



Navigating consensus, interprofessional collaboration between nurses and psychiatrists in hospital care for patients with deliberate self-harm

Elina Löfström, Jessica Nihlén Fahlquist, Johanna Lagerkvist, Anna-Sara Lind, Mia Ramklint & Caisa Öster

To cite this article: Elina Löfström, Jessica Nihlén Fahlquist, Johanna Lagerkvist, Anna-Sara Lind, Mia Ramklint & Caisa Öster (2025) Navigating consensus, interprofessional collaboration between nurses and psychiatrists in hospital care for patients with deliberate self-harm, Journal of Interprofessional Care, 39:3, 479-486, DOI: [10.1080/13561820.2025.2482691](https://doi.org/10.1080/13561820.2025.2482691)

To link to this article: <https://doi.org/10.1080/13561820.2025.2482691>



© 2025 The Author(s). Published with license by Taylor & Francis Group, LLC.



Published online: 31 Mar 2025.



Submit your article to this journal [↗](#)



Article views: 196



View related articles [↗](#)









View Crossmark data [↗](#)



Citing articles: 2 View citing articles [↗](#)

Navigating consensus, interprofessional collaboration between nurses and psychiatrists in hospital care for patients with deliberate self-harm

Elina Löfström ^a, Jessica Nihlén Fahlquist ^b, Johanna Lagerkvist ^c, Anna-Sara Lind ^d, Mia Ramklint ^a, and Caisa Öster ^a

^aDepartment of Medical Sciences, Uppsala University, Uppsala University Hospital, Uppsala, Sweden; ^bCentre for Research Ethics & Bioethics (CRB), Uppsala University, Uppsala, Sweden; ^cDepartment of Psychiatry, Uppsala University Hospital, Uppsala, Sweden; ^dPublic Law, Faculty of Law, Uppsala University, Uppsala, Sweden

ABSTRACT

We aimed to explore how specialist nurses and psychiatrists perceive and conceptualize their own responsibility and autonomy in relation to interprofessional colleagues when caring for inpatients with deliberate self-harm. Eight psychiatrists and 10 nurses were interviewed. The interviews underwent thematic analysis by an interdisciplinary group of experts in ethics, law, mental health nursing, and psychiatry. Three themes were found. The first theme focused on *role-specific tasks and perceived responsibility*. Psychiatrists more often emphasized the legal perspective and specialist nurses the ethical perspective. The second theme was to *adapt to other professionals' opinions*. When someone else had made a decision, autonomy was perceived to decrease, whereas responsibility increased. The third theme was *renunciation of autonomy for achieving cooperation*. It was considered important to strive for consensus in the team. Both nurses and psychiatrists believed they had a high degree of autonomy and responsibility when their roles were well-defined. The respondents considered clear roles, good communication, shared expectations, and mutual respect to be prerequisites for interprofessional collaboration in hospital care of patients with deliberate self-harm.

ARTICLE HISTORY

Received 18 June 2024
Revised 13 March 2025
Accepted 14 March 2025

KEYWORDS

Autonomy; deliberate self-harm; interdisciplinarity; interprofessional collaboration; psychiatric care; responsibility

Introduction

Interprofessional collaboration is the process by which different healthcare and social care professional groups work together to positively impact quality of care (World Health Organization, 2010). Collaboration between healthcare professions is characterized by different disciplines working together in a problem-focused way, and also involves the sharing of objectives, responsibility, decision-making, and power (Petri, 2010). Recently, constructive collaboration between healthcare professions has received increased interest from researchers as well as governments and organizations, as one way to improve healthcare (Engel & Prentice, 2013; Reeves et al., 2017; Tomizawa et al., 2017). Results from an increasing number of studies are indicative of the benefits of such collaboration, for both patients (L. Kaiser et al., 2022) and professionals (S. Kaiser et al., 2018; Zorek et al., 2021). Despite this, very little focus has been on interprofessional collaboration in hospital care of patients with deliberate self-harm (DSH) (National Institute for Health and Care Excellence [NICE], 2022; Nawaz et al., 2021).

Background

In the last decades, there has been increasing interest in improving the care of patients with DSH, defined as any form of self-inflicted injury or poisoning (Mughal et al., 2023). This has led to an upsurge in research, and many

specific treatments have been evaluated and implemented (Witt et al., 2021). The treatments shown to be successful are mainly psychological interventions delivered in outpatient clinics. However, there is a lack of knowledge about how to provide effective inpatient care (Nawaz et al., 2021). It has also been suggested that there is a need for improvements in the attitudes of professionals treating patients with DSH in hospitals (Holth et al., 2018; Lindgren et al., 2018; Tully et al., 2023).

In psychiatric wards, patients with DSH evoke strong emotions among professionals, including negative attitudes (Baker & Maude, 2021; Dickinson & Hurley, 2012; O'Connor & Glover, 2017). Professionals have reported their relationships to patients with DSH to be fear-based and emotionally demanding and experience the care as burdensome (O'Connor & Glover, 2017). At the same time, patients are dissatisfied with their care, experiencing it as meaningless and without meaningful content (Lindgren et al., 2018; Owens et al., 2020). The focus of care becomes restrictions for safety and prevention of DSH, despite the belief that such actions are insufficient (Baker & Maude, 2021; Murphy et al., 2019) and they have not been verified as effective for reducing self-harm (Mughal et al., 2023).

Researchers have shown that nurses and physicians sometimes have different perspectives and opinions on the care of patients with DSH (Baker & Maude, 2021) as well as a lack of clear division of responsibilities within care (Holth et al., 2018). Unclear professional roles for physicians and nurses

lead to uncertainty regarding expertise and responsibilities, which may affect interactions with patients with DSH (MacDonald et al., 2021). In the treatment and care of patients with DSH, clear and defined professional roles are important (Hay et al., 2015).

A defined role, with clearly designated tasks, can clarify what duties and responsibilities a person can be held accountable for (Hay et al., 2015). Individuals are commonly seen to be morally responsible if they act freely and have sufficient knowledge (Fischer & Ravizza, 1998). The ethical responsibility of professionals can be understood both as related to the professional role and as a virtue. Role responsibility extends to tasks that are associated with a specific professional role, for example that of a physician or nurse. Some parts of this responsibility are codified in law (The Swedish Parliament, 2010). In contrast, responsibility as a virtue is the willingness and disposition to actively take responsibility, which goes beyond specific tasks and roles (Nihlen Fahlquist, 2019).

Responsibility and autonomy are closely connected, as only autonomous moral and legal agents can reasonably be held responsible for their actions. Autonomy refers to both capacity and right. Conceived as a capacity, the underlying idea is that all human beings are able to make decisions concerning their own life. This capacity is generally believed to entail the right to make such decisions. The principle of individual autonomy, aimed at protecting that right, is the core of medical ethics (Beauchamp & Childress, 2013). It is also commonly codified in law (Kindström Dahlin, 2014; Lind, 2014; Litins'ka, 2018; Rynning, 1994).

Against this background, our aim for this study was to explore how nurses and psychiatrists perceive and conceptualize their own responsibility and autonomy in relation to interprofessional colleagues when caring for inpatients with DSH. We wanted to know how nurses and psychiatrists think of their responsibility in relation to patients, situations when their responsibility is perceived as decreasing or increasing, and whether they are autonomous in their professional role.

Methods

Design

A qualitative descriptive study was performed as an interdisciplinary collaborative research project. In interdisciplinary studies, theories from two or more disciplines are integrated and synthesized (Repko, 2021). The design made it possible to get a comprehensive understanding of the research questions, one that was more complex than the sum of its parts. The authors are researchers in ethics, public law, psychiatric nursing, and child and adolescent psychiatry, with some of them working as psychiatrists or nurses in psychiatric care. The consolidated criteria for reporting qualitative studies (COREQ; Tong et al.,

2007) were used to determine aspects of the research team, the research methods, the study context, and the findings, analysis, and interpretations reported.

Participants

Registered nurses with advanced education in mental health nursing and psychiatrists were recruited from the psychiatric clinic at Uppsala University Hospital in Sweden. The recruitment was based on information about the study given at staff meetings and provided to ward managers. Posters were put up in both wards and staff rooms, and individual information was given to psychiatrists and psychiatric nurses who worked on the wards. We included only those who reported at least 1 year's experience of working with inpatients with DSH. All the professionals who wanted to participate in the study and met the criteria were invited to interviews. No participants had to be excluded. A total of 18 participants were included, 10 mental health nurses (five women) and eight psychiatrists (three women).

Data collection

This study is part of a larger project exploring both patients' and professionals' perceptions of responsibility and autonomy in psychiatric hospital care of patients with DSH. This part of the project focuses on professionals and interprofessional collaboration. An interview guide with semi-structured questions was developed by the research team based on previous research of professionals' attitudes and collaboration when treating patients with DSH. The semi-structured questions were followed by probing questions if needed to clarify any particular area to get rich data that would be able to answer the research questions. The interview guide was tested in a pilot interview, to investigate how well the contents of the questions covered the area of interest. A few minor changes were made based on this pilot. The pilot interview was not included in the analysis. Before the interviews were conducted, the research team reviewed and discussed the interview guide thoroughly, to gain a shared understanding of the questions, thereby minimizing the risk of misunderstandings during the interviews. The interviews were conducted by four members of the research group (JL, EL, CÖ, MR), all familiar with semi-structured interviewing and care of patients with DSH. Twelve of the interviews were conducted during 2022 and six during 2023. The interviews, with an average length of 35 min (range 20–53), were recorded and transcribed verbatim. Please see Table 1 for the questions used in this part of the project.

Table 1. Interview questions used for data collection.

Q1	Do you have experience of caring for patients with DSH? If yes, please describe it.
Q2	Do you have experience of coercive measures related to caring for patients with DSH? If yes, please describe it.
Q3	What is your view of your responsibility in relation to patients in care due to DSH?
Q4	What in a caring situation can make you perceive that your responsibility decreases? Please describe. (Was it positive or negative?)
Q5	What in a caring situation can make you perceive that your responsibility increases? Please describe. (Was it positive or negative?)
Q6	Autonomy or self-determination is something that psychiatric care can affect. What does autonomy mean to you?
Q7	What is your view of your possibilities to make decisions based on your competence? (workplace, managers, colleagues, culture) Please give examples.

Data analysis

The data were analyzed using thematic analysis as described by Braun and Clarke (2006, 2023). To integrate the perspectives provided by the different interdisciplinary researchers in the collaborative analysis, inspiration was taken from Richards and Hemphill (2018). In the first step, all researchers read the material from the first 12 interviews individually. In the second step, the researchers had a group discussion of potential themes. After that, two of the researchers (EL & JL) worked together, created a pilot codebook, and made a first selection of text that seemed to fit the themes. Codes were inserted in the codebook under the corresponding themes. In the third step, the whole research group met several times and discussed the potential themes, sorted and resorted them, and made any necessary changes to the codebook. The second group of interviews ($n = 6$) were analyzed by one of the authors (EL). After the texts were read, codes were inserted into the codebook under the corresponding themes, also looking for any new potential themes. Data from the second data collection did not contribute to new themes or subthemes but provided some new information and confirmed the data analysis. In the last step, the whole research group processed the final themes repeatedly and went back-and-forth between them and the original text to determine that they were the most fitting themes.

Ethical considerations

The study was approved by the Swedish Ethical Review Authority (2021–02298) and performed in accordance with both legal requirements and ethical guidelines of the Helsinki Declaration (World Medical Association, 2013). The participants received verbal and written information about the aim of the study, that the interviews were recorded, that the study was voluntary, and that they could withdraw from the study at any point until publication, without needing to give any reason. All participants gave written consent to participate in the study. Data protection rules and rules relating to sound research were respected throughout the research process.

Results

Three themes were identified, representing how nurses and psychiatrists perceive and conceptualize their own responsibility and autonomy in relation to interprofessional colleagues when caring for inpatients with DSH: (a) Specific tasks and perceived responsibility, (b) Adapt to other professionals'

opinions, and (c) Renunciation of autonomy to achieve collaboration. See Table 2 for themes and subthemes. The themes and subthemes are described below, and representative quotations are used to illustrate how the findings and interpretations are related to the data. The respondents are indicated as P (psychiatrist) or N (nurse).

Specific tasks and perceived responsibility

This theme captured the participants' views of their responsibilities as a nurse or a psychiatrist. Generally, the participants viewed themselves as autonomous and not influenced by other colleagues in taking responsibility. Nurses and psychiatrists described their responsibilities related to ethical and legal perspectives, and also said that sometimes legal requirements contradict ethical standards and that created a conflict within them. Nurses described a strong sense of responsibility to safeguard the patient's perspective during care discussions in the team.

Responsibility associated with the professional role

Both psychiatrists and nurses emphasized the importance of providing good and evidence-based care. Both professional groups viewed themselves as completely autonomous in making decisions within their respective area of responsibility and related to how they perceived their professional role. The general view among psychiatrists was that they had overall responsibility for the care of the patients as well as the staff on the ward. Members of both professional groups stated that the psychiatrists had the ultimate responsibility for the patients and the care.

P1: If I make a decision and recommend that the patient undergoes a specific care intervention, that's on me, I can't share that responsibility with anyone else." Nurses, on the other hand, said that they had full responsibility for their own assessments when they planned care.

N18: Yeah, that's a positive thing, being responsible for your own assessments, being able to plan things without having to ask anyone [psychiatrist], being able to do things together with the care team, that increases your sense of responsibility.

The ethical good in a legal grey area

The participants had to deal with and make decisions balancing patient safety against patients' autonomy. Psychiatrists underlined their legal responsibility, and the importance of acting in accordance with the law, whereas nurses often emphasized the ethical aspects of the relevant legislative acts. P17: "I need to make this decision [on coercive measures] with

Table 2. Themes and subthemes identified in the analysis.

Theme	Subtheme
Role-specific tasks and perceived responsibility	Responsibility associated with the professional role The ethical good in a legal gray area The patient's advocate
Adapt to other professionals' opinions	Adapting to legacy assessments Dealing with questionable decisions Being ascribed responsibility
Renunciation of autonomy to achieve collaboration	Navigating consensus Collective responsibility Power to influence decision-making

your [patient's] best interests in mind, even if you [the patient] don't agree with me; we'll be doing this anyway."

Nurses described their ethical responsibility as doing what they perceived was important for the patient and respecting the patient's will and autonomy, even when the patient refused medical measures. Sometimes, the nurses were torn between adhering to physicians' decisions or trying to convince the patient and listening to what the patient wanted.

N6: But that the patient should also be able to refuse interventions that are not life-saving, that's something I'm passionate about, and that's something that maybe psychiatrists and nurses view a bit differently . . . but the difference is that the psychiatrist doesn't administer the medicine, it's my job to get the patient to actually take it.

The patient's advocate

Nurses stated that they sometimes believed they had a responsibility to advocate for the patient and account for the patient's perspective when a psychiatrist was about to make decisions concerning care. This was particularly important when decisions were considered to go against a patient's wishes. The nurses believed that they had to explain the patient's views even if they did not agree, to make sure that the opinions of the patient were presented to the psychiatrist. N7: "(. . .) but also that I don't need to say that I agree with the patient, but I do need to convey [to the psychiatrist] what is important to my patient."

Adapt to other professionals' opinions

When the participants' freedom of action was affected by decisions made by colleagues, they experienced either less responsibility or an unwanted burden of responsibility. There were also descriptions of how adapting to other professionals' opinions could lead to the experience of limited autonomy in their professional role.

Adapting to legacy assessments

The participants described an obstacle to making autonomous decisions when someone had previously made assessments they disagreed with but had to adapt to. This led to the belief that their own responsibility decreased and to a reduced sense of autonomy.

P3: If you come into a situation where someone has started to self-harm and the staff has already isolated the person, or restrained them, then I can't do, it's already done, so that takes away my possibility to take the responsibility and do what I think is best.

However, if participants had to bear the consequences of a decision made by someone else that they did not fully agree with, they believed that their responsibility increased. This was because they had to deal with those consequences, which could include a patient's negative reactions.

N12: It's very handy when someone makes a decision over my head, when a psychiatrist takes that responsibility, but if it's a psychiatrist who doesn't know the patient, where I know that the end result will be that the patient self-harms . . . then I have to bear the consequences.

Dealing with questionable decisions

This subtheme showed that decisions made by colleagues were sometimes perceived as being based on insufficient knowledge. This led to frustration if the quality of care was affected. Both psychiatrists and nurses believed they had a need to be loyal to their colleagues and stand behind decisions made, even if they knew a decision was ethically flawed. N10: "It becomes clear that she's been restrained on occasions where I and many others, who were more experienced, reacted very strongly, that we would never have used that method, it was used in the wrong way."

Being ascribed responsibility

This subtheme captured statements on the importance of being trusted as a capable psychiatrist or nurse able to take on responsibility. Psychiatrists described that they could make decisions and be responsible on the ward when their medical director trusted them. P15: "I have a medical director who I trust and who trusts me, which means that I have extremely large possibilities to make decisions."

Nurses believed that they had to prove themselves as capable in order to earn trust and be allowed to make autonomous decisions. This was easier if they knew a psychiatrist and the psychiatrist trusted their judgment.

N18: It depends on what managers you have, which psychiatrists you collaborate with, if you have someone who takes over a lot, you almost become like an assistant on the ward, as a nurse, which decreases your responsibility. (. . .) then all the responsibility might fall on the psychiatrist.

Nurses could gain and strengthen their responsibilities and autonomy by staying up-to-date with new knowledge, and trusting what they believed was right.

N10: In a situation where a patient is maybe actively self-harming and where I notice that I maybe know, or in the situation notice that the staff I'm working with don't really know how to manage that or are managing it in the wrong way, then I feel greater responsibility to make sure that it becomes, yeah, that the end result is positive.

Renunciation of autonomy to achieve collaboration

The importance of collaboration was underscored in this theme. Having good lines of communication and discussing care were seen as important. The participants agreed that they ultimately had to stand united behind decisions and set their own agenda aside, whatever their personal opinions were on how to handle situations and plan care.

Navigating consensus

The professionals described how they worked together to find a consensus. They relied on each other to make decisions. A consensus was seen as something positive to strive for, even if autonomy and power had to be set aside. This was achieved by discussions in the team, where all the professional roles and everyone's knowledge and experience were seen as important. N11: "But I still feel that we have a pretty good atmosphere for discussion and that there is a sense of humility, that it's not like one person has the right answer."

Collective responsibility

When professionals were striving for the same goal for a patient, there was a sense of collective responsibility. This happened when the care plan was clear, and the participants believed that they were part of a chain of care. The tasks were then well defined, everyone knew who was responsible for what, and they also believed they were united as professionals in support of the decisions made. The nurses and psychiatrists believed they were responsible for the group's actions as a whole. This was perceived as particularly important when caring for people with DSH. N9: "(...) you are united as staff, you say the same things, you interact with the person in the same way, and do what you've said that you'll do, to put it simply."

Power to influence decision-making

This subtheme included descriptions of discussions within teams and how professionals influenced each other's attitudes and opinions. This was described by the participants as an ongoing process that often resulted in adjustments in care, so that all the professionals in the team would be satisfied with the final decision. The psychiatrists could decide to discuss matters with nurses to make better decisions, whereas nurses stated that they sometimes actively tried to influence a psychiatrist's decision when they thought they had better knowledge of a patient's situation. N14: "Mm, because I've heard from a specialist that I can, in a positive sense, be manipulative and always get what I want."

Discussion

We aimed to explore how nurses and psychiatrists perceive and conceptualize their own autonomy and responsibility in relation to interprofessional colleagues and colleagues from the same profession when they cared for patients with DSH. The following three themes were identified: *role-specific tasks and perceived responsibility*, *adapt to other professionals' opinions*, and *renunciation of autonomy to achieve cooperation*. The professionals described how collaboration with colleagues could affect the possibility of being autonomous and taking responsibility.

Both nurses and psychiatrists described their professional responsibilities and emphasized the importance of taking responsibility for good-quality care of patients with DSH. While psychiatrists often referred to the legal and medical aspects of this responsibility, nurses more often focused on the ethical perspective and emphasized the ethical consequences of the decisions made. Professionals have described the care of patients with self-harm as challenging, involving ethical dilemmas, a lack of structure, and conflicts among healthcare staff (Holth et al., 2018; O'Connor & Glover, 2017). The importance of effective communication is commonly cited in the literature on interprofessional collaboration (Wei et al., 2022) and it has been found that if differing views on responsibility are not identified and discussed, this can negatively affect collaborative practice (Petri, 2010).

Nurses in this study stated that they, at times, had to act as the *patient's advocate*. Nurses described how they executed the administration of prescribed medication to

patients. In contrast to the psychiatrists, the nurses could have an ethical dilemma if a patient refused to take medication, where they either had to choose to adhere to the prescription of the psychiatrist and persuade the patient or respect the patient's autonomy. Nurses have previously described that their professional role includes the responsibility to safeguard, preserve, and represent the best interests and rights of the patient (Heck et al., 2022; Munday et al., 2015). The concept of "patient advocacy" is in the code of ethics for nurses (International Council of Nurses, 2021). Actions taken by nurses to achieve this could be conceptualized as related to responsibility as a virtue. This involves the willingness and disposition to actively take responsibility. This notion could be contrasted with the role-related responsibility of nurses (Nihlen Fahlquist, 2019). In psychiatric care, nurses describe that they make decisions seeking to preserve patient safety, especially when treatment limits a patient's freedom (Heck et al., 2022). The ambiguity of responsibility as a virtue or responsibility assigned to the nurse role could lead to conflicts in collaborations between professionals, although this was not seen in our study. Further, the role as a patient advocate has been related to nurses' autonomy, and could challenge the power dynamics between medical and nursing professionals (Heck et al., 2022). Psychiatrists in our study described that they had the overall responsibility for the care, which could result in nurses becoming subordinated in a structure that would not take advantage of all professionals' competencies (House & Havens, 2017). However, this was not described by the professionals. In contrast, both professions described how they balanced power with retained respect.

When participants had to *adapt to other professionals' opinions and to legacy assessments* both nurses and psychiatrists believed that their autonomy was reduced. Depending on how they dealt with the consequences of this adjustment they could perceive their responsibility to be either increased or decreased. In a Swedish study, Lundahl et al. (2022) found that psychiatric hospital staff believed that they had to adapt to decisions made by psychiatrists. The hospital stays for patients with DSH, decisions made by psychiatrists, were perceived to be too long and not beneficial for patients. The staff described the reasons for this as being related to psychiatrists' fear of discharging patients due to the risk of suicidal behavior and the fear of complaints and litigations (Lundahl et al., 2022). The specific topic of length of stay was not mentioned by any of the interviewed professionals in our study, nor did they provide any general descriptions of the other group. They talked more about individuals, and the difference between experienced and non-experienced physicians, and nurses. The subtheme *adapt to legacy assessments* is linked to the subtheme *dealing with questionable decisions*, as participants described their dissatisfaction with how a situation had been handled but still had to accept what had already been decided and work from those premises. Previous literature has described that nurses and physicians sometimes have different opinions on how care should take place (Baker & Maude, 2021), which might be one explanation for the dissatisfaction when the care was not in line with the participant's opinions.

Both nurses and psychiatrists described the importance of *being ascribed responsibility* to be autonomous. Nurses believed that, to be trusted, they had to prove their competence – even if they had an advanced education in mental health nursing. This could happen when they had to work with psychiatrists they did not know very well. This might be explained by these groups' differing perspectives on their respective roles as professionals at the ward. Psychiatrists may not know exactly what competence to expect from nurses. While nurses focus on shared decision-making and planning care around a patient, physicians often report that they themselves are ultimately responsible for the care and decisions (House & Havens, 2017). Physicians expressed an interest in having nurses assist them and answer questions about patients in such situations (House & Havens, 2017). Another explanation of the two groups' different perspectives could be the hierarchical structure. Both unclarity in roles and power dynamics within teams (Wei et al., 2022), as well as a patriarchal relationship between nurses and physicians (Abbas et al., 2022), have been identified as having a negative impact on communication and impairing collaboration in care settings. Clarification of roles is of importance for mutual respect and trust between professionals, as the roles and expectations of professionals in the care of patients with DSH are not always clear (Hay et al., 2015; MacDonald et al., 2021).

A strong collaboration was perceived by both nurses and psychiatrists as highly beneficial for the care of patients with DSH. All participants perceived *a collective collaboration* as something positive. Interestingly, they described that they were willing to withdraw from their autonomy for the benefit of collaboration. This became evident in the subtheme *navigating consensus*: making the best decisions for the patient was considered to be more important than the nurses' and psychiatrists' own opinions. A review found that professionals in healthcare are constantly contributing to collaboration, and two main activities could be identified: bridging professional and task-related gaps and negotiating overlaps in roles and tasks (Schot et al., 2020). Both of these activities can be interpreted as navigating to achieve consensus and minimize disagreements.

Schot et al. (2020) found that nurses are more engaged in bridging gaps than physicians, which might highlight nurses' central position in information flows within collaborative settings. Physicians are more engaged in negotiating overlaps than nurses, suggesting that they take the leading role in finding a feasible division of labor (Schot et al., 2020). Collaborating by navigating consensus corresponds with the subtheme *power to influence decision-making*, describing how participants influenced each other's decisions and planning of the care, which could be interpreted as the description of bridging professional gaps and negotiating tasks (Schot et al., 2020). Further, collaboration can be described as a social process encompassing the exchange of information and ideas focused on the patient's progress (Fewster-Thuente, 2015; Petri, 2010; Wei et al., 2022). The results of our study indicate that the ability to set personal agendas aside in an environment of respect is important for a true interprofessional collaboration, aiming to make the best decisions for patients with DSH.

Nurses and physicians can have different opinions of clinical care measures for patients with DSH, which leads to fragmented and unclear care (Baker & Maude, 2021; Holth

et al., 2018; MacDonald et al., 2021). At the same time, both healthcare professionals and patients with DSH express their dissatisfaction with care (Lindgren et al., 2018; Owens et al., 2020).

In this study, both professions highlighted the importance of a shared goal and effective collaboration in the care of patients with DSH. Education programs have to incorporate interprofessional learning activities in which students work together and improve their understanding of their respective professions and prepare them for their coming professional life (Centre for the Advancement of Interprofessional Education (CAIPE), 2002). By getting a better understanding of each other's perspectives, values, and dilemmas that come with professional roles, a closer collaboration could be formed (World Health Organization, 2010). We believe this is crucial for future care, as it would benefit patients as well as healthcare professionals and thereby improve health outcomes.

Strength and limitations

A strength of the study is that the number of participants was relatively large and included both nurses and psychiatrists. The study is unique in that the result was analyzed by an interdisciplinary research group with experts in ethics, law, medicine, and nursing. This has given broader perspectives and a possibility to cast light on aspects outside of each single discipline, where thinking often becomes based on conventions. This study is part of a larger project, meaning that the data supporting the aim – responsibility and autonomy within interprofessional work – had to be identified in the interviews. Other parts of the interviews focused on how professionals related to patients. A limitation in this study is that all interviews were conducted at the same university hospital, meaning that the workplace culture may have been homogenous. Perceptions and experiences in other care contexts may differ.

Conclusion

This study shows how nurses and psychiatrists try to set hierarchical structures and their own autonomy aside, to achieve a functional collaboration and shared responsibility to offer high-quality care to the vulnerable group of patients who self-harm. The study also shows some of the struggles nurses and psychiatrists face in doing this. Previous researchers have identified that hierarchical structures, role confusion, and diverse opinions are common in the care of patients with DSH. The willingness to collaborate, reported by the participants, indicates that there is an ongoing change in attitudes and that there may be an increase in interprofessional skills among psychiatric staff, compared with earlier studies. However, we believe that a better understanding of each other's perspectives and values would improve collaboration further between professionals in psychiatric care and could also lead to a more cohesive care for the patients.

Acknowledgements

The authors thank all the participating staff for their willingness to share their thoughts and experiences with us.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The author(s) reported there is no funding associated with the work featured in this article.

ORCID

Elina Löfström  <http://orcid.org/0009-0005-8374-7840>
 Jessica Nihlén Fahlquist  <http://orcid.org/0000-0001-9683-7005>
 Johanna Lagerkvist  <http://orcid.org/0009-0007-1612-5915>
 Anna-Sara Lind  <http://orcid.org/0000-0002-3520-5220>
 Mia Ramklint  <http://orcid.org/0000-0001-8203-8755>
 Caisa Öster  <http://orcid.org/0000-0003-2744-0586>

References

- Abbas, S., Zakar, R., Fischer, F., & Gilani, A. (2022). Challenges perceived by nursing professionals in physician-centred organizations: An exploratory qualitative study. *International Nursing Review*, 69(3), 384–391. <https://doi.org/10.1111/inr.12741>
- Baker, N., & Maude, P. (2021). What are nursing attitudes to youth who engage in self-harm? An integrative review. *Issues in Mental Health Nursing*, 42(5), 473–483. <https://doi.org/10.1080/01612840.2020.1806963>
- Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics* (7th ed.). Oxford University Press.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2023). Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a knowing researcher. *International Journal of Transgender Health*, 24(1), 1–6. <https://doi.org/10.1080/26895269.2022.2129597>
- Centre for the Advancement of Interprofessional Education. (2002). *Interprofessional education - A definition*. Author. www.caipe.org.
- Dickinson, T., & Hurley, M. (2012). Exploring the antipathy of nursing staff who work within secure healthcare facilities across the United Kingdom to young people who self-harm. *Journal of Advanced Nursing*, 68(1), 147–158. <https://doi.org/10.1111/j.1365-2648.2011.05745.x>
- Engel, J., & Prentice, D. (2013). The ethics of interprofessional collaboration. *Nursing Ethics*, 20(4), 426–435. <https://doi.org/10.1177/0969733012468466>
- Fewster-Thuente, L. (2015). Working together toward a common goal: A grounded theory of nurse-physician collaboration. *Medsurg Nursing*, 24(5), 356–362. <https://www.ncbi.nlm.nih.gov/pubmed/26665873>
- Fischer, J. M., & Ravizza, M. (1998). *Responsibility and control: A theory of moral responsibility*. Cambridge University Press.
- Hay, A., Majumder, P., Fosker, H., Karim, K., & O'Reilly, M. (2015). The views and opinions of CAMHS professionals on their role and the role of others in attending to children who self-harm. *Clinical Child Psychology and Psychiatry*, 20(2), 289–303. <https://doi.org/10.1177/1359104513514068>
- Heck, L. O., Carrara, B. S., Mendes, I. A. C., & Arena Ventura, C. A. (2022). Nursing and advocacy in health: An integrative review. *Nursing Ethics*, 29(4), 1014–1034. <https://doi.org/10.1177/09697330211062981>
- Holth, F., Walby, F., Rostbakken, T., Lunde, I., Ringen, P. A., Ramleth, R. K., Romm, K. L., Tveit, T., Torgersen, T., Urnes, O., & Kvarstein, E. H. (2018). Extreme challenges: Psychiatric inpatients with severe self-harming behavior in Norway: A national screening investigation. *Nordic Journal of Psychiatry*, 72(8), 605–612. <https://doi.org/10.1080/08039488.2018.1511751>
- House, S., & Havens, D. (2017). Nurses' and physicians' perceptions of nurse-physician collaboration: A systematic review. *The Journal of Nursing Administration*, 47(3), 165–171. <https://doi.org/10.1097/NNA.0000000000000460>
- International Council of Nurses. (2021). *The ICN code of ethics for nurses*. https://www.icn.ch/system/files/2021-10/ICN_Code-of-Ethics_EN_Web_0.pdf
- Kaiser, L., Conrad, S., Neugebauer, E. A. M., Pietsch, B., & Pieper, D. (2022). Interprofessional collaboration and patient-reported outcomes in inpatient care: A systematic review. *Systematic Reviews*, 11(1), 169. <https://doi.org/10.1186/s13643-022-02027-x>
- Kaiser, S., Patras, J., & Martinussen, M. (2018). Linking interprofessional work to outcomes for employees: A meta-analysis. *Research in Nursing & Health*, 41(3), 265–280. <https://doi.org/10.1002/nur.21858>
- Kindström Dahlin, M. (2014). *Psykiatrirität - Intressen, rättigheter & principer*. [Psychiatric Law - interests, rights & principles] [Doctoral dissertation]. Stockholm University. <https://libris.kb.se/48g5p7991bxsf2#it>
- Lind, A.-S. (2014). The right to health in Sweden. In C. Flood & A. Gross (Eds.), *The right to health at the public/private divide - A global comparative study* (pp. 51–78). Cambridge University Press.
- Lindgren, B. M., Svedin, C. G., & Werko, S. (2018). A systematic literature review of experiences of professional care and support among people who self-harm. *Archives of Suicide Research*, 22(2), 173–192. <https://doi.org/10.1080/13811118.2017.1319309>
- Litins'ka, Y. (2018). *Assessing capacity to decide on medical treatment: On human rights and the Use of medical knowledge in the laws of England, Russia and Sweden* [Doctoral dissertation]. Uppsala University. <https://uu.diva-portal.org/smash/get/diva2:1257439/FULLTEXT01.pdf>
- Lundahl, A., Helgesson, G., & Juth, N. (2022). Hospital staff at most psychiatric clinics in Stockholm experience that patients who self-harm have too long hospital stays, with ensuing detrimental effects. *Nordic Journal of Psychiatry*, 76(4), 287–294. <https://doi.org/10.1080/08039488.2021.1965213>
- MacDonald, S., Sampson, C., Biddle, L., Kwak, S. Y., Scourfield, J., & Evans, R. (2021). Theorising health professionals' prevention and management practices with children and young people experiencing self-harm: A qualitative hospital-based case study. *Sociology of Health and Illness*, 43(1), 201–219. <https://doi.org/10.1111/1467-9566.13211>
- Mughal, F., Burton, F. M., Fletcher, H., Lascelles, K., O'Connor, R. C., Rae, S., Thomson, A. B., & Kapur, N. (2023). New guidance for self-harm: An opportunity not to be missed. *British Journal of Psychiatry*, 223(5), 501–503. <https://doi.org/10.1192/bjp.2023.113>
- Munday, J., Kynoch, K., & Hines, S. (2015). Nurses' experiences of advocacy in the perioperative department: A systematic review. *Joanna Briggs Institute Database of Systematic Reviews and Implementation Reports*, 13(8), 146–189. <https://doi.org/10.11124/jbisrir-2015-2141>
- Murphy, C., Keogh, B., & Doyle, L. (2019). 'There is no progression in prevention' - the experiences of mental health nurses working with repeated self-harm. *International Journal of Mental Health Nursing*, 28(5), 1142–1151. <https://doi.org/10.1111/inm.12626>
- National Institute for Health and Care Excellence. (2022). *Evidence review for therapeutic risk taking strategies: Self-harm: Assessment, management and preventing recurrence*. National Institute for Health and Care Excellence (NICE). PMID:36595603.
- Nawaz, R. F., Reen, G., Bloodworth, N., Maughan, D., & Vincent, C. (2021). Interventions to reduce self-harm on in-patient wards: Systematic review. *British Journal of Psychiatry Open*, 7(3), e80. <https://doi.org/10.1192/bjo.2021.41>
- Nihlén Fahlquist, J. (2019). *Moral responsibility and risk in society: Examples from emerging technologies, public health and environment*. Routledge.
- O'Connor, S., & Glover, L. (2017). Hospital staff experiences of their relationships with adults who self-harm: A meta-synthesis. *Journal of Psychology & Psychotherapy*, 90(3), 480–501. <https://doi.org/10.1111/papt.12113>
- Owens, C., Fox, F., Redwood, S., Davies, R., Foote, L., Salisbury, N., Williams, S., Biddle, L., & Thomas, K. (2020). Measuring outcomes in trials of interventions for people who self-harm: Qualitative study of service users' views. *British Journal of Psychiatry Open*, 6(2), e22. <https://doi.org/10.1192/bjo.2019.93>

- Petri, L. (2010). Concept analysis of interdisciplinary collaboration. *Nursing Forum*, 45(2), 73–82. <https://doi.org/10.1111/j.1744-6198.2010.00167.x>
- Reeves, S., Pelone, F., Harrison, R., Goldman, J., & Zwarenstein, M. (2017). Interprofessional collaboration to improve professional practice and healthcare outcomes (review). *Cochrane Database of Systematic Reviews*, 2018(8). <https://doi.org/10.1002/14651858.CD000072.pub3>
- Repko, A. F. (2021). *Interdisciplinary research process and theory*. (4th ed.). SAGE Publications, Inc.
- Richards, K. A. R., & Hemphill, M. A. (2018). A practical guide to collaborative qualitative data analysis. *Journal of Teaching in Physical Education*, 37(2), 225–231. <https://doi.org/10.1123/jtpe.2017-0084>
- Rynning, E. (1994). *Samtycke till medicinsk vård och behandling, en rättsvetenskaplig studie*[Consent to medical care and treatment: A legal study] [Doctoral dissertation]. Uppsala University. Iustus ISSN 0282-2040; 44.
- Schot, E., Tummers, L., & Noordegraaf, M. (2020). Working on working together. A systematic review on how healthcare professionals contribute to interprofessional collaboration. *Journal of Interprofessional Care*, 34(3), 332–342. <https://doi.org/10.1080/13561820.2019.1636007>
- The Swedish Parliament. (2010). *Patientsäkerhetslagen* [Swedish Patient Safety Act] https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/patientsakerhetslag-2010659_sfs-2010-659/
- Tomizawa, R., Shigeta, M., & Reeves, S. (2017). Framework development for the assessment of interprofessional teamwork in mental health settings. *Journal of Interprofessional Care*, 31(1), 43–50. <https://doi.org/10.1080/13561820.2016.1233098>
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal of Quality in Health Care*, 19(6), 349–357. <https://doi.org/10.1093/intqhc/mzm042>
- Tully, S. M., Bucci, S., & Berry, K. (2023). “My life isn’t my life, it’s the systems”: A qualitative exploration of women’s experiences of day-to-day restrictive practices as inpatients. *Journal of Psychiatric & Mental Health Nursing*, 30(1), 110–122. <https://doi.org/10.1111/jpm.12855>
- Wei, H., Horns, P., Sears, S. F., Huang, K., Smith, C. M., & Wei, T. L. (2022). A systematic meta-review of systematic reviews about interprofessional collaboration: Facilitators, barriers, and outcomes. *Journal of Interprofessional Care*, 36(5), 735–749. <https://doi.org/10.1080/13561820.2021.1973975>
- Witt, K. G., Hetrick, S. E., Rajaram, G., Hazell, P., Taylor Salisbury, T. L., Townsend, E., & Hawton, K. (2021). Psychosocial interventions for self-harm in adults. *Cochrane Database Systematic Reviews*, 4(4), CD013668. <https://doi.org/10.1002/14651858.CD013668.pub2>
- World Health Organization. (2010). Framework for action on interprofessional education and collaborative practice. *JAMA*. <https://apps.who.int/iris/handle/10665/70185>
- World Medical Association. (2013). World medical association declaration of Helsinki. ethical principles for medical research involving human subjects. *JAMA*, 310(10), 2191–2194. <https://doi.org/10.1001/jama.2013.281053>
- Zorek, J. A., Lacy, J., Gaspard, C., Najjar, G., Eickhoff, J., & Ragucci, K. R. (2021). Leveraging the interprofessional education collaborative competency framework to transform health professions education. *American Journal of Pharmaceutical Education*, 85(7), 8602. <https://doi.org/10.5688/ajpe8602>