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Author(s): Gwen Adshead

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The community of the excluded: mental health and confidentiality in prisons

Gwen Adshead

The thought provoking paper by Elger *et al*¹ addresses a real and common issue for healthcare professionals who find themselves working outside traditional healthcare environments and in communities that may have very particular values and purposes. The authors set out to explore how mental health professionals (MHPs) deal with the ethical dilemmas that arise in situations where the disclosure of personal information might prevent harm, but would violate traditional duties of confidentiality. They gave MHPs who work in prisons a set of four vignettes: two that suggested that disclosure might prevent harm to the prisoner himself, and two where disclosure might prevent harm to others. They then analysed the responses of the MHPs and presented them in this paper. Teasingly, this paper only reports on the decisions relating to disclosure that prevented harm to the prisoner himself; I imagine another paper will deal with the other vignettes.

CONFIDENTIALITY OR A DUTY TO DISCLOSE?

Discussions about medical confidentiality traditionally go something like this: Healthcare professionals are held to be under a duty of confidentiality. This ethical duty is generally justified with reference to the good consequences that follow from it; that is, patients are more likely to disclose their problems accurately if they believe the doctor will keep their information confidential and, by extension, that harm may ensue if patients will not share important clinical details. In addition, it is usually argued that personal information is part of personal identity and an expression of autonomy: respect for a person's individual autonomy entails treating personal information about him or her with respect. However, the duty of confidentiality is not absolute. There is no duty to provide patients with 'secrecy'; only a duty to keep personal information private, and not to disclose it without the patient's permission.

Correspondence to Dr Gwen Adshead, Forensic Psychiatry, Ravenswood House, Knowle, Fareham, Hampshire PO17 5NA, UK; gwen.adshead@southernhealth.nhs.uk

Risk reduction has become an accepted justification for breach of confidentiality. Limits on personal freedom and choice are imposed in the name of public health; most countries have quarantine laws that limit personal movement to reduce infection. Disclosure of patients' personal information to reduce the risk of crime, however, is an additional justification for breach of confidentiality, which requires the healthcare professional to put duties regarding public safety ahead of any duties to the patient. Healthcare professionals may ironically spend more time discussing when to breach confidentiality than how to observe it. A clear example of this is articulated firmly in the National Health Service (NHS) Code of Confidentiality for NHS employees, which states that employees may disclose confidential medical information in 'the detection, prevention and punishment of serious crime' (p. 34).² Note that this stops short of a duty to disclose, but does suggest that crime prevention is more important than privacy.

LIFE IN PRISON COMMUNITIES

Prisons are strange and unusual communities in which prisoners find themselves placed against their will. Prisoners lead unusual lives where they have to depend on both the prison staff and to some extent on each other to make life bearable. Where liberty is compromised, there may be subtle and far-reaching effects on the more general capacity to make choices or to exert personal autonomy. Prisoners can and do affect each other's lives and choices in terms of their relationships with each other.

Prisoners' autonomy and capacity to be autonomous are also compromised by the very high levels of psychiatric morbidity in these populations: psychosis, personality dysfunction, substance misuse, anxiety and (most importantly) depression. Internationally, rates of suicide in prisons are higher than in the general community, and suicide prevention is usually seen as an essential clinical duty for healthcare professionals. As an example of clinical priorities, prisoner suicide has been identified as a 'never event' in England and Wales;³ that is, a disaster that should not happen and should be prevented at all

costs. For some healthcare professionals, suicide prevention is a good that trumps respect for autonomy, and other ethical duties (including the duty to keep confidences), mainly because most MHPs would think it unwise to assume that all suicidal intentions in prison represent a competent decision to end one's life.

The context of this decision-making process is crucial to consider as it affects both parties to the conversation. Asking to see an MHP in prison is not a decision to be taken lightly since it may alert others to one's vulnerability; it is hard not to think that telling an MHP that you are in danger from others is also a request for help. If a prisoner asks to see an MHP and informs that he or she is suicidal, it is difficult to see this as a bare value-free statement of fact, like an observation about the weather. What the right thing is to do will depend on the prison, the prisoner and the relationships available to him or her. In particular, it will depend on what kind of conversation the MHP has with the prisoner.

When people whose capacity to be autonomous is compromised, they need help to exercise autonomy and to explore what they think is best for them.⁴ Those who work in mental health services know this, and also know how complex it can be to help people make decisions that have significant consequences for them and others involved with them. When an MHP and a patient have a conversation, they are sharing information in the pursuit of helping that patient be autonomous and authentic: to help him or her be the person he or she wants to be.

In this paper, I thought the MHPs were particularly thoughtful about the psychological complexity of the conversations they would have with prisoners in situations described and the plight of the prisoners who talk about feeling afraid and vulnerable. I suspect that most of the real conversations that the MHPs would have had with prisoners who disclosed their suicidal feelings or fear of assault would have begun with a gentle enquiry such as 'What would you like to do?' and 'What would you like me to do for you, in this very difficult situation you find yourself in?'

PATERNALISM AND PRISONERS' RIGHTS?

Paternalism is used in this paper to describe the breaches of confidentiality, but the use of the word is misplaced in this context. More specifically, the negative connotations implied do not help correctional organisations develop more ethically sensitive systems. Respect for a

patient's autonomy has never entailed doing exactly and only what the patient wants and the same is true for keeping personal information private. MHPs undertake not to disclose personal information about patients without their consent, if they have capacity. On the other hand, if patients do not have capacity, MHPs have a duty to consult those who know the patient best and act in the patients' best interests until they have regained capacity. If MHPs feels that there is a strong argument for disclosing personal information to others, then they need to sit down with the patients and have that discussion, and take every minute of the time necessary to have the conversation. Indeed, they may need to have several such conversations. MHPs need to understand the basis for any refusal of disclosure because this refusal of consent to disclose may reflect fear, distress, shame or active mental illness.

However the conversation goes, it cannot be seen as a purely factual transaction. It is not clear that discussion of individual rights has much meaning in a place and context where the prisoner (and to some extent the MHP) is constrained and restrained, not only by the criminal law, the penal rules and the prison architecture, but by despair, fear, regret and distress. It, therefore, may be important to interpret those rights in a relational context that takes full account of everyone's vulnerabilities, hopes and neediness. The usual rights and duty-based analysis

may not be all that helpful when the ethical dilemma that is being addressed is one that profoundly affects a person's personal identity within an already constrained environment. Carol Gilligan argues that the ethical reasoning process is different when what is at stake affects the way one lives one's life or relates to others.⁵ When a prisoner consults a prison MHP about feeling suicidal or being bullied, he or she is not just asking what he or she should do, in ethical terms; he or she is also asking about how he or she can live his or her life with these sorts of choices. Bullying affects agency and suicide stops agency and identity altogether. Perhaps Isaiah Berlin's⁶ two accounts of liberty—freedom from interference and freedom to be one's authentic self—are pertinent in this context. MHPs working in prisons need to make time to think and talk with prisoners about their 'true' selves, and the sort of people they would like to be in the future. Not only would this be helpful to their rehabilitation,⁷ it may also help with complex and painful discussions about how to live with feelings of hopelessness and fear in the prison environment.

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