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A qualitative investigation of nurses' knowledge and practice gaps, regarding confidentiality and risk-actuated public interest disclosure-related decision-making

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There is a legal duty of confidentiality on the part of nurses working in mental health care. Nonetheless, it may be necessary to release some information if a patient is assessed as posing a potential credible risk, to protect the patient or others from harm. However, contemporary research literature reveals gaps in nurses' knowledge and practice, with respect to sharing patients' confidential information. The aim of this study was to understand potential causal factors for these knowledge and practice gaps, so they can be addressed. A theoretical thematic analysis of focus-group data was undertaken. Findings indicated nurses had limited knowledge of confidentiality. Additionally, participants described a paucity of support networks nurses could approach for information. Participants also emphasised their perception that health services unrealistically expected them to always identify and manage patient risk. In summarising these findings, recommendations for interventions to address these knowledge and practice gaps are outlined.

Keywords: confidentiality; disclosure; mental health; nurse; nursing; psychiatry; public interest disclosure; risk assessment; risk management.

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Introduction

A common law duty of confidentiality arises for nurses working in mental health care, who receive personal information about a patient on the understanding it is not to be shared without the patient's consent. The duty also applies when information made known to a nurse is reasonably understood to be confidential (*Australian Broadcasting Corporation v Lenah Game Meats Pty Ltd*, 2001; Griffith, 2007). Obligations of confidentiality are also found in professional guidelines, regulation and legislation (*Health Records and Information Privacy Act* (HRIP), 2002; New South Wales (NSW) Health, 2015; Nursing and Midwifery Board of Australia (NMBA), 2018).

The rules of confidentiality share similarities from one jurisdiction to another, but local legislation and practices lead to differences in how confidential information is handled (Conlon et al., 2021). For example, the handling of confidential health information in NSW is governed by the HRIP and enumerated in the Health Privacy Principles (HPP, see Table 1) that accompany the Act (HRIP, 2002; NSW Health, 2015). This Act applies only to confidential health information in

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Table 1. Health privacy principles, to accompany the Health Records and Information Privacy Act 2002.

HPP	Indicator	Description
Collection		
1.	Lawful	Only collect health information for a lawful purpose that is directly related to the agency or organisation's activities and necessary for that purpose. You should not collect health information by any unlawful means.
2.	Relevant	Ensure health information is relevant, accurate, up to date, complete and not excessive, and that the collection does not unreasonably intrude into the personal affairs of the person to whom the information relates to.
3.	Direct	Only collect health information from the person concerned, unless it is unreasonable or impracticable to do so.
4.	Open	Inform a person as to why you are collecting health information, what you will do with it, and who else may see it. Tell the person how they can view and correct their health information and any consequences that will occur if they decide not to provide their information to you. If you collect health information about a person from a third party you must still take reasonable steps to notify the person that this has occurred
Storage		
5.	Secure	Ensure the health information is stored securely, not kept any longer than necessary, and disposed of appropriately. Health information should be protected from unauthorised access, use or disclosure. (Note: private sector organisations should also refer to section 25 of the HRIP Act for further provisions relating to retention).
Access and accuracy		
6.	Transparent	Explain to the person what health information is being stored, the reasons it is being used and any rights they have to access it.
7.	Accessible	Allow a person to access their health information without unreasonable delay or expense. (Note: private sector organisations should also refer to sections 26–32 of the HRIP Act for further provisions relating to access).
8.	Correct	Allow a person to update, correct or amend their personal information where necessary. (Note: private sector organisations should also refer to sections 33–37 of the HRIP Act for further provisions relating to amendment).
9.	Accurate	Ensure that the health information is relevant, up to date, accurate, complete, and not misleading before using it.
USE		
10.	Limited	Only use health information for the purpose for which it was collected or for a directly related purpose, which a person would expect. Otherwise, you would generally need their consent to use the health information for a secondary purpose, unless one the exceptions in HPP 10 applies (e.g. emergencies, threat to health or welfare, research or training etc).
Disclosure		
11.	Limited	Only disclose health information for the purpose for which it was collected, or for a directly related purpose that a person would expect.

(*Continued*)

Table 1. (*Continued*).

HPP	Indicator	Description
		Otherwise, you would generally need their consent, unless one of the exceptions in HPP 11 applies (*e.g.* in some instances disclosure is allowed in the event of an emergency, serious threat to health or welfare, research or training etc).
Identifiers and anonymity		
12.	Not identified	Only identify people by using unique identifiers if it is reasonably necessary to carry out your functions efficiently.
13.	Anonymous	Give the person the option of receiving services from you anonymously, where this is lawful and practicable.
Transferrals and linkage		
14.	Controlled	Only transfer health information outside New South Wales in accordance with HPP 14.
15.	Authorised	Only use health records linkage systems if the person has expressly consented to this information being included (this includes disclosure of an identifier).

Note: Adapted from: Conlon et al. (2021); Information and Privacy commission NSW (2023). HPP = Health privacy principles.

NSW. Therefore, the present study is limited to that jurisdiction.

The term 'public interest' is not objectively defined in law or literature, because it may lead to compounding restrictions on the broad application of the concept to legal and other matters (Bezemek & Dumbrovský, 2021). Instead, public interest remains a common law concept that refers to anything that is in the overall interests of society (Conlon et al., 2021; *McKinnon v Secretary, Department of Treasury*, 2005). There is a public interest in confidentiality to ensure people are willing to share their information with clinicians, because certain personal health information has the potential to be embarrassing or carry negative social consequences for patients (Barloon & Hilliard, 2016). For example, relatives or friends may avoid a person labelled with a mental health condition because they believe them to be dangerous, or employers may discriminate against patients based on stigmatising attitudes regarding their mental health (Conlon et al., 2024b). Nonetheless, there are common law exceptions to confidentiality, whereby information can be disclosed: (a) with patient consent; (b) by law or judicial decree; or (c) where there is a predominant competing public interest to that of confidentiality, such as when a patient poses a risk of harm to self or others (Conlon et al., 2019). These are the only common law exceptions to confidentiality in jurisdictions where there is no legal duty to warn or protect, including the jurisdiction of the present study (Dolan, 2004; Mason et al., 2010; McSherry, 2008).

Background

Nurses face predicaments when confronted with a patient assessed as posing a potential credible risk of harm to self or others, because it may be necessary to release confidential information about the patient to prevent harm (Dolan, 2004). However, if patient consent is not provided, or a legal duty to disclose (such as those that arise when a child is at risk, or a person has a readily transmissible infection) does not apply, the nurse must balance the public interest in maintaining the patient's confidentiality against the public interest in disclosure to prevent harm (McHale, 2009)—a task that is not easy for nurses, because if information is released inappropriately, a patient's confidentiality may be breached, and the patient may be subject to a negative outcome. For example, a mistaken disclosure of mental health information to an employer who holds stigmatising attitudes about mental health conditions may put a patient's employment at risk. Conversely, should information be withheld inappropriately, a patient or others may come to harm (Dolan, 2004; Kämpf & McSherry, 2006). The potential harm that can be caused by (or to) patients or others can range from emotional or psychosocial injury to physical trauma or even death (Higgins et al., 2016; *NK v Northern Sydney Central Coast Area Health Service*, 2010). In either instance, patients may face reputational damage or other repercussions, stakeholders such as nurse employers may incur significant legal or financial penalties, and nurses can face professional or regulatory action (Conlon et al., 2021; Kämpf & McSherry, 2006). Additionally, releasing information may cause a patient to withhold personal information from nurses in the future, which is concerning if this information could be used to identify the patient poses a credible risk of harm (Conlon et al., 2023).

Despite the importance of nurses handling confidential patient information appropriately in risk-laden scenarios, recent empirical peer-reviewed research found risk-related confidentiality knowledge and practice deficits among nurses (Conlon et al., 2023, 2024a, 2024b).

Essentially, nurses appeared to understand risk-assessment processes. However, their knowledge of confidentiality was often incomplete or incorrect. Compounding matters, nurses had minimal understanding of risk-actuated public interest disclosure-related decision-making and-focused on dangerousness criteria, not dynamic risk, when managing risk.

Unfortunately, there is a paucity of research investigating this area of nurse practice to educate and guide nurses and improve their practice (Conlon et al., 2019). Therefore, the aim of this study was to explore potential causal factors for these knowledge and practice gaps, to lead interventions and inform future research to address these gaps.

Aim

To understand nurses' knowledge and practice gaps, regarding confidentiality and risk-actuated public interest disclosure-related decision-making in mental health care.

Method

Setting

This investigation was undertaken in NSW, Australia.

Ethics

This research forms part of a PhD at The University of Sydney, which was approved by the Human Research Ethics Committee (protocol number: 2019/564) of the University on the 13 August 2019 congruent with the National Statement on Ethical Conduct in Human Research published by the National Health and Medical Research Council (NHMRC) of the Australian Government (NHMRC, 2007).

Participants read and acknowledged they understood a participant information statement and were given the opportunity to ask questions at multiple junctures, before giving written informed consent to participate in the study.

Recruitment

Participants were recruited using advertising material shared via personal and professional nursing contacts. Invitations mailed to these contacts requesting dissemination of advertising material for the study among their networks or related forums. The first author was the contact person for expressions of interest in the study. Participant demographics were recorded for the study.

Table 2. Participant inclusion and exclusion criteria for study.

	Inclusion	Exclusion
Jurisdiction	NSW, Australia.	Not NSW, Australia.
Population	Registered nurses.	Not a registered nurse.
Context	Mental health settings.	Not mental health settings.
Exposure	Experience handling confidential patient information in the context of patient risk.	No experience handling confidential patient information in the context of patient risk.
Knowledge	Understood participant information statement.	Did not understand participant information statement.
Agreement	Gave written informed consent to participate in a focus group.	Did not give written informed consent to participate in a focus group.

Note: Adapted from Conlon et al., 2023.

Eligibility

Participants were required to meet all inclusion criteria to participate in the study (see Table 2).

Data collection

Contemporary research literature regarding risk-actuated confidentiality and disclosure decisions is generally derived from interviews of individual nurses (Conlon et al., 2023, 2024a, 2024b). However, nursing is a team-oriented profession (NMBA, 2016, 2018, 2020), and therefore a focus-group method was chosen for data collection, because a collaborative team-style environment may generate data that has not arisen in previous studies (Jayasekara, 2012). A focus-group guide comprising three vignettes pertaining to confidentiality and risk-actuated disclosures of patient information by nurses in mental health was piloted ($n = 2$) by the first author and reviewed and revised as necessary. The vignettes that were provided to participants during the focus groups comprised three real-world exemplars of scenarios that may arise in mental health nursing. Each vignette focused on previously recognised gaps in nurses' knowledge and practice regarding confidentiality and risk-actuated public interest disclosure-related decision-making identified during one-on-one interviews reported in contemporary nursing research literature (Conlon et al., 2023, 2024a, 2024b). Therefore, providing an opportunity for participants to provide information in a collaborative group setting may explain these gaps. The focus groups were undertaken by the first author in March and April 2023.

Time and availability considerations were of particular importance to this investigation, because participants were generally working full-time rotating rosters in multiple clinical contexts. Therefore, the following strategies were instigated to minimise inconvenience to participants: (a) An option was offered to attend focus groups via video-link; (b) Approximately 40 minutes was allocated to each group, because a sizable proportion of participants were only available during their allocated meal break during working hours. Consequently, groups ranged from 38 to 49 minutes (mean = 42 minutes). (c) Small group sizes are recommended for expert participants when exploring complex topics, because they can focus and expound on areas of interest to researchers (Jayasekara, 2012); groups were therefore capped at 3 participants, to give each participant ample time to discuss their perspectives within the 40-min window. Lastly, each focus group was recorded for transcription with all data anonymised prior to analysis. Data collection was terminated at four focus groups ($n = 4$) comprising a total of 12 participants ($n = 12$, see Table 3), when

Table 3. Demographic details of participants.

Participant	Gender	Experience	Qualification	Current practice area	Sector
1	F	13	Graduate certificate	Inpatient ward	Public
2	F	25	Masters	Community	Public
3	F	8	n/a	Outpatient clinic	Public
4	M	12	PhD	Education	Public–Private
5	F	20	Masters	Emergency department	Public
6	F	3	n/a	Inpatient ward	Public
7	F	8	Masters	Emergency department	Public
8	M	30	PhD	Education	Public–Private
9	F	20	PhD	Education	Public–Private
10	F	20	n/a	Emergency department and community	Public
11	F	15	Masters	Community	Private
12	F	12	n/a	Inpatient ward	Public

Note: Gender = nominated gender (genders nominated by participants were cisgender M = male and F = female; no other genders were nominated by participants). Experience = approximate years of experience in mental health. Qualification = highest post-graduate qualification in mental health (n/a indicates no post-graduate qualification specialising in mental health).

data coding and theme development indicated that sufficient rich data had been collected (Braun & Clarke, 2021).

Data analysis

Theoretical thematic analysis commences with a previously established framework or theoretical schema and takes a deductive strategy to coding of data. The previously established framework used for data analysis in the present study was the rules of confidentiality and disclosure (reflected in the HPP) in the context of patient risk for nurses in NSW (see Table 1) (HRIP, 2002; NSW Health, 2015). This analysis focused on knowledge and practice gaps of nurses found in contemporary research literature (Conlon et al., 2023, 2024a, 2024b). The six steps of the Braun and Clarke (2006) method led analysis of data by all authors: (a) Authors reviewed focus-group data until familiarity was achieved; (b) A systematic approach was then adopted for coding of these data, with an emphasis on ascertaining reasons for gaps noted in nurses' knowledge and practice. (c) Codes were then grouped into common themes. (d) Next, themes were revised and clarified. (e) Definitions and names for each theme were then agreed upon, relating to: limited knowledge among nurses; paucity of support networks; and unrealistic expectations of nurses. For example, when participants described a lack of mentors for nurses when handling confidential information in the context of patient risk, this was initially coded as 'limited experienced nurses to guide other nurses' and then grouped with correlated codes to form the theme 'paucity of support networks for nurses'. (f) Lastly, the final analysis was reported by the authors (Braun & Clarke, 2006).

Reflexivity

The identity and position of researchers is an element of qualitative research, with the experiences, attitudes and beliefs of researchers potentially influencing research processes. Therefore, it is critical that researchers understand, and report for end users, their identity and position in relation to the research and outline the steps they have taken to address these potential influences (Peddle, 2022).

For the focus groups, the first author was the convener and moderator, and a male PhD candidate, nurse academic, lawyer, and registered nurse, with experience working in mental health care with patients who may pose a risk to self or others. These qualities can shape the collection and analysis of participants' data (Olmos-Vega et al., 2023; Peddle, 2022). The second and third authors are experienced male mental health nurse practitioners, with extensive backgrounds in nurse-led research and clinical experience of patients at risk. Rigor and trustworthiness were supported by assessing the credibility, transferability, dependability, and confirmability of the study method and findings, particularly in relation to the research population (see Table 3) and the characteristics of the authors who are nurse researchers with experience working in mental health care (Lincoln & Guba, 1985).

To lessen the risk of potential influences on the study, a focus-group framework was developed, piloted, edited, and employed. Each group was audio-recorded and reviewed by all authors before transcription by the first author. Transcripts were then reviewed by all authors, with noted codes and themes discussed and agreed upon. The findings, discussion, and final draft of the study were led by the first author and subsequently reviewed and agreed upon by all authors. Lastly, the authors engaged in continued reflection throughout the research process, regarding their place relative to the research. This reflection was supported with a reflexive journal led and maintained by the first author.

Findings

Three themes emerged during analysis of focus-group data regarding potential causal factors for knowledge and practice gaps of nurses working in mental health care: (a) Participants outlined limited opportunities for nurses to acquire knowledge of confidentiality and mental health nursing, which impacted on their practice; (b) Participants described a paucity of support networks nurses could approach for information. (c) Participants emphasised the impact of unrealistic expectations of nurses regarding their risk-actuated public interest disclosure-related decision-making.

The letter P (for participant) and a dedicated participant number is appended to the quotes comprising the following themes. Participant numbers were randomly allocated when data were anonymised and do not correspond to any system used during data collection.

Theme 1: Limited opportunities to acquire knowledge

The first theme developed from focus-group data was limited opportunities for nurses to acquire knowledge of confidentiality and mental health nursing, which had a direct impact on the quality of their practice. Specifically, participants were concerned that there was a lack of education relating to confidentiality, and limited mental-health-related content, in the Australia general nursing degree. Participants cited the UK system (a dedicated mental health nursing degree) as a comparison:

> *You can get into mental health [nursing] with no qualifications except for your [Australian] undergraduate [general nursing degree]. [So], nurses are just totally following the biomedical framework and what doctors are saying. We need a lot more mental health literacy, especially for those who want to specialise. … I think we should go down the UK route, where you become a [dedicated] mental health nurse [who has undertaken a degree specifically in mental health nursing]. … Nurses are becoming more and more deskilled and [Australian university] curriculums taking out mental health subjects more and more.* (P.07)

Participants emphasised a belief that the general degree was too medically focused, to the detriment of instruction relevant to mental health care. Additionally, they noted that confidentiality was not sufficiently covered during the degree program.

> *The training [in Australia], for mental health [nurses] is not good. It's far too much medical model nurses here, and*

> *[they] don't feel proud to be mental health nurses. … [In the UK, students] train for four years as a mental health nurse. … I'm not saying it needs to be the same as that. But there has to be so much more than a two week [clinical] placement where you sit and you're not allowed to do anything. … I [also] don't think there's enough education at Uni for student nurses about confidentiality and privacy.* (P.10)

When questioned specifically about their exposure to education about their duty of confidentiality after completing their degree, participants reported that despite the importance of confidentiality in protecting stakeholders, there was also a lack of continuing professional development (CPD) to keep nurses updated and informed.

> *I think we don't get enough education around [confidentiality]. I know I was told, unless somebody is on our books currently or in our unit currently, you can't access the notes, but I think I was told that once. I don't think there's much follow-up with that, or reiteration.* (P.05)

Participants were also concerned that a lack of education in confidentiality meant that it was undervalued, and not a routine consideration during nurses' decision-making processes when planning patient care.

> *Yeah, I think it needs to be education, or even just talked about all the time. Something that just is part of the normal practice. To talk about the risks, and the confidentiality of each [patient] that you have is very important. So, even just starting from the basics of 'this is just going to be part of our routine and our practice to make a change' is needed.* (P.11)

Participants felt that the best way to address nurses' knowledge gaps was through the provision of education and guidance.

> *[Ongoing] education, on the legalities of medical records, confidentiality, privacy [is required]. Why … you can't look at your own notes, you can't look at your family's notes. And if the patient has gone, there should be no reason for you to have access [to their records].* (P.10)

However, irrespective of the lack of education and CPD, participants believed nurses also needed to take personal responsibility for their professional practice and registration requirements, which included addressing deficiencies in their knowledge of confidentiality and associated practice gaps.

> *Ownership, ultimately our registration to practice is bounded to us. So, we are responsible for how we maintain our own registrations as nurses. Now, that's determined by so many factors, and one of them is having a good solid knowledge of what you should do, what you can flexibly negotiate, and what you should not do.* (P.01)

One notable concern raised by participants was the form in which education was provided to nurses, which led to it becoming a tick-box surface-level endeavour that required little or no application of new or existing skills and knowledge.

> *There's mandatory training [but] they're all on the computer, and you don't even have to do them. You just click through the pages, and it shows that you've done it. I think we need to take ourselves more seriously as nurses, and our commitments to the general public.* (P.10)

A pertinent point was made by participants that might go some way to explaining (albeit not justifying) some nurses' lack of application to their education. Essentially, nurses were overloaded with large volumes of mandatory training and were trying to complete their requirements economically.

> *I think it's our personal responsibility to understand is that the right thing to do, can I do that legally? … It's your*

> *responsibility to seek support, but in terms of how? Your manager should put some [relevant education] into your Personal Development training, [make it] part of all the other mandatory trainings that's required. I think that might be useful, but then we're inundated with a lot of training, left, right, centre. So, [the question is] how to attract interest, to make this training of importance, a priority?* (P.03)

Theme 2: Paucity of support networks for nurses

The second theme constructed from focus-group data was a paucity of support networks nurses could access for information required for their practice. Participants were especially mindful of a lack of senior nurse mentors, which created experiential knowledge gaps that pervaded the profession and compounded over time.

> *People aren't learning from mentors anymore, because there's not as many mentors in the workplace. And suddenly they're out faced with this huge risky situation and trying to … decide what to do. And rather than balancing dignity of risk, they do go straight to that risk aversion.* (P.05)

Participants were especially concerned that a lack of mentors meant that nurses were entering the profession and, in the absence of senior nurses who could advise and guide their development, becoming improperly experienced. As a result, it is reasonable to conclude that these nurses would also compound this issue by passing their incomplete knowledge base to the next generation of nurses.

> *You need an experienced clinician to talk about things like the therapeutic relationship, to talk about boundaries, to talk about stigma and challenging people's thoughts about mental illness, … [nurses] need more of that embodied experience, and talking to somebody who is more experienced as well. And that's lacking. … The other thing is you have people who rise up [within the profession, but] who have never had those positive mentors, who are really, really experienced as well [but not appropriately so] and they might get a certificate, or they might even get a masters. But I would argue a lot of the time that they don't prepare people well for these sorts of issues.* (P.07)

The availability of temporary staff to cover nursing shortages was also problematic for participants, because it meant that there was no impetus to source, retain, and train permanent nursing staff.

> *As long as it's the norm, that you have agency nurses who can [work] without an ounce of background experience. As long as that's a normative way of running [a workplace], it seems to me you accept all the freight that comes with that style of staffing … You can't replace experienced nurses with an agency.* (P.12)

Participants also reported limited on-site avenues for nurses to explore when legal questions arose regarding confidentiality and disclosure pertaining to patients in mental health care.

> *If you've got a nurse in a situation where … they're aware disclosures might come back to bite them in the rear. They don't actually know what they're even supposed to do. And without someone [legal] on site who's readily accessible … for advice related to this kind of matter, it really puts him in a bit of a funny situation. The uncertainty about what people's responsibilities are towards people under their care, that probably doesn't help in a significant way.* (P.12)

Concerns were also raised by participants about a lack of leadership from relevant regulatory-related organisations.

> *[Confidentiality, and disclosure or breach]. There's always a grey area in mental health for us around this stuff. It's*

> *so grey. Even you know, I've been to the Tribunal … called the Mental [Heath] Review Tribunal about different things. And it's even … they give you grey answers.* (P.08)

Another factor that inhibited nurses from obtaining relevant information for their decision-making processes was a lack of immediately accessible patient records, which were often distributed across multiple unwieldly storage systems.

> *Our problem is that we have too many different medical records systems. ED (the emergency department) is still on paper, outpatients is on an [electronic] system, inpatients is on a different system. Those kind of systems don't talk to each other.* (P.11)

Concerningly, the quality and integrity of some records prepared by nurses and other clinicians was also questioned by participants.

> *We all write progress notes differently. We all hope that all the information is there, but some people write big stories and other people will just kind of make bullet points and quite short. I [also] find since we've gotten [computerised notes], things are cut and pasted. Things can follow people for years and years, that's not actually factual or accurate in the files.* (P.10)

Participants also felt that record-keeping was burdensome and led nurses to be task-oriented towards record-keeping, to the point that it often took them away from direct patient care.

> *The nursing staff when patients are on [high-risk] level two [observations], they have to make entries every 10 minutes into their notes. So, they don't get any care, these patients. … This is what the nurses are being taught. New grad nurses, they come in, and they spent all day on the computer. So, they're literally not giving any care, and that one little thing sets the tone for all their care.* (P.08)

Theme 3: Health services' unrealistic expectations of nurses' abilities

The third theme manufactured from focus-group data was a belief among nurses that health services had unrealistic expectations of their abilities—for participants, the most prominent and concerning of these being a perceived expectation that they could always identify and manage risk. This perception influenced their confidentiality and risk-actuated public interest disclosure-related decision-making practice, despite participants noting that risk is subjective, unpredictable, and difficult to manage.

> *We just simply can't control or predict people's behaviour [or] manage risks to the extent that's demanded [by the health service]. I think we actually really have to realistically engage with our limitations. You can't actually control someone's behaviour, though there seems to be a bit of an expectation that we do. … As long as there are unrealistic expectations about our ability to predict and control behaviour, issues are going to continue.* (P.12)

Overall, participants believed that risk assessment was not accurate, and being over-cautious at the expense of patient autonomy could cause unnecessary iatrogenic harm to patients.

> *We don't have a crystal ball about risk of what's going to happen, and I'm on the side of protecting people's liberty [not] putting them under the Mental Health Act and traumatising them more. … Risk assessment is not accurate, it will never be totally accurate.* (P.07)

Participants also emphasised that the concept of risk is subjective, and difficult to define.

> *Risk is very unclear. There's no definition about what risk is. What's risk to some people is no risk to others. Risk is interpreted different ways.* (P.06)

The perception among participants that they were always expected to identify and manage risk was exacerbated by a pervasive organisational aversion to risk in mental health care. Consequently, nurses calculated risk inaccurately, leading to actions that infringed on patients' rights and resulted in breaches of confidentiality.

> *People don't want to be assessed. They want to be assisted … and I think mental health has really done itself a disservice to the general public because not only are we … well, generally risk-averse, but [as a result] too custodial, punitive, stigmatising. discriminatory, all the other stuff that other people that don't have a label, i.e. 'mental health', aren't exposed to. Let's face it.* (P.06)

Additionally, concerns were raised by participants that patients in mental health care were afforded fewer rights than were medical patients, which was justified by inappropriately attaching an inherent quality of credible risk to people in mental health care. Participants believed that this persistent stigma relating to a mental health condition was also responsible for breaches of patient confidentiality.

> *I think a lot of the attitude [is] if someone has … mental ill health … they're not entitled to the same privacy and confidentiality as other people. I've heard some nurses say things that are just ridiculous … the stigma around mental health … is that people have no confidentiality. The breaches are made because people think, 'Oh, well, I'm a bit worried that they're going to do something. So, I'm going to tell everybody what this person's done, what they're up to.'* (P.10)

Additionally, participants reported that unrealistic expectations regarding risk identification and management led nurses to practice in a defensive manner that was mental-health-service-focused, not patient-centred.

> *I think what constrains [nurses] is that they work under a mental health service or psychiatric service, a medically modelled service. [Nurses are] driven or influenced by the threat that you could be in front of a coroner at any time, which is a really horrible way to work.* (P.06)

Essentially, fear of personal or professional repercussions resulted in nurses making decisions that were self-serving or aligned to what they believed the service wanted, rather than for the benefit of patients.

> *So many of our procedures and decisions are driven by fear of medico-legal ramifications, as opposed to what is actually helpful for the person. So perhaps that could be improved with nurses' literacy about more of a nursing- and recovery-oriented model of care.* (P.09)

Participants were mindful that, justified or not, nurses felt that they would be held personally responsible for failings in a patient's care, despite working within a system where risk was not treated as difficult to identify or mitigate (despite professional and clinical literature appropriately identifying risk-related difficulties in mental health care).

> *I think in the mind of a lot of nurses … a lot of them believe that if they do something wrong, they will be personally held liable, rather than there being acknowledgement of there being a systemic problem. … So that can lead to decisions, which are duly paternalistic, or unduly paternalistic.* (P.12)

Lastly, participants reported their perception that an inappropriate fear of legal processes actually caused nurses to breach patient confidentiality.

> *The irony of it is that anxiety and fear about litigation or things down the track, [can lead nurses] to breach [confidentiality]* (P.08)

Discussion

Several findings in this study assist in illuminating potential factors for knowledge and practice gaps of nurses regarding their confidentiality and risk-actuated public interest disclosure-related decision-making. First and foremost, participants believed that deficiencies relating to this area of practice were directly attributable to limited opportunities for nurses to acquire knowledge. Participants felt that in Australia this issue commenced with the university degree, which is a general 3-year Bachelor of Nursing (BN) degree (Happell, 2007).

Structurally the BN includes a small number of mental health subjects, with the added potential for students to major in mental health nursing in their final year, whereby they undertake courses in anything from one to several extra mental health subjects (Christiansen et al., 2018; Happell, 2010). However, student numbers are often limited, a place in the major is not guaranteed, and clinical placements may be in areas with limited exposure (if any) to mental health patients (Christiansen et al., 2018). Therefore, the greater portion of the BN is a medical model, which, participants in this study believed, left nurses with knowledge and skills gaps for confidentiality and risk-related issues in mental health care. Participants contrasted the BN with the UK model where students generally complete a 3-year discrete Mental Health Nursing Degree (Christiansen et al., 2018; Happell, 2010).

The impetus behind a general degree was to produce graduates who entered the workforce with the skills to commence in any entry-level nursing speciality (Happell & McAllister, 2014). However, places in the BN have been overwhelmingly filled by students who look unfavourably upon, or who do not want to work in, mental health care post-graduation, at the expense of applicants who would prefer to work in mental health care (Christiansen et al., 2018). A study by Edward et al. (2015) found less than 33% of Australian students would consider mental health as a career option. However, the authors also found increased exposure to clinical mental health contexts to be positively correlated with an interest in pursuing mental health nursing. Therefore, in the absence of a dedicated mental health nursing degree, it is reasonable to conclude that increased exposure to clinical mental health care contexts should translate into more students choosing a career in this underserviced area of nursing.

Furthermore, participants reported a lack of CPD opportunities for post-graduate nurses related to their duty of confidentiality. Contemporary literature indicates that this creates two distinct but related issues: (a) Knowledge gaps are associated with nurses who are not provided with CPD, and (b) a lack of instruction in specific content areas risks nurses minimising the importance of these areas, which creates and exacerbates knowledge gaps (Mlambo et al., 2021). Therefore, it is reasonable to presume that health services and nurse employers are inadvertently creating a barrier to nurses meeting their professional duty of confidentiality to patients (International Council of Nurses [ICN], 2021; NMBA, 2018).

Consequently, an industry-wide approach to implementing confidentiality-focused CPD is recommended, to address inappropriate withholding or disclosure of confidential information when patients are assessed as posing a potential risk. However, it is important to note that participants believed that an absence of CPD was not a legitimate claim for nurses to defend the inappropriate handling of confidential information, because their professional obligations also require them to take ownership of their own learning (ICN, 2021; NMBA, 2018). This includes ensuring that they have the requisite knowledge and skills for safe and effective nursing practice (NMBA, 2016).

Participants were also concerned at a lack of support networks for nurses who wished to obtain information for their decision-making. They were especially conscious that there were limited nurse mentors from whom nurses can learn. Contemporary literature indicates that a decreasing number of nurses has been a persistent issue in Australia since at least the 1940s, which, it is reasonable to conclude, leads to compounding experiential knowledge gaps in the profession (Australian Bureau of Statistics, 2005). Participants believed that this created a twofold practice problem for nurses: (a) novice nurses have no one to turn to for advice, and (b) nurses who become experienced without suitable mentors to guide them create schemas of knowledge that are not appropriate or correct, which they, in turn, pass on to junior nurses.

Participants were also concerned at a systemic lack of high-level specialised advice systems for nurses, particularly in complicated areas of practice, such as their duty of confidentiality to patients in mental health care. This created a perception that nurses were expected to make difficult decisions, within a system that treated these decisions as if they were not important. For example, when they asked for authoritative advice, they were often dismissed with ambiguous, insouciant responses that did not help them to meet their professional obligations to patients (NMBA, 2018, 2020). Furthermore, nurses felt unsupported in complex confidentiality-related decision-making at the clinical level, because they found that legal or other support persons were often remote, unapproachable, or not present. Therefore, it is reasonable to suggest that health service managers should take steps to ensure that advice and information support systems are readily available to nurses in their 24-hour-a-day 365-day-a-year profession.

Medical records were also cited as a barrier to information for nurses. Participants reported that they encountered multiple and fragmented systems used to store different types of records, both in electronic and hard copy form. Currently, there is no standard centralised storage system, so patient records were not always available to clinicians in other clinical areas or facilities. Notably, there is a federal government database of medical records, but it is voluntary, and many patients have elected to not participate (Australian Government, 2024). However, it should be noted that NSW Health have commenced moving patient records to a centralised cloud database, which will alleviate some of these problems regarding access to records once it is operational (NSW Government, 2022).

Participants also questioned the quality of some medical records—an unsurprising finding when the knowledge gaps outlined above are considered. These concerns related to sparse nursing (and clinician) notes and, more troublingly, instances where notes were copied and pasted from one day to the next. The latter created inaccuracies, because information was not reviewed before being entered into a patient's record, so outdated information remained present and unchallenged for extended periods. This is a clear breach of nurses' professional obligation to act respectfully towards their patients, and to 'clearly and accurately communicate relevant and timely information about the person to colleagues' (NMBA, 2018, p. 11).

Notably, participants felt that the issue of record quality was explicable, albeit not justifiable, because record-keeping is burdensome and time-consuming at the expense of direct face-to-face patient care. For example, participants reported that increased acuity reduces the amount of time a nurse can allocate to one-on-one interactions with a patient, because the volume and frequency of notes pertaining to the patient increases with perceived credible risk. In effect, patients who need more nursing oversight had less, because nurses' time is consumed meeting their obligation to provide accurate contemporaneous notes (NMBA, 2018).

Participants also strongly perceived that unrealistic expectations of nurses by health services were responsible for knowledge and practice gaps identified in previous nursing research, the most prominent of these expectations being that nurses can identify and mitigate risk by appropriately withholding or disclosing confidential information about a patient, even though participants noted, concordant with Caterino et al. (2013), that risk is subjective and unpredictable and can be difficult to identify or manage with any great certainty. The issue for participants with this expectation was twofold: (a) the systemic risk aversion permeating health services, coupled with unrealistic expectations regarding risk identification and management, led nurses to practice defensively, and (b) nurses were under the impression an incorrect decision is a failure on the part of the nurse.

For these reasons, some nurses were reported by participants to make decisions that were risk-averse and self-serving, because they feared legal or professional repercussions if they failed to identify and mitigate risk, (a), to protect themselves if they failed to identify when a patient posed a potential risk, that led to harm to self or others, and (b), to make decisions they believed were in line with expectations of employers or health services. Notably, contemporary research literature also found nurses to be speculatively risk averse in cases where their own previous risk assessment found a patient to be a credible risk, but a contemporary assessment by another clinician found the patient to not pose a risk (Conlon et al., 2021). In these cases, nurses deferred to their previous assessment for confidentiality- and disclosure-related risk management, which is focusing on static dangerousness, not dynamic risk (Faay et al., 2013; Murphy et al., 2011; Wand, 2012). Consequently, risk assessments and any confidentiality or disclosure decisions relying on those assessments may have been inaccurate or incorrect (Conlon et al., 2021).

Participants also believed that risk aversion led to punitive and discriminatory practices. For example, nurses were reported to take a paternalistic approach to mental health patients, because they believed that these patients did not know how to mitigate their own risk. Consequently, nurses felt that these patients needed to be physically detained for their own safety or the safety of the public. However, participants felt that no consideration was given to ‘dignity of risk’ comprising independence characterised by therapeutic or positive risk-taking associated with day-to-day living in the community, which is essential for a patient’s mental health maintenance or recovery processes (Marsh & Kelly, 2018). Additionally, a patient must be permitted to demonstrate to nurses that they can handle their own risk. This builds a positive collaborative relationship based on trust, because patients feel that the health system is doing its best to work with them and not against them (Marsh & Kelly, 2018).

Stigmatising beliefs and practices also compounded information management issues for patients in mental health. Participants reported that some nurses believed that people with a mental health condition have no right to confidentiality if they pose a potential risk, because people need to be warned about them. However, there is no legal duty in Australia to warn people in these circumstances (Mason et al., 2010). Therefore, this approach is problematic if the patient is found not to pose a credible risk, because there are no good faith disclosure protections for nurses if a nurse breaches confidentiality (Mason et al., 2010; McSherry, 2008; Sullivan, 2021). Additionally, there may be professional implications for the nurse, and legal or financial penalties for other stakeholders, including nurse employers, if a patient’s confidentiality is breached (Dolan, 2004; Kämpf & McSherry, 2006).

Implications and future research

This exploration of nurses’ confidentiality and risk-actuated public interest disclosure-related decision-making practices pertaining to patients in mental health care has contributed to contemporary research literature. Findings can be used as a foundation for future educational tools and strategies that address gaps in nurses’ current understanding. This exploration has also identified systemic issues impacting on risk-related decisions of nurses. Therefore, future research that investigates these systemic issues and their accompanying solutions is recommended to support nurses (and all clinicians) in their decision-making, for the benefit of nurses, their patients, and all other stakeholders.

Limitations

Small sample sizes associated with focus groups in qualitative research limit the generalisability of study findings. However, these findings do provide a rich in-depth description of potential causal factors for nurses' knowledge and practice gaps, regarding confidentiality and risk-actuated public interest disclosure-related decision-making in mental health care (Polit & Beck, 2010).

Additionally, mental health care and the role of the nurse share many similarities across jurisdictions, but there are also differences. For example, mental health acts and rules of confidentiality vary from one jurisdiction to the next. Consequently, the concept of duty of care may also differ, influencing nurse decision-making in mental health in the context of patient risk (Kerridge et al., 2013; Tosson et al., 2022). The present study took place solely in the state of NSW, Australia, which may have influenced the data presented by nurses and collected and analysed by the authors. Nonetheless, the jurisdiction and clinical context has been clearly identified, allowing readers to assess the relationship of this study to their own circumstances.

Conclusion

This study explored potential causal factors for gaps in nurses' knowledge of confidentiality and risk-actuated public interest disclosure-related decision-making pertaining to patients in mental health care. Findings indicate that there is a paucity of relevant knowledge among nurses due to limited mental health exposure in the nursing degree in Australia, compounded by very limited CPD post-graduation about confidentiality and disclosure in the context of patient risk. Nurses also expressed concerns that a lack of ownership regarding one's learning was exacerbating knowledge deficiencies among nurses.

Additionally, nurse staffing difficulties create pervasive and expanding shortages of mentorship and knowledge, while entities held as guiding authorities and sources of legal advice are perceived to be either unavailable when required, or reticent sources of information. Concerningly, at the clinical practice level reservations were also expressed about the accuracy of some patient records. Moreover, nurses were concerned that unrealistic expectations were leading to a persistent unrealistic belief that nurses could identify and manage risk with certainty.

This study has highlighted potential causal factors for nurses' knowledge and practice gaps regarding confidentiality and risk-actuated public interest disclosure-related decision-making in mental health care. Study findings can serve as a base for nurse education to improve their understanding of this area of their practice. Furthermore, these findings are relevant to organisations and health service managers regarding policies and procedures and health governance. Additionally, it is reasonable to conclude that future qualitative, quantitative, or mixed method research may also add to these findings.

Author statement

All listed authors meet the International Committee of Medical Journal Editors (ICMJE) requirements for authorship. All authors contributed to: the conception of this study; refining and further development of the original concept. Darren Conlon led, and all authors contributed to: the literature search and analysis; data collection; thematic analysis of data; extraction of findings; and manuscript editing. All authors agree that the manuscript is the authors' original work, has not received prior publication, and is not under consideration for publication elsewhere. All authors have seen and approved the final draft of the manuscript being submitted, agree with its submission to *Psychiatry, Psychology and Law*, and abide by the copyright terms and conditions of Taylor & Francis. All authors agree that Darren Conlon is the corresponding author for the manuscript.

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Ethical standards

Declaration of conflicts of interest

Darren Conlon has declared no conflicts of interest.
Toby Raeburn has declared no conflicts of interest.
Timothy Wand has declared no conflicts of interest.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the Human Ethics Research Committee of The University of Sydney (Protocol No. 2019/564) and with the 1964 Declaration of Helsinki and its later amendments and comparable ethical standards.

Informed consent

All participants gave written informed consent to participate in the study, on the understanding their data has been fully anonymised and they cannot be identified via this manuscript.

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