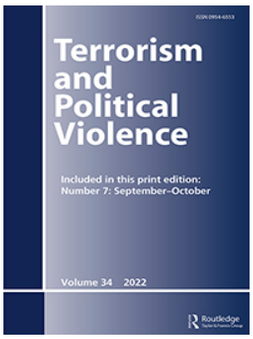

Terrorism and Political Violence

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/ftpv20

The Challenge and Promise of a Multidisciplinary Team Response to the Problem of Violent Radicalization

B. Heidi Ellis, Alisa B. Miller, Ronald Schouten, Naima Y. Agalab & Saida M. Abdi

To cite this article: B. Heidi Ellis, Alisa B. Miller, Ronald Schouten, Naima Y. Agalab & Saida M. Abdi (2022) The Challenge and Promise of a Multidisciplinary Team Response to the Problem of Violent Radicalization, Terrorism and Political Violence, 34:7, 1321-1338, DOI: 10.1080/09546553.2020.1777988

To link to this article: https://doi.org/10.1080/09546553.2020.1777988

TERRORISM AND POLITICAL VIOLENCE
2022, VOL. 34, NO. 7, 1321–1338
https://doi.org/10.1080/09546553.2020.1777988

Routledge
Taylor & Francis Group

The Challenge and Promise of a Multidisciplinary Team Response to the Problem of Violent Radicalization

B. Heidi Ellis[a,b*] Alisa B. Miller[a,b], Ronald Schouten[b,c*#], Naima Y. Agalab[d], and Saida M. Abdi[e]

[a]Department of Psychiatry, Boston Children's Hospital, Boston, MA, USA; [b]Department of Psychiatry, Harvard Medical School, Boston, MA, USA; [c]Department of Psychiatry, Massachusetts General Hospital, Boston, MA, USA; [d]Refugee and Immigrant Assistance Center, Boston, MA, USA; [e]School of Social Work, University of Minnesota, St. Paul, MN, USA

ABSTRACT

Violent radicalization is a complex process that results from multiple influences and experiences across the settings and contexts of an individual's life. No single pathway or characteristic determines who is at risk for it. Given this understanding, no single intervention aimed at this multiply-determined problem is likely to be successful if it is implemented in isolation. Multidisciplinary team approaches are increasingly seen as holding promise in the prevention and intervention of violent radicalization in the United States and internationally. A multidisciplinary team is typically a group of professionals who are members of different fields of study (psychology, medicine, social work, etc.) who provide a specific service to an individual. Team members independently focus on the issues in which they specialize and activities of the team are coordinated with a common goal. This paper aims to extend current knowledge by addressing questions related to challenges in implementing a multidisciplinary team approach with the capacity to address violent radicalization, presenting potential solutions to these challenges as well as highlighting one multidisciplinary team, Community Connect, that successfully worked with youth identified as being at risk for violence.

KEYWORDS

Multidisciplinary team; violent radicalization; prevention; intervention; radicalization to violent extremism

In recent years, the problem of violent radicalization (VR), or "the processes by which people come to adopt beliefs that not only justify violence but compel it, and how they progress—or not—from thinking to action,"[1] has emerged as a significant concern.[2] Violent radicalization stands in contrast to nonviolent radicalization, which involves growing commitment to radical beliefs that are nonviolent and do not espouse illegal actions; nonviolent radicalism can be an important component of societal change[3] and is constitutionally protected. In response to violent radicalization, various "soft" or non-enforcement approaches to preventing violent radicalization have been implemented under the heading of Countering Violent Extremism (CVE), Preventing Violent Extremism (PVE), or terrorism prevention.[4] Many of these approaches seek to work with individuals who have not crossed over the line of what constitutes criminal behavior, but who appear to be at risk for moving along a trajectory toward increasing acceptance of violence as a means of promoting radical ideology.

These efforts face many challenges, including the fact that there is no single pathway or characteristic that can determine who is, in fact, at risk for VR.[5] There is a growing recognition that VR is not the result of any single experience or problem, but rather a complex process that can result from multiple influences and experiences across differing levels of the social ecology.[6]

CONTACT B. Heidi Ellis Heidi.Ellis@childrens.harvard.edu Department of Psychology, Boston Children's Hospital, 300 Longwood Ave, Boston, MA 02115, USA

*Drs. Ellis and Abdi co-developed and co-led the Community Connect team. First and Senior authors contributed equally to the intellectual ideas that form the bases for Community Connect.

#New affiliation: St. Elizabeth's Hospital, Department of Behavioral Health, Washington, D.C.

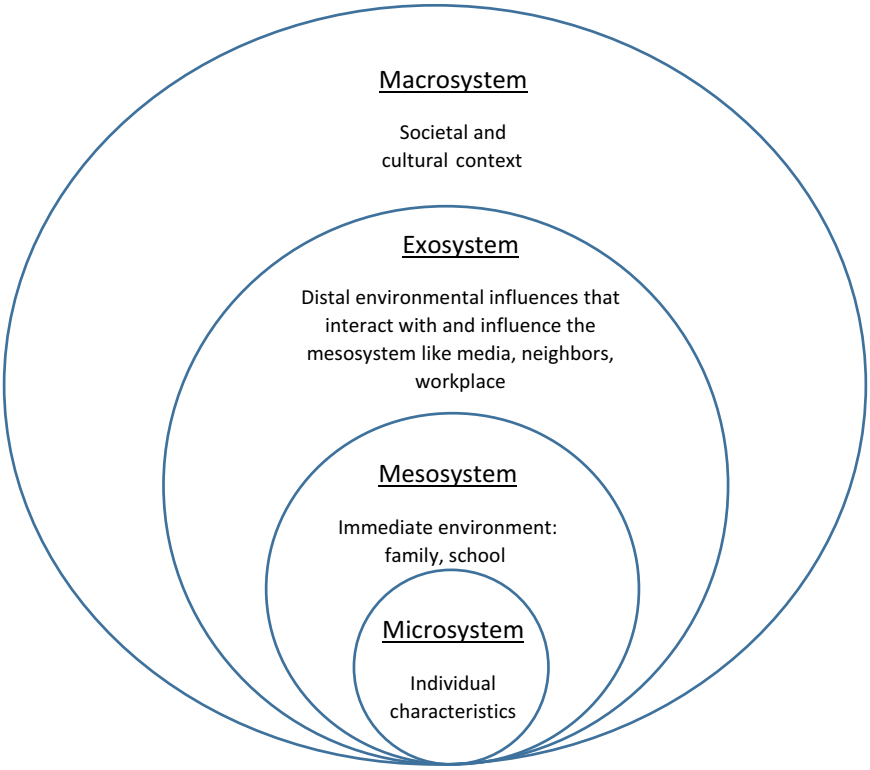

Figure 1. Bronfenbrenner's (1977) socio-ecological model.

The socio-ecological model developed by Bronfenbrenner[7] (Figure 1) asserts that an individual's development is a function of the strengths and challenges faced on multiple levels of the social ecology. This model can be particularly useful in considering how the interplay of multiple factors may shape youth development and, for some, result in VR. The social ecology consists of multiple layers starting with the microsystem, which accounts for the child's individual characteristics and how this shapes interactions in their immediate environment. The next layer, the mesosystem, encompasses the child's immediate environment, such as the family or school. Beyond this, more distal environmental influences such as community organizations (the exosystem) interact with and influence the mesosystem, and ultimately the macrosystem describes the influence of the larger social and cultural context. From a socio-ecological perspective, factors at multiple layers of the social ecology interact with each other, creating vulnerabilities (or, conversely, protective factors) that influence a child's developmental trajectory.[8] Given this understanding, any single intervention aimed at a multiply-determined problem is unlikely to be successful if it is implemented in isolation.

Multidisciplinary approaches: Diverse applications

Multidisciplinary approaches hold particular promise for multiply-determined problems that may result from processes that span different layers of the social ecology and compound each other. Hall and Weaver first identified the need for specialized health professionals and the necessity for these professionals to collaborate with others in order to respond to the increased complexity being faced by patients in healthcare systems.[9] Multidisciplinary teams (MDTs) are typically made up of a group of professionals who are members of different fields

of study (psychology, medicine, social work, etc.) who provide a specific service to an individual. Team members independently focus on the issue in which they specialize and activities of the team are coordinated with a common goal. MDTs have been used to address problems such as medical issues,[10] child abuse,[11] and human trafficking.[12] MDTs are especially useful when dealing with a multi-faceted and complex issue that requires collaboration and coordination among diverse providers to address the needs of the population served. Victims of sexual abuse/exploitation, for example, require care around issues such as mental health, legal, and physical and reproductive health. MDTs formed out of these diverse disciplines can ensure that all aspects of the client's needs are addressed, thus augmenting the potential for recovery. MDTs come together with the understanding that one single aspect of the clients' need, if left unaddressed, can impede recovery even if other needs are met.

Behavior-based threat assessment and management (BTAM) is an approach to identifying, assessing, and managing risks of targeted violence (e.g., school and workplace shootings, attacks on celebrities and public figures, stalking-related violence, lone actor terror attacks.) The MDT model is a core component of BTAM. In the educational setting, multidisciplinary BTAM members generally include administration, legal, behavioral health, student affairs, counseling service, and security or law enforcement. Multidisciplinary BTAM teams have also been implemented at a federal law enforcement level.[13] While multidisciplinary BTAM teams have the capacity to identify individuals at risk for violence and in need of integrated services, MDTs have the capacity to then work with the identified individual over time to address these multi-level needs in an integrated manner.

The potential of MDTs to address violent radicalization

Increasingly, practitioners, policymakers, and subject matter experts are pointing toward multidisciplinary approaches as a means of preventing VR.[14] Community actors including local police, community agencies, mental health practitioners, and educators who form trust-based networks can be the basis of a locally led community response to the problem of violent extremism;[15] Australia, Europe, and Canada have all implemented MDTs as a means of preventing radicalization to violence.[16] However, forming an MDT that has the capacity to address the problem of VR is not without its challenges. As Dalgaard-Nielsen notes, these networks "depend critically on trust and on the abilities of the involved actors to coordinate their perceptions and activities, to solve problems collaboratively, and learn as they go along."[17] Such trust may be exceedingly difficult to achieve in a country like the United States (U.S.), where P/CVE programming has been met with high levels of distrust and disengagement, especially at the community level.[18] Importantly, possessing radical political, social, civil, or religious ideologies and aspirations in and of themselves is not problematic.[19] Furthermore, any programmatic efforts that focus on a specific group or seek to curb political, social, and/or religious practice violate constitutionally protected civil rights and civil liberties in the United States.

Below we describe one example of an MDT with the capacity to serve youth at risk for VR that was successfully developed and implemented. We then describe two case examples of youth served by this team, illustrating the potential power of an MDT approach to work with radicalized youth. Finally, we pose several questions related to challenges in implementing an MDT approach for VR and discuss potential solutions drawing on both the above example and other MDT approaches.

Community Connect: Drawing on community partnerships to reduce risk for violence

Community Connect (CC) was an MDT (operational 2017 to 2019) based in a large urban area that worked with youth up to the age of twenty-four who were at risk for violence of any type, including gang involvement or VR. Table 1 presents descriptive information about referrals to CC. The CC team consisted of professionals and leaders from diverse backgrounds and disciplines, including faith-based leaders of diverse faiths, mental health, education, community

Table 1. Descriptive information for referrals to Community Connect

Characteristics of Referrals (N = 15)	% (n)	M (SD) Range
Referral Source by Discipline		
Education	8.3% (1)	
Mental Health	8.3% (1)	
Faith Leader	41.7% (5)	
Community Leader	16.7% (2)	
Local law enforcement	8.3% (1)	
FBI	16.7% (2)	
Other	0.0% (0)	
Referrals		
Accepted	80.0% (12)	
Declined*	20.0% (3)	
Characteristics of Accepted Referrals (n = 12)		
Gender		
Male	91.7% (11)	
Female	8.3% (1)	
Age in years		16.67 (3.82) 12 to 23 years
Time of engagement in months		14.42 (10.66) 1 to 30 months

*Reasons for declining referrals by Community Connect and families approached for inclusion into Community Connect included: outside of geographic area; stigma of mental services; parental preference to delay enrollment—"wait and see what happens."

leaders, and local law enforcement. CC team members were able to refer to the CC team any youth who they encountered through their particular spheres of service, and who they believed to be on a trajectory toward potential violence or criminal justice involvement. Although the CC team worked with youth of all ethnic backgrounds, because many of the CC partners served ethnic and religious minority populations, these youths formed the bulk of the clientele. In addition to these referrals, CC accepted referrals from the local Federal Bureau of Investigation (FBI) Field Office, with which one of the CC team members had had a previous productive and positive relationship. However, the FBI was not a formal partner of the CC team and its representatives did not attend CC team meetings or have access to case information.

Setting up the team and establishing partnerships: Building trust through action

Two of the authors (Ellis and Abdi) who had worked in the area of community-based mental health and violence research initiated a meeting with diverse stakeholders, drawing on their respective professional networks that included key thought leaders from a range of disciplines (religion/faith, mental health, law enforcement, education, and refugee and immigrant social and community services). In this initial meeting, stakeholders were asked to reflect on what unmet needs they saw among the youth they encountered in their various service sectors and what they saw as barriers to service engagement among this group of youth. A wide-ranging discussion ensued, with a commonality emerging that many youths were becoming engaged in the criminal justice system because they were underserved due to a lack of culturally or religiously appropriate services. Regional law enforcement noted that this also affected their ability to address the issue of radicalization to violence. Overall, the consensus was that violent radicalization was one of the multiple issues faced by youth that needed to be addressed but that it needed to be part of a larger focus on decreasing overall risk for violence or involvement in the criminal justice system. Stakeholders emphasized that focusing solely on VR without addressing other issues identified by communities as important would lead to individual and programmatic stigmatization, and diminished trust. Despite palpable distrust from some stakeholders toward law enforcement, at the conclusion of the stakeholder meeting, the group collectively agreed that there was a need to continue working together to address these unmet needs;

this stakeholder group later formalized into an MDT team later to be known as "Community Connect."

Over the next few weeks, several different events led to a series of unplanned phone calls that effectively built trust through action. First, a member of local law enforcement reached out via e-mail to the group of stakeholders to seek cultural consultation regarding a youth who was exhibiting concerning behavior. Following the consultation, and with new understanding of the individual's cultural background, the police decided to have the individual evaluated for a mental health problem rather than arrest them. The following week, a faith-based leader from the stakeholder group reached out to the rest of the stakeholder group seeking help related to vaguely threatening voicemails a local area mosque was receiving. Local law enforcement from the team engaged other members of their department, who acted swiftly to track the origins of the threatening voicemails and address the concern. Shortly after this, a stakeholder who had initially been very distrustful of law enforcements' presence at the stakeholder meeting reached out to the other stakeholders seeking support for a youth who they were concerned would soon be arrested if they did not receive needed support; the stakeholder groups' response was to help engage them into mental health services. Local law enforcement validated this response, thus demonstrating their interest in seeing the youth's needs addressed rather than acting on information to apprehend them. This youth became the first official CC case and the CC team, now with a newly emerging sense of trust that the goal of supporting youth was shared across disciplines, began to formally convene.

Defining the team: Cross-training and joint establishment of information sharing protocols

Once the stakeholder group agreed to operate as an official entity and began to meet monthly, CC team building and goal/processes definition began. The first half of each monthly CC meeting was dedicated to a different team member presenting information on their agency and discipline so that others could understand the resources, roles, responsibilities, ethical mandates, and professional terminology of the various team members. In addition, team members facilitated conversations about operating procedures, mission, scope of services, and risk management.

Defining the approach

(a) Who will be served by the team?

One of the main questions that the CC team grappled with was the population to be served. Several team members emphasized that defining the target population broadly, rather than limiting it to certain ages, ethnic backgrounds, or types and levels of risk, would allow for less stigmatization and enhance the ability to serve any and all who needed help. Counterarguments centered on concerns that the expertise of an MDT team, like CC, could never effectively address such a wide range of needs, that resources were limited and needed to be targeted toward those who were not being effectively served elsewhere, and that needs and resources changed with age. The CC team ultimately defined its target population as youth up to age twenty-four who were at risk for violence or criminal justice involvement and were not adequately being served by existing services. The determination of what made a youth "at risk" was made by the referrer, and allowed leeway for community partners to refer youth who they were concerned were on a trajectory toward violence without needing to demonstrate specific risk behaviors. In practice, the potential scope of referrals was limited by only accepting referrals from active members of CC or the FBI (see below).

(b) Who can refer to the team?

Initially, the team limited referrals to those made by existing CC members (e.g., any youth that members of the team encountered in their own service sectors that they felt met criteria for enrollment). Soon after starting, however, team members were contacted by agents from the local FBI Field

Office who requested that the CC team work with a youth about whom they had concerns. Initially, the idea of accepting referrals from the FBI was met with resistance. Some CC team members were concerned that any apparent association with the FBI would jeopardize trust by youth or communities served of both the team and its members, and that working with these cases might also place team members at legal risk. For instance, one CC team member taught classes at a local mosque and expressed concern that they might be held responsible if they accepted into their class an individual referred by the FBI who later engaged in a violent act. FBI leadership was invited to attend a CC monthly meeting so that team members could seek direct answers to their concerns. During this meeting, FBI leadership clarified that they viewed mosques providing guidance as a source of strength and protection for individuals, and also noted the limits to their powers to investigate without due cause. Ultimately, CC team members who represented community agencies not only agreed to accept these cases but advocated for doing so; they argued that these very cases were the reason they felt the CC program was needed, noting that early intervention and alternatives to law enforcement involvement were exactly what was needed.

Defining protocols related to risk and reporting

During the process of shared protocol development, the most contentious point of discussion related to information sharing and risk management. Some CC team members expressed concern that sharing information would lead to youth being arrested rather than getting the support they needed. Law enforcement reinforced their commitment to supporting youth but also noted that they could not "unhear" information and thus, if they learned of information that revealed significant risk, they would need to act on it. The team developed an agreement that local law enforcement could be asked to leave the room during case presentations if another CC team member requested this; the team also agreed to operate according to the limits on confidentiality observed by the mental health fields (to maintain confidentiality unless there was concern of imminent harm to self or others), and to seek additional support or intervention (including, as needed, from local law enforcement) if a youth posed imminent risk to self or others.

Another significant concern related to what, if any, information would be communicated back to the FBI or other law enforcement regarding the referrals they made. Because CC team members trusted the local law enforcement members of the team, they agreed that while they did not have to disclose information to local law enforcement, at times this could be helpful; thus, releases of information were attained at the beginning of each case that included the sharing of information, as needed, with local law enforcement. The CC team unanimously agreed that it would seek support from local law enforcement, rather than the FBI, if a case was determined to present a risk for violence. The determination as to whether federal law enforcement needed to be involved would then be left to local law enforcement.

While a clear line was drawn regarding sharing specific information with the FBI, it was also agreed that the FBI should be informed if a case they referred accepted services, declined services, or terminated services with the CC team. Standard Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations applied, including exceptions to protecting health information related to court orders and subpoenas, certain law enforcement investigations, or danger to self or others. All limits to confidentiality were made clear to individuals when they enrolled in CC.

Community Connect in operation

Phase 1: Engagement and assessment. Once a referral was received by the CC team, a mental health practitioner was paired with a "trusted liaison" (typically the referring partner) who met with youth and family members in their home or a place in the community to introduce the goals and policies of the CC. If in agreement, a signed consent/assent was obtained, as well as releases of information allowing communication between CC team members and existing providers.

Next, a more thorough psychosocial assessment took place with an emphasis on understanding the family and youth's primary concerns (what *they* believed to be the biggest problem). Additional collateral information was gathered as needed, and the full assessment was brought to the larger CC team. The CC team then provided suggestions from diverse disciplinary perspectives regarding services and/or supports that might be most critical to supporting the youth and family, and to address their identified concerns.

Phase II: Referral and ongoing support. Based on the CC team's recommendations and the family's interests, a plan of action was developed including specific referrals to providers who could best meet the identified needs. In cases where family perspectives aligned with provider perspectives, decisions about what services to engage were straightforward. Because CC was a voluntary service; however, if families or a majority age youth did not wish services or see a need for recommended services then they were free to refuse referrals. Because the initial assessment included a careful assessment of family and youth concerns, efforts were made to identify services that could address those problems, and in this way maintain engagement and build trust with families over time. This approach is commonly used with ethnic minority groups who may attach high stigma to mental health treatment and has been shown to facilitate engagement in services over time.[20]

Where possible, services that already exist in the community were engaged (e.g., mental health services, case management); in this case, the CC team worked closely with the family to identify a good match of providers and facilitate an introduction to these providers. These providers were then considered part of the youth's "services team" and were invited to participate in phone calls regularly with other service team members in order to share information. In addition, the CC team offered ongoing consultation, training, and support to the providers related to specific expertise regarding the youth's cultural or religious background or, if appropriate, particular expertise related to violent radicalization. These services were typically funded through existing mechanisms such as insurance or preexisting grants and contracts to community agencies. Some services were less readily available in the community or did not have any standard billing mechanisms to support them, for example, religious mentorship. In these cases, CC team members worked directly with the youth or family. In addition, one CC team member was identified as the "services team lead"; this person held the responsibility of ensuring that providers were communicating in a timely fashion regarding case updates or changes, monitoring any general perceived risk level based on the integrated information from providers, and serving as an additional "touch point" for the youth and family regarding their overall involvement in CC. This could take the form of a weekly text check-in, a casual conversation in a community setting such as a shopping mall, or a phone call. These additional services were supported via grant funding.

Phase III: Termination. The goal of CC was to adequately engage youth in appropriate and relevant services such that stressors and challenges across the layers of the social ecology that might have been contributing to an increased risk for violence could be addressed. Thus, termination was not predicated on all problems having been addressed; rather, the CC team ended their service when the youth had been stably engaged in appropriate services for the identified needs for a period of approximately six months. For example, in one case a youth who had recently immigrated from another country and was self-injuring was referred to the CC team; the CC team helped the family to engage in linguistically and culturally appropriate mental health services and facilitated their introduction to a supportive religious community. These two supports were stable and effective, and the CC team ended their involvement. In another case, an immigrant youth with schizophrenia was referred by local law enforcement due to repeated domestic violence concerns; after working with the family for more than a year, the youth became stabilized in a long-term residential treatment facility. The care was stable and appropriate to the youth's level of risk; the CC team terminated involvement. Because CC was a voluntary service, youth or their families could withdraw from the CC team or any of the recommended services at any time. Figure 2 graphically presents the three phases of Community Connect and corresponding multidisciplinary activities.

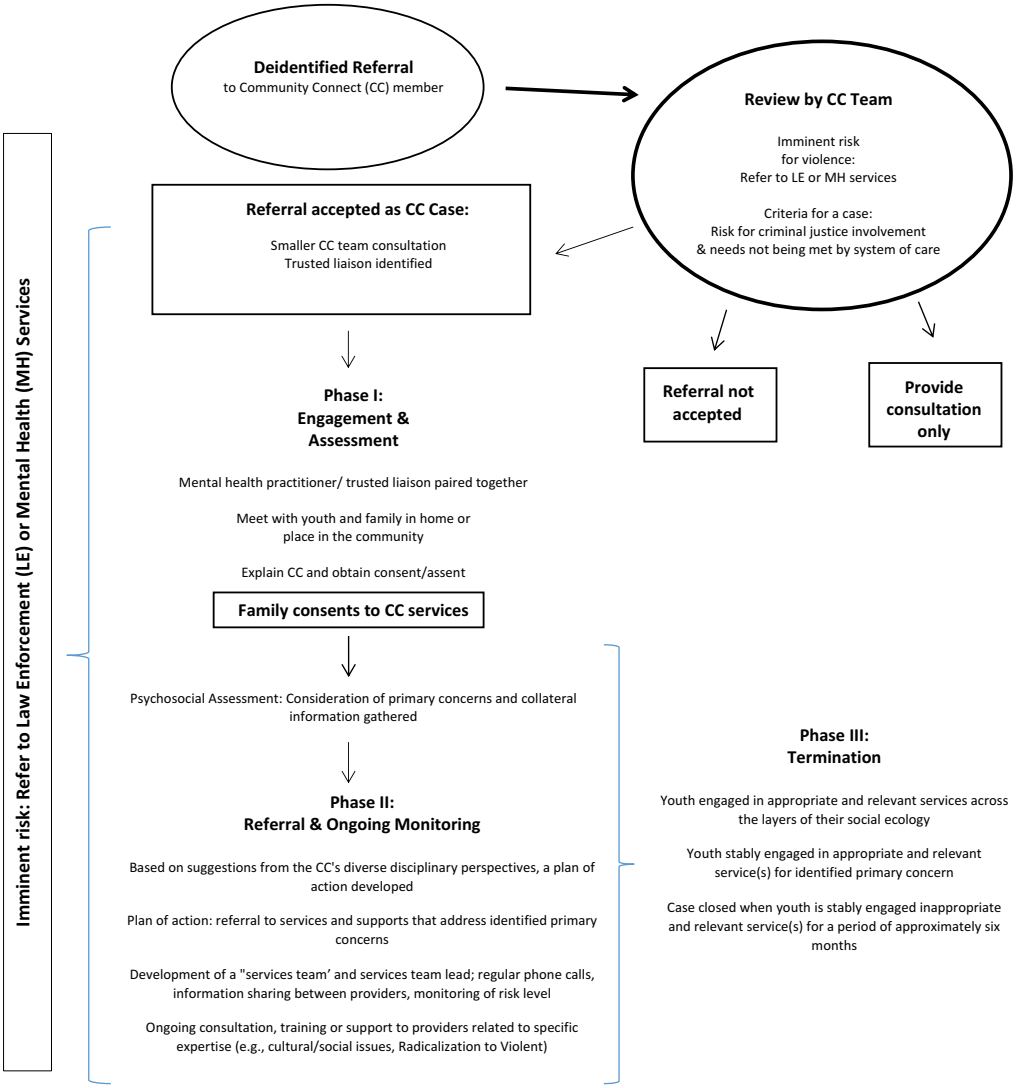

Figure 2. Flowchart for Community Connect referrals.

Cases could also be terminated in the event that they became too high risk or the youth/family withdrew from services. No cases met the first criteria. In the latter case, if a family disengaged by either no longer making contact or verbally withdrawing, efforts were first made to address any specific concerns the family had and, if services were still refused, then the CC stated clearly to the family that services were terminated and that, per initial agreements, the initial referrer would be informed that CC services were no longer engaged.

Over the past two years, the CC team provided services for youth and families from a range of backgrounds (immigrant, non-immigrant; Muslim, Christian, Nondenominational; Black, Latinx, Asian, White) facing risk for a range of violence, including targeted school violence, self-injury, domestic violence, sexual aggression, and VR. Referrals came from every discipline represented at CC multidisciplinary table, as well as the FBI; overall 25 percent of the referrals were from the FBI, suggesting that while working with youth at risk for VR was an important part of the CC effort it was only one of the many violence concerns being addressed. Referrals from the FBI included concerns

related to school violence, ISIS-inspired violence, and Incel. The CC team lacked the specific expertise to work with Incel-inspired youth, but accepted referrals related to both school violence and ISIS-inspired violence. The two cases presented below (identifying information has been changed to protect confidentiality) illustrate the way in which the CC team worked with referrals from the FBI related to VR, but do not represent the primary focus of the CC team and its work.

Community connect case examples

Case 1

Phase I. Youth 1 was a fifteen-year-old boy who had one parent born in the U.S. and of the Episcopal faith, and another who had immigrated to the U.S. decades earlier and was a non-practicing Muslim. The youth initially came to the attention of the FBI due to online activity in which he appeared to be planning, and recruiting others to engage in, a terrorist attack. Upon investigating and learning that the postings were being done by a minor, the FBI reached out to a local faith-based leader and CC team member to ask whether the CC team could work with the youth and his family. The CC team agreed to accept the case, and the FBI agreed to close the assessment and not to pursue an investigation. Upon accepting the case, the CC team identified a trusted liaison (a Muslim outreach worker and family therapist) who was paired with a faith-based leader who conducted a home visit to better understand the youth's circumstances, youth and family concerns, and their perspectives on what would be helpful. Consent was obtained after a full explanation of Community Connect and its voluntary nature. The CC outreach worker explained that participation was voluntary and that while no specific information would be shared with the referring FBI agents they would be informed about whether or not the family chose to accept CC services, or if these services were later terminated. Standard limits to confidentiality based on mental health provider protocols were explained, and released of information obtained for all providers working with the youth and the CC team. A more detailed psychosocial assessment was then conducted, followed by a full psychological evaluation.

Phase II. In reviewing the case, the CC team developed an individualized plan of action. It was determined that there were several opportunities for intervention across the youth's social ecology. At the individual level, the youth was connected to a therapist and psychopharmacologist who worked to address depression and social skill deficits. A religious mentor (and CC team member) was identified to help the youth learn about Islam and to help the family connect to a warm, supportive religious community. At the family level, several challenges were identified including one parent not receiving adequate treatment for an illness, overall lack of time to connect and share as a family, and the disconnect that the youth experienced from his parents as he found himself increasingly interested in a religion that neither of his parents understood. The CC team invited the family to events in the community, and the family began to develop routines that fostered connection and demonstrated an interest in something of importance to their child. Another CC team member began to meet with the parent with the illness to understand better the barriers to receiving appropriate health care and prompt a re-engagement with medical providers as well as to validate the challenges of raising a family while chronically ill. Finally, the family counselor encouraged the parents to work with the school to address a bullying problem, and around appropriate controls and limits to on-line access. Figures 3 and 4 show combined identified sources of pain and subsequent MDT interventions.

Phase III. Over the course of CC involvement, the above plan included five providers of different disciplines (religious mentor, social worker, psychologist, psychopharmacologist, medical advocate) who collectively had between three to five points of contact with the youth or family in a given week. After approximately oneyear of services, the youth appeared significantly improved as evidenced by less depression, active engagement in learning about Islam through a local mosque, improved school performance, and report of new friendships. While some providers remained in place (e.g.,

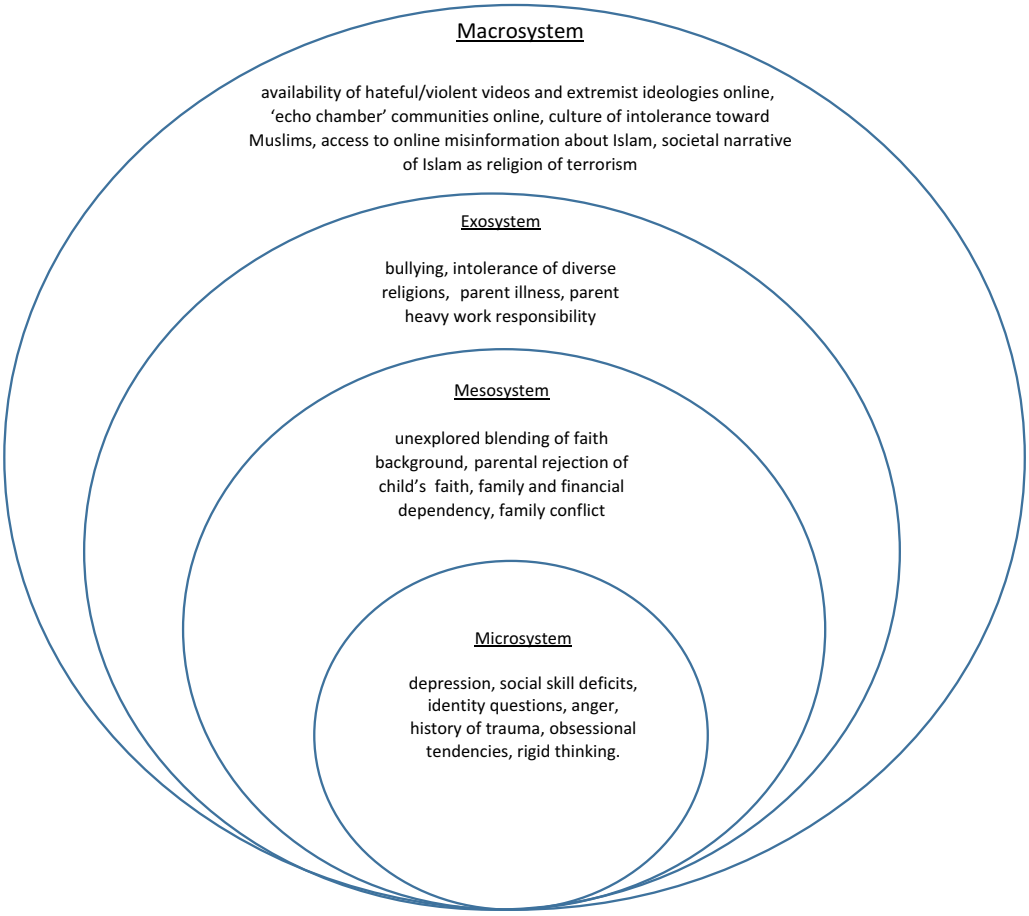

Figure 3. Identified vulnerabilities across the social ecology.

psychologist, religious mentor) the CC team gradually decreased frequency of connections and moved toward terminating the teams' involvement.

Case 2

Phase I. Youth 2 was a twenty-year-old white male who was born in the United States, as were his parents who were of Christian faith. The youth initially came to the attention of the FBI when his coworker notified them with concerns. Youth 2 had been collecting ISIS-related paraphernalia, converted to Islam, and demonstrated unusual behaviors that he stated were in the name of Islam. The FBI asked whether the CC team could work with the youth and his family. The CC team agreed to work with him, and the FBI determined that the risk level was sufficiently high that, even with the CC team in place, they needed to maintain an open investigation. An FBI agent introduced the youth and family to a member of the CC team, and after appropriate consents and releases of information were obtained the CC team opened the case. As with Case 1, the consent process included informing the family of limits to confidentiality, and clarified that no specific information would be shared with the FBI but that the youth's decision to engage, decline, or discontinue CC services would be shared. A Muslim mental health provider and a local faith-based leader, both CC members, met with the youth to conduct a psychosocial assessment. They also collected additional collateral information gathered from varying sources including his parents and existing mental health providers.

Phase II. In reviewing the case, the CC team determined that there were several opportunities for intervention across the youth's social ecology. At the individual level, the youth was connected with a psychiatrist as well as a Muslim therapist to help the youth work through family conflict related to his faith (and conversion to Islam), and mental health challenges related to obsessional tendencies and rigid thinking. A religious mentor was also identified to help the youth learn about Islam, and support his engagement in classes at a local mosque. At the family level, the CC team connected the youth's mother with a spiritual counselor to help explore her anger at, and rejection of, Islam and to encourage her to reconnect with her child in ways that did not challenge his new faith. A CC mental health clinician also continued to meet with the mother as a "touch point" and used these opportunities to reinforce engagement between family members that were not in conflict and to encourage participation in enjoyable family activities. A community advocate who was part of the Mosque community helped the youth apply for and get a part-time job near the mosque. This opened a path toward him becoming financially independent and building social connections to members of the Muslim community. In addition, the CC team provided consultation to mental health providers related to some of the youth's behaviors that were being diagnosed as delusional but that could also be understood as naïve attempts to engage in religious practices. Figures 3 and 4 show identified vulnerabilities and subsequent MDT interventions, respectively.

Phase III. Over the course of their involvement in CC, Youth 2 and his family worked with five providers from different disciplines (Christian spiritual counselor, Muslim mentor, community advocate, psychologist, psychiatrist) and had up to four points of contact in any given week. After approximately two years of service, the youth was stably engaged in relevant activities and services. He regularly engaged in events at the mosque where he attended classes about Islam and was employed part-time. CC services were terminated.

The potential of MDT approaches to VR: How an MDT was uniquely poised to work with the case examples

Although the two cases shared here presented with very different backgrounds and problems, several critical commonalities are apparent. In both cases, family stress, developmental challenges, and conflicts around developing identity are present. In both cases, diverse disciplinary teams were put in place, and frequent communication and learning between these providers were critical to providing effective care. For these two youths, while religious ideology was purportedly a motivator for their radicalization, in both cases, their understanding of Islam was superficial, focused on external markers rather than spirituality. Both experienced mental health problems that were not being appropriately diagnosed and treated. Finally, profound disconnection from, and rejection by, important others appeared to be central to their experiences. Figure 3 illustrates the types of stressors and vulnerabilities across the level of the social ecology that were identified across the two sample cases.

Also common across the two cases was a need for high-intensity, integrated care. Figure 4 illustrates the types of intervention that were implemented by the CC team in response to the two sample cases. The degree of integration and intensity of treatment and attention afforded to these two individuals is unusual and impossible to provide through standard billing structures. However, any one component on its own would have been unlikely to effectively engage and address the needs of these youths. The cost and resources dedicated to such intensive care need to be balanced against the potential cost of long-term involvement in the criminal justice system or, worse, the societal cost of a completed act of violence.

Challenges and questions

While the two cases above provide illustrations of the potential for an MDT to play a role in the prevention of VR, implementing such an approach can face a number of challenges. Some of the key questions related to the viability of implementing an MDT for VR are discussed below.

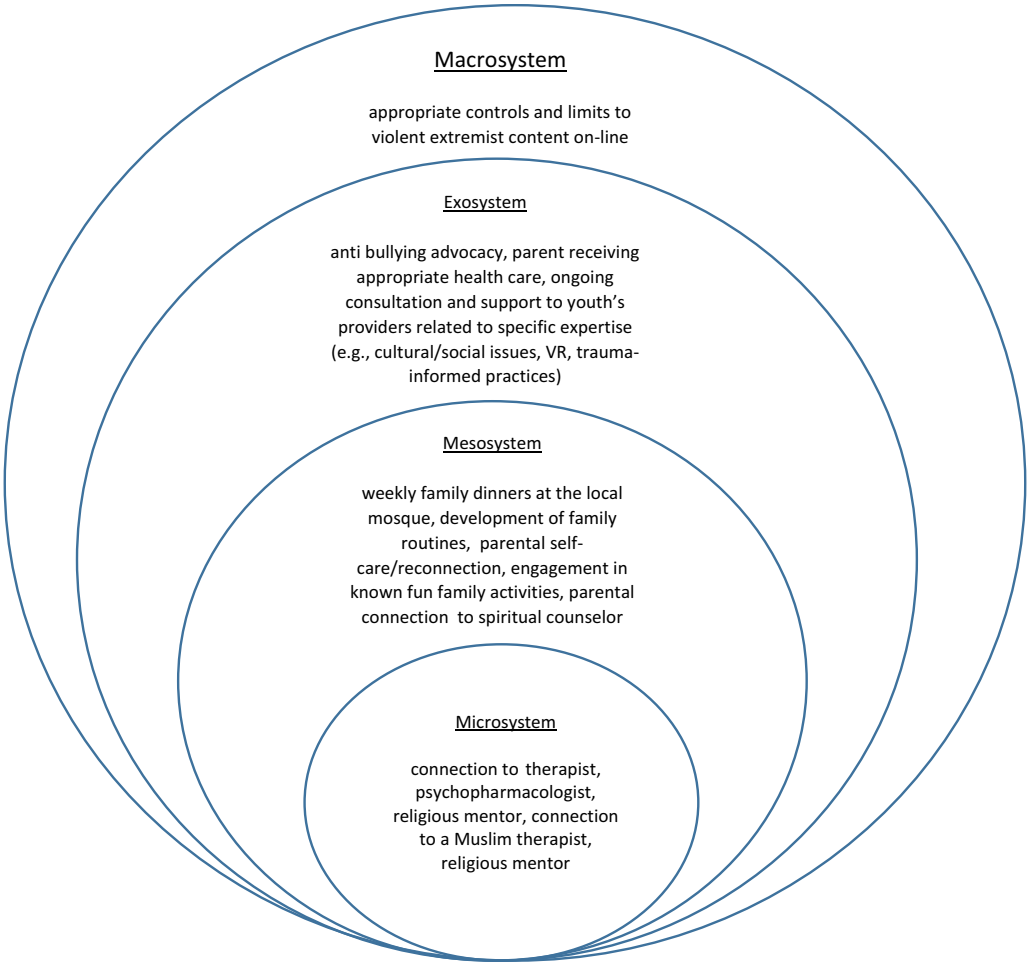

Figure 4. Identified multidisciplinary interventions across the social ecology.

How can an MDT be "stood up" and sustained when the base rate of VR is very low?

While there are relatively few individuals within any given community that are at serious risk for VR, there are regrettably many youths who are at risk for engaging in violence of some type. Developing differentiated violence prevention programs for the different types of violence (gang violence, domestic violence, school shooters, VR) is an inefficient use of resources and also fails to capitalize on the background knowledge that specialists in each of these areas may bring to bear on the problem.[21] Integrating unique VR expertise into existing violence prevention teams, as described earlier, may provide a more efficient and sustainable way of addressing VR while simultaneously diminishing the stigma associated with P/CVE programming.

One challenge in doing so, however, is that it may be difficult to keep the resources needed to sustain VR expertise at the table. These resources may be redirected toward other more common forms of violence, leaving a gap for a less frequent–but potentially very harmful–type of violence. Although the base rate of VR is low, the damage done by this type of violence can be high both in terms of lives lost and polarization of society. Thus, funding that specifically advances understanding of and interventions for VR needs to be allocated and protected so that the unique needs of these youths are not lost or left unattended.

Is VR just another type of violence? Or does it need a special program?

Different types of violence are each the product of unique confluences of individual and societal factors.[22] Similarly, unique factors and experiences may contribute to ideologically motivated violence. Grievances, identity, disconnection, or a quest for significance may all play a role.[23] Many of these issues, as well as other potential contributing factors such as trauma, mental illness,[24] or misinformation, may be addressed through an MDT. Whether or not an MDT can or should address ideological beliefs is an important question. One major distinction between how different countries have approached P/CVE is whether the focus is on radicalized beliefs or VR. Within the U.S., radical (nonviolent) beliefs are protected and have, at various points in history, been important catalysts for social change.

Whether ideology needs to be addressed in order to move someone off of a pathway toward VR remains an open question. Some have suggested that introducing complexity into narrow, ideologically driven thinking may be an important part of the work.[25] In the two examples provided above, challenging ideology was not a part of the work. However, ensuring that providers had an adequate understanding of both the client's ideology and the contrasting mainstream interpretation of Islam was critical. In the case of Youth 2, understanding the teaching of Salafi ideology helped to explain some of the behaviors that had initially led to his being reported to the FBI. In the case of Youth 1, having an understanding of Islamic teaching helped his therapist (who was not Muslim) to understand when his client's concerns about whether they were being sufficiently adherent to Islam were a natural reflection of his desire to be faithful, and when they were expressions of anxiety. In both cases, having access to a religious mentor to help the youth understand mainstream Islamic teaching was critical. Similarly, a deep understanding of other ideologies, such as far-right extremism, will be critical to adequately serving youth who espouse those ideologies. Within the CC team, ideological expertise was thus critical, though challenging the youth's ideology was not a part of the treatment.

The vast number of potential violently radical ideologies of all types presents a practical challenge to how to effectively and efficiently build in ideological expertise on an MDT. However, experts in these movements are available nationally and may be called on to help educate and build capacity and knowledge of these diverse ideologies within MDTs as they encounter the need. While experts on more prevalent types of VR may need to be built into a team (e.g., white supremacism), a network of experts nationally may be better positioned to support MDT efforts for less common forms of extremism.

Can an MDT address VR without stigmatizing youth?

One of the fundamental challenges of developing an MDT focused on VR is the potential stigma experienced by youth or communities served by the team. Eisenman and Flavahan (2017) note this problem is not unique to VR; gang programs can similarly struggle to accurately identify who would be best served and to do so in a manner that does not stigmatize youth as violent.[26] Within the U.S. concerns about the stigma associated with P/CVE run deep, contributing to the much slower uptake of MDTs to address VR in the U.S. compared to other industrialized nations.[27]

Integrating VR expertise into existing violence prevention MDTs is one means of diminishing stigma. Even if a team is focused on VR, addressing all forms of VE–regardless of ideology–can reduce the likelihood that the program will stigmatize one particular group.[28] MDTs that focus on a single ideology may, in fact, do more damage than good by suggesting that a single group is at high risk for violence. LA School Threat Assessment and Response Team (START) effort provides one example of how, in an intentional effort to avoid stigmatization associated with P/CVE, existing targeted school violence programs were expanded to also have the capacity to address the problem of ideologically motivated violence.[29] Several MDTs in Canada take this approach, building off of existing multidisciplinary hubs that are often led by local law enforcement.[30] In Toronto, for instance, an existing gang-prevention-focused hub provided an

existing team that was then expanded to address the issue of radicalization to ideologically based violence.[31] Similarly, in Finland, an existing team that focused on juvenile delinquency and domestic violence now also addresses VR.[32]

Can an MDT that addresses VR incorporate mental health, social service, and faith professionals without undermining trust in these professionals?

Social service (including mental health) and faith-based professionals may be reticent to join a team that addresses VR for the reasons outlined above, as well as additional reasons related to mistrust of government. As Dalgaard-Nielson notes, "When it comes to countering violent extremism, efforts to build governance networks are likely to be particularly challenging in societies that are already struggling with the polarization and lack of societal trust engendered by terrorist attacks, extremist propaganda, and possibly hard-handed government responses."[33] Some members of the Muslim community have expressed concerns that engagement of Muslim professionals in efforts to prevent VR are simply veiled attempts to encourage them to report on fellow community members as "at risk" for VR. Even if Muslim leaders do not believe this is the case, they must consider whether their standing in the community would be jeopardized by being seen as a participant in a P/CVE program. Thus, any MDT operating solely with a mission to address the problem of VR may create an impossible ask of community members or faith-based leaders. In contrast, building additional capacity to address VR within teams that have a broader service mission makes it possible for community members and faith-based leaders to participate in something that will more likely be seen as consonant with, or even central to, those individuals' role in the community.

Can federal law enforcement entrust at-risk individuals to an MDT?

The importance of trust in developing an MDT response to VR extends not only to community members, faith-based leaders, and service providers but also to law enforcement. They also face risks in asking an MDT to assume responsibility for a case in which some level of risk of VR is present.[34] Clear agreements around what information will or will not be shared are important. Integrating threat assessment professionals into the MDT can also help to ensure that an understanding of risk will be integrated into the service plan and changes to the level of care intensity or intervention made as needed.

Can an MDT accept referrals from the FBI and maintain clear separation of information?

The cases presented here provide two different examples of how an MDT can work with a referral from the FBI. In the first case, the FBI determined that it did not need to open an investigation (meaning to not continue to surveil or in other ways continue to intentionally gather information about the youth) once they knew that the CC team had taken on the case. Based on their initial assessment, they determined that the risk level was sufficiently managed given the engagement of the family, as well as the work of the CC team. Here, a clear hand-off occurred and the FBI was no longer involved with the family or case.

In the second case FBI agents determined that the risk level was sufficiently high that, even with the CC team in place, they needed to maintain an open investigation. The CC team members discussed potential challenges that could be raised by working with a youth that remained the subject of an active investigation; one of the most significant concerns raised was that this could be misperceived by community members as the CC team and associated providers participating in providing information or intelligence to the FBI. While both the CC team and the FBI recognized there were clear protocols in place that prohibited information sharing, this fact may not be known or understood by outside observers. Despite this risk, the CC team believed that mental health problems were central to the youth's needs and problems and that the importance of making sure the youth received needed

services outweighed the potential risk of community misperceptions. The CC team agreed to work with the youth but reiterated the explicit understanding that the role of the CC team was to provide referrals to treatment and support to the youth and family to engage in services, not information to the FBI. Thus, while this case was not a "hand off," the CC team and the FBI operated totally independently following the referral.

CC participants signed a release of information agreeing that information could be shared within the CC team, which included local (but not federal) law enforcement. Clients were made aware that concerns about imminent safety to self or others would be handled according to mental health providers' legal and ethical guidelines; duty to maintain confidentiality, and limits on this were clearly communicated. When the FBI referred cases to the CC team a transparent handoff was done, with the FBI introducing the family to a team member and explained that CC could provide supportive services but did not work with the FBI.

How can an MDT that has the capacity to address VR be funded?

Funding remains a central challenge to implementing an MDT approach that has the capacity to address VR. Funding from federal law enforcement or intelligence agencies is likely to alienate community partners, as well as many providers, and contribute to concerns that such a program could not exist without blurring the line between services and security. As illustrated by the cases above, some services critical to working with radicalizing youth, such as ideological experts, faith-based mentors, community advocates, or threat assessment professionals, are not funded through typical billing mechanisms. In addition, even those providers who can bill for services such as mental health professionals spend extra "unbillable" hours as part of the MDT meetings or service team calls/meetings. These unfunded portions of the MDT are essential to moving from the existing fragmented systems of care to a more comprehensive team approach that addresses factors throughout the social ecology.

Possible approaches to funding MDTs that have the capacity to address VR include: additional funding through service divisions such as Department of Education or Department of Health and Human Services to support MDTs; providing "capacity booster" grants that allow existing MDTs to build out expertise that is needed to address VR; local government block grants; private foundations or public–private partnerships. Funding for effective evaluation is also critical so that the knowledge base regarding what services work for whom can be increased and funds increasingly strategically focused.

How can the necessary trust be built in order to establish an MDT?

The formation of CC benefited from both preexisting relationships and serendipitous opportunities for trust-building in the early days. While these specific advantages may not be replicable in other settings, key principles that underlay the process of the team formation can be put into practice in any setting. Practitioners seeking to build the trusting foundation necessary for the successful implementation of an MDT with the capacity to address RV may benefit from approaches that have been successful in relation to other highly stigmatized or controversial problems, such as HIV/AIDS. Community-based participatory research provides one model for developing genuine, trusting partnerships between communities and researchers.[35] This approach outlines critical principles such as power-sharing, co-learning, being responsive to community concerns, and enhancing community capacity. These principles, applied to relations between service systems, law enforcement, and community agencies can build trust. Other approaches such as community policing[36] or gang violence prevention initiatives[37] may increase trust between community members and law enforcement, and even if these are not specific to preventing RV can build trust that can later benefit RV prevention programs. Such approaches can be time-consuming and slow but are nonetheless possible and, if done right, can yield sustainable programming and partnerships.

Conclusion

MDTs hold significant promise as a means of helping youth who may be radicalizing toward violence. Successful early prevention contributes to both a reduction in violence, as well as a profound and positive difference in the lives of youth who are struggling. This paper describes an approach that has successfully engaged critical partners from both community and law enforcement and implemented an MDT approach in a manner that was mindful of the significant cost of increasing stigma.

Acknowledgments

We thank each member for their invaluable contribution to the design and implementation of our multidisciplinary team.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This project was supported by the Substance Abuse and Mental Health Services Administration (SAMHSA; U79 SMSM080047), U.S. Department of Health and Human Services (HHS), and the John Leopold Weil and Geraldine Rickard Weil Memorial Charitable Foundation (PI Ellis). The views, findings, and conclusions expressed in this report are solely those of the authors and do not necessarily represent the official views of, the SAMHSA, HHS, or the Weil Memorial Charitable Foundation.

Notes on contributors

B. Heidi Ellis, PhD, is an Associate Professor in Psychology and Psychiatry at Harvard Medical School and Boston Children's Hospital, and a licensed clinical psychologist. She is also the Director of the Refugee Trauma and Resilience Center at Boston Children's Hospital, a partner in the National Child Traumatic Stress Network. Dr. Ellis' primary focus is on understanding and promoting refugee youth mental health and well-being, with a particular emphasis on understanding how trauma exposure, violence, and social context impact developmental trajectories. Over the past seventeen years she has conducted a Community Based Participatory Research program with Somali youth and was Principal Investigator of a multi-site, longitudinal research project examining developmental pathways to and away from violence, including ideological violence, gang involvement, and constructive civic engagement.

Alisa B. Miller, PhD, is Research Associate at the Refugee Trauma and Resilience Center at Boston Children's Hospital, Assistant in Psychology in the Department of Psychiatry at Boston Children's Hospital, and an Instructor in psychology at Harvard Medical School. Dr. Miller is also a licensed clinical psychologist. Her interests include exposure to trauma and sociocultural factors, and the impact these have on functioning and well being. Her overarching interest is reducing mental health disparities and improving systems of care to better serve all youth in U.S. communities.

Ronald Schouten, MD, JD, is Co-Director of the Forensic Psychiatry Fellowship Program at St. Elizabeths Hospital in Washington, D.C. and Director Emeritus of the Law & Psychiatry Service at Massachusetts General Hospital. Dr. Schouten has contributed to workshops sponsored by the National Institutes of Health and Department of Defense, DTRA, DOE, FBI the Nuclear Threat Initiative, and the Nautilus Institute. He was a member of the Amerithrax Expert Behavioral Analysis Panel investigating the 2001 anthrax attacks. He serves on the threat assessment teams of multiple corporations and educational institutions and is a member of the MassBay Threat Assessment Team based in the Boston FBI Field Office. He was on the expert panel for the 2019 National Council for Behavioral Health publication "Mass Violence in America" and is on the Advisory Board of Parents for Peace.

Naima Y. Agalab, BA, is the Director of Social Services at the Refugee and Immigrant Assistance Center (RIAC) in Boston, MA, where she coordinates the social service programs including the Community Counseling Center and provides case management and advocacy in the refugee/immigrant community. She has had experience providing care and services to the refugee/immigrant community for over twenty years in partnership with local resettlement organizations, hospitals among other local agencies. Ms. Agalab also provides consultation to the Refugee Trauma and Resilience Center on research-related activities by assisting with outreach, education and recruitment strategies for grant-funded studies which seek to better understand Somali mental health and resilience.

Saida M. Abdi, PhD, is an assistant professor in the University of Minnesota School of Social Work in the College of Education and Human Development. Dr. Abdi received a combined Social Work/Sociology PhD from Boston University. Prior to her position at the University of Minnesota, she was the Associate Director for Community Relations at the Boston Children's Hospital Refugee Trauma and Resilience Center (RTRC) where she has led RTRC's efforts to build community partnerships to increase mental health knowledge and services in diverse refugee communities. Her clinical practice focuses on supporting children and families impacted by violence and migration and her research focuses on factors related to resilience among refugee and immigrant children and families and the use of Community Based Participatory Research.

Notes

1. Randy Borum, "Radicalization into Violent Extremism I: A Review of Social Science Theories," *Journal of Strategic Security* 4, no. 4 (2011): 7–36, https://doi.org/10.5038/1944-0472.4.4.1.
2. National Security Council, "Strategic Implementation Plan for Empowering Local Partners to Prevent Violent Extremism in the United States," 2016.
3. Kiran M Sarma, "Risk Assessment and the Prevention of Radicalization from Nonviolence into Terrorism," *American Psychologist* 72, no. 3 (2017): 278–88, https://doi.org/10.1037/amp0000121.
4. National Security Council, "Strategic Implementation Plan for Empowering Local Partners to Prevent Violent Extremism in the United States."
5. Angela McGilloway, Priyo Ghosh, and Kamaldeep Bhui, "A Systematic Review of Pathways to and Processes Associated with Radicalization and Extremism amongst Muslims in Western Societies," *International Review of Psychiatry* (Informa Healthcare, February 1, 2015), https://doi.org/10.3109/09540261.2014.992008; John Horgan, *The Psychology of Terrorism* (Routledge, 2005), https://doi.org/10.4324/9780203496961.
6. David P. Eisenman and Louise Flavahan, "Canaries in the Coal Mine: Interpersonal Violence, Gang Violence, and Violent Extremism through a Public Health Prevention Lens," *International Review of Psychiatry* 29, no. 4 (2017): 341–49, https://doi.org/10.1080/09540261.2017.1343527; Sarma, "Risk Assessment and the Prevention of Radicalization from Nonviolence into Terrorism."
7. Urie Bronfenbrenner, "Toward an Experimental Ecology of Human Development," *American Psychologist* 32, no. 7 (1977): 513–31, https://doi.org/10.1037/0003-066x.32.7.513.
8. Ibid.
9. Pippa Hall and Lynda Weaver, "Interdisciplinary Education and Teamwork: A Long and Winding Road," *Medical Education*, September 2001, https://doi.org/10.1046/j.1365-2923.2001.00919.x.
10. S. Catt et al., "The Informational Roles and Psychological Health of Members of 10 Oncology Multidisciplinary Teams in the UK," *British Journal of Cancer* 93, no. 10 (November 4, 2005): 1092–97, https://doi.org/10.1038/sj.bjc.6602816; Doris Fay et al., "Getting the Most out of Multidisciplinary Teams: A Multi-Sample Study of Team Innovation in Health Care," *Journal of Occupational and Organizational Psychology* 79 (2006): 553–67, https://doi.org/10.1348/096317905X72128.
11. Lisa M. Jones et al., "Criminal Investigations of Child Abuse: The Research Behind 'Best Practices,'" *Trauma, Violence, & Abuse* 6, no. 3 (July 2005): 254–68, https://doi.org/10.1177/1524838005277440.
12. Karen I. Countryman-Roswurm, Bailey Patton Brackin, and Patton Brackin, "The Journey to Oz: How Practice, Research, and Law Have Been Used to Combat Domestic Minor Sex Trafficking in Kansas," *Journal of Applied Research on Children: Informing Policy for Children at Risk* 5, no. 2 (2014): 1–15, http://digitalcommons.library.tmc.edu/childrenatrisk/vol5/iss2/8.
13. John Van Dreal, *Assessing Student Threats: Implementing the Salem-Keizer System*, 2nd ed. (New York: Rowman & Littlefield Publishers, 2017); National Threat Assessment Center, "Enhancing School Safety Using a Threat Assessment Model: An Operational Guide for Preventing Targeted School Violence," 2018.
14. Anja Dalgaard-Nielsen, "Terrorism Research Initiative Countering Violent Extremism with Governance Networks," *Perspectives on Terrorism*, 10 (2016), https://about.jstor.org/terms; Eisenman and Flavahan, "Canaries in the Coal Mine: Interpersonal Violence, Gang Violence, and Violent Extremism through a Public Health Prevention Lens"; Stevan Weine et al., "Utilizing Mental Health Professionals to Help Prevent the next Attacks," *International Review of Psychiatry* 29, no. 4 (July 4, 2017): 334–40, https://doi.org/10.1080/09540261.2017.1343533; Hedieh Mirahmadi, "Building Resilience against Violent Extremism," *The ANNALS of the American Academy of Political and Social Science* 668, no. 1 (November 21, 2016): 129–44, https://doi.org/10.1177/0002716216671303; Eric Rosand, "Multi-Disciplinary & Multi-Agency Approaches to Preventing & Countering Violent Extremism: An Emerging P/CVE Success Story?" in *Global Terrorism Index 2018: Measuring the Impact of Terrorism*, ed. Institute for Economics and Peace (Sydney, 2018), 72–75, http://visionofhumanity.org/reports; Tami Amanda Jacoby, "How the War Was 'One': Countering Violent Extremism and the Social Dimensions of Counter-Terrorism in Canada," *Journal for Deradicalization* 6 (2016): 272–304.
15. Dalgaard-Nielsen, "Terrorism Research Initiative Countering Violent Extremism with Governance Networks."

16. Eric Rosand et al., "A Roadmap to Progress: The State of the Global P/CVE Agenda," 2018, www.organizingagainstve.org.
17. Dalgaard-Nielsen, "Terrorism Research Initiative Countering Violent Extremism with Governance Networks," 10:137.
18. Stevan Weine et al., "Building Community Resilience to Counter Violent Extremism," *Democracy and Security* 9, no. 4 (2013): 327–33, https://doi.org/10.1080/17419166.2013.766131; Kamran Bokhari, "Countering Violent Extremism and American Muslims" (Washington, D.C., 2015); Stevan Weine, Chloe Polutnik, and Ahmed Younis, "Understanding Communities' Attitudes Towards CVE," 2015, www.start.umd.edu.
19. Sarma, "Risk Assessment and the Prevention of Radicalization."
20. B. Heidi Ellis, Saida M. Abdi, and Jeffrey P. Winer, *Mental Health Practice with Refugee and Immigrant Youth: A Socioecological Framework* (Washington: American Psychological Association, 2019), https://doi.org/10.1037/0000163-000.
21. Eisenman and Flavahan, "Canaries in the Coal Mine: Interpersonal Violence, Gang Violence, and Violent Extremism through a Public Health Prevention Lens."
22. Brad J. Bushman et al., "Youth Violence: What We Know and What We Need to Know," *American Psychologist* 71, no. 1 (January 1, 2016): 17–39, https://doi.org/10.1037/a0039687.
23. B. Heidi Ellis, Georgios Sideridis, Alisa B. Miller, Saida M. Abdi, & Jeffrey P. Winer, "Trauma, Trust in Government, and Social Connection: How Social Context Shapes Attitudes Related to the Use of Ideologically or Politically Motivated Violence," *Studies in Conflict and Terrorism* 0, no. 0 (2019): 1–18, https://doi.org/10.1080/1057610X.2019.1616929; Matteo Vergani, Muhammad Iqbal, Ekin Ilbahar, & Greg Barton, "The Three Ps of Radicalization: Push, Pull and Personal. A Systematic Scoping Review of the Scientific Evidence about Radicalization Into Violent Extremism," 2018, https://doi.org/10.1080/1057610X.2018.1505686; Dina Al Raffie, "Social Identity Theory for Investigating Islamic Extremism in the Diaspora," *Journal of Strategic Security* 6, no. 4 (2013): 67–91, https://doi.org/10.5038/1944-0472.6.4.4; Jennifer M. Brinkerhoff, *Digital Diasporas: Identity and Transnational Engagement* (Cambridge: Cambridge University Press, 2009); Arie Kruglanski, Katarzyna Jasko, David Webber, Marina Chernikova, & Erica Molinario, "The Making of Violent Extremists," *Review of General Psychology* 22, no. 1 (March 1, 2018): 107–20, https://doi.org/10.1037/gpr0000144.
24. Ellis et al., "Trauma, Trust in Government, and Social Connection: How Social Context Shapes Attitudes Related to the Use of Ideologically or Politically Motivated Violence."
25. Sebastien Brouillette-Alarie, Ghayda Hassan, et al. "The Prevention of Violent Radicalization: Evidence-Based Guidelines to Promote Efficient Interventions." (report presented at the Canadian Practitioners Network for the Prevention of Radicalization and Extremist Violence workshop, Ottawa, ON, March 21-22, 2019), https://cpnprev.ca/.
26. Eisenman and Flavahan, "Canaries in the Coal Mine: Interpersonal Violence, Gang Violence, and Violent Extremism through a Public Health Prevention Lens."
27. Eric Rosand, "The 116th Congress and Preventing Extremist Violence: Look North for Guidance," *Just Security*, 2019, https://www.justsecurity.org/62060/116th-congress-preventing-extremist-violence-north-guidance/.
28. Weine et al., "Utilizing Mental Health Professionals to Help Prevent the next Attacks."
29. Ibid.
30. Rosand, "The 116th Congress and Preventing Extremist Violence: Look North for Guidance."
31. Rosand, "Multi-Disciplinary & Multi-Agency Approaches to Preventing & Countering Violent Extremism: An Emerging P/CVE Success Story?"
32. Ibid.
33. Dalgaard-Nielsen, "Terrorism Research Initiative Countering Violent Extremism with Governance Networks," 10:137.
34. Ibid.
35. B. Heidi Ellis and Saida M. Abdi, "Building community resilience to violent extremism through genuine partnerships," *American Psychologist*, 72, no. 3 (2017): 289–300. https://doi.org/10.1037/amp0000065.
36. David Schanzer, Charles Kurzman, Jessica Toliver, & Elizabeth Miller. "The Challenge and Promise of Using Community Policing Strategies to Prevent Violent Extremism: A Call for Community Partnerships with Law Enforcement to Enhance Public Safety," *Triangle Center on Terrorism and Homeland Security, Sanford School of Public Policy, Duke University*, January 2016, https://doi.org/10.13140/RG.2.1.3609.1927.
37. B. Heidi Ellis, Scott H. Decker, Saida M. Abdi, Alisa B. Miller, Colleen Barrett, & Alisa K. Lincoln, "A Qualitative Examination of how Somali Young Adults Think About and Understand Violence in Their Communities," *Journal of Interpersonal Violence* 37, no. 1-2 (2022): 803–829.