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Staff experiences of team case formulation in Psychiatric Inpatient Rehabilitation settings: a grounded theory study

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Submitted in partial fulfilment of the requirements for the degree of
Doctorate in Clinical Psychology

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Chapter 1

Clinicians' understanding, experiences and perceptions of trauma-informed care within adult psychiatric inpatient and rehabilitation settings: a qualitative evidence synthesis

Prepared in accordance with the author requirements for Frontiers of Psychology; [Frontiers in Psychology | Psychology for Clinical Settings](#)

Abstract

Background: Trauma-informed care (TIC) has been increasingly adopted within adult psychiatric inpatient and rehabilitation services to improve care for people with severe mental health presentations. While evidence suggests TIC may reduce restrictive practices and improve therapeutic relationships and promote recovery, less is known about the process of TIC and how clinical staff experience the implementation of it in everyday practice.

Aim: To synthesise qualitative evidence exploring clinical staff's understandings, experiences and perceptions of TIC within adult psychiatric inpatient and rehabilitation settings.

Methods: A systematic search of MEDLINE, PsycINFO, CINAHL and EMBASE identified six eligible studies, reported across seven publications. Data were synthesised using a constructivist grounded theory approach.

Results: The synthesis constructed TIC as representing a shift from achieving safety through control and hierarchy towards achieving safety through understanding, collaboration and choice. Staff reported greater understanding of trauma, shifted perspectives of patients' life experiences, working more collaboratively and becoming more emotionally reflective in their practice following the implementation of trauma-informed interventions. However, these changes were highly dependent on organisational context. Leadership, psychological safety, adequate staffing and organisational commitment facilitated implementation, whereas competing demands, staff shortages and cultures characterised by fear or blame constrained trauma-informed practice.

Conclusions: Trauma-informed care should be understood as a complex organisational intervention. The grounded theory constructed in this review suggests that organisational conditions shape staff's ability to adopt trauma-informed practice and influence whether safety is achieved through control or through understanding and collaboration. The model provides a foundation for future research exploring how organisations can create the conditions in which TIC can flourish, as well as how TIC may in turn influence the wider culture of inpatient and rehabilitation services.

Keywords: Clinical Psychology, Trauma Informed Care, Healthcare Staff Experience, Psychiatric Inpatient, Psychiatric Rehabilitation

Introduction

Trauma is highly prevalent among people who experience severe mental health difficulties (Grossman et al., 2021). Mauritz et al. (2013) estimated that around half of those in the mental health system had experienced physical abuse (range 25-72%) and more than one-third had experienced sexual abuse (range 24-49%). These high rates of trauma exposure among mental health service users can be further compounded by the fact that some aspects of psychiatric care may exacerbate previous trauma and psychiatric symptoms (Borckardt et al., 2007). A qualitative systematic review of adverse mental health inpatient experiences found that service users described power imbalances, feeling unsafe, poor communication and experiences of being traumatised or retraumatised while in hospital (Hallett et al., 2025).

Restrictive care practices (RCPs), including physical restraint, seclusion and chemical restraint are regarded as common therapeutic interventions to reduce violence or risk of harm in patients in inpatient settings. Belayneh et al. (2024) reported prevalence rates of 14.4% for physical restraint, 15.8% for seclusion and 25.7% for chemical restraint in adult mental health inpatient settings. Although these interventions may sometimes be necessary to maintain safety and can be lifesaving, they are associated with significant harmful physical and psychological effects (Chieze et al., 2019). RCPs have been linked to falls, bed sores, injuries, immobility, drug reactions, and other serious medical complications, including death (Whitecross et al., 2013). They are also frequently experienced by service users as anti-therapeutic, frightening, dehumanising and a violation of dignity (An et al., 2016; Griffin et al., 2025). For people with previous trauma histories, these experiences may reinforce threat-based responses and reduce trust in staff and services (Staniszewska et al., 2019).

Trauma is also highly prevalent among populations requiring inpatient rehabilitation care (Ranjbar & Erb, 2019). Rehabilitation services support individuals with particularly complex mental health difficulties, many of whom experience prolonged admissions and repeated contact with mental health services (Killaspy & Dalton-Locke, 2023). Service users may therefore be at increased risk of institutionalisation, dependency of services and reduced opportunities for autonomy and choice (Dalton-Locke et al., 2021). Rehabilitation settings have also been described as being dominated by biomedical models with an '*overwhelming faith to chemistry*' (Chadwick & Billings, 2022). Furthermore, considerable power imbalances

exist between staff and patients, with most patients detained under the mental health legislation (Whittle et al., 2024).

The quality of staff and patient relationships is a key determinant of outcomes within inpatient settings. However, frontline staff work in demanding environments characterised by frequent direct exposure to distress and aggression are at increased risk of burnout. Berry et al. (2016) reported that under conditions of high stress, limited support and poor understanding, staff may become more critical of patients, rely more heavily on restraints or reduce helping behaviour, thus potentially fuelling vicious cycles of negative interactions.

Trauma-informed care (TIC) emerged as a key paradigm for mental health services, recognising the pervasive impact of trauma and the potential for services themselves to retraumatise individuals if care is not shaped by an understanding of how trauma affects individuals (Sweeney et al., 2016). Although no universal definition of TIC is agreed upon (Hanson & Lang, 2016), most models are based on a common set of principles, including recognition of the impact of trauma, resistance to re-traumatisation, attention to cultural, historical and gender contexts, trustworthiness and transparency, collaboration and mutuality, empowerment, choice and control, safety, survivor partnerships, and pathways to trauma-specific care (SAMHSA, 2014; Sweeney et al., 2016).

Hanson and Lang (2016) further describe TIC as operating across three broad domains: workforce development, trauma-focused services, and organisational interventions.

Workforce development focuses on increasing staff knowledge of trauma and supporting staff wellbeing through addressing issues such as vicarious trauma and compassion fatigue. This is sometimes complimented by services involving the integration of trauma screening and evidence-based trauma interventions into routine care. And finally, organisational interventions focus on creating and sustaining trauma-informed systems through changes to policies, procedures, leadership and organisational culture.

As the evidence base for TIC continues to grow, organisational trauma-informed interventions and staff training have shown encouraging evidence of improved service quality, accessibility and service-user outcomes (Fernández et al., 2023). Within adult psychiatric inpatient settings, where trauma exposure is common and restrictive practices remain prevalent, TIC has increasingly been promoted as an alternative means of reducing

harm and supporting recovery (Kelly et al., 2023). For example, Borckardt et al. (2011) reported an 82% reduction in the use of seclusion and restraint following the implementation of a TIC care model and staff training programme over a 3.5-year period. Similarly, Nikopaschos et al. (2023) found that team formulation and psychological stabilisation training resulted in improved therapeutic engagement and ward culture while significantly reducing self-harm and restrictive interventions.

There is also emerging evidence examining the impact of TIC on staff. Purtle (2020) found that trauma-informed staff training resulted in significant improvement in staff knowledge, attitudes, and behaviour towards the patients. However, evidence regarding the sustainability of these changes and their translation into patient outcomes remains limited. Chandler (2008) similarly reported that staff developed collaborative relationships, implemented safety measures and prescribed more educational resources following the implementation of TIC. Despite these promising findings, little is known about how staff experience the process of implementing and sustaining TIC in everyday practice. It has been suggested that successful implementation of TIC depends heavily on how staff understand, interpret and carry out trauma-informed principles (Haines-Delmont et al., 2024; NHS, 2025). Qualitative studies suggest that while TIC may offer staff a more compassionate framework for making sense of service users' distress, its implementation can sometimes be constrained by organisational factors and existing institutional practices (Graham et al., 2024; F. Nikopaschos et al., 2025). A systematic synthesis of the qualitative evidence could provide a richer understanding of how TIC is experienced in practice by healthcare staff and the impact of it on services from stakeholder perspectives (Nikopaschos et al., 2023). The present review therefore aims to synthesise qualitative evidence on clinicians' understanding and experiences of TIC within adult psychiatric inpatient and rehabilitation settings. By bringing together findings across diverse contexts, this review seeks to develop a conceptual model of how staff experience TIC in practice and the organisational conditions that shape its implementation.

Methods

This review was conducted as a qualitative systematic review, synthesising findings from qualitative studies to address the review aims. A qualitative approach was selected because

the review sought to understand how clinicians understand and experience TIC within adult psychiatric inpatient and rehabilitation settings. Qualitative research is particularly well suited to exploring questions of experience and interpretation within the existing literature, as it enables an in-depth understanding of staff's subjective experiences of TIC in everyday clinical practice.

Registration

The systematic review protocol was registered with PROSPERO International Prospective Register of Systematic Reviews (CRD420261416300) on 05 June 2026. The review is reported in accordance with the PRISMA 2020 statement.

Search strategy

A systematic search of the literature was undertaken to identify qualitative studies exploring clinical staff's understanding and experiences of TIC within adult psychiatric inpatient and rehabilitation settings. The search strategy was developed using the SPIDER framework (Sample, Phenomenon of Interest, Design, Evaluation and Research type), which is considered particularly suitable for qualitative evidence syntheses (Cooke et al., 2012).

Electronic database searches were conducted in MEDLINE, PsycINFO, CINAHL, and EMBASE (search conducted on 19/02/2026). Search terms combined concepts relating to clinical staff, trauma-informed care, qualitative experiences and perspectives, and inpatient and rehabilitation settings. Search terms were adapted for each database and combined using Boolean operators. Reference lists of included studies were hand-searched and forward and backward citation tracking was undertaken to identify additional relevant studies. An example of the full search strategy can be found in Appendix B.

The search was restricted to studies published in English only. No date restrictions were applied due to the relatively recent emergence of TIC as an organisational model within mental health services. All search results were exported to reference management software Rayyan (2026) and duplicate records were removed prior to screening.

Eligibility criteria

Studies were eligible for inclusion if they explored clinicians' understandings, experiences or perceptions of TIC within adult psychiatric inpatient or psychiatric rehabilitation settings. Eligible participants included multidisciplinary mental health professionals working within

these services, such as nurses, psychiatrists, psychologists, occupational therapists, healthcare support workers and other ward-based professionals.

The phenomenon of interest was the implementation or evaluation of TIC within adult psychiatric inpatient or rehabilitation settings. This included studies evaluating the implementation of trauma-informed models of care or trauma-informed staff training, or other service initiatives intended to support trauma-informed practice.

The evaluation concerned clinical staff's understandings and experiences of TIC. This included how staff made sense of the TIC initiatives or their experiences of its implementation and perceived influence on everyday practice. Consequently, only qualitative studies employing methodologies such as thematic analysis, grounded theory, interpretative phenomenological analysis, content analysis, framework analysis and ethnography were eligible for inclusion. Mixed-methods studies were included where qualitative findings relating to staff perspectives could be extracted separately. Open-ended survey responses were included where they had undergone qualitative analysis.

Studies were excluded if they focused on child and adolescent inpatient services, forensic or secure psychiatric services, community mental health settings, primary care services, general medical hospitals or substance use services. Studies were also excluded where TIC was not the primary focus of investigation, where the focus was solely on trauma-specific therapeutic interventions such as EMDR or trauma-focused CBT, or where only quantitative outcome data were reported. Studies conducted across multiple service settings (e.g., inpatient and community services) were eligible only where findings relating specifically to adult psychiatric inpatient or rehabilitation settings could be clearly identified and extracted. Reviews, editorials, commentaries, conference abstracts and study protocols were excluded.

Study selection

Records were imported into Rayyan and duplicates removed. Titles and abstracts were screened against the eligibility criteria. Full texts of potentially relevant studies were retrieved and assessed for inclusion. A proportion (10%) of studies were independently screened by a second reviewer to enhance reliability. Disagreements were resolved through discussion until consensus was reached. The study selection process is reported using a PRISMA flow diagram (Figure 1).

Quality appraisal and data extraction

The methodological quality of included studies was assessed using the Critical Appraisal Skills Programme (CASP, 2018) qualitative checklist. All studies were appraised by the principal researcher and a random sample of three articles ($\approx 43\%$) was independently assessed by the second reviewer to ensure reliability in the quality appraisal process. An overview of the CASP ratings can be found in Table 3.

Descriptive study characteristics extracted included author(s), year of publication, country, study aims, service setting, participant characteristics, sample size, methodological approach, methods of data collection and analysis. The qualitative findings relevant to the review questions were then extracted separately and transferred into Microsoft Word for coding and analysis using the Constructivist Grounded Theory approach (Charmaz, 2014).

Method of synthesis

Constructivist Grounded Theory approach (Charmaz, 2014) was selected because the review sought not only to identify common themes across studies but also to develop a conceptual model to aid the understanding of how clinical staff experience and make sense of TIC within adult psychiatric inpatient and rehabilitation settings.

Analysis followed the constant comparative method, whereby data were continually compared within and across studies to identify patterns and relationships. Data extraction and analysis occurred concurrently, allowing emerging concepts to inform subsequent stages of coding and category development.

The findings sections of included studies, including participant quotations and authors' interpretations, were treated as the primary data for analysis. Initial coding involved line-by-line examination of extracted data to remain close to participants' accounts and minimise premature imposition of existing assumptions. Codes were compared across studies and refined through an iterative process of analysis. An example of the line-by-line coding excerpt can be found in Table 1.

Focused coding was then used to identify the most analytically significant and frequently occurring codes. These focused codes were applied across the dataset and used to synthesise larger segments of data. Through constant comparison, conceptually related

codes were grouped into provisional categories, which were progressively refined and developed throughout the analytic process.

Analytic memos were maintained throughout coding and synthesis to document emerging interpretations and reflexive observations. Memo-writing supported movement from descriptive coding towards higher-order categories.

As categories developed, relationships between them were explored to construct an explanatory account of staff experiences of TIC. Attention was given to both convergent and divergent findings across studies. The final stage of synthesis involved refining categories through discussions within supervision and integrating categories into a conceptual framework that captured the processes, conditions and contextual influences shaping staff understandings and experiences of TIC within inpatient and rehabilitation settings.

Table 1. Example of line-by-line coding

<i>Transcript text</i>	<i>Line codes</i>
<i>A participant described the process as such: “The Safety-First Plan helps staff think about how to work with patients differently. [To facilitate safety] takes someone else’s presence. [Safety] is more than just tasks; it takes presence, being aware, and intervening as [patients] are getting upset.”</i>	<i>Safety-First Plan helps staff think about how to work with patients differently. Safety is more than tasks. Safety is about presence, being aware, and intervening as patients are getting upset.</i>
<i>Another participant explained, We have an increased awareness of trauma behavior. We used to think that emotional lability was manipulative. Now we recognize [that this behavior] is a response to trauma. Cutting was seen as manipulative; now we know it can be a way to release emotions, a coping skill, so the staff response is more individualized. Now</i>	<i>Staff reported increased awareness of trauma behaviour. Staff used to think emotional lability was manipulative but now recognise is trauma response. Self-harm was seen as manipulative, now realise it’s a coping skill. Staff response is more individualised.</i>

<i>we include the patient in the plan. Through planned written exercises, we look at what are triggers, what are responses, and what are alternatives. We teach more skills for distractions. The Safety-First Plan takes the power struggle out and brings the patient in to collaborate.</i>	<i>Now include patient in the plan, through planned written exercises – look at triggers, responses and alternatives. Staff teach skills for distractions. Safety-First Plan takes the power struggle out and collaborates with the patient.</i>
--	--

Study 1, P 6, line 108 - 115

Reflexivity

Constructivist Grounded Theory (Charmaz, 2014) assumes that the meanings people assign to situations shape human behaviour. These meanings are influenced by individual's backgrounds, beliefs and experiences, and are actively constructed within social interactions. As such, meaning is viewed as a constructed process derived from the interaction between researcher and participants. Reflexivity therefore forms an integral part of the analytic process. In recognition of the role of the researchers' perspectives in the research process (Charmaz, 2014) the principal researcher responsible for study selection and data analysis maintained a reflective log throughout the conduct of the review (Appendix C). Regular research supervision also provided opportunities to reflect on emerging interpretations, challenge existing assumptions and consider how the researcher's perspectives may have influenced the analytic process.

Results

The database search returned 4,126 records, from which 2,792 titles and abstracts were screened. Following title and abstract screening, 262 full-text articles were assessed for eligibility. Six studies, reported across seven publications, met the inclusion criteria and were included in the final synthesis. One study was reported across two publications, both of which were analysed as they presented complementary findings from the same qualitative dataset. For reporting purposes, these two publications were treated as a single study. An additional seven papers were identified through citation search, of which none met the inclusion criteria. The PRISMA diagram can be seen in Figure 1. Characteristics of the included studies are shown in Table 2. The synthesis resulted in the construction of a

grounded theory and conceptual model illustrating staff experiences of TIC and the organisational conditions shaping its implementation, presented in Figure 2.

Figure 1. PRISMA flow diagram of study selection process

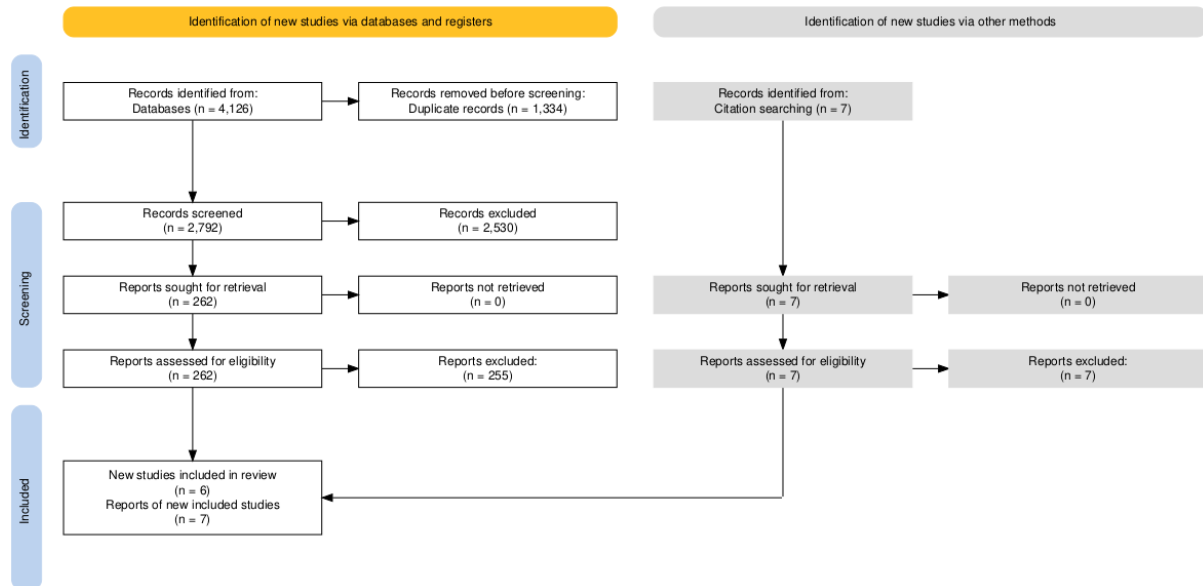
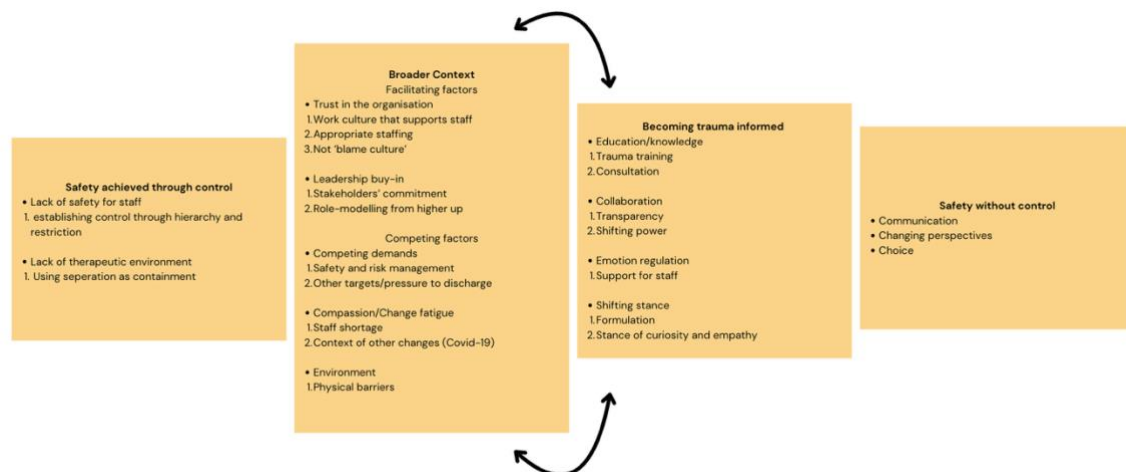


Table 2. Study characteristics

	Author, Year & Country	Study Aims	Service Setting	Participant Characteristics	Sample Size	Design and Method	Data Analysis
1	Chandler (2008) United States	To describe and compare staff experience in reducing patient symptoms in a traditional inpatient model and a trauma-informed treatment model. To describe how the staff created a trauma-informed culture of safety.	Inpatient psychiatric unit	Nurses, physicians, social workers, and mental health counsellors	N = 10	Qualitative	Inductive content analysis
2	Nation et al. (2022) Australia	To evaluate the organisational goal to have staff working in rehabilitation trained in TIC.	Mental health rehabilitation	Healthcare professional leaders	N = 14	Mixed methods Semi-structured interviews	Thematic analysis
3	Faye Nikopaschos et al. (2025) United Kingdom	To elucidate experiences and mechanisms of change through a qualitative exploration of the impact of TIC on staff and service users.	Acute inpatient unit	Occupational therapist = 2 Nurses = 3 Healthcare Assistant = 2	N = 7	Qualitative	Thematic analysis
4	Wilson et al. (2023)	To reveal the lived experiences of mental health nurses providing TIC in the acute mental health settings.	Acute inpatient unit	Mental health nurses	N = 29	Qualitative Semi-structured interview	Phenomenological interpretation

	Wilson et al. (2024)	Australia					
5	Cilia Vincenti et al. (2022)	To examine nurses' TIC attitudes at a psychiatric hospital.	Acute inpatient and rehabilitation unit	Mental health nurses	N = 10	Mixed method Focus group	Thematic analysis
	Malta						
6	O'Dwyer et al. (2019)	To gain in-depth understanding of healthcare professionals' perceptions of how Gender Sensitive Care (GSC) is enacted.	Acute inpatient units	Psychiatric nursing staff = 20 Allied health professionals = 10 Medical staff = 7 Peer support staff = 3	N = 40	Qualitative	Normalisation Process Theory
	Australia						

Figure 2. Grounded theory of TIC



Quality Appraisal

Table 3. CASP ratings

Study	Clear statement of aims?	Appropriate qualitative methodology?	Appropriate research design?	Recruitment strategy?	Data collected to address research issue?	Positionality addressed?	Ethical issues?	Rigorous data analysis?	Clear statement of findings?	Valuable research?
Chandler (2008)	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
Nation et al. (2022)	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
Faye Nikopaschos et al. (2025)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wilson et al. (2023)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wilson et al. (2024)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cilia Vincenti et al. (2022)	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
O'Dwyer et al. (2019)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Yes = ✓ No = ✗ Can't tell = —

Overall, the appraisal indicated sound methodological practices in most studies with the main limitations relating to the reporting of researcher reflexivity. No studies were excluded on the basis of methodological quality. In qualitative evidence synthesis, conceptual richness and contextual thickness of the examined studies should take priority over the quantity of included studies (Vander Linden & Palmieri, 2021). The Cochrane-Campbell Handbook for Qualitative Evidence Synthesis (Ames H, 2024) recommends using the GRADE-CERQual to consider the richness of the studies contributing to a synthesised finding. The GRADE-CERQual refers to data richness as “the extent to which the information provided in

individual included studies is detailed enough to allow the review author to interpret the meaning and context of the phenomenon of interest (Borhen et al., 2025)”. The adequacy component of the GRADE-CERQual approach was consulted to support consideration of the richness of the data contributing to the synthesis. This was conducted separately from the CASP quality appraisal as a single global evaluation of data richness across the included studies. Overall, the richness of the data was considered satisfactory, providing sufficient detail to support interpretation of the meaning and context of the phenomenon of interest.

Grounded theory construction

Traditional inpatient and rehabilitation care: safety through control

Understanding the context in which TIC emerged was central to understanding the process itself. Across the included studies, participants reflected on previous and existing approaches to care before the implementation of TIC. Adult psychiatric inpatient and rehabilitation settings care for individuals with complex mental health needs, many of whom experience significant emotional distress. Individuals may present with behaviours that challenge with potential aggression towards themselves, other service users and staff. Consequently, participants described environments in which both staff and service users could feel unsafe. In the absence of a shared sense of psychological and physical safety, traditional models of inpatient care may rely on hierarchy and restrictive practices to create and maintain safety and control. It was within this context that TIC was introduced as an alternative way of understanding and responding to distress. Although these traditional approaches were viewed as necessary responses to challenging inpatient environments, participants also described how they created an environment that was detrimental to building therapeutic relationships and therefore negatively impacting recovery. Study numbers outlined in Table 2 are used to identify the source of quotations below.

1. Maintaining safety through hierarchy and restriction

Traditional inpatient care operated within a pronounced hierarchy in which authority remained with the professionals and patients had relatively little influence over decisions affecting their care. Information and treatment planning were kept and largely directed by staff, with patients expected to fit existing ward routines rather than care being adapted to individual needs. As one participant reflected, *“under the traditional model, the staff exerted*

control with the best intention of keeping everyone safe in the face of limited alternate resources.” – Study 1, while practice was characterised by “strict interpretation of protocols” that were presumed necessary to maintain control.

Importantly, this emphasis on control appeared to arise from an underlying absence of safety experienced by staff themselves. Participants recalled environments where aggression and uncertainty were anticipated, describing how *“both patients and staff often felt unsafe”* and acknowledging that *“we did not talk about safety and violence directly; we just tiptoed around and hoped.” – Study 1.* Staff accounts from other studies reflected similar experiences, with staff recalling becoming anxious when conflict emerged and responding by seeking security or restrictive interventions. One participant explained that *“as soon as somebody is becoming angry and if the people working there are afraid of them, they will seek [security]...” – Study 4.*

Trauma-informed care offered an alternative way of thinking about how these responses influence recovery and relationships on the ward. Reflecting on power differentials, one participant commented that *“we’re doing what’s been done to them for how many years ... you’re just sort of reinforcing abuse that happens to them,” – Study 3* highlighting how existing practices could inadvertently mirror previous traumatic experiences. Similarly, another participant recalled that *“once a patient was in restraints, it took a long time to come out, one limb at a time... Looking back at it does feel like the shame-and-blame approach,” – Study 1* illustrating how restrictive practices came to be reconsidered through a trauma-informed lens. These practices were presented as established responses to maintaining order within environments perceived as unsafe, reinforcing unequal power relationships in which safety was achieved through professional control rather than collaborative or therapeutic engagement.

2. Fear and the absence of therapeutic safety

Participants also described inpatient and rehabilitation wards as environments characterised by uncertainty, with possibilities of aggression. Fear appeared to shape how staff navigated the ward and interacted with patients. One participant recalled becoming constantly alert to the possibility of violence - *“I notice myself, never turning my back on patients. I have this feeling of - I had one patient and he was known to be violent. I remember this one time I was*

walking down the corridor and he was just following me really closely. I just stopped and put my back to the wall and he laughed and said, 'I wasn't going to do anything to you.' Just ever since that, I just have – I just get prickles down my neck when I can't see them [consumers]. [RP 22]" – Study 4.

At the same time, staff recognised that patients often experienced the ward environments as equally unsafe due to restrictive practices and heightened security. Additionally, studies suggested that these environments often left little opportunity for repairing relational ruptures following incidents. The focus often shifted towards restoring order and reducing future risk, while reflection on what had occurred and its emotional impact on staff and patients received less attention. As one participant observed, *"every time there is an incident... instead of the staff going and speaking to them, finding out what's going on, and trying to resolve it, the staff calls security."* – Study 4. Consequently, safety was frequently experienced as something maintained through external control rather than through collaborative engagement with patients.

Conditions influencing trauma-informed care

Like all organisational transformation, TIC is shaped by the environment into which it was introduced. Staff highlighted the organisational and contextual factors that influenced their experiences of implementing TIC. They described trauma-informed practice as dependent on organisational conditions that enabled staff to work in this way. However, organisational pressures often constrained these efforts and reinforced more traditional approaches to managing safety. Analysis identified two broad categories that shaped implementation: organisational conditions that facilitated TIC and organisational barriers that constrained its delivery.

1. Organisational conditions that facilitate trauma-informed care

Organisational commitment was highlighted as essential to the successful implementation of TIC. Leadership was identified as central to creating and sustaining TIC, with participants identifying managers and senior clinicians as playing a key role in modelling trauma-informed values and creating a therapeutic culture within the ward. Participants described leaders who modelled trauma-informed values through their everyday interactions and reinforced them across the organisation. As one participant reflected, implementation

“flows down from management and senior clinicians... it trickles down into culture to support and take these incidences seriously,” – Study 6 highlighting the importance of collective organisational investment in the model of care. Similarly, another participant described how a skilled team leader could model the regulation of the therapeutic environment, explaining that *“If nurses know what mental health nursing is and, what they are there for and, how to apply it...they are led by a team leader on that shift...somebody who can regulate it beautifully [therapeutic milieu] you have just got it already. You do not have to worry’.* – Study 4.

Unsurprisingly, participants emphasised the importance of staff feeling psychologically safe within their teams. Adequate staffing and well-established teams enabled staff to engage therapeutically with patients rather than focusing primarily on self-protection. Reflecting on this, one participant explained, *“my feeling of uncertainty or feeling unsafeness is not because of the clients. It’s more of the team that I’m working with,”* – Study 4 while another noted, *“when the system is strong and we are appropriately staffed, I would say that I feel safe. But when there are problems with things like staffing or processes or procedures, I feel unsafe.”* These accounts suggest that staff members’ own sense of safety was strongly influenced by the organisational environment, creating conditions in which TIC could be more confidently enacted.

Participants also emphasised the importance of trust within the organisation. Feeling supported by colleagues and leaders enabled staff to reflect on challenging situations and adopt alternative approaches to care without fear of criticism or blame. One study pointed out that *“MHNs (Mental Health Nurses) feel they are unfairly blamed for incidents which are inevitable occurrences in a psychiatric setting.”* One participant shared: *“fear of blame makes them retract their steps and refrain from giving optimal care: “If you have a patient under your care and he scratches himself or self-harms they’ll go, ‘Where was the nurse’? I mean sometimes it’s impossible to stop a person from scratching themselves.”* – Study 5. Clinical supervision, reflective practice and opportunities for feedback were viewed as important mechanisms that supported staff to develop and maintain trauma-informed ways of working. Instead of viewing the implementation of TIC as a one-off training exercise, participants described it as requiring continual review and adaptation over time.

Staff further recognised that organisations needed to support staff as well as patients, acknowledging that *“staff may have traumas or have experienced trauma in the workplace”* – Study 2 and emphasising the importance of *“help[ing] support staff.”* Additionally, TIC required *“an individual and communal understanding of the intervention or process required and how it differs to previous work. For an intervention such as GSC (Gender Sensitive Care) to be normalised, all stakeholders need to understand and value the model of care and to demonstrate some investment in the meaning of it”* – Study 6. This speaks to the central role commitment across the MDT (multi-disciplinary team) plays in the successful implementation of TIC. These findings suggest that TIC became more sustainable when it was supported at both individual and organisational levels. It also highlights that TIC requires leadership buy-in, an organisation that fosters psychological safety and collective ownership from the team.

2. Organisational barriers constraining trauma-informed care

Alongside the facilitating conditions, participants also reported several organisational barriers that may have limited their ability to consistently work in trauma-informed ways. Some staff noted that services operating under competing demands that often leave little time to deliver TIC in practice. Staffing shortages and increasing organisational pressures meant that immediate clinical priorities frequently took precedence over collaboration and therapeutic engagement. As one participant explained, *“Not enough hours in the day, not enough time...you have to prioritize KPIs...You do get fired up about how you want to do this, [but] sometimes you get grind[ed] down by the ward.”* -- Study 5. Organisational changes further compounded these pressures, with one participant recalling *“Change fatigue especially in the general COVID climate. . . Bombarded by emails. . . Staff shortages and change capacity to invest in TIC. (Participant 4).”* – Study 2. This suggests that implementing TIC during period of substantial change such as the COVID-19 period could be particularly challenging, as staff capacity was often directed towards adapting to wider service demands.

Staff also highlighted the physical environments of wards that were poorly aligned with trauma-informed principles. The design of inpatient wards was frequently viewed as limiting opportunities to create therapeutic spaces and contributed further to the lack of safety for both staff and patient. One participant commented that the unit was *“not being designed to support the human relationship,”* while another reflected that *“there was nowhere where*

you could just sit down and feel a bit sheltered... where people can feel safe and feel at home.” – Study 4. Participants also “...suggested that the old, inadequate physical plant created opportunities for patients to inflict self-harm. For example, the unit had a full kitchen where patients could find the means to cut and burn themselves.” – Study 1.

The emotional demands of inpatient work further influenced implementation. Participants spoke of compassion fatigue and the intensity of long-term therapeutic relationships reducing their emotional capacity to consistently practise in trauma-informed ways. One participant reflected that, *“In chronic wards clients are there for a very long time, so you tend to consider them not as a client but more as family and what happens is if you get a negative response from that person your reaction won't be as professional, you respond to them as though they are family members.”* – Study 5. This potentially can make it more difficult to maintain therapeutic boundaries following negative interactions.

These findings suggest that TIC was experienced as highly dependent upon the organisational context in which it was introduced. Committed leadership, adequate staffing and supportive systems appeared to facilitate implementation, whereas competing demands and wider systemic pressures frequently constrained staff's ability to work in trauma-informed ways. Therefore, the implementation of TIC could not be understood solely as a change in individual practice, but as a process shaped by the wider organisational systems within which inpatient care was delivered.

Becoming trauma-informed

Within these organisational conditions, participants described becoming trauma-informed as a gradual shift in everyday practice as opposed to an isolated intervention. Services moved away from approaches primarily focused on managing behaviour towards developing a broader understanding of the person and their experiences. This process involved four interconnected components: developing an understanding of trauma and its impact, making sense of the person's story, working collaboratively, and developing the interpersonal skills required to deliver TIC.

1. Developing an understanding of trauma and its impact

Trauma-informed interventions and care allowed staff to develop a greater understanding of trauma and gain awareness of the psychological impact it has. Across the included studies,

participants recalled that the new knowledge they gained about trauma and its psychological consequences enabled them to reinterpret patients' distress in ways that had previously not been considered. Trauma-informed training, and interventions such as team formulation were described as introducing alternative perspectives that encouraged staff to look beyond patients' immediate presentations and consider the impact of earlier life experiences.

This shift not only changed what they knew, but how they understood behaviour. One participant reflected, *"We have an increased awareness of trauma behaviour. We used to think that emotional lability was manipulative. Now we recognise [that this behaviour] is a response to trauma."* – Study 1. Similarly, behaviours such as self-harm, previously viewed as attention-seeking or manipulative, came to be understood as *"a way to release emotions, a coping skill,"* – Study 1 resulting in more individualised responses and greater collaboration with patients through shared safety planning.

In another study, participants reported developing a growing *"curiosity about what had happened prior to the admission and in the service user's life overall."* – Study 3. Team formulation and trauma-informed training were perceived as providing *"new and compelling information and perspectives,"* – Study 3 shifting attention away from focusing solely on what was happening in the present. This change was also reflected in one participant's observation that *"I didn't realise that was kind of connected... the majority of their issues are due to childhood traumas,"* – Study 3 illustrating how understanding trauma enabled staff to place current difficulties within a broader life context.

2. Making sense of the person's story

As staff developed this understanding, they felt more confident discussing trauma with patients. They also highlighted the importance of understanding each person's individual stories and life experiences. This shift encouraged greater flexibility in responding to patients in a person-centred manner. One participant reflected on previous practice being *"...rigid, our practice then seemed very rigid. We followed protocols to the letter in response to symptomatic behavior."* – Study 1. This illustrates how TIC can encourage staff to look beyond immediate behaviours and adapt their responses to individual needs.

Storytelling and formulation were described as important processes that supported this understanding. Staff valued opportunities to explore what had happened to the person before admission and to consider how previous experiences continued to influence current behaviour. One area this perspective challenged is how information about patients were recorded – *“The MHN indicates that medical documentation is problem-orientated as opposed to strengths-orientated, a core premise of TIC. ‘(RP 26) Now, we have got a system of documentation that makes it almost impossible for us to understand what's going on for the person, to know their story. In the past, with the problem-oriented medical record system, everybody wrote in the same place’. The importance given to capturing and recording medical data as opposed to the lived experiences of the consumer emphasizes the value given to data in scientific medicine as opposed to a genuine connection and understanding of the person.”* – Study 4.

3. Working collaboratively

Collaboration emerged as a central process of becoming trauma informed. There has been a shift away from staff directing treatment towards greater partnership with patients. Instead of positioning patients as passive recipients of care, staff increasingly involved them in decisions regarding their treatment and recovery. This included collaboratively developing safety plans, discussing medication and encouraging patients to recognise what helped them during periods of distress. As one participant explained, *“Now we include the patient in the plan,”* and *“we tell patients that there’s a recipe for managing symptoms: ‘What ingredients work for you?’”* – Study 1, illustrating staff encouraging patients to identify the strategies they found most helpful in managing distress.

Participants also recognised collaboration requires openness and transparency especially within therapeutic relationships. Patients were provided with greater access to information regarding their care and offered more choice in how they engaged with therapeutic activities. These approaches positioned patients as active partners in their own care, fostering greater engagement whilst reducing unnecessary conflict and power struggles.

4. Developing therapeutic skills

A final process identified across the included studies was how staff understood their own emotions and their ability to manage responses within therapeutic relationships. Several

studies suggest that developing and implementing trauma-informed practice required staff to become more aware of their own emotions and reactions when supporting people experiencing distress.

Participants highlighted the concept of emotional intelligence and compassion being closely connected processes. One participant reflected: *“before you can even think about compassion, you actually need to have understanding of what’s going on with the person.”* Developing this understanding, alongside *“mental health literacy and emotional regulation within yourself”* – Study 4 was viewed as enabling staff to respond more thoughtfully to distress rather than reacting automatically to challenging behaviours. As another participant explained, *“you don’t come to a position of compassion until you actually have an understanding of what’s happening for the person.”* – Study 4.

Through TIC, participants became increasingly aware of how their own emotional state influenced therapeutic interactions. One participant highlighted that supporting people with trauma relied on staff themselves being emotionally regulated, explaining that *“it’s not as though a person can necessarily control what’s happening unless they’ve got people around them who are self-regulating themselves.”* – Study 4. Reflecting on team formulation, another participant spoke about how working through patients’ experiences often transformed staff’s emotional responses, recalling that discussions frequently began with staff describing patients as *“frustrating”* or *“intimidating,”* but ended with feelings of *“sadness”* and *“compassion.”* – Study 3.

These findings suggest that becoming trauma-informed involved considerably more than acquiring knowledge about trauma. The interconnected processes of developing greater understanding, working collaboratively and strengthening therapeutic skills formed the foundation of trauma-informed practice within inpatient and rehabilitation settings.

Giving up control without losing safety

The final piece of the model describes how staff shifts from the traditional inpatient and rehabilitation care model to a trauma-informed understanding of care. It describes how participants perceive TIC to change the way safety was achieved within inpatient and rehabilitation settings. Under trauma-informed principles, wards are able to move away

from relying on restrictive or control-based responses to placing greater emphasis on understanding and collaboration.

1. Changing perspectives on patient behaviour

One of the most consistently reported outcomes of TIC was a change in how staff understood and interpreted patient behaviour. Behaviours that had previously been viewed as intentionally challenging were increasingly understood within the context of patients' trauma histories and lived experiences. Reflecting on this shift, one participant explained, *"You get to understand why someone has reacted to you in a certain way... let's say it's bad behaviour... it's because of the trauma they've [experienced]."* – Study 3. Similarly, another staff noted how TIC provided *"so much more background to things that you would look at as symptoms,"* explaining that behaviours which had once been perceived as challenging *"make so much more sense"* – Study 3 when understood in the context of a person's life experiences.

Participants also linked this change in perspective to changes in their own responses towards patients. Greater understanding appeared to foster increased empathy and compassion. Staff described becoming less reactive and more curious about what behaviours might be communicating. As one participant reflected, *"If they were showing a lot of anxiety or anger, you kind of learnt to look at it from different perspectives and that helped me come up with different interventions."* – Study 3. Participants suggested that approaching behaviour in this way enabled them to respond more therapeutically and reduce unnecessary conflict within the therapeutic relationship.

2. Sharing responsibility for safety

Trauma-informed care reshaped the relationship between staff and patients through collaboration. Responsibilities for care and safety now involved patients. Reflecting on this change, one participant commented, *"What we're not doing before was, 'How do you think we can help you? What makes you safe in the past?' Just little things like that,"* – Study 3 illustrating a shift towards understanding safety from the patient's perspective.

Greater openness and shared decision-making encouraged patients to become more active partners in their care. Providing patients with information, inviting them to contribute to

treatment planning and maintaining open communication appeared to reduce power struggles and strengthen therapeutic relationships. Improved communication within MDT further supported more consistent approaches to care, ensuring that patients' needs and preferences were understood across the wider team.

3. Maintaining safety differently

Across the included studies, TIC served the function of changing how safety was understood and managed within inpatient and rehabilitation settings. Participants recognised that complex presentations and behaviours that challenge are linked to many patients' trauma experiences and this sense of diminished safety can often continue long after the traumatic event itself. Therefore, creating opportunities for patients to feel safe, understood and supported should be a central priority to preventing distress from escalating. As one study reported, *"participants demonstrated an awareness that a feeling of lack of safety is the core of the experience of trauma,"* – Study 3 with the majority describing actively using trauma-informed strategies to help service users *"gain a sense of safety and security."*

Staff can approach distress earlier and work more collaboratively, using evidence-based strategies to reduce the likelihood that restrictive interventions would become necessary. As highlighted by Study 1: *"Through planned written exercises, we look at what are triggers, what are responses, and what are alternatives. We teach more skills for distractions. The Safety-First Plan takes the power struggle out and brings the patient in to collaborate."*

These findings suggest that through TIC, staff experienced a shift in how safety was viewed and achieved, moving away from relying primarily on control towards creating conditions in which patients felt sufficiently safe to engage therapeutically. This change brought together the processes described throughout the preceding themes and represented the culmination of TIC within inpatient and rehabilitation settings.

Discussion

Key findings

The present review synthesised qualitative evidence on clinicians' experience of TIC within adult psychiatric inpatient and rehabilitation settings. The findings reinforce the rationale for TIC, suggesting that it emerged in response to inpatient environments that felt

psychologically and physically unsafe for both staff and patients. Traditionally within these environments, safety was often sought and achieved through control, hierarchy and restrictive practices, which were not always conducive to therapeutic engagement or recovery. The findings provide one possible explanation for why restrictive practices become embedded within inpatient care: when staff themselves feel unsafe, unsupported and under pressure, maintaining control can become the primary way of managing risk. This interpretation is consistent with wider literature. Lawrence et al. (2022) found that threats or acts of violence were amongst the most common factors influencing staff decisions to use seclusion and restraint. Similarly, Muir-Cochrane et al. (2018) found that nurses expressed considerable fear about reducing restrictive practices, describing concerns about being blamed should adverse incidents occur. Along with previous research, current review's findings highlight the difficult position staff occupy, balancing the responsibility of maintaining safety on the ward while also providing person-centred care. Therefore, creating organisational conditions within which staff can feel psychologically and physically safe should be viewed as a crucial part of trauma-informed implementation.

The findings of this review also suggest that TIC should be understood as a complex organisational intervention operating within a complex system. Although considerable attention has been given to the components of TIC, the present synthesis suggests that these components cannot be considered in isolation from the organisational context in which they are implemented. These findings are supported by the wider literature suggesting that implementing TIC requires a broader cultural shift, with changes occurring across disciplines, services and organisational levels rather than through individual practice alone (Berring et al., 2024). Menschner and Maul (2016) identified six key organisational ingredients for creating a trauma-informed approach to care. They proposed that for organisations to become trauma-informed, it requires the steady support of senior leaders and an implementation plan that actively involves staff in the process, which will help generate buy-in. Leadership is also responsible for establishing clear strategies for rolling out the changes, particularly by communicating the purpose and anticipated benefits of TIC to both staff and service users. It is important for both groups to understand why there will be changes in how the organization functions. As TIC continues to evolve, communication strategies will also continue to develop, and each organization will need to take its size and

structure into account when developing ways to discuss TIC (Menschner & Maul, 2016). The present findings also suggest that the relationship between TIC practice and the broader context is bidirectional. Organisational context shapes the extent to which TIC can become embedded, while successful implementation has the potential to reshape the organisational climate itself through changes in communication and collaboration.

The findings of this review also align closely with existing conceptualisations of TIC. SAMHSA (2014) described the six core principles that underpins TIC. These principles are reflected in the present synthesis. Staff highlighted the value of developing a greater understanding of trauma through training, consultation and reflective practice. Similarly, the emphasis on collaboration and choice was reflected in staff accounts of sharing decision-making with patients, promoting autonomy and developing more collaborative therapeutic relationships. These findings reinforce the importance of the core trauma-informed principles of safety, trust, collaboration, empowerment and choice.

The present synthesis extends existing frameworks by highlighting the importance of the emotional processes involved in implementing TIC. Beyond acquiring knowledge about trauma, staff described becoming more curious, empathic and reflective in their responses to patients, suggesting that emotional intelligence may play an important role in translating trauma-informed principles into everyday practice. Emotional intelligence has been associated with greater empathy and more compassionate care within healthcare settings (Nightingale et al., 2018) and the present findings suggest these capabilities may also be central to TIC. When supported by the wider organisational context, these changes appeared to foster more open communication, more collaborative relationships with patients and a shift away from viewing behaviour primarily through the lens of risk towards understanding it as a response to trauma.

Limitations

A limitation of this review is the small number of studies included, reflecting the limited qualitative research exploring the topic of interest. Even though the Cochrane-Campbell Handbook for Qualitative Evidence Synthesis (Ames H, 2024) suggests that the quality of a qualitative synthesis lies in the conceptual richness and contextual depth of the included studies, the included studies were drawn only from high-income Western countries. Therefore, the transferability of these findings to other settings should be considered with

caution. This is particularly relevant to TIC, as the contexts in which trauma occurs, how trauma is understood and responded to are influenced by cultural and individual factors (Ranjbar et al., 2020). Cultural and healthcare contexts may also shape broader approaches to psychiatric care, including expectations around therapeutic relationships, boundaries, autonomy and the management of risk. As such, the ways in which TIC is understood and implemented may differ across cultural and healthcare contexts. This also highlights an important gap in the existing qualitative literature and the need for further research across a broader range of psychiatric inpatient services and geographical contexts.

It is also important to consider the design and nature of the included studies. Only one of the six included studies adopted a more longitudinal perspective, exploring how a service had transformed over a five-year period following the implementation of TIC. The remaining studies largely explored staff experiences and perceptions of delivering TIC, but it was not always clear whether participants' accounts followed a specific training or implementation initiative. Although these studies were not primarily evaluating the effectiveness of TIC through pre- and post-intervention comparisons, the timing of data collection in relation to TIC may nevertheless have introduced potential biases into participants' accounts. Where data were collected following the introduction of TIC initiatives, positive accounts may also have been influenced by increased attention or engagement associated with organisational change, consistent with a possible Hawthorne effect. Additionally, staff familiar with TIC principles and terminology may have been more likely to describe their experiences in ways that aligned with how trauma informed practice is expected to be understood or delivered, without necessarily reflecting changes in everyday clinical practice. These factors should therefore be considered when interpreting the extent to which the findings reflect changes in practice.

A further limitation relates to the imbalance between inpatient and rehabilitation settings within the evidence base. Although this review sought to synthesise evidence from both settings, only one study included rehabilitation staff, with the remaining studies focusing primarily on acute inpatient services. Consequently, the synthesis may be weighted towards acute inpatient experiences. Comparatively little is known about how TIC is understood and experienced by staff within psychiatric rehabilitation. This represents an important priority for future qualitative research.

The inclusion of both acute inpatient and rehabilitation settings may also be viewed as a limitation, as these services differ in their treatment goals, length of stay and models of care. However, both settings provide multidisciplinary care for adults with complex mental health difficulties and share many of the organisational and relational challenges that TIC seeks to address. The decision to synthesise evidence across both settings was therefore considered appropriate, while recognising that the limited representation of rehabilitation services restricts the conclusions that can be drawn specifically about this context.

Consistent with a constructivist grounded theory approach, the model constructed represents one interpretation of the available evidence. The findings included in this review had already undergone processes of construction and co-construction between participants and the original researchers within each primary study. The present synthesis therefore represents a further interpretive reconstruction of these accounts, shaped by the principal researcher's own perspectives, experiences and understanding of mental healthcare systems. The categories should not be viewed as fixed or definitive, but rather as a conceptual representation of the processes identified across the included studies. Despite this, the model offers a coherent framework for understanding how organisational context and staff experiences interact to shape the experiences of TIC within psychiatric inpatient and rehabilitation settings.

Conclusion

This review summarises the limited evidence on staff's experience of TIC within adult psychiatric inpatient and rehabilitation settings. The conceptual model suggests that TIC is experienced by staff as more than a set of clinical practices; it represents a fundamental shift in how safety is understood and fostered. The model also provides a framework for understanding staff experiences of TIC and offers a foundation for future research to examine how the organisational conditions can be strengthened to support successful implementation and sustainability.

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Chapter 2

**Staff experiences of team case formulation in Psychiatric Inpatient Rehabilitation settings:
a grounded theory study**

Prepared in accordance with the author requirements for Frontiers of Psychology;

[Frontiers in Psychology | Psychology for Clinical Settings](#)

Plain language summary

Title: Understanding Staff Experiences of Team Formulation in Psychiatric Rehabilitation Services

Background: People receiving care in psychiatric rehabilitation services often have complex mental health needs. Staff from different professional backgrounds work together to support their recovery. Team formulation (TF) is a structured meeting where staff come together to think about a patient's experiences and develop a shared understanding of a person's difficulties. Although TF is widely used in mental health services, little is known about how staff experience it within psychiatric rehabilitation settings.

Aims and Questions: This study aims to explore how staff experience TF in psychiatric rehabilitation settings.

Methods: Seven members of a multidisciplinary rehabilitation team took part in individual interviews. A focus group with experienced clinical psychologists was also held to help refine and develop the emerging ideas. The data were analysed using Constructivist Grounded Theory, a qualitative research method equipped to help construct a theoretical explanation of the findings.

Main Findings and Conclusions: Staff reported that TF was helpful in developing a shared understanding of the patients, particularly when cases were complex or difficult to understand. It encouraged staff to think beyond patients' behaviours, increased empathy and compassion, and supported more consistent, person-centred care. Participants also identified TF as a psychologically safe space to reflect on challenging work and learn from one another. However, these benefits depended on wider organisational factors, including staffing levels, protected time, team relationships and support from the service. Overall, the findings suggest that staff's experiences of TF are shaped by the organisational context and the wider rehabilitation environment.

Abstract

Background: Team formulation (TF) is increasingly used within multidisciplinary mental health services to develop shared psychological understandings of service users and support psychologically informed care. Although previous research has reported positive outcomes associated with TF, little is known about how staff experience the process within psychiatric inpatient rehabilitation settings.

Aim: This study explored multidisciplinary team (MDT) staff experiences of TF in an adult psychiatric rehabilitation service and constructed a grounded theoretical account of how TF operates within this context.

Method: A Constructivist Grounded Theory methodology was employed. Five semi-structured interviews were conducted with MDT staff working within an adult psychiatric rehabilitation service. Preliminary analysis informed a focus group with three clinical psychologists experienced in facilitating TF, followed by two additional staff interviews to further develop emerging concepts. Data were analysed using constant comparative methods, line-by-line coding, focused coding and the use of memos to guide theory development.

Results: Team formulation was constructed as a context-dependent team process through which staff collaboratively developed shared psychological understandings of the patients. Three interrelated processes characterised these experiences: collaboratively making sense of complexity, creating a psychologically safe space for reflection, and challenging established narratives about patients. These processes were shaped by the wider rehabilitation context, including the culture and relationships within the MDT, competing clinical priorities and the team's readiness to engage with reflective practice.

Conclusions: The findings suggest that TF functions as a complex intervention operating within a complex adaptive system. The resulting grounded theory provides a conceptual framework for understanding how TF operates within psychiatric rehabilitation services and the contextual conditions that shape the process.

Keywords: Team Formulation, Clinical Psychology, Staff Experience, Psychiatric Rehabilitation

Introduction

Psychological formulation is widely regarded as a core competency within clinical psychology and is often used as a complementary or alternative framework alongside psychiatric diagnosis when understanding mental health difficulties. Formulation shifts clinical thinking away from solely focusing on symptom classification or asking ‘what’s wrong with you’ towards what may have happened to the person and how their current difficulties can be understood in the context of their life experiences by asking ‘what happened to you’ (Cole et al., 2011). In doing so, formulation provides a framework through which clinicians can make sense of a person’s difficulties, guide intervention and communicate a shared understanding of the service user’s experiences (Johnstone & Dallos, 2013b).

In many mental health settings, care is delivered not by single clinicians but by members of multidisciplinary teams (MDTs) made up of professionals from a range of backgrounds (Hartley, 2021). In these contexts, developing a shared understanding of a service user’s difficulties becomes particularly essential to ensuring consistent psychologically informed care. Team case formulation or team formulation (TF) has been broadly described as ‘*the process of facilitating a group of professionals to construct a shared understanding of a service user’s difficulties*’ (Johnstone & Dallos, 2013a). Johnstone and Dallos (2013a) suggest that several factors are central to effective TF, including protected time for discussion, involvement from the wider MDT and the creation of a reflective space in which staff can think openly about a service user’s difficulties. Team formulation is intended to encourage curiosity and psychological thinking, allowing staff to draw on their own clinical knowledge and experiences when developing a shared understanding of a service user’s presentation. It also provides an opportunity for staff to reflect on the challenges they encounter in their work and consider their emotional responses to service users, including relational processes that may arise within the therapeutic relationship.

However, practices labelled as ‘team formulation’ may be implemented in diverse ways. A systematic review by Geach et al. (2018) identified three distinct forms of TF described in the literature: 1) *highly structured, psychologist-led consultation approaches*, 2) *semi-structured reflective practice meetings*, and 3) *informal or unstructured sharing of psychological ideas through routine team interactions*. Variations in interpretation and operation may be due to factors such as the practitioner’s training, theoretical preference and work context (Geach et

al., 2018). The review highlighted a need for greater clarity and standardisation within 'team formulation' practice.

Nevertheless, a growing body of research has reported a range of positive outcomes associated with TF. Geach et al. (2018) found a degree of positive change over time - some staff reported improved psychological understanding and attitudes towards service users, and a small number of service users perceived changes to the therapeutic relationship and ward atmosphere. Short et al. (2019) found that staff reported increased knowledge and understanding of the service users. Closely linked to this is the reported altered perceptions, leading to altered relationships, feelings and behaviours towards patients. Team formulation can also provide a dedicated safe thinking space for reflection and to draw on the experience of the whole team (Hollingworth & Johnstone, 2014). When looking at the impact of TF within the team, Bealey et al. (2026) reported improved communication between staff members as well as knowledge sharing between individuals. The sense of working collaboratively also improved team working in general and fostered trust and sharing within the team. Qualitative research suggests that participation in TF can broaden staff perspectives, increase psychological awareness, and facilitate a shift away from exclusively diagnostic or medical explanations of distress towards more contextualised understandings of individuals' experiences (Christofides et al., 2012).

It has been suggested that TF may be particularly valuable in services for clients with severe mental health difficulties (McTiernan et al., 2021). Psychiatric rehabilitation wards typically support individuals with severe and enduring mental health difficulties, including complex psychosis, treatment-resistant symptoms, cognitive impairments, trauma histories, behavioural challenges, and significant interpersonal difficulties (Killaspy & Dalton-Locke, 2023). Additionally, admissions are often lengthy with staff regularly required to manage high levels of distress, risk and interpersonal complexity (Murphy et al., 2013). Staff in these services are likely to experience high levels of stress, low support and poor understanding. This may contribute to more critical responses towards patients, increased use of restraint and reduced helping behaviours, potentially fuelling vicious cycles of negative interactions (Berry et al., 2016). It is therefore important to create opportunities for reflection to maintain compassionate and person-centred care.

When teams feel “stuck” in their work with individuals presenting with complex mental health needs, TF can help make sense of the complex dynamics and maintain a therapeutic environment (Berry & Hartwell, 2023). The quality of relationships between staff and service user is a key determinant of recovery and relapse in psychosis treatment (Penn et al., 2004). This is particularly true in long-stay rehabilitation settings, as patients have limited access to people outside of the mental health system (Berry et al., 2016). Berry et al. (2009) found significant changes in staff perceptions of service user’s problems following attending TF. Staff also had more helpful attitudes towards working with service users and reported feeling less negative and greater confidence in working with them. Summers (2006) reported that staff viewed TF as valuable to gain a better understanding of service-users, which was seen to lead to better care planning, staff-service-user relationships, staff satisfaction and team working.

Berry et al. (2016) reported that patients whose staff attended TF felt less criticised by their key workers and reported improved relationships. In relation to behaviours that are perceived as challenging, Berry and Hartwell (2023) reported that TF may increase staff empathy by helping staff connect to the roots of these behaviours, which are often adverse early life experiences and unmet needs. This understanding of service user’s behaviour also gave staff clues about intervention strategies. Although the process of TF did not resolve staff struggles in working with behaviours that challenge, coming together as a team to think through the problems they faced felt therapeutic for staff.

Hartley (2021) describes the process of TF as similar to that of formulation in one-to-one sessions. And as with all formulation, TF is open to revision as understandings evolve (Johnstone, 2019). Despite its increasing use within mental health services, relatively little is known about how TF is experienced by staff working within inpatient rehabilitation settings. Existing research has primarily focused on perceived outcomes of TF, with less attention given to how inpatient rehabilitation staff understand its purpose, engage with the process, and make use of TF in their day-to-day practice (Bealey et al., 2026; Geach et al., 2018). Given the complexity of rehabilitation environments and the central role of multidisciplinary working, exploring staff experiences may provide valuable insight into how TF functions in practice.

Aim

The current study therefore aims to explore MDT staff experiences of TF within a psychiatric inpatient rehabilitation service. Using a Constructivist Grounded Theory method (Charmaz, 2014), the study seeks to construct a theoretical account of staff experiences of TF, contributing to the limited literature on TF and informing the development and implementation of psychologically informed practice within inpatient rehabilitation services.

Methods

Design

Constructivist Grounded Theory methodology

This study employed Constructivist Grounded Theory (Charmaz, 2014) to explore how MDT staff experience TF within an adult psychiatric inpatient rehabilitation setting. Constructivist GT assumes that meanings are co-constructed between researcher and participant and that knowledge is shaped by social, relational and contextual influences (Charmaz, 2014). This approach was selected as it allows the study to move beyond description towards the construction of a conceptual understanding of how TF is experienced, understood and utilised by staff.

Setting

The study was conducted within an adult psychiatric inpatient rehabilitation service in NHS Scotland. The service provides assessment, treatment and rehabilitation for individuals experiencing complex and treatment-resistant psychosis related presentations. Service users often present with complex psychological, social and occupational needs, alongside difficulties engaging with treatment and community access. Team formulation forms part of the routine clinical practice within the service and is facilitated by the ward clinical psychologist and attended by members of the MDT. Formulations are typically structured using the 5Ps model (Johnstone, 2019) providing a framework through which staff could collaboratively develop a shared psychological understanding of the patient.

Within the studied ward, TF is usually scheduled to take place approximately once a month, with each session focusing on an individual patient. However, the frequency of TF varied in practice, with sessions sometimes delayed due to limited staff availability and competing

service priorities. The relatively low turnover of patients within the rehabilitation service also influenced the frequency with which new formulations were required.

Procedure

Recruitment of staff involved the introduction of the principal researcher and present study to the MDT at a team meeting. Following this, the ward clinical psychologist distributed invitation emails containing the participant information sheet (Appendix G) and consent form (Appendix H) to eligible staff members. During the second stage of recruitment, invitation emails were distributed to qualified clinical psychologists identified through professional networks. Staff who wished to participate contacted the researcher directly to arrange an interview. Written informed consent was obtained prior to participation.

Participants

Staff Interviews

Participants were recruited using purposive sampling. Eligible participants were clinical members of the MDT working within the inpatient rehabilitation service for a minimum of six months. A six-month threshold was chosen to ensure participants had sufficient experience of the service context and team processes to contribute meaningfully to discussions regarding TF and ward culture. Attendance at previous TF meetings was not required for inclusion, as the study sought to explore a range of perspectives regarding TF.

Seven staff members participated in individual semi-structured interviews lasting between 36-50 minutes between April-May 2026. Participants represented a range of professional backgrounds within the MDT.

Table 4. Participant information - Staff

	Gender	Role	TF attendance
Participant 1	Female	Senior charge nurse	Yes
Participant 2	Female	Occupational therapist	Yes
Participant 3	Female	Psychiatrist	Yes
Participant 4	Male	Trainee psychiatrist	Yes
Participant 5	Female	Staff nurse	Yes
Participant 6	Female	Staff nurse	Yes

Participant 7	Male	Charge nurse	No
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Table 5. Participant information - Focus group

	Gender	Role
FG participant 1	Female	Consultant clinical psychologist
FG participant 2	Female	Clinical psychologist
FG participant 3	Male	Consultant clinical psychologist

Expert Clinical Psychologist Focus Group

Following preliminary analysis of the initial staff interviews (n=5), a focus group was conducted in May 2026 with three qualified clinical psychologists who had experience facilitating TF within inpatient and rehabilitation settings. Participants were recruited through professional networks and invited based on their experience of developing and facilitating TF practices.

In line with Constructivist GT, the focus group was incorporated as a form of theoretical sampling to further explore and develop the emerging theory. Its purpose was to help refine and challenge emerging interpretations developed from the staff interviews, and to explore how these resonated with the experiences of clinical psychologists across other inpatient and rehabilitation settings. This also provided an opportunity to consider the transferability of the developing theory beyond the immediate study setting. The focus group did not introduce additional categories to the developing theory, instead, it provided further elaboration and reflection which aided the refinement of the emerging construction of the relationships between existing categories.

Topic guide development

Semi-structured interview schedules were developed to facilitate exploration of participants' experiences of TF whilst maintaining sufficient flexibility to pursue issues of importance raised by participants. Consistent with Constructivist GT (Charmaz, 2014), interview questions were designed to be broad and open-ended, encouraging participants to describe their experiences in their own words.

The initial interview schedule was also discussed with an Expert by Experience (EbE) consultation group. The purpose of this was to ensure that the interview schedule included questions that are connected to the wider aim of understanding how TF may influence care for service users within inpatient rehabilitation settings. The initial topic guide can be found in Appendix I.

Data collection and analysis

Data were collected across three phases between 30/01/2026 and 29/05/2026.

In Phase One, five semi-structured interviews were conducted with MDT staff working within the inpatient rehabilitation service. Interviews explored participants' understandings of TF, their experiences of participating in TF, perceived impacts on clinical practice, and reflections on factors that facilitated or hindered the usefulness of TF within the service.

Preliminary analysis of these interviews informed Phase Two, which involved a focus group with three experienced clinical psychologists. Discussion centred on emerging ideas identified within the initial interviews, including the perceived purpose of TF, factors influencing engagement, and tensions surrounding its implementation in inpatient settings.

Two further staff interviews were conducted following the focus group. These interviews enabled further exploration of emerging conceptual categories across additional participant accounts.

All interviews and the focus group were conducted online via Microsoft Teams. Sessions were audio-recorded with participants' consent and transcribed verbatim using Microsoft Teams transcription software. Transcripts were subsequently reviewed alongside audio recordings by the principal researcher to check accuracy. Interviews ranged from 36 to 50 minutes in duration, while the focus group lasted 1 hour 38 minutes. All staff interviews were conducted by the principal researcher. The focus group was facilitated by the principal researcher and co-facilitated by the field supervisor.

The analysis followed the principles of Constructivist GT (Charmaz, 2014). Although constructivist GT advocates concurrent data collection and analysis, the iterative process was implemented pragmatically in response to the timing of recruitment and interview scheduling. The first five staff interviews were completed before formal line-by-line coding

commenced, after which the emerging analysis informed the subsequent focus group and two additional interviews. Initial analysis involved line-by-line coding of each transcript. An example of this process can be found below (Table 6). Focused coding was then used to synthesise frequently occurring and conceptually significant codes into broader categories. All coding was completed by the principal researcher. These categories were developed iteratively through constant comparison across transcripts and refined through discussion in supervision. As the primary aim of the study was to develop a theoretical account of ward staff experiences of TF, data from the focus group involving clinical psychologists with experience facilitating TF was not used to generate new categories. Instead, it was used to elaborate and refine the emerging categories developed from the staff interviews and to consider the transferability of the developing theory beyond the current study setting. Memo writing was used throughout the analytic process to record researcher reflections and support the development of the emerging analysis.

Table 6. Example of line-by-line coding

<i>Transcript text</i>	<i>Line codes</i>
<i>...but I think it (TF) just gives you a better understanding of the person and sometimes people maybe don't really know what that person's experiencing and why they're presenting in certain ways.</i> <i>So I think it gives you a better understanding of the person's history, their family dynamics, things like that. I think there's people that disagree and think that it's possibly a lot of rubbish. But for me personally, at the start, it was a fear of the unknown. And then when I went in, I started to enjoy it because it gives you a better knowledge of the person, it lets you see other like discipline's views on them and it</i>	<i>TF provides better understanding of the patient.</i> <i>Sometimes staff don't know what the patient is experiencing or why they're presenting in certain ways.</i> <i>TF provides better understanding of patient history and family dynamics.</i> <i>Some staff think TF is a lot of rubbish.</i> <i>A sense of fear of the unknown when first attended TF.</i> <i>Enjoyed TF once started attending.</i> <i>TF gives better knowledge of patient.</i>

<i>gives you a better understanding of the person as a whole. And you see what things that have happened to them in the past, and you just have a better understanding, more empathy and things, that's what I feel personally, because you know them and at a deeper level.</i>	<i>TF allows you to see different discipline's views on patients.</i> <i>TF gives better understanding of the patient.</i> <i>TF allows you to see what happened to the patient in the past, gives you more empathy.</i> <i>TF allows you to get to know the patient on a deeper level.</i>
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Transcript 5, p 4, 42 - 48

Ethical Considerations

Ethical approval was granted by the University of Glasgow College of Medical, Veterinary & Life Sciences Ethics Committee (Ref: 200250032; Appendix F) and NHS Research Ethics and Governance procedures (Ref: L25095; Appendix F). Participants received Participant Information Sheets, which outlined the purpose of the study and confidentiality limitations, including the need to report malpractice or harm to others if this was disclosed. In accordance with the BPS Code of Human Research Ethics, all data were anonymised to protect participants' privacy and confidentiality. Participants were assigned unique ID numbers. Interview transcripts were anonymised by replacing names with participant numbers and removing identifiable details such as professional roles or geographical references. All electronic data were stored securely on encrypted NHS devices during data collection before being transferred to the University of Glasgow OneDrive, a secure encrypted cloud-based storage system for analysis. All participants provided written informed consent and were reminded that participation was voluntary.

Researcher reflexivity

Constructivist GT (Charmaz, 2014) acknowledges that findings are co-constructed through the interaction between participants and the researcher. As a Trainee Clinical Psychologist

with no previous clinical experience in psychiatric rehabilitation, the principal researcher held the position of an 'outsider' within this study. This position allowed the researcher to approach participants' accounts with curiosity and without established assumptions about rehabilitation practice. However, it also required ongoing reflection on how unfamiliarity with the setting may have shaped the interpretation of participants' experiences. The researcher was also mindful that participants may have perceived an affiliation between the principal researcher and the ward clinical psychologist, as the study was conducted within a psychology-led context. This may have influenced the power dynamics during the interviews and how openly participants discussed their experiences of TF.

To support reflexive practice, the principal researcher maintained a reflective journal throughout the study (Appendix J), documenting assumptions and aiding development of interpretations. Regular supervision provided opportunities to reflect on how the researcher's position may have influenced the developing analysis.

Results

The findings highlighted that staff experiences of TF were closely shaped by the wider rehabilitation context in which it was delivered. TF was experienced as providing a space for shared sense-making and reflection, which could support shifts in staff understanding, compassion, communication and approaches to patient care. However, these processes and perceived outcomes were dependent on wider team and organisational conditions, including relationships and trust within the team, competing priorities and the team's readiness to engage in reflective practice. Each category is described below, with exemplar extracts. For readability, repeated words and hesitations have been removed from the extracts. The use of an ellipsis indicates that words have been removed. The final analysis resulted in a conceptual model (Figure 3) describing how TF is experienced by staff working within psychiatric rehabilitation settings. TF is a context-dependent team process through which MDT developed shared psychological understandings of patients. The form and function of TF are shaped by the rehabilitation system into which it is introduced, including the team's culture, relationships between staff, readiness for reflection and competing priorities.

Figure 3. Conceptual model of team formulation



The Rehabilitation Context: The conditions in which TF operates

One of the prominent findings across staff accounts was the importance of the team context in which TF occurred. Team formulation was not experienced as a standalone intervention. Staff spoke about TF as part of the wider discussions of team culture, relationships, professional identities and day-to-day rehabilitation practice. This suggests that staff experiences of TF were shaped not only by the formulation process itself, but also by the contextual environment in which it took place. Analysis of service-based staff participants' accounts identified three contextual themes that are particularly influential in shaping how TF was experienced: the evolving nature of rehabilitation services, the persistence of established ways of working, and staff burnout and disengagement.

1. Evolving landscape of rehabilitation

Participants described that rehabilitation services have changed considerably over time. Longer-serving staff reflected on changes in practice they experienced over the years from more custodial approaches towards a more recovery-oriented and least restrictive care model. Participants also noticed that patient presentations in rehabilitation services have changed. Whilst rehabilitation was traditionally associated with individuals experiencing enduring psychosis, patients with more heterogeneous and complex presentations are being admitted into these services. Staff are expected to care and treat patients with complex mental health presentation such as borderline personality disorder, and sometimes with co-morbid neurodevelopmental conditions such as autism spectrum disorder. However, some staff struggled to understand these presentations and have difficulties making sense of patient behaviours. As such, TF was frequently experienced as a space for developing

understanding. Service-based staff participants described using TF to increase their understanding of the patients' psychological and neurodevelopmental needs.

Quotes:

"...in some ways in rehab we have went back, we've went back in our practice in ways because of changes within the health service in terms of risk management and personnel changing management structure. Whereas 20 – 25 years ago in rehab, it was a bit 'raw' if you like, there wasn't as much emphasis put on risk and good or badly, I don't know." –

Participant 1

"...there is talk about the rehab ward moving to more sort of complex presentations and behaviours that challenge as opposed to schizophrenia..." – Focus group participant 2

2. Established ways of working

Alongside broader changes within rehabilitation services, staff described longstanding cultures of practice that had developed over many years. Staff expressed confidence in established approaches to caring for patients using knowledge gained through prolonged contact with them. For some staff, TF introduced a new and alternative way of understanding patients, and it prompted reflection on existing practices. However, participants suggested that staff who had been trained and worked within earlier models of rehabilitation sometimes found this shift more difficult to engage with. Team formulation was perceived as a challenge to established understandings of patients and care, which may contribute to resistance and variable levels of staff engagement.

Quotes:

"I think there's a lot of people that have been here a long, long, long time, very stuck and kind of...this is how the ward runs. We don't do anything different. It's worked for years. Why should we change it? That kind of thing." – Participant 2

"they're really used to long stay inpatient settings, but being really comfortable with that kind of setting, it means the staff are very experienced and very comfortable in their roles, but it makes it harder for them to then think about changes or differences or that there might be something to improve because they interpret it as a sense that things were not good enough before." – Participant 3

“it's unique to here because people been here a long time, there's certain ways of working here, and there's people don't like change.” – Participant 7

3. Staff burnout and disengagement

Across participants' accounts, there appeared to be a sense of tiredness and burnout amongst some members of staff. Those who were perceived as disengaged from TF were often described as similarly disengaged from other initiatives within the service. Participants spoke about staff who had *“lost their spark”* or become increasingly detached from aspects of their role that extended beyond day-to-day clinical responsibilities. One participant reflected that their enthusiasm for TF had been attributed to having worked in the service for a relatively short period of time, suggesting that motivation and engagement may change over the course of a career in rehabilitation.

This suggests that staff burnout may influence staff engagement with TF. Participants' accounts suggested that emotional exhaustion could reduce curiosity, limit openness to alternative perspectives, and make it more difficult for staff to engage with new ways of thinking about patients and their care.

Quotes:

“...unconditional positive regards...that was lacking a lot of the time and it's a hard thing to maintain for years on end...” – Participant 4

“...amongst members of staff they (team lead) probably hate change more than anyone else... just breathes on by and just make things as simple as possible.” – Participant 7

Team formulation within a complex system

A second key theme emerged from participants' accounts concerned the system within which TF was delivered. It is evident that the implementation and function of TF is influenced by the characteristics of the team itself. Staff's account of how TF is experienced is closely linked to their experiences of the team culture, professional relationships within the ward and competing demands.

The expert focus group further highlighted the importance of understanding the team context when facilitating TF. Clinical psychologists described adapting TF to the needs, culture and emotional climate of individual teams, suggesting that TF can serve different

functions depending on the system into which it was introduced. Consequently, participants' experiences of TF could not be understood independently of the wider team context.

Three main themes under this category were identified: adapting TF to team needs, relationships and trust within the team, and navigating competing priorities.

1. Adapting Formulation to Team Needs

Several staff highlighted the importance of how TF was structured and facilitated and its perceived helpfulness in increasing understanding of patient presentations. Within the studied service, staff valued the current TF model (based on the 5P model (Johnstone & Dallos, 2013a)) for its predictable format, visual structure and clear organisation. This helped staff engage in discussions about complex patients. The framework appeared to provide a shared language and increased confidence in contributing to TF meetings.

Interestingly, accounts from the focus group suggested that the value of any TF model lay not simply in its structure but in its ability to respond to the needs of the team. Clinical psychologists reflected on TF as requiring flexibility and adaptation, emphasising that different teams may require different TF models at different points in time.

This appeared particularly relevant within rehabilitation settings where teams varied in their readiness to engage with more relational or reflective forms of TF. Focus group participants suggested that some teams may initially benefit from a more psychoeducational approach focused on developing understanding of patients before they are able to engage in deeper reflection regarding team processes and relational dynamics. Facilitating TF therefore involved paying attention to what felt manageable and psychologically safe for the team at that point in time. Understanding where the team was developmentally, how relationships operated, and where influence and decision-making sat within the system appeared central to determining what type of TF would be most helpful. In other words, effective TF can be described as being attuned to the needs of the team.

Quotes:

"I think the thing that stood out most was how important it was to educate the staff there. Because the ones I think, particularly the staff that were around the patients that had the

most contact time found it, I think they found it difficult to distinguish between illness and personality and various deficits...” – Participant 4

“...need to read the needs of the room. And sometimes it's like, do you know what? Let's just leave this model in the white and let's just get together and have more of a reflection...because I'm based here and it can be easily rearranged, so I do try and tune into the room” – Focus group participant 2

2. Relationships, trust and team dynamics

Staff also emphasised the importance of relationships within the MDT team and the influence of that on how TF is experienced. The position of psychology within the wider team appeared particularly significant. Focus Group participants reflected that being positioned on the ward changes the relationship between psychologist and other staff, it is felt to be more involved and embedded as members of the team rather than external consultants. Being positioned on the ward gave the facilitator a chance to develop an understanding of the ward culture, team relationships and day-to-day clinical work. This in turn increased credibility and trust within the team and facilitated engagement.

Team dynamics also shaped whose voices were heard during TF. Staff described how different professional groups held different forms of knowledge regarding patients, which were shaped by their unique roles and level of contact. Although TF provided opportunities for multiple perspectives to be shared, existing hierarchies and power dynamics continued to influence participation.

Consequently, engagement with TF appeared dependent upon the relational climate of the team. Where trust and collaboration were present, staff are able to feel a greater sense of psychological safety to freely contribute, reflect and utilise TF to its effect.

Quotes:

“It was just the delivery, the method of delivery. I think the trainee was quite nervous. I think she was quite nervous and that kind of made it a bit sort of disjointed...(Trainee Clinical Psychologist) didn't know us and stuff like that. So it can be daunting presenting if you're not used to the team and stuff like that.” – Participant 1

“...it can maybe feel threatening, particularly because this isn't something we had before for people who see themselves as, you know, healthcare professionals who know their patients inside out because they're there 24/7 to be told to come into a room to learn about the patient...there's a sense of people being left to do all this stuff while the people in the room with protected time decide what to do.” – Participant 3

“I'm based on the ward full time, like my office is literally next to the living room. I don't know if then your experience of team formulation might be different from a psychologist who's just coming into the ward...because I then potentially have different relationships...because I am so embedded with the team, so I'm talking to the team all day...I don't ever feel that pressure at a team formulation to be the psychologist with the answer because they always see my fallibility. They always hear me saying, I'm a bit stuck with the patient. Can you help me today?” – Focus group participant 2

3. Navigating competing priorities

Staff reported clinical responsibilities as taking priority over TF and often presented this as an accepted reality of ward life. Service-based staff participants felt that some demands such as accompanying patients on leave and other immediate priorities such as responding to incidents could make attending TF difficult. Additionally, differences in job roles, responsibilities and shift patterns also meant that opportunities to engage with TF were not always experienced equally across staff groups.

The focus group offered a broader perspective on these challenges: participants suggested that tensions sometimes existed between the wider rehabilitation system and the principles underpinning TF. Whilst TF emphasised individualised understanding and treatment, rehabilitation services were often required to operate within systems shaped by risk management and standardised programmes. This could create uncertainty about where TF fitted within everyday clinical practice and contribute to variation in how strongly it was prioritised.

As a result, engagement with TF appeared influenced not only by practical demands but also by wider assumptions about what constituted meaningful clinical work. Whether TF was attended and protected reflected both the realities of ward life and the extent to which reflective practice was valued within the team.

Quotes:

“They (nurses) plan to come, but then they can't because there's stuff going on in the ward and they need all hands on deck or there's somebody off sick that day, so it means they can't free somebody up. So they maybe have in one way more flexibility than us, in another way, they don't.” – Participant 2

“Staffing levels is always a problem. Clinical activity will always trump the team formulations.” – Focus group participant 2

“...in an ideal world, we hope to have like formulation driven rehabilitation...there's also maybe like a competing model which is we've got a rehabilitation program to deliver and that being that is for adaptive daily living skills and meaningful activity...they need to engage with a rehabilitation program, which implies that it's standardized for everyone, and there's an expectation of...you know, most patients participating in the standardized program, whereas you might be trying to advocate for, well, formulation driven rehabilitation, I don't think they always match.” – Focus group participant 3

The Team Formulation Process

A substantial proportion of service-based staff participants' accounts focused on their understanding of TF itself. Staff described what they believed TF involved, the purpose it served, and the value it brought to their clinical practice. Analysis identified three processes that capture these accounts: collaboratively making sense of complexity, creating a psychologically safe space for reflection, and challenging established understandings of patients. Collectively, these processes reflected the functions that participants most commonly associated with TF within the studied setting.

1. Collaboratively making sense of complexity

The most prominent finding across service-based staff participants' accounts was that TF helped staff develop a better understanding of the patients they work with. Participants consistently described TF as a space to gain knowledge and make sense of complex patient presentations. This understanding was developed collaboratively with the MDT. Participants described how different professional groups often held different pieces of information regarding a patient. Team formulation created opportunities for these perspectives to be

shared collectively. Psychological and neuropsychological knowledge were frequently highlighted as particularly valuable, helping staff understand aspects of patients' experiences that had previously felt difficult and frustrating to explain and understand.

Team formulation was experienced as a collaborative process of meaning-making. Many felt that this helped the team *"get on the same page"*, creating a common understanding that informed day-to-day decision-making and promoted a more consistent approach to care.

Quotes:

"I think it's just having that shared understanding of the person. I think it kind of looks beyond what their diagnosis is, in a sense, it looks at other aspects of their life...it brings the team together. It's more cohesive with the team in terms of being able to listen to, you know, what other people have got to say." – Participant 1

"it gives you a better knowledge of the person, it lets you see other like discipline's views on them and it gives you a better understanding of the person as a whole." – Participant 5

2. Creating a psychologically safe space for reflection

Although the theme of reflection was discussed less explicitly, participants' accounts suggested that TF encouraged staff to think more deeply about the people they were working with. Rather than describing reflection directly, participants spoke about looking beyond immediate behaviours and considering alternative explanations.

A key underpinning of this process appears to be psychological safety. Service-based staff participants described feeling listened to, valued and able to express their views without fear of judgement. This encouraged staff to contribute ideas that they may not have felt comfortable sharing in other clinical meetings. For many, this created a space where uncertainty could be acknowledged and different perspectives openly explored.

The focus group expanded on this concept by suggesting that psychological safety could fluctuate depending on the team's emotional state. Clinical psychologists described how staff were sometimes less willing to engage with TF following incidents of physical aggression or periods of heightened stress. During these times, teams appeared less able to engage in reflective discussion and were more likely to focus on immediate clinical concerns.

This suggested that feeling psychologically safe was therefore an important condition for meaningful engagement with TF.

Quotes:

“Nobody talks over each other. Everyone's really respectful of everybody, and we're all entitled to our own opinion and our own clinical opinion and we're encouraged to say what we think, even if it's kind of different from what other people think.” – Participant 2

“...formulation has helped me become more aware of the things I can't change about myself that might evoke a response without me even knowing.” – Participant 4

“Although team formulation is formal and structured, it's less formal, I would say, and I feel it's a more of a safer space, more comfortable space.” – Participant 5

“...some have either not come along or reluctant to come along when the patient has been aggressive and especially if they've been the unfortunate recipient of the aggression...they still feel like it's been, well, that makes the aggression okay and that's absolutely not...” –

Focus group participant 2

3. Challenging established narratives

A further process of TF involved challenging established understandings and assumptions of patients and their behaviour. Participants described how long-standing explanations of patients' behaviours could become fixed, particularly where behaviours were viewed as reflecting personality and choice.

Team formulation introduced alternative ways of understanding these difficulties. Staff described becoming more able to consider developmental histories, trauma experiences, cognitive differences and emotional needs when making sense of patient behaviour.

Participants described this process as helping staff “*see things differently.*” Behaviours that had previously been experienced as deliberate or difficult became understood within broader psychological and relational contexts. This often resulted in increased empathy and compassion towards patients.

As such, TF appeared to function not only as a means of understanding complexity but also as a mechanism for disrupting established narratives and creating space for alternative interpretations to emerge.

Quotes:

“...when we had tricky patients with behaviours or symptoms that we couldn't get to the bottom of, people often thought that the person was...acting up or...doing things deliberately to annoy people...we had psychology because that gave that evidence for people to see like this person's not pretending that they're that they can't do it.” – Participant 1

“...looking at how to work in an alternative way with them...enabling that person to engage and to maintain that engagement, because otherwise they wouldn't.” – Participant 2

“I think when you get to know somebody for that long, like we were just into this normal routine with this person...(team formulation) made me think differently to how this person struggles daily.” – Participant 6

Perceived Outcome of Team Formulation

The findings suggest that staff experienced TF as an interactive process embedded within the wider rehabilitation system. The way TF is delivered and experienced appeared closely influenced by the context of the team, including its culture, relationships, competing priorities and readiness to engage with reflective practice.

When these conditions supported engagement, participants described TF as helping them develop a shared understanding of patients, think more deeply about complex presentations and reconsider established explanations for behaviour. This understanding was developed collaboratively through integrating different professional perspectives and psychological knowledge, enabling staff to work from a more consistent and psychologically informed understanding of the patient.

Participants reported that these changes influenced both individual practice and team functioning. Staff described approaching patient care with greater patience and empathy. At a team level, participants described improvements in consistency and communication. Shared understandings developed during TF were perceived to facilitate more coherent approaches to care and reduce discrepancies between staff responses.

“it does give you a better understanding and a bit more empathy and compassion towards the person when you realise the full story.” – Participant 5

“I just think I've got probably more of an understanding, it's helped us, develop, I think, a sense of trust...I just feel as if it's kind of strengthened my relationship with that person and they'll come and maybe open up a wee bit more to you...” – Participant 6

Taken together, the findings suggest that TF functions as a process through which MDT staff develop shared psychological understandings of complex patients. However, this process does not occur in isolation, it is shaped by the rehabilitation context within which TF is embedded and by the conditions that influence staff engagement with the intervention.

Discussion

The present study explored MDT staff's experiences of TF within an adult psychiatric rehabilitation service and constructed a grounded theory account of how TF is experienced within this context. Consistent with previous literature, participants described TF as improving psychological understanding and attitudes towards service users, as a space safe for reflection and a tool to draw on the experiences of the whole team (Berry et al., 2009; McTiernan et al., 2021; Summers, 2006). The present findings extend this literature by offering a theoretical account of how staff experiences emerge through interaction with the organisational environment. Form and function of TF varied according to the interpersonal dynamics within the team and the pressures affecting the service at the time. These conditions shaped both the discussion itself and what staff were able to take from it.

Craig et al. (2008) describe complex interventions as those involving multiple interacting components, requiring a range of behaviours from those delivering or receiving the intervention, allowing flexibility in implementation, producing variable outcomes and operating across multiple professional or organisational levels. Team formulation reflects each of these characteristics. As the current study showed, the TF process is influenced by the facilitator, the MDT, organisational priorities and the wider rehabilitation context. It also requires continual adaptation. While models and guidance provide a structure for delivery, no two teams are identical, and TF must respond to the needs, relationships and challenges of the team it is operating within.

Thinking about TF as a complex intervention also shifts attention towards the conditions required for it to operate effectively. Thirsk and Clark (2017) argued that the effects of complex interventions depend on multiple interacting processes occurring under particular conditions. Many of these conditions were described by participants - the facilitator needed sufficient understanding of the team to judge when reflection could be encouraged and when it might become overwhelming; trust within the MDT influenced whether staff felt able to contribute openly; existing relationships between psychology and other professional groups shaped engagement with the process, while competing service pressures often determined whether staff had the emotional capacity to reflect. These findings suggest that successful implementation depends not only on introducing TF, but also on understanding the context into which it is introduced.

Greenhalgh and Papoutsi (2018) argued that regardless of whether an intervention is simple or complex, the 'system' in which the intervention is implemented will almost invariably need to adapt in some way to accommodate it. Rehabilitation services comprise multiple professions, each bringing different knowledge, experiences and priorities into everyday clinical work. Team formulation enters that existing system and is shaped by it. At the same time, TF influences the system itself by changing how staff communicated, shared knowledge and understood service users. The intervention and the organisational context therefore develop alongside one another, with each influencing the other over time.

When these conditions were considered and present, participants experienced TF as facilitating a series of interconnected processes. Staff worked together to develop shared psychological understandings of patients whose presentations often felt uncertain or difficult to explain. Information was integrated across professional groups, allowing different perspectives to inform a more coherent account of the person's experiences. Team formulation created opportunities to reflect on emotional responses, reconsider assumptions about behaviour and recognise the influence of trauma, neurological conditions and wider life experiences.

The proposed model suggests that these processes represent potential mechanisms through which TF influences practice. Developing a shared understanding helped staff make sense of complex presentations and reduced feelings of 'stuckness'. Reflection supported more thoughtful responses to challenging situations. Revisiting established narratives encouraged

greater compassion and more psychologically informed decision-making. These findings offer one explanation of how TF may contribute to change within rehabilitation services while recognising that these mechanisms depend upon the organisational conditions that support them.

Although the present study did not explicitly explore the implementation of TF, the findings offer insight into the conditions that may support its implementation within rehabilitation services. Simply introducing TF alone may be unlikely to produce meaningful change if the surrounding conditions do not support engagement. Leadership, organisational commitment, protected time and psychologically safe team cultures may all influence whether staff are able to participate in TF in the way intended. Readiness for change therefore becomes an important consideration. Future work may benefit from exploring how services can strengthen these contextual conditions before introducing TF and how implementation can be adapted to meet the needs of different teams.

Limitations

Several limitations should be considered when interpreting the present findings. First, although participants represented a range of professional backgrounds within the MDT, the sample was comprised of staff who were willing to engage with both TF and research participation. Staff who consistently chose not to attend TF or perceived it as having limited value may have been less likely to volunteer for interviews. Consequently, the GT may primarily reflect the experiences of those who were more receptive to TF. Future research could benefit from specifically exploring the experiences of staff who choose not to engage, as these perspectives may provide further insight into the contextual factors that could facilitate or hinder its implementation.

A second limitation relates to the iterative design of the study. Interview questions and prompts were not fixed but developed iteratively alongside data collection and analysis, consistent with Charmaz (2014)'s approach. As understanding of the emerging categories developed, subsequent interviews increasingly explored concepts that appeared theoretically significant. This process allowed categories to be examined in greater depth but also meant that some areas received more attention than others. Participants' accounts were therefore shaped not only by their own experiences but also by the direction of the interview, which was informed by ongoing analysis, clinical judgement and the researcher's

developing theoretical understanding. While this iterative process is central to Constructivist GT, it is important to acknowledge that the resulting theory reflects a co-construction between researcher and participants rather than a neutral account of participants' experiences alone.

A further limitation relates to the relatively small sample size. Although Constructivist GT (Charmaz, 2014) does not prescribe a specific sample size, smaller samples require sufficient informational power to support the development of a meaningful conceptual model (Malterud et al., 2016). A smaller sample was anticipated at the outset of the study due to the practical challenges of recruiting staff within a specialist rehabilitation service. To enhance the informational power of the study, the research design incorporated a focus group with experienced clinical psychologists. The focus group was used to refine the developing theory while also increasing the informational power of the study and exploring the extent to which the emerging concepts resonated beyond the participating rehabilitation service. Whilst this strengthened the conceptual development and transferability of the findings, it remains possible that additional interviews, particularly with staff holding different perspectives on TF, may contribute to further construction of the proposed model.

Future Research

The present findings highlight several areas for future research. Further research would benefit from exploring staff experiences of TF across different rehabilitation services and clinical settings to examine how the organisational and relational conditions identified within the present model operate across different contexts. In particular, the perspectives of staff who choose not to engage with TF should be explored, as these may provide further insight into the factors that facilitate or hinder meaningful engagement with the process. Future research could also examine the proposed mechanisms through which TF may influence practice, including shared sense-making, reflective practice and shifts in staff understanding, and how these relate to subsequent changes in team functioning and patient care. Finally, research examining the implementation of TF within different organisational contexts may help identify how services can strengthen the conditions required to support its sustained use in practice.

Conclusion

The present study offers a theoretical account of how TF operates within psychiatric rehabilitation services and the conditions under which its potential benefits are most likely to emerge. The findings suggest that TF is shaped by the organisational context in which it takes place and, in turn, influences how teams make sense of patients, work together and approach clinical care. The conceptual model also provides a foundation for future research to explore how the organisational and relational conditions can be strengthened to support meaningful engagement with TF and enable it to flourish within psychiatric rehabilitation services.

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Appendices

Appendix A: PRISMA Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	P9
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	P10
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	P13
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	P13
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	P14-15
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	P14
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	P78
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	P15
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	P16
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	P16
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	P16
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	P16
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	P16

Section and Topic	Item #	Checklist item	Location where item is reported
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	N/A
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	N/A
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	N/A
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	P22
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	P18-19
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	-
Study characteristics	17	Cite each included study and present its characteristics.	P20-21
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	P22
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	N/A
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	P22
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	N/A
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	-
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	-
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	P22-33

Section and Topic	Item #	Checklist item	Location where item is reported
	23b	Discuss any limitations of the evidence included in the review.	P36-37
	23c	Discuss any limitations of the review processes used.	P36-37
	23d	Discuss implications of the results for practice, policy, and future research.	P37
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	P14
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	-
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	-
Competing interests	26	Declare any competing interests of review authors.	P18
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	-

Appendix B: Example Search Strategy

EBSCOhost

PsycINFO

#	Query	Limiters/Expanders	Last Run Via	Results
S106	S11 AND S91 AND S104 AND S105	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	1,395
S105	S32 OR S81 OR S85	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	2,930,109
S104	S92 OR S93 OR S94 OR S95 OR S96 OR S97 OR S98 OR S99 OR S100 OR S101 OR S102 OR S103	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	1,510,392
S103	TX (psychiatric rehabilitation OR mental health rehabilitation OR rehab unit* OR rehabilitation unit* OR inpatient rehabilitation OR psychiatric rehab* OR mental health rehab* OR rehabilitative care OR recovery-oriented inpatient*)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	16,962
S102	DE "Residential Treatment"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	2,079
S101	DE "Rehabilitation"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	26,288
S100	DE "Psychiatric Rehabilitation"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	227
S99	DE "Psychiatric Intensive Care Units"	Expanders - Apply equivalent subjects Search modes - SmartText Searching	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	30,533

S98	DE "Psychiatric Intensive Care Units"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	0
S97	DE "Psychiatric Hospitals"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	8,954
S96	DE "Hospitals"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	22,657
S95	DE "Inpatients"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	5,570
S94	TX (mental health OR psychiatr* OR psychiatric)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	1,475,295
S93	DE "Psychiatry"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	40,614
S92	DE "Mental Health"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	119,640
S91	S86 OR S87 OR S88 OR S89 OR S90	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	12,937
S90	TX (trauma-informed OR trauma-sensitive OR (trauma* N2 framework) OR (trauma* N2 informed) OR (trauma* N2 sensitive))	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	7,342
S89	TX (trauma N2 (aware OR sensitive))	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	562
S88	TX (trauma N2 (practice* OR approach* OR care OR framework*))	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	9,445
S87	TX (trauma N2 (implementation	Expanders - Apply equivalent subjects	Interface - EBSCOhost Research Databases Search Screen -	1,187

S78	TX (corbin* N2 strauss*)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	869
S77	TX foucault*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	3,642
S76	TX giorgi*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	7,072
S75	TX husserl*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	1,601
S74	TX (merleau N1 ponty*)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	939
S73	TX (van N1 kaam*)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	641
S72	TX (van N1 manen*)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	818
S71	TX speigelberg*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	0
S70	TX colaizzi*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	1,035
S69	TX heidegger*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	2,279
S68	TX narrative analy?is	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	10,052
S67	TX (constant N1 (comparative OR comparison))	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	6,471
S66	TX ((discourse* OR discurs*) N3 analy?is)	Expanders - Apply equivalent subjects	Interface - EBSCOhost Research Databases Search Screen -	18,622

S65	TX discourse analy?is	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	18,565
S64	TX "constant comparative"	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	4,339
S63	TX "thematic analysis"	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	41,332
S62	TX "content analysis"	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	42,364
S61	TX questionnaire*	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen - Advanced Search	629,624
S60	TX focus group*	Search modes - Proximity Expanders - Apply equivalent subjects	Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	78,221
S59	TX field stud*	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	70,114
S58	TX observational method*	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	7,908
S57	TX categor*	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	219,905
S56	TX (theme* OR thematic)	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	215,778
S55	TX cluster sampl*	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	4,651
S54	TX cluster sampl*v	Search modes - Proximity Expanders - Apply equivalent subjects SmartText Searching	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	0

S53	TX cluster sampl*v	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	0
S52	TX "life experience*"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	43,500
S51	TX "lived experience*"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	31,863
S50	TX ("life world" OR life-world OR conversation analy?is OR personal experience* OR theoretical saturation)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	34,269
S49	TX (account OR accounts OR unstructured OR open-ended OR "open ended" OR text* OR narrative*)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	501,121
S48	TX ((purpos* N4 sampl*) OR (focus N1 group*))	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	89,606
S47	TX theoretical sampl*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	2,026
S46	TX purposive sampl*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	11,255
S45	TX "qualitative validity"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	13
S44	TX "biographical method"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	68
S43	TX "human science"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	2,078

S42	TX (field N1 (study OR studies OR research))	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	53,619
S41	TX (humanistic OR existential OR experiential OR paradigm*)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	182,854
S40	TX ("action research" OR cooperative inquir* OR co operative inquir* OR co-operative inquir*)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	14,811
S39	TX (social construct* OR postmodern* OR post-structural* OR post structural* OR poststructural* OR post modern* OR post-modern* OR feminis* OR interpret*)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	321,374
S38	TX (emic OR etic OR hermeneutic* OR heuristic* OR semiotic*) OR TX (data N1 saturat*)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	59,944
S37	TX (grounded N1 (theor* OR study OR studies OR research OR analy?is))	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	28,056
S36	TX "grounded theory"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	22,451
S35	TX phenomenol*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	66,354
S34	TX ethnograph*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	39,006
S33	TX ethnonursing	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	77

S32	S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	175,288
S31	DE "Cluster Sampling"	Expanders - Apply equivalent subjects Search modes - SmartText Searching	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	8,200
S30	DE "Life Experiences"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Database - APA PsycInfo	32,184
S29	DE "Phenomenological Research"	Expanders - Apply equivalent subjects Search modes - SmartText Searching	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	30,742
S28	DE "Phenomenology"	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	20,174
S27	DE "Theoretical Sampling"	Expanders - Apply equivalent subjects Search modes - SmartText Searching	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	9,565
S26	DE "Field Studies"	Expanders - Apply equivalent subjects Search modes - SmartText Searching	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	94,044
S25	DE "Observational Methods"	Expanders - Apply equivalent subjects Search modes - SmartText Searching	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	21,662
S24	DE "Purposive Sampling"	Expanders - Apply equivalent subjects Search modes - SmartText Searching	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	7,325
S23	DE "Validity"	Expanders - Apply equivalent subjects Search modes - SmartText Searching	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	23,300
S22	DE "Constant Comparative Method"	Expanders - Apply equivalent subjects Search modes - SmartText Searching	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	14,641
S21	DE "Ethnonursing"	Expanders - Apply equivalent subjects	Interface - EBSCOhost Research Databases Search	4

S20	DE "Ethnology"	Search modes - SmartText Searching Expanders - Apply equivalent subjects	Screen - Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	2,156
S19	DE "Ethnography"	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	12,461
S18	DE "Content Analysis"	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	6,204
S17	DE "Discourse Analysis"	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	11,077
S16	DE "Focus Groups"	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	10,988
S15	DE "Attitudes"	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	33,869
S14	DE "Questionnaires"	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	29,200
S13	DE "Nursing Research"	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen - Advanced Search	1,952
S12	DE "Qualitative Research"	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	23,662
S11	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	642,939
S10	TX psychiatric hospital staff	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	1,673
S9	DE "Allied Health Personnel" OR TX allied health worker*	Search modes - Proximity Expanders - Apply equivalent subjects	Advanced Search Database - APA PsycInfo Interface - EBSCOhost Research Databases Search Screen -	2,629

S8	DE "Social Workers" OR TX social worker*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	40,243
S7	DE "Physicians" OR TX doctor*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	85,785
S6	DE "Nurses" OR TX nurse*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	100,210
S5	TX therapist*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	114,232
S4	DE "Psychiatrists" OR TX psychiatrist*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	68,464
S3	DE "Psychologists" OR DE "Clinical Psychologists" OR TX psychologist*	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	141,250
S2	DE "Mental Health Personnel" OR DE "Medical Personnel" OR TX staff	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	129,218
S1	DE "Health Personnel" OR TX health personnel	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	141,469

Appendix C: Sample of SR Reflexive Log

<https://osf.io/w3rky/files/osfstorage/6a62395f42151b039fa32507>

Appendix D: Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

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 for Quality in Health Care*, 19(6), 349-357.

Item No	Guide Questions/Description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/ facilitator	Which author/s conducted the interview or focus group?	Pg 52
2. Credentials	What were the researcher's credentials? E.g., PhD, MD	Pg 1
3. Occupation	What was their occupation at the time of the study?	Pg 53
4. Gender	Was the researcher male or female?	-
5. Experience and training	What experience or training did the researcher have?	Pg 53
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	Pg 53
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research?	Pg 53
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Pg 53
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Pg 49
Participant selection		
10. Sampling	How were participants selected? e.g., purposive, convenience, consecutive, snowball	Pg 50
11. Method of approach	How were participants approached? e.g., face-to-face, telephone, mail, email	Pg 50
12. Sample size	How many participants were in the study?	Pg 51

Item No	Guide Questions/Description	Reported on Page #
13. Non-participation Setting	How many people refused to participate or dropped out? Reasons?	-
14. Setting of data collection	Where was the data collected? e.g., home, clinic, workplace	Pg 52
15. Presence of nonparticipants	Was anyone else present besides the participants and researchers?	Pg 52
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Pg 50
Data collection		
17. Interview guide	Were questions, prompts, and guides provided by the authors? Was it pilot tested?	Pg 51
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	N/A
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Pg 52
20. Field notes	Were field notes made during and/or after the interview or focus group?	Pg 52
21. Duration	What was the duration of the interviews or focus group?	Pg 52
22. Data saturation	Was data saturation discussed?	Pg 68
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	Pg 52
25. Description of the coding tree	Did the authors provide a description of the coding tree?	N/A
26. Derivation of themes	Were themes identified in advance or derived from the data?	Pg 54
27. Software	What software, if applicable, was used to manage the data?	Pg 52
28. Participant checking	Did participants provide feedback on the findings?	N/A
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g., participant number	Pg 54-65
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Pg 54-65

Item No	Guide Questions/Description	Reported on Page #
31. Clarity of major themes	Were major themes clearly presented in the findings?	Pg 54-65
32. Clarity of minor themes	Is there a description of diverse cases or a discussion of minor themes?	Pg 54-65

Appendix E: Final Approved MRP proposal

*REMOVED FOR ENLIGHTEN REPOSITORY UPLOAD

Appendix F: Ethical Approval Letters

*REMOVED FOR ENLIGHTEN REPOSITORY UPLOAD

Appendix G: Participant Information Sheets

Phase 1 Staff Interview Participant Information Sheet

<https://osf.io/w3rky/files/osfstorage/6a60e053ad475d67cea32515>

Phase 2 Focus Group Participant Information Sheet

<https://osf.io/w3rky/files/osfstorage/6a60e0614d9d00ada3a71bab>

Appendix H: Consent Forms

Phase 1 Staff Interview Consent Form

<https://osf.io/w3rky/files/osfstorage/6a60e06f97c3bbb837a7196d>

Phase 2 Focus Group Consent Form

<https://osf.io/w3rky/files/osfstorage/6a60e07a48b2d488f6a32492>

Appendix I: Interview Schedules

Phase 1 Staff Interview Topic Guide

<https://osf.io/w3rky/files/osfstorage/6a60e177f0bb3b77f1d94d18>

Phase 2 Focus Group Topic Guide

<https://osf.io/w3rky/files/osfstorage/6a60e18366623ecea3a32280>

Appendix J: Sample of MRP Reflexive Log

<https://osf.io/w3rky/files/osfstorage/6a6239d5f597459704a321b6>

Appendix K: Data Analysis Plan

<https://osf.io/w3rky/files/osfstorage/6a623a1bf693123b1aa32207>

Appendix L: Development of Grounded Theory Model

Making sense of complexity collaboratively
(shared understanding → ?)
| broadening perspective → ?
Challenging established narratives.

AG.

Negotiating psychological ways of working

Psychologically safe space to reflect / no right/has
gets heard
structure.
↳ conditions where uncertainty can be tolerated Structure

Protecting established ways of working?

↳ TF is operating in?

↳ part of ward culture

Lack of engagement.

↳ about creating enough safety
to tolerate uncertainty?

↳ validating their work?
challenging behaviour?

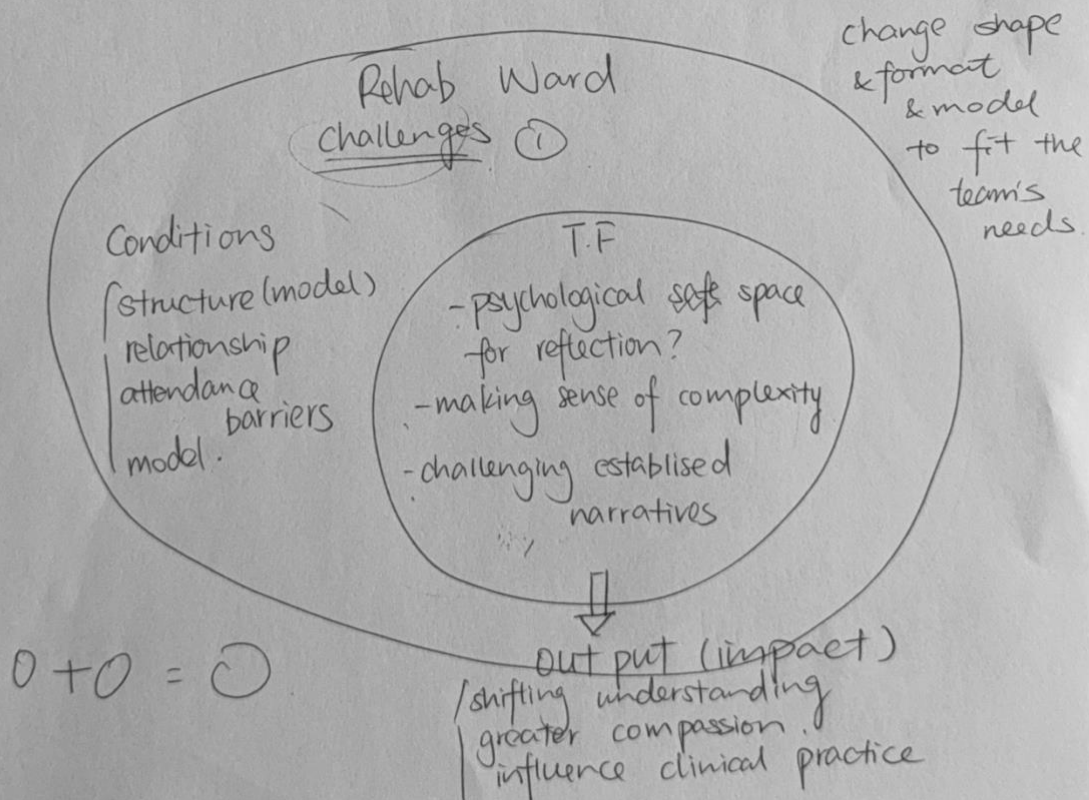
Practicing/working within an evolving rehab
culture

Explanatory Model

Core category → major category → sub-category → e.g.

Section 1.

- ① Context in which T.F. is trying to operate in
- evolving landscape
 - increased complexity
 - service change & uncertainty
 - ward set-up & entrenched views.
 - protecting established ways of working
 - 'expertise' & experience
 - resistance -
 - 'attendance' - younger staff etc.



MEMO.

Nurses feelings
about nursing
practice & changes
in rehab.
'regress'

MEMO

Older staff & their
relationship with
psychology.
Coming in &
changing things
- telling what to do

MEMO

Clinical psychologist
seen as an expert
- skilled, capable
- good at

MEMO

Divide between
nursing & other
professions
- staff burnout
apparent.

MEMO

- listening to the
team's needs
(educational etc)
- like clinical
practice - tailored
to patients

MEMO

Relationship with
team & how team
perceives facilitator
- in group / out group?
- like a lecture?
competency?

Appendix M: Data Availability Statement

The raw study data cannot be shared due to important ethical and confidentiality considerations. The dataset contains potentially identifiable information relating to participants' professional roles, clinical settings and demographic characteristics. Given the relatively small number of participants recruited from a single psychiatric rehabilitation service, there is an increased risk of deductive disclosure. To protect participant confidentiality, the raw data cannot be made publicly available. Audio recordings will be destroyed following transcription and verification, in accordance with the University of Glasgow data protection guidelines. Anonymised transcripts and study documentation will be retained securely for the period specified within the approved ethics application before being confidentially destroyed. The completed thesis will be made available through the University of Glasgow thesis publication website via Enlighten and further publication will also be considered in the *Frontiers of Psychology* journal. A summary of findings will be shared with participants and the participating NHS service. All disseminated findings will be fully anonymised. Interested researchers may contact the corresponding author for further information regarding the study.