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ORIGINAL RESEARCH

Disclosure of Past Crimes: An Analysis of Mental Health Professionals' Attitudes Towards Breaching Confidentiality

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Abstract Ensuring confidentiality is the cornerstone of trust within the doctor–patient relationship. However, health care providers have an obligation to serve not only their patient's interests but also those of potential victims and society, resulting in circumstances where confidentiality must be breached. This article describes the attitudes of mental health professionals (MHPs) when patients disclose past crimes unknown to the justice system. Twenty-four MHPs working in Swiss prisons were interviewed. They shared their experiences concerning confidentiality practices and attitudes towards breaching confidentiality in prison. Qualitative analysis revealed that MHPs study different factors before deciding whether a past crime should be disclosed, including: (1) the type of therapy the prisoner-patient was seeking (i.e., whether it was court-ordered or voluntary), (2) the type of crime that is revealed (e.g., a serious crime, a crime of a similar nature to the original crime, or a minor crime), and (3) the danger posed by the prisoner-patient. Based on this study's findings, risk assessment of dangerousness was one of the most important factors determining disclosures of past crimes, taking into consideration both the type of therapy and the crime involved. Attitudes of MHPs varied with regard to confidentiality rules and when to breach confidentiality, and there was thus a lack of consensus as to when and whether past crimes should be reported. Hence, legal and ethical requirements concerning confidentiality breaches must be made clear and known to physicians in order to guide them with difficult cases.

Keywords Confidentiality · Disclosure · Prison · Forensic doctor · Past crimes

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Introduction

To ensure trust within the doctor–patient relationship, it is critical that information shared by the patient is guarded by confidentiality rules and that patient privacy is respected. In the prison context, it is recognized that medical secrecy towards detained persons should be observed according to the same legal provisions applicable to persons who are not detained (Swiss Criminal Code 2014; Council of Europe and Committee of Ministers 1998; United Nations 1982). This is the basis of the principle of equivalence of care in prison medicine—to ensure that prisoners are not disadvantaged due to their legal status (Birmingham, Wilson, and Adshead 2006; Elger 2008; Niveau 2007). However, the prison setting could add an additional complication to the doctor–patient relationship, as third parties such as prison officers and judicial authorities may be involved to some extent (Konrad 2010). Hence, there could be circumstances where health professionals must maintain

confidentiality towards their patients but at the same time may be forced to disclose information. Such situations place health professionals in the uncomfortable position of acting as "double agents," owing loyalties to both their patients and their employers (IACFP, Practice Standards Committee 2010; Pont, Stover, and Wolff 2012). Supporting the absoluteness of confidentiality, Kottow (1986) claims that any exception to confidentiality erodes the value of the concept, resulting in a lack of trust within the doctor–patient relationship. He highlights that any confidentiality breach violates the right to secrecy of the confider. This right to medical secrecy is important in ensuring that patients are able to freely disclose any information to their physician without the fear that doing so will result in negative consequences. Thus, avoiding potential harm to third persons cannot, in Kottow's opinion, be weighed against the harm caused to the patient when confidentiality is breached. In addition, he argues, such unauthorised disclosures cause harm to the concept itself.

Safeguarding confidentiality is an important duty of the physician, but it is not absolute. According to medical guidelines (General Medical Council 2009; World Psychiatric Association 1996), health care providers both outside and inside prisons have an obligation to serve not only the interests of their patients, but also the interests of potential victims. It is thus widely accepted that confidentiality may or should be breached when harm to patients themselves or third parties is evident (Bonner and Vandecreek 2006; Konrad 2010; Pinta 2009). Additionally, in many jurisdictions laws define situations where denouncing is obligatory, typically in the case of child abuse, elder abuse, communicable diseases, or gunshot wounds (General Medical Council 2009; Rodriguez et al. 2006). However, in situations where disclosures are not obligatory and where interests of the patient collide with that of others, the health care provider must decide whether it is legally or ethically justifiable to breach confidentiality. Such judgements to breach or not to breach medical secrecy depend on various factors and attitudes of the health care provider (Bruggen et al. 2013; Elger 2009a). It is generally known that any breaches of confidentiality must occur with the consent of the patient, unless, as stated above, it is mandated by law or in the interest of the public (General Medical Council 2009).

Although a few medical guidelines delineate when and how confidentiality breaches should occur, in many cases it may not be clear for the health care provider what his or her course of action should be, since two or more ethical principles (e.g., non-maleficence and beneficence) might be in conflict with one another. In these circumstances, it is up to the health care provider to decide which principle should be given priority based on the particularities of each clinical case. Therefore, in many situations, it remains difficult to know in advance whether a decision is legally correct as well as ethically justifiable or not. If the particular case is challenged in the courts, the final decision will be made by judges or juries according to the jurisdiction (Appelbaum 2002; Appelbaum and Meisel 1986) and health care providers must have sound arguments to justify their actions.

The question of how health care professionals should react to circumstances where they must breach the confidential doctor–patient relationship has been troubling for generations of mental health providers (MHPs). The most prominent example of such a challenge is the 1976 *Tarasoff* case in the United States,[1] which called for a duty to protect identifiable potential victims by notifying the police and warning the party under foreseeable threat (Anfang and Appelbaum 1996; Appelbaum 1985; Melamed et al. 2011). However, the *Tarasoff* duty may not be so straightforward, as was illustrated by a case from Israel in which an MHP informed the police that his patient threatened to kill his father (Margolin and Mester 2007). The court's decision acquitted the patient and stated that the physician reacted too quickly without ensuring whether the patient presented a firm intention to act upon his threat and without adequately evaluating whether the risk to the third party was concrete.

Cases such as *Tarasoff* and its successors point to the heart of the problem faced by MHPs: What should physicians do if their patient discloses a desire to harm someone else, violate institutional rules, or take part in other "illegal" activities? Stated earlier, an obligation to warn exists on the part of MHPs (Felthous 2006; Melamed et al. 2011; Pinta 2009), but detailed guidelines regarding recommended actions in a range of specific situations remain unavailable. It may be impossible to develop a list of situations that could arise during the therapeutic relationship with a prisoner-patient, thus making recommendations, whether standard or customizable, also difficult. Despite a lack of guidelines, MHPs are nevertheless expected to make judgement calls and take appropriate action when faced with unknown

[1] *Tarasoff v. Regents of the University of California* (1976) 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14.

situations. The deficiency of clear ethical and legal guidelines and consensus as to how MHPs should act in cases of third-party danger or how to appropriately balance their duties towards their patients remains problematic. In this study, we address the example of how MHPs should act if prisoners seeking care mention past crimes for which they were never held responsible.

From available literature on physicians' attitudes towards confidentiality, we know that MHPs are often uncertain as to how strictly confidentiality should be respected, under what circumstances they could, should, or would breach confidentiality, and how such breaches are justified (Schutte 1995). This lack of understanding of confidentiality obligations has been found amongst medical and law students (Elger and Harding 2005) and can continue well into professionals' practice. Varying factors have been reported to affect physicians' attitudes towards confidentiality breaches, including ethics education, years of experience, and gender (Elger 2009a). Furthermore, upon studying professionals' attitudes towards confidentiality using case vignettes, Brueggen and colleagues (2013) found that professionals' attitudes differed based on the cases. They also found that medical professionals had a greater threshold for breaching confidentiality than legal professionals in the forensic setting, with legal professionals agreeing to disclosure of information more frequently. This suggests that, if we want to better understand the issue of disclosure of confidential information within the prison setting, this should be done from the viewpoint(s) of MHPs working within this particular context. This is particularly important given the various constraints and emergencies that occur in the prison environment and render it even more difficult for MHPs to come to legally and ethically correct and unbiased decisions (Pinta 2009). Moreover, higher rates of mental health issues have been found among imprisoned persons (Eytan et al. 2011; Fazel and Baillargeon 2011; Wilper et al. 2009), thus making confidentiality within this population that much more important and complex.

To our knowledge, studies examining thresholds for confidentiality disclosures are lacking in the prison setting. There are also no existing qualitative studies exploring MHPs attitudes towards disclosures of medical secrecy when a prisoner-patient informs them about past crimes or information that could harm a third party. To fill this gap in the literature, the overall goal of our exploratory qualitative study was to examine how MHPs in Swiss correctional settings make decisions concerning confidentiality breaches, perceive reasoning and difficulties associated with ensuring confidentiality or disclosing information, and understand the legal and ethical principles of confidentiality in general and in prison.

This article specifically highlights the attitudes of these MHPs when patients disclose information on past crimes. Examinations of how MHPs inform prisoner-patients about limits to confidentiality (Elger, Handtke, and Wangmo in press) and paternalistic breaches of confidentiality (Elger, Handtke, and Wangmo unpublished manuscript)—both important topics related to our overall project—are discussed elsewhere. Revelation of past crimes unknown to the justice system and for which the prisoner-patient has not been incriminated raises several questions: Why is this information being divulged now? What is its significance? Does this new information change the dangerousness or the situation of the prisoner-patient? Is there a possibility of harm to a third person? What could or should be done in relation to harms committed against third parties that exist not in the present or future but in the past? The attitudes of MHPs towards disclosing confidential information, as will be shown below, very much depend on how they process and respond to these questions.

Methods

For this study, 24 semi-structured face-to-face interviews took place between 2008 and 2009 with MHPs who work or have worked in correctional settings as forensic psychiatrists or psychologists. A purposive and convenience-based sampling method was employed to ensure the inclusion of experienced MHPs from a range of geographic regions, prisons, and forensic settings in order to achieve maximum variation of opinions and practices. Approval from the responsible ethic committee was obtained. Before contacting prospective participants, we first contacted the senior prison or forensic physician responsible for the canton to gain his or her consent and permission to approach MHPs working in prisons. Thereafter, with the aid of the Swiss Society of Prison Physicians, either all MHPs working in prisons or a selected sample of the most experienced MHPs were approached by phone or e-mail for an in-person interview. Oral consent was obtained before initiating and recording the interviews, which were conducted confidentially. The head physician was not informed

as to whether members of his or her team did or did not participate.

Of the 24 participants selected, 12 hailed from three cantons in the French linguistic region and 12 from six cantons in the German linguistic region of Switzerland. Recruitment based on the linguistic region is significant because MHPs belonging to the cantons of Geneva and Lausanne (i.e., the French linguistic region) are independent of both the justice system and the prison administration since they are employed as part of health care services attached to universities, whereas MHPs from most German-speaking cantons are directly employed by the justice system. Thus, regional differences were an important factor to consider during data analysis. Our participants, most of whom were men (n= 18), had anywhere from two to more than 10 years of experience working in prisons, and each reported performing a range of different tasks associated with the provision of mental health care. For instance, all currently work or have worked in mental health settings outside of prison and have been involved in providing regular as well as mandatory therapies inside prison. Almost all also reported providing expert opinions for legal cases as part of their job responsibilities.

An interview guide was developed that consisted of a number of open-ended questions about the practice of confidentiality and problems that MHPs have experienced, as well as hypothetical cases describing moral dilemmas concerning confidentiality. The hypothetical case relevant for this paper refers to a prisoner-patient who admits to having committed a crime in the past for which he has not been charged or punished. After each participant responded to this initial scenario, the vignette was then further clarified to suggest that an innocent person instead was wrongly incarcerated and convicted for this crime. Participants were asked what they thought was the appropriate action to take after the original confession and upon learning the additional information. Follow-up questions were posed as necessary to clarify responses. Interviews took place in either French or German, based on the preferences of the interviewee, and lasted between 40 and 90 minutes. All identifying information such as participant name, workplace, and reference to particular cantons were coded to ensure anonymity. All 24 interviews were recorded and transcribed.

Transcribed data were read several times and then analysed using qualitative analysis where main themes were identified from participants' words, phrases, and examples (Bryman and Burgess 1994; Corbin and Strauss 2008; Strauss and Corbin 1998). In addition, patterns among the strategies proposed by the interviewees to solve the case as well as arguments used to defend these strategies were identified (Silverman 1993). Data analysis was discussed among the authors, and differences in coding and interpretation were discussed to reach agreement. All quotes were translated from German or French into English and double-checked by a third person fluent in these languages. Participants' voices are highlighted in the presentation of the study results in order to ground the findings as close to the data as possible. In order to ensure anonymity, participants are represented using only a letter identifier and the linguistic region (German or French).

Findings

The reactions of MHPs who participated in this study to newly acquired information of past crimes committed by prisoner-patients and attitudes towards whether, when, and how to disclose past crimes are presented below. MHPs considered different factors before deciding whether or not the past crime should be disclosed. These included (a) type of therapy (court-ordered or voluntary), (b) type of crime (serious or not), and (c) evaluation of the danger posed by the patient.

Disclosure Based on Type of Therapy

The first reaction of many participants was to distinguish between the type of therapy the patient was receiving, that is, whether it was voluntary therapy or court-ordered therapy. This distinction was important because, for court-ordered therapy, the patient is informed about written reports sent once or twice per year to the responsible authorities delineating the patient's progress, where all relevant information discussed during the therapy is included—i.e., the patient is informed at the beginning of the therapy about the limits to confidentiality (Elger, Handtke, and Wangmo in press). Thus, for court-ordered therapies, many participants referred to the direct legal obligation of disclosing past crimes. However, there was ambiguity whether prior crimes should be disclosed in all cases. When the patient was seeking voluntary therapy, participants indicated that information about a past crime would only be disclosed if there was the chance of it happening again.

It is clear from participants' responses that the harm–benefit analysis for such a disclosure varies depending on the type of therapy. This decision-making process is revealed succinctly by one MHP (A) from the German linguistic region:

> If it is a patient who is not in court-ordered therapy, I would by no means pass on the information, unless the circumstances of that serious offense in the past would suggest that the same could happen again. … With patients who are in court-ordered therapy, I would report it [only] if that offense in the past was related to the current offense. If it is an old offense, any sin of his youth, which has nothing to do with the current offense and will not affect the future, I would not report it. I would evaluate each case individually.

This differentiation of therapy type was later compounded with the type of crimes disclosed. Participants' opinions varied concerning the types of crimes that should be disclosed and suggested that the way in which it should be mentioned in the reports was dictated by the type of therapy the patient was under. Most agreed that past crimes should be reported in detail if the crime changed the evaluation of future dangerousness. (The evaluation of future dangerousness was a recurring theme that will be discussed in more detail below.) As participant B from the German linguistic region explained:

> If it is a serious crime that is related to the past, and if it is a voluntary therapy, it is something that I will keep an eye on during the therapy. Now, one has to see the nature of the past crime. For example, if he tells me that he raped 20 women, the probability he will rape more is so high that the situation is different. Moreover, I would ask myself: "Is there an immediate risk for the future?" … If there is a strong risk, one should think about disclosing this information by requesting to be released from confidentiality rules [Swiss law provides for cantonal bodies where physicians may make a confidential request to obtain release]. If it is someone in a court-ordered therapy, then the question is a bit more difficult: Is this something that goes into the report or not, do you remain vague by saying this person has admitted to having committed other crimes in the past, will you concretely name the things? … [T]here is no clear guideline for this.

Disclosure Based on Type of Crime

Serious Crimes

Even for serious past crimes, the question of when to disclose such information was not perceived to be easy and participants' opinions varied. On the one hand, there were some who did not know what should be done, while, on the other, some were quite certain that serious crimes should be reported with or without patient consent, since there is an ethical and a legal obligation to do so. For example, one MHP, C from the French linguistic region, indicated he would not disclose the past crime if it does not affect dangerousness. His opinion is shared by many others concerning crimes related to using or dealing with illicit drugs:

> I think of someone who is accused of breaking the law on drugs and who tells me, "You know, basically, I already did something like that two years ago." Honestly, I do not care at all. Of course, this is a serious offense, but it has absolutely nothing to do with the medical care, nor with an immediate dangerousness. So, in this case, I will clearly not go ahead, I will talk about it within the team and all that, but I would not worry that much.

Participants' uncertainty about disclosing the information was also due to the absence of reporting laws for certain types of crimes. For example, D, a participant from the German linguistic region, remarked that there are reporting requirements for certain cases, but not for murder: "In the case of epidemics … different diseases must be reported. But for crimes, there is no rule. I had thought that homicide had to be reported, but it is not the case." Another MHP, E, also from the same region, stated:

> I would get advice from my colleagues, if you are legally obligated to report someone who says that he has committed a murder. I would discuss this and also talk with the cantonal physician [i.e., the cantonal body where according to Swiss law physicians may make a confidential request to obtain release], it is not that they have to know which patient it is about.

Where participants were certain that serious crimes ought to be reported, they stated they would tell patients that they are obligated to do so even if the patient refuses

to do so himself or does not consent to it. They also would seek authorisation to be relieved from confidentiality, as explained by participant F from the French linguistic region: "If he refuses to confess then I guess I would stop the therapy but I would not necessarily report him. … Or, if I think it is serious, I write to the cantonal physician and I ask him for the authorisation."

Similarly, other participants said they would justify disclosure without patient consent for serious crimes if it was likely that similar crimes would be committed again or there is the possibility of harming third persons:

> After analysing the situation and concluding that this man was not dangerous, we decided that there was no reason to ask for the release from professional secrecy. … We would have done so if we had the impression that this man still had a combined sadistic paedophilic pathology that posed a significant risk of recidivism (Participant G from the German linguistic region).

If it was likely that serious crimes would not result in the immediate endangerment of third parties, then there was agreement amongst participants that MHPs would not breach confidentiality.

> Past crimes, that are not relevant for what I am concerned with in the therapy, I do not report. … It is something completely different, if it is a serious crime that is to be expected, that he announces. There, I handle things differently. But if it is a past serious crime, that was never solved and I come in as a clinician and he tells me this and it does not result in any immediate endangerment of third parties that would justify breaching confidentiality, then I say nothing (Participant H from the German linguistic region).

Several respondents mentioned child abuse as a particular case because, while federal law stipulates a right but not a duty on physicians to report child abuse, in some regions cantonal law imposes a duty to report this crime. Thus, in these cantons, when the unknown crime relates to child abuse, there is an obligation to report. This is succinctly phrased by one MHP, Participant I from the French linguistic region: "The law of the canton actually obligates us to report all [cases of] child abuse."

A few participants also stated spontaneously that they would disclose information without a patient's consent if the crime has resulted in harm to or the imprisonment of an innocent person. One MHP, K from the German linguistic region, underscored: "If I don't have to suppose that someone else [is] sitting innocently behind bars because of it [the crime revealed by the patient], then I don't report it." Another participant, L from the same region, similarly voiced his opinion as such: "But for me personally, I wouldn't hesitate too much. It would be unbearable to keep something like that."

Other Crimes

Crimes of a similar nature—those that are similar to the original crime—and minor crimes are grouped as "other crimes." Participating MHPs disagreed on reporting less severe crimes or crimes of a similar nature for which a detainee was already in prison. In the case of crimes of a similar nature, many stated that they would only mention that a detainee showed progress because he talked about his weaknesses that could lead to understanding his prior actions. One MHP, M from the German linguistic region, used the example of child abuse to explain:

> I inform the client in advance. Suppose I am treating a patient for child sexual abuse, and he eventually tells me that he killed someone, I would strongly advise him to report himself. If he does not want to do that, I would ask my colleagues as to how I should deal with the case. But if he told me that he has abused a child three years ago, we would globally make a note of it as a dark figure of crime [that the client discussed his past crime].

One therapist—highly valuing confidentiality to ensure good therapeutic benefit for the patient—revealed that he would be against any disclosure. He stated he would even keep additional homicides to himself in a patient already convicted for homicide, because he judged the confidentiality in this case to take precedence over solving the crimes for the benefit of therapeutic progress:

> I had a mistrustful patient, paranoiac, in jail since several years, particularly dangerous, that I worked with therapeutically, whom I clearly told that he was in a privileged relationship of total confidentiality, who confessed four more murders to me, that I could never talk about in a substantial

> way with details. It was important for him to talk about it, it was important for his [therapeutic] process. And it does not change anything about whether he stays in prison or not. That depended upon other considerations, if he represented an additional danger if he was released. Else [without this strict confidentiality on my side] he would have never talked to me about it (Participant P from the French linguistic region).

For minor crimes, some participants said they would try to motivate the patient to report him- or herself, if they have the impression that this would help the patient cope with it or be of any other benefit to the patient or others. Minor crimes would bother them less and in uncertain cases, they would ask their medical superiors for advice.

> It is delicate because it depends on what it is about. If there were thefts, offenses that did not touch on another person's integrity, that would bother me less than if [the patient] hit or killed somebody. … If it refers to physical suffering, I would ask myself the question, I would ask [my superiors] if I need to do something (Participant N from the French linguistic region).

MHPs were unsure as to when they should report the patient (when a patient refuses to consent to disclosure), but if they found that their patient was trivialising their past crimes, they were more likely to disclose the past crime.

> I am not sure that I would report him. If he is absolutely not dangerous at the moment, if it is just about his past and if I realise that this person has learned something, that he has rebuilt his life and that, despite his crime, he has moved on, I do not see why his whole life should be destroyed. On the contrary, if it is a person that finds it completely normal and trivialises it, maybe there I would have more of a tendency to wanting to report it. It depends on the person and what he made from it, from his crime (Participant O from the French linguistic region).

Risk Evaluation

For participants who said that they would report past crimes, the key point was whether those crimes change the future dangerousness of the patient. For instance, when revealed crimes have no effect on the evaluation of current levels of dangerousness, confidentiality is kept. One participant, H from the German linguistic region, emphasised this as follows: "If it is a serious offense from the past, that was never solved … and it does not result in any immediate endangerment of third parties that would justify me to breach confidentiality, then I would say nothing." Another participant, Q from the same region, stated:

> It is not about initiating a prosecution, but about danger for the future. It may be that someone has committed a serious crime, but everything related to the risk is already known. If it does not have extra value, it does not matter. In therapy, I would even say that he has disclosed his dark figure of crime [discussed this past crime], which is something positive. … But if I see that because of the serious crime, there is a risk of homicides that I was unaware of before, I must naturally take it into account [for the risk assessment].

Inversely, if upon risk assessment it is determined that the past crime changes the patient's dangerousness, then information about the past crime is reported.

> The question is what that means for the current risk assessment. Is it relevant? Is it nothing new or do I need to make a new risk assessment? Everything that is relevant to the risk must be properly mapped (Participant Q from the German linguistic region).

And when asked the question—"If the crime that was confessed by the detainee influences the evaluation of danger, in this case, do you reveal it?—another participant, P from the French linguistic region, emphasised: "Of course. That's the paramount principle. One must not play any role in increasing the person's dangerousness."

It was also recognized by MHPs that risk assessment is not an easy task. Thus, the mapping of a patient's risk may at times require the assistance of third persons, so that an unbiased opinion can be obtained as to whether the reporting should or should not be done.

> It needs more than a suspicion and you have to keep your patient's interest in mind, but you are by all means obliged to thoroughly evaluate the degree of dangerousness that a patient represents.

> And if you doubt your capacity to have a realistic perception of this dangerousness, which is difficult for a therapist, you need to talk about it with someone. It is always the same principle. And if this person said that you do not need to worry about it or, on the contrary, said, "I also have a concern," from this moment on it is out of your reach (Participant P from the French linguistic region).

Seek Advice From Colleagues and Superiors

In addition to requesting support for the evaluation of dangerousness, MHPs also seek advice from peers and superiors with regard to whether or not they should disclose information about past crimes. This was primarily applicable in cases where MHPs were uncertain as to how they should solve a dilemma regarding disclosure of previously unknown information. For example, MHPs from both language regions of Switzerland stated they would refer to legal experts, colleagues, and the cantonal medical officer or responsible person at the state level. Advice would be sought regarding how to proceed in the face of difficult situations. An MHP, C from the French linguistic region, stated: "I would need to talk about it with the team and my superior because it is extremely delicate." The same participant also said that "[m]y answer is that I would not keep this to myself, I submit the case to the cantonal physician and if he authorises me to disclose it, I do it." Finally, participant R from the same region explained that such information about past crimes is disclosed by patients because they want to talk about it and it is an indirect way of them seeking help:

> Even if the danger is averted, from a therapeutic perspective it is not by accident that the person tells us about it. If he talks to me about it then it is because it burdens him. Now, what do I do with that? I cannot be held hostage by this information. The action to be taken is therefore clear to me, to me and to us here. And I would tell him that I submit the question to the cantonal doctor … and then what will happen next will depend on the decision of the cantonal physician (Participant R from the French linguistic region).

Also evident in the above quote is the uneasiness MHPs feel when they must refrain from disclosing a patient's past crimes. Knowledge of the crime makes them feel hostage to the information.

Encouraging Patients to Disclose

As stated earlier, when minor crimes are discussed and when the crime does not change future dangerousness, participants would ask patients to report the crime themselves because this would be advantageous to them, as it may reduce punishment in most cases. Making the unknown crime known was deemed important by the MHPs in order to protect the victims. This was particularly true from the interviews conducted in the German linguistic region. However, there were MHPs from both regions who stated that they would maintain confidentiality if patients refuse to report themselves. As one MHP, S from the French linguistic region, stated: "In this case, we would certainly try to make the patient report himself. … In case he refuses, I would possibly stop the treatment, but I would not necessarily denounce him." Another participant, T from the German linguistic region, echoed this sentiment: "I would advise the patient to turn himself in and apart from that let the matter rest, if it is clear that no consecutive crime will result from it."

In cases where patients are hesitant about reporting themselves, many participants indicated they would continue the therapy and seek to gain the patient's confidence, within the therapeutic encounter and using therapeutic means, so that they can convince the person to report. For example, Participant U from the German linguistic region reported that he would discuss the situation with his patient and seek to motivate him: "The first thing I would do in this situation is to discuss it with the patient. I would try to motivate him to report himself."

Discussion

Limitations of the study design include a social desirability effect that is common to qualitative investigations and may be a concern here as we investigated a sensitive topic. Additionally, because this is a qualitative study of a small sample of participants working in correctional institutions in Switzerland, the findings are not generalizable to all professionals working in this setting or to other countries, due to differences in health care and penal systems and varying levels of physicians'

experiences. As a qualitative interview-based study, we sought to understand the attitudes of MHPs and their course of action when a prisoner-patient discloses a past crime. This should not be confused with assessment of attitude, which would require a different study design and study goal. Although we cannot claim to predict future behaviour, we asked participants to report their approaches to cases they had faced in the past. We thus have good reason to believe that the attitudes they reported are close to reality and not only theories about how they think they should react. The above limitations notwithstanding, the responses of our participants were open and diverse enough to identify key points for ethical reflection and to gain a comprehensive overview of confidentiality breaches in the revelation of past crimes in correctional settings, particularly in Switzerland. While the findings are unique to Switzerland, they contribute to a better understanding of similar incidences and how MHPs respond in the forensic setting in different countries.

From the study results, we conclude that most participants would make their decision to disclose and thus breach confidentiality depending on whether the patient might commit further crimes in the future, that is, whether the patient poses a danger to a third person or persons. Such situations could be seen as being similar to *Tarasoff* and *Tarasoff*-like cases, where future danger to an identifiable victim is evident (Melamed et al. 2011; Mills, Sullivan, and Eth 1987; Pinta 2010). Conversely, if therapists consider that the risk of recidivism for the original crime is low and has not been altered by the additionally confessed crime, confidentiality is given more importance than the disclosure of past crimes. Such decisions by the therapist are based purely on their individual attitudes and their judgement of the patient. This finding is consistent with other studies that also have found professionals' attitudes towards confidentiality disclosures to be case dependent and subjectively determined (Bruggen et al. 2013). Also, decisions to disclose past crimes could be influenced by existing cantonal laws. One Swiss canton's laws[2] on confidentiality disclosures is particularly interesting because it provides a list of crimes that a physician may report (e.g., murder, physical harm, danger to life, robbery, human trafficking, kidnapping, extortion, sexual abuse, spread of communicable diseases). The existence of this law clearly shows that this canton is making it somewhat easier for physicians to reveal past crimes or at least provides general authorisation to breach confidentiality.

After analysing participants' perceptions on disclosure of past crimes, risk assessment of dangerousness was one of the most important factors undergirding disclosures, taking into consideration both the type of therapy the patient was receiving and the type of crime involved. This is an important finding, as therapists must assess the risks posed to and by a patient in order to be certain that they are making the right decision regarding a disclosure. In the inverted *Tarasoff* case from Israel, it was concluded that the therapist made a poor risk assessment by calling upon his *Tarasoff*-like duties when not applicable (Margolin and Mester 2007). Additionally, our finding is important because, despite cantonal differences in the organisation of prison health care, dangerousness was the driving factor and not particular cantonal or general prison rules regarding disclosures. For instance, in cantons where the prison health care is under the justice department (i.e., mostly the German linguistic region), one might expect MHPs to be less respectful of confidentiality than those who were completely independent of the justice department and/or the prison system (i.e., most parts of the French linguistic region). However, even physicians from those cantons where MHPs were deemed "less independent" reported not revealing past crimes systematically to the authorities but marking the confession of the detainee only as a correction of the dark figure.

An interesting finding relates to the feeling MHPs had of being held hostage by the revealed information, which might consequently "force" them to disclose the past crime. Although this perception was not prevalent amongst many participants, it nevertheless deserves further consideration and exploration. In this situation, the decision of the therapist to disclose information because he or she is uneasy with the gained knowledge raises questions regarding whose interests are prioritized. Is it professionally acceptable for therapists to forgo confidentiality rules when they feel uncomfortable with the new information? It is understandable that therapists may also feel the need to unload such information in order to be able to continue their professional duties. This could either be accomplished through seeking therapy themselves or consulting with their colleagues about their possible course of action.

A few participants stated that they would stop therapy when patients refuse to report themselves or do not provide consent for the MHP to do so. That the therapists

[2] Gesundheitsgesetz Basel Stadt (GesG). 2012. V. 6 Schweigepflicht § 27 Ausnahmen, Absatz 3. Switzerland.

would rather stop therapy than breach confidentiality is a peculiar situation and also warrants further investigation as to why confidentiality is held as a higher good than continuation of therapy. The fact that participants would report their patients if they trivialise their crimes also presents another concern of moral judgement. Is not showing remorse a morally sufficient reason to disclose, while ceasing therapy in response to a refusal to self-report a reasonable distinction? This attitude of a therapist towards trivialization of crime on the part of the prisoner-patient is noteworthy because the nature of the crime has not changed, while the attitude of the patient towards the crime somehow alters the actions that MHPs would undertake. Such physician attitude may result in disclosure of confidentiality even when not necessary to protect third parties. This certainly raises questions regarding physicians' legal and ethical obligations towards medical secrecy and beneficence of the patient. At the same time, MHPs seem to consider prisoners' own perceptions of their crimes to be an essential indication of whether the patient is actively engaging in therapy. An assessment that the patient is refractory to therapy on the basis of his or her attitude to past crimes may explain an MHP's judgement that discontinuation of therapy would be "normal" or acceptable.

An overarching concern that the study results reflect is the lack of consensus as to when and whether past crimes should be reported. This question underscores the dilemma faced by MHPs who may feel obligated to disclose such information if someone is in danger or when someone else is imprisoned for this crime. Here, as reported by the participants, seeking advice from superiors, lawyers, and colleagues may be a good option. It is not surprising, of course, that the attitudes of the MHPs in this study varied; as other research has shown, attitudes of physicians with regard to confidentiality rules, when to breach confidentiality, and their duties to maintain confidentiality differ (Bruggen et al. 2013; Elger 2009a, 2009b, 2005; Melamed et al. 2011). Two possible interventions that could help MHPs become more cognizant about confidentiality, its exceptions, and when and how they should act if faced with certain circumstances include greater and improved educational training and the development and availability of clear guidelines on this issue. If guidelines and educational training concerning confidentiality are put into place, the result could be more predictable outcomes on the part of therapists.

MHPs in correctional settings (as well as those in the community) can appropriately deal with difficult cases if the legal and ethical requirements concerning confidentiality are clear and known to them. Dilemmas associated with when to disclose past crimes could be resolved if existing guidelines better explained which types of crimes are protected by confidentiality rules and which are not. Furthermore, an indication of key factors related to the underlying ethical reasoning relating to disclosure of past crimes would also help MHPs in their judgements.

Our study findings presented risk assessment of dangerousness as an important guiding tool to determine whether confidentiality should be breached. However, such assessment is not straightforward and empirical evidence is needed as to how these assessments should be done and by whom and how results should be interpreted to ensure uniform application. We also saw hesitation of MHPs to disclose past crimes but a willingness to stop therapy. Such attitudes of MHPs could be due to unclear guidelines. This finding also poses questions in relation to what it is about the crime (and/or the patient or confidentiality itself) that makes MHPs uncomfortable breaching confidentiality but "justifies" an MHP to cease the therapeutic relationship with the patient. If guidelines were clear, MHPs may be more confident in their course of action and may be able to continue their therapeutic relationship with a patient, which is of utmost importance in light of their deontological duty of care. In addition, MHPs must have the opportunity to provide relevant details from their own experience, of which legal and ethical scholars may not be aware, to the tailoring of existing guidelines and the development of new laws and clinical tools. Given that such rules and regulations are often binding on MHPs, it is important that they reflect the realities of their practice.

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