Families and friends play a vital role in the care and support of people with serious mental illness. However, caregivers often complain that treating teams do not adequately inform them of their loved one’s condition and management plan. Failure or refusal to disclose such information can be very distressing for those offering support and, in circumstances where people with mental illness behave in threatening, violent or self-destructive ways, it can have serious repercussions.1

Health care professionals owe a duty of confidentiality to their patients. As a general rule, clinicians should seek a patient’s permission before disclosing information to others. This obligation is enforced in law. If health care professionals ignore this obligation, they risk civil liability for breach of confidentiality or statutory provisions that protect privacy, or a finding of professional misconduct by a professional standards tribunal.2

Generally, if a patient is able to understand the nature and effect of a disclosure of information and refuses to agree to that disclosure, it would be both unlawful and unethical to make the disclosure simply because the professional feels it to be the better course. On the other hand, the right to confidentiality and privacy is not without its limits, and it is widely accepted that confidentiality can be breached if a higher obligation is involved, such as a serious threat to the health and safety of the person or others.

Although it occurred in the United States and is not binding in Australia, the Tarasoff case is often cited as an example of a situation in which there is an identifiable risk of harm to others.3 In October 1969, Prosenjit Poddar stabbed and killed Tatiana Tarasoff. Poddar had previously told a clinical psychologist that he was going to kill an unnamed woman, who was readily identifiable as Tarasoff. The psychologist failed to warn the Tarasoff family, and a California court found him negligent. In the United Kingdom, a court held that a psychiatrist who sent a report, commissioned by a patient’s legal counsel, to the medical director of a secure hospital cautioning against the patient’s early release was held that a psychiatrist who sent a report, commissioned by a patient’s legal counsel, to the medical director of a secure hospital warning of a risk of harm to others was negligent.4

In addition, some, but not all, mental health Acts in Australia specifically allow disclosure of less vital information (usually about treatment decisions) to specified people such as close relatives, friends or other people nominated by the patient.5 In some circumstances, mental health Acts impose a duty on the clinician to impart specific information, such as involuntary admission of a person, to the person’s family or supporters.7

Mental illness might affect a person’s capacity to make decisions about information disclosure. A patient experiencing persecutory delusions about his or her parents may refuse to agree to a clinician discussing personal information with them for that reason. If a patient lacks the capacity to make the refusal, and disclosure is necessary in the best interests of the patient, then the disclosure can be made if it is necessary to discharge the clinician’s duty of care to the patient.2

When a patient with mental illness refuses to consent to disclosure of information to a close family member or supporter, the clinician should first discuss the issue with the patient. This allows the patient to reconsider consenting to disclosure if his or her concerns can be dealt with. It may be that the refusal is directly linked to features of the person’s mental illness and that these are impairing his or her capacity to consent to the disclosure. On the other hand, the person may have good reasons for wanting to maintain privacy, though even in these circumstances it may be possible to negotiate with the patient for some agreed limited disclosure.

It is important to remember that as long as doctors do not disclose confidential information, they are still permitted to see a patient’s family members and friends to listen to their concerns about the person and learn about the person’s history. Simply receiving information does not breach confidentiality.

In most cases, legal obligations around confidentiality and privacy are not valid reasons for clinicians failing to communicate effectively with families and supporters. Most patients will understand and agree to clinicians communicating with their close family or friends if the reason for the communication is carefully explained. Even in those rare cases where a doctor must keep matters confidential, family members will usually be satisfied by having an opportunity to be heard, and most will respect their relative’s right to privacy. On rare occasions when it is necessary to disclose information to protect the patient or other people from harm, this will be permitted without the consent of the patient — either because the patient does not have capacity to consent to the disclosure or because the law permits disclosure in these circumstances.

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Provenance: Commissioned; externally peer reviewed.

1 Tarasoff v Regents of the University of California 551 P2d 334 (Cal 1976).
3 W v Edgel (1990) 1 All ER 835.
4 Mental Health Act 2009 (SA) s 106(2)(e).
5 Mental Health and Related Services Act 1998 (NT) s 91(2)(h).
6 Mental Health Act 1986 (Vic) s 120A(3)(ca).
7 Mental Health Act 2007 (NSW) ss 75, 78.