁶¹ Disclosures of confidential information threaten the fundamental right to privacy and the trust necessary for effective mental health treatment without improving public safety.¹⁶² Because CVE encourages disclosures that may fit within existing exceptions to confidentiality laws and ethical obligations, alternative protections should be put in place to mitigate the harm that CVE inflicts.¹⁶³ Section A of Part III discusses how professional associations' responses to CVE can in some ways make up for the lack of legal protections.¹⁶⁴ Section B suggests specific areas where codes of ethics should be revised to respond to the danger of disclosure of private information under CVE.¹⁶⁵

A. The Importance of Revising Professional Codes of Conduct in the Context of the War on Terror

Certain guiding principles shape professional codes of conduct, including respect for privacy.¹⁶⁶ Like HIPAA and other statutory and common law confidentiality protections, however, codes of conduct include exceptions to the general obligation of mental health professionals to maintain patient confiden-

non-coercive public health program); *see also* *Countering Violent Extremism: The Trump Era – Panel I*, CATO INST. (Oct. 4, 2017), <https://www.cato.org/multimedia/events/countering-violent-extremism-trump-era-panel-i> [<https://perma.cc/QYW5-LA4H>] (speaking of the dangers of CVE and calling on fellow psychologists “to begin to step back . . . and ask . . . what are the ways that we’re doing good and what are the ways that we’re doing potential harm”).

¹⁶¹ *See* Snair et al., *supra* note 100, at 69–72 (describing the legal and ethical ambiguities for health professionals participating in CVE); LoCicero & Boyd, *supra* note 24 (voicing mental health professionals’ legal and ethical concerns about participating in CVE).

¹⁶² *See* OPEN SOC’Y JUSTICE INITIATIVE, *supra* note 24 (discussing how the Prevent program in the United Kingdom threatens trust between helping professionals and those they serve); PATEL & KUSHIK, *supra* note 33, at 13–20 (arguing that CVE is not based on empirical research and will not improve public safety); Aziz, *supra* note 14, at 269–72 (arguing that “CVE programs are unnecessary to prevent domestic terrorism”); *see also* U.S. CONST. amends. V, XIV (establishing the right to liberty from state intrusion into one’s private life without due process); *Lawrence v. Texas*, 539 U.S. 558, 578 (2003) (recognizing a right to privacy where a law “furthers no legitimate state interest which can justify its intrusion into the personal and private life of the individual”); *Griswold v. Connecticut*, 381 U.S. 479, 486 (1965) (recognizing “a right of privacy older than the Bill of Rights”); G.A. Res. 217 (III) A, Art. 12, Universal Declaration of Human Rights (Dec. 10, 1948) (recognizing the right not to be “subjected to arbitrary interference with . . . privacy”).

¹⁶³ *See infra* notes 166–199 and accompanying text.

¹⁶⁴ *See infra* notes 166–180 and accompanying text.

¹⁶⁵ *See infra* notes 181–199 and accompanying text.

¹⁶⁶ *See, e.g.*, AMA CODE OF MEDICAL ETHICS, *supra* note 90, at 1–2; APA ETHICAL PRINCIPLES, *supra* note 90, at 3–4.

tiality.¹⁶⁷ Because these exceptions have the potential to obscure mental health professionals' obligations in the context of CVE, mental health providers should revise the ethical rules governing their professions.¹⁶⁸

Mental health professionals should also take steps to address the dangers of CVE because of their commitment to cultural competence.¹⁶⁹ Mental health professionals often tailor their practice to account for the ways in which various forms of oppression, including biased targeting and surveillance, cause unique harm to targeted populations.¹⁷⁰ The ways in which CVE co-opts mental health services to monitor communities viewed as inherently suspect is an affront to the basic tenets of professional ethics, threatening privacy and exacerbating health disparities.¹⁷¹ Professional codes of ethics should therefore also be revised to ensure that mental health professionals are held to clear standards for providing culturally competent care in the context of the War on Terror.¹⁷²

In many ways, professional codes of conduct reflect domestic and international legal norms.¹⁷³ As the controversy surrounding health professionals' complicity in the torture of detainees in the War on Terror has shown, however, codes of ethics can hold mental health professionals to higher standards where

¹⁶⁷ See, e.g., AMA CODE OF MEDICAL ETHICS, *supra* note 90, at 54 (Standard 3.2.1(e)(ii)); AM. PSYCHIATRIC ASS'N, *supra* note 156; NASW CODE OF ETHICS, *supra* note 153, at 11–12 (Standard 1.07(c)); see also Sherman, *supra* note 152, at 617 (describing how the involvement of psychologists in interrogations as part of the War on Terror was a result in part of the APA's permissive code of ethics and the lack of clarity as to whether psychologists are bound by the Hippocratic oath to do no harm).

¹⁶⁸ See Marks, *supra* note 146 (advocating for ethical reforms where laws governing health professionals are ambiguous); Gerada, *supra* note 74 (requesting guidance from the UK's General Medical Council regarding physicians' ethical duties under Prevent); Carrie York Al-Karam, *APA—Urgently Evaluate and Take Official Position on CVE Programs*, CHANGE.ORG, https://www.change.org/p/susan-mcdaniel-apa-president-apa-urgently-evaluate-and-take-official-position-on-cve-programs?recruiter=486360906&utm_source=petitions_show_components_action_panel_wrapper&utm_medium=copy_link&recruit_context=copylink_long [<https://perma.cc/JEX4-8ZTB>] (calling on the APA to take an official position on CVE).

¹⁶⁹ See generally AM. PSYCHOL. ASS'N, *APA GUIDELINES ON MULTICULTURAL EDUCATION, TRAINING, RESEARCH, PRACTICE AND ORGANIZATIONAL CHANGE FOR PSYCHOLOGISTS* (2002) (presenting six guidelines on cultural competence in psychology).

¹⁷⁰ See Alexander J. O'Connor & Farhana Jahan, *Under Surveillance and Overwrought: American Muslims' Emotional and Behavioral Responses to Government Surveillance*, 8 J. MUSLIM MENTAL HEALTH 95, 101–02 (2014) (reporting results from an original study showing that Muslims subjected to surveillance in the United States reported increased levels of anxiety).

¹⁷¹ See O'Connor & Jahan, *supra* note 170.

¹⁷² See AM. PSYCHOL. ASS'N, *supra* note 169; O'Connor & Jahan, *supra* note 170.

¹⁷³ See Marks, *supra* note 146, at 724 (discussing how codes of medical ethics are sometimes grounded in international law, and sometimes impose broader obligations on professionals than applicable laws); Rothstein, *supra* note 133, at 106–07 (discussing how national professional codes of conduct include similar provisions as *Tarasoff* and HIPAA concerning confidentiality). *But see* Merriam, *supra* note 149, at 203 (discussing conflicts between health professionals' legal and ethical obligations concerning interrogation).

the law is used to justify abuse.¹⁷⁴ Provisions within professional codes of conduct demonstrate that there is a historical precedent for adopting standards governing situations in which mental health professionals may be permitted or even required under the law to violate fundamental rights.¹⁷⁵ The APA, for example, amended its code of conduct in 2010 to state that—where legal and ethical duties conflict—psychologists are never permitted to engage in human rights abuses.¹⁷⁶ Professional associations should continue to hold their members to higher standards than existing laws and amend their codes of conduct to specifically account for the dangers of CVE.¹⁷⁷

As a first step, professional associations should discourage their members from participating in CVE in any capacity.¹⁷⁸ Professional associations should also use their advocacy and organizing powers to encourage communities, organizations, and states to resist CVE.¹⁷⁹ As organizations respected for their

¹⁷⁴ See Marks, *supra* note 146, at 713, 717–18 (discussing how, in light of psychologists' lawful involvement in torture, a reaffirmation of strong codes of ethics is necessary for mental health professionals to "maintain the social and cultural status engendered by their perceived humanitarian ethos"); Merriam, *supra* note 149, at 212–14 (discussing the heightened power of professional associations where laws governing health professionals are ambiguous); Miles, *supra* note 148 (advocating that national medical associations "endorse strong standards" against complicity in torture).

¹⁷⁵ See *Amending the Ethics Code (2010)*, APA, <http://www.apa.org/monitor/2010/04/ethics.aspx> [<https://perma.cc/TJ3G-FM2P>] (discussing the 2002 and 2010 amendments to the APA Ethics Code responding to concerns about situations in which legal and ethical duties of psychologists conflict); Marks, *supra* note 146, at 724 (explaining that "[s]ome codes of professional ethics impose firm constraints on health professionals, irrespective of applicable legal norms").

¹⁷⁶ See *Amending the Ethics Code (2010)*, *supra* note 175. The APA amended its code of conduct in 2002 to articulate a process through which psychologists may attempt to reconcile conflicts between legal and ethical duties and permitting psychologists to engage in civil disobedience when they are required by law to act in an unethical manner. *Id.* In 2010, however, the APA incorporated amendments into its Ethics Code stating in unambiguous terms that legal and ethical conflicts may not justify psychologists' participation in human rights abuses. *Id.*

¹⁷⁷ See Marks, *supra* note 146 (advocating for ethical reforms where laws governing health professionals are ambiguous); Gerada, *supra* note 74 (advocating for clarification of medical professionals' ethical duties under Prevent); York Al-Karam, *supra* note 168 (petitioning the APA to take an official position on CVE).

¹⁷⁸ See *As a Doctor, I Refuse to Spy on My Patients*, *supra* note 74 (warning that the obligations of British health care professionals subject to the Prevent Duty will lead to the destruction of health institutions); LoCicero & Boyd, *supra* note 24 ("We will not spy on our patients. We do not read minds, and we know that none of us can predict the future."); see also Access California Services et al., Letter on Objections to DHS's Fiscal Year 2016 Countering Violent Extremism Grant Program (Aug. 31, 2016) (voicing concerns from organizations including the National Association of Social Workers about the CVE grant program).

¹⁷⁹ AMA CODE OF MEDICAL ETHICS, *supra* note 90, at 1 (Principle III) (articulating a physician's responsibility to "seek changes in those [legal] requirements which are contrary to the best interests of the patient"); see Access California Services et al., *supra* note 178 (advocating against the Department of Homeland Security CVE grant program); *APA Advocacy Issues*, APA, <http://www.apa.org/about/gr/issues/index.aspx> [<https://perma.cc/4PXX-ZVDH>] (listing topics on which the APA engages in advocacy, including "health disparities," "peer review," and "human rights issues"); Gerada, *supra* note 74 (arguing for advocacy from a medical professional association, despite British health professionals' inability to exercise free choice regarding participation in CVE).

scientific expertise and commitment to patient well-being, these professional associations should use their influence to speak out about the lack of sound evidence underlying CVE and the various harms it inflicts.¹⁸⁰

B. Incorporating Protections Against CVE Into Codes of Ethics

In addition to discouraging members' participation in CVE and advocating for its discontinuation, professional associations should take steps to minimize harm to patients receiving services through CVE programs.¹⁸¹ First, they should require mental health professionals providing services through CVE programs to make their patients aware of CVE's counter-terrorism aims and its funding sources.¹⁸² Some associations already require that health professionals communicate the limits of confidentiality to patients.¹⁸³ For example, where specific limitations to confidentiality exist, the APA requires that psychologists obtain informed consent from patients receiving services.¹⁸⁴ Considering CVE's ties to counter-terrorism and the broad national security exceptions within federal privacy laws, it is crucial that patients be informed of the unique risks of receiving treatment through such programs.¹⁸⁵

¹⁸⁰ See Donald M. Bersoff, *Autonomy for Vulnerable Populations: The Supreme Court's Reckless Disregard for Self-Determination and Social Science*, 37 VILL. L. REV. 1569, 1574–75 (1992) (discussing the role the APA has historically played in advocating on behalf of vulnerable individuals in legal settings, based on the APA's expertise in methodologically sound science); Dorothy Shaw, *Advocacy, the Role of Health Professional Associations*, 127 INT'L J. GYNECOLOGY & OBSTETRICS S43, S43 (2014) (arguing that advocacy is a fitting and appropriate activity in which medical professional associations should engage, particularly considering their "significant evidence-based expertise"); Rogers H. Wright, *The American Psychological Association and the Rise of Advocacy*, 23 PROF. PSYCHOL. RES. & PRAC. 443, 443 (1992) (summarizing the history of the APA's advocacy involvement).

¹⁸¹ See APA ETHICAL PRINCIPLES, *supra* note 90, at 3–4 (articulating the value of "tak[ing] care to do no harm"); OPEN SOC'Y JUSTICE INITIATIVE, *supra* note 24, at 65–106 (documenting cases in which students and patients were discriminated against by helping professionals subject to the Prevent Duty).

¹⁸² See APA ETHICAL PRINCIPLES, *supra* note 90, at 7 (Standard 4.02) (requiring psychologists to discuss the limits of confidentiality with patients); NASW CODE OF ETHICS, *supra* note 153, at 12 (Standard 1.07(e)) (requiring social workers to discuss confidentiality rights and limitations with clients); PATEL & KOUSHIK, *supra* note 33, at 13 (highlighting the confidentiality concerns CVE raises).

¹⁸³ See, e.g., APA ETHICAL PRINCIPLES, *supra* note 90, at 7 (Standard 4.02); NASW CODE OF ETHICS, *supra* note 153, at 12 (Standard 1.07(e)).

¹⁸⁴ APA ETHICAL PRINCIPLES, *supra* note 90, at 7 (Standard 3.10).

¹⁸⁵ See 50 U.S.C. § 1861 (2012) (permitting disclosure of private business records if ordered as part of an investigation related to foreign or domestic terrorism); 45 C.F.R. § 164.512(k)(2) (2017) (permitting disclosure of PHI under HIPAA in certain situations related to national security or intelligence activities); CAGE, CONSENT DENIED: HOW PREVENT QUESTIONS CHILDREN WITHOUT PARENTAL INVOLVEMENT 5 (2016) (discussing how British children are questioned under Prevent without their families' knowledge of or consent to potential breaches of confidentiality). See generally Ward, *supra* note 91 (exploring the legal possibilities for information-sharing among law enforcement and mental health professionals participating in CVE).

Second, professional associations should set clear standards regarding the *Tarasoff* duty and CVE.¹⁸⁶ In particular, they should specify that, unless supposed risk “indicators” are clearly linked to violence, as opposed to ideology, they do not trigger the *Tarasoff* duty.¹⁸⁷ Additionally, they should strongly state that any risk assessment tool that is not based on sound science should not predicate disclosure of confidential information.¹⁸⁸ Third, professional associations should review and comment on the scientific methods involved in the development of any risk assessment tools purporting to measure “vulnerability to radicalization.”¹⁸⁹

Finally, professional associations should emphasize that reprogramming individuals’ religious and political beliefs is not the business of mental health professionals.¹⁹⁰ They should therefore enact strict guidelines prohibiting referrals of patients to CVE intervention programs based on their supposed “vulnerability to radicalization.”¹⁹¹ While CVE is promoted as providing off-ramps, experience in the United States and abroad shows that it stigmatizes communities and sub-

¹⁸⁶ See *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 340 (Cal. 1976) (establishing a mental health professional’s duty to warn third parties); LoCicero & Boyd, *supra* note 24 (distinguishing between the *Tarasoff* duty and the expectations of mental health professionals participating in CVE); Ward, *supra* note 91, at 60 (explaining how the work of mental health professionals participating in CVE activities always involves the difficult balancing of confidentiality and public safety inherent in *Tarasoff*).

¹⁸⁷ See *Tarasoff*, 551 P.2d at 340 (recognizing a duty to warn only where a “patient presents a serious danger of violence”); PATEL & KOUSHIK, *supra* note 33, at 9–11 (explaining how CVE conflates ideology and violence).

¹⁸⁸ See PATEL & KOUSHIK, *supra* note 33, at 9–11 (criticizing CVE’s lack of a sound scientific foundation); QURESHI, *supra* note 50, at 26–33 (criticizing the methodology used to develop the ERG 22+ CVE risk assessment tool); Ross, *supra* note 122 (discussing a letter signed by 140 academics and experts criticizing the methodology in the development of the ERG 22+ tool).

¹⁸⁹ See QURESHI, *supra* note 50, at 26–33. Mental health professionals’ rejection of questionable risk assessment techniques may impact the weight these tests are afforded in legal settings. See *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 594 (1993) (stating that “[w]idespread acceptance can be an important factor in ruling particular evidence admissible”); *Frye v. United States*, 293 F. 1013, 1014 (D.C. Cir. 1923) (requiring that a scientific method be accepted by practitioners in the relevant scientific field for it to be admissible as evidence); Hana Church, Comment, *Prisoner Denied Sex Reassignment Surgery: The First Circuit Ignores Medical Consensus* in *Kosilek v. Spencer*, 57 B.C. L. REV. E. SUPP. 17, 21 (2016) (explaining how consensus of experts within a professional field influences the weight given to scientific evidence).

¹⁹⁰ See *Political Dissent*, APA, COUNCIL POLICY MANUAL, CHAPTER XII. PUBLIC INTEREST (1972), <http://www.apa.org/about/policy/chapter-12.aspx#political-dissent> [<https://perma.cc/2GJV-PQUU>] (stating the APA’s opposition to the pathologization of political dissent); see also Aziz, *supra* note 18 (describing the purpose of CVE as “stop[ping] people from embracing extreme beliefs”); Rascoff, *supra* note 17 (explaining that the goal of CVE is “to interfere with each individual’s radicalization process or to unwind it if it has already taken root” and that CVE techniques may include “inculcation of ‘mainstream’ religious beliefs”).

¹⁹¹ See APA Presidential Task Force on Evidence-Based Practice, *Evidence-Based Practice in Psychology*, 61 AM. PSYCHOL. 271, 273 (2006) (discussing “psychology’s fundamental commitment to sophisticated evidence-based psychological practice”); LoCicero & Boyd, *supra* note 24 (calling on mental health professionals to refrain from any form of participation in CVE).

jects participants to lengthy legal struggles and psychological harm.¹⁹² Khan's story, moreover, illustrates the long-term consequences for patients whose mental health care has a law enforcement component.¹⁹³ Given the lack of empirical evidence for CVE as a violence prevention program, professional associations should prohibit voluntary referrals to CVE intervention programs.¹⁹⁴

It should be noted that professional codes of conduct are not an adequate replacement for laws protecting civil and human rights.¹⁹⁵ When ethical obligations conflict with legal duties, mental health professionals are not held to clear standards.¹⁹⁶ They must engage in a complex balancing of their legal and ethical duties as well as possible professional, civil, or criminal consequences of their actions.¹⁹⁷ It is nonetheless essential that mental health professionals commit to collectively defending their patients' civil and human rights and the integrity of their profession.¹⁹⁸ Revising professional codes of conduct is one way to ensure that health professionals know what is required of them, that lawmakers are put on notice when policies conflict with clear ethical standards, and that patients receive safe and dignified care.¹⁹⁹

¹⁹² See OPEN SOC'Y JUSTICE INITIATIVE, *supra* note 24 (discussing the harmful impacts of Prevent); QURESHI, *supra* note 50, at 44–47 (summarizing a series of cases in UK family court concerning “vulnerability to radicalization”); Aziz, *supra* note 14, at 264 (describing how CVE “breed[s] distrust and divisiveness within Muslim communities”); Beydoun, *supra* note 15, at 1467, 1483 (discussing how CVE threatens civil rights and “endorses and mainstreams” Islamophobia).

¹⁹³ See Hussain, *supra* note 1 (discussing the FBI's involvement in Khan's mental health treatment and criminal prosecution).

¹⁹⁴ See APA Presidential Task Force on Evidence-Based Practice, *supra* note 191 (discussing psychologists' commitment to evidence-based practice); Huq, *supra* note 43, at 56–60 (describing methodological weaknesses in the foundational studies underlying the development of CVE); LoCicero & Boyd, *supra* note 24 (calling for mental health professionals' non-participation in CVE).

¹⁹⁵ See Merriam, *supra* note 149, at 204–06 (discussing how, in situations where ethics provide stronger safeguards than laws, health professionals are not afforded sufficient power to protect those in their care); see also Marks, *supra* note 146, at 724 (explaining that health professionals are faced with ethical and legal ambiguities when their codes of ethics reflect inconsistently interpreted international legal norms).

¹⁹⁶ See Marks, *supra* note 146, at 724.

¹⁹⁷ See Merriam, *supra* note 149, at 217–21 (discussing the professional, criminal, and civil risks faced by health professionals practicing in an environment in which legal and ethical obligations conflict).

¹⁹⁸ See Marks, *supra* note 146 (arguing that adapting codes of ethics to account for rights abuses is necessary “if health professionals are to retain our trust, and if they are to maintain the social and cultural status engendered by their perceived humanitarian ethos”).

¹⁹⁹ See Daniel N. Lermen, *Second Opinion: Inconsistent Deference to Medical Ethics in Death Penalty Jurisprudence*, 95 GEO. L.J. 1941, 1977–78 (2006) (arguing for increased judicial deference to medical ethics in cases dealing with “the intersection of medical ethics and constitutional law”); Marks, *supra* note 146, at 730 (mentioning that reforms to some codes of ethics have been intended to provide a tool that “legally and practically” enables non-participation in unethical activities); Steven H. Miles & Alfred M. Freedman, *Medical Ethics and Torture: Revising the Declaration of Tokyo*, 373 LANCET 344, 347 (2009) (advocating for ethical reforms considering that governments who engage in torture with impunity rely on medical professionals' complicity).

CONCLUSION

CVE is based on unsound science and the biased assumption that ideology and religion are at the root of terrorism. CVE harms targeted populations by dividing communities, causing distrust in health care systems, and criminalizing the mentally ill and developmentally disabled. Although state and federal laws and professional ethics codes provide some protections, exceptions permit lawful disclosures of private patient information, particularly when linked to national security and public safety. Given the lack of sufficiently robust patient privacy protections, mental health professionals can play an important role in safeguarding rights by pressuring their professional associations to revise their codes of ethical conduct. Professional associations should urge members to refrain from participating in CVE and from making referrals to CVE programs. At the very least, mental health professionals should be obligated to ensure that patients receiving services through a CVE program are made fully aware of the aims and potential harms of such programs. Moreover, by commenting publicly about the lack of sound science underlying CVE and the ways in which CVE threatens access to mental health care, professional associations can play a crucial role in defending the rights and dignity of their patients.

KELLY MORGAN