



**A QUALITATIVE EXPLORATION OF MENTAL HEALTH NURSES' DECISION-MAKING PROCESSES
REGARDING CONFIDENTIALITY AND DISCLOSURE OF PATIENT INFORMATION**

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I, Darren Martin Conlon, understand if I am awarded a higher degree for my thesis titled '*A qualitative exploration of mental health nurses' decision-making processes regarding confidentiality and disclosure of patient information*' being lodged herewith for examination, the thesis will be lodged in the University Library and be available immediately for use. I agree the University Librarian (or in the case of a department, the Head of the Department) may supply a hard copy or electronic copy of the thesis to an individual for research or study or to a library.

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Date: 14 February 2024

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ABBREVIATIONS INCLUDED IN THESIS

The following abbreviations are included in the thesis. These abbreviations are also set out in full at first instance in each chapter of the thesis in which they appear, except for NSW and MHN because these are common throughout the thesis.

CCT:	Cognitive Continuum Theory
HREC:	Human Ethics Research Committee
HRIP:	Health Records and Information Privacy Act
ICN:	International Council of Nurses
MHN:	Mental health nurse
N-CAT:	NSW Civil and Administrative Tribunal
NMBA:	Nursing and Midwifery Board of Australia
NSW:	New South Wales
PIS:	Participant Information Statement
RN:	Registered nurse

KEY TERMS INCLUDED IN THESIS

The following list of key terms are included in the thesis. This list clarifies the meaning ascribed to a key term that: has alternate meanings in extant literature; may be unfamiliar to the reader; or is otherwise open to interpretation. Alternative terms may be used in the thesis for these key terms, generally because of reviewer or editor preferences (for publications), or as an organic development arising from research and findings over the course of the thesis. Any alternative terms used will be presented in the following list of key terms.

(a) Actuarial

The term actuarial or ‘actuarial approaches’ refers to empirically derived static indicators of risk, used in patient risk assessment (Murphy et al., 2011).

(b) Breach of confidentiality

Breach of confidentiality is any release of confidential information where the permitted exceptions to disclosure does not apply (Kämpf & McSherry, 2006). Disclosure is also defined and these exceptions described in the key terms section of the thesis.

(c) Clinician

The term clinician refers to any health professional delivering clinical care, other than clinicians who meet the definition of ‘mental health nurse’ defined in the key terms section of the thesis.

(d) Cognitive Continuum Theory (CCT)

Cognitive Continuum Theory (CCT) is a single-system theory of cognition characterised by a wholly analytical pole and a wholly intuitive pole. Cognition occurs on a continuum between these poles comprising various blends of intuition and analysis, with the proportion of each decreasing as one moves towards its opposing pole (Cader et al., 2005).

(e) Confidentiality

Confidentiality is the common law duty that arises for a receiver, when certain personal information is shared by a person, with an expectation the information will not be released to others without their consent (Australian Broadcasting Commission v Lenah Game Meats Pty Ltd, 2001; Griffith, 2007).

(f) Disclosure

The term disclosure refers to the legally permitted release of confidential information by a person to others. There are three exceptions to confidentiality when information can be disclosed, (a) with consent, (b) by judicial or legislative decree, or (c) in the public interest (McHale, 2009). The concept of public interest is also defined in the key terms section of the thesis.

(g) Duty to warn or protect

A duty to warn or protect is a duty in many jurisdictions of the United States, but not in Australia or many other jurisdictions (Mason et al., 2010). The duty arises when a patient is assessed as posing a potential credible risk to self or others. It requires relevant parties to

alert entities (which may include disclosure of relevant confidential information pertaining to a patient) who may be able to prevent any potential harm. Disclosures are protected from action by a patient if made in good faith, even if the disclosure is later found to be invalid (Tarasoff v Regents of University of California, 1976). Good faith is also defined in the key terms section of the thesis.

(h) Functional relations

The term functional relations is associated with CCT and refers to the influence of an independent variable (a cue that cannot be seen) on a dependent variable (a cue that can be seen), which allows an observer to perceive and act upon the independent variable (Hammond, 1996).

(i) Good faith

The term good faith as used in the thesis refers to the release of information by a person who honestly believes the information must be released to prevent harm (Tarasoff v Regents of University of California, 1976).

(j) Lawyer

Lawyer is a defined term in NSW and refers to a person admitted to the Australian legal profession in NSW, or any jurisdiction of Australia. There is no requirement for a lawyer to hold a practising certificate, but they cannot engage in legal practice if they do not have one (Legal Profession Uniform Law, 2014).

(k) Legal practitioner

Legal practitioner is a defined term in NSW and refers to a lawyer who holds a current practising certificate which allows them to engage in legal practice in Australia (Legal Profession Uniform Law, 2014).

(l) Mental health nurse (MHN)

A registered nurse working (or who has worked) in mental health care, at any time in any clinical role post-graduation, at any level from novice to expert, in any public or private clinical context or capacity, with or without post-graduate qualifications in mental health.

This definition includes nurses in a range of clinical roles for example, clinical nurse specialists or clinical nurse consultants. The following variations on this key term are found in publications comprising chapters of the thesis: Nurses practising/working in mental health/care/settings (see chapters 5, 6, 7, 8, 9).

(m) Multimethod

For the purposes of the thesis, the term multimethod (or multiple-method) refers to the use of two or more data collection methods to investigate a research question in a qualitative study (Roller & Lavrakas, 2015).

(n) Nurse

The term nurse when used in the thesis generally refers to MHNs. The term is used where necessary for concise synthesis of information, clarity of expression, or flow of ideas. If the

term is used for nurses other than MHNs the meaning of the term in that instance is clearly delineated to remove ambiguity.

(o) Oscillation

The term oscillation is associated with CCT and refers to cognition of an individual moving over and back across the continuum of CCT, in response to the blend of cognition required for a cognitive task (Cader et al., 2005; Hammond, 1996).

(p) Patient

There are many descriptors for people requiring care in a mental health setting. For example, some terms used include, client, consumer, service user, and patient. The term patient was chosen for the thesis because it is widely understood and accepted interjurisdictionally as referring to a person receiving health care in any setting (Fischer et al., 2020).

(q) Pattern recognition

The term pattern recognition is associated with CCT and refers to the experientially acquired ability of an observer to recognise and act upon patterns in information, to reach conclusions regarding accessible information laden cues (Hammond, 1996).

(r) Privacy

The term privacy (in reference to information) refers to the common law right to be free from invasion of one's information by others (Grace, 2004). This right also creates a legal

duty to protect that information on the part of any person or entity deemed capable and responsible to do so.

(s) Public interest

The term public interest is purposefully not defined in law or literature, otherwise it risks becoming subject to limitation by judicial precedent or legislative decree. Nonetheless, public interest can be broadly described as anything that is in the interests of society as a whole (Dolan, 2004). In Australia the Full Bench of the High Court, held per French CJ “the term [public interest] derives its content from ‘the subject matter and the scope and purpose’ of the enactment in which it appears” (Hogan v Hinch, 2011, [31]).

(t) Quasirationality

The term ‘quasirationality’ refers to the various blends of intuition and analysis found on the continuum between the wholly intuitive and wholly analytic poles of CCT, with the proportion of each decreasing according to its degree of proximity to its opposing pole (Cader et al., 2005; Lauri & Salanterä, 2002). Quasirationality is also referred to as ‘common-sense’ reasoning (Hammond, 1980, 1996).

(u) Registered Nurse (RN)

A person who is registered as licenced to practice as a nurse. In Australia registered nurses are entitled to use the protected titles ‘nurse’ or ‘registered nurse’ (Health Practitioner Regulation National Law, 2009).

(v) Structured clinical judgement

The term structured clinical judgement refers to the application of intuition to actuarial indicators of risk to create a dynamic blending of intuition and analysis, which is used by MHNs for the assessment and management of patients who may pose a risk to self or others (Faay et al., 2013; Griffith et al., 2013; Murphy et al., 2011; Sands, 2009).

(w) Unstructured clinical judgement

The term unstructured clinical judgement refers to experiential-led clinical intuition, which is used by MHNs for the assessment and management of patients who may pose a risk to self or others (Dhami & Thomson, 2012; Downes et al., 2016).

(x) Vicarious functioning

The term vicarious functioning is associated with CCT and refers to the ability of individuals to engage with the “multiplicity, flexibility, intersubstitutability, and combination” of cues and the organising principles of this information to determine the nature of their environment (Goldstein, 2004, p. 41).

(y) Vicarious mediation

The term vicarious mediation is associated with CCT and refers to the ability of an environment to convey data through information laden cues, partial cues, or redundant cues (Hammond, 1981; Hammond, 2007).

PUBLICATIONS INCLUDED IN THESIS

The thesis includes four original publications and three original papers submitted to peer reviewed journals for publication at the time of submission of the thesis for examination.

1. Conlon, D., Raeburn, T., & Wand, T. (2019). Disclosure of confidential information by mental health nurses, of patients they assess to be a risk of harm to self or others: An integrative review. *International Journal of Mental Health Nursing*, 28(6), 1235–1247. <https://doi.org/10.1111/inm.12642>

Darren Conlon was responsible for:

- Conception and planning of the integrative review
- Literature search
- Data Collection and Analysis
- Preparation of the final report

2. Conlon, D., Raeburn, T., & Wand, T. (2021). Decision-making processes of a nurse working in mental health, regarding disclosure of confidential personal health information of a patient assessed as posing a risk. *Collegian*, 28(3), 261–267. <https://doi.org/10.1016/j.colegn.2020.08.010>

Darren Conlon was responsible for:

- Conception and planning of the theoretical paper
- Literature search

- Data Collection and Analysis
- Preparation of the final report

3. Conlon, D., Raeburn, T., & Wand, T. (2023a). Cognitive Continuum Theory: Can it contribute to the examination of confidentiality and risk-actuated disclosure decisions of nurses practising in mental health? *Nursing Inquiry*, 30(2), e12520–e12520. <https://doi.org/10.1111/nin.12520>

Darren Conlon was responsible for:

- Conception and planning of the legal review and case study
- Literature search
- Data Collection and Analysis
- Preparation of the final report

4. Conlon, D., Raeburn, T., & Wand, T. (2023b). Risk-actuated public interest disclosure practices of nurses working in mental health, pertaining to confidential information of patients. *Issues in Mental Health Nursing*, 44(6), 474-481. <https://doi.org/10.1080/01612840.2023.2214225>

Darren Conlon was responsible for:

- Conception and planning of the investigation and interviews
- Literature search
- Data Collection and Analysis
- Preparation of the final report

5. Conlon, D., Raeburn, T., & Wand, T. (Submitted for publication to *Psychiatry, Psychology and Law*). A qualitative investigation of nurses' knowledge and practice gaps, regarding confidentiality and risk-actuated public interest disclosure-related decision-making in mental health care.

Darren Conlon was responsible for:

- Conception and planning of the investigation and interviews
- Literature search
- Data Collection and Analysis
- Preparation of the final report

6. Conlon, D., Raeburn, T., & Wand, T. (Under second round of peer review for publication at *Issues in Mental Health Nursing*). Mental health risk assessments of patients, by nurses working in mental health settings: A qualitative study using Cognitive Continuum Theory.

Darren Conlon was responsible for:

- Conception and planning of the investigation and interviews
- Literature search
- Data Collection and Analysis
- Preparation of the final report

7. Conlon, D., Raeburn, T., & Wand, T. (Under second round of peer review for publication at *Collegian*). Nurses' understanding of their duty of confidentiality to patients in mental health care: A qualitative exploratory study.

Darren Conlon was responsible for:

- Conception and planning of the investigation and focus groups
- Literature search
- Data Collection and Analysis
- Preparation of the final report

I certify the above attribution statements are true and correct.

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Date: 14 February 2024

As supervisors for the candidature upon which this thesis is based, we confirm the authorship attribution statements above are true and correct.

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Date: 14 February 2024

ABSTRACT

Introduction and aim

Mental health nurses have a duty of confidentiality to their patients. However, they routinely face difficult decisions regarding confidentiality and disclosure of patient information, when patients are assessed as a potential credible risk to self or others. At common law, there is a public interest in protecting patient confidentiality, and a competing public interest in disclosing relevant confidential information to protect the patient or others from harm. Unfortunately, confidentiality and risk-actuated public interest disclosure-related decision-making is poorly understood by mental health nurses. Therefore, the aim of this thesis is to explore these decision-making processes of mental health nurses, with a view to considering how their knowledge and practice of this important area of nursing can be improved.

Methodology and methods

An interpretivist paradigm was adopted for this thesis, using theoretical thematic analysis of data to describe mental health nurses' decision-making processes in a sequential qualitative multimethod design. Data collection method 1 was a documentary examination of the legal framework pertaining to confidential health information in New South Wales; method 2 was an instrumental case study examining a legal matter involving a mental health nurse and disclosure of confidential patient information; method 3 was semi-structured interviews of mental health nurses exploring their risk assessment practises, knowledge of confidentiality, and risk-actuated disclosure of confidential information; and method 4 was focus groups

comprising mental health nurses exploring reasons for knowledge gaps noted in interview data.

Findings

This thesis demonstrates mental health nurses' risk assessment and management decision-making processes are subject to inapposite factors such as fear of personal or professional repercussions, which may lead to the inappropriate handling of confidential information. Furthermore, nurses' knowledge and understanding of their duty of confidentiality to patients is shown to be variable and not always correct, leading to improper practices that may have negative implications for stakeholders. Additionally, nurses demonstrate minimal understanding of public interest decision-making, that is also inappropriately influenced by perceived or actual professional, legal, or organisational factors.

Conclusion

Confidentiality and risk-actuated public interest disclosure-related decision-making in mental health care is a complex area of nursing practice that requires intervention at a clinical and organisational level. Failing to do so may have, personal, professional, legal, financial, or reputational implications for stakeholders. Therefore, this thesis concludes with recommendations for: education, continuing professional development, mental health nurses' practice, organisational policy and procedures, health governance, and future research.

CHAPTER 1: INTRODUCTION TO THESIS

1.1 Introduction

People experiencing mental ill health (patients) commonly interact with mental health nurses (MHNs) when they engage with mental health services. Therefore, there is considerable potential for the care provided by MHNs to enhance or hinder patients' recovery journeys. Unfortunately, one significant area of knowledge and practice that has regularly been found deficient among MHNs relates to confidentiality of patient information and risk-actuated public interest disclosure-related decision-making (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).

This is an important area of MHNs' practice to investigate, because effective patient assessment and ongoing mental health care is predicated on MHNs having access to all relevant information about a patient (Kämpf & McSherry, 2006). However, some of this information may be embarrassing or have negative social consequences for patients. Therefore, there is a duty of confidentiality on the part of MHNs to ensure patients are willing to share their information with them (Barloon & Hilliard, 2016; Kämpf & McSherry, 2006; McHale, 2009).

Nonetheless, there may be times when some of this information must be disclosed, such as when a patient is assessed as posing a potential risk to self or others (Dolan, 2004). However, if this occurs patients may be reluctant to share their information in the future, which is problematic if that information is necessary to identify patient risk and the potential for harm to self or others (Dolan, 2004; Kämpf & McSherry, 2006). Therefore, MHNs must be

reasonably certain a disclosure is necessary. Complicating matters, there may be professional sanctions for a MHN, or significant legal or financial penalties for other stakeholders (such as MHNs' employers) if information is inappropriately withheld or confidentiality is breached (Kämpf & McSherry, 2006; NK v Northern Sydney Central Coast Area Health Service, 2010).

Clearly, education and guidance to address MHNs' knowledge and practice gaps in this complex area of their practice would be beneficial for all stakeholders, but there is a paucity of literature investigating MHNs' decision-making processes in this area of practice to guide these interventions. Therefore, in presenting the first study to investigate this aspect of MHNs' decision-making processes in NSW, this thesis adopts a sequential qualitative multimethod study design to investigate the important topic of MHNs' decision-making processes regarding confidentiality and disclosure of patient information.

1.1.1 A note on the use of 'patient' in this thesis

Terms like consumer, client, or service user, are common in contemporary research literature when referring to people in mental health care (Costa et al., 2019; Dickens & Picchioni, 2012; Simmons et al., 2010). However, many people with a mental health condition dislike these terms (Dickens & Picchioni, 2012; Lugg, 2023; Victorian Mental Illness Awareness Council, 2021). For example, because they are associated with people making informed choices about their care, a descriptor that does not apply to every person with a mental health condition including those involuntarily admitted to a mental health facility. Many alternative terms have been suggested by clinicians and people with a mental health condition, which led Dickens and Picchioni (2012) to conclude the most appropriate term to use is the one each person chooses. However, those authors also advised this approach is impracticable in

literature relating to multiple people. Contemporary researchers have generally concluded the only term widely recognised and accepted by and for people requiring voluntary or involuntary mental health care services is patient (Costa et al., 2019; Dickens & Picchioni, 2012; Lugg et al., 2023; Priebe, 2021; Simmons et al., 2010). Another relevant consideration was that confidentiality is a legal principle and patient is the term used in mental health legislation to refer to people with a mental health condition (Health Records and Information Privacy Act [HRIP], 2002; Mental Health Act, 2007).

1.2 Impetus for thesis

As is the case for many research projects, the impetus for this thesis emerged from a confluence of factors related to my cross-disciplinary professional background. Firstly, I am a registered nurse (RN) with contemporary experience working as a MHN, including with patients who may pose a credible risk to self or other. Secondly, I am a legal practitioner. Thirdly, I am an academic teaching health law and ethics to pre-registration nursing students.

I initially became interested in confidentiality when studying to be a legal practitioner, and concomitantly working as a MHN. I noted many instances where MHNs' (and indeed all clinicians') decision-making processes regarding disclosure-related decision-making in the context of patient risk required further information and guidance, which I was happy to show MHNs (and others) how to attain. This collaborative educative approach is in keeping with the codes and standards of the Australian nursing profession (International Council of Nurses [ICN], 2021; Nursing and Midwifery Board of Australia [NMBA], 2016; 2018, 2020).

My interest in assisting others to acquire knowledge led me to academia, where I set out to deliver for student nurses (amongst other required information) a comprehensive overview of confidentiality and risk-actuated public interest related disclosures to guide their decision-making processes. However, when undertaking an integrative literature review (see Chapter 2) I found a paucity of contemporary empirical literature on the topic, leading to information gaps. Consequently, the integrative literature review led to the study presented in this thesis.

1.3 Thesis structure

This section outlines the structure and provides an overview of each chapter of this thesis.

1.3.1 Thesis including publications

This thesis is a ‘thesis including publications’ (The University of Sydney, 2022). The University of Sydney (2020) supports the thesis including publications approach: per University guidelines, “[s]tudents may include as a publication material that is: (a) submitted for publication; (b) under review for publication; (c) in press; or (d) published” (p. 18). However, “[t]he thesis must form a cohesive and unified whole” (p. 19).

Consequently, this thesis comprises a collection of closely related works. Each publication is the core of the chapter in which it appears, presented as a fundamental part of a systematic and cohesive thesis. Nonetheless, each publication is also complete unto itself, in that it can be read and understood as a stand-alone piece of literature. This approach is possible because this thesis is composed of distinct elements. For example, Chapter 2 includes an integrative literature review, whilst Chapter 3 outlines the theoretical

framework of CCT. This approach ensures thesis-based research adds to extant literature at the earliest opportunity, before a thesis is complete (Mason et al., 2020). The thesis was written by me under supervision, as expected of a PhD candidate. Therefore, authorship and credit statements accompany each publication, reflecting the contributions made by me and my research supervisors to each publication (The University of Sydney, 2020). There are ten chapters in this thesis. A brief overview of each chapter is provided below.

1.3.2 Chapter 1: Introduction to thesis

This chapter introduces the thesis. First, the impetus for the qualitative multimethod study presented in the thesis is proffered. Next, each chapter is briefly described. Following this, the background and context to the thesis is laid out, which includes the origin of confidentiality in NSW. Finally, the aim of the thesis, and research questions derived from an integrative literature review that direct subsequent chapters of the thesis, are outlined.

1.3.3 Chapter 2: Integrative literature review of MHNs and confidentiality

Chapter 2 comprises an integrative literature review of MHNs' understanding of confidentiality, and their processes regarding risk-actuated, public interest disclosure-related, decision-making. Specifically, the chapter presents a publication synthesising current research literature pertaining to the disclosure of confidential information by MHNs, relating to patients they assess to be a potential credible risk of harm to self or others.

1.3.4 Chapter 3: Cognitive Continuum Theory and risk-actuated decision-making

Chapter 3 outlines the theoretical framework of Cognitive Continuum Theory (CCT), within which MHNs' decisions are framed in the thesis. Specifically, Chapter 3 presents a

publication describing CCT and how it has been used to inform previous studies. The chapter also discusses the suitability of CCT for studies pertaining to confidentiality and risk-actuated public interest disclosure-related decision-making processes of MHNs.

1.3.5 Chapter 4: Methodology

Chapter 4 presents the methodology of the thesis, outlining the systematic approach taken to answer the research question and sub-questions presented in Chapter 1. The chapter lays out the methodological design used and the choice of study setting and population, whilst data collection, data analysis, and ethical considerations are explained.

1.3.6 Chapter 5: Confidentiality, legal framework and application in NSW

Chapter 5 presents a legal analysis of the framework of confidentiality for MHNs in NSW and an instrumental case study of a legal matter involving a MHN and confidential information about a patient, heard before the NSW Civil and Administrative Tribunal. Specifically, the chapter presents a publication examining the duty of confidentiality of MHNs to patients in mental health care in NSW, and how allegations of inappropriate risk-actuated public interest disclosure-related handling of confidential information are dealt with by legal decision makers.

1.3.7 Chapter 6: Risk assessment decision-making processes of MHNs

Chapter 6 is the first of three consecutive chapters that report themes identified by deductive theoretical thematic analysis of data obtained from a series of individual semi-structured interviews of MHNs. Specifically, the chapter presents a paper undergoing peer

review for publication exploring risk assessment decision-making processes of MHNs for patients in mental health care in NSW, framed by CCT.

1.3.8 Chapter 7: MHNs' understanding of their duty of confidentiality

Chapter 7 also reports themes identified in the semi-structured interview data obtained from these MHNs. Specifically, the chapter presents a paper undergoing peer review for publication exploring MHNs' understanding of their duty of confidentiality to patients in mental health care in NSW.

1.3.9 Chapter 8: Risk-actuated disclosure-related decision-making processes of MHNs

Chapter 8 is the final chapter to report themes from the individual semi-structured interviews of these MHNs. Specifically, the chapter presents a publication exploring MHNs' risk-actuated public interest disclosure-related decision-making processes pertaining to confidential patient information, framed by CCT.

1.3.10 Chapter 9: Causal factors for MHNs' knowledge and practice gaps

Chapter 9 reports themes identified by the deductive theoretical thematic analysis of data obtained from focus groups comprising MHNs. Specifically, the chapter presents a paper submitted for publication exploring in a collaborative group setting, causal factors for gaps in MHNs' confidentiality and risk-actuated public interest disclosure-related decision-making processes revealed in the semi-structured interviews.

1.3.11 Chapter 10: Conclusion to thesis

Chapter 10 closes the thesis with an overview of study findings in light of the research question and sub-questions posed in Chapter 1, followed by a conclusion to the thesis. Research strengths and limitations are described, and areas for future research are identified. The chapter also makes recommendations for: the management of confidential information in the clinical environment; organisational policies and procedures; health governance; future research; education; and other strategies to promote appropriate handling of confidential information when patients pose a potential credible risk to self or others.

1.4 Background to thesis

This section provides the background to the thesis. First, the foundation and development of NSW from an English penal colony to a self-governing jurisdiction of the common law federation of modern Australia is described. Next, the origins and legal status of confidentiality for MHNs (and all clinicians) in NSW as it exists today is outlined. Lastly, an outline of terminology related to confidentiality concludes this section.

1.4.1 The jurisdiction of NSW

The common law system of judicial precedent emerged in England following the Norman Conquest of 1066, accompanied by the development of equitable doctrines to ensure fairness in application of the law (Hudson, 1996; Mousourakis & Nicolini, 2019). The common law was subsequently promulgated in the various countries conquered or colonised by England over the centuries, where it now sits parallel to and in tandem with

legislation (Mousourakis & Nicolini, 2019). Consequently, the Commonwealth of Australia was founded as a common law federation of states and territories from a group of English colonies established on First Nations' lands in Oceania between 1778 and 1901 (Macintyre, 2020). Post-federation, each jurisdiction of the Commonwealth (including the state of NSW) maintained its own legal and administrative systems within permitted limits, under the jurisdictional umbrella of the Australian government (Commonwealth of Australia Constitution Act, 1900).

As time progressed, state legislatures made new legislation and their courts handed down state specific decisions, so differences in the law amongst the states and territories emerged (Hill, 2005). As a result, research regarding interpretation of the law in Australia (excluding Commonwealth law) that is not comparative in nature must generally be limited in jurisdiction. Confidentiality is an example of a legal concept that shares the same heritage across Australian (and international common law) jurisdictions because it originated in common law and equity, but is also subject to local legislative, judicial, and cultural influences (Kerridge et al., 2013). For example, rules governing health information in NSW are not necessarily mirrored in the legal frameworks of other states (HRIP, 2002; Kerridge et al., 2013). Nonetheless, confidentiality remains primarily a common law concept, with a supplementary legislative overlay that generally directs how confidential information should be handled in certain circumstances (HRIP, 2002; Privacy and Personal Information Protection Act, 1998).

1.4.2 Duty of Confidentiality

A duty of confidentiality manifests at common law in NSW when information is shared by a person with the proviso it is not to be released to others without consent, or where the

person receiving the information is reasonably expected to understand the information is confidential (Australian Broadcasting Corporation v Lenah Game Meats Pty Ltd, 2001; Griffith, 2007). Certain relationships carry an inherent duty of confidentiality, such as those between a MHN and their patients (Griffith, 2007). A breach of confidentiality occurs if information is used for a purpose other than the purpose for which it was shared (Dal Pont, 2015).

The concept of confidentiality and the duty it imposes have been known for millennia. For example, the original ancient Greek version of the Hippocratic Oath from circa 400 BC, versions of which are still sworn by many doctors today, in translation states “[w]hatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge ...” (Hippocrates & Adams, 1849).

In the early days of colonisation in NSW, the concept of confidentiality was based on the English understanding of a ‘gentleman’s agreement’ to not share certain sensitive information to which one was privy (Jerian, 1989). However, judicial precedent for our current approach to confidentiality was finally established in English law in the middle of the nineteenth century, when efforts by a publisher to disseminate publicly for profit, drawings provided for a private family printing, were considered by the courts to be actionable for relief (Albert v Strange, 1849).

Subsequent jurisprudence crystallised: the duty of confidentiality; the right of people to take action for breach of confidence; and the three exceptions when confidential information may be released which are, with consent, by operation of the law, or in the public interest (McHale, 2009; Solove & Richards, 2007). The common law, legislative, and

regulatory frameworks that frame the duty of confidentiality for MHNs (and all clinicians) in NSW will be described in detail in Chapter 5.

1.4.3 Secrecy and privacy

The term confidentiality is often used interchangeably with secrecy or privacy, but there are differences. Firstly, secrecy refers to information a person does not want made known to others, whereas confidential information is information that is disclosed in confidence (generally for a specific purpose) with the expectation it will not be shared further without consent (Griffith, 2007; Solove & Richards, 2007). A key distinction in character between the two concepts is a person can release their own secrets, but their confidentiality can only be breached by another (Kuan, 1990). Additionally, confidential information may be secret, but becoming privy to secret information does not necessarily impart a duty of confidentiality on the receiver (Solove & Richards, 2007).

The term privacy (in reference to information) differs in that it refers to the common law right to be free from invasion of one's information by others. This right also creates a duty to protect that information on the part of any person or entity deemed capable and responsible to do so under the law (Grace, 2004; HRIP, 2002). For example, a MHN caring for a patient has a duty to not leave the patient's medical record open and unattended, because it could be accessed by a third party with no legal interest in knowing the information contained in the record.

1.5 Overview of thesis

This section will provide an overview of the thesis by presenting the aim, research question, and significance of the thesis.

1.5.1 Aim of thesis

The aim of the thesis is to explore confidentiality and risk-actuated public interest disclosure-related decision-making processes of MHNs, pertaining to confidential information of patients.

1.5.2 Research question

What are MHNs' decision-making processes regarding confidentiality and disclosure of confidential information pertaining to patients assessed as posing a potential credible risk of harm to self or others?

Sub-questions

1. How are the concepts of risk, confidentiality, and the public interest, understood by MHNs?
2. Does the setting in which a decision is made influence MHNs' decision-making processes?
3. Does the level of experience of MHNs influence their decision-making processes?
4. For what reasons do MHNs justify withholding or disclosing confidential information in the public interest, when a patient is assessed as posing a credible risk of harm to self or others?

1.5.3 Significance of thesis

Patients experiencing mental ill-health often face significant levels of distress accompanied by considerable social and emotional challenges. Therefore, how MHNs understand confidentiality, and make risk-actuated public interest disclosure-related decisions for people when they engage with mental health care services, can have a considerable impact on their mental health recovery journeys (and that of their families and significant others).

Consequently, this thesis is significant because it aims to determine how MHNs understand confidentiality and disclosure in regard to patients who may pose a credible risk to self or others in mental health care. Research findings can contribute to: the management of confidential information in the clinical environment; educational strategies to promote appropriate handling of confidential information; handling of confidential information when patients pose a potential risk to self or others; organisational policies and procedures; health governance; and future research in this area of MHNs' practice.

1.6 Conclusion

Chapter 1 commenced by proffering the impetus for the thesis. The thesis structure was outlined, and a brief overview of each chapter of the thesis was presented. The background and context of the research was described. The chapter concluded by laying out the aim of the thesis, and the research question derived from an integrative literature review that directs the focus of subsequent chapters of the thesis. Next, Chapter 2 presents the integrative literature review of MHNs' knowledge of confidentiality, and their processes regarding risk-actuated public interest disclosure-related decision-making.

CHAPTER 2: INTEGRATIVE LITERATURE REVIEW OF MENTAL HEALTH NURSES AND CONFIDENTIALITY

2.1 Introduction

Chapter 2 presents an integrative literature review of MHNs' understanding of confidentiality, and their processes regarding risk-actuated public interest disclosure-related decision-making. Specifically, this chapter presents a publication synthesising current research literature pertaining to the disclosure of confidential information by MHNs, of patients they assess to be a potential credible risk of harm to self or others. Gaps identified in the literature by this integrative review are then addressed by the study presented in subsequent chapters of the thesis.

2.2 Integrative literature review

Author attribution statement and attestation

Chapter 2 of this thesis is published as '*Disclosure of confidential information by mental health nurses, of patients they assess to be a risk of harm to self or others: An integrative review*'.

I, Darren Conlon was responsible for:

- Conception and planning of the integrative review
- Literature search
- Data Collection and Analysis
- Preparation of the final report

Signature:

Name: Darren Conlon

Date: 14 February 2024

As supervisors for the candidature upon which this thesis is based, we confirm the authorship attribution statement above is correct.

Signature:

Name: Timothy Wand

Date: 14 February 2024

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REVIEW ARTICLE

Disclosure of confidential information by mental health nurses, of patients they assess to be a risk of harm to self or others: An integrative review

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ABSTRACT: *There is a duty of confidentiality on the part of mental health nurses when they handle confidential patient information. Nonetheless, it may be necessary to disclose confidential information of a patient if the patient is assessed as being a risk to self or others, to protect the patient or others from harm. However, disclosing information inappropriately may constitute a breach of confidentiality. There is a paucity of information on how mental health nurses understand the rules of confidentiality when deciding to withhold or disclose confidential information in these circumstances. An integrative review of the literature was undertaken to explore the disclosure of confidential information by mental health nurses when they assess a patient as being a risk of harm. The findings indicate the rules of confidentiality are not well understood, or are not adhered to by mental health nurses. Risk assessments were found to underpin deliberations to withhold or disclose confidential information of a patient, despite risk being difficult to predict with any certainty. For risk assessment, mental health nurses were noted to prefer their unstructured clinical judgement over actuarial methods; and defer to their clinical intuition over scores of a structured risk assessment instrument, when making structured clinical judgement-backed decisions in this area of their practice. Gaps in the literature that may be addressed by future empirical research were revealed during this integrative review.*

KEY WORDS: aggression, confidentiality, psychiatric nursing, risk assessment, self injurious behaviour.

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Authorship statement: All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors. DC contributed to the conception of this integrative review. All authors contributed to refining and further development of the original concept; literature search and analysis; thematic analysis of data; extraction of findings; manuscript editing; and approval of final draft of manuscript.

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INTRODUCTION

For effective assessment and care to take place, it is ideal for clinicians such as mental health nurses to have access to pertinent personal health information of patients (Kämpf & McSherry 2006). However, from the patients' perspective, sharing personal information with mental health nurses may be considered highly sensitive and even embarrassing (Barloon & Hilliard 2016). Accordingly, there is a public interest in ensuring the confidentiality of personal information, to encourage patients to share this information with mental health nurses (Kämpf & McSherry 2006). This duty of confidentiality on the part of mental health nurses (and all health professionals) protects patients' personal health information from being released inappropriately (McHale 2009).

In the literature, 'confidentiality' is often closely associated with the term 'privacy'. The two concepts are even used interchangeably, when they do not mean the same thing. It is important for mental health nurses to understand the difference (Grace 2004). Confidentiality in health care refers to the common law duty that arises, when certain personal information is shared by a person, with an expectation that this information will not be released to others (Griffith 2007). Privacy differs in that it is the right to be free from interference in one's personal affairs (Grace 2004). The concepts of privacy and confidentiality are derived from the ethical principle of autonomy, which refers to the right of an individual to self-determination (Grace 2004; Griffith 2007). Particular relationships are deemed to give rise to a duty of confidentiality, including the relationship between a patient and a mental health nurse (Griffith 2007). However, the duty of confidentiality may be overridden and confidential information disclosed with patient consent; by statutory or judicial disclosure; or when there is a paramount competing public interest in disclosure of certain information (McHale 2009).

Several studies have explored concepts related to mental health nurses and confidentiality. Yet, no synthesis of the existing literature related to confidentiality and disclosure of confidential information when a patient poses a risk of harm to self or others has been undertaken. This paper provides an integrative review of contemporary literature regarding the decision-making processes that underpin mental health nurses' considerations on confidentiality in such circumstances.

BACKGROUND

Dilemmas arise for mental health nurses when consent or the law does not permit disclosure of confidential information, particularly when the mental health nurse develops a belief that the patient is a risk of harm to self or others. There is a public interest in disclosing this information to persons (including potential victims) or authorities that may be in a position to protect the patient or others from harm (Dolan 2004). However, should the mental health nurse disclose this information, the patient may be reluctant to share information in the future (Dolan 2004; Kämpf & McSherry 2006). Although unlikely, there is the possibility the mental health nurse may be vulnerable to claims for negligence or breach of confidentiality, or (more likely) regulatory or professional sanction, if confidentiality is breached unnecessarily (Kämpf & McSherry 2006).

Education and training is important, to assist mental health nurses to only disclose confidential information in the public interest when absolutely necessary (Gray *et al.* 2008). There is an expectation amongst the public that mental health nurses can conduct an adequate risk assessment, correctly identifying or discounting potential harm and intervening only when required (Higgins *et al.* 2016). However, there is a persistent stigma of inherent dangerousness attached to a mental health diagnosis, which may impact on judgements of potential harm (Wand 2011). Furthermore, dangerousness criteria are an integral part of the mental health legislation of most developed countries (Large *et al.* 2008). Mental health nurses are advised to replace consideration of dangerousness with consideration of risk, a dynamic concept that operates along a continuum from no detectable risk to a present risk of harm (Norko & Baranoski 2008).

However, for disclosure following a risk assessment, there is a paucity of literature on balancing the public interest in confidentiality against the public interest in disclosure, to determine when the threshold for disclosure has been reached. The term 'public interest' is not defined in the literature, but described as a relative legal concept pertaining to any matter necessary for the good of society as a whole (Dolan 2004). The application of the public interest was explored at common law in an Australian case that confirmed the validity of suppression orders on certain information about alleged and convicted paedophiles. French CJ, in a unanimous decision of the Full Bench of the Australian High Court, held 'the term [public interest] derives its content from 'the subject matter and the scope and purpose' of the enactment in which it appears' (Hogan v Hinch 2011, [31]). Mental health nurses are required to ensure their public interest disclosures of confidential patient information are validly made to circumvent harm, and to understand how they do so requires an exploration of the literature on disclosure of confidential information by mental health nurses.

AIM

The aim of this integrative review was to explore and synthesize existing research related to the disclosure of confidential information by mental health nurses, of patients they assess to be a risk of harm to self or others.

METHODS

An integrative review was chosen for this exploration and synthesis of the literature because this approach

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permits researchers to include diverse methodologies. This sets the integrative review apart from all other literature reviews, and enables a synthesis of the literature that may include both empirical and theoretical studies. In presenting the findings of this integrative review: existing literature was synthesized; deficits in the literature were identified; and areas for future research were explicated. The literature search for this integrative review was conducted using a five-step approach which includes question formulation; literature search; data appraisal; data analysis; and presentation of findings (Whittemore & Knafl 2005).

Search strategy

A literature search was conducted in March 2019 scrutinizing literature published between the years 2008–2019 using the following databases: CINAHL; Health Source: Nursing/Academic Edition; Lexis Advance Pacific; MEDLINE; Psychology and Behavioral Sciences Collection; PsycINFO; Scopus; and Westlaw AU. The following keywords were used as search terms independently and in combination: psychiatric nurs*; mental health nurs*; forensic nurs*; risk assessment; risk management; harm*; confidentiality*; aggressi*; violent*; self harm*; risk*; and suicid*.

Screening

A total of 1,728 publications were identified and downloaded to EndNote. Duplicate publications were

searched for electronically and manually using End-Note, and 928 duplicates were removed. The remaining 800 publications were reviewed for relevance by reading the title and/or abstract and applying the inclusion and exclusion criteria outlined in Table 1. This incorporated the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA, see Fig. 1). Twenty-eight publications were identified for reading the full text, and a further eight publications were identified from the reference lists of these publications. The full text of the thirty-six publications was read by the three researchers, and eleven full-text empirical publications outlined in Table 2 were included in this integrative review.

Quality appraisal

The Mixed Methods Appraisal Tool was used to assess these publications (Hong *et al.* 2018a). The tool has been evaluated for validity and reliability in assessing qualitative, quantitative, and mixed methods approaches to empirical research (Hong *et al.* 2018b). Each publication was appraised by Researcher One and Researcher Two against the five criteria of the tool that corresponded to the method of research used in that publication. When appraisals differed, the publication and the criteria of the tool were discussed by the researchers until consensus was reached. The results of the appraisal for each publication are represented in Table 2. A bullet point (●) denotes each criterion of the tool met by the publication. All eleven publications

TABLE 1: Inclusion and exclusion criteria

	Inclusion criteria	Exclusion criteria
Context	● Mental health ● Risk of harm ● Confidentiality and disclosure	● Did not relate to mental health ● Did not relate to risk of harm ● Did not relate to confidentiality and disclosure
Purpose	● Studied confidentiality and disclosure for mental health nurses, for patients who may pose a risk of harm to self or others	● Did not study confidentiality and disclosure for mental health nurses, for patients who may pose a risk of harm to self or others
Content	● Referred to confidentiality and disclosure in the healthcare setting for mental health nurses. ● Referred to issues relevant to confidentiality and disclosure in the healthcare setting for mental health nurses	● Did not refer to confidentiality and disclosure in the healthcare setting for mental health nurses. ● Did not refer to issues relevant to confidentiality and disclosure in the healthcare setting for mental health nurses
Language	● English language	● Non-English language
Timeframe	● Published between 2008 and 2019	● Published prior to 2008
Publications	● Peer-reviewed: ○ qualitative studies; ○ quantitative studies; ○ mixed methods studies	● Opinion pieces ● Letters ● Academic textbooks ● Literature reviews ● Discussion papers ● Unpublished conference papers

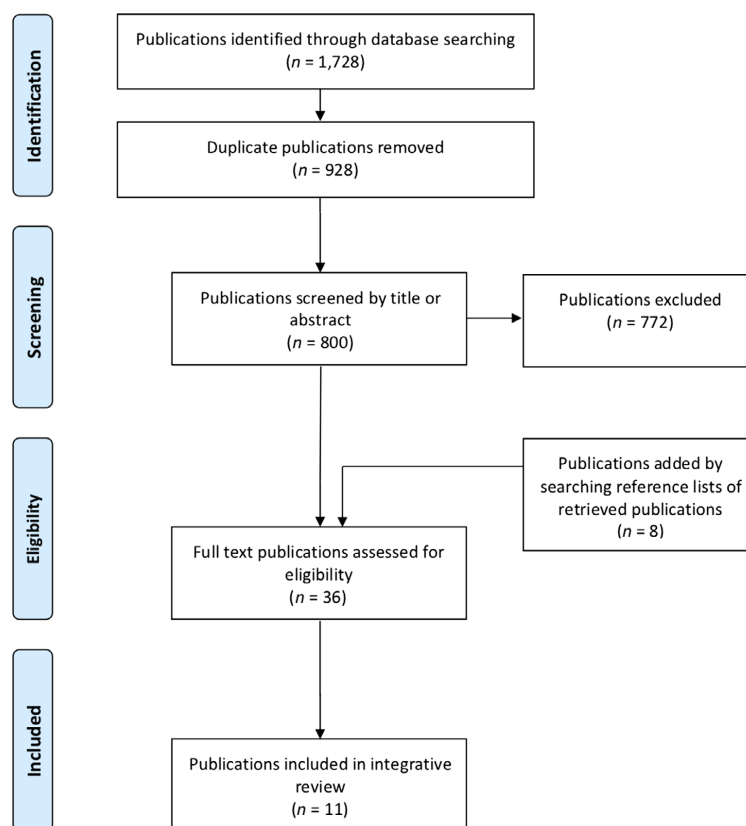


FIG. 1: PRISMA search strategy diagram, adapted from Moher et al. (2010). [Colour figure can be viewed at wileyonlinelibrary.com]

were considered methodologically sound. One publication met three criteria, one met four, and the other nine publications met all five criteria of the Mixed Methods Appraisal Tool (Hong *et al.* 2018a).

Analysis

The diverse methodologies incorporated in an integrative review can make comparative analysis difficult because of the various ways in which findings are reported. Therefore, a thematic extraction method was applied to the publications in this integrative review. The publications were read and re-read until the researchers were familiar with the material. Data were extracted from each publication and coded by content

in accordance with the aim of the integrative review, using NVivo software. Data with similar codes were then grouped together into themes. The themes were defined and named according to the content of each theme. The relationship between each theme was determined, and each theme was then edited a number of times to ensure a logical flow of information. This allowed the researchers to synthesize the data from each publication into a comprehensive overview of the area (Crowe *et al.* 2015).

FINDINGS

Eleven published studies were identified from the literature searched for this integrative review. Three were

TABLE 2: List of publication included in Integrative Review

Author (Year) Country	Method	Participants	Aim	Outcome	Mixed methods assessment tool score
Blando <i>et al.</i> (2013) United States	Mixed methods, Cross-sectional survey, Documentary review of injury logs	Mental health nurses from a mental health unit (<i>n</i> = 143), and emergency department nurses (<i>n</i> = 314)	To assess how nurses' perception of their safety and risk of violence was affected by their work environment, and whether this perception correlated with their actual risk	a. Mental health nurses were exposed to verbal assault more often, but only 1% described feeling unsafe. b. Emergency nurses' fears did not correlate with assault data and were not a predictor of assault. c. Emergency nurses were less fearful if not regularly exposed to verbal abuse, whilst a perceived lack of safety resources had a negative effect on feeling safe a. Assessment of self-harm highly variable amongst institutions. b. Presence of assessment policies is associated with higher assessment rates. c. Assessment rates varied, based on patient characteristics. d. A substantial proportion of current risk of self-harm may go unidentified.	•••••
Caterino <i>et al.</i> (2013) United States	Quantitative, Prospective observational cohort study	Patient ED-SAFE screening instrument records (<i>n</i> = 94 354) from a number of emergency departments (<i>n</i> = 8)	a. Describe current self-harm assessment practice. b. Identify department and patient characteristics predictive of being assessed for self-harm in the general emergency department population.	a. 19.5% of respondents had not received training on violence management. b. Most common interventions were physical restraint, seclusion and medications. c. Top priorities for education and research included circumventing violence; the influence of environment and staff on levels of aggression; best practice in responding to aggression; and risk assessment and the aetiology and triggers for aggression and violence	•••••
Cowan <i>et al.</i> (2017) Bahrain	Mixed methods, eDelphi study, Qualitative survey, Quantitative Likert scale survey	Members of mental health professional and service organisations (<i>n</i> = 2809) from seventeen European countries. 57.1% of participants were mental health nurses (<i>n</i> = 1598)	To describe response to aggression and violence, and priorities amongst staff in mental health services, across seventeen European countries	a. Tool has substantial interrater reliability. b. Tool provides useful information to inform nursing care. c. Description of subscales is unclear, making tool difficult to score. d. Tool only suitable for adult patients	•••••
Fay <i>et al.</i> (2013) Netherlands	Mixed methods, Cross-sectional questionnaire study, Focus groups	Inpatient and outpatient mental health units. Study mental health nurses (<i>n</i> = 23), and focus groups (<i>n</i> = 2)	To evaluate the interrater reliability and clinical utility of the Kennedy Axis V instrument in assessing risk of violence and other adverse patient outcomes		•••••

(Continued)

TABLE 2: (Continued)

Author (Year) Country	Method	Participants	Aim	Outcome	Mixed methods assessment tool score
Gray <i>et al.</i> (2008) United Kingdom	Qualitative. Semi-structured interviews	Strategic staff from various settings in mental healthcare delivery, including mental health nurse managers ($n = 65$)	a.To examine confidentiality barriers to information shar- ing with carers of people with mental health conditions. b.To determine key issues, and legal and ethical resource and practice dilemmas staff see for themselves and carers	a.Clinicians withhold information from carers, even in scenarios of risk management and potential harm. b.Carers have the capacity to be 'experts' in care, when facilitated by mental health clin- icians. c.Clinicians require training, particularly in carer rights and including carers' assess- ments when assessing patients	• • • • •
Griffith <i>et al.</i> (2013) Australia	Quantitative. Analysis of DASA-IV scores versus unaided clinical judgement; and DASA-IV completed with structured clinical judgement	One acute and one secure, nonforensic mental healthcare unit. Pilot study of mental health nurses ($n = 35$), followed by an experimental study of mental health nurses ($n = 42$)	a.To compare predictive validity of DASA-IV to unaided clinical judgement. b.To examine the incremental predictive validity of actuari- ally derived risk assessment scores using DASA-IV total score with structured clinical judgement	a.Total DASA-IV scores were more accurate in identifying imminent aggression than unaided clinical appraisals of risk in non- forensic mental health settings. b.Inclusion of clinical judgement following review and scoring of the DASA-IV wors- ened the predictive accuracy of the DASA- IV	• • • • •
Higgins <i>et al.</i> (2016) Ireland	Quantitative. Statistical analysis of anonymous hardcopy survey	Mental health nurses working in various mental health settings ($n = 381$)	a.To explore practices in risk assessment and safety plan- ning. b.To identify: level of confi- dence in risk assessment and safety planning; extent of adoption of principles of recovery in relation to risk; and training needs in risk assessment and management	a.Mental health nurses concentrate on high- consequence/low-frequency end of risk spectrum. b.There is an emphasis on risk to self and others, but other risks to patient are over- looked. c.Practice is risk-adverse, not recovery-ori- ented. d.Education is required on holistic conceptu- alisation of risk, incorporating safety plan- ning and dignity of risk and the right to failure	• • • • •

(Continued)

TABLE 2: (Continued)

Author (Year) Country	Method	Participants	Aim	Outcome	Mixed methods assessment tool score
Mason <i>et al.</i> (2010) United Kingdom	Mixed methods. Quantitative analysis of key Tarasoff-related words, and phenomenological thematic exposition of participant responses, in completed Tarasoff vignette schedules	External recruitment by poster of forensic practitioners ($n = 40$), including forensic mental health nurses ($n = 10$)	To explore forensic multidisciplinary decision- making when a patient is at risk to others, and perspectives of Tarasoff liability	a. Passing on information is important. b. Patients should be advised confidential information may be disclosed. c. Mental health nurses agreed persons at risk ought to be informed. d. Mental health nurses passed threats to psy- chiatrists or managers rather than 'others' at risk, and felt blameless should harm occur after information had been passed to psy- chiatrists	• • •
Murphy <i>et al.</i> (2011) United Kingdom	Quantitative. Prospective cohort study of assessment forms completed for individuals presenting with self-harm	Mental health triage ($n = 3$) assessment forms ($n = 3491$) completed by mental health nurses ($n = 2626$) and psychiatrists ($n = 865$)	To compare risk assessments by psychiatrists and mental health nurses following an episode of self-harm	a. Risk assessments are comparable by profes- sion. b. Repeat self-harm is difficult to predict. c. There was strong agreement on factors asso- ciated with high-risk assessment by both professions. d. Psychiatrists are more likely to admit people for inpatient treatment	• • • • •
Sands (2009) Australia	Mixed methods. Descriptive statistical survey. Semi-structured interviews	Mental health triage, survey ($n = 139$) and semi- structured interviews ($n = 21$) of mental health nurses	To investigate the scope of mental health triage nursing practice in Victoria, Australia	a. There is a lack of evidence-based frame- works to inform and support triage decision- making practice. b. Clinicians rely on clinical experience to underpin decision-making and have little knowledge of theoretical models	• • • • •
Sands <i>et al.</i> (2013) Australia	Mixed methods. Preliminary reliability testing, with mental health nurses assigning triage categories to scenarios. Observational data collection	Mental health triage observation using dual wireless headphones, during mental health telephone triage by mental health nurses ($n = 197$)	To identify the core competencies required to perform safe and effective mental health telephone triage, including key role tasks, skills, knowledge, and responsibilities	There are seven core areas of competence required including opening the call; performing mental status examination; risk assessment; planning and action; termination of call; referral and reporting; and documentation	• • • • •

from Australia, three from the United Kingdom, two from the United States, and one each from Ireland, the Netherlands, and Bahrain. All studies related to mental health nurses, and confidentiality and disclosure for patients who are a risk of harm to self or others.

Theme 1: confidentiality and mental health nurses' duty of care

The first theme to emerge from the literature related to confidentiality and disclosure is *decision-making by mental health nurses when a patient is assessed to be a risk of harm to self or others*. A disclosure of confidential information in the public interest to prevent potential harm to others is part of risk management and may be categorized as a 'duty to warn or protect' from harm. A mixed method vignette study of mental health clinicians' (including mental health nurses) attitudes by Mason *et al.* (2010) revealed that a 'duty to warn or protect' is a legal obligation in many states of the United States and a moral one outside these jurisdictions. The researchers noted confidentiality is considered a core value in mental health practice. However, in the absence of a legal duty to warn mental health clinicians still believed the duty of confidentiality is limited when a patient was assessed as posing a risk of harm to others (Mason *et al.* 2010).

There is guidance in the literature on the disclosure of confidential information in acute mental health care. An observational study of mental health telephone triage undertaken by Sands *et al.* (2013) to identify and describe the management of these mental health emergencies by mental health nurses identified that a 'Triage Code A' permitted mental health nurses to immediately disclose the patient's condition to emergency services, including the police. This category was indicated when 'current actions endangering self or others' were evident and was assigned to callers engaged in overdose, siege, suicide attempt in progress, and extreme violence including with a weapon (Sands *et al.* 2013). Mason *et al.* (2010) discovered mental health nurses were the clinicians most likely to disclose confidential patient information and issue a warning to others should a risk of harm become apparent. However, mental health nurses were least likely to disclose confidential information to the police. Their preference was to escalate this information to a psychiatrist or nurse manager. Mental health nurses also believed they were blameless should harm occur once they had passed the information on (Mason *et al.* 2010).

Evidence suggests the legal rules surrounding confidentiality and disclosure are not always understood, or are understood but not adhered to in practice. Gray *et al.* (2008) interviewed carers of mental health consumers and strategic staff (including mental health nurse managers) who engaged with these carers. Their study revealed that information about mental health consumers was being withheld from their carers and significant others. A lack of knowledge of the rules of confidentiality proved to be a barrier to sharing patient information that might circumvent harm (Gray *et al.* 2008). Conversely, Sands (2009) determined information on mental health consumers is gathered by mental health nurses from multiple sources including relatives. It is reasonable to argue that the collection of collateral information from third-party sources including relatives can be problematic, because some disclosure is unavoidable. At a minimum, the source will need to be advised of the identity of the patient. However, it is not clear from the study if patient consent was obtained prior to information collection from relatives, or whether there was a law that permitted this information collection method (Sands 2009). In the absence of either of these exceptions to confidentiality, this disclosure to relatives requires a public interest exception to prevent harm, something that would only be possible to determine following a focused assessment (Gray *et al.* 2008).

Higgins *et al.* (2016) noted patient consent is usually required to involve carers and significant others in a patient's care. However, both carers and significant others complain their concerns about patient risk are not taken seriously or acted upon by mental health clinicians, and they remain the stakeholder group least likely to be consulted about a patient. They also report being marginalized during discussions about medical diagnosis, treatment, and patient recovery (Gray *et al.* 2008; Higgins *et al.* 2016). Mental health nurses conveyed to Higgins *et al.* (2016) that the inclusion of significant others was an area of mental health care where they lacked confidence in their ability to do so. These mental health nurses viewed further training in risk assessment and management as important, but significantly for confidentiality and disclosure only a small number of participants identified the importance of further training in national policy and the law (Higgins *et al.* 2016). Gray *et al.* (2008) concluded training in confidentiality and disclosure is necessary for mental health clinicians. However, the researchers also discovered a lack of resources available to inform clinicians when

resolving the complex ethical and legal questions that arise in this area of mental health care.

Theme 2: mental health nurse roles in assessment and management

The *relationship of mental health nurses' decisions on risk to decision-making on confidentiality and disclosure* was the second theme to emerge during this review of the literature. A quantitative study by Higgins *et al.* (2016) found most mental health nurses undertook risk assessments in their practice, and that the risks most commonly assessed were risk of harm to self and risk of harm to others. However, the researchers discovered a focus on risk prevention despite risk being unpredictable, at the expense of risk management and the incorporation of positive risk in recovery planning. Many mental health nurses were observed to not enact a safety plan for a patient after conducting a risk assessment, but a positive correlation was noted between staff training and a propensity to undertake safety planning (Higgins *et al.* 2016).

The location of practice has been demonstrated to have an incongruent impact on perceptions of risk. Blando *et al.* (2013) revealed nurses in an emergency department were more likely to feel at risk when exposed to verbal abuse from patients, than mental health nurses on a mental health unit. Despite this fear, these researchers found verbal abuse or perceived level of safety has no correlation with actual risk of assault. When discussing their observations, the researchers noted mental health nurses in the study were more likely to have some knowledge of their patients, in contrast to the unknown quantity inherent in acute patient presentations to the emergency department. However, mental health nurses also reported having more training to deal with abusive situations, suggesting the differences in perceived level of risk might not be explained by location of practice alone (Blando *et al.* 2013). Sands (2009) also detected differences in the level of perceived responsibility in one's decision-making of mental health nurses depending on their location. The researcher found city-based mental health nurses felt more responsibility than rural-based mental health nurses, whilst mental health nurses in emergency departments felt more responsibility than community-based mental health nurses or mental health nurses on inpatient mental health units. For the emergency department, the responsibility felt during mental health triage decision-making was reported to be a stressful experience by mental health nurses (Sands 2009).

Cowman *et al.* (2017) ascertained in an eDelphi study of members of experienced mental health professional and service organizations including mental health nurses, that a large number of mental health clinicians had never undertaken education and training in risk assessment, and many others had not received any training in the previous 5 years. Participants felt education was required in risk assessment; harm prevention; and precipitators of patient violence and aggression (Cowman *et al.* 2017). Education would also benefit junior mental health nurses whilst they were learning to prioritize their observations, because many formal undergraduate and postgraduate courses do not cover risk assessment in any great detail, if at all (Faay *et al.* 2013).

Caterino *et al.* (2013) in a prospective observational cohort study noted a majority of patients presenting to the emergency department with suicidal ideation were not identified as requiring a risk assessment. These authors found proactively increasing the number of patients given a risk assessment did pick up a greater number of patients at risk of harm. However, there was no improvement to the overall percentage of patients identified as at risk. Consequently, it is reasonable to conclude that choosing a random sample of patients for a risk assessment would yield a similar percentage as targeting specific patients based on perceived indicators of potential risk of self-harm, indicating that identifying risk in these circumstances using targeted risk assessment may be little better than chance. The researchers were unable to ascertain whether it would be more effective to augment clinicians' targeted screening strategies to identify patients who may need a risk assessment, or to implement an improved screening instrument for all presentations to the emergency department (Caterino *et al.* 2013). Notably, Murphy *et al.* (2011) in a prospective cohort study observed little difference between psychiatrists and mental health nurses in their ability to anticipate subsequent incidents of self-harm amongst self-harm presentation to the emergency department.

Theme 3: actuarial approaches versus clinical intuition in decision-making

The third theme to emerge from the literature was *the continuum of objective actuarial approaches to subjective clinical intuition that underpins mental health nurses' decision-making*. For mental health nurses' decisions on risk that precede and underpin disclosure, Griffith *et al.* (2013) support the premise that statically

backed actuarial approaches surpass in accuracy mental health nurses' clinical intuition-backed unstructured clinical judgement. However, these researchers also discovered mental health nurses prefer their clinical intuition over empirically derived instrument scores when making structured clinical judgement-backed decisions. Sands (2009) reported mental health nurses defer to 'clinical experience and common sense' rather than theoretical models when making decisions at mental health triage. Sands et al. (2013) described mental health telephone triage as unreliable because mental health nurses are not face to face with a patient and cannot use all of their intuition-backed clinical skills of observation when assessing risk. However, despite the propensity noted in the literature of mental health nurses to defer to their clinical intuition, there is a paucity of literature on how mental health nurses conceptualize risk when making risk-related decisions (Higgins et al. 2016).

Sands (2009) recommended mental health nurses exercise caution when using unstructured clinical judgement, because a definitive link between unstructured clinical judgement and effective triage decision-making has not been demonstrated. Higgins et al. (2016) concluded mental health nurses tend to focus on dramatic or high-impact observations when using unstructured clinical judgement that may not indicate a risk of harm in most mental health patients, and can lead to inaccurate determinations of level of risk. Consequently, it is reasonable to assume these determinations may be followed by inappropriate decisions on risk management; confidentiality; and disclosure. Conversely, '[a]ctuarial approaches involve the mathematical combination of risk factors based on epidemiological evidence', but do not take a patient's individual characteristics into consideration (Murphy et al. 2011, p. 134). Consequently, Murphy et al. (2011) note actuarial approaches may predict but will not manage risk.

Therefore, a theoretical fact-based approach that takes advantage of the positive aspects of actuarial approaches and mental health nurses' clinical intuition, and minimizes the shortcomings of each, is recommended. This structured clinical judgement approach involves the application of mental health nurses' intuition-backed discretion to findings of extant empirically derived risk factors, to create a dynamic approach to risk prediction and management (Faay et al. 2013; Griffith et al. 2013; Murphy et al. 2011; Sands 2009). Structured clinical judgement surpasses unstructured clinical judgement and is similar in ability to actuarial approaches in predicting risk.

Furthermore, unlike actuarial approaches, structured clinical judgement is also suitable for use in risk management (Griffith et al. 2013; Sands 2009). Structured clinical judgement surpasses unstructured clinical judgement and is similar in ability to actuarial approaches in predicting risk. Furthermore, unlike actuarial approaches, structured clinical judgement is also suitable for use in risk management (Griffith et al. 2013; Sands 2009). However, for structured clinical judgement-backed decisions the literature does not describe for mental health nurses how to apply their clinical intuition to ensure the most suitable risk prediction and management decisions are made.

There exist instruments that may aid mental health nurses in using structured clinical judgement for structured risk assessment (Faay et al. 2013; Griffith et al. 2013). A small randomized control study of the predictive validity of the DASA-IV short-term violence risk assessment instrument by Griffith et al. (2013) reported this scoring tool designed for use with structured clinical judgement to be more accurate than unstructured clinical judgement, in predicting harm in an adult population within twenty-four hours of risk assessment (Griffith et al. 2013). Notably, the researchers determined the scores derived from the instrument when used on the adult population to be more accurate than structured clinical judgement using the instrument. In fact, the application of mental health nurses' clinical intuition in this study following scoring and review of the DASA-IV worsened the predictive accuracy of the DASA-IV (Griffith et al. 2013). However, despite the findings of Griffith et al. (2013), Murphy et al. (2011) detected no improvement in risk prediction using self-contained actuarial instruments, over structured clinical judgement.

Furthermore, a number of issues regarding the limitations of risk assessment instruments are recorded in the literature. Self-contained actuarial instruments that rely solely on static indicators of risk are of limited use because they are designed to predict potential harm not address how risk should be managed (Faay et al. 2013; Murphy et al. 2011). Instruments designed for structured clinical judgement-backed decisions that require comprehensive records to complete or are otherwise time-consuming, are unsuitable for rapid risk assessment in acute mental health care (Faay et al. 2013). Many instruments for structured clinical judgement were developed for use with high-risk populations and may not be transferrable to the general population (Griffith et al. 2013). Faay et al. (2013) in a quantitative study revealed mental health nurses had difficulty using the

Kennedy Axis V short-term violence risk assessment instrument for structured clinical judgement because it was only suitable for adult patients.

A deficit of instruments suitable for use in acute care led Sands (2009) to advise that all instruments be piloted for mental health nurses' feedback prior to being approved for use in these settings. Education in the implementation of instruments is also recommended prior to their use by mental health nurses (Higgins *et al.* 2016). Faay *et al.* (2013) observed mental health nurses to report descriptors used in the Kennedy Axis V instrument confusing, with interventive education improving mental health nurses' ability to utilize the instrument effectively for structured clinical judgement in the eyes of these researchers.

DISCUSSION

This integrative review explored modern peer-reviewed empirical studies related to confidentiality and disclosure of confidential information by mental health nurses when a patient poses a risk of harm to self or others. Confidentiality practice for mental health nurses in this area is complex, and a decision to withhold or disclose confidential information is not made in isolation (Sands *et al.* 2013). It is one of a series of decisions, commencing with decisions regarding risk and cumulating in a decision to withhold or disclose confidential information. However, there is a lack of guidance for mental health nurses on the steps to take when deciding to withhold or disclose confidential information, other than advising that a disclosure may be necessary if harm is believed imminent (Gray *et al.* 2008; Higgins *et al.* 2016). The findings generated by this integrative review suggest a lack of knowledge of the rules of confidentiality can cause mental health nurses to either withhold or disclose information inappropriately (Gray *et al.* 2008; Higgins *et al.* 2016; Sands 2009).

For disclosure, in the absence of patient consent or a particular statute prescribing disclosure, a decision to disclose confidential information can be justified if made in the public interest to protect the patient or others from a risk of harm (Gray *et al.* 2008). However, the concept of the public interest is not clearly defined. Therefore, when applied to mental health nurses' decision-making, it is open to interpretation of individual mental health nurses. Furthermore, decisions on confidentiality and disclosure are underpinned by subjective decisions on risk (Higgins *et al.* 2016; Sands *et al.* 2013). Yet, for mental health clinicians including mental health nurses, gaps have been identified in the risk

education and training required to make these types of decisions (Cowman *et al.* 2017).

Mental health nurses have been observed to be risk-averse rather than recovery-oriented when making decisions, leading to defensive practice that may include the inappropriate withholding or unnecessary disclosure of confidential information (Higgins *et al.* 2016). This may occur because mental health nurses feel pressured to act in accordance with legal requirements, despite the fact that many mental health nurses are unclear about what those legal requirements actually are. A perception of personal susceptibility to harm may also have a negative impact on the outcome of decisions made by mental health nurses, as may the geographical location of mental health nurses' practice (Blando *et al.* 2013).

There is a dearth of research on how mental health nurses decide to use unstructured clinical judgement, an actuarial approach, or structured clinical judgement, to make decisions (Cowman *et al.* 2017; Higgins *et al.* 2016). Unstructured clinical judgement is considered by researchers to be less accurate than actuarial approaches in predicting risk, whilst actuarial approaches may predict but do not manage risk (Griffith *et al.* 2013; Murphy *et al.* 2011). Therefore, it appears effective mental health nurses' decision-making to justify public interest disclosures requires the application of mental health nurses' clinical intuition-backed discretion to extant empirically derived risk factors, to create a dynamic structured clinical judgement approach to risk prediction and management (Faay *et al.* 2013; Griffith *et al.* 2013; Murphy *et al.* 2011; Sands 2009).

In spite of this, and regardless of the methods used for assessment, the available research indicates determinations of risk, and therefore valid decisions to withhold or disclose confidential information of a patient, may at times be little better than chance (Caterino *et al.* 2013). Education in this complex area of mental health is recommended for mental health nurses, which requires focused training based on evidence-backed best practice (Faay *et al.* 2013; Higgins *et al.* 2016). However, for mental health nurses' decision-making there is limited understanding on how mental health nurses: conceptualize risk; undertake risk assessments; incorporate the concepts of the public interest; and consider the fundamentals of patient confidentiality and disclosure (Cowman *et al.* 2017; Gray *et al.* 2008; Higgins *et al.* 2016).

IMPLICATIONS AND FUTURE RESEARCH

This integrative review has enhanced the available literature by exploring and synthesizing current empirical

studies relating to issues of confidentiality, and disclosure of patient information regarding risk of harm to self or others. It has identified that where indicated, mental health nurses are expected to make a valid disclosure of confidential information. However, there is a gap in the literature on how mental health nurses conceptualize the term 'public interest' and balance the public interest in confidentiality against the public interest in disclosure to circumvent harm. Valid disclosures of confidential information in the public interest require reliable identification by mental health nurses, of a potential risk of harm. Additional exploratory research is required to understand mental health nurses' decision-making regarding confidentiality and disclosure of confidential information in the public interest, when a patient may pose a risk of harm to self or others.

LIMITATIONS

Approaches to mental health care and mental health nurses' practice share similarities internationally. However, laws related to mental health and confidentiality often differ between jurisdictions. For example, the duty to disclose confidential information to protect others from harm is a legal obligation in many states of the United States, but not so in other jurisdictions. The studies included in this integrative review were sourced from various jurisdictions, and the location of any one study may have had an impact on the type of data collected or the interpretation of these data by researchers. The qualities of reasonableness that constitute a duty of care for mental health nurses may also vary between jurisdictions, and this may impact on decisions made by mental health nurses.

The limitations in this integrative review have been outlined and addressed by way of a literature table identifying the location of each study (see Table 2). The method, participants, aim, and outcome, of each study are also clearly delineated in the table. This permits the reader to make an independent judgement of the relationship between the findings of this integrative review, and their own jurisdiction and circumstances.

CONCLUSION

Mental health nurses are often the first point of contact between the healthcare system and patients who need mental health care. Therefore, the mental health nurse may be the first clinician to identify a situation requiring a public interest disclosure to circumvent a risk of

potential harm. There is a paucity of literature to guide mental health nurses in understanding and applying the concept of the public interest to issues of confidentiality and disclosure. However, existing literature makes clear that risk-backed decisions are unreliable, with a level of accuracy often little better than chance. For mental health nurses, education and training that addresses the complexities of this area of mental health practice is essential. Consequently, future research that addresses the gaps identified in the literature by this integrative review of mental health nurses' decision-making on confidentiality and disclosure will be of benefit to mental health nurses.

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2.3 Conclusion

This section concludes Chapter 2 which presented an integrative literature review. The chapter commenced with an introduction and background to confidentiality and disclosure-related dilemmas for MHNs when a patient is assessed as posing a potential credible risk to self or others. Next, the aim and methods of the integrative review were outlined. A list of eleven empirical publications retrieved from the literature search was then presented, followed by an overview of common themes identified in these publications. Lastly, the relevance of these themes was discussed and gaps in the literature that would benefit from further research were identified. This led to the study reported in this thesis. Next, Chapter 3 presents Cognitive Continuum Theory (CCT) and discusses the suitability of CCT for studies regarding confidentiality and risk-actuated public interest disclosure-related decision-making processes of MHNs.

CHAPTER 3: COGNITIVE CONTINUUM THEORY AND RISK-ACTUATED DECISION-MAKING

3.1 Introduction

Chapter 3 presents an overview of the theoretical framework used to guide analysis of MHNs' decision-making processes in the study. Specifically, the chapter outlines Cognitive Continuum Theory (CCT) and describes how it has been used to inform previous studies. This chapter will also discuss the suitability of CCT for studies pertaining to confidentiality and risk-actuated public interest disclosure-related decision-making processes of MHNs.

Publication of this chapter led to an unsolicited invitation from The Brunswik Society (of which Kenneth Hammond the architect of CCT, was a founding member) to submit an article to the thirty-seventh volume of the Brunswik Society Newsletter (Conlon, 2022, see Appendix K) and attend the annual meeting of The Brunswik Society on 8 December 2022.

3.2 Theoretical overview of Cognitive Continuum Theory

Author attribution statement and attestation

Chapter 3 of this thesis is published as '*Cognitive Continuum Theory: Can it contribute to the examination of confidentiality and risk-actuated disclosure decisions of nurses practising in mental health?*'.

I, Darren Conlon was responsible for:

- Conception and planning of the theoretical paper
- Literature search
- Data Collection and Analysis
- Preparation of the final report

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As supervisors for the candidature upon which this thesis is based, we confirm the authorship attribution statement above is correct.

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Cognitive Continuum Theory: Can it contribute to the examination of confidentiality and risk-actuated disclosure decisions of nurses practising in mental health?

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Abstract

Nurses practising in mental health are faced with challenging decisions concerning confidentiality if a patient is deemed a potential risk to self or others, because releasing pertinent information pertaining to the patient may be necessary to circumvent harm. However, decisions to withhold or disclose confidential information that are inappropriately made may lead to adverse outcomes for stakeholders, including nurses and their patients. Nonetheless, there is a dearth of contemporary research literature to advise nurses in these circumstances. Cognitive Continuum Theory presents a single-system intuitive-analytical approach to examining and understanding nurse cognition, analogous to the recommended single-system approach to decision-making in mental health known as structured clinical judgement. Both approaches incorporate cognitive poles of wholly intuition and analysis and a dynamic continuum characterised by a 'common sense' blending of intuitive and analytical cognition, whereby cues presented to a decision-maker for judgement tasks are weighed and assessed for relevance. Furthermore, Cognitive Continuum Theory promotes the importance of determining pattern recognition and functional relations strategies, which can be used to understand the operationalisation of nurse cognition.

KEYWORDS

Cognitive Continuum Theory, confidentiality, mental health, nursing, psychiatric, quasirationality, risk assessment, structured clinical judgement

1 | INTRODUCTION

Confidentiality for nurses (and for all clinicians handling patient information) is the duty that comes about when information has been shared by a patient on the condition the information will not be communicated further without their consent (Griffith, 2007). The duty of confidentiality is of particular importance in mental health care, because there is a persistent stigma pertaining to a mental health condition amongst the public (Wand, 2012). Therefore, disclosure of sensitive confidential health information by nurses working in mental health has the potential to give rise to negative

social consequences for patients (Barloon & Hilliard, 2016). Furthermore, patients may be unwilling to share their information thereafter if they believe it may be released to others without their consent (Kämpf & McSherry, 2006). There may also be legal or (more commonly) professional ramifications for a nurse, or legal issues for the health service in which the nurse is operating, if confidentiality is breached (Conlon et al., 2021).

However, in cases where patient consent or a legally-backed duty to disclose is not available, nurses face difficult decisions regarding confidentiality if a patient is deemed a potential risk to self or others (Conlon et al., 2019). There is a public interest in

safeguarding confidentiality to ensure patients are willing to share their personal health information with nurses, but there is an opposing public interest in disclosure of pertinent information to protect patients or others from harm (Conlon et al., 2019; Kämpf & McSherry, 2006; McHale, 2009). Nurses are often the first clinician to make contact with a patient engaging in mental health services, so may be the first clinician to recognise when disclosure of confidential information is recommended (Conlon et al., 2019).

Decision-making for nurses in this context is complex. Therefore, education and training would be of benefit but there is a dearth of contemporary research literature to assist nurses practising in these circumstances. Consequently, it is uncertain how nurses conceptualise risk, comprehend the concept of 'public interest', understand rules of confidentiality, or balance competing public interests, before withholding or disclosing confidential information pertaining to a patient (Conlon et al., 2019). Investigative studies that address these uncertainties would be of benefit to both nurses and their patients, and may also assist other mental health clinicians faced with similar decisions (Conlon et al., 2019, 2021).

Cognitive Continuum Theory (CCT) supports a dynamic single-system framework of intuitive-analytical cognition that has informed a number of studies in general nursing, but few CCT-guided studies have examined decision-making processes of nurses practising in mental health (Bjørk & Hamilton, 2011; Dowding et al., 2009; Lauri et al., 2001). Notably, contemporary literature holds nurse decisions in mental health in the context of risk are best made using a dynamic single-system intuitive-actuarial framework known as structured clinical judgement (Conlon et al., 2019). Therefore, this theoretical review paper considers the suitability of CCT to examine decision-making processes of nurses practising in mental health in these circumstances.

2 | HISTORICAL BACKGROUND TO CCT

CCT originated in the United States through the work of Kenneth Hammond (1917–2015) who used Social Judgement Theory to build upon psychologist Egon Brunswik's (1903–1955) Probabilistic Functionalism Theory before proposing CCT (Dhami & Mumpower, 2018; Dhami & Thomson, 2012; Hammond, 1980).

Probabilistic Functionalism Theory seeks to explain how organisms function in their environments (Brunswik, 1956; Goldstein, 2004). The theory is one of perception and suggests that decision-makers are confronted with complex and potentially inconstant environments they must perceive accurately to act effectively (Brunswik, 1956; Dhami & Mumpower, 2018; Goldstein, 2004). Brunswik proposed that every environment and organism (including humans) are comprised of overt (obvious) areas, and covert (hidden) areas. These properties of organisms and environments can be categorised as variables that are either distal, proximal, peripheral, or central (Brunswik, 1956; Goldstein, 2004).

Distal variables of environments are viewed as 'covert characteristics' that must be discerned centrally by a decision-maker to be

understood but can never be known with certainty. Therefore, it is information laden proximal variables (cues) presented by an environment and received by sensory receptors of an organism that are perceived by the organism to understand the environment, and subsequently relied upon to guide ensuing action (Brunswik, 1956; Goldstein, 2004).

Notably, not every possible cue (or partial cue) will be accessible to a particular organism at a given time, whilst those that are accessible will vary in degrees of relevance (Goldstein, 2004). Consequently, the correlation in validity between distal variables and accessible cues available to an organism (described by Brunswik as the 'ecological texture' of the environment) should be determined to ascertain their relevance (Brunswik, 1956; Goldstein, 2004). The level of accuracy of an organism in assessing and acting upon accessible cues is measurable to the extent it matches the ecological texture of the environment (Goldstein, 2004).

Insights drawn from Probabilistic Functionalism Theory were applied by Hammond in research using Social Judgement Theory (Doherty & Kurz, 1996). In doing so Hammond took Brunswik's principles regarding perception and applied them to human judgement, to explain how people undertaking judgement-related tasks (such as decision-making) learn to achieve and agree (Dhami & Mumpower, 2018). Furthermore, Social judgement Theory adheres to Brunswik's assertion that it is impossible for an organism to know their environment with certitude, meaning the relationship between people and an environment can only ever be described in probabilistic rather than absolute terms (Doherty & Kurz, 1996).

Hammond used Social Judgement Theory to examine differences in clinicians' assessments of clinical data and their resultant socially motivated judgement-backed decisions. Notably, demonstrating that clinicians were not only users of decision-making strategies and instruments, but were themselves instruments whose judgement processes could be measured and ascribed using a probability model (Dhami & Mumpower, 2018; Goldstein, 2004). Hammond's research on decision-making led to the subsequent development of what became known as CCT (Hammond, 1980, 1981).

3 | COGNITIVE CONTINUUM THEORY

There are five premises that underpin the operation of CCT. First, the theory proposes cognition appears on a continuum that ranges from wholly intuitive at one pole, to wholly analytical at the other. Second, the area between these poles is comprised of various combinations of intuition and analysis known as quasirationality. Third, cognitive tasks can be positioned on a task continuum corresponding to the cognitive continuum. Fourth, the cognitive processes of a decision-maker are not static and can oscillate over and back across the cognitive continuum. Fifth, functional relations and pattern recognition are capabilities of a decision-maker when assessing environmental cues (Hammond, 1996). A brief overview of each premise is now provided.

3.1 | Cognition on a continuum

The first premise of CCT is cognition, which can be ascribed as appearing at any point on a continuum that ranges from wholly intuitive at one pole to wholly analytical at the other (Hammond, 1980). This principal assumption that cognition is a single process system represented a major shift in decision-making theory, because it countered prevailing dichotomous dual-process system theories that hold intuition and analysis in opposition to one another (Björk & Hamilton, 2011; Dhimi & Thomson, 2012; Hammond, 1980, 1981).

System 1 of the dual-process dichotomy absorbed into CCT refers to intuitive processes, which are typically viewed as automatic, associative, rapid, and holistic, with a low cognitive demand (Dhimi & Thomson, 2012; Hammond, 1996). Considered part of natural evolutionary processes, intuition is the process whereby experience and knowledge is converted to new learning (Dhimi & Thomson, 2012). Conversely, System 2 of the dichotomy absorbed into CCT refers to analytical processes, viewed by decision-making theorists as a rules-based systematic approach. Analytical decision-making is generally characterised as a slow, methodical, prescriptive method, using formalised steps taught to decision-makers that emphasise logic and critical thinking (Björk & Hamilton, 2011; Dhimi & Thomson, 2012; Hammond, 1996; Parker-Tomlin et al., 2017).

3.2 | Common-sense reasoning

The second premise of CCT is the area between the poles of the continuum is comprised of various blends of intuition and analysis known as 'quasi'-rationality, with the proportion of each ascending in proximity to its corresponding pole (Cader et al., 2005; Lauri & Salanterä, 2002). Quasirational cognition is not arbitrarily bound to wholly intuition or analysis, but instead uses the best available combination of the two for decision-making (Brunswick, 1956; Dhimi & Thomson, 2012). For CCT, Hammond wrote '[a]nalysis provides precision; intuition provides robustness; quasirationality offers something of both' (Hammond, 1996; p. 180). Therefore, quasirationality can be described as a form of cognitive reasoning better known to the layperson as 'common sense' (Hammond, 1980, 1996).

Hammond proposed quasirational cognition to be the most frequent and efficacious form of cognition, whilst wholly intuitive or analytical cognition is rare (Dhimi & Thomson, 2012; Hammond et al., 1983, 1980). Therefore, most decision-making is a dynamic interplay between intuition and analysis, depending on which combination best suits a particular decision (Björk & Hamilton, 2011; Hammond, 1996). Notably, cognition located closer to the intuitive pole is associated with experienced decision-makers, whilst cognition located closer to the analytical pole is associated with inexperienced decision-makers (Björk & Hamilton, 2011; Hammond, 1996; Lauri & Salanterä, 2002).

3.3 | Cognitive tasks and modes of inquiry

The third premise of CCT is cognitive tasks can be arranged on a task continuum, corresponding to the cognitive continuum (Dhimi & Thomson, 2012). Cognitive tasks are understood as comprising accessible cues presented by an environment containing information that requires cognition to be processed and assessed for relevance (Hammond, 1981). These tasks have three principal operational characteristics: 'complexity of task structure; ambiguity of task content; and form of task presentation' (Hammond, 1986; p. 30). It is these properties predicated on underlying cues that will induce either intuitive, analytical, or quasirational organising principles (Dhimi & Thomson, 2012; Hammond, 1980, 1981). Ill-structured tasks involving uncertainty and many conflicting or questionable cues tend to correlate with the intuitive pole, whilst well-structured tasks involving certainty and a small number of relevant cues are more often associated with the analytical pole (See Table 1) (Cader et al., 2005; Doherty & Kurz, 1996; Dunwoody et al., 2000).

These organising principles are further arranged into six modes of (cognitive) inquiry (see Table 2) corresponding to defined intuitive-analytical cognitive reasoning strategies of the cognitive continuum, that direct the arrangement of cognitive tasks along the task continuum (Dhimi & Thomson, 2012; Hammond, 1996). Functional validity (satisfactory achievement) is more likely when the characteristics of a cognitive task match the mode of inquiry used for the task (Björk & Hamilton, 2011; Dhimi & Mumpower, 2018; Hammond et al., 1983, 2007).

3.4 | Oscillation

The fourth premise of CCT is cognitive processes are not static. When time permits the mode of inquiry used may change as a decision-maker moves over and back along the cognitive continuum, in response to the specific combination of intuitive and analytical cognition required to complete a cognitive task. A process Hammond referred to as oscillation (Cader et al., 2005; Hammond, 1996). Successful performance of a cognitive task inhibits movement along the continuum, whilst failure stimulates it (Dhimi & Mumpower, 2018; Doherty & Kurz, 1996; Hammond, 1980). Consequently, cognitive tasks are also conceived as being responsive and dynamic, continuously oscillating along the task continuum according to the mode of inquiry required for completion (Björk & Hamilton, 2011; Hammond, 1996).

Notably, oscillation towards the slower-paced analytical pole may be pertinent should time permit, to enhance performance accuracy of cognitive tasks activated by intuition. Conversely, oscillation towards the faster-paced intuitive pole is potentially more appropriate in time poor scenarios for the performance of cognitive tasks activated by analysis (Hammond, 1981, 1986). Oscillation

TABLE 1 Correlation of tasks and cognition

Intuition	Quasirationality	Analysis
Task is familiar		Task is unfamiliar
Absence of prior training or information about a task	A blend of task properties	Presence of prior training and information about a task
Greater than five cues	Inducing both intuition and analysis	Two to four cues
Contemporaneous presentation of cues		Sequential presentation of cues
Intercorrelated cues		Orthogonal cues
Cues are distributed normally		Cue distribution is skewed, peaked, multimodal, or of binary distributions
Pictorial cues		Quantitative cues
Decision-maker measures cue levels		Objective measures, pointer readings
Judgement scale has multiple alternatives		Judgement scale has minimal alternatives
Rapid response required		Open response time
Criteria are of normal distribution		Criteria are skewed, peaked, multimodal, or binary
Linear functions relating cues to criteria		Nonlinear functions relating cues to criteria
No available organising principle		Organising principle readily available
Cues of equal weight		Cues of unequal weight
Organising principle is linear		Organising principle is nonlinear
Presence of 'outcome knowledge'		Absence of 'outcome knowledge'
Minimal or absent feedback		Presence of cognitive feedback

Note: Adapted from Doherty and Kurz (1996, p. 131).

TABLE 2 Modes of inquiry

Cognition	Mode of inquiry		
1. Pure analysis		<u>Most control</u>	True experimental
2. Mostly analysis, with some intuition		Control group experimental and statistics	
3. Somewhat more analysis than intuition		Quasi-experimental with relaxed controls	
4. Somewhat more intuition than analysis		Computer modelling	
5. Mostly intuition, with some analysis		Data-based expert judgement	
6. Pure intuition	Unrestricted judgement	<u>Least control</u>	

Note: Adapted from Hammond (1996) and Cader et al. (2005).

also provides a means to measure cognitive responsiveness to task requirements, and in doing so draw comparisons between decision-makers or classes of decision-makers such as experienced versus inexperienced nurses (Hammond, 1996).

3.5 | Functional relations and pattern recognition

The fifth premise of CCT is decision-makers have the capacity to seek functional relations and recognise patterns in their environment

(Hammond, 1996; Standing, 2008). Functional relations refers to the impact of an independent variable (an area of an environment hidden from view) on a dependent variable (accessible cues) and the ability of a decision-maker to discern and act appropriately on these relationships. Pattern recognition refers to inferences made from the experientiality-facilitated recognition of patterns of information, to reach conclusions regarding accessible cues (Hammond, 1996).

Functional relations and pattern recognition are underpinned by two metatheories of truth, which are used to determine the calibre of judgements (Dhami & Mumpower, 2018). Coherence metatheory is associated with functional relations and focusses on rational and consistent process. It is decision-making based on defensible logic and mathematical formulas, that may or may not lead to an accurate judgement. Correspondence metatheory is associated with pattern recognition and focusses on the empirical accuracy of judgements, in preference to the rationality of the steps taken to make a judgement (Custers, 2019; Hammond, 1996). A decision-maker can engage in either correspondence or coherence but not at the same time (Hammond, 1996). Nonetheless, a total dichotomous switch from reliance on one to the other is possible and is referred to as alternation (Cader et al., 2005; Hammond, 1996). Notably, coherence and correspondence are not bound solely to intuition or analysis and a decision-maker may use either or both forms of cognition with these metatheories (Custers, 2019).

4 | SHORTCOMINGS OF CCT

CCT, as with any theory, is subject to a number of shortcomings. First, the prevalence of dichotomous decision-making theories in nursing research and nurses' familiarity with these theories, means CCT may present as a complex theory that requires education for researchers and consumers of research to understand (Cader et al., 2005). In the absence of understanding, it is reasonable to conclude CCT or findings from CCT-based research may be misunderstood or misapplied.

Second, irrespective of a researcher's knowledge regarding CCT, the theory does not outline the number or type of task properties that drive a switch from one mode of inquiry to another. This may make it difficult for researchers to decide when a decision-maker has moved between modes (Dhami & Thomson, 2012; Parker-Tomlin et al., 2017). Difficulties identifying when a modal switch has occurred may influence researchers to concentrate on the poles of CCT and ignore the quasirational elements of decision-making (Parker-Tomlin et al., 2017).

Third, a focus on cognition risks researchers not applying sufficient weight to potentially relevant elements such as sociological, emotional, ethical, or other comparable considerations that may impact on nurse decision-making (Chaffey et al., 2010; Melin-Johansson et al., 2017; Miller & Hill, 2018). For example, a nurse may be fatigued by their working conditions and make a poor decision, rather than the best decision possible in that instance (Wolf et al., 2017). The culture of a workplace may also lead a nurse to make a decision that is in keeping with their perception of what is

expected by their workplace, rather than a decision they may have otherwise made (Nibbelink & Brewer, 2018). Personal thinking style may also influence the mode of cognition applied to a task, at least in the initial phase of consideration (Dhami & Thomson, 2012).

However, the shortcomings of CCT outlined above can be limited or negated with the collection of rich qualitative data, that affords researchers a means to understand and elucidate the operationalisation of principles of CCT and other nurse decision-making processes (Dunwoody et al., 2000). A range of research using CCT is now outlined.

5 | HOW CCT HAS BEEN USED TO INFORM RESEARCH

CCT has been used to guide studies of decision-making in various contexts (Chaffey et al., 2010; Dunwoody et al., 2000; Molinaro & Bolton, 2019). A number of studies have focused on nursing, but few (if any) of these have examined nurses working in mental health (Bjørk & Hamilton, 2011; Dowding et al., 2009; Lauri et al., 2001).

An early study by Dunwoody et al. (2000) tested university students' threat identification judgement processes. Participants were found to tend towards analysis when judgements tasks were complex. The researchers found predominantly analytical cognition for quantitative tasks led to more accurate outcomes. However, there was a noted satisficing in the balancing of accuracy versus effort, whereby intuition was pragmatically preferred for analysis-inducing tasks of low complexity. The researchers also noted cues were weighed evenly for relevance by participants when intuition was preferred, despite some cues being of uneven weight. However, errors made when using analytical cognition were greater than errors made when using intuition. The researchers also noted the form in which information was presented influenced cognition, with iconic information inducing intuition whilst numeric information induced analysis (Dunwoody et al., 2000). The researchers concluded CCT is a suitable theory to examine decision-making but advise it is essential to elicit qualitative aspects of an individual's decision-making processes, to understand why a specific type of cognition has been used if initial findings appear incongruent with CCT (Dunwoody et al., 2000).

A recent study by Molinaro and Bolton (2019) used CCT to examine phishing victimisation. The researchers found participants use intuition and analysis when judging emails for authenticity. However, participants who used a higher proportion of analytical versus intuitive cognition uniformly scored higher on phishing recognition, leading to the conclusion that phishing recognition is an analytical process. Furthermore, reinforcing Hammond's position that task characteristics must match the mode of cognition required for a task to ensure satisfactory achievement. The researchers concluded interfaces designed to promote analytical cognition can assist decision makers with phishing recognition. The researchers also recommended strategies be used to identify users who deferred to intuition where analysis is preferred, for training and direction to become more pro-actively analytical in their processes (Molinaro & Bolton, 2019).

A study of occupational therapists practising in mental health used CCT to describe their perceived use of intuition (Chaffey et al., 2010). The researchers found participants understood intuition as knowledge arising outside of their conscious awareness. Furthermore, intuition was perceived to be influenced by professional experience, with emotional intelligence deemed necessary to process the impact of personal feelings on decision-making. The researchers determined intuition arises in conjunction with analysis for clinical reasoning, and both forms of cognition require consideration. Importantly for risk-related scenarios in high-energy environments, the ability to use intuition appropriately was reported by participants to be negatively impacted by both stress and fatigue (Chaffey et al., 2010).

An international study of five jurisdictions across Europe (Finland, Sweden, and Switzerland) and North America (Canada, and the United States) examined nurses' cognition when making decisions (Lauri et al., 2001). The study strengthened the notion of quasirationality as fundamental to decision-making, with intuition and analysis prevalent in the planning stages of care. Nonetheless, nurses were found to prioritise analytical cognition for information collection and, defining problems, whilst intuitive cognitive was prioritised when implementing, and evaluating care. A positive association was also demonstrated between a nurse's increasing level of education and experience and use of intuitive cognition. However, analytical cognition was observed of nurses practising in long-term care irrespective of length of experience, whilst intuition was more common in short-term care. Relatedly, long-term care was also associated with lower levels of education (Lauri et al., 2001).

A study conducted by Dowding et al. (2009) used CCT to examine how nurses make decisions related to medication titration and palliative care in heart failure patients. The researchers corroborated successful decision-making is predicated on effective correlations between task properties and the mode of cognition utilised by a decision-maker. The researchers also found participants veered towards analysis in a controlled and nonurgent scenario (palliative care). However, misinterpretations in analysis based on informal guidelines or social guidance of peers could lead to incorrect judgements. Errors were also found in the outcome of decisions made, if intuition was used where analysis was required. Well-structured frameworks for analysis were proposed to correct this issue and assist nurses to make informed decisions, by facilitating oscillation along the continuum if a cognitive task requires an analytically dominant mode of inquiry (Dowding et al., 2009).

Bjork and Hamilton (2011) examined nurses' perception of their cognition when admitting an elective patient, an undertaking characterised by well-structured cognitive tasks that are not time pressured. Cognition was reported to be closer to the intuitive pole for data processing; and closer to the analytical pole for data-collection, implementation, and evaluation. The study found nurses report oscillating between intuition and analysis for well-structured tasks that are not time pressured, perceiving their cognition to be mostly quasirational albeit spending more time closer to the analytical pole. Notably, participants reported some tasks were found to solely use cognition at the analytical pole, whilst no

cognition was perceived as taking place solely at the intuitive pole (Bjork & Hamilton, 2011).

6 | RELEVANCE OF CCT TO RESEARCH REGARDING NURSE DECISIONS IN MENTAL HEALTH

There is a dearth of research literature regarding decision-making processes of nurses practising in mental health, concerning confidentiality and disclosure in the context of risk (Conlon et al., 2019). Therefore, further research would be beneficial in guiding nurse decision-making and CCT is a suitable theory to examine and describe how nurses operate in these circumstances.

Decisions related to the assessment and management of risk in mental health (including those for confidentiality and disclosure) are made using unstructured clinical judgement, actuarial approaches, or structured clinical judgement (Conlon et al., 2019). Unstructured clinical judgement refers to intuition-led strategies based on experience, consistent with the intuitive pole of CCT. Actuarial approaches refer to the weighing and balancing of statistically significant empirically derived static indicators of risk, consistent with the analytical pole of CCT (Conlon et al., 2019; Hammond, 1980).

Inexperienced nurses tend to use slower-paced systematic logically-defensible analytically-dominant actuarial approaches, which are considered superior to intuition in predicting risk (Griffith et al., 2013; Miller & Hill, 2018; Sands, 2009). Nonetheless, static actuarial approaches have no utility in ongoing risk management because risk is dynamic and continually moves over and back along a continuum of no apparent risk to a credible potential for harm (Conlon et al., 2021; Griffith et al., 2013; Sands, 2009). Conversely, experienced nurses tend to prefer faster-paced intuition dominant strategies, which are also appropriate for risk management (Conlon et al., 2019). However, intuition is considered less accurate in assessing risk because there is a tendency to focalise on dramatic or impactful cues that may not represent risk in many patients (Higgins et al., 2016; Miller & Hill, 2018).

Structured clinical judgement refers to a single-process system of cognition that supports a 'continuum of objective actuarial approaches to subjective clinical intuition that underpins mental health nurses' decision-making' (Conlon et al., 2019; p. 1243). For structured clinical judgement, the experientially-led discretion of nurses is applied to actuarial determinants of risk to create a dynamic CCT-analogous quasirational and oscillatory approach to risk assessment and management (Conlon et al., 2019; Griffith et al., 2013). Structured clinical judgement is considered a common-sense approach to decision-making that outperforms unstructured clinical judgement. Furthermore, it is comparable to actuarial approaches in assessing risk because it maximises the positive aspects and minimises the shortcomings of each (Faay et al., 2013; Griffith et al., 2013; Murphy et al., 2011; Sands, 2009). Consequently, structured clinical judgement is the recommended preferred method for risk assessment and

management decisions of nurses practising in mental health (Conlon et al., 2019).

Crucially, decisions made in the context of risk are often time pressured, to promote a maximum reduction of the potential for harm to self or others (Conlon et al., 2019, 2021). Environmental pressures for rapid decision-making promote intuitive-dominant strategies, whereby nurses defer to their experience to make rapid informed decisions. Conversely, environmental pressures for accuracy (a necessity in risk prevention) promote analytical-dominant approaches (Hammond, 1981, 1986). For accuracy, nurses focus on professional and organisational rules and regulations, which limits the scope of nurse-guided intuitive decision-making and adds to cognitive decision-making load (Gordon et al., 2015; Hagbaghery et al., 2004).

Nonetheless, risk is notoriously difficult to identify, and the validity of determinations of risk may be no better than chance (Caterino et al., 2013; Conlon et al., 2021). However, public interest decisions of nurses on confidentiality and disclosure pertaining to potential harm are predicated on a valid determination of risk (Conlon et al., 2019). Therefore, it is of pertinence to nurses that CCT indicates environments possess the ability to convey uncertain information linearly or non-linearly by way of a variety of relevant or redundant cues (or partial cues) in a process termed vicarious mediation (Dhami & Mumpower, 2018; Hammond, 1981, 2007). Nurses have the capacity to process these cues (whilst removing fallible cues) using the relevant operating principle in which information is arranged in the environment to create a coherent understanding of a patient's risk profile and initiate subsequent action (Buckingham et al., 2008; Hammond, 1981, 1996). Understanding and subsequent knowledge of a decision-maker is maximised when the same analysis-inducing organising principle of the environment is used to arrange information obtained from cues. However, a high degree of knowledge may be possible even when a substitute organising principle is used, which may take the form of an intuition-induced weighed averaging procedure for cues in the absence of a suitable alternative principle (Dhami & Mumpower, 2018; Hammond, 1986).

According to CCT this 'multiplicity, flexibility, intersubstitutability, and combination' of cues and organising principles is termed vicarious functioning (Brunswik, 1956; Goldstein, 2004; p. 41; Hammond, 1981). Vicarious functioning allows nurses who appropriately take this approach to establish the ecological texture of the environment. Therefore, establishing the empirically derived validity of risk-related cues relating to distal patient variables (true cue validity), and discerning supporting interrelationships between cues, to promote satisfactory achievement in their risk-related decision-making (Goldstein, 2004; Hammond, 1981). Furthermore, in reacting to accessible cues, nurse judgements are analytical, systematic and logical, whilst being subject to existing knowledge and experience to ensure valid patient outcomes (Conlon et al., 2019). Therefore, functional relations and pattern recognition would be expected to play a part in nurse decision-making (Hammond, 1996).

Decision-making on confidentiality and disclosure in the context of risk is patently complex. Furthermore, nurses are human actors, and are subject to overt and covert sociological, cultural, ethical, emotional, and other human-centric influences that complicate CCT-guided examinations of nurse decision-making (Goethals et al., 2010; Hagbaghery et al., 2004; Lopez, 2009; Nibbelink & Brewer, 2018). Notably, issues may arise for nurses should these extrinsic or intrinsic factors influence decision-making to the extent outcomes are not beneficial for stakeholders (Fry & MacGregor, 2014; Willmott et al., 2020). Consequently, the collection of rich qualitative data may assist in determining factors (both within and beyond a nurse's perception) that may impact cue recognition and vicarious functioning (Dunwoody et al., 2000).

For example, sociologically nursing practice (even when a nurse operates alone) generally takes place in the context of a wider team-focussed organisational structure (Nibbelink & Brewer, 2018). A team culture impacts decisions, because in some instances a nurse may base their reasoned deliberations in part on how they believe they will be perceived by their peers (Goethals et al., 2010; Nibbelink & Brewer, 2018). Nurse decisions may also be influenced by nominated leaders or other specific individuals into whose sphere of influence a nurse gravitates toward in the workplace (Nibbelink & Brewer, 2018). Importantly, it is pertinent to ascertain if nurses would carry out instructions of these influential leaders, in circumstances where the instructions may be inconsistent with evidence-based requirements of a patient (Goethals et al., 2010; Hagbaghery et al., 2004).

Furthermore, personal ethics and a belief in prosecuting right from wrong influences nursing practice (Goethals et al., 2010). Nurses attach significant weight to their personal ethical principles and their understanding of the types of decisions made by a good nurse, to the extent nursing has been cited on multiple occasions internationally as amongst the most trusted of professions by the public (Girvin & Hutchinson, 2016; Goethals et al., 2010; Landis et al., 2020). Research indicates ethical considerations of nurses are consistently well-reasoned and underpinned by evidence-based knowledge and skills (Goethals et al., 2010). However, perceived expectations of the profession (or other stakeholders) and a human desire to seek validation of their peers may create tension for nurses when making decisions comprising their ethics (Goethals et al., 2010; Lopez, 2009). Consequently, when confronted with professional codes of ethics and ethical positions assumed by their peers that conflict with their personal position, nurses may resort to delayed or deferred decision-making. Furthermore, when pressed to decide, nurses may defer to practice norms or adapt their practice to concur with the expectations of their peers (Goethals et al., 2010). This is problematic if a nurse is correct when deciding to withhold or disclose confidential information, and their peers are not (Goethals et al., 2010; Nibbelink & Brewer, 2018).

A fear of legal or professional repercussions can also negatively impact on the decisions nurses make, if predicated on an illogical perception of the law or professional frameworks (Hagbaghery et al., 2004; Willmott et al., 2020). Conversely, it is reasonable to conclude a valid knowledge of laws and professional frameworks may instil nurses with self-confidence in their decision-making

capabilities, with a demonstrable positive impact on the validity of nurse decisions (Conlon et al., 2019, 2021; Fry & MacGregor, 2014). A level of autonomy to make decisions in complex and challenging risk-laden clinical environments has the potential to enhance self-confidence, enabling nurses to expand the scope of their decision-making and leading to more efficacious outcomes (Fry & MacGregor, 2014). However, the presence of perceived or actual tension in a clinical environment (as can occur in the presence of risk) may potentially impact negatively on self-confidence and diminish the efficaciousness of decision-making (Conlon et al., 2019; Fry & MacGregor, 2014). A lack of emotional support from peers when a nurse requires reassurance may cause negative emotions to diminish self-confidence further, leading to even less effective outcomes (Hagbaghery et al., 2004).

Crucially, emotional considerations are commonly incorrectly interpreted as part of intuitive reasoning, often as the result of nebulous or inadequately presented cues (Hutchinson et al., 2018). Current research literature generally promotes the idea emotions inhibit reasoning and should have no role in decision-making (Kozłowski et al., 2017). Conversely, certain emotions are perceived by nurses as positively effecting, directing, augmenting, and otherwise contributing to the decision-making process, enhancing reasoning (Hutchinson et al., 2018; Kozłowski et al., 2017). Consequently, nurses would be expected to identify and manage relevant emotions (when aware of them) to inform decision-making, whilst setting irrelevant emotions aside. Therefore, it is important to identify and categorise emotions and their impact on decision-making when perceived by nurses as forming an integral part of decisions made in complex or enervating scenarios (Hutchinson et al., 2018). CCT-guided research is an appropriate framework to distinguish intuition from emotional responses, and the consequent impacts of emotions on analytical approaches to decision-making (Hammond, 1996; Hutchinson et al., 2018).

Once complete, should a perceived or actual lack of weight be attached to nurse decisions, even those that result in outcomes congruent with expectations, nurses may become task rather than person oriented (Nibbelink & Brewer, 2018). Furthermore, if decision-making results in outcomes that are incongruent with expectations and nurses are left feeling unsupported by those in charge, it may cause disillusionment and act as a barrier to subsequent effective decision-making (Hagbaghery et al., 2004). Task-oriented approaches may also result from heavy workloads, whereby nurses adopt coping strategies that prevent them from fully participating in patient-oriented care (Goethals et al., 2010; Hagbaghery et al., 2004). Incidentally, fatigue may also cause a nurse to make a decision that is the easiest to implement, rather than one that in the best interests of a patient (Wolf et al., 2017).

It is reasonable to conclude the collection of rich qualitative data as a part of CCT-guided studies will assist in identifying and accounting for these and other overt and covert influences on nurse decision-making, regarding confidentiality and disclosure in the context of risk (Hammond, 1996).

7 | IMPLICATIONS

This theoretical review has added to contemporary literature by demonstrating the suitability of CCT for the examination of decision-making processes of nurses practising in mental health, concerning confidentiality and disclosure of patient information in the context of risk. It has identified CCT is analogous in arrangement to structured clinical judgement. Therefore, CCT is not limited to examining decision-making for confidentiality and disclosure but is suitable for the examination of all risk-related decision-making of nurses (and indeed all clinicians practising in mental health). Furthermore, CCT offers researchers the opportunity to enhance structured clinical judgement by describing and aligning task properties, cognition, and modes of inquiry, for accurate nurse decision-making. Notably, CCT encourages researchers to engage in studies that assist nurses in ascertaining the ecological texture of the environment of a patient at risk, to ensure judgements that underpin nurse decision are validly made. In ascertaining true cue validity of the environment, CCT also offers a pathway to assess professional prowess and engage in practice improvement by comparing nurse determinations with statistically derived available indicators of risk. Furthermore, CCT guides researchers investigating the impact of sociological and other human-centric considerations on nurse decision-making, whilst nurses' ability to process functional relations and engage in pattern recognition to make decisions can also be explored.

8 | CONCLUSION

Nurses practising in mental health are often positioned to be the first clinician to recognise when disclosure of confidential health information pertaining to a patient may be necessary to circumvent harm. However, decision-making in this context is complex and breaches of confidentiality may lead to adverse consequences for stakeholders. Nonetheless, there is a dearth of research literature to assist decision-making of nurses in these circumstances.

CCT provides a suitable approach to understand decision-making processes of nurses practising in mental health. It is a single-system model of cognition built upon quasirational 'common-sense' reasoning that naturally aligns with structured clinical judgement. CCT-guided research can lead to practical guidance and practice improvement of nurses (and potentially other clinicians) by examining and describing how nurses: conceptualise risk; comprehend the concept of 'public interest'; understand rules of confidentiality; and balance competing public interests. The principles of functional relations and pattern recognition are also consistent with data-collection practices of nurses and are suitable for investigating the operationalisation of nurse cognition, when deciding to withhold or disclose confidential information pertaining to a patient deemed a potential risk to self or others. Additionally, the collection of rich qualitative data within the framework of CCT-guided research may assist in identifying human-centric considerations that impact on decision-making.

AUTHORS CONTRIBUTIONS

All authors contributed to: The conception of this theoretical review; refining and further development of the original concept; literature search and analysis; extraction of findings; and manuscript editing. 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, and agree with its submission to Nursing Inquiry.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

PERMISSION TO REPRODUCE MATERIAL FROM OTHER SOURCES

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This manuscript is not drawn from a clinical trial.

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3.3 Conclusion

This section concludes Chapter 3, which discussed the suitability of CCT for studies pertaining to confidentiality and risk-actuated public interest disclosure-related decision-making processes of MHNs. The chapter commenced with an introduction to the historical background of CCT. Next, CCT and some shortcomings of the theory were described.

Research informed by CCT was then presented. Finally, the relevance of CCT to research regarding MHNs' decisions was outlined, which will be used to frame MHNs' confidentiality and risk-actuated public interest related decision-making processes presented in chapters 6, 7, and 8. Next, Chapter 4 presents the methodology adopted for this qualitative multimethod study.

CHAPTER 4: METHODOLOGY

4.1 Introduction

Chapter 4 outlines the methodology used to conduct the qualitative study presented in this thesis. The term methodology is derived from the Greek words *method* (a means or action to achieve an end) and *logos* (logic) which can be taken to mean the science or theory of method (Lukenchuk, 2017). The methodology of research has many descriptions in contemporary literature, but ultimately it is the strategic approach taken by researchers to acquire knowledge (Creswell & Poth, 2018). A methodology generally requires identification of a research paradigm and comprises; a study setting and population; data collection methods, data analysis, and ethical considerations (Makombe, 2017). The choice of research paradigm and the type of data required to answer a research question dictates the methodology and data collection methods of a study (Howell, 2016). This chapter will outline the steps taken to achieve the research goals of this thesis, by highlighting each of these systematic processes and procedures implemented to answer the research question and accompanying sub-questions enumerated in Chapter 1.

4.2 Research paradigm

A research paradigm is the philosophical assumptions or beliefs that guide a researcher (Creswell & Poth, 2018). The identification of a research paradigm is guided by epistemological and ontological considerations and a research question, which feeds into data collection methods and ethical considerations (Makombe, 2017). Epistemology refers to the study of knowledge, our ways of knowing reality, and the investigation of the validity of

information, whilst ontology refers to the study of our beliefs about the nature of reality, which can also depend on other systems for meaning (Campbell, 2015). In effect, ontology accepts there are many versions of reality according with individual perspectives.

The following epistemological and ontological considerations were accounted for when deliberating upon the paradigm for the study. Firstly, the concept of confidentiality depends on the perspectives of individuals, and the significance attached to confidentiality by the society in which an individual resides (Ellenchild Pinch, 2000; Solove & Richards, 2007). Furthermore, the importance attached to confidentiality can also vary depending on a particular context or circumstances, including when confronted with a decision to withhold or disclose confidential information in the context of patient risk (Health Records and Information Privacy Act [HRIP], 2002; NSW Health, 2015). Therefore, the reality of what comprises confidential information is both contextual and relative, whereby it depends on the perspective and interpretation of a MHN and also the viewpoint and perception of the person to whom the information pertains (Ellenchild Pinch, 2000). The concept of public interest is also undefined in law or literature (Dolan, 2004). Instead, it is a relative contextual concept that requires the balancing by individuals of competing interests in confidentiality and disclosure (Hogan v Hinch, 2011). Adding to this complexity, confidentiality and confidential information are also objectively defined and protected at law and in nursing self-regulation, and MHNs are expected to know these rules and apply them consistently but they do not (HRIP, 2002; NSW Health, 2015; Nursing and Midwifery Board of Australia [NMBA], 2018).

The research question was also considered when identifying a paradigm for the study, because it influences the type of data collection methods required (Creswell & Poth, 2018). The research question is “What are MHNs’ decision-making processes regarding

confidentiality and disclosure of confidential information pertaining to patients assessed as posing a potential credible risk of harm to self or others?”. The aim of the question was to provide a descriptive overview of MHNs’ decision-making processes. Finding an answer to this question depended on illuminating MHNs’ understanding of the framework of confidentiality in NSW, and how they apply these rules to their risk-actuated public interest disclosure-related decision-making. Epistemologically, the best way to address the research considerations of this question was through the collection of subjective qualitative data from participants, whilst ontologically accepting these data may present differently for the same areas of interest depending on the perspective of each participant (Creswell & Poth, 2018).

Consequently, epistemologically, ontologically, and supported by the type of data required to answer the research question, the study is congruent with an interpretivist paradigm, which takes the philosophical position that reality requires interpretation, to discover its underlying meaning (Houghton et al., 2012). Knowledge exists in the relationships between a researcher and participants, with a researcher gathering and interpreting data to illuminate this situated knowledge (Bukamal, 2022). An interpretivist paradigm is generally associated with the collection of qualitative data, using methods such as interviews and focus groups (Braun & Clarke, 2006). Qualitative data includes the collection of words, viewpoints, opinions, experiences, and perceptions. It is generally subjective and unmeasurable and instead deals with the quality of these data to analyse, interpret, and describe, reasons for human behaviour (Billups, 2020).

4.3 Research setting and population

4.3.1 Setting

The aim of the qualitative multimethod study presented in this thesis was to understand MHNs' confidentiality and risk-actuated public interest disclosure-related decision-making processes, pertaining to confidential information of patients in mental health care. The study was limited to NSW because (1) it was the jurisdiction in which I was working and undertaking this research, and (2) rules of confidentiality share a common origin across common law jurisdictions and have similarities with other jurisdictions, but legislative and regulatory overlays have created differences (Kerridge et al., 2013; Knoppers, 2000). For example, in NSW protecting confidential health information is considered a state responsibility, and as such is legislated by the NSW parliament (HRIP, 2002). Therefore, the rules that apply to health information in other states or countries may differ (Kerridge et al., 2013; Knoppers, 2000). There were no other limits on the setting because all health information is generally considered to be confidential in NSW irrespective of the context in which the information becomes known to a MHN, unless proven otherwise (HRIP, 2002; NSW Health, 2015).

4.3.2 Population

The target population for the study was MHNs in NSW, defined in this thesis as a registered nurse (RN) "working (or who has worked) in mental health care, at any time in any clinical role post-graduation, at any level from novice to expert, in any public or private clinical context or capacity, with or without post-graduate qualifications in mental health.". This multimethod study comprised four distinct data collection methods with only methods 3

(semi-structured interviews) and 4 (focus groups) requiring MHN participants. There were several reasons for choosing and limiting participation in the study to MHNs. Firstly, the impetus for the study was my conversations with MHNs in the clinical setting, regarding handling of confidential information of patients assessed as posing a credible risk. Secondly, MHNs are the clinical interface of the mental health care system and often the initial contact point for patients or potential patients (Wand et al., 2021). Therefore, they may be the first clinician to identify if a patient poses a credible risk, and thus tasked with deciding to withhold or disclose confidential information pertaining to that patient. Thirdly, MHNs have specialist education, knowledge, and professional clinical foci, such as a holistic approach to patient care, that is common with all RNs but sets them apart from other clinicians (Happell, 2010; NMBA, 2016). Consequently, leading to potential differences in the way patient care (and matters of patient confidentiality) is conducted. Fourthly, all nurses in Australia complete the same general 3-year Bachelor of Nursing, but MHNs undertake specialist training or gain experience post-graduation that sets them apart from other nurses. As a result, their decision-making processes regarding risk-laden scenarios and confidentiality and disclosure may differ from other nurses (Christiansen et al., 2018; Happell, 2010).

4.3.3 Recruitment

Recruitment of MHN participants took place using personal and professional nursing networks in NSW. Nursing is particularly suitable for this recruitment strategy because it is a collaborative team-oriented profession, with many formal and informal interlinking networks (Intrahealth International, 2019; NMBA, 2018, 2020). Invitation letters were forwarded by email for the semi-structured interviews, and later the focus groups, to nursing organisations (for example, the Australian College of Nursing) and personal nursing contacts

seeking expressions of interest (EOI) to participate in the study. Advertising material for the study (see sample at Appendix J), a Participant information Statement (PIS, see Appendices B, and F), and a consent form (see Appendices C, and G), were included with each letter, with a request the advertising material be disseminated amongst each network's contacts. The consent form included a statement confirming interested parties had read the PIS prior to providing their written informed consent to participate in the study. Applicants were also invited to ask questions prior to consenting to the study. Lastly, applicants were required to meet all inclusion criteria to participate in the study (see chapters 6-9).

4.4 Data collection

Four distinct data collection methods were used in the study, (1) a legal review, (2) an instrumental case study, (3) semi-structured interviews, and (4) focus groups. Analysis of these data obtained from each method was undertaken progressively and sequentially. Therefore, data from each method were analysed and reported before the next method was implemented. This was because the data from each method informed the processes and instrumentation of subsequent methods.

4.4.1 Method 1: Legal review of confidentiality framework in NSW

Data collection method 1 comprised an examination of the legal framework of confidentiality in NSW, because it was necessary to contextualise MHNs' common law duty of confidentiality within the legal framework of the common law jurisdiction in which an MHN is practising. The aim of this examination was to ascertain this framework, before

exploring MHNs' confidentiality and risk-actuated public interest disclosure-related decision-making processes.

A search was undertaken in November 2019 scrutinising laws relating to confidentiality in NSW. Databases searched were Austlii and NSW legislation. The search revealed information about an individual's mental health is 'health information', and this information is inherently confidential (HRIP, 2002; NSW Health, 2015). Additionally, the search found the *HRIP* (2002) was the legislation that directed the handling of health information in NSW. The *HRIP* confirmed confidentiality of health information in NSW remains a common law duty, with an accompanying public interest in protecting confidentiality (HRIP, 2002; NSW Health, 2015). Two other acts were found to deal with confidential information but not health information in NSW, the Privacy Act (1988) and the Privacy and Personal Information Protection Act (1998). This examination was subsequently published in conjunction with the findings of method 2 of this research (see Chapter 5).

4.4.2 Method 2: Instrumental case study

Having established the legal framework of confidential health information in NSW, data collection method 2 comprised an instrumental case study of a tribunal matter, *NK v Northern Sydney Area Health Service* (2010). An instrumental case study is one where the objective is to illuminate an issue or theory, with the case study itself being secondary to the objective (Lucas et al., 2018). The aim of this case study was to provide insight into how the NSW legal system deals with the mishandling of confidential patient information within the health system, before moving on to methods 3 and 4 exploring MHNs' confidentiality and risk-actuated public interest disclosure-related decision-making processes. A search was undertaken in November 2019 examining court cases and tribunal matters in NSW from

2009, because that was the year the current legal and professional framework under which MHNs' practice is governed began (Health Practitioner Regulation National Law, 2009). *NK v Northern Sydney Area Health Service* (2010) was chosen because it was the only legal matter where a MHN was the key decision-maker regarding confidentiality and disclosure of information for a patient assessed as posing a risk. This case study was subsequently published in conjunction with the findings of method 1 of this research (see Chapter 5).

4.4.3 Method 3: Semi-structured interviews

Data collection method 3 comprised semi-structured interviews. Findings from methods 1 and 2 revealed three distinct but complimentary components to MHNs' confidentiality and risk-actuated public interest disclosure-related decision-making processes. The three components were risk assessment, understanding of confidentiality, and risk-actuated disclosure. Therefore, it was decided to explore and report each one of the three components individually, to ensure all themes in this complex area of nursing practice were identified and thoroughly explored. Semi-structured interviews were chosen for these explorations because they are versatile and flexible, and allow for the collection of large volumes of similar types of relevant qualitative data from each participant. Additionally, data obtained from this method is similar in form to data obtained from a focus group method (Kallio et al., 2016).

An interview guide was developed, reviewed by my supervisors, piloted prior to interviews, and reviewed and edited again before being used in interviews. Interview data were collected by me either in person or *via* video-link between April 2020 and March 2021. Interviews were generally performed at a time elected by participants, that did not clash with my own work commitments. A safety protocol was prepared by me and approved by

the university Human Research Ethics Committee (HREC) for the in-person interviews prior to interviews commencing (see Appendix D). All interviews were originally intended to be completed in person. However, the use of video-link for data collection was necessitated by the emergence of the Covid-19 pandemic and accompanying health advice that recommended social isolation where possible. This method of video-link data collection was also endorsed by the University of Sydney.

Interviews ranged from 38 to 80 min in duration (mean = 56 min) and were audio recorded, transcribed, and these data anonymised pending analysis. Covid 19 consideration meant interviews had to be rescheduled on numerous occasions due to participants being unwell with Covid-19, or undertaking overtime at work to cover for colleagues exposed to or unwell with Covid-19. Nonetheless, no participants requested to leave the study. Overall, the Covid-19 pandemic had a negative impact on data collection methods and transcription of these data, causing an extended delay to these undertakings.

4.4.4 Method 4: Focus groups

Lastly, data collection method 4 comprised focus groups. The aim of the focus groups was to explore in a collaborative team-style environment, causal factors for gaps in MHNs' confidentiality and risk-actuated public interest disclosure-related decision-making processes revealed in the semi-structured interviews. This method of data collection was chosen because nursing is a team-oriented profession, and focus groups are an effective way to explore how a group collaboratively builds meaning about a research topic. Furthermore, a focus group dynamic assists participants to express and clarify data in a way that is less common in interviews (Jayasekara, 2012). Therefore, a group setting where MHNs could interact with each other was predicted to generate authentic data that had not arisen in

interviews, because interactions between study participants is itself a source of data (Jayasekara, 2012). Additionally, this method is easily combined with a semi-structured interview method (Kallio et al., 2016).

A focus group guide was developed, reviewed by my supervisors, piloted prior to interviews, and reviewed and edited again before being used. A safety protocol was also prepared by me and approved by the university HREC for in-person focus groups prior to the groups commencing (see Appendix H). However, when given the option of in-person or video-link participation, all participants requested to participate by video-link. Focus groups data were then collected by me in March and April 2023. Each group was conducted at a time that was suitable for all participants and did not clash with my own work commitments.

Time and availability considerations were of particular importance to this data collection method, because systemic staffing shortages exacerbated by the Covid 19 pandemic meant participants were generally working full-time rotating rosters in multiple clinical contexts, accompanied by paid and unpaid overtime. A planner was distributed to participants in advance, whereby they could indicate their preferred dates and times for a focus group. Participant preferences were then cross-referenced to identify a date and time that was acceptable to an adequate number of participants to fill a group. Nonetheless, groups had to be moved several times when participants' work commitments changed at short notice.

The following strategies were also put in place to minimise inconvenience to participants. Firstly, all focus groups were held via video-link at participants' request, which removed the need for participants to travel to attend a group. Secondly, approximately 40 minutes was allocated to each group, because some participants were only available during their allocated lunch hour at work. Consequently, groups ranged from 38 to 49 minutes

(mean=42 minutes). Thirdly, groups were capped at 3 participants to give each participant ample time to discuss their perspectives within the 40-minute window. Small group sizes are recommended for expert participants when exploring complex topics, because they can focus and expound on areas of interest to researchers (Jayasekara, 2012). Notably, small group sizes that allowed each MHN ample time to speak were also proven reasonable when participants indicated they often felt as if their voices were not heard by relevant others, which was reflected in systems that did not appear to consider nursing concerns. Each focus group was audio recorded, transcribed, and these data anonymised, pending analysis.

4.5 Data analysis

Historically, data analysis in qualitative research was associated with an inductive approach, whereby data is coded in the absence of a pre-existing frame of reference. However, contemporary qualitative research is not bound to a specific approach. Therefore, a theoretical thematic analysis was chosen for the study. Theoretical thematic analysis differs from a traditional inductive approach because it commences with an existing theory, conceptual framework, or set of organisational tools, and takes a deductive approach to data coding (Bingham, 2023). For example, the pre-existing reference points comprising the study were the law of NSW, rules of confidentiality and risk-actuated disclosure, and CCT. For theoretical thematic analysis, a clearly specified research question guides data coding, which then allows a researcher to provide a detailed targeted analysis of data to answer that question (Braun & Clarke, 2006). The data collection methods used for the study were chosen because they collected data suitable for theoretical thematic analysis (Braun & Clarke, 2006).

The six steps of the Braun and Clark (2006) system for theoretical thematic analysis guided each stage of the study. First, research data were repeatedly reviewed, until familiarity was achieved with these data. Audio data were listened to repeatedly, whilst textual versions of these data were read and re-read to achieve this goal. Next, a systematic approach was taken to data coding, guided by the research question. For example, in respect of risk-actuated disclosure, codes focused on disclosure of confidential information in the public interest. These codes were subsequently grouped into related themes, which were then reviewed, revised, and clarified. NVivo, Microsoft Excel, and Microsoft Word, were used to group data for codes and themes. Next, themes were defined and named. “For example, not greeting patients in a familiar manner in a public setting, was first 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 [MHNs’] understanding of the potential negative impacts to a patient if their information was released to others” (Chapter 7, p. 117). Lastly, a final report of data obtained from each data collection method was made, before preparing a conclusion for this thesis. Data collection for methods 3 and 4 was terminated at 14 interviews and 4 focus group sessions when data coding and theme development indicated sufficient rich data were collected (Braun & Clark, 2021).

4.6 Ethical considerations

4.6.1 Ethics approval

Data collection methods 1 and 2 did not require human participants, whilst methods 3 and 4 did. Therefore, the study was assessed and approved by the Human Research Ethics

Committee (HREC) of the University of Sydney. Two modifications were later made that also required assessment by the HREC (see Appendix A). The first modification was a condition of the original ethics approval which required a detailed interview guide to be submitted after data obtained from methods 1 and 2 were analysed, because the final version of the semi-structured interview guide was guided by this analysis (see Appendix E). The second modification was a change to method 4 from a survey to focus groups. This change was made because a collaborative group environment was predicted to generate data that has not arisen in previous studies. Data for the study were collected, handled, and stored, according to the requirements of the HREC approval associated with this thesis.

A PIS was distributed with the recruitment letter for the semi-structured interviews (see Appendix B) and a separate PIS distributed prior to focus groups (see Appendix F), and written informed consent obtained before data collection commenced. Anti-spam measures were implemented during the dissemination of research materials, in keeping with anti-spam legislation which requires the consent of parties before marketing messages are received (Spam Act, 2003).

4.6.2 The researcher within research

Qualitative researchers are an instrument of the research process. Furthermore, in interpretivist research it is assumed that knowledge exists in the relationships between a researcher and participants, with the researcher interpreting data to illuminate this knowledge (Bukamal, 2022). Consequently, how a researcher identifies, and their beliefs, perspectives, and experiences, may influence proceedings (Olmos-Vega et al., 2023; Peddle, 2022). Therefore, researchers must outline their identity and position relative to their

research and describe for consumers how they have accounted for their position (Peddle, 2022).

4.6.3 Identity and positionality

Identity refers to how a researcher self-identifies. For example, as a cisgender or transgender male or female, or as a member of a specific profession. A researcher's identity has the potential to influence every aspect of a study, from developing a research question, to data collection and analysis, to a final report of these data (Bukamal, 2022; Wilson et al., 2022). Therefore, for qualitative research maintaining objectivity is generally paramount but never complete (Olmos-Vega et al., 2023). Consequently, it is necessary to accept all researchers will influence their research to some extent. However, they should aim to minimise any influences in so far as possible. To do so, researchers should critically reflect on their identity and the position this may lead them to adopt within a study, and account for their position (Braun & Clarke, 2006; Bukamal, 2022).

The position adopted by a researcher relative to their research is termed positionality, a term which is also used to describe how a researcher is positioned by others (Wilson et al., 2022). For positionality, an insider researcher is one who shares with a research population, qualities that shape their identity and give them intimate knowledge and a shared perspective of the population (Braun & Clarke, 2013). Conversely, an outsider researcher is one who does not share qualities of the research population. Therefore, they do not have any special knowledge or experience that sets them apart from any other person who is not a member of that population (Bukamal, 2022).

For qualitative research, it is accepted researchers may be either an insider or an outsider, or their position relative to their research may change depending on the aspect of

the study, or specific trait or quality of the participant, they are engaging with at any given point in time (Savvides et al., 2014). Therefore, positionality is not necessarily dichotomous. Instead, it is reasonable to suggest it is best viewed as a continuum ranging from a wholly insider to a wholly outsider pole, with the proportion of each position decreasing as one moves away from its associated pole.

There are both positive and negative aspects to being an insider or an outsider. For example, insiders may have important knowledge of a study area that outsiders may not be aware of, such as a common professional terminology or perspective. Consequently, they may find it easier to access relevant data and communicate with sources, when approaching a research question (Savvides et al., 2014; Wilson et al., 2022). Additionally, this knowledge may also grant insiders a unique perspective, that allows them to ask the right questions when approaching a research topic (Greene, 2014).

However, insider knowledge can lead to preconceived ideas or notions that may also increase the potential for bias by an insider, which must be guarded against. Consequently, there is greater objectivity on the part of outsiders when compared to insiders, which lessens the risk of improper influences on a study (Greene, 2014). Furthermore, a lack of insider knowledge means outsiders are less likely to make assumptions or pre-empt findings, or overlook or miss important data (Court & Abbas, 2022). Finally, outsiders are generally not in a position to consciously prejudice or subconsciously misrepresent data as a consequence of existing loyalties or socio-cultural positions, which reduces the risk of unsupportable findings (Miller, 2021).

Nonetheless, human participants may feel more comfortable talking to an insider because they see them as a peer rather than an external observer. Therefore, making the participant more comfortable and willing to disclose information to a researcher, allowing

the insider to collect data that is more authentic than that collected by an outsider (Wilson et al., 2022). Conversely there is a risk that insiders who are known to participants may unknowingly impact the actions or responses of a participant. For example, participants may be unwilling to share information they perceive as embarrassing, disempowering, or controversial, to a person they know outside of the study environment. This problem is less likely to occur with outsiders (Greene, 2014).

In assessing my own position relative to this thesis, my main insider qualities are I am a registered nurse and MHN, with contemporary experience dealing with confidential information of patients in mental health care who may pose a risk to self or others. My main outsider qualities are I am a legal practitioner (solicitor) and co-owner of a law firm with experience in corporate compliance for Australian financial service licensees. There are also qualities I share with some participants, that make me outsider or an insider depending on the participant I am engaging with. For example, I am a cisgender male, with experience working as a nurse academic. I was also known to a small number of participants in the study prior to their recruitment. Therefore, I consider myself to be an insider-outsider researcher.

4.6.4 Reflexivity

Reflexivity refers to the practice of reflection upon, and practical strategies put in place by researchers to account for, potential influences of identity and positionality on their research. Researchers should clearly outline how they moved through the research process, and explicitly state the relevant processes and procedures put in place at each stage (Olmos-Vega et al., 2023; Peddle, 2022).

For the thesis, the following strategies were put in place to minimise potential influences on the study. Firstly, the methodology of the study is clearly outlined. Next, for methods 1 (legal review) and 2 (instrumental case study), data were collected by me from existing resources. My search strategy and these resources and data were reviewed and approved by the two supervisors of my PhD, both of whom are experienced researchers, academics, and Nurse Practitioners.

Additionally, for methods 3 (semi-structured interviews) and 4 (focus groups), interview and focus group guides were developed, which were reviewed by my supervisors, edited, piloted, and reviewed and edited again, before being used (see Appendices E, and I). These guides were used to ensure data were collected consistently and were relevant to the deductive approach taken to data analysis in the study.

Interviews and focus groups were recorded and these recordings reviewed by my supervisors to ensure an accurate record of participants' data were made, and to ensure I was not leading participants' responses or drawing skewed conclusions based on personal views or perceptions. The Braun and Clark (2006) system led analysis of these data for all four data collection methods (see above). The final report of each method and the contents of this thesis were also reviewed and approved by my supervisors.

Lastly, I engaged in continued reflection regarding my identity and position relative to my research at each stage of the study, and thesis.

4.7 Conclusion

This section concludes Chapter 4, which outlined the methodology of this thesis. The chapter commenced with the identification of an interpretivist research paradigm for the

study. Next the choices of NSW as the study setting and MHNs as the target population were described and justified. Data collection and data analysis methods were then described. Finally, ethical considerations relating to the study were outlined. Next, Chapter 5 will present data obtained from methods 1 and 2 of the study, a legal review of confidentiality in NSW and an instrumental case study of *NK v Northern Sydney Central Coast Area Health Service* (2010).

CHAPTER 5: CONFIDENTIALITY, LEGAL FRAMEWORK AND APPLICATION IN NSW

5.1 Introduction

Chapter 5 presents data obtained from methods 1 and 2 of the study. Method 1 is a legal analysis of the framework of confidentiality for MHNs in NSW, whilst method 2 is an instrumental case study of *NK v Northern Sydney Central Coast Area Health Service* (2010). Specifically, this chapter will examine the duty of confidentiality of MHNs to patients in mental health care in NSW, and how allegations of inappropriate risk-actuated public interest disclosure-related decision-making processes are dealt with by legal decision makers.

5.2 Legal review and case study

Author attribution statement and attestation

Chapter 5 of this thesis is published as '*Decision-making processes of a nurse working in mental health, regarding disclosure of confidential personal health information of a patient assessed as posing a risk*'.

I, Darren Conlon was responsible for:

- Conception and planning of the legal review and case study
- Literature search
- Data Collection and Analysis
- Preparation of the final report

Signature:

Name: Darren Conlon

Date: 14 February 2024

As supervisors for the candidature upon which this thesis is based, we confirm the authorship attribution statement above is correct.

Signature:

Name: Timothy Wand

Date: 14 February 2024

Signature:

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Date: 14 February 2024



Decision-making processes of a nurse working in mental health, regarding disclosure of confidential personal health information of a patient assessed as posing a risk



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ABSTRACT

Background: Nurses working in mental health routinely face difficult decisions regarding confidentiality and disclosure of patient information. There is public interest in protecting patient confidentiality, and there is a competing public interest in disclosing relevant confidential information to protect the patient or others from harm. However, inappropriate disclosures may constitute a breach of confidentiality. Despite the gravity of this situation, there is a paucity of literature to guide nurses' decision-making processes regarding confidentiality and disclosure.

Aim: To examine decision-making processes of a nurse working in mental health, regarding disclosure of personal health information of a patient assessed as posing a risk.

Methods: Qualitative interpretivist approach using thematic analysis of data derived from an instrumental case study of NK v Northern Sydney Central Coast Area Health Service 2010, a Civil and Administrative Tribunal matter in New South Wales, Australia.

Findings: Three important legal concerns relevant to nurses' decision-making processes are illuminated. Firstly, for risk assessment there was an emphasis on a static notion of dangerousness. Secondly, rules of confidentiality and disclosure were not adequately observed. Thirdly, confidential information was disclosed without valid justification.

Discussion: Inappropriate decision-making processes that may lead to a breach of patient confidentiality were evident in the findings. Gaps in understanding nurses' decision-making processes pertaining to confidentiality and disclosure of patient information that may be addressed by future research were also revealed.

Conclusion: Future research that addresses gaps in understanding nurses' decision-making processes identified by this instrumental case study would provide greater guidance for nurses when making decisions regarding confidentiality and disclosure related to risk.

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Summary of Relevance

Problem or Issue

Little is known about disclosure of confidential information by nurses, of patients assessed as posing a risk.

What is Already Known

Disclosure requires a valid determination of risk, but it unclear how nurses conceptualise risk. Rules of confidentiality are complex, and not always observed. Nurses' understanding of the concept of public interest disclosures in the context of patient risk, is unclear.

What this Paper Adds

Overruling assessment of dynamic risk with static assessment of dangerousness is not recommended. Clear rules do not necessarily lead nurses' to adequately observe confidentiality. It is unclear how nurses understand the concept of 'public interest', in the absence of a duty compelling disclosure.

1. Introduction

Nurses routinely collect or access personal information to ensure each patient receives appropriate care (Kämpf & McSherry, 2006). However, this information may be sensitive, or have the potential to lead to negative repercussions for a patient (Barloon & Hilliard, 2016). The potential or actual harms that may arise from inappropriate disclosure of personal information are more pronounced in mental health care. Stigmatising attitudes regarding the perceived dangerousness of people who experience mental illness persist in society, and releasing information regarding a patient's mental health may cause the patient to be avoided (Large, Ryan, Nielssen, & Hayes, 2008; Wand, 2012). Consequently, there is a duty of confidentiality on the part of nurses (and all health care clinicians) regarding patient information, to encourage patients to share their information (Griffith, 2007).

There is limited literature to guide nurses' decisions on confidentiality and disclosure, when a patient is assessed as posing a risk (Conlon, Raeburn, & Wand, 2019). Therefore, this paper presents an instrumental case study of nurse-decision making in the publicly available case of *NK v Northern Sydney Central Coast Area Health Service* (2010), a legal matter before the New South Wales (NSW) Civil and Administrative Tribunal (the Tribunal). The Applicant (NK) was both an employee and a patient of the Respondent (the Hospital), with a diagnosis of 'bipolar disorder'. NK's complaint centred on the handling of his confidential health information by the Hospital following an episode of care.

1.1. Facts of the matter

NK presented to the Hospital for assistance, after being directed at short-notice by co-worker Nurse M to take a day off work that coincided with a visit to the Hospital by a politician. NK had also been directed to take a day off work the previous week. NK was assessed by Nurse W, an acting Clinical Nurse Consultant in the Hospital's mental health service. Nurse W documented that NK had presented with thoughts of self-harm and of harming a co-worker (Nurse M), related to perceived sustained bullying. In addition, Nurse W documented NK denied frequently considering self-harm, but admitted similar thoughts had occurred in the past. Nurse W also documented NK denied thoughts of harming others until now, apart from the occasional instance following consumption of alcohol.

NK was then reviewed by a psychiatrist who arranged for NK to be admitted to the Hospital under the NSW *Mental Health Act* (2007). NK was then transferred to a different hospital (the second facility) to protect his confidentiality, because he was an employee of the Hospital. NK was discharged the following day. Six days later,

Nurse W contacted the second facility to check on NK, ostensibly because she continued to have concerns regarding her assessment of NK. On being informed NK had been discharged, and after reaching consensus with the co-workers she consulted on the matter, Nurse W took NK's medical records to Human Resources at the Hospital. Human Resources subsequently blocked NK's employee access to the Hospital, and NK was advised to only attend the premises if presenting as a patient requiring care.

NK subsequently attended a meeting with Human Resources, where it became apparent his personal health information had been forwarded by Nurse W. Some weeks later NK became unwell and required care. However, NK reported being afraid to approach the Hospital lest his confidentiality be breached again. NK then attempted suicide. Following his suicide attempt, and after reflecting on the events outlined above, NK took legal action against the Hospital for inappropriately handling his personal health information and breaching his confidentiality.

2. Literature review

The duty of confidentiality is derived from equity and common law. The duty arises when personal information is communicated by a patient, with an understanding the information will not be disclosed to others without consent; or in circumstances where the person receiving the information should have reasonably known the information was confidential (*Australian Broadcasting Commission v Lenah Game Meats Pty Ltd*, 2001; Griffith, 2007). Certain relationships give rise to a duty of confidentiality, including the relationship between a nurse and a patient (Griffith, 2007). Duties of confidentiality may also be promulgated by statute and found in professional nurse regulation (NSW Health, 2015; Nursing and Midwifery Board of Australia, 2018).

There is a public interest in protecting the confidentiality of patient information, as patients may be otherwise reluctant to share essential health information with clinicians (Kämpf & McSherry, 2006). Notably, the concept of 'public interest' is not defined in law or literature (Conlon et al., 2019). The term refers to a broad concept encompassing anything deemed to be in the interests of society as a whole (Dolan, 2004; *McKinnon v Secretary, Department of Treasury*, 2005). However, the duty of confidentiality is not absolute and information can be disclosed, with patient consent, by operation of the law, or where there is a competing public interest in disclosing the information (McHale, 2009). A competing public interest in disclosure includes the public interest in protecting a patient or others from potential harm (Dolan, 2004).

With regard to mental health, dilemmas can arise when a nurse assesses a patient to be a risk to self or others, but patient consent does not permit, or the law does not mandate, disclosure of information (Conlon et al., 2019). Nurses must balance the public interests in confidentiality and disclosure, to determine which interest carries the greatest weight (McHale, 2009). Decisions made in the context of risk are not straightforward, because rules of confidentiality in this area of nursing practice are complex (Sands et al., 2013). A review of relevant literature indicates rules of confidentiality are not always observed for patients considered to pose a risk. However, it is unclear if the rules are not understood, or not adhered to, by nurses (Conlon et al., 2019).

The inappropriate disclosure of personal information may have negative repercussions for patients, and nurses may face disciplinary action if confidentiality is breached (Kämpf & McSherry, 2006). Furthermore, rules of confidentiality differ from one jurisdiction to another, and between different professions (Mason, Worsley, & Coyle, 2010; NSW Health, 2015; Nursing and Midwifery Board of Australia, 2018). Consequently, for specific jurisdictions

such as NSW the paucity of available literature is more pronounced.

2.1. Confidentiality framework for nurses in NSW

There are three statutes that prescribe how confidential information is to be handled in NSW. The *Privacy Act* (1988), the *Privacy and Personal Information Protection Act* (1998); and the *Health Records and Information Privacy Act* (2002) (HRIP, 2002). The HRIP (2002) was established to focus specifically on personal health information in the public and private sectors, highlighting the importance of protecting patient information. The HRIP (2002) defines 'personal information' as information or an opinion about an individual where the identity of the person is clear or can be reasonably ascertained, whilst 'health information' is personal information or opinion about: an individual's physical or mental health; the express wishes of an individual regarding future health care; the health care delivered or to be delivered to an individual; or personal information collected from an individual for health care (HRIP, 2002). Therefore, the term 'personal health information' may be used to refer to health information where a patient's identity is clear or can be reasonably ascertained (NSW Health, 2015).

Personal health information is confidential and may not be 'used or disclosed' for any purpose other than the primary purpose for which it was collected, a directly related purpose within the reasonable expectations of the person to whom the information pertains, or by operation of a law requiring disclosure. Notably for nurses, the definition of 'use' includes disclosure between members of an organisation, whilst 'disclosure' is the release of information to a third party (HRIP, 2002).

For clarity, the HRIP (2002) is accompanied by a list of 15 Health Privacy Principles (HPP, see Table 1) that outline in unambiguous terms, responsibilities when handling personal health information in NSW. Health service providers may also have systems in place to ensure employees are aware of and agree to adhere to the requirements of the HRIP (2002) (Information and Privacy Commission NSW, 2019b; NSW Health, 2015).

When a complaint arises in the public health sector, a request may be made for an internal review of alleged contraventions of the HRIP (2002). If the complainant is unhappy with the outcome of the internal review, a request for a review of the public health sector provider's decision can be made to the Tribunal (HRIP, 2002). For the private health sector, complaints regarding breaches of confidentiality may be made to the Privacy Commissioner of NSW. If the private health sector complainant is unhappy with the outcome of the complaint, and only if the Privacy Commissioner has made a report, a request for the review of the outcome of the complaint can be made to the Tribunal (HRIP, 2002; Information and Privacy Commission NSW, 2019a). Statutory breaches of confidentiality may attract compensation for the breach (HRIP, 2002).

Notably, under the HRIP (2002) it is the health sector provider as employer, not the nurse, who will be found at fault for a breach of confidentiality of personal health information. However, nurses may still be subject to investigation and disciplinary action by employers or professional nursing authorities if patient confidentiality is breached (Kämpf & McSherry, 2006; NSW Health, 2015). A Code of Conduct for Nurses outlines the professional obligations of confidentiality expected of nurses in NSW (Nursing and Midwifery Board of Australia, 2018). This Code of Conduct is complemented by a Code of Ethics that reiterates the importance of confidentiality for nurses (International Council of Nurses, 2012). Professionally, a breach of confidentiality by a nurse may lead to a finding of unsatisfactory professional conduct or professional misconduct, and risk temporary or permanent removal of the nurse from the register of

nurses (Health Practitioner Regulation National Law No 86a, 2009; Nursing and Midwifery Board of Australia, 2018).

2.2. Confidentiality and risk

A decision to withhold or disclose confidential information because of patient risk is not made in isolation. It requires a valid determination of risk underpinning the decision to disclose (Conlon et al., 2019; Sands et al., 2013). Nurses' decisions on risk are made using actuarial approaches, unstructured clinical judgement, or structured clinical judgement (Conlon et al., 2019). Actuarial approaches are based on predictor variables that research has demonstrated are related to increased risk, whereas for unstructured clinical judgement nurses use their 'clinical experience and common sense' to make risk related decisions (Murphy, Kapur, Webb, & Cooper, 2011; Sands, 2009).

Statistically derived actuarial approaches have been demonstrated to surpass clinical intuition backed unstructured clinical judgement in predicting harm. However, predicting harm remains an imprecise science with a low success rate and is not clinically useful (Caterino et al., 2013; Higgins et al., 2016; Murphy et al., 2011). Clinicians are concerned with assessing and responding to risk, but actuarial approaches do not take a patient's individual characteristics or the dynamic nature of risk into account. Therefore, actuarial approaches cannot be used to manage risk (Murphy et al., 2011). Conversely, clinical intuition can be used to manage risk and nurses prefer unstructured clinical judgement over actuarial approaches for risk assessment (Conlon et al., 2019).

Structured clinical judgement involves the application of nurses' intuition backed discretion to actuarial risk factors to establish a dynamic approach to risk assessment and management (Conlon et al., 2019; Murphy et al., 2011). Structured clinical judgement enhances the positives and minimises the negatives of unstructured clinical judgement and actuarial approaches (Conlon et al., 2019). However, the literature does not outline for nurses the most appropriate way to apply clinical intuition in structured clinical judgement, to ensure the most appropriate risk assessment and management decisions are made. Furthermore, there is a paucity of literature regarding how nurses conceptualise risk when using a structured approach to make risk related decisions (Higgins et al., 2016).

3. Aim

To examine decision-making processes of a nurse working in mental health, regarding disclosure of personal health information of a patient assessed as posing a risk.

4. Methods

A qualitative interpretivist approach using thematic analysis of data derived from an instrumental case study of *NK v Northern Sydney Central Coast Area Health Service* (2010), was chosen for this examination of nurse decision-making. An interpretivist approach is indicated when "[t]he researcher's intent is to make sense of (or interpret) the meanings others have about the world" (Creswell & Roth, 2018, p. 125). Case studies drawn from existing records are useful when studying human behaviour, as they provide a source of naturally occurring data free from the conscious or unconscious bias of previous researchers (Denzin & Lincoln, 2000; Silverman, 2013). Naturally occurring data may also reveal issues or ideas for further investigation that had not previously occurred to researchers (Silverman, 2013). Researcher 1, who is both a lawyer and mental health nurse led data collection, coding, extraction of findings, discussion, and conclusion. Researchers 2 and 3 are expe-

Table 1
Health Privacy Principles (HPP), to accompany the [Health Records and Information Privacy Act \(2002\)](#). Adapted from Ref. [Information and Privacy Commission NSW \(2019b\)](#).

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.
2.	Relevant	Ensure health information is relevant, accurate, up-to-date and not excessive, and that the collection does not unreasonably intrude into the personal affairs of a person.
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 and accurate 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.
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.
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 records linkage systems if the person has provided or expressed their consent.

rienced researchers and nurse practitioners in mental health, who provided critical research, data analysis and writing expertise.

4.1. Search strategy

A search was conducted in November 2019 scrutinising legal matters between the years 2009 and 2019, regarding nurses working in mental health as a key decision-maker on confidentiality and disclosure of information for patients assessed as posing a risk. The search was conducted using: Austlii; NSW caselaw, and NSW and Australian legal databases. The following keyword search terms were used independently and in combination: confidential*; disclos*; mental health; and nurs*. The search strategy, and reading of full text by all researchers, identified one Tribunal matter as adequately meeting all search criteria, [NK v Northern Sydney Central Coast Area Health Service \(2010\)](#).

4.2. Analysis

Following selection of [NK v Northern Sydney Central Coast Area Health Service \(2010\)](#) as a pertinent case for this study, a theoretical thematic analysis was conducted. Theoretical thematic analysis differs from inductive thematic analysis (where data is coded without reference to a pre-existing frame of reference), because it begins with a previously established theoretical framework (in this case the law of NSW) and assumes a deductive strategy to coding. Initially, Researcher 1 used his background as a lawyer to build familiarity with legal frameworks relevant to nurse decision making in NSW. Analysis was then guided by the six steps suggested by [Braun and Clarke \(2006\)](#). Firstly, familiarisation with data was achieved through reading and re-reading the case. Codes were then generated in a systematic fashion, focusing on how nurse decision making played out in the case study. Themes were searched for,

represented by patterns in codes. These themes were reviewed and refined. Themes were then defined and named, with reference to: nurse decision-making; relevant NSW legal frameworks; and legal and nursing guidelines and precedents. Lastly, a coherent report was made of the final analysis ([Braun & Clarke, 2006](#)).

5. Findings

Once analysed, data from the case study highlighted three important legal concerns congruent with the overall findings of the Tribunal regarding nurses' decision-making processes related to, confidentiality, disclosure, and risk. A focus on dangerousness, a failure to adequately observe clear and unambiguous rules for handling information, and disclosure of confidential information without a reasonable justification.

5.1. Legal concern 1: inappropriate risk assessment

The first legal concern to emerge from the case study is a focus on dangerousness. Historically, risk assessment in mental health commonly focussed on anticipating a patient's potential for harm, based on the presence or absence of a static criteria of dangerousness. Internationally, many mental health statutes and diagnostic risk assessment instruments continue this approach ([Large et al., 2008](#); [Wand, 2012](#); [Wand, Buchanan-Hagen, Derrick, & Harris, 2020](#)). However, focussing on dangerousness does not recognise a patient's potential for harm may fluctuate ([Hewitt, 2008](#); [Wand, 2012](#)). Therefore, nurses are advised to focus on patient risk, a dynamic phenomenon that may appear at any point on a continuum from no present risk, to a credible risk of imminent harm ([Norko & Baranoski, 2008](#)).

Nurse W's initial risk assessment of NK was undertaken using a 12-page assessment form. These forms facilitate a standardised

structured clinical judgement approach to risk related decisions, which underpin decisions to withhold or disclose confidential information (Conlon et al., 2019; Monahan & Skeem, 2014). Nurse W recorded NK's thoughts of harm to be current only, not persistent. No special precautions were taken by Nurse W regarding any alleged fear of NK when conducting the face-to-face assessment in the Emergency Department, and Nurse W assessed and recorded NK as 'low-risk'. Furthermore, the psychiatrist on duty admitted NK to the Hospital under the [Mental Health Act \(2007\)](#) as a 'mentally disordered person', indicating a transient episode of irrational behaviour requiring only temporary detention of NK. NK was then cleared for discharge the following day, because the irrational behaviour had resolved.

However, having discovered NK was discharged, Nurse W retrospectively amended the assessment form to suggest specific threats had been made by NK against his co-worker (Nurse M). This amendment portrayed NK as 'high-risk', because specific threats to a named person indicate a credible risk of harm (McSherry, 2000). Notably, no reasonable explanation or justification was made by Nurse W regarding the amended finding of high-risk.

Nurse W then disclosed NK's information to Human Resources based on the amended assessment of 'high risk'. However, even had NK been 'high risk' at the time of assessment, no contemporaneous warning of credible and imminent harm was issued by Nurse W. Furthermore, no consideration appears to have been given to the fact that NK's level of risk may have altered in the week since NK had been assessed. In fact, NK had been subsequently assessed at the second facility and found to be safe for discharge. This retrospective assessment of dangerousness was inappropriately prioritised over the initial contemporaneous assessment of risk, eventually leading to NK's confidentiality being breached (Hewitt, 2008; Wand, 2012).

5.2. Legal concern 2: failure to observe rules of confidentiality and disclosure

The second legal concern to emerge from the case study is a failure to adequately observe clear and unambiguous rules for handling information, leading to a breach of confidentiality. Firstly, Nurse W requested NK's discharge summary and medical record from the second facility where NK had been transferred to protect his confidentiality, because NK had been released back into the patient catchment area of the Hospital and might come under her care again in the future. However, NK was not under Nurse W's care at the time, and there was no defensible justification for requesting NK's health information. The collection of NK's information contravened HPP 3 (see [Table 1](#)), whereby information should be collected from the person to whom it pertains (HRIP, 2002).

Secondly, Nurse W collected NK's personal health information from the second facility without seeking NK's consent to do so, or advising NK the information had been collected. This was a contravention of HPP 4 (see [Table 1](#)), whereby Nurse W was required to notify NK of his (and the Hospital's) rights and responsibilities regarding the collection of information from a third party (HRIP, 2002).

Thirdly, Nurse W accessed NK's file in the Hospital's records. The Tribunal heard evidence it was unusual for a clinician to access a patient's file after (in this case) seven days, unless the patient required further care or review. Furthermore, patient consent is required to access information for any purpose other than the primary purpose for which it was collected, or a secondary purpose reasonably within the expectations of the person to whom the information pertains (HRIP, 2002). HPP 5 regarding retention and security of patient information was contravened (see [Table 1](#)), because patient information must be protected by health service providers from unauthorised access (HRIP, 2002).

Fourthly, the retrospective comment inserted in NK's risk assessment by nurse W framing NK as "high-risk" was found to be inaccurate by the Hospital and the Tribunal. Furthermore, a second retrospective comment inserted by Nurse W Nurse W advised NK had been treated at the second facility for only two hours before being discharged. However, the medical records obtained by Nurse W from the second facility clearly stated NK had spent twelve hours admitted to the second facility. NK suggested Nurse W appeared to feel he was not adequately treated at the second facility, because she incorrectly asserted NK had spent much of this time in the waiting room before being treated. However, NK's suggestion was not investigated further by the Tribunal, because it was not required in coming to a decision. Both retrospective comments were found to contravene HPP 9 (see [Table 1](#)), which requires health service providers to take steps to ensure records are accurate and not misleading (HRIP, 2002).

Fifthly, Nurse W disclosed NK's confidential personal health information to the Human Resources department of his employer, the Hospital. The information was not released for the primary purpose for which it was collected, a directly related purpose within the reasonable expectations of NK, or by operation of a law requiring disclosure (NSW Health, 2015). The disclosure was a contravention of HPP 10 (see [Table 1](#)) regarding the limits on the use of health information. The Tribunal found "[o]n the view of the evidence most favourable to Nurse W it may be said that she acted in some misguided belief that she had a legal obligation or clinical responsibility to bring her concerns to the attention of others" (NK v Northern Sydney Central Coast Area Health Service, 2010, [76]). Regardless, a disclosure of personal health information within an organisation, to agents of the organisation who do not have a legitimate reason for having it, is a breach of patient confidentiality (HRIP, 2002; NSW Health, 2015).

5.3. Legal concern 3: understanding the public interest exception

The third legal concern to emerge is the disclosure of confidential information without a reasonable justification. There is a public interest in confidentiality, but there is also a competing public interest in disclosure in the context of patient risk, whereby confidential information may be disclosed to lessen or prevent a serious threat to the life, health or safety of a patient or others (Conlon et al., 2019). This exception is reflected in the statutory framework protecting confidential health information in NSW (NSW Health, 2015).

For nurses in NSW, the context in which the public interest in disclosure will outweigh the public interest in confidentiality requires the following criteria be present. Firstly, there must be a reasonable belief the patient presents a credible risk of harm (Director General, Department of Education and Training v MT (GD), 2005). However, NK had no history of harm to self or others. Furthermore, NK self-presented to the Emergency Department, which according to expert evidence put to the Tribunal demonstrated a desire to seek support rather than act on thoughts of harm.

The potential harm must also be serious and imminent (FM v Vice Chancellor, Macquarie University, 2003; HRIP, 2002). NK's level of risk was not treated as serious by Nurse W during the face-to-face assessment. Furthermore, NK was admitted to the Hospital under the [Mental Health Act \(2007\)](#) as a 'mentally disordered person', and NK's episode of irrational behaviour soon resolved.

Moreover, disclosure must be necessary to prevent potential harm from occurring (MT v Director General, NSW Department of Education & Training 2004). However, Nurse W was unable to describe the harm posed by NK, or why disclosure was necessary to prevent harm.

Disclosure must be required immediately (not delayed to some future point in time) to prevent the potential harm (NK v Northern Sydney Central Coast Area Health Service, 2010). However, Nurse

W's decision to disclose NK's information was made based on a risk assessment undertaken 7-days prior, and 6-days since NK had been cleared as safe for discharge.

Significantly, the Hospital also sought to rely on expert evidence that Nurse W's decision to disclose (in consensus with her co-workers) was permissible, based on a legal duty to warn or protect potential victims of a patient (Mason et al., 2010). The duty arises from the case of *Tarasoff*, in which a Californian mental health clinician failed to alert a named target of specific threats made by a patient, and the target was subsequently murdered by the patient (*Tarasoff v Regents of the University of California*, 1976).

The duty permits notifying the victim or authorities of a realistic threat, to prevent potential harm. However, the Hospital as employer is not in one of these categories and Nurse W did not take any steps to advise Nurse M or the police of the alleged threat. Furthermore, following *Tarasoff* disclosure to prevent harm became a legal duty to warn or protect in many states of the United States, but it remains at most a moral impetus in other jurisdictions including NSW and Australia (Mason et al., 2010; McSherry, 2008).

6. Discussion

This instrumental case study has highlighted complex legal concerns relating to inappropriate disclosure of personal health information by a nurse in NSW. A decision to disclose can be justified if made to prevent a serious and imminent risk of harm. However, potential harm remains notoriously difficult to anticipate, because risk is a dynamic phenomenon that fluctuates over time. Consequently, retrospective assessments of potential harm are not recommended (Hewitt, 2008; Wand, 2012).

Nurses apply clinical intuition to actuarial indicators, for structured clinical judgement backed decisions on risk that underpin a decision to withhold or disclose information (Conlon et al., 2019; Murphy et al., 2011). Nevertheless, it remains unclear how nurses conceptualise risk to make these decisions, or decide when intuition may be used to overrule actuarial findings or decisions of other mental health clinicians (Higgins et al., 2016).

Rules of confidentiality are complex and not always observed by nurses. However, it is unclear if these rules are not well understood, or are not adhered to in practice (Conlon et al., 2019). However, despite the availability of the clear and unambiguous HPPs in NSW (NSW Health, 2015), rules for handling personal health information were not adequately observed in the case study.

There is a public interest in disclosure to prevent harm in many jurisdictions, including NSW. A position reflected in the statutory framework protecting confidential information (NSW Health, 2015). There is legal guidance regarding the concept of the public interest in disclosure to prevent harm (Director General, Department of Education and Training v MT (GD, 2005; FM v Vice Chancellor, Macquarie University, 2003; MT v Director General, NSW Department of Education & Training, 2004). Regardless, it remains unclear how the concept of the public interest, and the balancing of competing public interests, are understood by nurses.

Concerns regarding when confidential information may be validly withheld or disclosed are exemplified in the North American case of *Tarasoff*, which led to the promulgation in many jurisdictions of a legal duty to disclose patient information. This legal duty to warn or protect from harm requires information to be disclosed if a potential victim is named, irrespective of level of risk (Mason et al., 2010; *Tarasoff v Regents of the University of California*, 1976). However, the duty has not been adopted universally, and in many jurisdictions (including NSW and Australia) it is at most a moral impetus to disclose (Mason et al., 2010; McSherry, 2008). The case study illustrates there is a belief amongst clinicians that the legal duty applies in NSW, and Australia. It is important that the prevalence of the belief be ascertained, because health service providers

may face legal action, and nurses disciplinary action, if information is disclosed inappropriately (Kämpf & McSherry, 2006).

7. Implications and future research

This instrumental case study reveals a number of legal concerns for nurses regarding decision-making processes that may lead to a breach of confidentiality. Firstly, nurses should focus on assessing the dynamic criteria of 'risk', not the static criteria of 'dangerousness', when applying clinical intuition backed discretion to actuarial indicators of risk. Secondly, nurses must take steps to improve their knowledge of rules of confidentiality and disclosure of personal health information. Thirdly, nurses must endeavour to enhance their understanding of the concept of the public interest relative to confidentiality and disclosure. Appropriately addressing these concerns has the potential to enhance nurses' decision-making, improve patient outcomes, and reduce employers' exposure to legal liability for breach of confidentiality.

Extrapolation of the naturally occurring data collected for this case study has also illuminated a need for further research to inform decision-making processes on confidentiality and disclosure when a patient is assessed to be a risk to self or others.

8. Limitations

The rules of confidentiality, and nurses' practice in the context of mental health and risk, share similarities internationally. However, statutory rules of confidentiality, and laws governing nurses' practice regarding risk, may differ from one jurisdiction to another. For example, the *HRIP* (2002) creates rules regarding handling of personal health information that only apply in NSW. The quality of reasonableness that indicates the threshold for a risk-related disclosure has been reached may also differ from one jurisdiction to another.

The limitations in this case study have been addressed by way of an outline of the legal framework of confidentiality in NSW, and the application of this framework to the handling and disclosure of confidential information by a nurse based on an assessment of risk in that jurisdiction. Therefore, the reader is able to use their judgement to independently assess the concordance between the findings of this case study, and their own jurisdiction and area of practice.

9. Conclusion

Nurses frequently encounter difficult situations regarding confidentiality, and risk-related disclosures of patient information. Risk is a dynamic phenomenon so potential harm is difficult to predict, and focussing on dangerousness of a patient is not recommended. Nurses are also advised to exercise caution when applying clinical intuition during structured clinical judgement enabled risk assessment, because failing to recognise the importance of actuarial findings and the dynamic nature of risk underpinning a decision to disclose, may lead to an inappropriate assessment of risk. Furthermore, if nurses are to deliver optimal care, they require knowledge regarding the rules of confidentiality and disclosure in the context of patient risk, because failure to understand or adhere to these rules may lead to a breach of patient confidentiality. Nevertheless, rules of confidentiality are not always observed by nurses, and there is a paucity of literature to guide nurses' decision-making in this area of practice.

In circumstances where disclosure of confidential information may be indicated, the nurse must identify and balance the public interests in confidentiality and disclosure to decide which interest carries the greatest weight. However, despite the importance attached to nurses' decision-making processes, it remains unclear how nurses conceptualise risk when assessing a patient, under-

stand and operationalise rules of confidentiality and disclosure, and understand the concept of the public interest. Future research that addresses the gaps in understanding nurses' decision-making processes pertaining to confidentiality and disclosure of patient information identified by this case study, would provide guidance for nurses when making these types of decisions.

Ethical statement

The manuscript is drawn from publicly available material, and does not involve human or animal research. It constitutes a chapter of a PhD study at the University of Sydney. Ethics approval was granted for the PhD study by the Human Research Ethics Committee of the University of Sydney (protocol number: 2019/564) on 13 August 2019.

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CRedit authorship contribution statement

All authors contributed to: the conception of this study; refining and further development of the original concept; literature search and analysis; data collection; thematic analysis of data; extraction of findings; and manuscript editing. Darren Conlon 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.

Conflict of interest

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5.3 Conclusion

This section concludes Chapter 5 which presented data obtained from methods 1 and 2 of the study, a legal review of confidentiality in NSW and an instrumental case study of *NK v Northern Sydney Central Coast Area Health Service* (2010). The chapter commenced with a brief introduction to disclosure-related dilemmas for MHNs regarding confidential information of patients in mental health care, when a patient is assessed as posing a potential credible risk to self or others. Next, the facts of NK were outlined. Following this, a comprehensive overview of the legal framework supporting confidentiality in NSW which focused on patient information in mental health care was presented. The aim and methods of the legal review and case study were then described. Themes identified in legal review and case study data were presented. Finally, the relevance of these themes to the research goals of this thesis were discussed. Next, Chapter 6 presents the first of three sets of data obtained from method 3 of the study, semi-structured interviews exploring MHNs' risk assessment decision-making processes regarding patients in mental health care.

CHAPTER 6: RISK ASSESSMENT DECISION-MAKING PROCESSES OF MENTAL HEALTH NURSES

6.1 Introduction

Chapter 5 presented data obtained methods 1 and 2 of the study, a legal review and instrumental case study. These data revealed there are three distinct but complimentary components of MHNs' confidentiality and risk-actuated public interest disclosure-related decision-making processes. Chapter 6 is the first of three consecutive chapters (chapters 6, 7, and 8) that present data obtained from method 3 of the study, semi-structured interviews exploring MHNs' risk assessment decision-making processes. Specifically, the chapter illuminates risk assessment by MHNs, whilst taking the novel approach of using Cognitive Continuum Theory (CCT) as a framework to discuss the findings of this exploration.

6.2 MHNs and risk assessment

Author attribution statement and attestation

Chapter 6 of this thesis is under its second round of peer review for publication in *Issues in Mental Health Nursing* as 'Mental health risk assessments of patients, by nurses working in mental health settings: A qualitative study using Cognitive Continuum Theory'.

I, Darren Conlon was responsible for:

- Conception and planning of the investigation and interviews
- Literature search
- Data Collection and Analysis
- Preparation of the final report

Signature:

Name: Darren Conlon

Date: 14 February 2024

As supervisors for the candidature upon which this thesis is based, we confirm the authorship attribution statement above is correct.

Signature:

Name: Timothy Wand

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Date: 14 February 2024

TITLE

Mental health risk assessments of patients, by nurses working in mental health settings: A qualitative study using Cognitive Continuum Theory

ABSTRACT

Mental health risk-assessments are an important part of nursing in mental health settings, to protect patients or others from harm. Even so, nurses often have difficulty identifying patients posing a credible risk (either to self or others), so guidance is recommended. However, despite an extensive and growing body of risk-oriented literature, comparatively little expands upon contemporary knowledge of nurses and patient risk assessment. Therefore, it remains unclear how nurses understand risk and undertake their risk assessments. To address this knowledge gap in nurses' decision-making processes, this study used the established Cognitive Continuum Theory as a novel means to explore risk-assessment of patients by nurses working in mental health settings.

KEYWORDS

Cognitive Continuum Theory, Mental health, Nurs*, Risk assessment, Risk to self or others

INTRODUCTION

Mental health risk-assessments are a core aspect of nursing in mental health settings, and of invaluable assistance in the identification and mitigation (or prevention) of potential harm by a patient to self or other (Higgin et al., 2016; Hautamäki, 2018). This key decision-making process usually takes place in response to perceived indicators of risk, a history of harmful behaviour, or sometimes as a matter of routine (Ayer et al., 2022; Kim et al., 2022). Each

assessment is specific to an individual and their current circumstances, but stratification of risk (low, medium, or high) is discouraged, or if unavoidable requires a rationale (NSW Health, 2022; South Eastern Sydney Local Health District, 2022). Instead a patient is assessed to poses a risk, or not. Examples of harm that may arise from risk include: self-harm, suicide, self-neglect, exploitation by others, loss of reputation, loss of property, sexual assault to self or others, or injury or death to others (Higgins et al., 2016).

Researchers affirm human decision-making (including risk assessment decisions of nurses) is principally a cognitive exercise that is either a 'dual process' system which has intuition and analysis as distinct (but complementary) cognitive strategies, or a single process system characterised by a dynamic blended interplay of intuitive and analytic cognition (Björk & Hamilton, 2011; Dhami & Thomson, 2012). When applied to risk-assessment, dual-process cognition is described as dynamic experientially led intuition (known as unstructured clinical judgement), paired with analysis which focuses on empirical static actuarial risk indicators (Conlon et al., 2023). Actuarial indicators (actuarial approaches) are generally deemed superior for the identification of risk. Even so, they must be applied contemporaneously, or nurses are assessing static 'dangerousness' criteria not inconstant risk (Faay et al., 2013; Wand, 2012). However, risk-related activities of nurses generally include elements of contemporaneous risk assessment followed by risk management, for which actuarial approaches are not suitable. Therefore, a single-process system of cognition (known as structured clinical judgement) is recommended for all risk-related decisions. Structured clinical judgement is described in contemporary literature as a process whereby nurses' intuition-led discretion is blended with actuarial indicators, to produce a dynamic 'common-sense' approach to the assessment and management of patient risk (Faay et al., 2013; Griffith et al., 2013; Murphy et al., 2011).

Contemporary literature indicates incorrect assessments of patient risk are regularly made by nurses, with discernible negative consequences for patients and other stakeholders (Conlon et al., 2019). For example, an assessment that finds no credible risk when a patient poses a risk can result in a patient causing harm to self or others, whilst incorrect determinations of credible risk may cause a patient to be avoided by others or placed in the control of mental health services (Conlon et al., 2021). Therefore, education and guidance would be beneficial in improving nurses' practice. Nonetheless, despite the presence of a sizeable and growing body of contemporary risk-oriented literature, comparatively little expands upon current limited knowledge of nurses' risk assessment of patients (Conlon et al., 2019; Higgins et al., 2016). As a result, it remains unclear how nurses understand risk and undertake their risk assessments (Higgins et al., 2016).

It is reasonable to propose the use of novel theoretical approaches may assist in illuminating this area of practice, whilst informing education and guidance to address nurses' knowledge gaps. Additionally, these novel approaches may also serve as a foundation for future research in this complex area of nurses' practice. Evidently, single-system theories that align with structured clinical judgement are the most appropriate strategy to explore risk assessment by nurses, because theories and findings can be seamlessly extended to concurrent or future research involving management of credible risk (Conlon et al., 2023).

Recently, Conlon et al. (2023) concluded Cognitive Continuum Theory (CCT) is suitable for investigating nurses' risk assessments, because it is comparable to structured clinical judgement. Notably, CCT has been used by researchers in multiple studies of numerous professions, including nursing (Bjørk & Hamilton, 2011; Chaffey et al., 2010; Dowding et al., 2009; Molinaro & Bolton, 2019). Nonetheless, the theory has not yet been

used by researchers in mental health to explore risk assessment of patients by nurses (Conlon et al., 2023).

Cognitive Continuum Theory

The dynamic 'single-process system' theory known as CCT was developed by Kenneth R. Hammond (1917-2015). Five premises underpin CCT (Hammond, 1981, 1986, 1996). (i) Cognition comprises a continuum extending from a completely intuitive pole to a completely analytical pole. (ii) The continuum itself is termed quasirationality (or '*common sense*' reasoning) and is composed of varied blends of intuition and analysis, the proportion of each decreasing as a decision-maker moves away from its associated pole. Time pressured decisions promote intuition, whilst precision focussed decisions promote analysis (actuarial approaches). (iii) Parallel to the continuum of CCT runs a task continuum, where tasks can be ordered per the blend of cognition required to complete them (see Table 1). It is thus possible to predict the blend of cognition required for similar tasks in the future. Notably, amorphic tasks with multiple unreliable cues are associated with the intuitive pole, whilst defined tasks with limited apposite cues are associated with the analytical pole. (iv) Cognition of a decision-maker is not fixed but oscillates across and back the continuum of CCT, according with the cognitive blend required of a task or the components of a task. (v) Decision-makers employ pattern recognition and functional relations (outlined hereunder) to assess cues from an environment (Hammond, 1981, 1986, 1996).

Observers are considered data processing instruments in studies informed by CCT (Dhami & Mumpower, 2018). Taking the example of nurses and patient risk assessment: CCT holds risk-related information communicated by a patient is arranged in visible and invisible ways, known as its organising principle. So, some information is directly observable by

nurses, and some must be deduced. This information is made accessible to nurses using vicarious mediation, whereby nurses receive, perceive, and then process and organise, information obtained from patient cues, using pattern recognition and functional relations where necessary (Buckingham et al., 2008; Hammond, 1980, 1981, 1996, 2007).

According to the principles of CCT, pattern recognition is the ability to recognise patterns in information derived from cues. Functional relations is the ability to detect and understand invisible cues by their impact on visible ones (Hammond, 1996). A determination of risk is enhanced when the same organising principle for risk related information communicated by a patient is used by a nurse to arrange this information during a risk assessment. Hammond termed this process vicarious functioning (Dhami & Mumpower, 2018; Hammond, 1986).

For nurses, risk assessment is complex because it takes place in environments characterised by multiple, visible or invisible, complete or partial, comparative or conflicting, risk-related cues that require nurses to instrumentalise various blends of intuitive and analytical cognition (Conlon et al., 2023). Consequently, this study used CCT to explore this aspect of patient care.

AIM

Using CCT, the aim of this study was to explore risk assessment of patients by nurses working in mental health settings.

METHOD

Setting

This study took place in New South Wales (NSW), Australia, where nurses' risk-related decisions are guided by the legal and health systems pertaining to that jurisdiction.

Ethics

This research constitutes part of a PhD at The University [REDACTED]. Approval was granted by the Human Research Ethics Committee (protocol number:[REDACTED]) of the University on the [REDACTED] 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). The Social Research Association research ethics guidance guidelines (2021) were also consulted and followed by the researchers for this study. Furthermore, 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 prior to being interviewed. All participant data were anonymised prior to analysis, and it is not possible to identify participants from the final report of this study.

Recruitment

Recruitment of participants was undertaken via professional nursing networks including the NSW Nurses and Midwives Association and the Australian College of Nursing, and peer nursing contacts. Individual participants were not approached by the researchers, to ensure participants did not feel coerced into the study. Instead, invitations were sent requesting dissemination of advertising material for the study to their networks, seeking expressions of interest. The first researcher was the contact person for applicants.

Eligibility

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

Data collection

The study comprised semi-structured interviews with questions focussed on risk assessment in mental health. Questions were designed to systematically explore and facilitate description of participants' conceptualisation of risk and their risk assessment processes. Some examples of questions used were: 'Can you describe for me your understanding of the concepts of 'risk' and 'harm'?'; 'Can you describe for me the criteria that might indicate to you a patient is a risk?'; and 'Please describe if the context in which you are working affects your perception of risk, or not?'. The first researcher collected interview data either face-to-face or by video link commencing April 2020 and concluding March 2021. Two participants who independently volunteered for the study were previously known to the first researcher. The objectivity of the first researcher was emphasised for these participants, as was the anonymity of their data and their right to withdraw from the study at any stage. They were also encouraged to speak up if at any time they felt coerced in their responses or obliged to continue with the study, if they did not want to proceed. Interviews lasted between 38 to 80 minutes (mean=56 minutes) and were electronically recorded, transcribed by the first researcher, and anonymised, for review and analysis. Data collection was terminated at 14 interviews, when data coding and theme development indicated sufficient rich data were collected (Braun & Clark, 2021). Interviewees comprised 10 female and 4 male nurses with 3 to 25 years-experience (mean=15 years) in a range of public and private mental health related inpatient, outpatient, and community settings (See Table 3). No participant elected

to vacate the study. Data collection and transcription were negatively affected by the Covid-19 pandemic, leading to significant procedural delays. Therefore, an extended timeframe from commencement of interviews until data analysis was required.

Data analysis

This study is part of a larger sequential multimethod PhD project and was designed to provide a descriptive overview of nurses' risk assessment. A theoretical thematic analysis of interview data was performed by the researchers, which commenced with the theoretical framework of CCT and took a deductive approach to data coding. The first researcher in collaboration with all researchers, led analysis of data which adhered to the Braun and Clarke (2006) method. To commence, participants' responses were read and re-read until familiarity with interview data was achieved. A systematic approach was then taken to data coding, focusing on risk assessment. Patterns in codes were identified. These codes were grouped into themes, and then refined, defined, and named. For example, when participants described incorporating analytical (actuarial indicators) or intuitive cognition in their risk assessments, this was initially coded as 'actuarial', 'intuition', or 'both', and then arranged with associated codes as the theme 'quasirational approach to risk assessment', because participants reported generally using both forms of cognition for their risk-related decision-making. Lastly, the final analysis was reported by the researchers (Braun & Clarke, 2006). A COREQ checklist was completed when preparing this report, to ensure the study was clearly and thoroughly reported (Tong et al., 2007).

Reflexivity, rigour, and credibility

Qualitative research positions researchers as a component of research processes.

Consequently, researchers' experiences, assumptions, and stances, can shape proceedings.

For example, a researcher who works in mental health may have preconceived ideas about the optimum weight of certain risk-related cues in a particular clinical setting. Therefore, researchers must critically acknowledge their place relative to their research, and describe for research consumers how they have accounted for this relationship (Olmos-Vega et al., 2023; Peddle, 2022).

The interviewer (and first researcher) for the present study is a male registered nurse, legal practitioner, academic, and PhD candidate, who has worked in mental health with patients assessed as credibly posing a potential risk of harm. The other researchers are experienced nurse practitioners and university academics acquainted with mental health, patient risk, and PhD research and supervision. Therefore, to forestall any potential influences on the study, the following strategies were implemented. Firstly, the first researcher designed a semi-structured questionnaire to guide interviews, which was approved by all researchers, piloted (n=3), reviewed and edited by the first researcher, and approved again by all researchers. Each interview was recorded for transcription, with the recordings and transcriptions scrutinised for consistency by all researchers. Analysis of data, led by the first researcher and independently verified by all researchers, was then guided by Braun and Clarke's (2006) six steps outlined above. The researchers then reviewed and concurred with the findings and discussion and agreed with this report. Additionally, the researchers engaged in continued reflection on their place relative to the research at each stage of the research process.

FINDINGS

Theme 1: Risk as a dynamic omnipresent phenomenon

The first theme developed from interview data was participants conceived patient risk as a dynamic omnipresent phenomenon. Overall, it was clear risk was conceived by participants as occurring on a continuum comparable to the task continuum of CCT, ranging from an imperceptible risk of insignificant harm to a credible risk of significant harm.

I think risk firstly is probably the likelihood they are going to act on a behaviour. The likelihood [something harmful] is going to happen, but also the risk is around the severity of the incident. [For example,] if it's superficial cutting, it's not likely to result in significant harm. (P.03)

Participants were careful to note risk is not limited to patients in mental health settings. Instead, they emphasised it is something inherent in all people. Therefore, the key question to be answered by a patient risk assessment is whether there is a credible likelihood of significant harm, or not.

[Risk is] always there with everyone. It's just to what extent, and it's something that's transient and something that's not fixed. (P.14)

Participants were also keen to point out credible foreseeable harm arising from patient risk takes many forms, both physical and non-physical in nature.

I think the outcome is basically a negative impact on the person or someone close to them, so whether or not that is a physical outcome, or mental outcome, or reputational outcome. (P.13)

Unsurprisingly, systematic processes pertaining to risk assessment featured prominently in participants' responses, whereby they indicated taking a multi-focal approach to determining a patient's likelihood for harm to self or others.

I guess in terms of risk, it would be assessing the level of risk there for the person. So, for example, if they're having suicidal ideation, how progressive is that? Is there a plan? How far have they gone with enacting that plan? ... If it's risk of harm to someone else, is that person in their immediate vicinity? Are they seeking out that person? How much risk is that person at? (P.01)

However, a risk assessment was not a one stop endeavour for participants. Instead, the dynamic nature of risk led them to emphasise the importance of nurses continually assessing and reassessing a patient's risk profile throughout the patient review process, with adjustments made to the handling of each patient in accordance with their findings.

Risk can change, it's dynamic. So, I would be looking at the documentation, if the ... risks now are extremely high ... I would be ... following up the patient and implementing whatever needs to happen. (P.11)

The dynamism of risk raised issues for participants about the utility of risk assessments for patients deemed suitable for release from care. They noted risk assessments were contemporaneous determinations that were subject to change, causing future predictions of risk to be indeterminate at best.

We do these risk assessments [but] how valuable are they? Because the person gives us their word that they're not going to hurt themselves and that we can send them home and ... they could change their mind when they walk out the doors, course they can. (P.02)

Participants also emphasised that despite the best efforts of nurses, contemporaneous risk can sometimes be difficult to identify with any great certainty because humans by their nature can act in unpredictable ways.

When we do a risk assessment it is purely that, an assessment. ... I think ... people are looking for an absolute. Will this happen, or will this not happen? And that's just not possible because we are dealing with human beings, we can't. (P.10).

Lastly, participants observed that even if credible risk and consequential potential significant harm are identified, they can often be mitigated to some extent but are difficult to eliminate in full.

Risk is something that we can mitigate, ... we can't eliminate but we can mitigate through our actions. (P.14)

Theme 2: A quasirational approach to risk assessment

The second theme constructed from interview data was participants took a quasirational approach to risk assessment, whilst indicating they felt actuarial data carried more weight than intuition in risk assessment.

[Risk assessment is] certainly both [analysis and intuition], and I think it is important to trust instincts and if something doesn't feel right to follow up on things, but obviously your data is so important and the documenting of it, because that's what we have, that's our evidence. (P.02)

However, participants emphasised a belief their intuition was based on experience as they progressed from novice to expert. Therefore, they perceived intuition to be a valid instrument for the evaluation of actuarial determinations of credible risk.

I think ... intuition comes from experience. and it's not something airy fairy. ... The feeling I had about [a patient who then did go and] assault another patient ... I think it was based on my previous knowledge of him. So, it wasn't just "I have a bad feeling". I might have worded it like that, but it was actually based on data and observation and assessment. (P.05)

Congruency between data and their intuition was important for participants. Overall, they believed any discrepancy between the two would eventually be dispelled if they continued to collect more data.

For me ... [actuarial] data needs to be [in agreement] with my intuition. So, if there was at that point a doubt in my mind, that I was questioning myself. I think it would be more anxiety than clinical confidence. ... I would look for more data and a bit of context to that too is. (P.11)

Participants also believed their hunches and feelings supplemented their intuition and were integral to their risk assessment related decision-making. Regardless, systemic structures caused them to preference actuarial data because they believed these hunches and feelings (and intuition) did not provide the same weight of evidence before the law.

If there's a high level of [actuarial] data, I would probably more push towards data. ... I've learned through the courts that I've been through, in the cases I've reviewed, how legal people can just rip your apart on data. Legally, they don't go for hunches and feelings. (P.03)

Consequently, participants felt their reliance on intuition (and at times hunches and feelings) in their quasirational decision-making was limited when their intuition contradicted actuarial data regarding a patient. Essentially, intuition was reported to influence a nurse to upgrade but not downgrade an actuarial guided assessment of risk.

Certainly, upscale based on your gut feeling, but don't downscale based on your gut feeling. You've got to downscale based on evidence. And if you're not sure ... you don't downscale. (P.04)

Interestingly, despite their views on the importance of actuarial data in explaining their decisions to others, participants reported they did not like using empirically derived actuarial instruments for their risk assessments.

I wouldn't use a grading system. I'm not really into the tick boxes either. I think risk and harm are very hard to quantify, and I think anyone that thinks they can quantify it is probably kidding themselves completely. (P.09)

Even when instruments were used by participants for risk assessments, they were often completed after an assessment because they were viewed as interfering with therapeutic communication during patient assessment processes.

I have to admit that sometimes you do it all in your head first and then go back and use the assessment tool, because you have to trust what you're doing. I also find that when patients see you ticking too many boxes, they get upset. (P.07)

Theme 3: Environmental and relational forces influence risk assessments

A final theme engineered from interview data was environmental and relational factors were reported to influence participants' perception of risk. For example, the same risk-laden cues were perceived to be credible or non-credible actuarial indicators based on the environment in which the cue was encountered (which for CCT includes the nature of the patient).

*In the city if we found out that our client had a gun, that would set off alarm bells, ...
whereas in the country it would almost be like, well, everyone's got a gun, that's like
the norm. (P.04)*

Participants explained it was sustained exposure to overt risk-related patient cues that led them to interpret cues differently, as they became more assured (and intuitive) in their knowledge and skills. Essentially, they focused less on visible dramatic potential actuarial indicators (that may or may not be correct), and more on covert risk-related cues.

*I've worked in settings ... where there's been high levels of aggression and violence,
where we just see that as a regular day to day experience. I've been moved into
places like rehab units and community settings where that isn't a day-to-day
experience and the culture around how acceptable certain behaviours are is different.
(P.13)*

A variation between participants was the reasons underpinning their perception of risk in acute and non-acute settings. For example, some participants perceived patient risk to be higher in acute settings (such as emergency departments), because they were time-pressured, and patients were generally admitted on foot of a determination of risk by a first-responder or responsible clinician.

*If someone's in the emergency department they're at a higher risk anyway than just
being seen in the Community, because of their clinical presentation requiring them
attending ED. The other thing in ED, it's an incredibly busy emergency department,*

things may get missed whereas at home you might have the time to really assess the situation very clearly. (P.02)

However, other participants disagreed and emphasised patient risk was less common but had a greater potential for harm (including personal risk to a treating nurse) in non-acute settings.

[If] I was in the [emergency department] or hospital. I would probably [tolerate] more risk because I press the duress [alarm] or call out and security would come running. In the emergency department there's 20 staff around me, whereas in an [offsite] office with one door to get out of [and minimal staff], I'd have a very low threshold to risk. (P.03)

Notably, several participants concluded that all contexts carried risk, recommending nurses did not discriminate between the possibility of potentially harmful behaviours in any context.

I think ... all [settings] have varying degrees of risk ... I don't like to say that one area is riskier than the others. I find that's too descriptive, and it doesn't give credit for chaos. Chaos can occur anywhere. (P.07)

Pre-existing relationships between nurses and patients were also considered relevant by participants when analysing data collected during a risk assessment, because they were

familiar with a patient's presentation and had greater insight into the relationship between the patient's overt and covert risk-related cues.

If you know a patient well, if you've worked with someone for years, you know them [and can recognise if] there's a disparity between the clinical data, and what you know about them. (P.02)

As a result, participants believed they exercised less undue caution when dealing with patients whom they had prior personal knowledge of.

I found over the years, a psychotic person will sometimes verbalise insults or threats and they come to nothing, ... so familiarisation with a patient can lessen your heightened expectation. (P.08)

However, the risk of becoming temporally desensitised to risk was a factor of concern for some experienced participants, and something they cautioned against.

As mental health clinicians in general, we are comfortable with and tolerate a level of risk ... I think you tend to become more comfortable as you become more experienced. But then there's also ... where you just get so comfortable with it, it's almost like you don't see it anymore, desensitised. You might not think about it until a [novice nurse] or someone comes with you and they say "that guy's got a big samurai sword collection in his room", and you go, "oh, yeah, he does". (P.04)

DISCUSSION

This qualitative study made several important findings that add to current knowledge, and confirms the continued capacity of ongoing novel risk related research to illuminate this area of nursing practice. In the present study, participants commenced by describing risk as a dynamic concept which they understood operated on a continuum of imperceptible risk of insignificant harm to credible risk of significant harm. This is a notable finding because Higgins et al. (2016) found nurses' conceptualisation of risk to be unclear in extant literature.

Participants description of risk supported their belief patient risk profiles should be viewed as a fluid evolving phenomenon requiring regular assessment and review. This belief is supported by Conlon et al. (2021), Higgins et al. (2016), and Norko and Baranoski (2008) who all concluded risk was a dynamic ever-changing phenomenon. Therefore, indicating participants thought it reasonable for two or more nurses (or other clinicians) to independently reach different determinations of risk for the same patient, if the assessments took place at different points in time. Participants also emphasised a contemporaneous assessment will have greater validity than one previously made. A position that extends the work of Conlon et al. (2021) who found relying on an antecedent risk assessment can result in incongruent determinations of static dangerousness, and a concomitant failure to consider inconstant risk.

The continuum of risk outlined by participants is noteworthy in this CCT-informed study because it corresponds to Hammond's description of the task continuum that runs parallel to the cognitive continuum of CCT (Hammond, 1981, 1986, 1996). Therefore, suggesting it may be possible to arrange risk-actuated cognitive tasks on a risk continuum according to the blend of cognition required for each risk-related task, enabling nurses to

predict the blend of cognition required to undertake similar tasks in the future. It was not possible to ascertain from this exploratory study if CCT may help nurses predict the blends of cognition required for each task comprising a risk assessment, but this observation does offer novel and valuable direction for future risk-related research.

However, the study was able to ascertain participants' cognition when undertaking risk assessments was quasirational, irrespective of their area of practice or level of experience, whilst adhering to the established principle that decision-making and other cognitive processes of seasoned nurses are more intuitive than those of novices (Miller & Hill, 2018). In a position adopted by the researchers, participants considered themselves to be experienced if they had a longer relative duration of practice and were knowledgeable and proficient in risk assessment, and novices if they had a shorter relative duration of practice or required support or guidance in their deliberations. Participants emphasised a belief that novice nurses tended to focus on written data and analysis (actuarial indicators), whilst experienced nurses preferred their intuition. A finding consistent with Hammond's position that experience leads decision-makers to oscillate towards the intuitive pole of CCT (Hammond, 1980, 1981, 1996). Participants explained they understood their intuition to have developed from the subsuming of actuarial approaches into their intuitive processes, where it was then enhanced by personal experience and observing how other clinicians dealt with risk.

Therefore, it was unsurprising that experience was cited by participants as a significant factor in cognitive-led risk assessment, with intuitive-dominant participants becoming more comfortable dealing with risk as they transitioned from novice to expert. Nonetheless, contemporary literature reports actuarial approaches to be more accurate than intuition for identifying risk, because nurses tend to focus on dramatic cues that may

not necessarily reflect a patient's potential for harm (Molinaro & Bolton, 2019; Higgins et al., 2016; Miller & Hill, 2018). However, Payne (2015) also reports decisions made by experienced nurses are more accurate than those of novice nurses, so it is reasonable to conclude these nurses have appropriately subsumed actuarial processes into their intuition-led frameworks of knowledge. Therefore, corroborating the findings of Miller and Hill (2018) and Downes et al. (2023) who concluded risk-assessment can be elevated with educational strategies and validated risk assessment instruments, that assist nurses to develop or enhance their intuition.

Having made this observation, it is notable participants admitted disliking empirically derived actuarial instruments designed for contemporary use during an assessment. There is limited and contradictory research literature investigating nurses' views on these instruments, but Clancy et al. (2015) found nurses in their survey preferred their clinical intuition whilst Downes et al. (2023) concluded instruments were preferable to intuition-led unstructured decision-making. However, in the present study participants perceived instruments as being too objective and formulaic, because they understood risk is unique to each patient and as noted by Conlon et al. (2019) can be difficult to identify. Participants also felt, as did some participants in Downes et al. (2023), that instruments impeded communications between nurses and patients, with patients becoming upset if a nurse appeared more interested in completing paperwork than talking with them. Consequently, it is reasonable to suggest any potential instruments developed to assist nurses with their risk assessments must be accompanied by strategies that address nurses' concerns, thereby encouraging contemporary use of the instrument.

Albeit not considered or discussed in CCT per Conlon et al. (2023), hunches and feelings were nominated as important facets of risk assessment by participants, who

perceived them to be a manifestation of previously encountered data, existing knowledge, and experience. Contemporary nurse literature also places these components commensurate with intuition at the centre of holistic nursing practice (Cork, 2014; Melin-Johansson et al., 2017; Miller & Hill, 2018). Notably, Glöckner and Witteman (2010) conclude hunches and feelings are learned behaviours, emotional responses to previously encountered cognitive stimuli that form a component of intuitive cognition. Therefore, it is reasonable to suggest additional studies considering the role of hunches and feelings as components of nurse-intuition have the potential to add a critical new dimension to CCT-informed research.

Despite their reservations with risk assessment instruments, participants still understood objective actuarially derived data to be more readily explicable than their subjective intuition (or hunches, and feelings) if they were required to justify their risk assessments to others (for example, before a Court of law). As a result, participants reported they would upgrade a patient's risk profile based on their intuition (or a hunch, or if things did not 'feel right') but would only downgrade if based on actuarial data, irrespective of the pole of CCT towards which their cognition initially oscillated. This was an important determination because errors made using analysis, first outlined in the seminal writings of Egon Brunswik (1956), iterated by Hammond (1996), and affirmed in a seminal study using CCT by Dunwoody et al. (2000), are greater in order of magnitude than those made using intuition. This finding has yet to be reasonably disputed in CCT studies and is an invaluable consideration for subsequent risk management (Björk & Hamilton, 2011; Chaffey et al., 2010; Dowding et al., 2009; Lauri et al., 2001; Molinaro & Bolton, 2019).

Overall, study findings indicated pattern recognition and functional relations were integral to participants' risk assessments. Pre-existing relationships were identified as

influencing participants' perception of risk because they could leverage their existing knowledge of a patient, indicating the key role pattern-recognition plays in nurses' cue-driven risk assessment (Hurteau et al., 2020). Nonetheless, several participants referred to the potential for experienced nurses dealing with a familiar patient to become desensitised to that patient's risk-related cues, which could result in harm if they failed to identify the patient posed a credible risk (Caterino et al., 2013; Conlon, 2019; Murphy, 2011). As a result, participants were generally mindful that complacency towards risk should be avoided.

Information-laden visible patient cues were reported to uncover invisible risk-related concerns, highlighting the key role of functional relations in participants' risk-related decision-making (Hammond, 1996). The importance of nurses' (and researchers) ongoing engagement in determining functional relations between visible and invisible cues was emphasised by participants, because they believed invisible risk-related cues can remain undiscovered due to the complex nature of risk. Consequently, future research exploring the relationships between visible cues and invisible risk-related cues pertaining to patients in mental health settings is recommended.

Participants reported they interpreted vicariously mediated cues differently in dissimilar environments (acute versus non-acute), which according to Hammond (1981) influences their vicarious functioning when establishing the empirical validity of these cues. For example, some participants perceived patient risk to be more credible in acute care settings characterised by multiple risk related cues, when deciding if involuntary detention of these patients was required. This phenomenon was also noted by Blando et al. (2013) in a study of emergency department nurses without mental health training, when they were observed dealing with patients with a mental health condition. Conversely, risk was perceived lower by these participants in non-acute care settings, because patients had

arrived voluntarily to the setting and were according with Masood (2017) less likely to be experiencing a mental health crisis. However, several experienced participants emphasised non-acute facilities often had smaller numbers of staff and no security, whereas acute settings tended to have numerous clinical staff or security officers to assist during a potentially harmful event. Consequently, in a finding consistent with previous research by Blando et al. (2013), these participants perceived risk to be lower in acute settings that were tightly controlled (or perceived to be tightly controlled) than in non-acute settings. Additionally, several participants reported risk-induced chaos can occur anywhere at any time.

According with Marsh and Kelly's (2018) findings that fear of harm and specific environments lead nurses' to be overly cautious in their risk-related decision-making, these observations suggest subjective risk aversion may play a role in tempering nurses' objective actuarial findings. Albeit it was not clear from interview data if participants were acting on their experiential intuition (or hunches or feelings), or as suggested by Blando et al. (2013) a paucity of relevant clinical skills or training. Notably, Marsh and Kelly (2018) also found clinician's (including nurses) perception of risk is not always correct, whilst Blando et al. (2013) concluded education and experience dealing with mental health presentations led nurses to make risk assessments more in line with actual risk, than incongruent perceived risk.

IMPLICATIONS AND FUTURE RESEARCH

Contemporary risk-related research literature has been enhanced by the researchers using CCT to explore nurses' risk assessment of patients in mental health. Furthermore, participants also identified areas of their practice that would benefit from further education

or guidance. For example, experienced nurses may become desensitised to risk, despite harm potentially occurring at any time in any setting. Therefore, the findings provide a base for nurse education and provide a useful guide for nurse practice. The findings also indicate the potential for CCT to open new avenues of research, that may assist nurses (and other clinicians) to better understand this aspect of clinical care.

Additionally, CCT holds it is possible to predict the blend of cognition required for similar tasks in the future, once the most effective blend of cognition to complete a task has been determined. Therefore, reducing decision-makers cognitive load and the time required for effective decision-making. This study found nurses' mental health risk-related decisions are quasirational, comprising a blend of intuition and analysis that became more intuitive with experience. Nonetheless, nurses accepted their intuition was predicated in part on actuarial approaches, suggesting their cognition was probably somewhat more analytical than intuitive. However, it was beyond the scope of the study to determine the precise blend of cognition used by nurses. Therefore, future research investigating this aspect of nurses' mental health risk assessment decision-making would add to the findings of this study.

Notably, participants were not in a position to discuss their interview responses with their peers, because interviews were undertaken on an individual basis. However, nursing as a profession is team-oriented, with nurses expected to consult others to inform their decision-making (Nibbelink & Brewer, 2018; Nursing and Midwifery Board of Australia, 2020). Additionally, participants reported they would often seek counsel with their peers when making decisions in the clinical environment. Therefore, research that explores risk assessment processes of nurses by gathering data in a group context may augment the

findings of this study. Further qualitative, quantitative, or mixed-methods research would also be beneficial in illuminating this complex area of nursing practice.

LIMITATIONS

Internationally, mental health care has many similarities, such as an authority to involuntarily detain patients assessed as posing a credible risk (Georgieva et al., 2019). However, there are also differences between jurisdictions. For example, various states of Australia have their own mental health acts that inform mental health practice, whilst at a national and international level the attributes of reasonableness that characterise a duty of care may vary (Conlon et al., 2019; Tosson et al., 2022). This study was undertaken in NSW, Australia, which may have regulated the form and interpretation of data collected. However, the location and context of the study is clearly outlined, so research consumers can assess the relevance of study findings to their individual jurisdiction and clinical circumstances.

CONCLUSION

Contemporary research literature regarding risk assessment by nurses who work in mental health has been enhanced by this study using CCT. Findings indicate nurses conceptualise risk as a dynamic omnipresent phenomenon intrinsically associated with their perception of harm, ranging on a continuum of imperceptible risk of insignificant harm to a credible risk of significant harm. The potential similarities between this risk continuum and the concept of a task continuum associated with CCT has the potential to open avenues of research that may enhance identification of patient risk. Therefore, protecting patients and others from harm.

Overall, nurses were found to take a dynamic quasirational approach to risk assessment, with decision-making becoming more intuitive and less analytical with experience. Experienced nurses preferred their intuition over actuarial approaches, albeit acknowledging their intuition was predicated in part on their subsuming of actuarial approaches into their intuitive processes. Notably, they also believed actuarial data carried more weight than intuition if required to explain their decision-making to others. The study also revealed environmental and relational forces influence nurses' perception of risk, as does their level of experience or a pre-existing relationship with a patient. Interestingly, these elements were reported to sometimes assist and at other times inhibit risk assessment. The researchers concluded research that explores nurses' risk assessment in a group context may augment study findings. They also found CCT has the potential to inform nurse education and practice, and future risk-related research related to mental health care.

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DECLARATION OF INTERESTS

The researchers have no sources of funding or competing interests to declare.

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Table 1: CCT Modes of Inquiry. Adapted from Hammond (1996) and Conlon et al. (2023).

Cognition	Mode of least control	Mode of most control
1. Pure analysis		True experimental
2. Mostly analysis, with some intuition		Control group experimental and statistics
3. Somewhat more analysis than intuition		Quasi-experimental with relaxed controls
4. Somewhat more intuition than analysis		Computer modelling
5. Mostly intuition, with some analysis		Data-based expert judgement
6. Pure intuition	Unrestricted judgement	

Table 2: Participant inclusion and exclusion criteria for study.

	Inclusion	Exclusion
Jurisdiction	• NSW, Australia.	• Not NSW, Australia.
Population	• Registered nurses.	• Not a registered nurse.
Context	• Mental health care.	• Not mental health care.
Exposure	• Experience of risk assessment of patients in mental health settings.	• No experience of risk assessment of patients in mental health settings.
Knowledge	• Read and understood participant information statement.	• Did not read or understand participant information statement.
Agreement	• Gave informed consent in writing to be interviewed.	• Did not give informed consent in writing to be interviewed.

Table 3: Demographic details of participants.*

Nominated gender**	Approximate years of experience in mental health	Highest post-graduate qualification in mental health***	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

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

**The genders nominated by participants were cisgender M=Male and F=Female. No other genders were nominated by participants.

*** n/a indicates no post-graduate qualification specialising in mental health.

6.3 Conclusion

This section concludes Chapter 6, which presented the first of three sets of data obtained from method 3 of the study, semi-structured interviews exploring MHNs' risk assessment decision-making processes. The chapter commenced with an introduction to risk assessment of patients and CCT. Next, the aim and methods of the semi-structured interviews were described. Themes identified in semi-structured interview data were then presented, and the relevance of these themes to the research goals of this thesis was discussed. Finally, implications and future research, and limitations, were highlighted. Next, Chapter 7 presents the second of the three sets of data obtained from method 3 of the study, exploring MHNs' understanding of their duty of confidentiality to patients in mental health care in NSW.

CHAPTER 7: MENTAL HEALTH NURSES' UNDERSTANDING OF THEIR DUTY OF CONFIDENTIALITY

7.1 Introduction

Chapter 7 is the second of three consecutive chapters (chapters 6, 7, and 8) that presents data obtained from method 3. Specifically, this chapter explores MHNs' understanding of their duty of confidentiality to patients in mental health care in NSW. In doing so, this chapter illuminates MHNs' understanding of this important area of mental health care, and outlines potential impacts of their level of understanding on their practice.

7.2 MHNs and confidentiality

Author attribution statement and attestation

Chapter 7 of this thesis is under its second round of peer review for publication at *Collegian* as ‘Nurses’ understanding of their duty of confidentiality to patients in mental health care: A qualitative exploratory study’.

I, Darren Conlon was responsible for:

- Conception and planning of the investigation and interviews
- Literature search
- Data Collection and Analysis
- Preparation of the final report

Signature:

Name: Darren Conlon

Date: 14 February 2024

As supervisors for the candidature upon which this thesis is based, we confirm the authorship attribution statement above is correct.

Signature:

Name: Timothy Wand

Date: 14 February 2024

Signature:

Name: Toby Raeburn

Date: 14 February 2024

TITLE

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

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.

KEYWORDS

Confidentiality, Education, Mental health, Nurs*, Psychiatric nursing, Social stigma

SUMMARY OF RELEVANCE

Problem

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.

INTRODUCTION

A duty of confidentiality arises for nurses working in mental health when information is shared by a patient (a) on the understanding the information is not be released to others without consent, or (b) if the nurse receiving the information is reasonably expected to understand the information is confidential (Australian Broadcasting Commission v Lenah Game Meats Pty Ltd, 2001; Griffith, 2007). 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 et al., 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 (see Table 1) which accompany the Act (HRIP, 2002; NSW Health, 2015b). The HRIP only applies to the handling of confidential health information NSW. Therefore, the present study of nurses' understanding of their duty of confidentiality is limited to that state.

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., 2019; Dickens & Picchioni, 2012; Simmons et al., 2010). However, many people with a mental health condition do not like these terms or find them unsuitable (Dickens & Picchioni, 2012; Lugg, 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 people. Overall, contemporary researchers have generally concluded the only term universally recognised and accepted by and for people requiring voluntary or involuntary mental health care services is patient, leading to the use of that term in this study (Costa et al., 2019; Dickens & Picchioni, 2012; Lugg et al., 2023; Simmons et al., 2010).

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 have 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 implication for patients and other stakeholders including nurses, their employers, health services, and the public (Conlon et al., 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 is the first to explore this under-researched area of nursing practice in NSW.

AIM

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

METHODS

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 health care system, and takes place in a network of acute and non-acute, in-patient and outpatient, public and private (with some-NGOs) clinician led facilities and clinics (Doessel, 2009; Dunlop & Pols, 2022).

Ethics

This research constitutes part of a PhD at The University [Redacted]. Approval was granted by the Human Research Ethics Committee (protocol number: [Redacted]) of the University on the [Redacted] 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 prior to 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 was solely accessible by the researchers, was anonymised before analysis, and could be removed from the study and destroyed at their request.

Recruitment

Participants were recruited using advertising material seeking nursing 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.

Eligibility

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

Data collection

Data were collected during one-on-one semi-structured interviews using an interview guide, comprising questions related to confidentiality in NSW. For example, 'Can you describe for me what the term 'confidentiality' means to you?'. The interview guide was piloted (n=3) prior to the interviews, reviewed and edited by the first researcher, and approved again by all researchers. The pilot process led to minor clarifying changes to the wording of three questions and no other edits. The Interviews were conducted by the first researcher via video link or in-person commencing April 2020 to March 2021. Interviews lasted 38 to 80 minutes (mean=56 minutes), were electronically recorded for transcription to text, and then anonymised prior to data analysis. Data collection was concluded at 14 interviews, because data coding and theme development indicated abundant rich data were collected (Braun & Clark, 2021). Participant demographic details were 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.

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 perused 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, 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).

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 co-owning currently practising 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 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 is also an academic and a legal practitioner and 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.

FINDINGS

The following themes were developed from interview data. (1) Nurse participants' knowledge of confidentiality and its rules varied from one participant to the next, and this knowledge was often incomplete or incorrect. (2) Participants recognised and focused on their responsibilities to patients and other stakeholders when handling confidential information. (3). 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.

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)

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 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 harm 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)

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)

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 rules-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, post-graduate 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 not a legally mandated release of information. Consequently, as demonstrated by Sullivan (2021) and Mason (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 was 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 et al. (2023), Jacobs and Quinn (2022), and Wand et al. (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 (NMBA, 2018; National Law, 2009).

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, health care 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 et al. (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 Health Privacy Principles (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. However, 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 et al. (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 respond 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 et al. (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 health care clinicians in NSW (NSW Health, 2015a; 2015b).

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 et al., 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.

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. The level of knowledge of participants can also vary. For example, in the present study four (n=4) participants had no postgraduate qualifications majoring primarily in mental health nursing, albeit one of these four (n=1) had undertaken an undergraduate mental health nursing degree. However, interview questions need to be understood by all participants. 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 health care systems (Mental Health Act, 2007; Tosson et al., 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.

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 rules-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.

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- A COREQ checklist was consulted when preparing and reporting this study (Tong et al., 2007).

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

HPP	Indicator	Description
COLLECTION		
1.	Lawful	Only collect health information for a lawful purpose that is directly related to the agency or organisation's activities and necessary for that purpose. You should not collect health information by any unlawful means.
2.	Relevant	Ensure health information is relevant, accurate, up to date, complete and not excessive, and that the collection does not unreasonably intrude into the personal affairs of the person to whom the information relates to.
3.	Direct	Only collect health information from the person concerned, unless it is unreasonable or impracticable to do so.
4.	Open	Inform a person as to why you are collecting health information, what you will do with it, and who else may see it. Tell the person how they can view and correct their health information and any consequences that will occur if they decide not to provide their information to you. If you collect health information about a person from a third party you must still take reasonable steps to notify the person that this has occurred
STORAGE		
5.	Secure	Ensure the health information is stored securely, not kept any longer than necessary, and disposed of appropriately. Health information should be protected from unauthorised access, use or disclosure. (Note: private sector organisations should also refer to section 25 of the HRIP Act for further provisions relating to retention).
ACCESS AND ACCURACY		
6.	Transparent	Explain to the person what health information is being stored, the reasons it is being used and any rights they have to access it.
7.	Accessible	Allow a person to access their health information without unreasonable delay or expense. (Note: private sector organisations should also refer to sections 26-32 of the HRIP Act for further provisions relating to access).

HPP	Indicator	Description
8.	Correct	Allow a person to update, correct or amend their personal information where necessary. (Note: private sector organisations should also refer to sections 33-37 of the HRIP Act for further provisions relating to amendment).
9.	Accurate	Ensure that the health information is relevant, up to date, accurate, complete, and not misleading before using it.
USE		
10.	Limited	Only use health information for the purpose for which it was collected or for a directly related purpose, which a person would expect. Otherwise, you would generally need their consent to use the health information for a secondary purpose, unless one of the exceptions in HPP 10 applies (e.g. emergencies, threat to health or welfare, research or training etc).
DISCLOSURE		
11.	Limited	Only disclose health information for the purpose for which it was collected, or for a directly related purpose that a person would expect. Otherwise, you would generally need their consent, unless one of the exceptions in HPP 11 applies (e.g. in some instances disclosure is allowed in the event of an emergency, serious threat to health or welfare, research or training etc).
IDENTIFIERS AND ANONYMITY		
12.	Not identified	Only identify people by using unique identifiers if it is reasonably necessary to carry out your functions efficiently.
13.	Anonymous	Give the person the option of receiving services from you anonymously, where this is lawful and practicable.
TRANSFERRALS AND LINKAGE		
14.	Controlled	Only transfer health information outside New South Wales in accordance with HPP 14.
15.	Authorised	Only use health records linkage systems if the person has expressly consented to this information being included (this includes disclosure of an identifier).

Table 2: 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 handling confidential information of patients in NSW.	• No experience handling confidential information of patients in NSW.
Knowledge	• Read and understood participant information statement.	• Did not read or understand participant information statement.
Agreement	• Provided written informed consent prior to being interviewed.	• Did not provide written informed consent to be interviewed.

Table 3: Demographic details of participants.*

Nominated gender**	Approximate years of experience in mental health	Highest post-graduate qualification in mental health***	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

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

**The genders nominated by participants were cisgender M=Male and F=Female. No other genders were nominated by participants.

*** n/a indicates no post-graduate qualification specialising in mental health.

7.3 Conclusion

This section concludes Chapter 7 which presented the second of three sets of data obtained from method 3 of the study, semi-structured interviews exploring MHNs' understanding of their duty of confidentiality to patients in mental health care in NSW. This chapter commenced with an introduction to confidentiality in mental health care in NSW. Next, the aim and methods of the semi-structured interviews were described. Themes identified in semi-structured interview data were then presented, and the relevance of these themes to the research goals of this thesis was discussed. Finally, implications and future research, and limitations, were highlighted. Next, Chapter 8 presents the third of the three sets of data obtained from method 3 of the study exploring MHNs' risk-actuated public interest disclosure-related decision-making processes, whilst taking the novel approach of using CCT as a framework to discuss the findings of this exploration.

CHAPTER 8: RISK-ACTUATED DISCLOSURE-RELATED DECISION-MAKING PROCESSES OF MENTAL HEALTH NURSES

8.1 Introduction

Chapter 8 is the third of three consecutive chapters (chapters 6, 7, and 8) that presents data obtained from method 3. Specifically, this chapter explores MHNs' risk-actuated public interest disclosure-related decision-making processes. In doing so, this chapter illuminates MHNs' practice in this important area of mental health care, whilst taking the novel approach of using CCT as a framework to discuss the findings of this exploration.

8.2 MHNs and risk-actuated disclosure

Author attribution statement and attestation

Chapter 8 of this thesis is published as '*risk-actuated public interest disclosure practices of nurses working in mental health, pertaining to confidential information of patients*'.

I, Darren Conlon was responsible for:

- Conception and planning of the investigation and interviews
- Literature search
- Data Collection and Analysis
- Preparation of the final report

Signature:

Name: Darren Conlon

Date: 14 February 2024

As supervisors for the candidature upon which this thesis is based, we confirm the authorship attribution statement above is correct.

Signature:

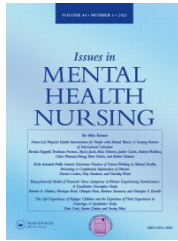
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Risk-Actuated Public Interest Disclosure Practices of Nurses Working in Mental Health, Pertaining to Confidential Information of Patients

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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.	• No 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 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 your 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. (P04)

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. (P11)

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. (P13)

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. (P01)

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. (P03)

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. (P09)

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. (P02)

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. (P04)

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 (P09)

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. (P09)

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? (P06)

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. (P09)

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. (P04)

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 of 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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Data availability statement

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8.3 Conclusion

This section concludes Chapter 8 which presented the third of three sets of data obtained from method 3 of the study, semi-structured interviews exploring MHNs' risk-actuated public interest disclosure-related decision-making processes. The chapter commenced with an introduction to risk-actuated public interest disclosure-related decision-making by MHNs, regarding confidential information of patients in mental health care. Next, the aim and methods of the semi-structured interviews were described. Themes identified in semi-structured interview data were then presented, and the relevance of these themes to the research goals of this thesis was discussed. Finally, implications and future research, and limitations, were highlighted. Next, Chapter 9 presents data obtained from method 4 of the study, focus groups exploring causal factors for MHNs' knowledge and practice gaps identified in the semi-structured interviews.

CHAPTER 9: CAUSAL FACTORS FOR MENTAL HEALTH NURSES' KNOWLEDGE AND PRACTICE GAPS

9.1 Introduction

Chapter 9 presents data obtained from method 4 of the study, focus groups exploring causal factors for MHNs' knowledge and practice gaps identified in data obtained from the semi-structured interviews. Specifically, this chapter will explore these causal factors in a collaborative group setting, to inform strategies to address MHNs' knowledge and practice gaps and guide future research.

9.2 MHNs and their knowledge and practice gaps

Author attribution statement and attestation

Chapter 9 of this thesis is submitted for publication to *Psychiatry, Psychology and Law* as ‘*A qualitative investigation of nurses’ knowledge and practice gaps, regarding confidentiality and risk-actuated public interest disclosure-related decision-making in mental health care*’.

I, Darren Conlon was responsible for:

- Conception and planning of the investigation and focus groups
- Literature search
- Data Collection and Analysis
- Preparation of the final report

Signature:

Name: Darren Conlon

Date: 14 February 2024

As supervisors for the candidature upon which this thesis is based, we confirm the authorship attribution statement above is correct.

Signature:

Name: Timothy Wand

Date: 14 February 2024

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Date: 14 February 2024

TITLE

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

ABSTRACT

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

KEYWORDS

Confidentiality, Disclosure, Mental health, Nurs*, Psych*, Risk assessment, Risk management

INTRODUCTION

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

The term 'public interest' refers to anything that is in the overall interests of society (Conlon et al., 2021; McKinnon v Secretary, Department of Treasury, 2005). There is a public interest in confidentiality to ensure people are willing to share their information with clinicians, because certain personal health information has the potential to be embarrassing or carry negative social consequences for patients (Barloon & Hilliard, 2016). For example, relatives or friends may avoid a person labelled with a mental health condition because they believe them to be dangerous, or employers may discriminate against patients based on stigmatising attitudes regarding their mental health. Nonetheless, there are exceptions to confidentiality, whereby information can be disclosed. Firstly, with patient consent; secondly, by law or judicial decree; or thirdly, where there is a predominant competing public interest to that of confidentiality (Conlon et al., 2019). These are the only common law exceptions to confidentiality in jurisdictions where there is no legal duty to warn or protect, including the jurisdiction of the present study (Dolan, 2004; Mason et al., 2010; McSherry, 2008).

BACKGROUND

Nurses face predicaments when confronted with a patient assessed as posing a potential credible risk, because it may be necessary to release confidential information about the patient to prevent harm (Dolan, 2004). However, if patient consent or a legal exception to confidentiality do not permit disclosure, the nurse must balance the public interest in maintaining the patient's confidentiality against the public interest in disclosure to prevent harm (McHale, 2009). A task that is not easy for nurses, because if information is released inappropriately a patient's confidentiality may be breached. Conversely, should information be withheld inappropriately a patient or others may come to harm (Dolan, 2004; Kämpf & McSherry, 2006). In either instance, patients may face reputational or other repercussions, stakeholders such as nurse employers may incur significant legal or financial penalties, and nurses can face professional or regulatory action (Conlon et al., 2021; Kämpf & McSherry, 2006). Additionally, releasing information may cause a patient to withhold personal information from nurses in the future, which is concerning if this information could be used to identify the patient poses a credible risk of harm (Conlon et al., 2023).

Despite the importance of nurses appropriately handling confidential patient information in risk-laden scenarios, recent empirical peer-reviewed research found risk-related confidentiality knowledge and practice deficits amongst nurses (Conlon et al., 2023). Essentially, nurses appeared to understand risk assessment processes. However, their knowledge of confidentiality was often incomplete or incorrect. Compounding matters, nurses had minimal understanding of risk-actuated public interest disclosure-related decision-making and focused on dangerousness criteria not dynamic risk when managing risk.

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

AIM

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

METHOD

Setting

This investigation was undertaken in New South Wales (NSW), Australia.

Ethics

This research forms part of a PhD at [REDACTED FOR PEER REVIEW], which was approved by the Human Research Ethics Committee (protocol number: [REDACTED FOR PEER REVIEW]) of the University on the [REDACTED FOR PER REVIEW] congruent with the National Statement on Ethical Conduct in Human Research published by the National Health and Medical Research Council (NHMRC) of the Australian Government (NHMRC, 2007). Participants: read and acknowledged they understood a participant information statement and were given the opportunity to ask questions at multiple junctures, before giving written informed consent to participate in the study.

Recruitment

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

Eligibility

Participants were required to meet all inclusion criteria to participate in the study (see Table 1).

Data collection

Contemporary research literature regarding risk-actuated confidentiality and disclosure decisions is generally derived from interviews of individual nurses (Conlon et al., 2023). However, nursing is a team-oriented profession (NMBA, 2016, 2018, 2020). Therefore, A focus group method was chosen for data collection, because a collaborative team-style environment may generate data that has not arisen in previous studies (Jayasekara, 2012). A focus group guide comprising three vignettes pertaining to confidentiality and risk actuated disclosures of patient information by nurses in mental health was piloted (n=2) by the first author. The guide was then reviewed and revised as necessary. Vignettes focussed on gaps in nurses' knowledge and practice regarding confidentiality and risk-actuated public interest disclosure related decision-making identified in contemporary nursing literature (Conlon et al., 2019, 2023). Focus groups were then undertaken by the first author in March and April 2023.

Time and availability considerations were of particular importance to this investigation, because participants were generally working full-time rotating rosters in multiple clinical contexts. Therefore, the following strategies were instigated to minimise inconvenience to participants. Firstly, an option was proffered to attend focus groups via video-link. Secondly, approximately 40 minutes was allocated to each group, because a sizable proportion of participants were only available during their allocated meal break during working hours. Consequently, groups ranged from 38 to 49 minutes (mean=42 minutes). Thirdly, small group sizes are recommended for expert participants when exploring complex topics, because they can focus and expound on areas of interest to researchers (Jayasekara, 2012). Therefore, groups were capped at 3 participants to give each participant ample time to discuss their perspectives within the 40-minute window (see Table 2). Lastly, each focus group was recorded for transcription with all data anonymised prior to analysis. Data collection was terminated at four focus groups (n=4) comprising a total of 12 participants (n=12) when data coding and theme development indicated sufficient rich data were collected (Braun & Clark, 2021).

Data analysis

Theoretical thematic analysis commences with a previously established theoretical framework and takes a deductive strategy to coding of data. A theoretical thematic analysis of focus group data was conducted based on the frameworks of confidentiality and disclosure in the context of risk in NSW, focusing on nurses' knowledge and practice gaps established in contemporary research literature (Conlon et al., 2023). The six steps of the Braun and Clarke (2006) method led analysis of data by all authors. (1) Authors reviewed focus group data until familiarity was achieved. (2) A systematic approach was then adopted

for coding of these data, with an emphasis on ascertaining reasons for gaps noted in nurses' knowledge and practice. (3) Codes were then grouped into common themes. (4) Next, themes were revised and clarified. (5) Definitions and names for each theme were then agreed upon, relating to: limited knowledge amongst nurses; paucity of support networks; and unrealistic expectations of nurses. For example, when participants described a lack of mentors for nurses, this was initially coded as 'limited experienced nurses to guide other nurses', and then grouped with correlated codes to form the theme 'paucity of support networks nurses could approach for information'. (6) Lastly, the final analysis was reported by the authors (Braun & Clarke, 2006).

Reflexivity

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

For the focus groups, the first author was the convener and moderator, and a male PhD candidate, nurse academic, lawyer, and registered nurse, with experience working in mental health care with patients who may pose a risk to self or others. These qualities can shape the collection and analysis of participants' data (Olmos-Vega et al., 2023; Peddle, 2022). The second and third authors are experienced male mental health nurse practitioners, with extensive backgrounds in nurse led research, and clinical experience of patients at risk.

To lessen the risk of potential influences on the study, a focus group framework was developed, piloted, edited, and employed. Each group was audio recorded and reviewed by all authors, before transcription by the first author. Transcripts were then reviewed by all authors, with noted codes and themes discussed and agreed upon. The findings, discussion, and final draft of the study were led by the first author, and subsequently reviewed and agreed upon by all authors. Lastly, the researchers engaged in continued reflection throughout the research process, regarding their place relative to the research. Rigor and trustworthiness were maintained by assessing the credibility, transferability, dependability, and confirmability, of the study method and findings (Lincoln & Guba, 1985).

FINDINGS

Three themes were developed during analysis of focus group data, regarding causal factors for knowledge and practice gaps of nurses working in mental health care. Firstly, participants outlined limited opportunities for nurses to acquire knowledge of confidentiality and mental health nursing, that impacted on their practice. Secondly, participants described a paucity of support networks nurses could approach for information. Thirdly, participants emphasised the impact of unrealistic expectations of nurses regarding their risk-actuated public interest disclosure related decision-making.

Theme 1: Limited opportunities to acquire knowledge

The first theme developed from focus group data was limited opportunities for nurses to acquire knowledge of confidentiality and mental health nursing, which had a direct impact on the quality of their practice. Specifically, participants were concerned there was a lack of

education relating to confidentiality, and limited mental health related content, in the Australia general nursing degree. Participants cited the UK system (a dedicated mental health nursing degree) as a comparison.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Theme 2: Paucity of support networks for nurses

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

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

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

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

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

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

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

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

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

[Confidentiality, and disclosure or breach]. There's always a grey area in mental health for us around this stuff. It's so grey. Even you know, I've been to the Tribunal ... called the Mental [Heath] Review Tribunal about different things. And it's even ... they give you grey answers. (P.08)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I think a lot of the attitude [is] if someone has ... mental ill health ... they're not entitled to the same privacy and confidentiality as other people. I've heard some

nurses say things that are just ridiculous ... the stigma around mental health ... is that people have no confidentiality. The breaches are made because people think, 'Oh, well, I'm a bit worried that they're going to do something. So, I'm going to tell everybody, what this person's done, what they're up to.' (P.10)

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

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

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

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

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

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

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

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

DISCUSSION

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

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

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

Furthermore, participants reported a lack of CPD opportunities for post-graduate nurses related to their duty of confidentiality. Contemporary literature indicates this creates

two distinct but related issues. Firstly, knowledge gaps are associated with nurses who are not provided with CPD. Secondly, a lack of instruction in specific content areas risks nurses minimising the importance of these areas, which creates and exacerbates knowledge gaps (Mlambo et al., 2021). Therefore, it is reasonable to presume health services and nurse employers are inadvertently creating a barrier to nurses meeting their professional duty of confidentiality to patients (International Council of Nurses [ICN], 2021; NMBA, 2018).

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

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

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

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

Participants also questioned the quality of some medical records, an unsurprising finding when the knowledge gaps outlined above are considered. These concerns related to sparse nursing (and clinician) notes and more troublingly, instances where notes were

copied and pasted from one day to the next. The latter created inaccuracies because information was not reviewed before being entered into a patient's record, so outdated information remained present and unchallenged for extended periods. This is a clear breach of nurses' professional obligations to act respectfully towards their patients, and to "clearly and accurately communicate relevant and timely information about the person to colleagues" (NMBA, 2018, p. 11).

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

Participants also strongly perceived that unrealistic expectations of nurses by health services were responsible for knowledge and practice gaps identified in previous nursing research. The most prominent of these expectations being nurses can identify and mitigate risk, by appropriately withholding or disclosing confidential information about a patient. Despite participants noting concordant with Caterino et al. (2013), that risk is subjective and unpredictable and can be difficult to identify or manage with any great certainty. The issue for participants with this expectation was twofold: (1) the systemic risk aversion permeating health services, coupled with unrealistic expectations regarding risk identification and management, led nurses to practice defensively, and (2) nurses were under the impression an incorrect decision is a failure on the part of the nurse.

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

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

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

IMPLICATIONS AND FUTURE RESEARCH

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

LIMITATIONS

Small sample sizes associated with focus groups in qualitative research limit the generalisability of study findings. However, these findings do provide a rich in-depth

description of causal factors for nurses' knowledge and practice gaps, regarding confidentiality and risk-actuated public interest disclosure-related decision-making in mental health care (Polit & Beck, 2010).

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

CONCLUSION

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

Additionally, nurse staffing difficulties create pervasive and expanding shortages of mentorship and knowledge, whilst entities held as guiding authorities and sources of legal advice are perceived to be either unavailable when required, or reticent sources of

information. Concerningly, at the clinical practice level reservations were also expressed about the accuracy of some patient records. Moreover, nurses were concerned that unrealistic expectations were leading to a persistent unrealistic belief nurses could identify and manage risk with certainty.

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

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Table 1: Participant inclusion and exclusion criteria for study (adapted from Conlon et al., 2023).

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

Table 2: Demographic details of participants.

Participant	Nominated gender*	Approximate years of experience in mental health	Highest post-graduate qualification in mental health**	Current practice area	Private or public sector
1	F	13	Graduate certificate	Inpatient ward	Public
2	F	25	Masters	Community	Public
3	F	8	n/a	Outpatient clinic	Public
4	M	12	PhD	Education	Public-Private
5	F	20	Masters	Emergency department	Public
6	F	3	n/a	Inpatient ward	Public
7	F	8	Masters	Emergency department	Public
8	M	30	PhD	Education	Public-Private
9	F	20	PhD	Education	Public-Private
10	F	20	n/a	Emergency department and community	Public
11	F	15	Masters	Community	Private
12	F	12	n/a	Inpatient ward	Public

*The genders nominated by participants were cisgender M=Male and F=Female. No other genders were nominated by participants.

** n/a indicates no post-graduate qualification specialising in mental health

9.3 Conclusion

This section concludes Chapter 9 which presented data obtained from method 4 of the study, focus groups exploring causal factors for MHNs' knowledge and practice gaps identified in data obtained from semi-structured interviews. The chapter commenced with an introduction to confidentiality, risk-actuated public interest related decision-making by MHNs, and knowledge and practice gaps identified in data obtained from semi-structured interviews. Next, the aim and methods of the focus groups were described. Themes identified in focus group data were then presented, and the relevance of these themes to the research goals of this thesis was discussed. Finally, implications and future research, and limitations, were highlighted. Next, Chapter 10 will present the overall findings of the study and provide a conclusion to this thesis.

CHAPTER 10: CONCLUSION TO THESIS

10.1 Introduction

The aim of the thesis was to investigate MHNs' decision-making processes regarding confidentiality and risk-actuated public interest disclosure-related decision-making. A research question and four sub-questions outlined in Chapter 1 guided the investigation.

Research question

What are MHNs' decision-making processes regarding confidentiality and disclosure of confidential information pertaining to patients assessed as posing a potential credible risk of harm to self or others?

Sub-questions

1. How are the concepts of risk, confidentiality, and the public interest, understood by MHNs?
2. Does the setting in which a decision is made influence MHNs' decision-making processes?
3. Does the level of experience of MHNs influence their decision-making processes?
4. For what reasons do MHNs justify withholding or disclosing confidential information in the public interest, when a patient is assessed as posing a credible risk of harm to self or others?

As the final section of the thesis, this chapter synthesises and discusses the study findings, summarises the strengths, limitations, and implications of the study, and provides some recommendations for clinical practice, systemic governance, and areas of future research.

10.2 Discussion of findings

The thesis was presented as a ‘thesis including publications’ in accordance with University of Sydney policy, whereby each publication is an individual piece of literature that also forms the core of the chapter in which it appeared. In this section, a synthesis of study data reported in chapters 5-9 is presented.

10.2.1 Confidentiality is a common law duty in NSW

The study established confidentiality in NSW is a common law duty, with an accompanying public interest in protecting confidentiality. Therefore, the common law exceptions to the duty also apply, whereby information can be shared with consent, by legal or judicial order, or where there is a competing public interest to that of disclosure. Notably for the study, an example of a competing public interest arises when a patient in mental health care poses a potential credible risk to self or others. There is no additional legal duty to disclose a patient’s confidential information in NSW. These findings are important because they provide a benchmark for safe practice, that can also be used to guide research regarding MHNs’ knowledge and practice gaps that influence their decision-making.

10.2.2 Decision-making is a quasirational cognitive exercise

Data obtained from the study and informed by Cognitive Continuum Theory (CCT) indicated MHNs' confidentiality and risk-actuated public interest disclosure-related decision-making is a cognitive exercise. Firstly, participants described how relevant information-laden visible patient cues played a role in uncovering invisible risk-related concerns, indicating the role of functional relations in their decision-making. Additionally, pre-existing relationships with patients or previously encountered risk-related experiences were reported to influence their perception of risk, highlighting the presence of experiential intuition-led pattern-recognition in cue-driven risk assessment.

Moreover, participants described their decision-making processes as comprising a series of three components pertaining to, risk assessment, confidentiality, and disclosure. These decisions were generally made using a framework of structured clinical judgement, which is analogous to Cognitive Continuum Theory (CCT). Essentially, participants outlined a tendency to apply their intuition to static indicators of risk (actuarial indicators) to create a dynamic quasirational oscillatory approach to risk assessment and management. Notably, the blend of intuition and analysis used for a cognitive task may facilitate the allocation of the task to one of the modes of inquiry associated with the task continuum of CCT, which could then be used to predict the most appropriate blend of cognition for similar tasks in the future. This level of interrogation was beyond the scope of the study, but it emphasises the relevance of ongoing CCT-related research to this area of MHNs' practice.

10.2.3 Caution influences risk assessment

Additional study data demonstrated participants generally understood risk and appropriately undertook risk assessments, prior to their confidentiality related decisions. Essentially, they

appeared to conceptualise risk as a dynamic omnipresent phenomenon, ranging from imperceptible risk of insignificant harm to a credible risk of harm that is significant. For risk assessment, intuition dominant cognition was reported to be preferred for their quasirational decision-making processes. However, study data revealed participants often deferred to actuarial data over their intuition because it was objective, and they considered it to be more readily explicable if they needed to justify their decisions to others. Nonetheless, they appeared willing to overrule findings of a quasirational risk assessment and oscillate to their intuition to upgrade (but not downgrade) an actuarial guided assessment of risk. This finding indicates an over-cautious approach and supports the implementation of interventions to re-orientate MHNs' risk-assessment processes in this regard.

10.2.4 MHNs' knowledge is incomplete or incorrect

An urgent need for education to address MHNs' limited knowledge of confidentiality and the public interest to assist their decision-making was also indicated by study findings. For confidentiality, the legal framework for handling confidential information in NSW has established principles and rules. Therefore, it is reasonable to surmise MHNs would rely mostly on analytical cognition. Nonetheless, participants reported taking an intuitive approach to confidentiality, basing their decisions on previous experience and their perceived existing knowledge of their duty of confidentiality to patients.

However, participants' knowledge of the concept of confidentiality and the rules that govern their handling of confidential information varied from one participant to the next, and was almost always incomplete or incorrect. In fact, there was no significant difference between participants' knowledge of confidentiality, irrespective of their gender, age, area of

practice, level of post-graduate education, or years of experience. Additionally, participants did not understand and were unable to articulate the concept of public interest, other than in terms of making a disclosure when a patient is assessed as posing a risk to self or others. Unsurprisingly, they also displayed little knowledge of balancing the public interest in confidentiality against the public interest in disclosure, to guide their decision-making processes. These findings reinforce the importance of including education and support to assist and encourage MHNs to take ownership of their learning, thereby increasing the likelihood their decisions will be validly made with outcomes that can be defended.

10.2.5 MHNs have misguided beliefs about disclosure and risk

In addition to the knowledge deficits noted above, study data also revealed MHNs maintain misguided beliefs that influence their risk-actuated public interest disclosure-related decision-making processes. Firstly, participants expressed a misguided belief they were always legally bound to disclose a patient's confidential information if they felt a patient may pose a risk. Consequently, they also incorrectly believed they were protected by law if these disclosures were made in good faith, even if they breached a patient's confidentiality. This notion appeared to provide a false sense of security for participants when assessing whether their disclosures may amount to a breach of confidentiality. Essentially, they seemed willing to discount the findings of their quasirational assessments or overrule contemporaneous assessments of risk with assessments of static dangerousness, and consider disclosing a patient's confidential information if they continued to perceive (without further evidence) the patient posed a credible risk.

Additionally, MHNs carry a misguided belief (justified or not) that they are expected by employers or health services to always identify and manage risk, which included releasing

a patient's confidential information when required to do so. Participants described how this perception led them to engage in pre-emptive harm reduction practices, such as overruling as assessment of no credible risk to declare a patient posed a credible risk of significant harm to self or others. Concerningly, this was done to protect their professional standing amongst their employers (and at times their reputation amongst their colleagues) by ensuring they did not fail to identify risk, rather than being in the best interests of a patient or others. These findings, which illuminate behaviour that can lead to negative repercussions for patients and other stakeholders, emphasise the need for supportive education and guidance to neutralise or dispel these misguided and potentially damaging beliefs.

10.2.6 Organisational level education and support is required

Gaps revealed in participants' confidentiality and risk-actuated public interest disclosure-related decision-making processes were unfortunate but unsurprising, due to organisational factors that influenced MHNs' frameworks of knowledge. Firstly, study data showed a paucity of tertiary mental health education and exposure to the clinical environment left many MHNs unprepared to make their decisions. Additionally, there was no standardised training provided for MHNs entering the profession, so participants' level of knowledge was unpredictable and unique to each individual. Moreover, participants reported receiving little if any continuing professional development (CPD) pertaining to these important and complex topics (especially confidentiality) when they enter the workforce.

Other organisational factors reported to influence MHNs' decision-making processes included a paucity of MHN mentors from whom novice MHNs can learn, because limited places in the general nursing degree are taken by students who do not want to work in mental health care. Additionally, participants described having difficulty accessing or

interpreting incomplete or irrelevant medical records, or encountering legal departments or regulatory authorities that were uncontactable, unavailable, or unwilling to assist, when urgent guidance or timely advice was required.

These findings emphasise the importance of streamlined organisational level education and other support networks, because it is currently difficult for MHNs to appreciate the importance of confidentiality when there is a perception their guiding authorities do not lead by example.

10.3 Significance of thesis

There were several observations made during the thesis that outline its significance to MHNs' practice. First, to the best of my knowledge this is the first thesis to examine MHNs' confidentiality and risk-actuated public interest disclosure-related decision-making processes. Additionally, the study reported in this thesis is believed to be the first to: (a) examine the framework of confidentiality in NSW from the perspective of MHNs; (b) explore MHNs' knowledge of confidentiality in NSW; (c) explore MHNs' understanding of the concept of public interest pertaining to confidentiality and disclosure in any jurisdiction; and (d) explore risk-actuated public interest disclosure-related decision-making by MHNs in any jurisdiction. Data obtained from the study illuminated areas for improvement in MHNs' knowledge, beliefs and practice, which have a demonstrable influence on their decision-making processes.

Furthermore, the thesis ascertained MHNs understand risk and can make risk-actuated public interest disclosure-related decisions regarding patients' confidential information. However, perceived (or actual) pressures from health services and employers

lead MHNs to make decisions in pursuance of their own interests and those of employers and health services, rather than in the best interests of patients. For example, in cases where a health service expects MHNs to always identify and mitigate risk, decisions are made based on feelings or fears of failure not patient data, leading to negative outcomes for patients (such as the inappropriate disclosure of their confidential information). Notably, this finding can be extrapolated to any risk-related decision made by MHNs.

Lastly, this thesis presents the first study demonstrating CCT is a suitable theory to explore MHNs' decision-making processes regarding confidentiality and risk-actuated disclosure, because it is analogous to structured clinical judgement. Consequently, the study strengthens the validity of CCT and creates a niche for structured clinical judgement amongst established cognitive theory, by grounding and centring MHNs' confidentiality and disclosure decision-making processes within the greater body of cognitive theoretical literature. This outcome also provides a starting point for future research in this area of practice. For example, by indicating the possibility of identifying potential cues relating to typical cases, that will aid MHNs' probabilistic functionalism and pattern recognition skills. Therefore, assisting MHNs to choose the correct mode of inquiry when making these decisions in the future. Furthermore, this also positions CCT as a compatible theoretical framework to guide the design of educational packages for MHNs' decision-making processes.

10.4 Limitations of thesis

The thesis has several limitations that require acknowledgement. Firstly, confidentiality is a common law concept that is also subject to legislation, so is bounded by jurisdiction (Health

Records and Information Privacy Act, 2002; Kerridge et al., 2013). As a result, the findings of the study are limited to NSW and MHNs practising in that state. Nonetheless, the concept of confidentiality and the exceptions to confidentiality predate Australia's secession from the English legal system, so the duty of confidentiality owed by MHNs to their patients shares many commonalities across these jurisdictions (Mousourakis & Nicolini, 2019). Therefore, the study findings presented in the thesis may still be extrapolated to other legal systems, if jurisdictional considerations are taken into account.

Secondly, the small sample sizes in interviews and focus groups limit the generalisability of findings. Nonetheless, the study findings do provide a rich in-depth description of decision-making processes of MHNs in NSW pertaining to confidentiality and risk-actuated public interest related disclosures (Polit & Beck, 2010).

Thirdly, many jurisdictions (including states of Australia) have their own mental health acts (Tosson et al., 2022). Therefore, the duty of care expected of and perceived by MHNs relating to confidentiality and risk-actuated public interest disclosure-related decision-making may vary from one jurisdiction to the next. For example, thresholds for disclosure are lower in jurisdictions where MHNs have enhanced obligations under a mental health act to prevent harm, and higher in jurisdictions where they have enhanced obligations to protect patient information from being released inappropriately.

Fourthly, MHNs' education and clinical training differ considerably between different jurisdictions and countries, thereby influencing the level of knowledge graduates have regarding decision-making processes in mental health care. For example, in the United Kingdom MHNs undertake a dedicated degree in mental health nursing, whilst their Australian counterparts undertake a generalised nursing degree and specialise in mental health care after graduation. Further education is recommended for Australian graduates

who choose to specialise in mental health care, but it is not mandatory (Christiansen et al., 2018; Happell, 2010). Therefore, MHNs in the United Kingdom may receive more education and clinical exposure to decision-making processes in mental health care than their Australian counterparts, which some researchers suggest can positively enhance MHNs' knowledge and practice (Moyo et al., 2023).

10.5 Implications of findings

The findings outlined in the thesis have several important implications for MHNs and decision-making literature. First, they emphasise the importance of MHNs' decision-making processes for stakeholders, some of whom may tend to overlook or minimise the importance of MHNs' duty of confidentiality to their patients. Additionally, the findings identified specific gaps in MHNs' knowledge regarding confidentiality and risk-actuated public interest disclosure-related decision-making, which until this point in time have been obscured. These findings provide a starting point for designing educational and guidance strategies to address these gaps. These strategies may include short courses, self-guided learning activities, and university level interventions for undergraduate nurses. Additionally, the findings may be used to address practice gaps with targeted training and skills assessment, at the student and graduate level of practice.

Another useful application of the findings is as a baseline for ongoing research to develop an instrument to assist MHNs with their confidentiality and risk-actuated public interest disclosure-related decision-making processes. Initially, by pointing researchers and MHN leaders towards areas of weakness in MHNs' knowledge and practice that should be investigated and addressed. Then, by suggesting the inclusion of strategies to ensure this

instrument is used contemporaneously by MHNs during their risk assessment, confidentiality, and risk-actuated public interest disclosure-related, decision-making; not asynchronously as the findings indicate commonly happens with other instruments. Any intervention that can address the asynchronous element of MHNs' decision-making processes for this instrument can also be implemented to encourage the contemporaneous use of other instruments in various contexts.

Notably, MHNs' risk-related decision were found to be made using structured clinical judgement, which is analogous to CCT. However, unlike structured clinical judgement, CCT is not limited to risk-related decision-making but is extendable to all MHNs' decisions. This indicates CCT can provide a useful theoretical framework for combining investigations of structured clinical judgement related decision-making with other associated decision-making processes. For example, the processes pertaining to confidentiality and the public interest interrogated in the study.

Many cognitive theories do not subscribe to the idea that hunches and feelings (sometimes coupled with or used interchangeably with emotions) should play a role in decision-making (Hammond, 1996; Hutchinson et al., 2018; Kozlowski et al., 2017). However, nursing literature ascribes to the notion hunches and feelings are experientially derived or based on empathy, and are an important aspect of nurses' (including MHNs') therapeutic decision-making processes (Melin-Johansson et al., 2017). Therefore, the findings have the potential to add to CCT and other cognitive theoretical literature by demonstrating that hunches and feelings may form a legitimate accompaniment to intuitive cognitive processes in decision-making, especially for MHNs dealing with patients in their care.

10.6 Recommendations

Several recommendations emerge from the thesis. Firstly, study findings repeatedly emphasised the need for enhanced education related to confidentiality and public interest disclosures in Australian undergraduate and post graduate mental health nursing. This is an important consideration for universities and health services, because it has the potential to increase MHNs' ability to care effectively for patients who pose a potential risk to self or others. If education in this area is not enhanced the *status quo* is likely to continue, whereby MHNs maintain poor levels of knowledge and misguided or unfounded beliefs that influence their confidentiality and risk-actuated public interest disclosure-related decision-making processes.

A second recommendation is employers, health services, and regulators, should consider taking steps to ensure information required for confidentiality and public interest disclosure-related decision-making is readily available to MHNs. For example, having a dedicated 24-hour legal hotline for MHNs to ask questions, including about confidentiality and public interest disclosures. Moreover, encouraging MHNs to the profession would create a sound mentorship structure to support novice MHNs. For example, by giving student nurses greater exposure to mental health setting during their degree program. These steps would assist MHNs to make appropriate effective decisions, whilst easing the decision-making process by allowing them to feel supported in their decisions. Additionally, the quality of their decisions would be improved.

Thirdly, health services, regulatory authorities, and employers should reframe their and MHNs' understanding of risk, and the limitations on risk identification, mitigation, and prevention. Currently, MHNs are under an apprehension they must always identify and

manage risk, that arises from their dealings with employers and health services. Additionally, they are fearful of perceived repercussions if they unwittingly make an incorrect decision, and a person comes to harm. However, identifying risk is challenging and harm is often difficult to identify or manage, and employers and health services must acknowledge and accept these facts (Caterino et al., 2013). Moreover, MHNs need to be assured they will not be punished for simply making a decision, because currently they often maintain an inappropriate focus on dangerousness criteria when assessing and managing risk.

Fourthly, study findings can be used by researchers as a baseline for further studies investigating interventive and educative strategies to improve MHNs' decision-making processes in this area. For example, identifying relevant cues present in typical risk-related scenarios. Additionally, research that ascertains the most appropriate CCT-associated mode of inquiry for each task, would assist the development of interventional strategies to guide MHNs towards improving their decision-making processes.

Lastly, study findings have provided a starting point for research to develop interventions such as an instrument to assist MHNs with their confidentiality and risk-actuated public interest disclosure-related decision-making processes. However, MHNs appear to dislike decision-making instruments and only use them sparingly, or sometimes inappropriately when they do so. Therefore, any research furthering the development of such instruments will also need to investigate how they can be effectively integrated into MHNs' practice.

10.7 Conclusion

The genesis of this thesis was in my observations of deficiencies in MHNs' knowledge and practice regarding confidentiality and risk-actuated public interest disclosure-related decision-making processes. Currently, this is an under-researched and *prima facie* underappreciated area of MHNs' practice. Consequently, from the outset the thesis has been primarily concerned with ascertaining MHNs' decision-making processes, with a view to illuminating the importance of this topic for MHNs and all stakeholders.

The thesis identified knowledge and practice gaps in these processes that can be addressed by education and guidance, whilst opening avenues of potential research in this important area of practice. It has also laid a foundation for further research to design an instrument to assist MHNs (and potentially all clinicians) in their confidentiality and risk-actuated public interest disclosure-related decision-making. Having achieved its aim of investigating MHNs' decision-making processes in this area of their practice, I provide a personal reflection and my final thoughts regarding the thesis below.

10.8 Reflection and final thoughts

As stated above, the first observation I made on commencing the thesis was a paucity of literature related to MHNs' confidentiality and risk-actuated public interest disclosure-related decision-making processes, which made it difficult at times to discuss data obtained during the study in the context of existing literature. Consequently, composing the thesis over the past five years has emphasised to me the importance of promoting research in this area of MHNs' practice. The thesis has also confirmed for me the importance for patients of MHNs' duty of confidentiality regarding their information, whilst illuminating the steps

necessary to improve the handling of confidential information by MHNs in NSW (and in all jurisdictions and health care settings).

It is clear there is a general lack of knowledge amongst MHNs regarding their duty of confidentiality. Nonetheless, on a positive note MHNs have demonstrated both an awareness their knowledge of confidentiality and risk-actuated disclosure requires further information and guidance, and a willingness to ensure their confidentiality related actions are generally taken in the best interests of patients. However, organisational structures and pressures within health services often exert negative influences on MHNs' decision-making processes, and it is important these influences are recognised and acted upon.

Midway through my thesis the Covid-19 pandemic proved itself to be an unwelcome impediment to data collection, traditionally carried out face-to-face with interviewees. However, a supportive university network and an agile supervisory team swiftly facilitated my adapting the interview process to an online format, which meant data collection could continue albeit with some delays due to study participants' illness. Furthermore, it is widely accepted that negative situations also create opportunities, and this became apparent to me during the focus groups, whereby MHNs who were unavailable to travel to participate in a face-to-face group were able to attend a session online. Consequently, my mind has been opened to trialling innovations and inventions that may enhance or strengthen research processes.

Finally, it has been a privilege to complete a thesis that has helped to improve our understanding of MHNs' decision-making processes. This study has increased my interest in the compelling fields of confidentiality and human decision-making, and I intend to continue working on opportunities arising from my thesis findings. I am looking forward to the next step in my research journey, which will involve the development of an instrument that MHNs

(and possibly all clinicians) can use to assist them with their confidentiality and risk-actuated public interest disclosure-related decision-making processes.

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APPENDIX A

Human Research Ethics Committee approval letters.



Research Integrity & Ethics Administration HUMAN RESEARCH ETHICS COMMITTEE

Tuesday, 13 August 2019

Assoc Prof Timothy Wand
Faculty of Nursing & Midwifery; Faculty of Medicine and Health
Email: twan0077@uni.sydney.edu.au

Dear Timothy,

The University of Sydney Human Research Ethics Committee (HREC) has considered your application.
I am pleased to inform you that after consideration of your response, your project has been approved.

Details of the approval are as follows:

Project No.: 2019/564
Project Title: An exploration of the decision-making processes of mental health nurses' (MHN) regarding confidentiality and disclosure of information pertaining to patients at risk of harm to self or others.
Authorised Personnel: Wand Timothy; Conlon Darren; Raeburn Toby;
Approval Period: 13 August 2019 to 13 August 2023
First Annual Report Due: 13 August 2020

Documents Approved:

Date Uploaded	Version Number	Document Name
27/07/2019	Version 2	Poster 1 clean copy
27/07/2019	Version 2	Poster 2 clean copy
27/07/2019	Version 2	Flyer 3 clean copy
27/07/2019	Version 2	Flyer 1 clean copy
27/07/2019	Version 2	Flyer 2 clean copy
27/07/2019	Version 2	Poster 3 clean copy
21/06/2019	Version 1	Email to peer network
21/06/2019	Version 1	Email to professional network (if researcher not a member)
21/06/2019	Version 1	Email to professional network (if researcher a member)
21/06/2019	Version 1	Safety Protocol
21/06/2019	Version 1	Email of introduction to potential participants
21/06/2019	Version 1	Letter of introduction to potential participants
21/06/2019	Version 1	PIS Interview
21/06/2019	Version 1	PIS Survey
21/05/2019	Version 1	Consent form

Special Condition/s of Approval

1. It is a condition of approval that a more detailed interview guide be submitted for review by the Modification Review Committee (MRC) after the law and legal research component has informed direction the research. Please refer to the MRC meeting schedule on our website when preparing your submission. The broad themes to be addressed in interviews were not substantial enough for the committee to fully consider all the ethical implications of the research.
2. It is a condition of approval that the survey instrument to be distributed to mental health care nurses and informed by both legal research and analysis of interview data is submitted for review by the MRC prior to its dissemination.
*Note that when submitting a modification request it may be necessary to alter information presented in the PIS (e.g. time commitment) and advertising material to be more accurate. For this reason, these documents will not be approved for use at this stage.

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CRICOS 00026A



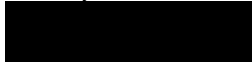
Condition/s of Approval

3. Research must be conducted according to the approved proposal.
4. An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.
5. You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
 - Serious or unexpected adverse events (which should be reported within 72 hours).
 - Unforeseen events that might affect continued ethical acceptability of the project.
6. Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate *immediate* risk to participants).
- Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.
7. Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, as relevant to this project.
8. Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.
9. Ethics approval is dependent upon ongoing compliance of the research with the *National Statement on Ethical Conduct in Human Research*, the *Australian Code for the Responsible Conduct of Research*, applicable legal requirements, and with University policies, procedures and governance requirements.
10. The Ethics Office may conduct audits on approved projects.
11. The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring all others involved will conduct the research in accordance with the above.

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Sincerely,



Dr Helen Mitchell
Chair
Human Research Ethics Committee (HREC 1)

The University of Sydney of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) [National Statement on Ethical Conduct in Human Research \(2007\)](#) and the NHMRC's [Australian Code for the Responsible Conduct of Research \(2007\)](#)



THE UNIVERSITY OF
SYDNEY

**Research Integrity & Ethics Administration
HUMAN RESEARCH ETHICS COMMITTEE**

Monday, 24 February 2020

Assoc Prof Timothy Wand
Faculty of Nursing & Midwifery; Faculty of Medicine and Health
Email: timothy.wand@sydney.edu.au

Dear Timothy,

Your request to modify this project, which was submitted on 5 December 2019, has been considered.

After consideration of your response to the comments raised, this project has been approved to proceed with the proposed amendments.

Protocol Number: 2019/564

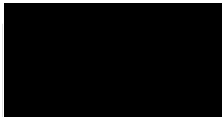
Protocol Title: An exploration of the decision-making processes of mental health nurses' (MHN) regarding confidentiality and disclosure of information pertaining to patients at risk of harm to self or others.

Documents Approved:

Date Uploaded	Version Number	Document Name
05/12/2019	Version 4	Interview questions

Please contact the ethics office should you require further information.

Sincerely,



Dr Clifton Chan
Acting Chair, Modification Review Committee (MRC 3)

The University of Sydney of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) [National Statement on Ethical Conduct in Human Research \(2007\)](#) and the NHMRC's [Australian Code for the Responsible Conduct of Research \(2007\)](#)

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Wednesday, 6 July 2022

Assoc Prof Timothy Wand
Faculty of Nursing & Midwifery; Faculty of Medicine and Health
Email: timothy.wand@sydney.edu.au

Dear Timothy,

Your request to modify this project, which was submitted on 12/03/2022, has been considered.

After consideration of your response to the comments raised, this project has been approved to proceed with the proposed amendments.

Protocol Number: 2019/564

Protocol Title: An exploration of the decision-making processes of mental health nurses (MHN) regarding confidentiality and disclosure of information pertaining to patients at risk of harm to self or others.

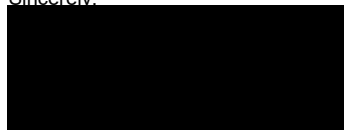
Annual Report Due: 13/08/2022

Documents Approved:

Date Uploaded	Version Number	Document Name
14/06/2022	Version 1	Email to peer network
14/06/2022	Version 1	Email to professional network 1
14/06/2022	Version 1	Email to professional network 2
14/06/2022	Version 1	Focus group questions
14/06/2022	Version 1	Letter of introduction to participants
14/06/2022	Version 2	Participant Consent Form
14/06/2022	Version 1	Safety protocol
06/04/2022	Version 4	Conlon_1_MHNs_Flyer_v.4_clean_copy
06/04/2022	Version 4	Conlon_2_MHNs_Flyer_v.4_clean_copy
06/04/2022	Version 4	Conlon_3_MHNs_Flyer_v.4_clean_copy
06/04/2022	Version 5	Conlon_PIS_FOCUS_GROUPS_clean_copy

Please contact the ethics office should you require further information.

Sincerely,



Associate Professor Stephen Fuller
Chair
Modification Review Committee Chair (MRC 1)

The University of Sydney of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) [National Statement on Ethical Conduct in Human Research \(2018\)](#) and the NHMRC's [Australian Code for the Responsible Conduct of Research \(2018\)](#)

APPENDIX B

Participant Information Statement for semi-structured interviews.



School of Nursing
Faculty of Medicine and Health

ABN 15 211 513 464

A/Prof Timothy Wand
Chief Investigator (Supervisor)

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An exploration of mental health nurses' decision-making processes regarding confidentiality and disclosure of information pertaining to patients who may be at risk of harm to self or others.

PARTICIPANT INFORMATION STATEMENT

(1) What is this study about?

You are invited to take part in a research study exploring Mental Health Nurses' (MHN) decision-making regarding patient confidentiality, when a patient is deemed by a MHN to pose a risk of harm to self or others. The research will illuminate how MHNs determine a reasonable level of disclosure of confidential information, based on the perceived level of risk of a patient. This research is important because it involves an area of MHN practice that is not widely represented in current empirical literature. The findings of this research are expected to contribute to the knowledge base regarding confidentiality practice of MHNs. The findings of this research may also be transferable to: nursing fields outside of mental health; and to the practice of health care professionals other than MHNs.

You are invited to participate in this study because you are a nurse working in the area of mental health. This Participant Information Statement tells you about the research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this information sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary.

By giving your consent to take part in this study you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.

You will be given a copy of this Participant Information Statement to keep.

(2) Who is running the study?

The study is being carried out by the following researchers:

- Dr Timothy Wand, University of Sydney
- Dr Toby Raeburn, University of Sydney
- Mr Darren Conlon, PhD candidate, University of Sydney

Mr Darren Conlon is conducting this study as the basis for the degree of Doctor of Philosophy at The University of Sydney. This will take place under the supervision of A/Prof Timothy Wand, and Dr Toby Raeburn.

(3) What will the study involve for me?

The study requires you to take part in an interview process. The interview will involve discussion of your knowledge and practice in the area of confidentiality, and the disclosure of confidential information, when a patient may be at risk of harm to self or others. The interview will be conducted by Mr Darren Conlon, and no preparation is required by you prior to the interview. The interview will take place at a time and location that is suitable for you, and is strictly confidential. An audio recording will be made of the interview, for the purpose of subsequently transcribing the interview to text. All of your interview data will be anonymised, by replacing your identifying details with a non-identifying number.

(4) How much of my time will the study take?

The interview should take approximately 45 minutes.

(5) Who can take part in the study?

This study is open to: MHNs; nurses working in the field of mental health; or nurses working in areas relating to mental health.

(6) Do I have to be in the study? Can I withdraw from the study once I've started?

Participation in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of Sydney.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time. You can do this by contacting Mr Darren Conlon in writing at dcon8955@uni.sydney.edu.au and advising him that you no longer wish to be included in the study. Please advise Mr Conlon in your email if you consent to him retaining your data for the purposes of this study. If you choose to not do so all data pertaining to you will be deleted or otherwise erased.

You are free to stop the interview at any time. Unless you say that you want us to keep them, any recordings will be erased and the information you have provided will not be included in the study results. You may also decline to answer any questions that you do not wish to answer during the interview.

(7) Are there any risks or costs associated with being in the study?

For the interview process, whilst unlikely, your participation may give rise to feelings of discomfort from reflecting on experiences of your decision making. However, any potential emotional impact of the interview process is balanced by the potential for the research experience to provide you with a

valuable opportunity to actively reflect on your practice should you care for individuals at risk of harm to self or others.

Aside from also giving up your time, we do not expect that there will be any other risks or costs associated with taking part in this study. However, the researchers will monitor you for visual signs of emotions greater than discomfort, and will also ask you how you are feeling at several points during the interview. In the event that you find the interview distressing, the interview will be stopped and you will have the choice of either: continuing after a break; continuing at a later date; or withdrawing completely.

Services and numbers you may contact if you feel distressed include:

- *Your GP*
- *BeyondBlue, for 24 hour crisis support and advice: Call 1300 22 4636, or for further information and online forums go to <https://www.beyondblue.org.au>*
- *Lifeline: Call 13 11 14, or if you prefer to chat to someone online from 7:00pm to Midnight EST go to <https://www.lifeline.org.au/get-help/online-services/crisis-chat>*
- *The Samaritans: Call 13 52 47, or for further information go to <https://thesamaritans.org.au>*

(8) Are there any benefits associated with being in the study?

The findings from this study will be used to illuminate nurse decision making on confidentiality and disclosure of a patient deemed to be at risk of harm to self or others. We cannot guarantee that you will receive any direct benefits from being in the study.

(9) What will happen to information about me that is collected during the study?

By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise. Your information will be stored securely and your identity/information will be kept strictly confidential, except as required by law.

During this research study, your information will be encrypted and stored in password locked files, on secure University of Sydney supported platforms. If electronic copies of study materials are created they will be encrypted and stored in password locked files on a password locked computer. If paper transcripts, or hard-copies of other study materials are created, they will be stored in a locked cabinet in the office of a researcher in this study, at the University of Sydney. Only researchers involved in this study will have access to this cabinet.

At the conclusion of this study, electronic data will be managed on secure University of Sydney supported platforms. If paper transcripts, or other hard-copies of study materials exist, they will be stored in a locked cabinet in the office of the chief researcher in this study, at the University of Sydney. Only researchers involved in this study will have access to this cabinet. Data for this study will not be used for any other purpose, and will be destroyed five years after the completion of this study.

The information we collect from you is concerned with confidentiality practice, and disclosure of confidential information when a patient is at risk of harm to self or others. Interviews will be recorded. These recordings are important to ensure content accuracy when transcribing interview data to written form. An audio copy of interview data will be provided to a data transcription service recommended by the University of Sydney. Personal identifiers will be removed from your interview data during transcription, and replaced by numeric codes. A copy of these numeric codes will be encrypted and stored separately and apart from your interview data in a password locked file. These codes are retained and stored solely to identify these data if you request us to remove them from the study.

Study findings will be published in a student thesis, and may be published in academic journals or conference presentations. You will not be individually identifiable in these publications.

(10) Can I tell other people about the study?

Yes, you are welcome to tell other people about the study.

(11) What if I would like further information about the study?

When you have read this information, Mr Darren Conlon will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact Mr Darren Conlon, Doctor of Philosophy student, University of Sydney at dcon8955@uni.sydney.edu.au or by text or phone call to **0484 776 866**.

(12) Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback by ticking the yes box on the Participant Consent Form (PCS) accompanying this Participant Information Sheet, and indicating your preferred form of feedback (electronic or hardcopy) and relevant contact address on the PCS. This feedback will be in the form of a one page lay summary of the overall results of this study. You will receive this feedback after the study is finished.

(13) What if I have a complaint or any concerns about the study?

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of the University of Sydney protocol number **2019/564**. As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect people who agree to take part in research studies.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university using the details outlined below. Please quote the study title and protocol number.

The Manager, Ethics Administration, University of Sydney:

- **Telephone:** +61 2 8627 8176
- **Email:** human.ethics@sydney.edu.au
- **Fax:** +61 2 8627 8177 (Facsimile)

This information sheet is for you to keep

APPENDIX C

Consent form for semi-structured interviews.



School of Nursing
Faculty of Medicine and Health

ABN 15 211 513 464

A/Prof Timothy Wand
Chief Investigator (Supervisor)

Room A3.12
88 Mallett Street, M02
The University of Sydney
NSW 2006 AUSTRALIA
Telephone: +61 2 9351 0607
Email: timothy.wand@sydney.edu.au
Web: <http://www.sydney.edu.au/>

An exploration of mental health nurses' decision-making processes regarding confidentiality and disclosure of information pertaining to patients who may be at risk of harm to self or others (Protocol number: 2019/564).

PARTICIPANT CONSENT FORM

I, [PRINT NAME], agree to take part in this research study.

In giving my consent I state that:

- I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- The researchers have answered any questions that I had about the study and I am happy with the answers.
- I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of Sydney now or in the future.
- I understand that I can withdraw from the study at any time.
- I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise any recordings will then be erased and the information provided will not be included in the study. I also understand that I may refuse to answer any questions I don't wish to answer.
- I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.
- I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.

I consent to:

- **Audio-recording**

YES

☐

NO

☐

I would like to receive feedback about the overall results of this study YES

☐

NO

☐

If you answered **YES**, please indicate your preferred form of feedback and address:

☐

Postal:

☐

Email:

.....
Signature

.....
PRINT name

.....
Date

APPENDIX D

Safety protocol for semi-structured interviews.

SAFETY PROTOCOL

Supervisor: Timothy Wand
Student: Darren Conlon

Safety protocol for research involving one-on-one interviews to be conducted by a student researcher for mental health nurses in a public location in Australia.

This research involves mental health nurses working in NSW. The interviews will take place at the University of Sydney, or (only if strictly necessary) at a time and place convenient to the individual. Skype, or another electronic means of communication may be used if an interviewee is unable to attend a face-to-face interview.

Darren Conlon will be conducting the interviews, and in the event that an interview needs to be held at a place convenient for a mental health nurse (that is not the University of Sydney), his supervisor considers that the safeguards provided in this safety protocol are sufficient to manage the safety risks. An example of a suitable convenient location where the interview can be conducted and not be overheard by others is a designated study room in a public library, close to the participant's home or place of work.

- The researcher will carry a mobile phone and be contactable at all times.
- The researcher will discuss interview safety, and perform practice interviews with his supervisor.
- The time and location of the interviews will be communicated to a third party, Timothy Wand timothy.wand@sydney.edu.au.
- The researcher will communicate with the third party prior to commencing the interview, and after the interview is completed.
- Interviews should not take place in private homes.
- Should anything untoward happen, or the researcher becomes uneasy for any reason, the interview will be terminated immediately and the interviewer will leave. The supervisor will be contacted as soon as practically possible.
- Interviews will be conducted in daylight hours or in the early evening.
- Transport to and from the interview will be by public transport, or where necessary a taxi or Uber. Where a taxi or Uber is needed, both the outward and return journeys will be booked in advance.
- This safety protocol has been agreed and accepted.

Tim Wand

21 June 2019

Darren Conlon

21 June 2019

APPENDIX E

Semi-structured interviews guide.

Questions	Prompts (for interviewer)
1. Can you tell me a little about yourself and your nursing career?	- Time since graduation (in years)? - Designation, RN, CNS, CNC? - Experience in mental health nursing (and in years)? - What a title or designation indicates to you about your skills in mental health nursing, versus those of your colleagues? - Please indicate on the line, your level of proficiency in handling confidential information, and outline for me why you have chosen this point on the line. Experience, education, etc. (see Fig.1)
2. Can you describe for me what the term 'confidentiality' means to you?	
3. Can you describe for me your understanding of your 'duty of confidentiality' regarding patient information?	
4. Can you outline for me your understanding of rules of confidentiality (legal, ethical or professional) that apply to you, or to patient information in your nursing practice?	- Legal framework? - Per <i>Health records and Information Privacy Act 2002</i> - Collection, access, accuracy, use/disclosure? - Ethical considerations? - Professional regulation?
5. Can you describe for me what the term disclosure (of confidential information) means to you?	
6. Can you outline for me your knowledge of exceptions to confidentiality, where you can disclose confidential information of a patient?	- Consent to disclosure? - Mandatory disclosure laws? - Public interest disclosures?

1 of 4

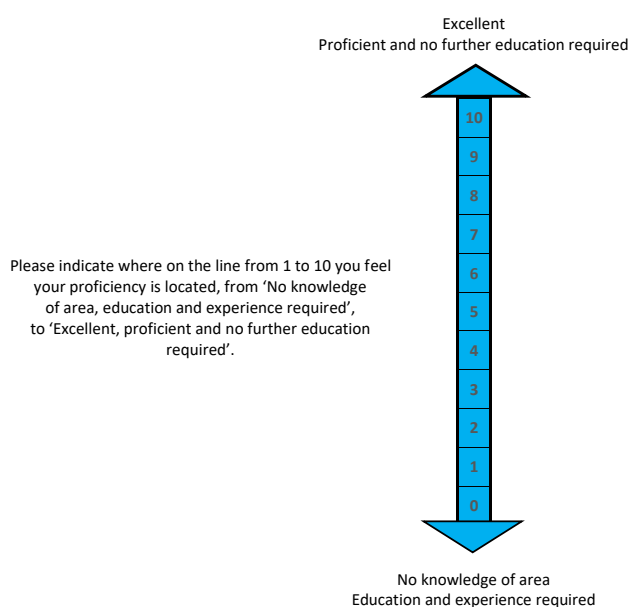
7. Having considered confidentiality, please describe for me a potential scenario/s in your nursing practice when you might disclose confidential information of a patient, and to whom?	- Describe the steps you might take? - Describe your reasoning process? - Outline some third parties that you might disclose information to?
8. Can you describe for me your understanding of the concepts of 'risk' and 'harm'?	
9. Please tell me what the term 'risk to self or others' means to you?	- Risk to self? - Risk to others?
10. Can you describe for me the criteria that might indicate to you a patient is a risk?	For you, which criteria would indicate low risk versus high-risk, and why?
11. Please describe if the context in which you are working affects your perception of risk, or not? For example, emergency department v community mental health clinic, city based medical centre v rural or remote clinic, etc.	
12. When determining a patient's level of risk, please outline if you rely specifically on the data you collect about a patient, or also rely on your 'feelings' or 'hunches/gut instincts' regarding the presence of risk?	- Have you ever felt the data you collect about a patient's risk is wrong, or is not showing the full picture about a patient's level of risk? For example: Something 'just doesn't feel right'. - Would you then prioritise your feelings or instincts over the data you have collected? - If not, why not?
13. Please outline any tools/instruments or other supports you might use for a risk assessment?	
14. Please describe for me what you believe your responsibilities are as a mental health nurse, when you assess a patient to be a risk to self or others?	- What steps might you take to address risk to self to others? - What if the 'other/s at risk' was named or identified by the patient?

2 of 4

15. Regarding a patient's confidential information, please explain what you would do with this information if you assessed a patient as being a risk to self or others, and subsequently found out the patient had been cleared and discharged from hospital by another clinician?	• If you originally found patient to be low-risk? • If you originally found patient to be high-risk?
16. For the same patient scenario as Question 15: Please outline if you would rely specifically on the data you collect, or also rely on your 'feelings' or 'hunches/gut instincts' to justify your decision, if deciding whether to withhold or disclose confidential information of that patient?	• In what circumstances would you disclose? • Which takes preference, data or feelings, and why? • If not, why not?
17. Tell me about your understanding of the potential risks of releasing confidential information of a patient, and if these potential risks may influence your decisions to disclose confidential information?	• Risks to patient? • Risks to you as mental health nurse releasing the information? • Risks to the health service? • Potential to breach patient confidentiality?
18. Please describe for me whether or not you feel your practice regarding confidentiality and patients at risk requires further education or experience?	• Once more, please indicate on the line your level of proficiency in handling confidential information, and outline why you have chosen this point on the line (See Fig.1) • If not, please explain why?

3 of 4

Fig.1. Line for indication of proficiency



4 of 4

APPENDIX F

Participant Information Statement for focus groups.



School of Nursing
Faculty of Medicine and Health

ABN 15 211 513 464

A/Prof Timothy Wand
Chief Investigator (Supervisor)

Room A3.12
88 Mallett Street, M02
The University of Sydney
NSW 2006 AUSTRALIA
Telephone: +61 2 9351 0607
Email: timothy.wand@sydney.edu.au
Web: <http://www.sydney.edu.au/>

An exploration of mental health nurses' decision-making processes regarding confidentiality and disclosure of information pertaining to patients who may be at risk of harm to self or others.

PARTICIPANT INFORMATION STATEMENT

(1) What is this study about?

You are invited to take part in a research study exploring mental health nurses (MHNs) decision-making on patient confidentiality, when a patient is deemed by a MHN to pose a risk of harm to self or others. This research will illuminate the decision making process behind how MHNs determine a reasonable level of disclosure of confidential information, based on their perceived level of risk of a patient. This research is important because it involves an area of MHN practice that is not widely represented in current empirical literature. The findings of this research are expected to contribute to the knowledge base regarding confidentiality practice of MHNs. The findings of this research may also be transferable to: nursing fields outside of mental health; and to the practice of health care professionals other than MHNs.

You have been invited to participate in this study because you are a nurse working in the area of Mental Health. This Participant Information Statement tells you about the research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary.

By giving your consent to take part in this study you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.

You can download a copy of this Participant Information Statement to keep.

(2) Who is running the study?

The study is being carried out by the following researchers:

- A/Prof Timothy Wand, University of Sydney
- Dr Toby Raeburn, University of Sydney
- Mr Darren Conlon, PhD candidate, University of Sydney

Mr Darren Conlon is conducting this study as the basis for the degree of Doctor of Philosophy at The University of Sydney. This will take place under the supervision of A/Prof Timothy Wand, and Dr Toby Raeburn.

(3) What will the study involve for me?

The study requires you to take part in a focus group. The focus group will involve discussion of your knowledge and practice in the area of confidentiality, and the disclosure of confidential information, when a patient may be at risk of harm to self or others. The focus group will be conducted by Mr Darren Conlon, and no preparation is required by you prior to the focus group. The focus group will take place at a time and location that is suitable for you and the other members of the group, and is strictly confidential. An audio recording will be made of the focus group, for the purpose of subsequently transcribing the focus group discussions to text. All of your focus group data will be anonymised, by replacing your identifying details with a non-identifying number.

(4) How much of my time will the study take?

The focus group should take approximately 60 minutes.

(5) Who can take part in the study?

This study is open to: MHNs; nurses working in the field of mental health; or nurses working in areas relating to mental health.

(6) Do I have to be in the study? Can I withdraw from the study once I've started?

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of Sydney.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time. You can do this by contacting Mr Darren Conlon in writing at dcon8955@uni.sydney.edu.au and advising him that you no longer wish to be included in the study. Please advise Mr Conlon in your email if you consent to him retaining your data for the purposes of this study. If you choose to not do so all data pertaining to you will be deleted or otherwise erased.

You are free to stop the focus group at any time. Unless you say that you want us to keep them, any recordings will be erased and the information you have provided will not be included in the study results. You may also decline to answer any questions that you do not wish to answer during the focus group.

(7) Are there any risks or costs associated with being in the study?

For the focus group process, whilst unlikely, your participation may give rise to feelings of discomfort from reflecting on experiences of decision making. However, any potential emotional impact of this survey is balanced by the potential for the research experience to provide you with a valuable

opportunity to actively reflect on your practice should you care for individuals at risk of harm to self or others.

Aside from also giving up your time, we do not expect that there will be any other risks or costs associated with taking part in this study. However, the researchers will monitor you for visual signs of emotions greater than discomfort, and will also ask you how you are feeling at several points during the focus group. In the event that you find the focus group distressing, the focus group will be stopped and you will have the choice of either: continuing after a break; continuing at a later date; or withdrawing completely. Services and numbers you may contact if you feel distressed include:

- Your GP
- *BeyondBlue*, for 24 hour crisis support and advice: Call 1300 22 4636, or for further information and online forums go to <https://www.beyondblue.org.au>
- *Lifeline*: Call 13 11 14, or if you prefer to chat to someone online from 7:00pm to Midnight EST go to <https://www.lifeline.org.au/get-help/online-services/crisis-chat>
- *The Samaritans*: Call 13 52 47, or for further information go to <https://thesamaritans.org.au>

(8) Are there any benefits associated with being in the study?

The findings from this study will be used to illuminate nurse decision making on confidentiality and disclosure of a patient deemed to be at risk of harm to self or others. We cannot guarantee that you will receive any direct benefits from being in the study.

(9) What will happen to information about me that is collected during the study?

By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise. Your information will be stored securely and your identity/information will be kept strictly confidential, except as required by law.

During this research study, your information will be encrypted and stored in password locked files, on secure University of Sydney supported platforms. If electronic copies of study materials are created they will be encrypted and stored in password locked files on a password locked computer. If paper transcripts, or hard-copies of other study materials are created, they will be stored in a locked cabinet in the office of a researcher in this study, at the University of Sydney. Only researchers involved in this study will have access to this cabinet.

At the conclusion of this research study, electronic data will be managed on secure University of Sydney supported platforms. If paper transcripts, or other hard-copies of study materials exist, they will be stored in a locked cabinet in the office of the chief researcher in this study, at the University of Sydney. Only researchers involved in this study will have access to this cabinet. Data for this study will not be used for any other purpose, and will be destroyed five years after the completion of this study.

The information we collect from you is concerned with confidentiality practice, and disclosure of confidential information when a patient is at risk of harm to self or others. Focus groups will be recorded. These recordings are important to ensure content accuracy when transcribing focus group data to written form. An audio copy of focus group data will be provided to a data transcription service recommended by the University of Sydney. Personal identifiers will be removed from your focus group data during transcription, and replaced by numeric codes. A copy of these numeric codes will be encrypted and stored separately and apart from your focus group data in a password locked file. These codes are retained and stored solely to identify these data if you request us to remove them from the study.

Study findings will be published in a student thesis, and may be published in academic journals or conference presentations. You will not be individually identifiable in these publications.

(10) Can I tell other people about the study?

Yes, you are welcome to tell other people about the study.

(11) What if I would like further information about the study?

When you have read this information: If you would like to know more at any stage during the study, please feel free to contact Mr Darren Conlon, Doctor of Philosophy student, University of Sydney at dcon8955@uni.sydney.edu.au or by text or phone call to **0484 776 866**.

(12) Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback by ticking the yes box on the Participant Consent Form (PCS) accompanying this Participant Information Sheet, and indicating your preferred form of feedback (electronic or hardcopy) and relevant contact address. This feedback will be in the form of a one page lay summary of the overall results of this study. You will receive this feedback after the study is finished.

(13) What if I have a complaint or any concerns about the study?

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of the University of Sydney **2019/564**. As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect people who agree to take part in research studies.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university using the details outlined below. Please quote the study title and protocol number.

The Manager, Ethics Administration, University of Sydney:

- **Telephone:** +61 2 8627 8176
- **Email:** human.ethics@sydney.edu.au
- **Fax:** +61 2 8627 8177 (Facsimile)

This information sheet is for you to keep

APPENDIX G

Consent form for focus groups.

Participant Consent Form



An exploration of mental health nurses' decision-making processes regarding confidentiality and disclosure of information pertaining to patients who may be at risk of harm to self or others.

Associate Professor Timothy Wand (Responsible Researcher)

Room A3.12, 88 Mallett Street, M02

The University of Sydney

NSW 2006 AUSTRALIA

Telephone: +61 2 9351 0607

Email: timothy.wand@sydney.edu.au

Web: <http://www.sydney.edu.au/>

Darren Conlon, PhD candidate

Email: dcon8955@uni.sydney.edu.au

Participant Name _____

I agree to take part in this research study. In giving my consent, I confirm that:

- The details of my involvement have been explained to me, and I have been provided with a written Participant Information Statement to keep.
- I understand the purpose of the study is to investigate decision-making processes of nurses working in mental health, regarding confidentiality and disclosure of patient information in the context of patient risk.
- I acknowledge that the risks and benefits of participating in this study have been explained to me to my satisfaction.
- I understand that in this study I will be required to participate in a focus group comprising nurses working in mental health in NSW.
- I understand that my participation may be audio taped.
- I understand that being in this study is completely voluntary.
- I am assured that my decision to participate will not have any impact on my relationship with the research team or the University of Sydney.

- I understand that I am free to withdraw from this study and that I can choose to withdraw any information I have already provided (unless the data has already been de-identified or published).
- I have been informed that the confidentiality of the information I provide will be protected and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.
- I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.

- I confirm the following:

I consent to audio recordings Yes ☐ No ☐

I would like to review my interview transcripts Yes ☐ No ☐

I would like feedback on the overall results of this study Yes ☐ No ☐

If you answered **yes**, please provide your preferred contact details (email/telephone/postal address):

- I understand that after I sign and return this consent form it will be retained by the researcher, and that I may request a copy at any time.

Participant Name

Signature

Date

APPENDIX H

Safety protocol for focus groups.

SAFETY PROTOCOL

Supervisor: Timothy Wand
Student: Darren Conlon

Safety protocol for research involving focus groups to be conducted by a student researcher for mental health nurses in a public location in Australia.

This research involves mental health nurses working in NSW. The interviews will take place at the University of Sydney, or (only if strictly necessary) at a time and place convenient to the members of a focus group. Skype, Zoom, or another electronic means of communication may be used if a participant is unable to attend a focus group face-to-face.

Darren Conlon will be conducting the interviews, and in the event that a focus group needs to be held at a place convenient for a mental health nurse (that is not the University of Sydney), his supervisor considers that the safeguards provided in this safety protocol are sufficient to manage the safety risks. An example of a suitable convenient location where the interview can be conducted and not be overheard by others is a designated study room in a public library, close to a participant's home or place of work.

- The researcher will carry a mobile phone and be contactable at all times.
- The researcher will discuss focus group safety, and perform practice interviews with his supervisor.
- The time and location of the focus group will be communicated to a third party, Timothy Wand,
Phone: +61 2 9351 0607,
Email timothy.wand@sydney.edu.au
- The researcher will communicate with the third party prior to commencing the focus group, and after the focus group is completed.
- Focus groups should not take place in private homes.
- Should anything untoward happen, or the researcher becomes uneasy for any reason, the focus group will be terminated immediately, and the researcher will leave.
- The supervisor will be contacted as soon as practicable.
- Focus groups will be conducted in daylight hours or in the early evening.
- Transport to and from a focus group will be by public transport, or where necessary a taxi or Uber. Where a taxi or Uber is needed, both the outward and return journeys will be booked in advance.
- This safety protocol has been agreed and accepted.

Timothy Wand

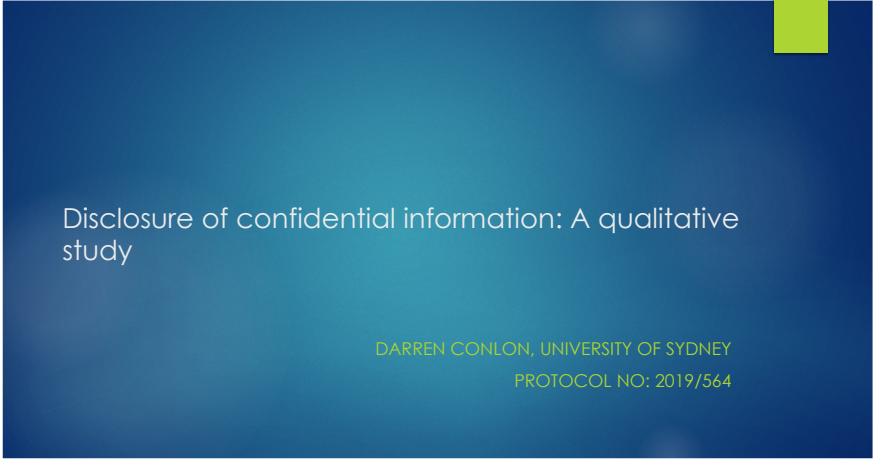
14 June 2022

Darren Conlon

14 June 2022

APPENDIX I

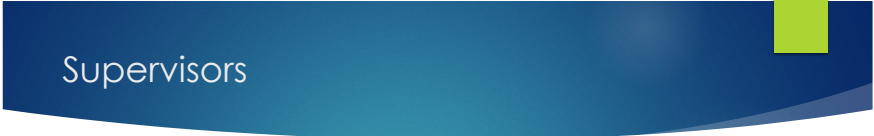
Focus groups guide.

A presentation slide with a dark blue background and a light blue gradient. The title "Disclosure of confidential information: A qualitative study" is in white. The presenter's name and protocol number are in yellow at the bottom right. A small yellow square is in the top right corner.

Disclosure of confidential information: A qualitative study

DARREN CONLON, UNIVERSITY OF SYDNEY
PROTOCOL NO: 2019/564

1

A presentation slide with a dark blue header and a white body. The title "Supervisors" is in white. Two bullet points are listed below. A small yellow square is in the top right corner.

Supervisors

- ▶ Associate Professor Timothy Wand, NP RN, MN(Hons) PhD
- ▶ Associate Professor Toby Raeburn RN, MN (Hons), PhD, FACMHN, Churchill Fellow

2

Aim of this focus group

- ▶ To gather feedback from you to understand how mental health nurses' literacy regarding dilemmas of confidentiality in the context of patient risk can be improved

3

Strategy

- ▶ I have constructed three short vignettes which I hope will be useful to promote discussion and allow you to share your knowledge.

4

Vignette 1

Mr Kumar was admitted involuntarily to Jen's hospital-based service on Wednesday for a comprehensive mental health assessment, including a risk assessment. Jen's assessment indicated Mr Kumar was clinically quite unwell and posed a credible high risk of harm to self or others.

Jen believes Mr Kumar's level of risk is higher because he is an acute involuntary presentation to her service.

My research indicates nurses have varying (sometimes conflicting) ideas about how the following criteria can impact nurses' perception of risk:

- ▶ location (e.g., ED v nurse led community clinic, rural and remote v city, etc.).
- ▶ level of clinical experience.

What are your thoughts in the vignette?

My research indicates many nurses do not understand this area of practice and how the law applies. Do you have ideas about how nurses' literacy in this area might be improved?

5

Vignette 2

Jen hands over Mr Kumar to another nurse because her shift is finished, and she has a number of days leave.

Jen returns to work the following Saturday and finds Mr Kumar was discharged on Friday evening, on foot of a follow-up assessment carried out by an agency nurse whom she does not know. Jen retrieves Mr Kumar's medical records and reviews them. Having read the agency nurse's assessment, Jen is concerned at the sparse notes made by the agency nurse and junior psychiatrist and decides she will speak with the consultant psychiatrist and advocate for readmission.

What are your thoughts on the vignette?

My research indicates many nurses do not understand this area of practice and how the law applies. Do you have ideas about how nurses' literacy in this area might be improved?

6

Vignette 3

Jen releases relevant confidential information of Mr Kumar to acute care services and the police to convey her concern that he is at risk. Mr Kumar is subsequently returned to Jen's care and she undertakes a comprehensive mental health assessment, including a risk assessment. Jen assesses Mr Kumar to no longer be a credible risk of harm. Jen is concerned she may have breached Mr Kumar's confidentiality. However, her colleague Sarah assures her that because her intentions were solely to protect the patient or others from harm, there is no problem, and she is protected under law.

However, in reality Jen is not protected under law. Her actions may:

- amount to a breach of Mr Kumar's confidentiality;
- have placed the organisation she works for at risk of being sued;
- have lowered her reputation amongst her peers; and
- leave her subject to professional sanction by the NMC or other nursing authorities.

What are your thoughts on the scenario?

My research indicates many nurses do not understand this area of practice and how the law applies. Do you have ideas about how nurses' literacy in this area might be improved?

7

Conclusion and thanks

- Thank you for your participation, your expertise, and your invaluable feedback.

8

References

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APPENDIX J

Copy of sample recruitment advertisement. From Lamp magazine March 11, 2020, published with the generous assistance of the NSW Nurses and Midwives' Association.

Professional Issues / Research

Confidentiality practices of mental health nurses study



Lamp Editorial Team | March 11, 2020

Are you a mental health nurse or a nurse who works in mental health?

Researchers at the University of Sydney are interested in understanding your decision-making on confidentiality and disclosure of confidential information for patients posing a risk of harm to self or others. They are looking to interview nurses working in mental health around their views and knowledge in this area of practice.

Interviews can occur in person, or via phone call or video conferencing.

To participate, please contact Darren Conlon on 0484 776 866 or email dcon8955@uni.sydney.edu.au.

This research is being conducted by PHD candidate Darren Conlon, with supervision from Dr Tony Raeburn and Associate Professor Timothy Wand at the University of Sydney.

Confidentiality practices of mental health nurses (*sic.*) study. (2020, March 11). The Lamp. <https://thelamp.com.au/professional-issues/research/confidentiality-practices-of-mental-health-nurses-study/>

APPENDIX K

Copy of article submitted to the Brunswik Society Newsletter and presented at the annual meeting of The Brunswik Society in response to publication of CCT article (see Chapter 3).



A PhD Journey in the Steps of Brunswik and Hammond

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I was first introduced to the work of Egon Brunswik during the research phase of my current PhD journey, where I examined decision-making processes of nurses working in mental health pertaining to confidentiality and disclosure in the context of patient risk. There is a public interest in confidentiality, but there is a competing public interest in releasing confidential information to protect a patient or others from harm. Decision-making in this area of practice is complex because withholding or disclosing information inappropriately creates risks for stakeholders (Conlon et al., 2019; 2021). This study focused on understanding the cognitive processes underpinning the fine balancing act nurses must undertake to make these decisions.

One of the core components of Brunswik's lens theory is that decision-makers are often faced with complex unknown environments they must perceive accurately to act effectively (Brunswik, 1956; Dhimi & Mumpower, 2018; Goldstein, 2004). Brunswik proposes that each environment consists of overt and covert areas, and one such covert area is patient risk (Brunswik, 1956; Conlon et al., 2022). Therefore, in assessing patient risk a decision-maker must analyse data-laden proximal cues to discern risk-related distal variables of the environment (Brunswik, 1956; Goldstein, 2004). Furthermore, building on Brunswik's work, Kenneth Hammond's Cognitive Continuum Theory (CCT) holds that decisions may be made by a blending or oscillating between intuitive and analytical approaches (Bjork & Hamilton, 2011; De Neys, 2022; Dhimi & Thompson, 2012; Hamm, 1988; Hammond, 1996).

Principles outlined by both Brunswik and Hammond are analogous with the decision-making approach to clinical risk known as Structured Clinical Judgement (SCJ), whereby nurses' (and indeed all clinicians') intuition is applied to analytical (actuarial) indicators of risk to create a dynamic approach to risk assessment and management (Conlon et al., 2019). The analytical approach in this instance is informed by rules of confidentiality before a final decision is made (Conlon et al., 2022). Furthermore, SCJ recognises the importance of the decision-maker as an instrument of the decision-making process, whereby intuition is an important arbitrator in difficult and sometimes incongruent scenarios (Conlon et al., 2022; Dhimi & Mumpower, 2018; Goldstein, 2004). Therefore, Brunswik and Hammond have created a theoretical framework that aligns with my PhD research examining clinical decision-making of nurses working in mental health, regarding confidentiality and disclosure in the context of risk (Conlon et al., 2022).

Author's note: This PhD project takes place at the University of Sydney (Australia) under the mentorship of Associate Professor Timothy Wand and Associate Professor Toby Raeburn.

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Conlon, D. (2022). A PhD Journey in the Steps of Brunswik and Hammond. In J. Adaryukov, A. Collsiöö, R. M. Hamm, E. Kaufmann & K. A. Molinaro. *The Brunswik society newsletter*, 37 (pp. 26-27). The Brunswik Society. <https://brunswiksociety.org/newsletters/>