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Risk-Actuated Public Interest Disclosure Practices of Nurses Working in Mental Health, Pertaining to Confidential Information of Patients

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ABSTRACT

For nurses working in mental health, the inappropriate handling of confidential information may cause issues for stakeholders. However, there is a paucity of research literature to guide nurses. Therefore, this study aimed to add to the extant literature on risk-actuated public-interest disclosure practices of nurses. The study found participants understood exceptions to confidentiality, but not the concept of public interest. Furthermore, disclosure for risk management in perceived risk laden scenarios, was described by participants as a collaborative endeavour, albeit one where peer advice was not necessarily followed. Finally, participants' risk-actuated disclosure-related decision-making focussed on protecting a patient or others from harm.

Introduction

There is a duty of confidentiality originating in equity and common law. For nurses (and all clinicians) working in mental health the duty arises when a person shares confidential personal information with the understanding it will not be distributed further without consent. The duty also arises if the nurse receiving the information should have reasonably understood the information was confidential (Australian Broadcasting Commission v Lenah Game Meats Pty Ltd, 2001; Griffith, 2007). Legislative and regulatory duties of confidentiality also apply to nursing practice (NSW Health, 2015; Nursing and Midwifery Board of Australia, 2018).

Confidentiality is important in healthcare because certain personal health information can be personally embarrassing or have negative social repercussions for a patient (Barloon & Hilliard, 2016). Confidentiality is of even greater importance in mental health care because there is a persistent stigma of inherent dangerousness pertaining to a mental health diagnosis (Wand, 2012). Consequently, there is a public interest in ensuring confidentiality is respected (Kämpf & McSherry, 2006). Notably, there is no definition in law or contemporary literature for 'public interest' (Conlon et al., 2019). Instead, "[t]he term refers to a broad concept encompassing anything deemed to be in the interests of society as a whole" (Conlon et al., 2019, p. 1236; McKinnon v Secretary & Department of Treasury, 2005).

Nonetheless, the duty of confidentiality is conditional. Material information may be disclosed, with consent, by operation of the law, or if a predominant public interest in disclosure takes precedence (McHale, 2009). Disclosure to prevent patient harm to self or others exemplifies a predominant public interest (Dolan, 2004). Notably, a disclosure to prevent harm is categorised as a 'duty to warn or protect' in some jurisdictions, including many states of the United States, whereby disclosure is mandated (Mason et al., 2010). Consequently, there are often legal provisions that protect clinicians from breaches of confidentiality when information is released in 'good faith' to protect from harm in these jurisdictions (Sullivan, 2021). However, outside of these jurisdictions (which includes the jurisdiction of the present study) disclosure is generally a moral impetus not a legally mandated duty (Mason et al., 2010; McSherry, 2008). Nurses should note good faith protections are not normally in place for public interest disclosures in this context, including in the present jurisdiction (Conlon et al., 2019, 2021).

Procedural quandaries arise if a nurse suspects a patient may pose a risk to self or others, but neither consent nor the law enable disclosure. There is a public interest in confidentiality, but there is a competing public interest in disclosing pertinent information pertaining to a patient that may assist in preventing potential harm (Dolan, 2004). However, a patient may hesitate sharing information in the future if

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a nurse discloses this information (Dolan, 2004; Kämpf & McSherry, 2006). This scenario is particularly troubling if the information withheld by a patient could assist in the identification of patient risk. Furthermore, a nurse also risks regulatory or professional sanction, whilst other stakeholders such as employers may be subject to negative legal or financial penalties if confidentiality is breached (Conlon et al., 2021; Kämpf & McSherry, 2006). Conversely, if information is withheld inappropriately the patient or others may come to harm (Dolan, 2004). Therefore, nurses must endeavour to make the most appropriate decision based on a patient's specific circumstances.

For nurses, a decision to withhold or disclose confidential information commences with a risk assessment (Conlon et al., 2019; Sands et al., 2013). The findings of which are perused with knowledge of rules of confidentiality, before forming an individualised risk management plan for a patient. Nurse decisions related to risk are made using intuition backed unstructured clinical judgement, empirically derived analysis (manifested as actuarial indicators of risk), or structured clinical judgement (Conlon et al., 2019). Actuarial approaches are considered superior to intuition in risk assessment (Griffith et al., 2013). However, actuarial approaches are static and not suitable for ongoing management of inconstant risk, because in the absence of multiple ongoing contemporaneous actuarial risk assessments nurses would be relying on anachronistic assessments of static dangerousness (Faay et al., 2013; Murphy et al., 2011; Wand, 2012). Conversely, unstructured clinical judgement is fluid and adaptable, and therefore suitable for risk management (Conlon et al., 2019). Therefore, structured clinical judgement is considered the superior approach for risk-related decisions of nurses, because it incorporates the experiential intuition of nurses and empirically derived static actuarial indicators of risk to create a comprehensive dynamic approach to risk assessment and management (Conlon et al., 2023; Griffith et al., 2013; Sands, 2009).

Nonetheless, potentially risk-laden scenarios are complex because they are often characterised by the presence of multiple partial, overlapping, or conflicting, risk-laden cues. Consequently, the likelihood of identifying risk is often little better than chance (Caterino et al., 2013; Conlon et al., 2023). Therefore, decision-making is complicated for nurses, because a decision must be made but breaches of confidentiality or the inappropriate withholding of confidential information can have significant negative implications for stakeholders (Conlon et al., 2021). For example: in the matter of NK v. Northern Area Health Service (2010), a patient (NK) presented to a hospital (the Hospital) which also happened to be his place of work. On admission NK was assessed by a nurse (Nurse W) experienced in both mental health and risk assessment. Following this assessment, NK was referred to a psychiatrist who reviewed NK and admitted him to the Hospital under the Mental Health Act (2007) as a risk of harm to self or others. NK was then relocated to a second hospital to protect his confidentiality from his work colleagues. Six days later, Nurse W decided to contact the second hospital because she reportedly continued to have concerns about NK and found he had been discharged. Nurse W accessed NK records and based on her retrospective risk assessment and consultation with her peers, took NK's record and her concerns to Human Resources who subsequently blocked NK's access to the Hospital. Nurse W's position was she had acted to prevent what she saw as a credible risk of harm to NK's colleagues. It is reasonable to conclude no consideration appeared to have been given by Nurse W or the Hospital to subsequent risk assessments of NK in the second hospital. NK later attempted to take his life and reported he had been unwell prior but afraid to approach the Hospital lest his confidentiality be breached again. NK later successfully took action against the Hospital for breach of confidentiality, whereby Nurse W had inappropriately preferred the public interest in disclosure over the public interest in confidentiality based on a retrospective assessment of static dangerousness, not contemporary risk (Conlon et al., 2021).

It is clear that guidance in this area of practice is essential, to ensure disclosure related decisions are validly made. Nonetheless, there is limited research literature describing nurses' understanding of both the processes and implications of valid risk-actuated public interest disclosures versus breaches of confidentiality, or conversely the appropriate and inappropriate withholding of confidential information (Conlon et al., 2019). Consequently, the aim of this study was to explore this important area of nursing practice.

Aim

The aim of this study was to explore risk-actuated public interest disclosure practices of nurses working in mental health, pertaining to confidential information of patients.

Method

Setting

The setting for this exploratory study was the state of New South Wales (NSW), Australia.

Ethics

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

Recruitment

Participants were recruited through professional nursing networks and peer nursing network contacts. Invitation letters were mailed to networks asking that recruitment information be circulated amongst their members or contacts. Details of the first researcher were included as the contact person for the study.

Table 1. Inclusion and exclusion criteria (adapted from Conlon et al. (2019).

	Inclusion criteria	Exclusion criteria
Jurisdiction	• NSW, Australia.	• Jurisdictions other than NSW, Australia.
Population	• Registered nurses.	• Clinicians who are not registered nurses.
Context	• Mental health care.	• Not mental health care.
Exposure	• Experience dealing with patients who may pose a risk to self or others in NSW. • Experience handling confidential information of patients at risk in NSW.	• No experience dealing with patients who may pose a risk to self or others in NSW. • No experience handling confidential information of patients at risk in NSW.

Eligibility

Applicants underwent purposive sampling, whereby they had to meet all inclusion criteria to participate in the study (see Table 1).

Theoretical framework

This qualitative exploratory study was guided by Cognitive Continuum Theory (CCT), a single-system theory of cognition that can be used to explore nurse decision making processes (Conlon et al., 2023; Hammond, 1980).

CCT comprises five key premise. (i) Cognition is a continuum ranging from one pole that is wholly intuitive, to its corresponding pole which is wholly analytic. (ii) the continuum between the poles is characterised by various blends of analysis and intuition called quasirationality, whereby the proportion of each form of cognition decreases in proximity to its opposite pole. (iii) A task continuum corresponds with the cognitive continuum on which tasks can be positional based on the blend of cognition used for each task. (iv) Cognition is dynamic and oscillates over and back the cognitive continuum according to task requirements. (v) Decision-makers utilise functional relations and pattern recognition when assessing environmental cues, including cues relative to risk (Conlon et al., 2023; Hammond, 1996).

Analogous to structured clinical judgement, CCT is a dynamic interplay of intuition and analysis (Conlon et al., 2023). Therefore, CCT is an appropriate theoretical framework for this exploration of nurse disclosure of confidential information in the context of patient risk. Notably, CCT is not limited to decision-making regarding risk but is applicable to all decisions made by nurses (Conlon et al., 2019, 2023).

Data collection

Individual semi-structured interviews were conducted with questions focussed on public interest disclosures of confidential information of patients assessed as posing a risk. The interview guide was piloted ($n = 3$) and refined before use. Interview data were collected by the first researcher either in person or *via* video link between April 2020 and March 2021. Example of interview questions included: 'Can you describe for me what the term disclosure of confidential information means to you?'; and 'Tell me about you understanding of the potential risks of releasing confidential information about a patient, and if these potential risks may influence your decisions to disclose confidential information?'. Interviews ranged approximately 38 to 80 min in duration (mean = 56 min) and were audio recorded, transcribed, and anonymised, for data analysis. A total of 14 interviews (10 female and 4 male) led to data saturation. No participants requested to leave the study. Notably, the Covid-19 pandemic had a negative impact on data collection methods and transcription of data, causing an extended delay to these undertakings.

Data analysis

A theoretical thematic analysis was conducted based on the established framework of CCT and the rules of confidentiality and risk-actuated disclosure of confidential information in NSW, using a deductive strategy for coding of data. Theoretical thematic analysis contrasts with inductive thematic analysis (where data is coded without a pre-existing frame of reference) in that it commences with a previously established theoretical framework and applies a deductive strategy to coding of data. Data analysis was guided by the six steps of Braun and Clarke (2006). Interviews were repeatedly read to achieve familiarity with participants' data. Data were then coded in a systematic fashion, focussing on disclosure of confidential information in the public interest. Themes illustrated by patterns in codes were ascertained and subsequently refined. Themes were then defined and given names, with reference to: knowledge of exceptions to confidentiality; risk management in perceived risk laden scenarios; and considerations of nurses for risk actuated disclosure. Finally a coherent report was generated of the final analysis (Braun & Clarke, 2006). For example, when participants described preferencing their own previous risk assessment findings over a subsequent assessment with different findings conducted by another clinician, this was initially coded as 'dangerousness' and then grouped with related codes under the theme 'risk management in perceived risk laden scenarios, because they related to difficulties nurses faced when making decisions in environments that may be complex because of multiple partial, overlapping, or conflicting, risk-laden cues.

Reflexivity

Researchers, due to the nature of qualitative research, are a part of the research process. Therefore, their experiences, viewpoints, and beliefs, have the potential to influence proceedings. Consequently, researchers must acknowledge their position in regard to the research, and outline for research

consumers the steps they have taken to account for their position (Peddle, 2022).

For the present study, the first researcher (and interviewer) is a male academic, lawyer, registered nurse, and current PhD candidate, with a background in mental health, that includes interactions with patients who may present a risk. This experience and knowledge has the potential to impact upon data collection and analysis (Olmos-Vega et al., 2023; Peddle, 2022). However, the second and third researchers (also male) are long-standing nurse practitioners with extensive experience in nurse research and supervision, mental health, and patient risk. Consequently, the following procedures were instigated to reduce the likelihood of potential impacts on the study. Firstly, interviews were guided by a semi-structured questionnaire created, piloted, reviewed, and agreed to by all researchers. Next, each interview was recorded and analysed by all researchers. Following transcription to written form, data from interviews were then assessed and confirmed as accurate, and codes and themes agreed to, by all researchers. The findings and discussion were then reviewed and supported by all researchers. Finally, all researchers assented to the final draft of the study.

Findings

Three broad themes were identified from analysis of these data. Firstly, participants discussed their understanding of exceptions to confidentiality. Secondly, disclosure as it applied to the management of risk in perceived risk laden scenarios was described by participants. Thirdly, participants outlined their considerations when engaged in risk-actuated disclosure-related decision-making.

Theme 1: Exceptions to confidentiality

The first theme noted during interviews was participants' understanding of common law exceptions to confidentiality. Initial questioning revealed participants were able to identify consent and legal reasons as exceptions to confidentiality, as evidenced by comments such as:

> One is with their permission, so their verbal, implied or written consent. And then if there was a risk of harm to themselves or somebody else, [or by law for] risk of harm to a child. If their file was subpoenaed, so if they end up in court for some reason, if we get a subpoena a copy of their whole file goes. (P.04)

> Where I believe [the] … Mental Health Act, or the mental health legislation permits me to [disclose]. … Where I am required by law, whether I'm subpoenaed, that I would need to disclose information provided that I am aware of what I need to disclose. (P.11)

> I think it's risk aspects, … child protection issues and welfare issues, also the person themselves being at risk from others. … I think there's issues around whether or not people have capacity and so, … it's about sharing that information with a guardian … and I think the other aspect is people being involved in illegal activity where you've got to some make some disclosures to the *police*. (P.13)

However, it was clear participants had varying degrees of knowledge of the concept of the public interest exception to confidentiality. When asked directly to describe the concept, participants were unable to articulate public interest other than in relation to risk-related disclosures, as evidenced by comments such as:

> I would think they're the ones which are about risk of harm to self or others. If somebody is posing a suicide risk. (P.01)

> It's around harm. So, if there actually is a confirmed harm to the individual, or harm [to] the community [if a patient was released], you could literally breach that confidentiality to keep the community safe, or the individual safe. (P.03)

> I would say [disclosure] if there's a significant risk to anybody, whether that be the patient, a family member or a staff member, just any significant risk to anyone's well-being. (P.09)

Furthermore, some participants perceived disclosure if a patient was assessed as posing a potential risk to self or others as protected if made in good faith. Participants appeared unaware this is contrary to public interest principles at common law and legislation within the jurisdiction of this study. Some relevant comments included:

> The risk is if I don't act enough on information that I know about a patient, and then in the other direction if you've released too much you've breached confidentiality. Really, I think there would be some protection as a clinician. If … there's some sort of grey area there, but that is sort of within the realm of your duties. I think you'd be at least fairly safe. (P.02)

> I don't know all the names of the policies and guidelines, but there's a number of policies and guidelines around privacy and the care coordination, care management kind of guidelines. …I feel reasonably confident that if you follow the rules around when you disclose, and you document it properly … then the client's unhappy about it and tries to sue you. You've got the legislation and the guidelines that protects … the decision that you've made is the right decision. (P.04)

> I think if I'm concerned enough about a situation that I feel I need to disclose confidential information. Then I feel like I can justify that, I can say this was my concern, and it wasn't a concern that I could not pass on (P.09)

Theme 2: Risk management in perceived risk laden scenarios

The second theme noted from interviews was risk management in perceived risk-laden scenarios. Participants described how they would seek (albeit not necessarily follow) advice from other clinicians if a risk assessment indicates a patient is low risk, but a participant has doubts about this finding. This strategy accords with collaborative practice. Participants' comments related to this theme included:

> If I was unsure, I would discuss it with another clinician. … I'd say, look, this is my concern. What do you think I should let this person know … what do you think … so I would have a conversation if I was doubting myself. (P.09)

> When you know that your disclosure is going to destroy someone's relationship or career, you take it into account and you would think about it, and you would maybe seek more kind

> of supervision and consult with manager or higher-level clinicians and what have you …. But it wouldn't stop me from disclosing. If I felt like I had to disclose something. (P.04)

> If I have assessed someone, and I asked the doctor, can you please enforce the section [of the Mental Health Act for temporary detention of the patient] while I arrange for security and things, and then they just refuse to do so. And then that person has left. I do call the emergency services, and then I will disclose that that person has a serious risk. (P.14)

Furthermore, participants advised they understood their risk-actuated intuition, hunches, and feelings, to be founded on actuarial principles and clinical experience. Consequently, intuition, hunches, and feelings, were important in assessing actuarial data, whilst actuarial data provided objective evidence to back up one's intuition, hunches, and feelings, in potentially risk laden scenarios. This was illustrated by participants' comments such as:

> The trend for me, and I can only speak for myself, is that the data that I will inevitably collect and review should sit well with me. … that it needs to be congruent with my intuition. (P.11)

> If I have a hunch or see, it means that there's something there. … It would mean that my hunch is coming from something objective. … I may be driven by my gut, but I would act on the objective, because that's what can be used as evidence. … I just can't call a police officer and say … I've got a bad feeling about this one. (P.14)

> It might be a hunch, but you need to be able to articulate that in some way**…** You might as a junior nurse feel like, "Oh, I've just got a bad feeling about this", but not necessarily be able to articulate it. Whereas I think, as you get more experienced, … there might be more things to look for in the objective data. (P.09)

However, it transpired that a small number of participants focussed on static dangerousness rather than dynamic risk when assessing patients. For example, when participants discussed situations where a patient was determined to be high-risk, but a subsequent review by another clinician found the patient to be low-risk and the patient was discharged from care, as evidenced by comments such as:

> Yeah, so I think risk is a sliding scale. There are static risks and dynamic risks. … For example, neglect over time is harmful, and active neglect may not be as harmful as the neglect over time. (P.13)

> In a short period of time, where I've assessed a person [as high-risk] an hour before, I would not expect risk to change so dramatically in an hour. I would be looking at if the documentation [of a subsequent care giving clinician] is such that it was negligent, or it was dubious and it was clinically unsound. That those risks now are extremely high due to that decision made at that time of discharge. (P.11)

> If I personally still felt that person was at risk. I'd probably … send them back to ED, call an ambulance, call the police. … even if it had been another clinician … even if [the review was completed by] a psychiatrist, a senior psychiatrist. If I truly felt there was a risk, send them back through the exact same process. (P.03)

Theme 3: Considerations for risk-actuated disclosure

The third theme noted was participants' considerations for risk actuated decisions. Participants volunteered various considerations for their withholding information about a patient, ranging from risks to self and other, to professional practice norms, to legal considerations. One's professional reputation and the loss of standing amongst one's peers also featured amongst proffered considerations. Some relevant comments included:

> The risk of doing the wrong thing legally … I need to make sure I'm doing it in the right circumstances to ensure there's not both legal and ethical ramifications for me as a clinician. (P.01)

> If I disclosed information and it was found by another mental health nurse, or another clinician of a similar standing, to not be in line with current professional practice … I think there would be a risk of losing my … [nurse] registration. (P.03)

> The main risk potentially to us would be the client's unhappiness, which then can lead to anything from verbal abuse, physical abuse, stalking, suing. … If you say, very clearly at the beginning, if you tell me this or that, or this or that happens, I'm going to have to disclose, then they're not so shocked when it happens. (P.04)

Conversely, participants also volunteered various reasons for disclosing patient information in the context of risk. Generally, participants disclosed to prevent negative outcomes for a patient or others if information was withheld, and to also stymie any resultant personal repercussions that may arise. Some relevant participant comments were:

> I'd be concerned that I assessed it very high, another person assessed it very low. What if something did happen and I'm called up to Coroner's [Court]? I would have the concern that the Coroner would say, well, you assessed this way. Why did you let it just stay with that person's assessment if you were so concerned. (P.01)

> Experiencing [two Coroner's Court cases] in my earlier years of practice has embedded, not a risk aversion, but just mindfulness that if anything does happen, I need to be sure, I need to be confident that I can … explain it. And I need to share that has saved me [at] so many points in my career, which hasn't been the case for other clinicians. (P.11)

> If I felt somebody's life was at risk … I ethically would need to be able to put that out there [if] I believe that they had the means and the intention to do that, I would not be too concerned about my own registration at that particular point because I wouldn't be able to live with myself. (P.07)

The entities to whom a participant would consider disclosing information pertaining to a patient discharged from, or who had otherwise departed, the clinical area, was also a common element during interviews. Notably, participants reported they would avoid any form of wide-spread public dissemination of patient information, to protect the interests of the patient. Instead, participants would disclose to community-based entities with the expertise and experience to handle patients at risk, outside of the clinical setting. Some pertinent comments included:

> If I truly believed I would definitely [disclose], even if it is just to the police, but … I'd rather [disclose to the Adult Community Mental Health team]. I'd also be talking to the person, or to

> whoever discharged them to see maybe, what was the go then? (P.06)

> I guess it would depend on what that risk was and how concerning that risk was. If I thought they were going to go home and shoot their wife, I would be calling the cops straightaway. If I thought they were going to go home and just become more and more unwell over the next couple of days, I'd refer to the [Adult Community Mental Health team] to follow up. (P.09)

> Lower level would be certainly telling [a potential victim] … other clinicians involved in their care, but also depending on the situation, maybe their next of kin, their family, their flatmate. Then it brings up that whole confidentiality thing … your flatmates are not your family. (P.04)

Discussion

This study explored risk-actuated public interest disclosure practices of nurses working in mental health, pertaining to confidential information of patients. During interviews, participants outlined their understanding of exceptions to confidentiality, when a patient's information can be legitimately disclosed. Participants correctly identified consent and legislative or judicial backed dictates as exceptions to confidentiality. However, participants were unable to articulate the concept of the public interest, whereby they identified patient risk rather than the overarching principle of public interest as the third exception to confidentiality.

Notwithstanding, in high-risk scenarios participants demonstrated they could apply public interest principles when they described their decision-making as a balancing act between the potential risks of withholding information versus the potential risks if information is disclosed. However, several participants incorrectly believed their disclosure decisions were protected if made in good faith, irrespective of whether withholding information led to harm, or a disclosure amounted to a breach of confidentiality. This incorrect belief is consistent with participants' inability to articulate the concept of public interest.

Nonetheless, participants did raise concerns about their ability to manage risk appropriately in potentially risk laden scenarios. These concerns were particularly prevalent when a patient was assessed as low risk of harm, but the participant had reservations about the assessment. Participants stressed the importance of seeking albeit not necessarily following advice from other clinicians (if possible) to assess if a potential disclosure was recommended or not.

Overall participants described their public interest disclosure related decision-making as quasirational, but more influenced by intuition than analysis. Some participants in the present study also strongly believed their hunches or feelings augmented their decision-making. Participants perceived their hunches and feelings (as with intuition) to be based on experience and clinical knowledge built on a solid analytical foundation, that could be linked back to empirical evidence if required. Therefore, a patient's actuarial data provided objective evidence to back up one's intuition (or hunches or feelings) in risk laden scenarios. This is important, because participants preferred proffering actuarial approaches if justifying their reasons for disclosure to others, because these approaches have a clear empirically derived evidence base.

Importantly, the present researchers noted a small number of participants inappropriately focussed on static dangerousness rather than dynamic risk when assessing potential risk of a patient. This finding was demonstrated in cases where a participant had assessed a patient as at risk, but the patient was subsequently assessed and discharged by another clinician. The focus on dangerousness became apparent when some participants reported they would refer to their previous risk assessment to make a contemporary determination of potential harm to self or others, irrespective of subsequent risk assessments by other clinicians. This finding is significant in the context of this study because these participants believed a disclosure was warranted in the circumstances, when in all likelihood it was not.

For the most part, participants identified common reasons why they would choose to withhold or disclose patient information in these circumstances. Participants were mainly motivated to withhold information to protect patients from potential harms should their mental health information become known to others. However, other reasons provided by participants included: concerns about acting inconsistently with regulatory, legal or ethical codes; repercussions from colleagues, employers, or regulatory authorities, if accepted nurse practice was not followed; personal or professional retaliation from a patient due to actual or perceived harms; or legal action (mainly civil action for damages) instigated by stakeholders.

Conversely, regarding disclosing patient information, participants were mainly motivated to protect patients or others from a credible risk of harm. However, other reasons provided by participants included: potential professional or reputational implications if information was withheld and a patient was subsequently assessed as high-risk by another clinician; fear of being responsible if a patient causing actual harm to self or others; legal implications arising from a harmful incident; psychosocial and emotional impacts for self or others arising from an incident; and previous experience dealing with mental health related fatalities in the Coroner's Court.

Nonetheless, participants were mindful disclosure should be limited to information required to address an identified risk and should not include other patient information. Disclosure should also only be made to people with a legitimate reason to know the information. The entities participants foresaw as possibly requiring some form of disclosure when a patient was assessed as posing a credible risk included the police, acute care services, a relative, or a 'housemate'. Notably, participants were somewhat more uncomfortable with notifying a housemate because they were neither a relative nor involved in a patient's care. Finally, participants were careful to note information disclosed to one person may be different to information disclosed to another. For example, a mental health nurse involved in a patient's direct care would require treatment records or historical psychosocial information that a police officer or relative may not.

Implications and future research

This study has augmented current research literature by exploring and describing risk-actuated public interest disclosure practices of nurses working in mental health, for patients who may pose a risk. The findings can guide nurses and provide a foundation for nurse education in this area of practice, leading to practice improvements for nurses. Consequently, it is reasonable to expect improved protections for patients against the inappropriate withholding or release of their information. Furthermore, stakeholders would also be safeguarded from negative professional, legal, or reputational, outcomes of inappropriately dealing with patient information.

Notably, nursing is a team-oriented profession and nurses are expected to engage collaboratively with their peers for decision-making (NMBA, 2020). Furthermore, participants also made clear they would seek further advice from their colleagues regarding potential disclosures. This approach included nurses working alone because electronic communications with other clinicians are still possible. However, these interviews took place on a one-to-one basis. Therefore, it was not possible to determine if their understanding of, or approach to, public interest decision-making would differ if nurses had the opportunity to discuss their decision-making processes with other clinicians. Consequently, future research that explores risk-actuated disclosures of confidential information by nurses in a collaborative context would add positively to the findings of this study.

Limitations

Approaches to risk-actuated disclosures of confidential information in the context of patient risk share similarities internationally. However, laws and practices related to mental health and confidentiality may differ between jurisdictions. For example, there is a legal obligation to disclose confidential information to protect others from harm in many states of the United States, but not so in other jurisdictions (including the jurisdiction of the present study). This study was conducted exclusively in the common law jurisdiction of NSW, which may have influenced the type of data collected and analysis of these data. The limitations of this study have been addressed by clearly identifying the jurisdiction and context of this study. Therefore, the reader can judge independently the relationship of the findings of this study, to their own jurisdiction and clinical circumstances.

Conclusion

This study has added to existing research literature regarding disclosure of confidential information about patients by nurses working in mental health. The findings demonstrate nurses are familiar with exceptions to confidentiality when confidential information of a patient may be disclosed. However, there is a knowledge deficit amongst nurses regarding the concept of the public interest. Therefore, ongoing education and guidance is recommended. Furthermore, there is belief amongst some nurses that disclosures are protected from sanction if confidentiality is breached when a nurse releases information in good faith, when they are not. Notably, nurses report finding risk management difficult in potentially risk laden scenarios, so they often engage in collaborative practice seeking albeit not necessarily actioning the advice of other clinicians. Furthermore, nurses believe their intuition (or feelings or hunches) and actuarial data are intrinsically entwined, with each backing up and supporting the other. Notably, a focus on retrospective risk assessments coupled with a lack of sufficient weight attached to subsequent risk assessments by other clinicians may amount to an improper focus on dangerousness by a small number nurses, which may lead to inappropriate decision-making. Nonetheless, it is clear any withholding or disclosing of information by nurses is generally undertaken to protect a patient or others from harm, which includes limiting the disclosure of relevant information to entities with a legitimate interest in knowing the information. This study also found future research exploring this area of nursing practice in a collaborative context would add to the findings of this study.

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Authorship statement

All researchers listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors. All researchers contributed to: the conception of this study; refining and further development of the original concept; literature search and analysis; thematic analysis of interview data; extraction of findings; and manuscript editing. Darren Conlon led development of the semi-structured interview framework, data collection and transcription, and (where required) legal analysis of data. All researchers agree the manuscript is the researchers' original work, has not received prior publication, and is not under consideration for publication elsewhere. All researchers have seen and approved the final draft of the manuscript.

Disclosure statement

The researchers have no sources of funding or other conflicts of interest to disclose.

Ethics approval statement

Ethics approval for the study was granted by the Human Research Ethics Committee of the University of Sydney, Australia (protocol number: 2019/564) concordant with the National Statement on Ethical Conduct in Human Research published by the National Health and Medical Research Council of the Australian Government.

Informed consent

Participants provided informed consent in writing to participate in the study, after reading and understanding a comprehensive Participant Information Statement. Participant data were anonymised before analysis and reporting of these data.

Relevance statement

This research is of interest to mental health nurses because the findings can guide nurse practice and serve as a foundation for nurse education relating to risk-actuated public interest disclosure practices of nurses working in mental health, leading to practice improvements for nurses. Consequently, it is reasonable to expect improved protections for patients against the inappropriate withholding or release of their information. Furthermore, stakeholders would also be safeguarded from negative professional, legal, or reputational, outcomes of inappropriately dealing with patient information.

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