



Nurses' understanding of their duty of confidentiality to patients in mental health care: A qualitative exploratory study



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ABSTRACT

Background: There are significant personal repercussions for patients, and professional, legal, financial, or reputational repercussions for stakeholders, when confidential patient information is mishandled by nurses working in mental health care. Education and guidance would be helpful for nurses, to address any knowledge or practice gaps related to their duty of confidentiality to patients, but there is limited empirical literature exploring their understanding of this important area of nursing practice to guide these interventions.

Aim: To explore nurses' understanding of their duty of confidentiality to patients in mental health care.

Methods: Theoretical thematic analysis employing a deductive approach to coding of interview data.

Findings: Nurses have a general knowledge of the concept of confidentiality and its rules, but this knowledge is often incomplete or incorrect. Nonetheless, they recognise and prioritise patients' interests when considering how confidential information should be handled, whilst also demonstrating awareness of potential risks to patients if their mental health information becomes known to others.

Discussion: Nurses' understanding of their duty of confidentiality is based on information and knowledge that is incomplete or incorrect. However, in general, they are genuinely motivated to protect the interests of patients and other stakeholders. Several key knowledge and practice gaps that would benefit from education and guidance have been identified. Addressing these gaps should lead to improvements in nurses' handling of confidential patient information.

Conclusion: Confidentiality is an integral element of good mental health care. Findings from this qualitative exploratory study will lead to the development of nurse education and guidance that will assist nurses to thoroughly understand the duty of confidentiality they owe to their patients. Consequently, these findings have the potential to safeguard patients against the mishandling of their personal information by nurses and protect other stakeholders (including nurses) from consequential, personal, professional, legal, or financial repercussions. Further research in this area of practice would also enhance the findings of this study.

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Summary of relevance

Problem or Issue

There are significant personal repercussions for patients, and professional, legal, financial, or reputational repercussions for other stakeholders, when confidential patient information is mishandled by nurses working in mental health care.

What is already known

Little is known about nurses’ understanding of their duty of confidentiality to patients in mental health care. However, rules of confidentiality are complex and not always observed by nurses, even when they are clearly delineated. Furthermore, nurses continue to mishandle patients’ confidential information, with negative repercussions for patients and other stakeholders. Education and guidance would be helpful to address any knowledge or practice gaps regarding confidentiality, but there is limited research literature to guide these interventions.

What this paper adds

Nurses’ knowledge of the concept of confidentiality and its rules varies from one nurse to the next, and it is often incomplete or incorrect. Nonetheless, they recognise and focus on their responsibilities when handling confidential information, whilst also emphasising their awareness of risks related to the release of this information to others. Knowledge and practice gaps have been identified that can be addressed with education and guidance.

1. Introduction

A duty of confidentiality arises for nurses working in mental health when information is shared by a patient (i) on the understanding

that the information is not to be released to others without consent, or (ii) if the nurse receiving the information is reasonably expected to understand the information is confidential (Australian Broadcasting Corporation v Lenah Game Meats Pty Ltd, 2001; Griffith, 2007). The principles of confidentiality share similarities from one country to the next, but local laws and cultural practices also create differences in how nurses are expected to handle confidential information (Conlon, Raeburn, & Wand, 2021). For example, the rules pertaining to the handling of confidential health information in New South Wales (NSW) are found in the Health Records and Information Privacy Act (HRIP) and summarised in a set of Health Privacy Principles (HPP) (see Table 1), which accompany the act (HRIP, 2002; NSW Health, 2015b). The HRIP only applies to the handling of confidential health information in NSW. Therefore, the present study of nurses’ understanding of their duty of confidentiality is limited to that state.

1.1. A note on nomenclature

Terms like consumer, client, or service user are common in contemporary research literature when referring to people in mental health care (Costa, Mercieca-Bebber, Tesson, Seidler, & Lopez, 2019; Dickens & Picchioni, 2012; Simmons, Hawley, Gale, & Sivakumaran, 2010). However, many people with a mental health condition do not like these terms or find them unsuitable (Dickens & Picchioni, 2012; Lugg, Levine, & Boyd, 2023). For example, because they are associated with people electing to seek treatment and care, when this characterisation does not apply to many people with a mental health condition, including those involuntarily admitted to a facility. Many alternative terms have been suggested, which led Dickens and Picchioni (2012) to conclude the most appropriate term is that which each person chooses, which those authors also advised is impracticable in literature relating to multiple

Table 1
Health Privacy Principles (HPP), to accompany the Health Records and Information Privacy Act (2002).
Adapted from: Conlon et al. (2021) and Information and Privacy Commission NSW (2023).

HPP	Indicator	Description
1.	Lawful	COLLECTION 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
5.	Secure	STORAGE 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).
6.	Transparent	ACCESS AND ACCURACY 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.
10.	Limited	USE 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 of the exceptions in HPP-10 apply (e.g., emergencies, threat to health or welfare, research or training, etc.).
11.	Limited	DISCLOSURE Only disclose health information for the purpose for which it was collected, or for a directly related purpose that a person would expect. 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.).
12.	Not identified	IDENTIFIERS AND ANONYMITY 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.
14.	Controlled	TRANSFERRALS AND LINKAGE Only transfer health information outside New South Wales in accordance with HPP-14.
15.	Authorised	Only use health record linkage systems if the person has expressly consented to this information being included (this includes disclosure of an identifier).

HRIP: Health Records and Information Privacy.

people. Overall, contemporary researchers have generally concluded the only term universally recognised and accepted by and for people requiring voluntary or involuntary mental healthcare services is patient, leading to the use of that term in this study (Costa, Mercieca-Bebber, Tesson, Seidler, & Lopez, 2019; Dickens & Picchioni, 2012; Lugg, Levine, & Boyd, 2023; Simmons et al., 2010).

2. Background

A duty of confidentiality is associated with certain relationships, including those between a nurse and their patients (Griffith, 2007). Confidentiality is important in health care because some personal information may be discomfiting or has negative repercussions for a patient or others (Barloon & Hilliard, 2016). Therefore, there is a public interest in ensuring the duty of confidentiality is maintained (Kämpf & McSherry, 2006). The term ‘public interest’ is not defined in contemporary literature. Instead, it is described as referring to anything that is in the best interests of all of society (Conlon et al., 2021). Nonetheless, it is still possible to disclose confidential information if a patient consents; if a law or a court of law deems it permissible; or where a competing public interest in disclosing the information is paramount (McHale, 2009).

Confidentiality comprises a set of clearly defined rules. Nonetheless, contemporary literature indicates the mishandling of confidential information by nurses is prevalent (Health Care Complaints Commission [HCCC], 2018; HCCC v Aref, 2018; HCCC v Payne, 2021; NK v Northern Sydney Central Coast Area Health Service [NK], 2010). ‘Mishandling’ in this context referring to any occasion where a patient’s confidential information is handled contrary to the HRIP (2002) (see Table 1). Identifying and preventing the mishandling of confidential information where possible is important, because it can have significant negative implications for patients and other stakeholders, including nurses, their employers, health services, and the public (Conlon, Raeburn, & Wand, 2019). For example, an incorrect disclosure of mental health information to an employer who holds stigmatising attitudes about mental health conditions may put a patient’s employment at risk, whilst on the other hand, if information that indicates a patient poses a risk is erroneously withheld, the patient or others may come to harm. 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, 2010). Additionally, nurses may be subjected to regulatory or professional sanction by nursing regulators or the NSW Civil and Administrative Tribunal (which could be as serious as temporary or permanent removal from the profession) if information is inappropriately withheld, or confidentiality is breached (HCCC v Payne, 2021; Health Practitioner Regulation National Law [National Law], 2009; Nursing and Midwifery Board of Australia [NMBA], 2018). Additionally, other stakeholders (including nurse employers) may be subject to legal or financial penalties if nurses mishandle patient information, which can run into tens of thousands of dollars and damage their reputations amongst the public (Conlon et al., 2021; Kämpf & McSherry, 2006). Therefore, it is important that nurses working in mental health care (and in all health-related areas) understand their duty of confidentiality to patients, which comprises knowledge of confidentiality and its rules and the ability to apply this knowledge appropriately in their practice (Conlon et al., 2019; NSW Health, 2015b).

Despite this importance, the prevalent mishandling of confidential information indicates there are knowledge and practice gaps in this area of nurses’ practice that need to be addressed with education and guidance. However, there is a paucity of research literature exploring nurses’ understanding of the duty, that can be used to identify these gaps. This paucity is even greater when contemporary research is limited to mental health care and restricted to studies based in NSW (Conlon et al., 2019). Therefore, this study is significant because it is the first to explore this under-researched area of nursing practice in NSW.

3. Aim

The aim of this study was to explore nurses’ understanding of their duty of confidentiality to patients in mental health care.

4. Methods

4.1. Setting

This exploration took place in NSW, a self-governed state of the federation of Australia. Mental health care in NSW is integrated with a federally funded NSW Government-led healthcare system, and takes place in a network of acute and non-acute, inpatient and outpatient, public and private (with some NGOs) clinician-led facilities, and clinics (Doessel, 2009; Dunlop & Pols, 2022).

4.2. Ethics

This research constitutes part of a PhD at The University of Sydney. Approval was granted by the Human Research Ethics Committee (protocol number: 2019/564) of the University on the 13 August 2019 in accordance 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). For the study, participants read and acknowledged they understood a participant information statement; were given the opportunity to ask questions at multiple junctures; and gave written informed consent before being interviewed. Applicants were also advised their participation in the study was voluntary and they could withdraw from participating at any time. Furthermore, they were advised their data were solely accessible by the researchers, were anonymised before analysis, and could be removed from the study and destroyed at their request.

4.3. Recruitment

Participants were recruited using advertising material seeking nurses working in mental health with experience handling patients’ confidential health information. This advertising material was disseminated via personal and professional nursing networks, which included past and present colleagues, the Australian College of Nursing, and the NSW Nursing and Midwifery Society. Letters of invitation were sent to each network requesting dissemination of the advertising material pertaining to the study amongst their own networks. Chosen networks were limited to those with mental health nursing contacts. The advertising material sought expressions of interest (EOI) in participating in the study from nurses working in mental health care in NSW.

4.4. Eligibility

Applicants who submitted an EOI were required to meet all inclusion criteria (see Table 2) before being included in the study.

4.5. Data collection

Data were collected during one-on-one semi-structured interviews using a piloted ($n = 3$) and edited interview guide, comprising questions related to confidentiality in NSW. For example, ‘Can you describe for me what the term ‘confidentiality’ means to you?’. Interviews were conducted by the first researcher via video link or in-person commencing April 2020–March 2021. Interviews lasted 38–80 min (mean = 56 min), were electronically recorded for transcription to text, and then anonymised before data analysis. Data collection was concluded at 14 interviews, because data coding and theme development indicated abundant rich data were collected (Braun & Clarke, 2021). Participant demographic details were

Table 2
Inclusion and exclusion criteria.
Adapted from: Conlon et al. (2019).

	Inclusion criteria	Exclusion criteria
Jurisdiction	<ul style="list-style-type: none"> NSW, Australia. 	<ul style="list-style-type: none"> Jurisdictions other than NSW, Australia.
Population	<ul style="list-style-type: none"> Registered nurses. 	<ul style="list-style-type: none"> Clinicians who are not registered nurses.
Context	<ul style="list-style-type: none"> Mental health care. 	<ul style="list-style-type: none"> Not mental health care.
Exposure	<ul style="list-style-type: none"> Experience handling confidential information of patients in NSW. 	<ul style="list-style-type: none"> No experience handling confidential information of patients in NSW.
Knowledge	<ul style="list-style-type: none"> Read and understood participant information statement. 	<ul style="list-style-type: none"> Did not read or understand participant information statement.
Agreement	<ul style="list-style-type: none"> Provided written informed consent before being interviewed. 	<ul style="list-style-type: none"> Did not provide written informed consent to be interviewed.

NSW: New South Wales.

recorded during the interviews (see Table 3). All participants remained in the study. An extended period was required for collection and transcribing of these data due to delays caused by the Covid-19 pandemic, whereby interviews had to be rescheduled on numerous occasions due to participants either being unwell with Covid-19 or undertaking overtime at work to cover for colleagues who had been exposed to or were unwell with Covid-19.

4.6. Data analysis

A theoretical thematic analysis of interview data was made, which takes an existing framework or theoretical schema and implements a deductive approach to data coding. The existing framework used for this analysis was the legal and practical rules pertaining to the duty of confidentiality for nurses in NSW (HRIP, 2002; NSW Health, 2015b) (see Table 1). This framework outlined confidentiality requirements for health information in NSW, which provided a benchmark to determine nurses' level of understanding (or not) of their duty of confidentiality to patients. Data analysis was guided by the six steps recommended by Braun and Clarke (2006). Firstly, interviews were pursued until the researchers were familiar with these data, which were subsequently coded relative to participant's understanding of their duty of confidentiality. Themes were developed from these codes, agreed upon by all researchers, and then refined, defined, and named. For example, not greeting patients in a familiar manner in a public setting, was coded 'inadvertent release of information' and then arranged with related codes and themed 'awareness of risks related to mental health information', because it corresponded to nurses' understanding of the potential negative impacts to a patient if their information was released to others. Lastly, a report of this analysis was produced and assented to by all researchers (Braun & Clarke, 2006).

Table 3
Demographic details of participants.^a

Nominated gender ^b	Approximate years of experience in mental health	Highest postgraduate qualification in mental health ^c	Current practice area	Private or public sector
F	13	Graduate certificate	Inpatient ward	Public
M	4	n/a	Inpatient ward	Public
F	11	Masters	Emergency department	Public
F	20	n/a	Emergency department and community	Public
F	15	Masters	Community	Private
M	16	Masters	Community	Public
F	19	Graduate certificate	Health service management	Public
F	25	Masters	Community	Public
M	16	Masters	Community	Public
F	20	Masters	Community	Public
F	24	n/a	Emergency department	Public
F	3	n/a	Inpatient ward	Public
F	16	Graduate certificate	Health service administration	Private
M	13	Masters	Emergency department	Public

^a N.B., Participants appear in Table 3 in no specific order. The placement of a participant in the table does not correspond with any numbering system used for participants' quotes in the study.

^b The genders nominated by participants were cis-gender M=male and F=female. No other genders were nominated by participants.

^c n/a indicates no postgraduate qualification specialising in mental health.

4.7. Reflexivity

Researchers are an element of qualitative research processes. Consequently, their views, personal experience, perceptions, and assumptions may lean upon research proceedings. Therefore, researchers must reflect upon their position in relation to a study, and explain how they have accounted for this relationship (Peddle, 2022).

The first researcher is a male PhD candidate who works as a university academic and registered nurse in mental health care, and a legal practitioner in a law firm. The second and third researchers are senior registered nurses and qualified nurse practitioners with experience in mental health care and PhD supervision. All researchers are nurses and share characteristics and insight into the nursing role. As a result, the interviewer (and first researcher) had to think carefully about how this knowledge might affect their interactions with participants, whilst all researchers contemplated how it might create assumptions regarding nurses' practice or influence their dealings with participants' data. The interviewer also had to look thoughtfully upon how their academic and legal knowledge might create differences in their conceptualisation of confidentiality, and their development and instrumentation of schemata related to principles of confidentiality.

5. Findings

The following themes were developed from interview data: (i) nurse participants' knowledge of confidentiality and its rules varied from one participant to the next, and this knowledge was often incomplete or incorrect. (ii) Participants recognised and focused on their responsibilities to patients and other stakeholders when handling confidential information. (iii) Participants demonstrated awareness of risks related to mental health information, but also

reported the presence of associated knowledge and practice gaps in some nurses' practice.

5.1. Theme 1: variable knowledge of confidentiality

The first theme developed from interview data related to participants' knowledge of the concept and rules of confidentiality, which provided the framework for their understanding of their duty of confidentiality to patients. At first instance, they generally appeared to be able to describe this framework appropriately in broad terms.

The only information that needs to be shared is what is pertinent to the person's care and to the other staff member or to the family member. So, if you had a family member, there would be information that [they] wouldn't be entitled to know that maybe the professional would, that would be helpful to the person's care. (P.10)

Participants also understood the importance of protecting the confidentiality of patient information in mental health (and all health) care settings, to protect a patient from potential negative repercussions if their information became known to others.

[Confidentiality is] probably around information that might be sensitive to a degree. ... I think it's quite broad, but I think it's probably information that if it wasn't controlled has the potential to either cause further conflict or upset [for a patient], and it's potentially information [they] probably don't necessarily want released out to the public. (P.03)

Nonetheless, participants also demonstrated they were aware confidential information may need to be released in specific circumstances, especially if doing so was necessary to protect a patient's interests.

Confidentiality [includes] disclosing information as required to preserve a person's life, to maintain their safety and to act upon their mental health well-being at that point in time. (P.11)

However, as interviews progressed, participants' responses became less accurate and assured, and in some instances, were incorrect. For example, some participants conflated their duty of confidentiality with the protections granted by privacy.

Privacy means that what is kept in exchange between one person or another, either between the [patient] and the [nurse], that it's kept private, that it's not released ... and we have to maintain that we're not going to share that with other people. I can't say that I know [of a distinction between privacy and confidentiality] (P.14)

Compounding matters and exemplifying participants' knowledge gaps, several participants suggested confidentiality and privacy were interchangeable concepts, when they are not.

I suppose [confidentiality] has a legal connotation, but it also has a moral connotation. So, confidentiality I think [and privacy], they're one and the same in my view. (P.05)

Subsequent responses to interview questions also revealed underlying gaps in knowledge of practical aspects of their duty of confidentiality, such as when nurses are permitted to access patient information, or with whom it can be shared.

I don't go looking at other [patient] files that I don't need to, though certainly if there's someone on my ward, I feel I have free access to that and I can read their files. I guess I may share anecdotal stories with friends, but I don't obviously without identifying factors. I don't know if I should or not though? (P.06)

Additionally, participants also had trouble describing when information can be disclosed if the patient or the law did not give

them permission to do so. They appeared unaware of the concept of public interest, instead focusing solely on scenarios where a patient posed a risk to self or others.

It's around harm. So, if there actually is a confirmed harm to the individual, or harm in the community, you could literally breach that confidentiality to keep the community safe, or the individual safe. I think probably largely they're the only reasons that confidentiality can be broken or disclosed. (P.03)

Lastly, participants reflected openly on their current skill base and demonstrated insight into their knowledge gaps. Nonetheless, it is noteworthy that some participants had not taken steps to address these gaps.

I fully expected to be really stumped with [confidentiality]. ... every day I practice this, and I see maybe five, six [patients] a day, and [yet] how well do I really know the systems? [Clearly, I don't.] This is really interesting to know this about myself. It's like a self-reflecting thing. (P.14)

5.2. Theme 2: focus on nursing responsibilities

The second theme constructed from interview data was participants recognised and focused on their responsibilities related to patient information that comprised their duty of confidentiality.

So ethically, I wouldn't be sharing information about a [patient] or their family or whatever with people who don't need to know. If a family member rang up ... I wouldn't even positively affirm that the [patient] was there ..., to make sure that information isn't given out to people who the [patient] doesn't want to have it. (P.01)

Participants were mindful to not share patient information with people who did not need to know the information, which included fellow employees not involved in a patient's care.

Not to share it with people who have no value in needing that information. ... say there was a cleaner and they said, "what's wrong with that person?" That's not their business, that's not their concern. They wouldn't need to know, so I wouldn't share that information with them. (P.07)

Despite referring to their responsibilities, several participants inappropriately believed it permissible to share anonymised information with colleagues in a social setting. Other participants incorrectly thought there was no confidentiality in a work setting.

[Responsibilities] means I don't take stuff outside of work. I don't have a chat around a couple of beers at the pub with my friends about what's going on at work or [if I do then] no names or identifying factors for a [patient]. But within ... the work context, I actually don't think there is a great deal of confidentiality. (P.06)

Most participants also believed it was important a patient was aware that information they provided would be shared with their treating team, via their permanent patient record. It is reasonable to conclude this advice would also alert a patient to the fact their information would be available to the future caregiver.

It's really important, [for] the clinical relationship with the [patient], that they know that there is no confidential information from the treating team. That what the [patient is] reporting goes in the notes and so therefore, the treating team have access to that. (P.02)

Participants also felt they had an obligation to inform patients that at times it might be incumbent upon nurses (or other clinicians) to disclose their information outside of their treating team, and to tell them why it might be necessary to do so.

Often, we'll say to people "just so you know what we're going to talk about is confidential, but there might be situations where I have to share that information [outside of the treating team]. And that's usually around risk, and risk to others." That allows them to have an understanding of what guides us in terms of how information's shared and the expectation of us in terms of how we manage that information for them. (P.13)

Ascertaining who the patient might like their information to be shared with was important for participants, as was confirming who the patient did not want to have access to their information. However, they also felt it was important to make patients aware that disclosure of their information would take precedence over their preferences in the context of patient risk.

As a mental health nurse ... my legal obligation would require me asking them who they consent for me to share information with [or not]... [However,] my professional and ethical obligation would be to highlight that ... if there is a risk of safety, ... suicidal risks, self-harming risk, risk of harm to others, and their mental health, then ... disclosure would need to take precedence. (P.11)

Nonetheless, participants felt their duty included not informing a patient in cases where knowledge of that disclosure might itself cause a patient to become a risk of harming self or others.

If you had been made aware of something that puts somebody else at risk ... you have an obligation ... to share that information ... [but] I would always talk to them, and ask them, and explain to them what I needed to do, and why I was going to do [it] ... to keep them as informed as possible ... unless that information is then going to provide some type of a catalyst, that they were going to react to that bad. (P.07)

Overall, participants believed their decisions to not inform patients about how their information might be handled should only be made in patients' best interests, and to lessen the risk of iatrogenic harm.

I'm not fully disclosing to the [patient] that I think that they have no insight and that they're psychotic. ... they're delusional, because I think that's going to exacerbate the situation and cause further agitation, and I don't want to have to then use more restrictive forms of having to manage them. (P.14)

5.3. Theme 3: awareness of risks related to mental health information

The third theme engineered from interview data was participants' awareness of risks to a patient if their mental health information was released to others. A particular concern of participants was how information in a patient's mental health history can be stigmatising, and sometimes inaccurate.

Risk is even in small things like passing on past diagnoses that have been given to someone which are quite stigmatising, that may or may not be accurate [or] at all relevant. ... Stigmatising history. Yeah, I think it is quite common actually in adult mental health. (P.02)

As a result, participants felt their duty of confidentiality included protecting patients from negative repercussions in their personal relationships that can be caused by the release of their information.

I think the biggest risk for me is to the [patient who] ... has [undisclosed] mental health issues. The person might be very private and goes to a GP (general practitioner) or a private psych but then has an unfortunate episode and ends up [in hospital]. So, there could be stigma from family, stigma from friends [if that information is disclosed]. (P.10)

Concerns were raised by participants that a patient's mental health information might imperil the patient's professional relationships if it was released. For example, the relationship between a patient and their employer.

I think [it is] particularly important in mental health, having that awareness of confidentiality due to stigma [that can impact on] their jobs. I think [confidentiality] has a role in advocacy and the partnership with the [patient]. (P.01)

Participants also reported some nurses may 'label' patients negatively based on their mental health history or carry preconceived misguided notions of people with a mental health condition, if this information became known to them.

I think it's important to ask the question about what is being gained by passing on [a patient's] information? Because there can be a voyeuristic nature to some of these stories. and sensationalism. ... I often think it's better to not bring up any past diagnoses people have been given, ... [Nurses] minimise, for example, suicidal disclosures because they see an attached diagnosis of borderline personality disorder. (P.02)

The inadvertent release of information that might be harmful for a patient was something participants were also mindful of. Therefore, suggesting it is important that nurses remain vigilant to scenarios where this might occur.

I see [patients] in the street [and] I might smile or even say hi if you come face to face with someone, but I would never use their name or anything to indicate that I know them, or how I know them. And then it's up to them to choose if they want to do that. Knowing that it's their personal business that's being exposed, potentially, to anyone they're with. (P.04)

A common work-related scenario nominated by participants that required vigilance was during phone calls, whereby responses offered by an unwitting nurse in a mental health setting might alert a caller to the fact a patient was under their care. Essentially, the nurse would have breached the patient's confidentiality.

The first one which every one of us does every single day is when we receive a call ... "can you tell me something about [the patient]" and I never respond. ... Just by entering into a conversation ... [we] acknowledges somehow or other [that the patient is here]. (P.08)

Finally, participants felt there were no risks to patients from the limited release of certain non-sensitive information to family or personal carers, if disclosure was made in the patient's best interests.

I think one of the things clinically that people get concerned about is [risks from] transfer of information to family members and carers. But I think that we can always ... give general psychoeducation, which doesn't breach the confidentiality of the [patient]. (P.13)

6. Discussion

At the outset, nurse participants were generally able to describe the concept of confidentiality in broad terms. This was an uncontroversial finding congruent with contemporary literature, such as a study by Newman and Kjervik (2016) that found nurses were generally knowledgeable about confidentiality. However, as interviews progressed, it became clear participants' knowledge of the concept of confidentiality and its associated rules varied from one participant to the next, and this knowledge was generally incomplete or incorrect. For example, most participants conflated confidentiality with privacy or used the terms interchangeably,

when they do not mean the same thing. Essentially, these participants were unaware confidentiality is a nurse's duty to not share patient information that is known to them, whilst privacy (in this instance) is their duty to protect a patient's information from being accessed by others. A key distinction of privacy (from confidentiality) being a nurse does not need to know the content of the information they are protecting (Conlon et al., 2019).

The limited knowledge base exhibited by participants was especially noteworthy for the purposes of the present study, because it comprised the framework supporting their understanding of their duty of confidentiality to patients. As a result, participants were observed relying on experientially derived intuitive processes, despite confidentiality being an objectively delineated rule-based regime (HRIP, 2002; NSW Health, 2015b). This finding suggested a more in-depth approach was required to assess nurses' understanding. Interestingly, there was no discernible relationship between participants' age, gender, postgraduate qualifications, years working in mental health, or area of practice, and their level of understanding.

Participants also demonstrated gaps in their practice when making confidentiality-related decisions. For example, participants could describe consent and the law as exceptions to confidentiality but appeared unaware of the concept of public interest. They correctly understood information could be released if a patient posed a risk to self or others but did not know it was a public interest disclosure, which NSW Health (2015b) advises is a balancing act between competing interests and not a legally mandated release of information. Consequently, as demonstrated by Sullivan (2021) and Mason, Worsley, and Coyle (2010) there are no legal protections for nurses who make a public interest disclosure incorrectly but in good faith and breach confidentiality. Participants also seemed to be unaware of this fact. It is important these practice gaps of nurses be addressed, because incorrectly withholding information or breaching confidentiality also has demonstrable negative personal, professional, legal, financial, or reputational implications for other stakeholders (Conlon et al., 2021).

Risks posed to patients by the release of their confidential information were a primary consideration of participants when deciding if information should remain confidential. They were especially cognisant that a persistent stigma of dangerousness (and other misconceptions) exists amongst the public regarding a mental health condition (Wand, 2012). This observation concurred with the findings of numerous studies such as those undertaken by Conlon, Raeburn, and Wand (2023), Jacobs & Quinn (2022), and Wand, Isobel, and Derrick (2015), who all ascertained that an inappropriate focus on dangerousness criteria by participants can lead to negative repercussions for a patient from many sources, including friends, family, or employers.

A particular concern of participants that is not prevalent in contemporary literature was some stigmatising information in a patient's medical record may be inaccurate or irrelevant, which can also be problematic for stakeholders other than patients and nurses. For example, the matter of NK (2010) discussed how the HRIP (2002) can hold a health service liable for monetary damages if incorrect information about a patient is released to others. It is also important to note that any action taken against a health service or other stakeholder does not prevent the nurse (or clinician) who created the record from professional sanction, for creating or recording inaccurate information (National Law, 2009; NMBA, 2018).

Confusion was observed amongst participants regarding the release of confidential information not required for a patient's care to clinicians caring for a patient. For example, the release of mental health information to clinicians attending to a patient's medical needs. Some participants questioned if this was antithetical to their duty of confidentiality, because they believed there was no (or little) confidentiality in the clinical environment. However, healthcare policy, contemporary literature, and the law, all advise it can amount

to a breach of confidentiality if the exceptional circumstances permitting disclosure do not apply (Conlon et al., 2023; HRIP, 2002; NSW Health, 2015b).

Differing opinions amongst participants were also noted in regard to the sharing of information with nurses (or other clinicians) in the workplace, who were not caring for a patient. Some participants believed it was appropriate to do so, whilst others disagreed. In respect of those who disagreed, their reasons for doing so were not specifically based on their understanding of their duty of confidentiality. Instead, they reported being concerned that some nurses 'label' patients negatively based on their mental health history or hold preconceived notions of a patient with a mental health condition. This concern was not unfounded, as demonstrated by Kolb, Liu, and Jackman (2023) who found stigmatising beliefs about mental health conditions were not uncommon amongst nurses.

Additionally, there is (in the words of P.02) a voyeuristic or sensationalist nature inappropriately attached to mental health information by some nurses, which NSW Health (2015b) advises risks breaching confidentiality (at the very least) if a patient's information is shared through gossip or for other irrelevant purposes. Notably, there are also legal sanctions under the National Law, and professional repercussions for nurses who choose to deal with confidential information in this manner ranging from reprimand to removal from the profession (National Law, 2009; NMBA, 2018).

Confusion was also noted amongst participants about whether the release of anonymised information to people outside of the clinical environment constituted a breach of confidentiality, which again it generally does (HRIP, 2002; NSW Health, 2015b). For example, some participants thought it permissible to discuss anonymised patient information in a social setting, with people who had no legitimate legal interest in knowing that information. These participants appeared unaware that doing so is a breach of the HRIP (2002), which mandates information only be used for the purpose for which it was shared, and the NSW Health Code of Conduct (2015a), which requires all employees of NSW Health to keep all patient information confidential.

Despite any knowledge deficits, it was clear participants were generally motivated to act in the best interests of their patients and in line with NSW Health (2015b) requirements, whereby they correctly asserted their primary responsibility was to only share a patient's information if the person receiving the information had a legitimate reason to know it. This position is supported by the HRIP (2002) and accompanying HPP (see Table 1), which clearly outline for nurses their obligations when handling patient information. Encouragingly, by the end of their interview, most participants had also independently concluded their understanding of their duty of confidentiality required further education and guidance. Having said this, it is important to note some participants demonstrated prior awareness of their knowledge and practice gaps during the interviews, but had not taken any steps to address them.

Participants also articulated they understood their duty of confidentiality included ensuring a patient retained control of their information, within reason. This position is supported by Conlon et al. (2019) who described the relationship of confidentiality to the ethical principle of autonomy. Participants believed in keeping with NSW Health (2015b) recommendations; this could give patients control by advising them of the limits of confidentiality (where possible) at the commencement of any interaction where information may be shared. In cases where risk-related information has already been collected from a patient before the limits of confidentiality had been explained, participants recommended still advising the patient about how their information might be handled to protect them from any element of surprise.

However, participants also felt there were occasions when it was appropriate to not advise a patient of the limits of confidentiality (albeit generally temporarily, with the assent of a medical doctor) if

that information might lead the patient to cause harm to self or others. This position is congruent with the expectations of *NSW Health* (2015b, 2020) and the law (HRIP, 2002). This important consideration is also supported by *Tonso et al.* (2016), who advised nurses as primary holistic caregivers are often the person in closest physical proximity to patients, and statistically the clinicians most at risk.

Despite their best efforts to retain a patient's sensitive information, participants also reported confidentiality can be breached inadvertently. For example, by addressing a patient in a familiar fashion in a social setting, if the nurse is known to be a mental health clinician by people in the vicinity of the patient. *Cheesmond, Davies, and Inder* (2019) and *Kitchen Andren et al.* (2013) found this to be an especially relevant consideration for nurses working with small populations or in close-knit communities, because the nurse was more likely to be recognised. Ultimately, participants suggested nurses should take their lead from patients. If a patient offers a greeting, then responds in kind, if the patient does not, then the nurse should not.

Participants were also mindful of breaching confidentiality by the thoughtless transfer of information to carers or relatives, or parties who may know a patient. For example, if they accidentally confirmed a patient was under their care by advising a caller to hold whilst the nurse checks to see if the patient is happy to speak with them. Participants felt it was important to take steps in conjunction with education and guidance to mitigate this type of breach, such as an awareness campaign reminding nurses (and all clinicians) of these obligations. A position also taken by *Beltran-Aroca, Girela-Lopez, Collazo-Chao, Montero-Pérez-Barquero, and Muñoz-Villanueva* (2016) in their recommendations for future practice, when concluding their study of confidentiality breaches in a tertiary hospital. However, in keeping with *NSW Health* (2015b) requirements, participants believed the release of limited non-sensitive information was not a breach of confidentiality if it would help a caregiver or family member (or other related party) assist a patient.

Finally, participants also suggested some nurses needed to be reminded to not converse about a patient in a public area or with parties who do not need to know the patient's information, because breaches of confidentiality can easily occur. Notably, doing so is also a breach of their professional obligations as mental healthcare clinicians in NSW (*NSW Health*, 2015a, 2015b).

7. Implications and future research

This study has illuminated nurses' understanding of their duty of confidentiality to patients in mental health care in NSW, and identified knowledge and practice gaps that will benefit from education and guidance. Therefore, potentially safeguarding patients from the mishandling of their confidential information by nurses, and protecting other stakeholders (including nurses) from subsequent professional, legal, or financial repercussions. Commonalities in confidentiality frameworks amongst common-law jurisdictions (and at times other jurisdictions) suggest the findings of this study may also be extrapolated to those jurisdictions (*Kerridge, Lowe, & Stewart*, 2013). Furthermore, additional studies exploring why these gaps occur would enhance study findings.

Participants stated at several junctures during interviews that in a real-world setting, they would approach other nurses (or clinicians) for advice if possible. This scenario applied even if they were working in a location that was removed or isolated from other nurses, because they could still communicate electronically with them. For example, by phone or email. Consequently, further research that explores nurses' understanding of their duty of confidentiality to patients in a group setting would build upon this

study. Additional qualitative, quantitative, or mixed-method research may also add to study findings.

8. Limitations

Qualitative interviews are dynamic, with questions and clarifying questions that can differ in form or interpretation from one interview to the next. Therefore, this can negatively impact the validity of data collected from participants. Furthermore, there is the risk of researcher bias, whereby leading questions are asked to generate specific responses. Additionally, participants may also endeavour to provide responses they believe will please the interviewer. Therefore, to address these limitations, the researchers prepared, piloted, reviewed, edited, and piloted again, a semi-structured interview guide. Once this guide was agreed upon, it was used consistently during each interview to mitigate these limitations.

Confidentiality frameworks share similarities globally. Nonetheless, local judicial, legislative, and cultural overlays in individual jurisdictions have created differences to the duty of confidentiality owed by nurses (*HRIP, 2002; NSW Health, 2015b*). Furthermore, many jurisdictions, including NSW, have their own mental health acts, which govern how patients are treated within mental healthcare systems (*Mental Health Act, 2007; Tosson, Lam, & Raeburn, 2022*). Consequently, the duty of care expected when handling confidential information belonging to patients in mental health care can differ from one jurisdiction to the next. This study was undertaken in the Australian state of NSW, which may have influenced the type of data collected and analysis of these data. The researchers have identified the location and methods of the study, so readers can independently judge the relationship of these data to their current jurisdiction and clinical context.

9. Conclusion

Confidentiality is an integral element of good information-handling in mental health care. Nonetheless, this study identified knowledge and practice gaps related to nurses' understanding of the duty of confidentiality they owe to patients. Overall, the study found nurses rely on experientially derived intuition to understand their duty of confidentiality, despite confidentiality being a clearly delineated rule-based regime. However, their knowledge of the concept of confidentiality and its rules varies from one nurse to the next, and it is often incomplete or incorrect. Unsurprisingly, this is partnered by a concomitant deficit of skills for handling confidential information in their nursing practice.

Overall, nurses believe their primary responsibility is to only disclose a patient's information to people with a legitimate reason to know the information, whilst also remaining cognisant of circumstances in which a patient should be informed (or not) about how their information is handled. They are motivated to protect confidential information to ensure a patient is safeguarded from stigma or other negative repercussions arising from the release of mental health-related information to others, including nurses who are not caring for a patient. Additionally, nurses understand confidentiality can be breached inadvertently, so it is important to guard against this occurring.

This study has highlighted areas where nurses would benefit from education and guidance to improve their understanding of their duty of confidentiality to patients, which will also enhance their information-handling skills. It also found further studies exploring why these gaps occur would enhance study findings, as would studies exploring this facet of nursing in a group setting. It is reasonable to conclude additional qualitative, quantitative, or mixed-method research may also add to these findings.

Authorship contribution statement

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 paper editing. Darren Conlon also led the legal analysis of data. All authors agree 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 *Collegian*, and abide by the copyright terms and conditions of Elsevier and the Australian College of Nursing.

Ethical statement

This research constitutes part of a PhD at The University of Sydney. Approval was granted by the Human Research Ethics Committee (protocol number: 2019/564) of the university on the 13 August 2019 in accordance 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). For the study, participants read and acknowledged they understood a participant information statement; were given the opportunity to ask questions at multiple junctures; and gave written informed consent before being interviewed. Applicants were also advised their participation in the study was voluntary and they could withdraw from participating at any time. Furthermore, they were advised their data were solely accessible by the researchers, were anonymised before analysis, and could be removed from the study and destroyed at their request.

Conflict of interest

The researchers have no conflicts of interest to disclose.

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- The researchers have no financial affiliations to disclose.
- A COREQ checklist was consulted when preparing and reporting this study (Tong, Sainsbury, & Craig, 2007).

Addendum

Since this research was completed Toby Raeburn has accepted the position of Associate Professor at the Australian Catholic University, whilst Timothy Wand has accepted a professorship at the University of Wollongong, Australia.

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