

Decisions to Breach Confidentiality When Prisoners Report Violations of Institutional Rules

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As a general principle, standards of care in prisons, including patient confidentiality, should strive to be the same as those in the open community. This is the position taken by a recent American Psychiatric Association (APA) Task Force on jails and prisons and in an earlier APA position statement.^{1,2}

Accordingly, confidentiality can be breached when inmates are at risk of serious harm to themselves or others. The APA Task Force report also included those situations in which confidentiality may not be protected: when an inmate presents a clear and present risk of escape or when the inmate is responsible for “the creation of disorder within the facility” (Ref. 1, p 12) without defining the phrase. One example would be planning a riot. Other situations in which there is limited confidentiality include sharing necessary medical information on a need-to-know basis with prison officials for patients transferred to observation cells or other institutions (Ref. 1, p 13).

Security needs and the adversarial nature of the prison environment affect mental health care in a variety of ways. The safety of staff, visitors, and inmates is a primary concern for correctional departments. The APA Task Force acknowledged that confidentiality must be weighed against institutional needs of safety and security (Ref. 1, p 12). Paul Appelbaum, writing on ethics and forensic psychiatry, suggested that ethics in the correctional system may

involve rules of confidentiality different from those in the open community.³ Other experts have recognized that there are unique situations in prisons that require broader than usual limits on confidentiality.^{4–6}

Institutional Rules Violations

Balancing security and treatment needs can create role ambiguities and ethics-related concerns for psychiatrists and other correctional mental health professionals. One situation that has received only cursory attention occurs when an inmate discloses institutional rules violations in the context of a therapeutic relationship. Is it ever ethical to breach confidentiality and report violations to prison authorities?

Disclosures of rules violations can run the gamut from masturbation and consensual sex with other inmates, to possession of knives, guns, and other weapons. If the mental health professional believes that withholding information would threaten the security of the prison and present a danger to members of the prison community, he might feel a duty to notify authorities. Potentially, any rules violation can disrupt security functions, lead to conflict between officers and inmates, and create disorder within the facility. In my experience as a psychiatry consultant, no clinician would notify authorities if a patient admitted to masturbation or to having safe, consensual sex with another inmate. All would immediately notify authorities if an inmate admitted to having a gun. If an inmate admitted to having a knife or shiv, many

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clinicians initially would try to convince the inmate to give this weapon to security personnel voluntarily, but all, in my experience, would inform authorities if the inmate did not.

But what about admissions that fall within grayer areas, such as having makeshift weapons for protection, such as soap or a lock in a sock; making alcohol (hooch or pruno); possessing and using marijuana and other illegal drugs; buying drugs from other inmates; selling drugs; extorting favors from inmates; or having sex with a staff member? For some of these examples there are no easy answers, and there would probably be different opinions among mental health professionals about where to draw the line for breaching confidentiality.

Professional Guidelines

Psychologists in corrections have ethics guidelines developed by the American Association for Correctional and Forensic Psychology (AACFP; formerly the American Association for Correctional Psychology) and the Committee on Ethical Guidelines for Forensic Psychologists, formed from a division of the American Psychological Association.^{7,8} They also follow principles of ethics and codes of the main body of this organization. Most codes espouse general principles of confidentiality: informing patients of any limits on confidentiality and protecting confidentiality to the fullest extent possible. However, the AACFP has more specific guidelines requiring confidentiality in treatment settings except in life- or security-threatening emergencies.⁷

The most comprehensive guidelines for correctional psychiatrists are those contained in the APA Task Force report on treatment in jails and prisons. As noted, confidentiality can be broken when withholding information could result in the creation of disorder within the institution (Ref. 1, p 12). Psychiatrists are obligated to follow APA's "Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry," which gives only brief attention to correctional settings.⁹ Similarly, AAPL's "Ethics Guidelines for the Practice of Forensic Psychiatry" addresses only a few aspects of correctional work.¹⁰

Those working in other disciplines follow their professional codes of ethics. There are also guidelines developed by standards-setting organizations such as the National Commission on Correctional Health Care, the American Public Health Association, and the American Correctional Health Services Association.¹¹⁻¹³

However, no guidelines for correctional settings, to my knowledge, provide an ethics-based analysis of the more ambiguous examples mentioned previously. If there are no clear standards, mental health professionals must rely on personal values and judgment. Even when there are codes applicable to problematic situations, they are frequently subject to different interpretations and lead to contradictory viewpoints.^{12,14} For example, what is the exact definition of a security-threatening emergency or the creation of disorder in correctional facilities?

Matters are further complicated by the fact that, some of the examples mentioned, such as selling and buying drugs, would constitute in-prison felonies. In general, civilian mental health professionals are not legally required to breach confidentiality if they learn of prior illegal activity (misprision of a felony) in treatment settings.¹⁵ Exceptions are situations in which clinicians are required to notify authorities, such as child abuse. Presumably, this immunity extends to correctional settings. American Bar Association standards require confidentiality in prison counseling sessions unless the disclosed information concerns a contemplated crime or is required by court order.¹⁶ There are also *Tarasoff* duties that may include notifying authorities when there are serious threats of physical violence toward identifiable individuals. Case and statutory laws regarding patient privilege and *Tarasoff* responsibilities vary from state to state, and correctional mental health providers need to know applicable laws for their jurisdictions.

Treatment- or Security-Driven Decisions

I believe it is useful to categorize decisions to breach confidentiality as treatment-driven or security-driven. Although these are oversimplified constructs, they can illustrate opposing ethics-based arguments and the dual-agent conflicts common in correctional settings. It is important to bear in mind that there is no inherent conflict between treatment and security. No treatment can take place in an unsafe environment.

In treatment-driven decisions, the therapeutic relationship is given priority, and principles of confidentiality and beneficence (i.e., acting in the best interests and welfare of patients) are given strict adherence. This approach shows an understanding of the need for institutional security and protection of staff and other inmates, but gives credence to the concern that violations of confidentiality in non-

emergency situations can threaten security in the long term. The role of mental health providers is distorted if they take on police functions and thus prevent inmates who are concerned about the consequences of admitting to rules violations from seeking help. Institutions become more dangerous places when inmates are reluctant to seek treatment or disclose information for fear of punishment.

In security-driven decisions, the confidential nature of the treatment relationship is respected, but the safety of staff and inmates is given greater importance when there are conflicting values. This viewpoint argues that an essential goal of mental health treatment is to help ensure the safety of the prison community—a goal supported by the APA Task Force (Ref. 1, p 16). It takes the position that security is threatened and treatment is compromised when clinicians have knowledge of serious rules violations and take no action, in effect colluding with inmates against the institution and reinforcing asocial behavior.

There are arguments in support of both viewpoints.¹² In my 35 years as a psychiatry consultant to Ohio prisons, I have seen an increase in recent years in security-driven decisions to breach confidentiality. One explanation may be that in Ohio in 1995 responsibility for correctional mental health care was transferred from the Department of Mental Health to the Department of Rehabilitation and Correction. Full-time mental health professionals now receive much the same orientation and training as correctional officers, leading to a closer identification with security staff. These clinicians often view the role as a member of the correctional team as primary.

Others have noted that clinicians assign greater importance to security needs when mental health programs are under the jurisdictions of correctional departments and have viewed this as a cause for concern.¹⁴ An accepted position for correctional psychiatrists is that they should be advocates for their patients and consider duties to patients to be foremost when faced with difficult decisions.¹⁷ If psychiatrists and other clinicians abandon these principles, they abandon their professional identities as caregivers.

A Decision-Making Process for Ethics-Related Conflicts

Faced with contradictory roles and values and without clear guidelines, how can correctional psychiatrists and other clinicians reach decisions when informed of serious institutional violations? I believe

the essence of any ethics-based decision is the decision-making process and have suggested the basic elements of this process in a prior publication.¹⁸

Elements of this process are:

Awareness of the ethics-related concerns in the situation. Unless there is a good understanding of these concerns, decisions will be uninformed. Awareness of the ethics can be developed in a manner similar to awareness-training in other areas by becoming familiar with readings and through discussions with colleagues, other professionals, and supervisors.

Establishment of ethics-based priorities. Self-honesty is essential for this part of the decision-making process. Decisions should be examined as to whether they are motivated by the best interest of the patient, professional codes of ethics, and benefit to society in general or by fear of litigation, financial and employment considerations, obedience to authority, or other self-interests.

Period of deliberation. Most difficult questions of ethics are not easily answered, and clinicians should be wary of quick decisions. It takes time to struggle with the various aspects of the ethics of a situation and for the self-examination that is necessary. Discussions with other professionals are important in this phase. Challenges to opinions should be welcomed and viewed as a way of testing and strengthening beliefs. Applicable laws must be taken into account.

Making a decision and taking responsibility for the decision. An important aspect of any ethics-based decision is having the freedom to make a choice while taking responsibility for that choice.

By using this process, I believe it is possible for diligent and responsible professionals to approach the same conflict in ethics and yet arrive at different decisions. To enhance awareness of ethics-related problems in correctional settings, there are several helpful sources, some of which have already been noted.^{1,4-6,8,12,14,19,20}

As an example of how the process might work, consider the following vignettes.

Vignette 1

You are a psychiatrist at a medium-security prison, and a prisoner you are treating informs you that he recently bartered his prescribed medications for co-

caine from a fellow inmate. He doesn't give the inmate's name for fear of being labeled a snitch. He denies intentions of repeating this behavior, stating that he now realizes he should take his medication as prescribed. Illegal drug use has been a problem at your institution and a serious security matter. You must decide whether to notify prison authorities.

You consider the ethics-related concerns involved and define the situation as a dual-agent, treatment-security conflict, and you weigh the consequences of breaching confidentiality. Notifying authorities would benefit security, but this benefit might be small in comparison to the harm done to your patient with whom you have had good rapport. Your patient has described a past event, a criminal offense, but denies intentions of repeating his behavior. However, you have no guarantee of his intent. Your inclination is to maintain confidentiality and consider duty to your patient as primary in accordance with principles of beneficence and "doing no harm." You discuss the situation with a psychiatric colleague at the institution, who concurs with your decision. He suggests you obtain random serum levels to ensure that your patient is taking medication and not trading it for drugs.

At the next meeting with your patient, you tell him that you considered informing the authorities, but decided against it. One factor in your decision was his intention to stop using illegal drugs. To be reassured that he is not "cheeking" and selling his medication, you get his agreement to obtain random blood samples to check medication levels. You also tell him that if he informs you in the future that he is using cocaine or other illegal drugs, you will be obligated to notify authorities. You document this discussion in treatment notes.

Vignette 2

Your colleague doesn't realize it, but he is treating the prisoner who provided your patient with cocaine. This inmate informs your colleague that he has been dealing drugs that are brought into prison by a visitor. He shows little remorse for his behavior and no inclination to stop. Your colleague uses the same decision-making process, but decides in this case that security needs outweigh treatment needs and confidentiality. He meets with the clinical director of mental health services for the prison. Although it is not likely that withholding information would be life-threatening or create an imminent emergency,

both agree that authorities should be notified because of a potentially dangerous security concern and their knowledge of an ongoing felony. They briefly consider giving an anonymous tip to prison officials, so that the inmate doesn't realize that this information came from mental health staff, but you decide against taking this course. It would still be a breach of confidentiality and would involve deceit and dishonesty, which are contrary to professional codes.

The clinical director notifies authorities, who search the inmate's cell and find illegal drugs. The patient is placed into segregation pending criminal charges, and a transfer is recommended to a higher security prison. Your colleague visits his patient in segregation, takes responsibility for his decision, and explains his reasons for violating confidentiality. Because breaching confidentiality has now produced an adversarial relationship, he arranges for you to treat his patient pending the institutional transfer.

These two examples are contrived, but are representative of situations that mental health staff can encounter in prisons and of approaches to deal with them.

Reprisals Resulting From Reports of Rules Violations

Inmates may face reprisals when rules violations are disclosed to prison authorities. Depending on the violation, consequences can range from commissary and visitor restrictions, to placement in segregation and criminal charges.

Although unlikely, it is conceivable that lawsuits could be filed against clinicians for damages resulting from violations of confidentiality. If there is no legal requirement to breach confidentiality when patients disclose rules violations, mental health professionals who do so may be vulnerable to civil actions for damages. However, jurors in a lawsuit for breach of confidentiality are likely to be influenced by the fact that the plaintiff is a known felon, and they would appreciate the need for security and control in the prison environment.

Informing Prisoners of Limits on Confidentiality

The ethics of confidentiality depends on expectations regarding the confidential nature of the therapeutic relationship. As part of the informed-consent process, it is essential before beginning treatment that patients be informed as thoroughly as possible, orally and in writing, about the limits of confidentiali-

ality. As an example, the National Commission on Correctional Health Care's website suggests informing patients that authorities will be notified "if you tell me that you are going to harm or kill yourself or someone else, or engage in behavior that jeopardizes the safety or security of the facility."²¹

Because it is difficult to formulate rules of confidentiality that encompass all situations, some experts have suggested that clinicians inform inmates that there is no guarantee of confidentiality in the prison setting and that they must rely on the judgment of their health care providers regarding information that is shared with prison officials.^{11,22} This explanation has the advantage of reducing expectations and setting parameters so that no violations of confidentiality occur. However, confidentiality is a time-honored concept considered essential to treatment.²³ Concern about confidentiality and lack of trust in staff have been identified as factors that prevent inmates from seeking mental health care.²⁴ On the other hand, it could be argued that lowering expectations of confidentiality may improve trust because patients are not deceived by false claims.

Most correctional institutions have written policies on confidentiality that require signed acknowledgments by patients. If psychiatrists work in settings without policies, both the APA Task Force (Ref. 1, pp 13–14) and guidelines of AAPL¹⁰ recommend that they collaborate with institutions to clarify rules of confidentiality and to develop written policies.

In conclusion, psychiatrists should clarify and prioritize their values in making decisions to violate confidentiality when inmates disclose rules violations. Discussions with colleagues, other professionals, supervisors, and prison authorities can help develop a perspective for difficult decisions of this type.

For some decisions, there are no clear answers, and mental health professionals may disagree about breaching confidentiality. The development of ethics guidelines by AAPL and other psychiatric organizations specifically for correctional psychiatrists could provide additional direction in resolving these complex problems.

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