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Containing Uncertainty: Experiences of Acute Inpatient Mental Health Care

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Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

School of Health and Wellbeing

College of Medical, Veterinary and Life Sciences

University of Glasgow

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Chapter 1: Systematic Review

The Erosion of Containment: Stakeholder Perspectives on Psychiatric Readmission to Adult Acute Inpatient Mental Health Services a Systematic Review

Prepared in accordance with the author requirements for the Journal of Psychiatric and Mental Health Nursing:
https://onlinelibrary.wiley.com/page/journal/13652850/homepage/forauthors.html

Accessible Summary

What is known on the subject

• Psychiatric readmission is common and costly to individuals and services and can be seen as an important indicator of how well mental health services support people.

•Research based on numerical data and statistics has highlighted factors linked to readmission, such as housing instability and gaps in follow-up care, but tells us little about how service users, informal caregivers and clinicians experience this process.

• Research that explores people's experiences of readmission has mostly focused on a single group, yet service users, caregivers and clinicians see the process of from different perspectives, and it is unclear how their perspectives agree or differ.

Originality

• This is the first review to bring together research on service user, informal caregiver and clinician perspectives on psychiatric readmission to see how they agree or differ.

• The review shows these perspectives are mostly in agreement, except for one genuine point of difference, around the importance and responsibility of continuing to follow treatment guidance after discharge.

• This review suggests that when the emotional, relational and practical support that service users need to cope with distress and not become overwhelmed is not consistent in the community, they are more likely to be readmitted.

Significance

• Findings support ways of understanding service users' difficulties and access to resources across different areas of life; personal, relational and practical, and thinking about what people may need when planning discharge to the community.

• Readmission rates on their own may not be the most accurate indicator of how well hospitals care for people, since readmission can also reflect the difficulties people experience being fully included in society and the gap that hospital only temporarily fills.

• The more people experience therapeutic and continuous relationships with their care team in the community, the less likely they are to need to come back to hospital.

Abstract

Introduction: Psychiatric readmission is a significant clinical, organisational and policy concern, yet no qualitative evidence synthesis has so far integrated the perspectives of service users, informal caregivers and clinicians who experience readmission from different positions on the care pathway.

Aim/Question: To identify, appraise and synthesise qualitative studies exploring stakeholders' perspectives' on psychiatric readmission to acute adult inpatient mental health services.

Method: A systematic search of OVID (EMBASE and MEDLINE), EBSCO (CINAHL and PsycINFO) and SCOPUS was conducted following PRISMA and ENTREQ guidance. Thirteen qualitative studies were quality-appraised using CASP and synthesised using thematic synthesis.

Results: Three analytical themes were generated: readmission as a failure of containment beyond hospital; involvement, responsibility and competing understandings of readmission; and the paradox of inpatient care as both refuge and exclusion. Stakeholders' perspectives' were largely complementary, though clinicians and service users/caregivers diverged on the importance and responsibility of treatment adherence.

Discussion: Psychiatric readmission may be understood as occurring when psychological, relational and organisational forms of containment progressively become insufficient to sustain community living.

Implications for Practice: Findings support collaborative, systemic ways of understanding service users' difficulties and resources at the point of discharge planning, alongside community care that attends to social inclusion and consistent clinical follow-up.

Recommendations: Future research should evaluate the role collaborative and systemic ways of understanding service users' difficulties and resources in discharge planning, investigate interventions that strengthen social inclusion alongside continuity of care, and further explore stakeholders' perspectives' across the care pathway.

Keywords: psychiatric readmission; qualitative evidence synthesis; thematic synthesis; inpatient mental health; clinicians; informal caregivers

Introduction

Psychiatric Readmission: Context and Significance

Severe mental health difficulties are among the leading causes of disability worldwide and represent a substantial public health challenge (World Health Organization [WHO], 2021). Mental health policy has progressively moved from long-term institutional care and towards community-based models that emphasise recovery and continuity of care (WHO, 1990; National Health Service and Community Care Act, 1990). In the United Kingdom (UK), this has been reinforced by policies promoting collaborative care planning and the continuity of support following discharge (NHS England, 2019; NHS England & National Collaborating Centre for Mental Health, 2019). Acute psychiatric inpatient services nonetheless remain essential for people experiencing severe mental health crises.

Psychiatric readmission is therefore an important clinical, organisational and policy concern. Readmission can represent an appropriate response to renewed clinical need. Nevertheless, repeated or avoidable readmissions are associated with poorer outcomes, disrupted community life, caregiver burden and substantial costs (Durbin et al., 2007; Byrne et al., 2010). In England, 21.4% of people discharged from acute mental health services were readmitted within six months, with a median time to readmission of 34 days (Osborn et al., 2021), with similar trends observed globally (WHO, 2021). Reducing avoidable readmission is therefore a national and international health service priority. Moreover, readmission rates have been widely used as a quality indicator for inpatient psychiatric care, yet their validity for this purpose is unclear (Durbin et al., 2007), suggesting that what readmission actually reflects is itself an open question.

Quantitative and Qualitative Perspectives on Readmission

Quantitative research consistently frames psychiatric readmission as multifactorial; it arising through interacting clinical, social and organisational influences, rather than any single determinant (Donisi et al., 2016). Prior hospitalisation, symptom severity and treatment adherence increase readmission risk (Kalseth et al., 2016), as do social circumstances such as unstable housing (Sfetcu et al., 2017), and organisational factors

including discharge planning and continuity of care (Donisi et al., 2016). The transition from inpatient to community care is consistently identified as a period of heightened vulnerability, in which continuity of care, family involvement and community support are critical (Biringer et al., 2017). Longitudinal evidence indicates that changes in recovery following discharge may better predict readmission, rather than symptom severity at a single point (Taquet et al., 2023). Recovery Capital offers one way of making sense of the factors linked to readmission, describing the personal, social and community resources; relationships, roles, housing, a sense of belonging, that sustain recovery over time (Hennessy, 2017; Best & Hennessy, 2022). The Social Ecological Model complements this by distinguishing between the levels at which such influences operate; individual, relational, organisational and community (Reupert, 2017). Together, these frameworks aid understanding of the factors that support recovery and avoid readmission, and where that support is generated and sustained. The frameworks are utilised in the discussion.

While the quantitative evidence above identifies associated factors with readmission, it offers limited insight into how these influences are experienced and negotiated by those involved. Qualitative research is well suited to examining how people make sense of health experiences within the contexts in which they occur (Green & Thorogood, 2018) and can illuminate the processes through which readmission comes about. Existing qualitative studies exploring hospitalisation, discharge and community living also suggest readmission is shaped by more than clinical deterioration; therapeutic relationships, continuity of care, and practical and social support all play a part (Biringer et al., 2017; Davidson et al., 2005; De Ruysscher et al., 2020).

Integrating Service User, Informal Caregiver and Clinician Perspectives

Psychiatric readmission unfolds across interactions between service users, informal caregivers and clinicians, who occupy different positions within the care pathway and experience different aspects of the process. Service users offer first-hand accounts of living with severe mental health difficulties and navigating recovery (Okoroji et al., 2023). Informal caregivers provide sustained support whereby they observe both recovery and renewed crisis (Rowe, 2012). Clinicians contribute perspectives shaped by assessment, discharge decision-making, and organisational realities (Bhugra et al., 2011). Together, these perspectives offer complementary insight no single stakeholder group

could provide; which is concordant with contemporary approaches to collaborative mental healthcare that integrate experiential and professional knowledge rather than privileging one perspective (Rose et al., 2006; Okoroji et al., 2023) and is reflected in frameworks such as the Triangle of Care (Hannan, 2013). However, qualitative studies have predominantly explored single stakeholder groups, therefore understanding of the convergence and divergence of service user, caregiver and clinician perspectives remains limited.

Qualitative evidence synthesis offers a rigorous approach to combining findings together across studies, identifying patterns of convergence and divergence while generating interpretive insights grounded in participants' own experiences (Thomas & Harden, 2008). To the author's knowledge, no published synthesis has yet integrated the perspectives of service users, informal caregivers and clinicians on psychiatric readmission to adult acute inpatient mental health services.

Aim

The aim of this review was to identify, appraise and synthesise qualitative studies exploring the perspectives of service users, informal caregivers and clinicians on psychiatric readmission to acute adult inpatient mental health services. In doing so, the aim was to build a more comprehensive understanding of readmission's causes, experiences and prevention, and to identify areas of convergence, divergence and gaps in the evidence base.

Methods

Registration

In line with PRISMA guidelines (Page et al., 2021), the protocol was registered with PROSPERO on 26/01/2026 (CRD420251183911) and was reported in accordance with PRISMA (Appendix 1.1) and ENTREQ (Appendix 1.2) guidance (Tong et al., 2012).

Search Strategy

A preplanned systematic search was conducted between 21st November and 19th December 2025. Five databases were searched: OVID (EMBASE and MEDLINE), EBSCO (CINAHL and PsycINFO) and SCOPUS, to ensure comprehensive coverage across the biomedical, psychological and nursing/allied health literatures relevant to psychiatric readmission. The search strategy was constructed using the SPIDER

framework (Cooke et al., 2012), and developed in consultation with a specialist librarian. No search limits were used. The full search strategies for each database can be found in Appendix 1.3; the search strategies consisted of an existing qualitative research filter (Shaw et al. 2004) and the following:

1. Key terms for: psychiatric inpatient care and readmission
2. MeSH/subject headings
3. Boolean operators.

Study Selection

This review included qualitative studies reporting perceptions of readmission to acute adult psychiatric inpatient services from the perspectives of service users, caregivers and clinicians, generated through interviews, focus groups or similar methods. The review synthesised findings using thematic synthesis (Thomas & Harden, 2008); mixed-methodological studies were therefore excluded to preserve methodological coherence between the review question, evidence and synthesis method (Lockwood et al., 2024). Studies published before 1990 were excluded as this corresponded with the National Health Service and Community Care Act (1990) and WHO (1990) shift in policy toward community-based mental health care. Inclusion and exclusion criteria are presented in Table 1.

Table 1. Criteria for Inclusion and Exclusion

Inclusion criteria	**Exclusion criteria**
• Qualitative studies (interviews, focus groups, ethnographies, qualitative surveys) exploring stakeholder perspectives' on readmission to psychiatric inpatient care	• Quantitative or mixed-methodological studies
• Studies addressing causes, experiences of and/or prevention to readmission to inpatient psychiatric care	• Specialist acute populations (eating disorders, learning disabilities, forensic care, older adults, substance detox, perinatal, emergency department)
• Participants: service users (18 year+, experienced at least one readmission of to inpatient psychiatric	• Single case studies or case reports

care), informal caregivers, and or clinicians working in acute psychiatric inpatient services	
• Peer-reviewed, English-language articles published between 1990-2025	• Non-peer-reviewed articles, opinion pieces, reflective pieces, editorials. Non-English language.
	• Meta-analyses, systematic and literature reviews

Review Process

Database searches were managed using EndNote and Rayyan (Ouzzani et al., 2016). Titles and abstracts were independently screened by the first author against the eligibility criteria, with a random 10% sample screened by an independent second reviewer (CD) to assess consistency; agreement was 100%. Full texts of potentially eligible studies were then reviewed by the first author against the inclusion criteria. Data were extracted by the first author into a pre-defined table in Microsoft Excel capturing study aims, participants, methods, findings and study characteristics.

Quality appraisal was conducted by the first author using the CASP Qualitative Studies Checklist (CASP, 2023) (Appendix 1.4), assessing methodological rigour, transparency, reflexivity and credibility, with studies rated as low (0-4), moderate (5-7) or high (8-10) quality (Milner et al., 2020). CASP was selected as it is the most widely used appraisal tool in qualitative evidence synthesis for health research, endorsed by Cochrane (Hannes, 2011), although its sensitivity has been criticised compared to alternatives such as the JBI checklist (Hannes et al., 2010). Consistent with Cochrane guidance (Noyes et al., 2018), quality appraisal informed interpretation rather than exclusion, as appraisal tools may not adequately capture the significance of qualitative findings (Sattar et al., 2021). The second reviewer (CD) independently appraised a random 15% sample (2 of 13 studies); agreement on overall quality was 100%, with minor disagreement on individual items resolved through discussion.

Method of Synthesis

The synthesis was interpretative, integrating rather than aggregating findings across studies (Booth, 2016). Thematic synthesis which is primarily inductive, was conducted

manually using Microsoft Excel and followed Thomas and Harden (2008) across three stages:

1. Familiarisation and line-by-line coding;
2. Development of inductive descriptive themes;
3. Development of analytical themes extending beyond description.

Findings from service users, informal caregivers and clinicians were synthesised together, with greater weight given to studies with a higher quality appraisal rating; however caregiver and clinician findings were less numerous and therefore disproportionately included, to ensure representation across stakeholder groups. Consistent with Thomas and Harden (2008), all reported results/findings were treated as data; participant quotations were treated as primary data, prioritised during initial coding, and authors' interpretations as secondary data incorporated during a second coding phase to compare similarities and differences across studies.

Reflexivity Statement

The primary researcher was a trainee clinical psychologist undertaking a clinical placement within an acute adult inpatient mental health service in Scotland while conducting this review. This professional context, and an entering assumption that readmission reflects an interaction between individual experience and systemic factors, may have shaped the review question, literature interpretation and theme development. To support reflexivity, the primary researcher kept a reflective journal and undertook regular supervision with the wider research team, including a member who did not work clinically within the NHS. The review was informed by a critical realist perspective, treating participants' accounts as reflecting real social and healthcare phenomena while acknowledging that both primary studies and the present synthesis involve interpretation (Fletcher, 2017), a position considered congruent with thematic synthesis (Thomas & Harden, 2008).

Results

A total of 18,247 records were identified across five databases (Scopus n = 4,941; PsycINFO n = 2,805; Ovid MEDLINE n = 4,165; Ovid EMBASE n = 5,065; CINAHL n = 1,271). After removing 3,697 duplicates, 14,550 records underwent title and abstract screening (10% independently screened by a second reviewer (CD) with 100%

agreement), leaving 52 full-text articles for eligibility assessment. Of these, 39 were excluded, primarily for not employing a qualitative methodology or not exploring psychiatric readmission as the primary phenomenon of interest. Backward and forward citation searching of the 13 included studies identified a further 695 records, with no additional eligible studies found. Thirteen studies were therefore included in the thematic synthesis. The PRISMA 2020 flow diagram is presented in Figure 1.

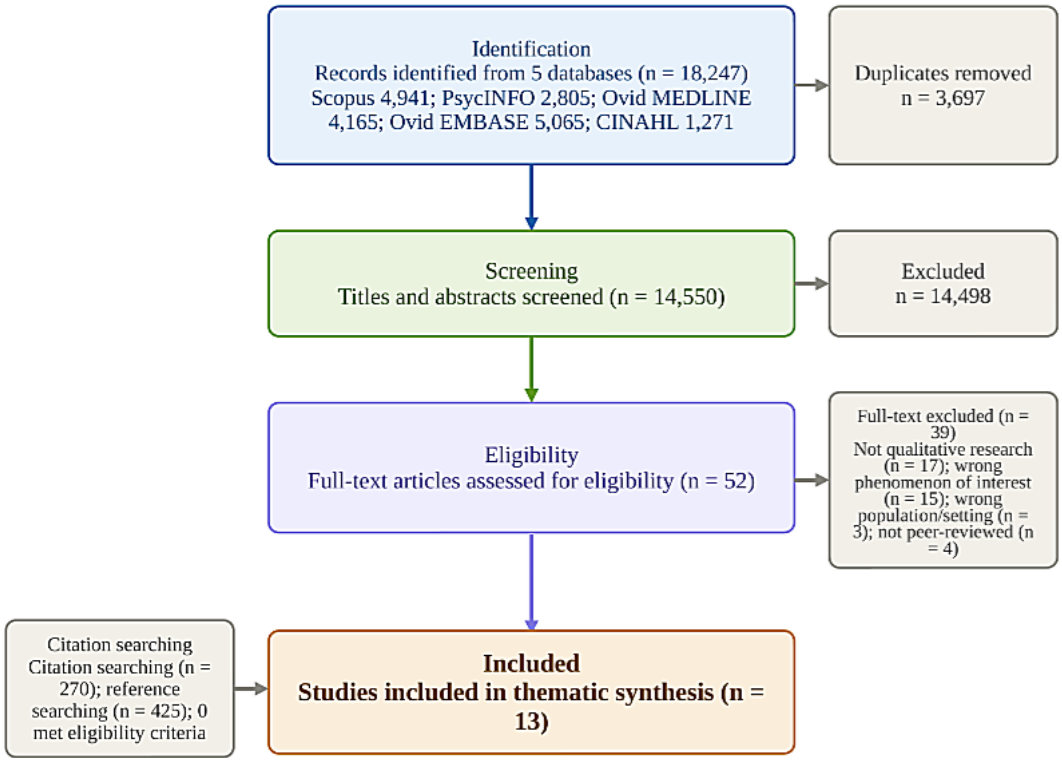


Figure 1. PRISMA 2020 flow diagram of record selection process.

Study Characteristics

The thirteen included studies were published between 1996 and 2025, conducted across fifteen countries, including two six-country multinational studies (Ådnanes et al., 2018, 2020), and involved 246 unique participants (160 service users, 29 informal caregivers, 57 mental health nurses; participants were counted once where samples overlapped across studies). Sample sizes ranged from 10 to 55 participants. Service user samples included adults with schizophrenia, psychosis, bipolar, affective, personality and mood disorders. Two studies included caregivers alongside service users (George & Howell, 1996; Mlay et al., 2024), one study included only informal caregivers (Raluthanga et al., 2023) and three examined mental health nurses' perspectives (Dlamini & Shongwe, 2019;

Kassim et al., 2021; Nxasana & Thupayagale-Tshweneagae, 2014). Study characteristics are summarised in Table 2, and full characteristics are presented in Appendix 1.5.

Table 2. Summary of Characteristics of Included Studies

Study, Country	Participants	Design & Analysis	Key Findings
Martino et al. (2025), Switzerland	n=20 service users with 3-8 re admissions	Semi-structured interviews; reflexive thematic analysis	Hospital as safety/containment vs. escape from external pressures
Mlay et al. (2024), South Africa	n=24 service users and 6 caregivers	Semi-structured interviews; descriptive phenomenology	Personal, family and health-system risk/protective factors for relapse
Raluthanga et al. (2023), South Africa	n=18 caregivers	Semi-structured interviews; inductive thematic analysis	Misconceptions about illness, supervision barriers, alternative healing
Phillips et al. (2022), UK	n=8 service users with 3-17 readmissions	Semi-structured interviews; interpretative phenomenological analysis	Quality of therapeutic relationships; abrupt discharge; unmet needs
Kassim et al. (2021), Brunei	n=24 psychiatric nurses	Focus groups; thematic analysis	Role of family support and psychoeducation in preventing readmission
Ko & Park (2021), South Korea	n=11 service users with 2-10 readmissions	In-depth interviews; thematic analysis	Social maladjustment, loneliness, family shame, revolving-door pattern

Ådnanes et al. (2020), 6 European countries	n=55 service users (shared sample w/ 2018)	Focus groups; systematic text condensation	Strategies to avoid rehospitalisation: planning, coping, follow-up, peer/family support
Dlamini & Shongwe (2019), Eswatini	n=9 mental health nurses	In-depth interviews; thematic analysis	Non-adherence, substance use, stigma, family belief systems, admin barriers
Ådnanes et al. (2018), 6 European countries	n=55 service users	Focus groups; systematic text condensation	Rehospitalisation as relieving, necessary, or part of recovery
Brännström et al. (2018), Sweden	n=10 service users	Semi-structured interviews; content analysis	Affect regulation, relational sensitivity, resignation, ambivalence
Duhig et al. (2017), Australia	n=13 service users readmitted <28 days	Semi-structured interviews; grounded theory	Discordant discharge; inadequate relief; readmission as sanctuary
Nxasana & Thupayagale-Tshweneagae (2014), South Africa	n=10 psychiatric nurses	In-depth interviews; Tesch's method	Medication management, family support, stigma, cultural influences
George & Howell (1996), USA	n=5 service users, 5 caregivers	Semi-structured interviews; phenomenological	Safety, medication stabilisation, hope, frustration with system

Quality Appraisal

CASP appraisal (Table 3) rated seven studies as high quality, five as moderate, and one as low quality. No studies were excluded on this basis; appraisal instead informed interpretation. Research aims and qualitative methodologies were generally appropriate and well-justified, and ethical procedures and analytic rigour were generally well

reported. Reflexivity was the most consistent limitation, with few studies explicitly considering researcher positionality or its influence on data generation and interpretation. Overall, the evidence base was considered sufficiently robust to support thematic synthesis, although these limitations were considered when interpreting findings from moderate- and low-quality studies. The second reviewer (CD) independently appraised 15% of studies (2 of 13) using CASP, with 100% agreement on overall quality category.

Table 3. CASP Quality Appraisal of Included Studies

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Overall Rating
Martino et al. (2025)	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	High (9/10)
Mlay et al. (2024)	?	Y	Y	?	?	?	Y	Y	Y	?	Moderate (5/10)
Raluthanga et al. (2023)	Y	Y	?	Y	Y	N	Y	N	?	?	Moderate (5/10)
Phillips et al. (2022)	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	High (9/10)
Kassim et al. (2021)	Y	Y	?	Y	Y	?	N	?	Y	Y	Moderate (6/10)
Ko & Park (2021)	Y	Y	?	Y	Y	?	Y	Y	Y	?	Moderate (7/10)
Ådnanes et al. (2020)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	High (9/10)

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Overall Rating
Dlamini & Shongwe (2019)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	High (9/10)
Ådnanes et al. (2018)	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	High (9/10)
Brännström et al. (2018)	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	High (9/10)
Duhig et al. (2017)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	High (10/10)
Nxasana & Thupayagale-Tshweneagae (2014)	Y	Y	?	?	?	N	Y	?	?	N	Low (3/10)
George & Howell (1996)	Y	Y	Y	Y	Y	?	Y	?	?	?	Moderate (6/10)

Q1-Q10 correspond to the ten CASP Qualitative Studies Checklist items. Y = Yes, N = No, ? = Can't tell.

Table 3. Key

Score (Y)	Rating
8–10	High Quality
5–7	Moderate Quality
0–4	Low Quality

Thematic Synthesis Findings

Thematic Synthesis generated 40 initial codes, including comparison between studies, which were ultimately organised into 10 descriptive themes and subsequently synthesised into three analytical themes. The resulting Themes are presented in Figure 2; the full set of descriptive codes and an audit trail of study contribution is reported in Appendix 1.6.

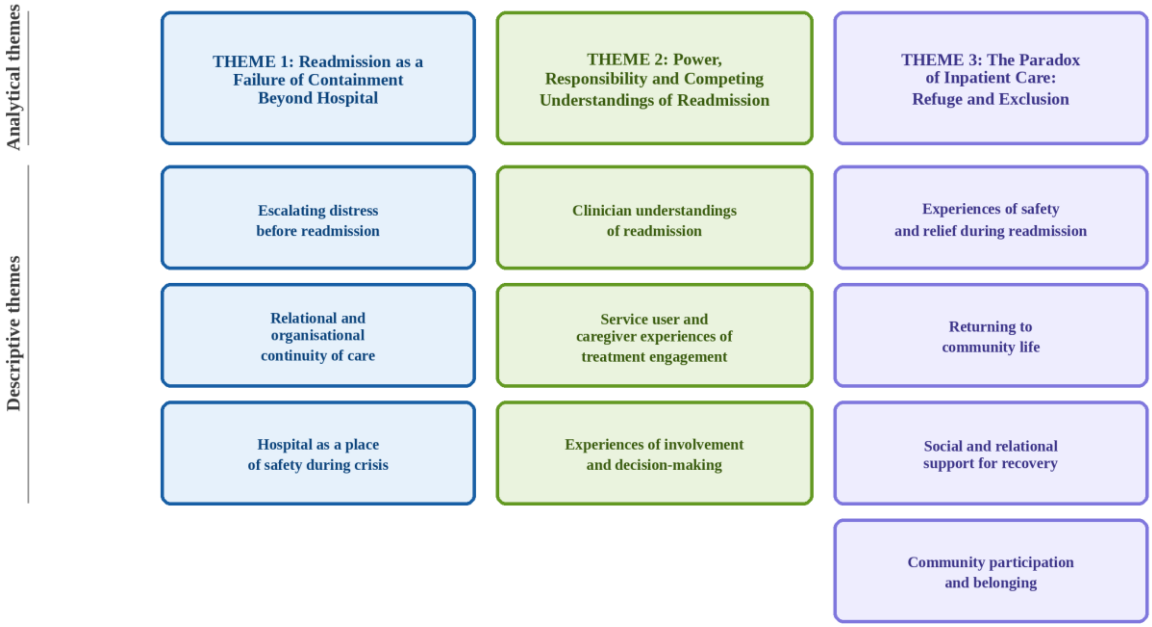


Figure 2. Thematic diagram of the thematic synthesis.

THEME 1: READMISSION AS A FAILURE OF CONTAINMENT BEYOND HOSPITAL

Across studies, readmission was described as unfolding through a gradual accumulation of distress, the loss of relationships that had previously offered support, and disruptions in the organisational continuity of care that could have sustained support. Service users, caregivers and clinicians all recognised that readmission occurred when existing psychological, relational and organisational sources of containment were no longer sufficient.

Escalating distress before readmission

Across service user studies, psychiatric readmission was described as emerging through gradual deterioration rather than sudden relapse, with worsening symptoms, declining daily functioning and diminishing capacity to manage everyday life (Brännström et al., 2018; Duhig et al., 2017; Ko & Park, 2021; Martino et al., 2025; Phillips et al., 2022). Rather than a single event, there was an accumulation of interacting stressors. As one participant put it, *"It's a whole... several elements... have interlocked to form a big ball of wool... there are several threads of different colours, but it's still a big ball of wool"* (Martino et al., 2025, Service user, p. 5).

Caregivers similarly described increasing vulnerability as they witnessed relatives becoming progressively less able to care for themselves, with accounts highlighting concerns about exploitation, homelessness and growing exposure to risk (George & Howell, 1996; Mlay et al., 2024). One caregiver reflected, *"I am always relieved... he is not able to take care of himself. People take advantage of him—sex... drugs"* (George & Howell, 1996, Caregiver, p. 6).

Across stakeholder groups, crisis rarely occurred without warning, but as the endpoint of a narrowing set of options, once distress exceeded the psychological, relational and practical resources available to contain it. One service user described waiting for support *"all alone"* until *"it explode[d]"* (Brännström et al., 2018, Service user, p. 4), while a clinician reflected that many people readmitted in crisis were *"so uncontrollable we are even scared of them too"* (Nxasana & Thupayagale-Tshweneagae, 2014, Clinician, p. 9).

Relational and organisational continuity of care

Whether distress could be contained in the community depended partly on how discharge was handled. Across service user studies, discharge was frequently abrupt and poorly planned, lacking continuity between inpatient and community services (Ådnanes et al., 2020; Brännström et al., 2018; Duhig et al., 2017; Mlay et al., 2024; Phillips et al., 2022), and often experienced as something done to them rather than with them. One participant reflected, *"There was no transfer process, you just got thrown out... it became too scary... then it was just too much"* (Brännström et al., 2018, Service user, p. 5).

This lack of continuity made it harder to sustain recovery after discharge, with participants describing inadequate follow-up and the sudden loss of therapeutic relationships built during readmission (Ådnanes et al., 2018, 2020; Brännström et al., 2018; Duhig et al., 2017; Phillips et al., 2022). One participant described preparing

emotionally for appointments only for professionals to *"not turn up"*, leaving *"all these feelings floating around"* (Phillips et al., 2022, Service user, p. 7).

Where continuity was maintained, participants described more confidence managing recovery beyond hospital, valuing collaborative discharge planning and relationships with familiar professionals who *"knew"* their history (Ådnanes et al., 2018, Service user, p. 4) and creating *"an enormous [feeling of] safety"* (Ådnanes et al., 2020, Service user, p. 3). Caregivers, by contrast, described discharge as premature when relatives returned home before meaningful recovery, while clinicians highlighted organisational barriers including staffing shortages, limited time for psychoeducation and under-resourced community services (Dlamini & Shongwe, 2019; Kassim et al., 2021; Nxasana & Thupayagale-Tshweneagae, 2014).

Hospital as a place of safety during crisis

Once distress had reached this point, hospital was rarely wanted but often the only option once distress had reached the point at which the community resources were no longer sufficient, making hospital the only remaining place of safety (Ådnanes et al., 2018, 2020; Brännström et al., 2018; Duhig et al., 2017; George & Howell, 1996; Martino et al., 2025). As one participant put it, *"I didn't want to come back, but I had no place else to go"* (George & Howell, 1996, Service user, p. 6).

Participants consistently imagined forms of community support that might have prevented readmission; timely, flexible and responsive, rather than more hospital care. One participant imagined *"somebody who comes [to my home]... quite flexible"* (Ådnanes et al., 2020, Service user, p. 3), while another explained that *"you are taken seriously only when you have taken an overdose"* (Brännström et al., 2018, Service user, p. 4).

Despite this reluctance to be readmitted, hospital was frequently experienced as offering safety and containment unavailable elsewhere, including regular contact with professionals, protection during suicidality, and support no longer accessible in the community (Duhig et al., 2017; George & Howell, 1996; Martino et al., 2025). Caregivers described readmission as *"my only hope"* (George & Howell, 1996, Caregiver, p. 9), while clinicians acknowledged the emotional complexity of repeatedly supporting people whose crises had escalated this far, including the impact on staff of caring for individuals with histories of violence or aggression (Kassim et al., 2021).

THEME 2: INVOLVEMENT, RESPONSIBILITY AND COMPETING UNDERSTANDINGS OF READMISSION

Service users, caregivers and clinicians all recognised continuity of treatment as important in preventing readmission, but differed in their understanding of who was responsible for maintaining it. Clinicians frequently explained readmission through treatment adherence and illness insight, while service users and caregivers situated these same behaviours within broader social, relational and practical contexts. Readmission, in this sense, emerged as a site where responsibility and expertise were negotiated differently by those giving, receiving and supporting care.

Clinician understandings of readmission

Across clinician studies, psychiatric readmission was predominantly understood through the lens of treatment engagement, particularly medication adherence (Dlamini & Shongwe, 2019; Kassim et al., 2021; Nxasana & Thupayagale-Tshweneagae, 2014). Clinicians frequently described discontinuing medication, missed appointments and limited insight into mental illness as key contributors to relapse, one describing medication discontinuation as creating *"a vicious cycle"* in which service users repeatedly defaulted on treatment before returning to hospital (Dlamini & Shongwe, 2019, Clinician, p. 3).

Although clinicians acknowledged wider influences on readmission, including side effects, substance use, co-occurring physical illness and cultural beliefs, these were typically interpreted through their impact on treatment adherence (Dlamini & Shongwe, 2019; Kassim et al., 2021; Nxasana & Thupayagale-Tshweneagae, 2014). Preventing readmission was, correspondingly, closely associated with psychoeducation and medication monitoring, as one clinician concluded: *"there are no people to monitor patient compliance... medication compliance is critical*" (Kassim et al., 2021, Clinician, p. 3).

Service user and caregiver experiences of treatment engagement

In contrast to clinician accounts, service users and caregivers described treatment engagement as embedded within everyday life rather than simply adherence. Decisions about medication were shaped by financial insecurity, side effects, competing responsibilities and previous experience of treatment (Ko & Park, 2021; Martino et al.,

2025; Mlay et al., 2024; Raluthanga et al., 2023), including stopping medication due to intolerable side effects or adjusting treatment according to how well they felt. One participant questioned how they could continue after losing employment, asking, *"I wasn't working anymore. How am I going to continue because I have to get my pills?"* (Mlay et al., 2024, Service user, p. 6).

Treatment decisions were also shaped by broader cultural, spiritual and relational contexts, with participants describing seeking help from traditional healers or receiving advice from religious leaders to stop medication (Dlamini & Shongwe, 2019; Mlay et al., 2024; Raluthanga et al., 2023). Engagement with treatment, then, involved ongoing negotiation between biomedical recommendations and other sources of knowledge and support, rather than straightforward acceptance or rejection of clinical advice.

Caregivers described the emotional burden of supporting treatment while having limited authority to influence it, monitoring medication and recognising early signs of relapse yet often being unable to intervene when relatives refused treatment (Mlay et al., 2024; Raluthanga et al., 2023). One caregiver reflected, *"I do not know what we can do to make him take his treatment because that is the only thing that can save him from relapsing"* (Raluthanga et al., 2023, Caregiver, p. 8).

Experiences of involvement and decision-making

These differing accounts reflected a wider divergence in how responsibility for preventing readmission was understood across the care pathway. Clinicians tended to emphasise individual responsibility for treatment adherence (Dlamini & Shongwe, 2019; Kassim et al., 2021; Nxasana & Thupayagale-Tshweneagae, 2014), while service users and caregivers described responsibility as shared across individuals, families and services.

Service users often described feeling responsible for managing their own recovery while lacking the resources to do so, encountering fragmented services and inconsistent professional support (Ådnanes et al., 2018, 2020; Brännström et al., 2018; Duhig et al., 2017; Ko & Park, 2021; Martino et al., 2025; Phillips et al., 2022). One participant reflected, *"I have to take responsibility for myself, but I can't do it on my own"* (Phillips et al., 2022, Service user, p. 8).

Caregivers similarly described assuming substantial responsibility for recognising deterioration and managing crises, often without meaningful involvement in care planning or decision-making (George & Howell, 1996; Mlay et al., 2024; Raluthanga et al., 2023), and frequently feeling excluded from information despite being expected to support recovery. One caregiver explained, *"You are expected to cope, but nobody tells you what to do"* (George & Howell, 1996, Caregiver, p. 8). Rather than reflecting competing explanations, these accounts illuminate different aspects of the same process, shaped by participants' respective positions within the mental healthcare services.

THEME 3: THE PARADOX OF INPATIENT CARE: REFUGE AND EXCLUSION

Across studies, inpatient readmission was described as both a place of safety and a reminder of the difficulty of sustaining life beyond hospital. Hospital offered protection, structure and temporary relief from overwhelming demands, yet repeated readmission also reflected loneliness, exclusion and limited opportunities to build a meaningful life within the community. Consequently, inpatient care emerged as both refuge from crisis and evidence that ordinary life remained insufficiently supported.

Experiences of safety and relief during readmission

Participants frequently described hospital as a place of safety, protection and temporary relief during periods of overwhelming distress, associated with consistent routines and proximity to professionals (Ådnanes et al., 2018; Brännström et al., 2018; Duhig et al., 2017; George & Howell, 1996; Martino et al., 2025; Phillips et al., 2022). One participant reflected, *"In here I feel quite safe and comfortable... there's a consistency which is good"* (Duhig et al., 2017, Service user, p. 5).

Hospital also provided relief from responsibilities participants no longer felt able to manage, with service users describing stepping away from work and everyday decision-making to regain emotional stability (Ådnanes et al., 2018; Duhig et al., 2017; George & Howell, 1996; Martino et al., 2025). One participant likened readmission to *"going to a vacation"* where they could *"rest my brain and pull myself together"* (Ådnanes et al., 2018, Service user, p. 6).

Despite this safety, participants rarely wanted to remain in hospital. One acknowledged that readmission allowed them to *"relapse into the role of the patient... not having to take*

responsibility", before adding, *"I don't want that kind of life*" (Brännström et al., 2018, Service user, p. 5); another captured the ambivalence of discharge, questioning, *"Am I ready for this?"* (Phillips et al., 2022, Service user, p. 6).

Returning to community life

Once discharged, however, returning to community life was frequently described as harder than leaving hospital, involving the loss of structure, routine and support that had enabled safety during readmission (Ådnanes et al., 2018; Brännström et al., 2018; Duhig et al., 2017; Ko & Park, 2021; Martino et al., 2025; Mlay et al., 2024; Phillips et al., 2022). One participant reflected, *"I can't get used to this society... It's more comfortable to be hospitalized"* (Ko & Park, 2021, Service user, p. 5).

Participants consistently described loneliness and the loss of supportive relationships following discharge, missing the regular contact available on the ward (Duhig et al., 2017; Martino et al., 2025; Mlay et al., 2024; Phillips et al., 2022). One participant recalled, *"One day [a nurse] was going home and I felt so alone! I used to put a chair out on the landing and just sit there"* (Phillips et al., 2022, Service user, p. 7).

Alongside this isolation, the practical demands of community living often became overwhelming, with everyday responsibilities, financial insecurity and housing difficulties compounding distress following discharge (Duhig et al., 2017; Ko & Park, 2021; Martino et al., 2025). One participant explained that outside hospital *"daily mundane things"* could become *"a burden depending on how we feel"* (Martino et al., 2025, Service user, p. 8), while another described feeling that, without someone to talk to, *"there will be a snowball effect, and everything will be chaos"* (Brännström et al., 2018, Service user, p. 4).

Social and relational support for recovery

Across stakeholder groups, supportive relationships were consistently described as central to sustaining recovery, with service users, caregivers and clinicians all portraying recovery as something achieved through relationships rather than in isolation, yet each group emphasised different aspects of this (Ådnanes et al., 2018, 2020; Dlamini & Shongwe, 2019; Duhig et al., 2017; George & Howell, 1996; Kassim et al., 2021; Mlay et al., 2024; Phillips et al., 2022; Raluthanga et al., 2023).

Service users valued relationships characterised by trust, continuity and feeling understood, describing stronger recovery when professionals listened, involved them in decisions and remained consistently available over time (Ådnanes et al., 2018, 2020; Duhig et al., 2017; Phillips et al., 2022). One participant reflected that *"someone who genuinely cares and sticks with you"* (Phillips et al., 2022, Service user, p. 9) made the greatest difference to remaining well.

Caregivers similarly described relationships as essential to recovery but emphasised shared responsibility, reporting emotional support and recognising early signs of deterioration, while also describing the burden of carrying this with limited professional support (George & Howell, 1996; Mlay et al., 2024; Raluthanga et al., 2023). One caregiver explained that recovery depended upon *"working together*" rather than families or professionals managing alone (Raluthanga et al., 2023, Caregiver, p. 8).

Clinicians also highlighted collaborative relationships as fundamental to preventing readmission, citing that organisational pressures, including time constraints, staffing shortages and fragmented services, limited opportunities to build them (Dlamini & Shongwe, 2019; Kassim et al., 2021). Across stakeholder groups, these accounts suggest relationships were not simply beneficial additions to care but an essential resource through which recovery could be sustained following discharge.

Community participation and belonging

Beyond relationships, participants frequently described repeated readmission as reflecting more than the recurrence of mental illness, with recovery also associated with opportunities to participate in meaningful activities and contribute to everyday life (Ådnanes et al., 2018; George & Howell, 1996; Ko & Park, 2021; Mlay et al., 2024; Phillips et al., 2022). As one participant put it, *"the answer isn't always medication or therapy"* but helping people *"find a balance doing things they are passionate about"* (Phillips et al., 2022, Service user, p. 10).

Repeated readmission was also closely linked to exclusion from employment, education and valued social roles, with participants describing being unable to work and spending long periods isolated at home (Ko & Park, 2021; Mlay et al., 2024). One participant reflected, *"I don't do anything but stay at home... watch TV and spend the entire day at home and feel bored"* (Ko & Park, 2021, Service user, p. 6).

Experiences of stigma, dependence and social isolation further restricted participation in every day life (George & Howell, 1996; Ko & Park, 2021), with participants describing being viewed as *"not normal"* (Ko & Park, 2021, Service user, p. 6) and struggling to meet expectations around employment and independence. Yet many wanted ordinary lives with stable housing and belonging, as one participant put it, *"I've been coming in and out of hospital for years... I just want normality to come back in my life... for me it's just loneliness"* (Phillips et al., 2022, Service user, p. 10).

Discussion

This review synthesised the perspectives of service users, informal caregivers and clinicians on psychiatric readmission to acute adult inpatient mental health services. The three themes identified described readmission as a failure of containment beyond hospital, explored how involvement, responsibility and competing understandings shaped the readmission process, and highlighted the paradoxical role of inpatient care as both refuge and exclusion. Containment, understood as the process of holding and responding to distress across psychological, relational and organisational levels (Robin et al., 2023), is the idea this discussion returns to throughout. Together, the three themes move from individual distress, to who is seen as responsible for care, to the wider social exclusion that keeps people vulnerable to future readmission, addressing the review's aim to build a fuller picture of the causes and experiences of readmission, considering where accounts converge and diverge, and pointing towards what might help prevent avoidable readmissions. This conceptualisation of the role of containment and its erosion is depicted in Figure 3.

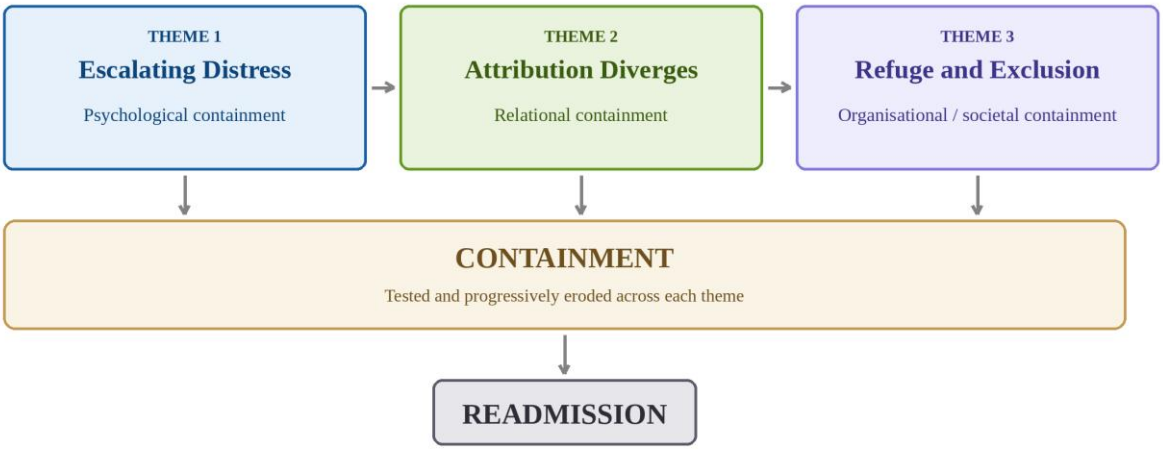


Figure 3. Conceptual model of containment across the three analytical themes.

Psychiatric readmission as a progressive loss of containment

Across stakeholder groups, readmission was consistently described as a cumulative process. Escalating distress, fragmented continuity of care, diminishing relational and community support, and contested responsibility for treatment engagement built up until readmission became necessary, consistent with the Stress-Vulnerability Model's account of crises emerging once accumulating stress outpaces a person's capacity to cope (Nuechterlein & Dawson, 1984). Similar trajectories were evident across studies (Martino et al., 2025; Brännström et al., 2018; Ådnanes et al., 2018, 2020; Duhig et al., 2017). Readmission may therefore be understood as occurring when psychological, relational and organisational forms of containment become progressively insufficient to sustain community living, supporting Robin et al.'s (2023) conceptualisation of containment as a multilevel process, and evidence that continuity of care and connected community networks are central to sustaining recovery after discharge (Biringer et al., 2017; Brooks et al., 2020). Readmission, seen this way, may reflect the erosion of containment across interacting systems, rather than individual factors alone.

Integrating stakeholder perspectives

There was considerable agreement among stakeholders that readmission developed through interactions between distress, relationships and services, rather than isolated relapse; service users described the lived experience of deterioration and discharge, caregivers highlighted the practical and emotional challenges of supporting recovery, and clinicians emphasised treatment engagement and organisational limitations. This convergence held across countries, suggesting it is not a feature of any one health system. Much of the difference between accounts reflected where participants sat in the care pathway rather than genuinely different understandings. However, one difference did appear to reflect a divergence in understanding; clinicians tended to see readmission as caused by individual non-treatment adherence, while service users and caregivers more often pointed to understanding the structural and financial barriers to sustaining that same treatment. In containment terms, this appears to be a divergence whether responsibility ultimately sists with the individual, or with the relationships and systems around them. This is concordant with adherence literature, which cautions against attributing non-adherence to the service user alone and instead frames it as being shaped by the patient, condition, therapy, health system and socioeconomic factors (World Health Organization, 2003), it may also reflect cultural differences, since explanatory models of

illness are known to vary across cultures and between clinicians and families within the same culture (Kleinman et al., 1978). Alternatively, this divide could reflect differences in study design and country-level service structures across the many countries represented in the studies rather than a genuine difference in responsibility (Noyes et al., 2018), though its consistency across studies and countries makes a purely methodological explanation less likely alone. This supports the arguments that knowledge in mental healthcare is strengthened through dialogue between experiential and professional perspectives (Gillard et al., 2012), and recognition of lived experience as a legitimate form of expertise (Okoroji et al., 2023).

The paradox of refuge and exclusion

Theme three complicates a simple, positive view of containment. Hospital gave people relief, structure and safety that community life could not, yet the same readmission also highlighted exclusion from ordinary roles, work and belonging (Ko & Park, 2021; Mlay et al., 2024; Phillips et al., 2022). A similar pattern was identified in the Duhig et al. (2017) study, whose *"admission as sanctuary"* sat within a cycle of inadequate community resources and discordant discharge that never resolved; this synthesis suggests the pattern recurs across the evidence base. Across these accounts, the qualitative evidence points to a consistent mismatch; readmission does not provide what appears to be missing for individuals. The Stress-Vulnerability Model explains the relief; hospital removes people, at least briefly, from stress that has become unmanageable, matching descriptions of readmission as a chance to *"rest my brain and pull myself together"* (Nuechterlein & Dawson, 1984; Ådnanes et al., 2018, Service user, p. 6). This fits wider literature where social exclusion itself raises readmission risk (Webber & Huxley, 2004), and more readmissions are linked to lower social inclusion (Mezey et al., 2022), meaning exclusion and readmission may reinforce each other. Nevertheless, Recovery Capital helps explain why readmission is not the solution as the resources that protect people are exactly what readmission does not address (Hennessy, 2017; Best & Hennessy, 2022), and Ware et al.'s (2007) account of citizenship names what is lost, not just symptom relief, but a valued place in social life. Hospital cannot replace this because, per the Social Ecological Model, it works as an organisational container while community life is sustained mainly at the level of relationships and community structures (Reupert, 2017). Repeated readmission may therefore do little to address the underlying

exclusion, and may compound it over time; this does not mean readmission is unhelpful in a crisis, only that it treats the endpoint of exclusion rather than its cause.

Why containment?

Several of these frameworks explain only part of the findings, but not all of it. Recovery Capital (Hennessy, 2017; Best & Hennessy, 2022) explains the persistence of exclusion, but describes what a person has, not the process of support being offered or withdrawn. The Social Ecological Model (Reupert, 2017) shows where influences operate, but not how they interact. Continuity-of-care literature (Biringer et al., 2017; Brooks et al., 2020) explains service-level breakdown, but not relational attribution or societal exclusion. Containment (Robin et al., 2023) was chosen because it captures both, whether distress is held, by whom, and at what level, rather than naming a resource or structure. The other frameworks became most useful not as alternatives, but as explanations of particular facets within that wider understanding.

Clinical and policy implications

Reducing avoidable readmissions has implications at more than one level. During readmission, there is a greater focus on collaborative, systemic ways of understanding a person's difficulties and resources (one such way is psychological formulation (Division of Clinical Psychology, 2011), though similar approaches exist across disciplines) rather than risk or diagnosis alone, which could be factored into discharge planning. This would give consideration to individuals support in the community. Within that consideration, this review highlighted the importance of continuity of care, relational follow-up, caregiver involvement, and opportunities for social participation and belonging.

More broadly, the validity of readmission rates as a measure of inpatient care quality is unclear (Durbin et al., 2007); as readmission may say as much about gaps in community support and social exclusion as about inpatient care itself, supporting national investment in integrated pathways and wider measures of recovery.

Strengths and limitations

Key strengths of this review include a rigorous, transparent methodology, studies from diverse international settings, and integrating the perspectives of service users, caregivers and clinicians offering a novel synthesis across these groups. Limitations include the analytical themes representing an interpretive synthesis rather than a

definitive account, and the small number of English-language studies, with service users more frequently represented than caregivers or clinicians, whose perspectives came predominantly from mental health nurses, which may limit transferability. Furthermore, this review did not formally assess reporting bias through a grey literature search. Restricting inclusion to peer-reviewed studies was deliberate, to ensure all studies could be quality-appraised using CASP, though unpublished accounts of readmission may be under-represented in the evidence base.

Future research should evaluate the role of collaborative and systemic ways of understanding a service users' difficulties and resources in discharge planning, investigate interventions that strengthen social inclusion alongside continuity of care, and further explore stakeholder perspectives across the care pathway.

Conclusion

This qualitative systematic review suggests psychiatric readmission can be understood as a dynamic process, shaped by interactions between psychological, relational and organisational influences. By integrating the perspectives of service users, informal caregivers and clinicians, it extends current understanding of psychiatric readmission beyond individual risk factors. Viewed through the interpretive lens of containment, the findings point to the importance of sustaining support across the transition from hospital to community.

References

Ådnanes, M., Cresswell-Smith, J., Melby, L., Westerlund, H., Šprah, L., Sfetcu, R., Straßmayr, C., & Donisi, V. (2020). Discharge planning, self-management, and community support: Strategies to avoid psychiatric rehospitalisation from a service user perspective. *Patient Education and Counseling, 103*(5), 1033-1040. https://doi.org/10.1016/j.pec.2019.12.002

Ådnanes, M., Melby, L., Cresswell-Smith, J., Westerlund, H., Rabbi, L., Dernovšek, M. Z., Šprah, L., Sfetcu, R., Straßmayr, C., & Donisi, V. (2018). Mental health service users' experiences of psychiatric re-hospitalisation: An explorative focus group study in six European countries. *BMC Health Services Research, 18*, 516. https://doi.org/10.1186/s12913-018-3317-1

Best, D., & Hennessy, E. A. (2022). The science of recovery capital: Where do we go from here? *Addiction, 117*(4), 1139-1145. https://doi.org/10.1111/add.15784

Bhugra, D., Tseng, W. S., Takei, N., & Prince, M. (2011). *Principles of social psychiatry* (2nd ed.). Wiley-Blackwell.

Biringer, E., Hartveit, M., Sundfør, B., Ruud, T., & Borg, M. (2017). Continuity of care as experienced by mental health service users: A qualitative study. *BMC Health Services Research, 17*, Article 763. https://doi.org/10.1186/s12913-017-2719-9

Booth, A. (2016). Searching for qualitative research for inclusion in systematic reviews: A structured methodological review. *Systematic Reviews, 5*(1), 74. https://doi.org/10.1186/s13643-016-0249-x

Brooks, H. L., Bee, P., Lovell, K., & Rogers, A. (2020). Negotiating support from relationships and resources: A longitudinal study examining the role of personal support networks in the management of severe and enduring mental health

problems. *BMC Psychiatry, 20*, Article 50. https://doi.org/10.1186/s12888-020-2458-7

Brännström, E., Strand, J., & Sand, P. (2018). A patient perspective on recurrent or prolonged contact with psychiatric inpatient care for affective disorder. *International Journal of Mental Health Systems, 12*, 29. https://doi.org/10.1186/s13033-018-0205-3

Byrne, S. L., Hooke, G. R., & Page, A. C. (2010). Readmission: A useful indicator of the quality of inpatient psychiatric care? *Journal of Affective Disorders, 126*(1-2), 206-213.

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research, 22*(10), 1435-1443. https://doi.org/10.1177/1049732312452938

Critical Appraisal Skills Programme. (2023). *CASP (Qualitative Studies Checklist)*. https://casp-uk.net/casp-tools-checklists/qualitative-studies-checklist/

Davidson, L., O'Connell, M. J., Tondora, J., Styron, T., & Kangas, K. (2005). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services, 56*(5), 640-645.

De Ruysscher, C., Vandevelde, S., Tomlinson, P., & Vanheule, S. (2020). A qualitative exploration of service users' and staff members' perspectives on the roles of inpatient settings in mental health recovery. *International Journal of Mental Health Systems, 14*(1), 15. https://doi.org/10.1186/s13033-020-00347-w

Division of Clinical Psychology. (2011). Good practice guidelines on the use of psychological formulation. British Psychological Society.

Dlamini, S. B., & Shongwe, M. C. (2019). Exploring mental health nurses' perceptions on factors contributing to psychiatric readmissions in Eswatini: A qualitative study. *International Journal of Africa Nursing Sciences, 11*, 100157. https://doi.org/10.1016/j.ijans.2019.100157

Donisi, V., Tedeschi, F., Wahlbeck, K., Haaramo, P., & Amaddeo, F. (2016). Pre-discharge factors predicting readmissions of psychiatric patients: A systematic review of the literature. *BMC Psychiatry, 16*, 449. https://doi.org/10.1186/s12888-016-1114-0

Duhig, M., Gunasekara, I., Patterson, S., & Whittle, E. (2017). Understanding readmission to psychiatric hospital in Australia from the service users perspective: A qualitative study. *Health & Social Care in the Community, 25*(1), 75-82. https://doi.org/10.1111/hsc.12269

Durbin, J., Lin, E., Layne, C., & Teed, M. (2007). Is readmission a valid indicator of the quality of inpatient psychiatric care? *Journal of Behavioral Health Services & Research, 34*(2), 137-150.

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology, 20*(2), 181-194. https://doi.org/10.1080/13645579.2016.1144401

George, R. D., & Howell, C. C. (1996). Clients with schizophrenia and their caregivers' perceptions of frequent psychiatric rehospitalizations. *Archives of Psychiatric Nursing, 10*(6), 373-383.

Gillard, S., Simons, L., Turner, K., Lucock, M., & Edwards, C. (2012). Patient and public involvement in the coproduction of knowledge: Reflection on the analysis of qualitative data in a mental health study. *Qualitative Health Research, 22*(8), 1126-1137. https://doi.org/10.1177/1049732312448541

Green, J., & Thorogood, N. (2018). *Qualitative methods for health research* (4th ed.). SAGE.

Hannan, J. (2013). *The Triangle of Care: Carers included*. Carers Trust.

Hannes, K. (2011). Chapter 4: Critical appraisal of qualitative research. In J. Noyes, A. Booth, K. Hannes, A. Harden, J. Harris, S. Lewin, & C. Lockwood (Eds.), *Supplementary guidance for inclusion of qualitative research in Cochrane systematic reviews of interventions* (Version 1). Cochrane Collaboration Qualitative Methods Group.

Hannes, K., Lockwood, C., & Pearson, A. (2010). A comparative analysis of three online appraisal instruments' ability to assess validity in qualitative research. *Qualitative Health Research, 20*(12), 1736-1743. https://doi.org/10.1177/1049732310378656

Hennessy, E. A. (2017). Recovery capital: A systematic review of the literature. *Addiction Research & Theory, 25*(5), 349-360. https://doi.org/10.1080/16066359.2016.1243685

Kalseth, J., Lassemo, E., Wahlbeck, K., Haaramo, P., & Magnussen, J. (2016). Psychiatric readmissions and their association with environmental and health system characteristics: A systematic review of the literature. *BMC Psychiatry, 16*, 376. https://doi.org/10.1186/s12888-016-1099-8

Kassim, K. H. H., Safar, M. S. B. H. M., Lupat, A., & Zolkefli, Y. (2021). Mental health nurses' views of ward readmission: A focus group study in Brunei Darussalam. *Belitung Nursing Journal, 7*(5), 402-408. https://doi.org/10.33546/bnj.1666

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine, 88*(2), 251–258. https://doi.org/10.7326/0003-4819-88-2-251

Ko, Y., & Park, S. (2021). Life after hospital discharge for people with long-term mental disorders in South Korea: Focusing on the “revolving door phenomenon”. *Perspectives in Psychiatric Care, 57*(2), 531-538. https://doi.org/10.1111/ppc.12575

Lockwood, C., Porritt, K., Munn, Z., Rittenmeyer, L., Salmond, S., Bjerrum, M., Loveday, H., Carrier, J., & Stannard, D. (2024). Systematic reviews of qualitative evidence. In E. Aromataris, C. Lockwood, K. Porritt, B. Pilla, & Z. Jordan (Eds.), *JBI manual for evidence synthesis*. JBI. https://doi.org/10.46658/JBIMES-24-02

Martino, P., Saraga, M., Dubuis, J., & Kovacevic, M. (2025). Why go to the psychiatric hospital? The experiences of people living with mental disorders hospitalized multiple times in one year: A qualitative study. *Nursing Reports, 15*(4), 132. https://doi.org/10.3390/nursrep15040132

Mezey, G., White, S., Harrison, I., Bousfield, J., Killaspy, H., Lloyd-Evans, B., & Payne, S. (2022). Modelling social exclusion in a diagnostically-mixed sample of people with severe mental illness. *International Journal of Social Psychiatry, 68*(2), 420–428. https://doi.org/10.1177/00207640211001893

Milner, K., Crawford, P., Edgley, A., Hare-Duke, L., & Slade, M. (2020). The experiences of spirituality among adults with mental health difficulties: A qualitative systematic review. *Epidemiology and Psychiatric Sciences, 29*, e34. https://doi.org/10.1017/S2045796019000234

Mlay, J. P., Naidu, T., Ramalili, S., Mnhungu, S. S., Zondi, T., Lessells, R. J., Naidoo, I., & Tomita, A. (2024). Risk factors and strategies for relapse prevention among individuals living with serious mental illness in South Africa: Qualitative inquiry from patients' and caregivers' perspectives. *PLOS ONE, 19*(8), e0309230. https://doi.org/10.1371/journal.pone.0309230

NHS England, & National Collaborating Centre for Mental Health. (2019). *The community mental health framework for adults and older adults*. NHS England.

NHS England. (2019). *The NHS long term plan*. NHS England.

National Health Service and Community Care Act 1990, c. 19 (UK). The Stationery Office.

Noyes, J., Booth, A., Flemming, K., Garside, R., Harden, A., Lewin, S., Pantoja, T., Hannes, K., Cargo, M., & Thomas, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series-paper 3: Methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. *Journal of Clinical Epidemiology, 97*, 49-58. https://doi.org/10.1016/j.jclinepi.2017.06.020

Nuechterlein, K. H., & Dawson, M. E. (1984). A heuristic vulnerability/stress model of schizophrenic episodes. *Schizophrenia Bulletin, 10*(2), 300-312.

Nxasana, T., & Thupayagale-Tshweneagae, G. (2014). Nurses' perceptions on the readmission of psychiatric patients one year after discharge. *Africa Journal of Nursing and Midwifery, 16*(1), 89-102.

Okoroji, C., Mackay, T., Robotham, D., Beckford, D., & Pinfold, V. (2023). Epistemic injustice and mental health research: A pragmatic approach to working with lived experience expertise. *Frontiers in Psychiatry, 14*, Article 1114725. https://doi.org/10.3389/fpsyt.2023.1114725

Osborn, D. P. J., Favarato, G., Lamb, D., Harper, T., Johnson, S., Lloyd-Evans, B., Marston, L., Pinfold, V., Smith, D., Kirkbride, J. B., & Weich, S. (2021).

Readmission after discharge from acute mental healthcare among 231,988 people in England: Cohort study exploring predictors of readmission including availability of acute day units in local areas. *BJPsych Open, 7*(4), e136. https://doi.org/10.1192/bjo.2021.961

Ouzzani, M., Hammady, H., Fedorowicz, Z., & Elmagarmid, A. (2016). Rayyan—A web and mobile app for systematic reviews. *Systematic Reviews, 5*(1), 210. https://doi.org/10.1186/s13643-016-0384-4

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., & Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ, 372*, n71. https://doi.org/10.1136/bmj.n71

Phillips, C., Tai, S., & Berry, K. (2022). Experiences of acute mental health inpatient care in the UK: From admission to readmission. *Psychosis, 14*(1), 22-33. https://doi.org/10.1080/17522439.2021.1881596

Raluthanga, N., Shilubane, H., & Chauke, M. P. (2023). Relapse among MHCUs after a short-term admission in an acute psychiatric unit: Primary caregivers' perspective. *International Journal of Environmental Research and Public Health, 20*(24), 7184. https://doi.org/10.3390/ijerph20247184

Reupert, A. (2017). A socio-ecological framework for mental health and well-being. *Advances in Mental Health, 15*(2), 105-107. https://doi.org/10.1080/18387357.2017.1312292

Robin, M., Bellone, L., Belbèze, J., Kazemian, K., Radjack, R., & Corcos, M. (2023). *Three-level containment model of hospitalized adolescents with borderline pathology: A holistic therapeutic perspective*. *Frontiers in Psychiatry, 14*, Article 1110788. https://doi.org/10.3389/fpsyt.2023.1110788

Rose, D., Fleischmann, P., Schofield, P., & Thornicroft, G. (2006). 50 years of psychiatric hospital experiences from the perspective of service users. *Journal of Mental Health, 15*(4), 349-360.

Rowe, J. (2012). Great expectations: A systematic review of the literature on the role of family carers in severe mental illness. *Journal of Clinical Nursing, 21*(19-20), 2882-2894.

Sattar, R., Lawton, R., Panagioti, M., & Johnson, J. (2021). Meta-ethnography in healthcare research: A guide to using a meta-ethnographic approach for literature synthesis. *BMC Health Services Research, 21*(1), 50. https://doi.org/10.1186/s12913-020-06049-w

Sfetcu, R., Musat, S., Haaramo, P., Ciutan, M., Scintee, G., Vladescu, C., Wahlbeck, K., & Katschnig, H. (2017). Overview of post-discharge predictors for psychiatric re-hospitalisations: A systematic review of the literature. *BMC Psychiatry, 17*, 227. https://doi.org/10.1186/s12888-017-1386-z

Shaw, R. L., Booth, A., Sutton, A. J., Miller, T., Smith, J. A., Young, B., ... & Dixon-Woods, M. (2004). Finding qualitative research: an evaluation of search strategies. BMC medical research methodology, 4(1),

Taquet, M., Griffiths, K., Palmer, E. O., Ker, S., Liman, C., Wee, S. N., ... Patel, R. (2023). Early trajectory of clinical global impression as a transdiagnostic predictor of psychiatric hospitalisation: A retrospective cohort study. *The Lancet Psychiatry, 10*(5), 334-341.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology, 8*, Article 45. https://doi.org/10.1186/1471-2288-8-45

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology, 12*, 181. https://doi.org/10.1186/1471-2288-12-181

Ware, N. C., Hopper, K., Tugenberg, T., Dickey, B., & Fisher, D. (2007). Connectedness and citizenship: Redefining social integration. *Psychiatric Services, 58*(4), 469–474. https://doi.org/10.1176/ps.2007.58.4.469

Webber, M., & Huxley, P. (2004). Social exclusion and risk of emergency compulsory admission: A case-control study. *Social Psychiatry and Psychiatric Epidemiology, 39*(12), 1000–1009. https://doi.org/10.1007/s00127-004-0836-3

World Health Organization. (1990). *The introduction of a mental health component into primary health care*. World Health Organization.

World Health Organization. (2003). Adherence to long-term therapies: Evidence for action. World Health Organization.

World Health Organization. (2021). *Guidance on community mental health services: Promoting person-centred and rights-based approaches*. World Health Organization.

Chapter 2: Major Research Project

Compounding Uncertainty: How Service Users Make Sense of MDT Ward Rounds in Acute Adult Inpatient Mental Health Through a Trauma-Informed Care Lens

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Plain Language Summary

Why we did this study

When people are admitted to hospital during a mental health crisis, their care is regularly discussed and planned in meetings involving doctors, nurses and other members of the care team, sometimes with the patient present. These meetings, often called MDT ward rounds, are designed to provide an opportunity for people to be involved in decisions about their own care. Previous research suggests these meetings can feel difficult and overwhelming for patients, particularly when experiencing distress.

What we did

We interviewed seven adults who were currently receiving care on two acute inpatient hospital wards in Scotland, asking them about their experiences of the MDT ward rounds. We were especially interested in whether people felt safe, trusted staff, were involved in decisions, had a say in what happened, and could make choices about their care. These are the five key principles of an approach called trauma-informed care, designed to help services avoid causing further distress to people who have already been through difficult or frightening experiences.

What we found

People often felt uncertain during these meetings: unsure how staff understood their distress, what decisions were being made, or their own place in the conversation. This uncertainty built up over their time on the ward, especially when they felt misunderstood, had little control over decisions, or found the ward round itself crowded and rushed. Warm, attentive staff could make this feel easier to manage. But this did not always change how confusing the wider system felt. Someone could trust and feel calmer with a nurse, while still feeling unsure about decisions being made about them elsewhere on the ward.

What this means

Our findings suggest a few practical changes. Just being in the room does not mean someone can take part. Room size, the number of staff present, and how someone is feeling all make a difference. Talking things through before and after the ward round, not just during it, could help. Being clearer about why decisions are made, especially restrictive ones, also helps, even when the decision has not changed. But kindness from individual staff is not enough on its own. Trauma-informed care needs to work at both levels, in how staff act with someone, and in how clear the wider ward processes are, for uncertainty to ease rather than build up, in ward rounds and in wider hospital care.

Abstract

Multidisciplinary team (MDT) ward rounds are positioned as central to collaborative care in acute inpatient mental health, yet service users describe them as overwhelming spaces where participation is difficult. Trauma-informed care (TIC) offers a framework for understanding how safety, trust, collaboration, empowerment and choice shape interactions in ward rounds. This study explored how service users make sense of MDT ward rounds through the principles of TIC. Seven adults receiving acute inpatient care in Scotland took part in a semi-structured interview, analysed using Interpretative Phenomenological Analysis (IPA). Four Group Experiential Themes (GETs) were developed: Compounding Uncertainty: Misattuned Meanings of Distress, Diagnosis and Care; Navigating Power and Loss of Agency in Systems of Care; the MDT Ward Round as a Silencing and Uncertain Space; and Relational Care as a Counterweight: Trust, Safety and Being Listened To. Together, these themes showed that uncertainty was a central organising experience of participants' care. Viewed through TIC's principles, this uncertainty could be held interpersonally while remaining compounded organisationally, at the same time. Clinically, TIC must therefore operate at both levels, individual interactions and organisational process, for uncertainty to be held rather than compounded within MDT ward rounds and wider acute inpatient care.

Keywords: trauma-informed care; ward rounds; acute inpatient mental health; uncertainty; Interpretative Phenomenological Analysis; service user experience

Introduction

Acute Adult Inpatient Care and MDT Ward Rounds

Acute adult inpatient mental health services provide short-term, intensive care for people experiencing severe distress or risk that cannot be safely managed in the community, aiming to provide stabilisation while supporting people to participate in decisions about their own care and recovery (NHS, 2019). In Scotland, where this study was conducted, mental health policy increasingly emphasises recovery-oriented, trauma-informed approaches to care (Scottish Government, 2023). Achieving these aims is inherently complex. Service users are frequently admitted during periods of significant distress and reduced coping capacity (Scottish Government, 2023), while staff must balance competing responsibilities within systems facing increasing need and constrained resources (Care Quality Commission, 2017).

Multidisciplinary team (MDT) ward rounds are a central organisational mechanism through which clinicians review mental state and risk, discuss treatment and discharge planning, and facilitate service user involvement in care planning (Williams et al., 2024), conceptualised not only as clinical meetings but as relational spaces in which service users make sense of their care (Fiddler et al., 2010). Despite this collaborative intent, service users often experience ward rounds as anxiety-provoking, describing power imbalance, reduced agency, and discomfort speaking within these formalised environments (Cappleman et al., 2015; Radwan & Mallik, 2024; Rapsey et al., 2023). MDT ward rounds are therefore of particular interest as a site where this tension becomes visible, and trauma-informed care (TIC) offers one way of understanding both the tension and its possible resolution, developed below through shared meaning-making and epistemic justice.

Shared Meaning-Making in Acute Inpatient Care

The discrepancy between clinicians' intentions and service users' experiences of ward rounds can be understood by looking at the processes of shared meaning-making in acute inpatient care. Individuals admitted to acute inpatient services are often trying to understand confusing, overwhelming or frightening experiences of distress, shaped by

trauma, psychosis, neurodivergence or loss, while concurrently, making sense of rapidly changing circumstances and decisions about their own care (Grossman et al., 2021; Ritunnano et al., 2022; Stenhouse, 2011).

Within this context, interactions with staff become central to how service users understand their distress and care. Frank (1995/2013) argues that illness disrupts an individual's narrative understanding of themselves, so recovery involves reconstructing meaning through relationships in which personal stories are heard and validated. Therapeutic relationships characterised by listening and involvement have consistently been identified as fundamental to positive inpatient experiences (Gilburt et al., 2008, Sweeny et al., 2018), while mismatches in communication contribute to patients feeling misunderstood (Huang, 2024), particularly where service pressures limit these relational moments (Myklebust & Bjørkly, 2019).

Clinicians and services are, concurrently, engaged in their own process of understanding distress, drawing on diagnostic frameworks and organisational responsibilities to interpret individuals' experiences (Köhne et al., 2023). Service users, clinicians and carers frequently hold different conceptualisations of distress and diagnosis (Perkins et al., 2018), extending into experiences of care itself, for example continuous observation has been experienced as intrusive (Anstee et al., 2024), and behavioural interventions as coercive (McGuinness et al., 2018).

From a hermeneutic perspective, understanding is an interpretive process through which meaning is negotiated between individuals, not passively transferred (Gadamer, 1989). The gap between the intended purpose of care and service users' experience of it can be understood through two related concepts; hermeneutical injustice, whereby individuals lack the shared interpretive resources needed to understand and communicate their experiences (Ritunnano, 2022; Hassall, 2024), and epistemic injustice, where experiential knowledge is afforded less credibility than dominant institutional accounts (Hultman & Hultman, 2023; Spencer, 2025). Together, these concepts suggest that the challenges within inpatient care may not arise from individual interactions alone, but from broader mismatches in the meanings attached to distress and care. When this shared meaning-making breaks down, service users may be left not simply disagreeing with the accounts offered to them, but unsure what to make of them at all. TIC may therefore offer a useful framework for exploring how relational and

organisational conditions shape opportunities for collaborative understanding in clinical practice.

Trauma-Informed Care in Acute Inpatient Settings

TIC was developed to support care providers in recognising how traumatic experiences shape individuals' beliefs, expectations and engagement with services, while also recognising their strengths and resilience (NHS Education for Scotland [NES], 2024). Traumatic experiences are highly prevalent among mental health service users, with estimates suggesting 70–90% report trauma exposure (Hennessy et al., 2023), with broader adversity and marginalisation increasingly recognised as shaping distress (Grossman et al., 2021).

As defined by the Scottish National Trauma Training Programme (SNTTP), a trauma-informed model of care is underpinned by the principles of safety, trustworthiness, collaboration, empowerment and choice, guiding everyday interactions and wider organisational cultures of care (Fallot & Harris, 2009; NES, 2024). Viewed through the lens of shared meaning-making, TIC can be understood as a systemic framework that creates the relational conditions for collaboratively developing shared understandings of distress and care, and under which hermeneutical and epistemic injustice become less likely (Isobel et al., 2021; Sweeny et al., 2018).

Research suggests trauma-informed approaches within acute inpatient services can improve outcomes for both service users and staff (O'Dwyer et al., 2021), with safety and collaboration within hierarchical ward rounds highlighted specifically (Rapsey et al., 2023). However, implementing TIC remains challenging, with staff reporting practical and organisational barriers (Huo et al., 2023; O'Dwyer et al., 2021). Despite growing policy commitment (NES, 2024), little is known about how service users themselves experience acute inpatient systems of care as trauma-informed.

Rationale for the Current Study

The current study focuses on service users' experiences within ward rounds in acute adult inpatient care, because they provide a central organisational space in which shared understandings of distress, care and recovery can be collaboratively developed and translated into care planning. TIC's principles of safety, trust, collaboration,

empowerment and choice provide the lens through which this study explores how service users experience and make sense of interactions within ward rounds.

The current study therefore aims to explore how service users experience and make sense of interactions within MDT ward rounds, through the principles of TIC.

Methodology

Interpretative Phenomenological Analysis (IPA) was used to explore how participants experienced and made sense of interactions within MDT ward rounds. IPA is grounded in phenomenology, hermeneutics, and ideography, focusing on lived experience as inherently interpretative, and emphasising case-by-case analysis before identifying patterns across participants (Smith, Flowers & Larkin, 2022). This approach suited the current study, given limited exploration of how service users make sense of their experiences in MDT ward rounds (Biggerstaff & Thompson, 2008). Additionally, the current study was informed by a critical realist position, recognising that experiences of distress and care are real, yet understood through socially and institutionally mediated interpretations, complementing IPA by attending to both participants' subjective meaning-making and the broader institutional contexts shaping those experiences (Pilgrim, 2014).

Positionality and Reflexivity

The primary researcher was a trainee clinical psychologist, and two members of the wider research team were practising clinical psychologists within NHS Scotland, one employed within the recruiting service; this shared background may have shaped how the research question was framed, and a shared desire for improvements in care. The primary researcher identifies as a white British woman, not from Scotland, which may have influenced interpretation of linguistic and culturally specific aspects of participants' accounts. The analysis was also approached from within a clinical framework shaped by professional training. While the double hermeneutic inherent in IPA may have enhanced ecological validity in a clinical setting, it also carried a risk that accounts were predominately interpreted through clinical understanding. To support reflexivity, the primary researcher kept a reflective journal and undertook regular supervision with the wider research team, which included a member who did not work clinically within the NHS

Ethical Approval

Ethical approval was obtained from the Welsh Research Ethics Committee (25/WA/0195), which specialises in reviewing qualitative research. NHS Research and Development approval (L25057) and Caldicott Guardian approval (CG2699) were also obtained from the relevant NHS Scotland Health Board (Appendix 2.3).

Recruitment

Participants were recruited using convenience sampling from service users currently accessing care within two acute adult inpatient wards in a hospital in the West of Scotland. Individuals were excluded if they were under 18 years, lacked capacity to consent, were considered too unwell to participate by the clinical team (e.g. experiencing an acute episode of psychosis), or required an interpreter due to limited English proficiency.

Recruitment took place between November and December 2025. The primary researcher consulted NHS Research Scotland Mental Health Patient and Public Involvement group regarding the use of a video for recruitment and the use of accessible language on the recruitment poster. Informed by this, the primary researcher discussed the study with clinical ward staff at a monthly clinical meeting, and a poster with a QR code linking to an explanatory video was displayed on both wards, giving service users a way to learn about and respond to the study directly. Interested service users could then contact the primary researcher directly, or via their care team (Appendix 2.5).

The theory of information power was applied in line with the principles of IPA, and data collection stopped once the research team judged that sufficient depth and richness of understanding had been achieved to address the research aims (Malterud, Siersma & Guassora, 2016).

Data Collection

The primary researcher conducted seven semi-structured interviews in a private room on hospital grounds, after checking with the clinical team that participants were well enough that day. Three potential participants who indicated interest declined on the day, citing a loss of interest. Verbal and written informed consent were obtained from

all participants, and the limits of confidentiality were discussed before each interview (Appendix 2.4).

Initial demographic and contextual questions were asked (age, gender, whether this was a first admission, and its duration). Participants were not asked whether they had a clinical diagnosis; this was left open for them to disclose if relevant to their own sense-making. The interview guide was developed by the primary researcher and the wider research team to explore participants' experiences of MDT ward rounds through the TIC principles set out by the SNTTP (safety, trust, collaboration, empowerment and choice), informed by the language and questioning style of the Adult Attachment Interview, with the aim of exploring how interactions in ward rounds shaped experience (George et al., 1985) (Appendix 2.5). Participants were also encouraged to share wider experiences on the ward that felt meaningful, since the MDT ward round is understood as an aspect of care embedded in ward life, not as a standalone experience. Follow-up questions explored participants' meaning-making in more depth.

Interviews lasted between 25 and 60 minutes and were audio-recorded; the interviewer made observational field notes during the interviews. Given the potentially distressing subject matter, participants were able to bring a third party for support and could pause or end the interview at any point. None utilised these options. No repeat interviews were conducted.

Data Analysis

Audio recordings were anonymised and transcribed verbatim independently by the primary researcher, with transcripts reviewed for accuracy by a member of the research team. Transcripts were not returned to participants for checking in line with IPA's utilisation of the double hermeneutic (Smith, Flowers & Larkin, 2022). Data were analysed by the primary researcher using IPA, following an iterative process broadly informed by Smith et al. (2022) detailed in Appendix 2.6. Repeated reading and detailed exploratory noting generated experiential statements, capturing both participants descriptions and how they made sense of their experiences. These statements were then examined for patterns, leading to Personal Experiential Themes (PETs) for each participant. This idiographic process was repeated across all transcripts before moving to a more interpretative, cross-case analysis, in which Group

Experiential Themes (GETs) were developed by identifying shared patterns and points of divergence.

Throughout, the analytic process moved flexibly between individual cases and the dataset as a whole. Themes were developed as interpretative accounts, not as summaries of the data. Emerging interpretations were discussed with members of the research team as a reflexive check, aiding the primary researcher to consider alternative interpretations and stay attentive to the influence of clinical assumptions, while keeping the idiographic and interpretative commitments of IPA intact. Structuring the interview guide around the five TIC principles created a possible tension with IPA's usually inductive and phenomenological framing; to manage this, the principles were used to guide the interview process rather than to structure the analysis, and participants' accounts were not mapped deductively onto principles, with the analytic process itself remaining idiographic and interpretative throughout. Participants did not give feedback on the results of the analysis, owing to the double hermeneutic of IPA.

Participants

Participant demographics are displayed in Table 1. The seven participants interviewed were each assigned a pseudonym, in keeping with the idiographic and person-centred ethos of IPA, which emphasises representing participants' lived experiences as fully as possible (Smith et al., 2022).

Table 1. Participant Pseudonyms and Demographics

Pseudonym	**Gender**	**Age**	**Number of admissions**	**Current admission (weeks)**
Louise	F	54	5	8
Kirsty	F	31	2	4
Alan	M	51	3	2
Michelle	F	38	4	Above 8
Daniel	M	33	4	6
Peter	M	37	4	6

Ryan	M	22	2	3

Analysis Findings

Participants' accounts of their experiences of interactions within MDT ward rounds were understood to converge into four GETs and sixteen subthemes, represented in Figure 1.

The themes depict an experiential progression through participants' encounters with inpatient care: from uncertainty in understanding distress (GET 1), through experiences of unequal power (GET 2), to the concentration of these dynamics within the MDT itself (GET 3) and counterbalanced by the containing effect of relationally attuned care (GET 4). Confusion and uncertainty recurred throughout each GET, not just GET 1, often alongside more visible experiences of power and coercion**.** Consistent with the analytic approach outlined above, the GETs are reported here in the terms that emerged from participants' own accounts, rather than mapped onto the principles of TIC that shaped the interview guide; their relationship to TIC is developed in the discussion.

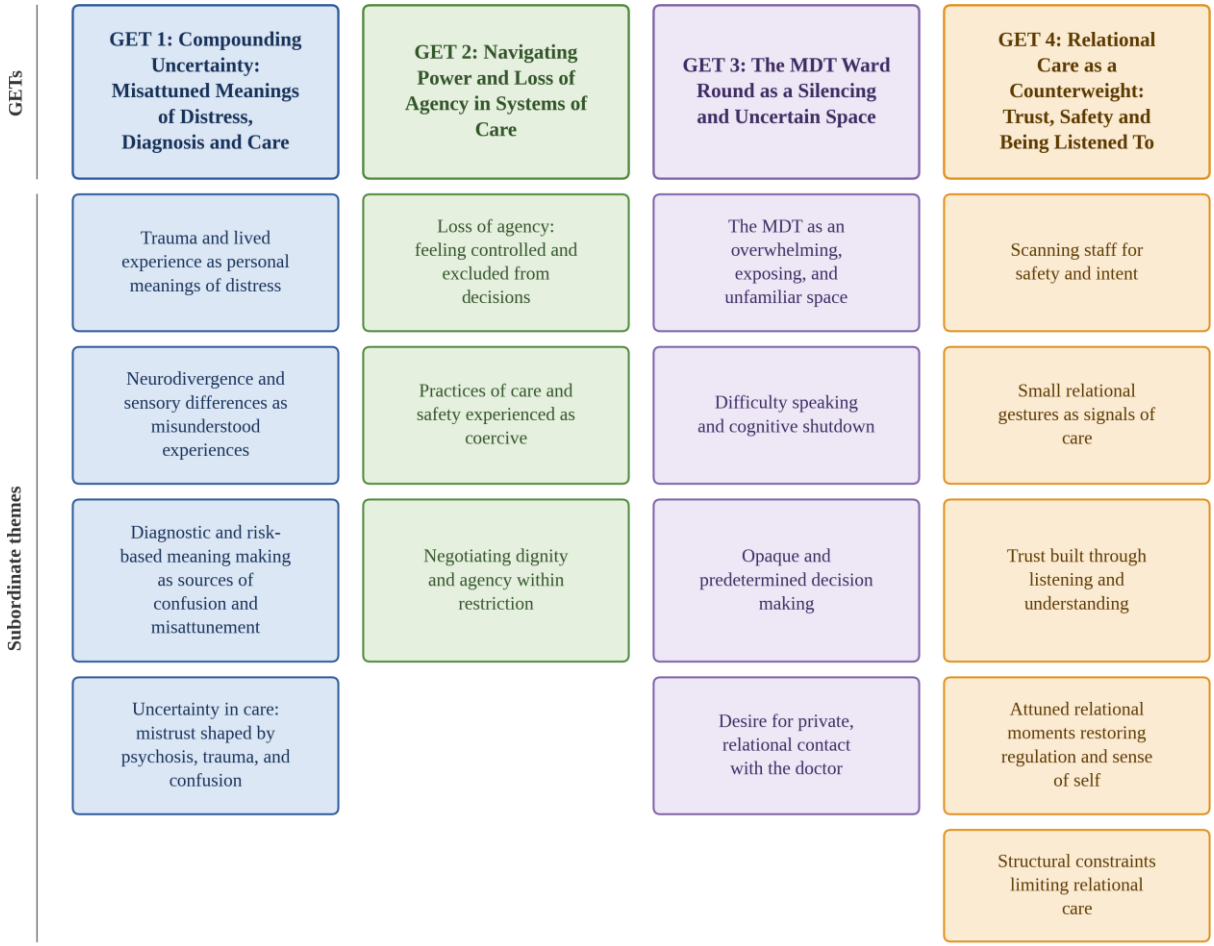


Figure 1. Group Experiential Themes and Subordinate Themes.

Figure 1. Group Experiential Themes and Subordinate Themes.

GET 1: COMPOUNDING UNCERTAINTY: MISATTUNED MEANINGS OF DISTRESS, DIAGNOSIS AND CARE

Trauma and lived experience as personal meanings of distress

GET 1 was evident across five of the seven participants (Alan, Kirsty, Peter, Louise and Daniel). Participants described active attempts to understand distress through trauma, loss, and overwhelming life experiences. Alan used the image of juggling to communicate a sudden loss of manageability:

"I feel as if I was good with my three or four juggling balls, and I just stepped into the circus ring, and they were all doing it on the highwire."

The movement from *"juggling balls"* to *"highwire"* conveys a shift from coping to precarity. Kirsty located her distress more explicitly in trauma, while also describing the absence of a safe relational context in which this could be explored:

"I've never felt safe enough, in a safe enough space, to actually discuss why I'm not well, because it is trauma that's made that's made me so unwell."

The repetition of *"safe enough"* suggests that meaning-making depended not only on being asked about distress, but on whether the context felt emotionally safe enough. Peter felt clinical documentation flattened the complexity of his life, describing disappointment that his childhood was recorded as *"normal"* when it was *"actually very turbulent."* Louise contrasted care on the ward with psychotherapy, where she could begin *"piecing it all together again."* Across accounts, participants were not simply describing symptoms, but locating distress within lived histories that had left them overwhelmed.

Neurodivergence and sensory differences as misunderstood experiences

For Kirsty and Peter, neurodivergence and sensory experiences shaped both distress and care. Kirsty linked her vulnerability to autism, but described feeling blamed when she sought help after feeling threatened by another patient:

"I've got a lot of bad experiences from being naive like, and I think that its ma autism like, I'm, I'm really naive" …. "they go, argh well, you were being flirtatious with him… and I'm like, that's, that's victim blaming."

The movement between *"naive"* and *"flirtatious"* shows a misalignment between her self-understanding and the meaning she felt staff placed on her behavior. Peter also described being interpersonally misread:

"despite being described as guarded, I urrr, always try to give my honest, honest uuurrr, views on things, and I am urrr, autistic."

The phrase *"despite being described as guarded"* captures how clinical description could feel at odds with his experience of openness. Peter also described the ward through sensory overwhelm, where *"the noise became too much"* and *"it was a fight or flight response."* This language framed his absconding from the ward as immediate sensory survival rather than planned risk-taking.

Diagnostic and risk-based meaning-making as sources of confusion and misattunement

Participants described confusion when their experiences were framed through clinical language, diagnosis, relapse, insight, or risk. Kirsty challenged the word relapse because it did not match her experience of ongoing depression:

"this is a relapse? Which, I don't think is a relapse, because I've not been not depressed since my first admission."

Peter similarly resisted documentation that positioned him as lacking insight, stating *"I'm fully aware when things are not going well"* and referring to signs he had *"logged in my journal."* Diagnostic inconsistency also undermined his confidence in his care, after years of shifting professional opinion:

"It's only now, after five years… and it's quite unsettling. One doctor in the community says I don't have a condition, and then a doctor in the ward says he's very confident that I do have a condition, and there doesn't seem to be any cohesion."

Louise's account conveyed how psychiatric language could feel fragmenting and dehumanising: *"I sold my soul being in psychiatric units"* and *"I was broken up into pieces."* Risk-based interpretations also shaped participants' feelings about the responses they received. Louise described staff acting in anticipation of escalation:

"they pin ya down, your pinned down, aye, before you get out, before you escalate, they think your gonna escalate."

Kirsty similarly perceived the doctor as *"scared of the patients"* and worried about *"what kind of risk they are."* Diagnosis, psychiatric language, and risk framings therefore often compounded uncertainty rather than reducing it.

Uncertainty in care: mistrust shaped by psychosis, trauma, and confusion

Within these experiences of misattunement, participants described mistrust and uncertainty about care. Kirsty described wanting help while becoming paranoid about whether help was actually being offered:

"even though I wanted the help, I got really paranoid about if they were helping me or not" …. "it's weird, because my illness was all like kind of surrounding my trauma."

Her account shows how trauma and possible paranoid thinking shaped the meanings attached to care. Peter similarly described possible paranoid fear that *"information was being withheld"* and that his food *"was being laced with medication,"* but also that this was *"something I didn't want to share."* The withholding of disclosure suggests mistrust also narrowed opportunities for understanding. Daniel linked mistrust to loss and self-reliance, describing himself as *"always been… on my own,"* and described staff communication as evasive:

"Part of staff's education in medical treatment is to not always tell you the truth, they don't lie, but they run you in circles."

Louise described staff as having *"two sides to them, a good side and a bad side."* The binary used here suggests relational experiences in which staff could not be seen as consistently safe, splitting them instead into predictable categories she could watch for. Mistrust therefore appeared to emerge through trauma, paranoia, confusion, and previous experiences of being misunderstood.

GET 2: NAVIGATING POWER AND LOSS OF AGENCY IN SYSTEMS OF CARE

Loss of agency: feeling controlled and excluded from decisions

Building on the uncertainty described above, GET 2 was evident across six of the seven participants (Peter, Ryan, Louise, Kirsty, Michelle and Daniel) and captures how that uncertainty extended into participants' experiences of power and control, described around admission, detention, discharge, and medication. Peter reflected on not being offered voluntary admission before detention:

"I just wish in the very beginning, that doctor in the community had asked me did I want, would I come voluntarily, voluntarily, voluntarily, yes, but that was not presented."

The repetition of *"voluntarily"* conveys the importance of the choice not being offered. Ryan described a similar contradiction within voluntary admission, his correction revealing not only imbalance but a genuine uncertainty about what he had actually agreed to:

"I've come in voluntarily, but I can't leave until the doctor and I agree, well not agree, until the doctor signs me off."

His correction from *"agree"* to *"signs me off"* exposes the felt imbalance beneath the language of agreement. Louise described admission as surrendering control: *"it seems like I'm putting down ma life,"* while Ryan felt he should not be *"subdued, or forced to do anything."* Kirsty described becoming used to hierarchy, feeling *"all the staff there are the boss of me."*

However, Michelle recognised that having decisions made for her could feel protective, stating, *"I feel as if I canne make decisions, so sometimes the staff make decisions for me."* Care appeared therefore to be experienced ambivalently as both protective and disempowering for participants.

Practices of care and safety experienced as coercive

Practices intended as care or safety were at times experienced as coercive. Ryan described restrictions on his leave as staff *"working against"* him, while Peter experienced constant observation as *"very overbearing"* and something that *"definitely didn't help my, my, state."* After absconding from the acute ward Peter described restrictions in the Intensive Psychiatric Care Unit (IPCU) through imagery of lost freedom:

"having things taken, having your freedom, taking away possessions, taking away the, the few possessions that you own."

Medication was also experienced as dehumanising and imposed at times. Ryan described *"they basically zombie me for two, three months ... getting a needle stuck in me every two weeks"* and having *"not got a choice in it."* Louise described a restraint and being forcibly injected with Lorazepam in language of exposure and violation:

"I was down on the floor… dragged down to my bedroom and was injected with ummm, lorazepam ... they just took ma jammie bottoms down… so I was shouting rape, rape."

The intensity of *"rape rape"* conveys how behavioral management could be experienced as bodily violation, even when framed institutionally as safety or

treatment. In the same account, Louise went on to describe calling the police in the aftermath:

"I thought I picked up the phone to phone the police, and they were gonna take ma phone aff me… but it was the staff that called me back."

This disjointedness, sitting immediately alongside the violation, suggests confusion and powerlessness were co-occurring rather than sequential.

Negotiating dignity and agency within restriction

Participants did not describe responding with passive resignation within restriction; they described attempts to preserve dignity and agency. Daniel contrasted the inability to act when he witnessed someone struggling on the ward with his identity outside hospital:

"sit on my fucking ass watch this pass, what can I do? but in the real world I am not like this."

The phrase *"in the real world"* suggests the ward created a version of self that felt alien to him. He also described asserting himself: *"I'm not the sort of person who just takes an explanation until I agree with that."* Peter also described preserving dignity through self-advocacy: *"I find myself being the person that insists on shaking hands."* Kirsty described negotiating the acceptance of care as emotionally conflicted:

"I don't ever fully accept it… it's me giving them that control…anxiety tells me to be resistant to it."

Agency was therefore negotiated through resistance, compliance and self-advocacy.

GET 3: THE MDT WARD ROUND AS A SILENCING AND UNCERTAIN SPACE

The MDT as an overwhelming, exposing, and unfamiliar space

This dynamic of misattuned meaning-making and care experienced as being done to participants converged within the MDT ward round itself, a pattern evident across all seven participants. The room itself was described as crowded, unfamiliar, exposing, and anxiety-inducing. Ryan described entering as embodied anxiety:

"every time I come in, I'm a bag of nerves when I come in, especially knowing that everyone's gonna be there."

Michelle similarly stated, *"I get so worked up before the MDT, and that's me for the rest of the day,"* suggesting the encounter extended beyond the meeting itself. The number and unfamiliarity of people heightened this exposure. Ryan stated *"I don't even know half the people in there,"* while Daniel described *"carers," "council,"* and *"God knows what else,"* concluding *"this can be stressful."* Participants also described feeling watched. Daniel captured the quiet scrutiny of the room:

"There's plenty of people sitting in the room, plenty of people looking at you … umm quietness… you're on the radar."

The phrase *"on the radar"* conveys being monitored rather than met. Peter felt suspicious about *"so, so much notes about you, but not talk to you face to face."* Kirsty's uncertainty extended to the purpose of the meeting itself:

"It's called multidisciplinary team like, but not to get that confused [with] the patient's being disciplined, thats their job is their discipline."

That she had to consciously distinguish *"discipline"* from *"disciplined"* suggests the MDT's purpose was not self-evidently benign. The MDT was therefore experienced not simply as a meeting, but as an exposing environment of observation, unfamiliarity, and sensory demand.

Difficulty speaking and cognitive shutdown

Within this context, participants described wanting to engage but being unable to communicate as they wished. Ryan articulated a clear tension between desire and inhibition:

"too many people, and I want to speak ma truth, but there's too many people in the room, you don't feel comfortable, you canne open up."

The repeated *"too many people"* positions the environment itself as the barrier to openness. Louise described the MDT as disrupting her ability to hold onto her thoughts:

"I always get put off with what I want to say… there is too much interference, there is too much power in there for me."

The pairing of *"interference"* and *"power"* captures both cognitive disruption and felt relational hierarchy. Michelle described trying to follow everyone and forgetting *"what I meant to say,"* while also describing moments where she agreed with explanations despite not understanding them:

"ill just say it makes sense, but it disnae make sense."

Kirsty described the overwhelming need to escape when invited to ask questions:

"I'm just dying to get out of that room, with all those people in it."

She also described forgetting *"most of what's said in the MDT"* because *"it's like, too much for me."* Michelle located a similar difficulty in the body rather than the room:

"sometimes I canne, I canne get it out, what I wanted to say… I really don't know, just what feelings I get and stuff."

These accounts suggest participants were silenced not by unwillingness to collaborate, but by the cognitive and emotional effects of the MDT ward round context.

Opaque and predetermined decision-making

Participants described the MDT as a space where information and decisions were difficult to access. Louise vividly described her felt ineffectiveness in trying to get understandable information as:

"it's like trying to get blood out of a stone… nothing that I could ever understand."

Daniel located this difficulty specifically in clinical language itself:

"You're talking about the medicals, medical terms, and sometimes this is confusing people, especially people who… are not into medical."

Peter looked forward to the MDT as a chance to *"find out information,"* but was confused that meetings were *"only 5 minutes."* Peter also questioned whether decisions were coordinated at all:

"At one particular stage I didn't think staff really knew what they were doing with me… I don't know if they set out to keep [me] there for three weeks, or they were just deciding how they go."

For Peter, the opacity may have concealed not a settled plan, but an absence of one. Kirsty similarly experienced decision-making as illegible rather than simply withheld, describing staff as following *"a weird protocol… [that] doesn't seem very person centered."* Alan described leaving meetings *"puzzled"* and trying to *"read wider signs,"* suggesting that lack of transparency left him searching for hidden meanings. Louise described decisions being discussed around her rather than with her:

"He's just saying to the rest of the team, no change, nothing to me, nothing, no explanation to me, not a thing."

The repetition of *"nothing"* conveys exclusion from a conversation about her own care. Ryan expressed the strongest sense of futility:

"you could ask questions, yeah, but I guess that's a bit sad, you can ask questions, but it doesn't, it doesn't change the outcome."

He later stated, *"you feel voiceless"* and *"he's [doctor] made his mind up prior to me even getting in."* Participation therefore often felt symbolic rather than influential.

Desire for private, relational contact with the doctor

Despite the difficulty of MDT ward rounds, participants still wanted contact, understanding, and discussion about care. Michelle wanted *"more time with the doctor"* for help with flashbacks, but stated that *"when the ward round, when the MDT's busy, it's harder to get that, get that moment."* Kirsty similarly wanted to discuss trauma privately:

"I don't like talking to him with people there… I've not been able to talk to the doctor about things that I'd like to discuss with them in private, like trauma, its traumatic stuff."

She also described one-to-one contact as helping her *"solidify anything"* because *"I'll remember what was said."* Participants therefore appeared not to be rejecting engagement with doctors or care planning. Rather, they described needing a context that felt private, relational, and manageable enough to support speaking, understanding, and remembering.

GET 4: RELATIONAL CARE AS A COUNTERWEIGHT: TRUST, SAFETY AND BEING LISTENED TO

Scanning staff for safety and intent

Set against this backdrop, GET 4 was evident across six of the seven participants (Kirsty, Alan, Daniel, Peter, Louise and Michelle), who described assessing staff for signs of safety, warmth, and trustworthiness. Kirsty described the vulnerability involved in trusting staff: *"I've had to trust a lot of people that have not gave me… much reason to trust them."* Alan described sensing warmth through body language:

"Some of the staff, just kind of, just body language… it's warm and I'm drawn to that."

Daniel similarly described trustworthiness as physically embodied and difficult to explain:

"you just feel that, you cannot just explain, it's just the feeling inside."

Peter described trust in the doctor through noticing someone *"searching to understand better."* This scanning process did not always resolve towards trust, however; Ryan described concluding that openness itself was unsafe, regardless of the nurses' warmth as individuals:

"You can't really trust them because they're taking notes on me and [the] notes are going to the doctor, so, so I feel as if I canne really open up even to the nurses."

Ryan's account suggests safety was assessed through the wider system staff reported into, not warmth alone. Relational safety was therefore communicated through tone, warmth, body language, curiosity, and perceived intention.

Small relational gestures as signals of care

Small gestures carried significant meaning within restrictive environments. Daniel described staff opening the tuck shop outside usual times:

"they give me a lot actually, and I know that might sound simple… but it's about the approach, it's about the timing."

Alan described sitting *"man to man"* in the canteen, a phrase that positions the interaction within normality as between equals rather than between patient and

authority. Louise similarly valued staff she could *"get a laugh with,"* suggesting that shared humour offered a rare moment of ordinariness within an otherwise clinical routine. These interactions communicated warmth and humanity, in contrast to more procedural experiences of care.

Trust built through listening and understanding

Participants described trust as built through being listened to and understood. Peter described one-to-one time as *"a rare treat,"* a phrase that conveys how uncommon protected relational space felt. Michelle expressed the importance of listening plainly:

"Aye, they listen so, that's all that I need, is somebody to listen."

Daniel emphasised that trust had to be earned:

"He win this trust, he win it, it didn't just came."

He later poignantly described finally being listened to by a doctor as *"the first moment where something, something break in me."* Alan described care as something felt through the doctor's concern: *"I can feel the care."* Listening, inquiry, and emotional presence therefore appeared to support trust, communicating relational recognition rather than management alone.

Attuned relational moments restoring regulation and sense of self

Participants described attuned relational moments as restorative in different ways. Michelle described trusted night staff as protective during acute distress, helping her regulate in the moment:

"if it wasnae for her I would have probably done something stupid."

For Peter, attunement was evident in how a member of staff responded to his earlier suspicions:

"he felt it was perfectly natural to have such a suspicion, well, he didn't agree with it, but he said it's not surprising that I thought this way."

The member of staff did not need to agree with Peter's suspicion, or resolve it, for the exchange to feel containing; being met with understanding rather than correction allowed the uncertainty to be held collaboratively, rather than carried alone. Louise

described psychotherapy as helping her *"hold things in ma brain,"* suggesting the relational support aided her in making sense of and processing her experience. Alan described empathy from staff as *"the most important human quality,"* eliciting feeling *"found"* and *"feeling… myself, feeling not judged."* Daniel linked relational care to a restored sense of connection with the world beyond hospital:

"I think I'll be walking out of here in way better relationship with the world."

Together, these accounts suggest relationally attuned care supported participants across several interconnected but distinct restorative functions: regulation, containment, sense-making, validation and reconnection, each rooted in feeling met by another person rather than managed by a system.

Structural constraints limiting relational care

Participants also recognised that the relational care they desired was constrained by wider institutional pressures on staff. Alan described the nursing team as *"fabulous,"* Peter described staff as *"very empathetic,"* and Daniel stated:

"they go a hundred miles to make everybody happy."

At the same time, Daniel expressed empathy for staff, *"I feel sorry for them because, they was running, they was tired, you can see this on their faces."*

This awareness shaped participants' own help-seeking. Alan described wanting to reach out while not *"encroaching,"* and Michelle worried staff might think she was *"annoying."* Participants therefore appeared to hold both appreciation for staff humanity and awareness that systemic pressures limited the consistency and availability of relational care.

Discussion

Uncertainty as a central experience of inpatient care

The present study explored how service users experienced and made sense of interactions within MDT ward rounds, through the principles of TIC. The findings suggest that when care was experienced as trauma-informed, uncertainty could be held; when it was not, uncertainty compounded. This did not occur uniformly, however;

uncertainty could be held interpersonally, within a specific relationship, while remaining compounded organisationally, within the wider system that encompassed that relationship. This contrast, between uncertainty held and uncertainty compounded, recurred across every stage of participants' experience of care, and is the organising thread of the discussion below. This process, and its cumulative and protective consequences, is summarised in Figure 2. The sections that follow examine how this holding and compounding occurred in practice, drawing on wider literature to make sense of each stage, before returning explicitly to TIC to consider what this means for its principles and the practical implications for MDT ward rounds.

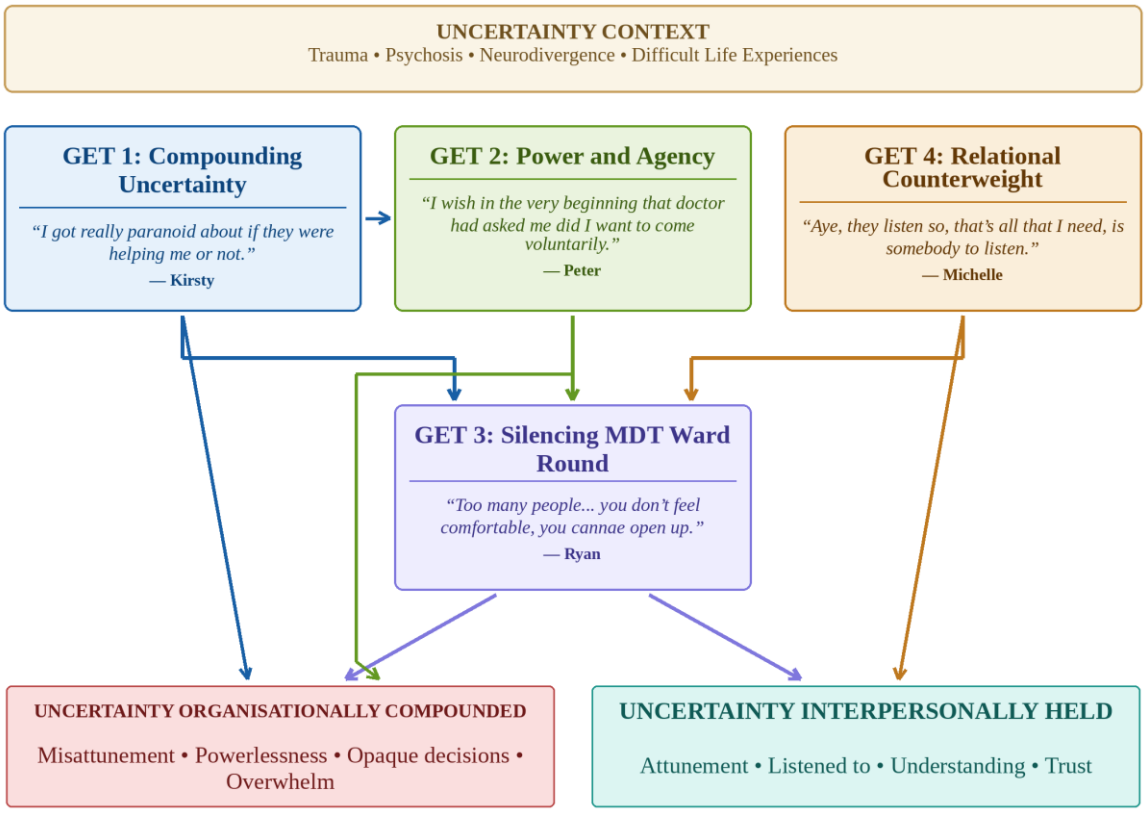


Figure 2. Participants' experiences of care in MDT ward rounds, showing compounded and contained uncertainty.

Why uncertainty?

Participants' accounts of care on the ward were often emotionally intense, capturing real experiences of fear, powerlessness and coercion; Louise's description of being

restrained and forcibly medicated while *"shouting rape, rape,"* and Ryan's correction from feeling he could *"agree"* with his discharge to recognising the doctor *"signs me off,"* both revealed a painful awareness of their own powerlessness. Yet these emotionally charged accounts were often recounted with comparatively little affect within the interviews themselves and were accompanied by confusion about what was happening and why, rather than the emotion being clearly expressed. This was reflected in how the accounts were subsequently organised into themes with a more cognitive, procedural tone than their emotional content. This mismatch may itself be meaningful; reflecting the lack of relational spaces that felt safe enough to hold difficult emotion, as Kirsty described never having *"felt safe enough, in a safe enough space, to actually discuss why I'm not well".* Therefore, fear, powerlessness and coercion may rarely have had the opportunity to be felt and expressed as such, leaving confusion and uncertainty about what was happening as the most consistently visible thread. The systemic power imbalance within the ward, and a possible fear of consequences for expressing such feelings openly, may partly explain why relational moments so rarely felt safe enough for feelings to be expressed. Uncertainty was therefore chosen as the organising construct not because fear, powerlessness and coercion were absent, but because it appeared to accompany them throughout; where relationally attuned moments did occur, participants described this uncertainty being held collaboratively, raising the possibility that such moments were also where the underlying emotion could have begun to emerge given the opportunity.

This interpretation builds on existing literature describing psychiatric admission as a profoundly disruptive experience, involving disorientation and a loss of familiar explanatory frameworks (Callen-Davies et al., 2025), with coercive aspects of care further undermining predictability and agency (Silva et al., 2023). Qualitative research increasingly frames experiences like psychosis and trauma as requiring active meaning-making, through which individuals reconstruct coherence after overwhelming events (O'Keeffe et al., 2026). Uncertainty itself is a well-established construct in wider nursing literature; Mishel's (1988, 1990) Uncertainty in Illness Theory describes how ambiguity around symptoms and treatment shapes patients' experience of physical illness. Peter's account of conflicting diagnostic opinions reflects this directly, *"One doctor in the community says I don't have a condition, and then a doctor in the ward says he's very confident that I do have a condition."* The present findings add

something related but distinct; uncertainty here did not only arise from the ambiguity of illness itself but was also relationally and organisationally produced; the cumulative consequence of mismatches in meaning-making, transparency and relational attunement within the inpatient system. Its resolution therefore lies less within the individual and more in the conditions of care around them.

Misattuned understandings as one pathway through which uncertainty is compounded

Participants consistently attempted to understand their distress through narratives integrating trauma, relational adversity, neurodivergence and psychotic experiences within their broader life histories. These understandings, however, encountered alternative clinical explanations grounded in diagnosis, relapse prevention and risk management. Participants did not simply disagree with clinicians; rather, uncertainty appeared to compound when explanatory frameworks remained insufficiently integrated.

Hermeneutic philosophy offers a useful lens for this finding. Gadamer (1960/1989) argued that understanding emerges through dialogue and a "fusion of horizons," while Frank (1995/2013) proposed that healing depends on opportunities for personal narratives to be witnessed and co-constructed. Participants' accounts suggest opportunities for collaborative interpretation were often limited, leaving competing understandings unresolved. Kirsty, for example, rejected the clinical label applied to her presentation outright, *"this is a relapse? .... I've not been not depressed since my first admission."* Kirsty's own narrative was separate to the clinical account rather than fused with it.

This interpretation aligns with hermeneutical injustice (Ritunnano, 2022) and epistemic injustice (Hultman & Hultman, 2023), introduced above. This lack of reconciliation between explanatory frameworks, rather than disagreement itself, appeared to compound uncertainty. Participants were left holding two competing accounts of their own distress, with no shared way of resolving them, as in Louise's description of psychiatric language leaving her feeling *"broken up into pieces."* Whether that reconciliation becomes possible, in turn, may depend on the conditions for collaborative meaning-making itself.

Uncertainty extending into care, power and organisational practice

A particularly important finding was that uncertainty extended into participants' experiences of care, rather than remaining with their understandings of distress. Detention, medication, observation and restrictive practices were often difficult to interpret, leaving participants unsure about staff intentions and their own role within the care process. Uncertainty appeared to shift from an internal experience of distress into something relational and organisational.

Previous literature demonstrates that interventions intended to promote safety may be experienced as coercive or retraumatising when not properly explained (Hennessy et al., 2023; Silva et al., 2023). These practices did not compound uncertainty because they occurred, but because their rationale remained opaque, leaving participants to infer intent rather than understand it through dialogue. Ryan, for example, described restrictions on his leave as staff *"working against"* him, rather than him understanding the reasoning. Predictability, transparency and trustworthiness (Sweeney et al., 2018) therefore made the difference between restriction being understood and it being endured.

This interpretation resonates with wider literature on trust and institutional relationships. Trust develops through predictability and confidence that another's actions are oriented towards one's wellbeing (Berry et al., 2021), while institutional betrayal occurs when systems meant to provide care may be experienced as confusing or harmful (Lewis et al., 2025). Daniel captured earning of trust directly; *"He win this trust, he win it, it didn't just came."* Participants' accounts suggest uncertainty and mistrust developed together, where organisational systems were transparent enough to be trusted, uncertainty could be tolerated; where they were not, uncertainty and mistrust appeared to feed into one another.

MDT ward rounds as the organisational concentration of uncertainty

Participants entered ward rounds already carrying uncertainty about their distress, previous interactions, anticipated decisions and their own standing within care. This accumulated uncertainty intensified into cognitive overload, silence, acquiescence and difficulty communicating. Peter's and Kirsty's accounts extended this further, doubting whether the process itself was coherent at all. Peter described a stage of his admission where *"I didn't think staff really knew what they were doing with me… I don't know if they set out to keep [me] there for three weeks, or they were just deciding how they*

go," while Kirsty experienced the MDT's own procedure as arbitrary, describing staff as following *"a weird protocol… [that] doesn't seem very person centred."* For both, the uncertainty was not only about what had been decided, but about whether anything had been settled at all.

Consistent with previous qualitative research, MDT ward rounds were experienced as intimidating spaces for participation (Cappleman et al., 2015; Rapsey et al., 2023), understood within the broader organisational context of inpatient care rather than as isolated encounters (Williams et al., 2024). The ward round did not create this uncertainty alone, but was the point at which it became most visible: hierarchical, time-limited, crowded and highly visible, revealing whether the safety, trust and collaboration practiced across life on the ward had held or failed.

Participation can depend upon the psychological conditions for collaboration

Participants described wanting to participate in conversations and decisions about their care in the ward round, while simultaneously becoming overwhelmed, forgetting information, or feeling unable to communicate. Michelle's account was among the clearest; unable to identify what stopped her speaking beyond a felt sense, *"I really don't know, just what feelings I get and stuff."* These findings suggest participation depends not only on opportunities for involvement, but on the psychological conditions needed to use those opportunities.

Research demonstrates that cumulative stress and traumatic experiences may impair executive functioning and reflective capacity (Fonagy & Adshead, 2012; Kira et al., 2022), while information overload reduces cognitive processing capacity (Sigolo & Casarin, 2024), and psychological safety is increasingly recognised as fundamental to participation within inpatient settings (Vogt et al., 2024, 2025). Current shared decision-making frameworks tend to emphasise opportunities for participation (Verwijmeren & Grootens, 2024); the present findings suggest an important addition. Participation was not withheld by choice but became unavailable once uncertainty exceeded what could be processed in the room. Participation, in this sense, depended less on being given an opportunity to speak than on whether uncertainty could be tolerated for long enough that speaking became possible at all.

Relationally attuned care as containing uncertainty

Across participants' accounts, relationally attuned interactions acted as a counterweight to compounded uncertainty. Being listened to, recognised and understood did not remove uncertainty, but created conditions in which it could be explored collaboratively rather than endured alone, enabling participants greater capacity to regulate and reconnect with their own experiences and participate in their care. This containment was, however, achieved interpersonally, within a specific relationship or interaction; whether it extended to the wider systems around that relationship is returned to below.

Bion's (1985) concept of containment offers a useful account of what this looks like in practice; another's capacity to think about overwhelming experience, restoring the reflective functioning that attachment-informed accounts also link to relational safety (Fonagy & Adshead, 2012), supported psychological organisation, not resolution, but containment for long enough that reflection and shared exploration became possible again. For Peter, this did not require his suspicion to be confirmed or corrected, only met without judgement: a member of staff *"felt it was perfectly natural to have such a suspicion, well, he didn't agree with it, but he said it's not surprising that I thought this way."* The uncertainty itself was not resolved but held collaboratively rather than carried alone. Louise described a related process in relation to her psychotherapy, which helped her *"hold things in ma brain,"* suggesting that relational support aided processing in a way that mirrors containment as much as it explains it. This aligns with trauma-informed models that position relationships as the primary vehicle through which healing occurs (Sweeney et al., 2018). This relational experience enabled uncertainty to be interpersonally held despite oransiational aspects of care that compounded it.

Holding or compounding uncertainty: the role of Trauma Informed Care principles

Across these findings, TIC's principles appear to do the same underlying work, determining whether uncertainty can be held, or whether it compounded. Safety related to the extent to which uncertainty could be emotionally contained, not just the absence of threat; Kirsty's account of never having *"felt safe enough, in a safe enough space, to actually discuss why I'm not well"* shows this failing interpersonally. Trustworthiness meant transparent enough decisions that their meaning did not have to be inferred, and not simply staff being kind; as shown above, this could fail not through any individual's

bad intent but through a process that felt fundamentally unintelligible. Collaboration and empowerment revealed the psychological conditions that made participation plausible, not just opportunities to participate; for Michelle, this broke down before the point of speech itself, unable to locate what had stopped her rather than simply choosing not to speak. Choice restored the agency that compounding uncertainty eroded, not only offered options, as Peter's repeated *"voluntarily"* makes clear.

These findings suggest uncertainty was not only held or compounded as the outcome of a particular relationship, but it could be held interpersonally while organisationally it remained compounded. Ryan's account of the ward nurses makes this most visible; individually, they were *"lovely,"* warm enough that uncertainty could plausibly be held between him and them; but because *"notes are going to the doctor,"* whatever he shared re-entered a wider system he could not understand, and *"I canne really open up even to the nurses*" despite that warmth. The relationship itself was not where the uncertainty ultimately settled. TIC's principles may therefore operate at both an interpersonal and an organisational level, and safety, trust or collaboration achieved at one level does not guarantee it at the other; a relationship can hold uncertainty even as the system around it continues to compound it. This may help explain why staff have described TIC as difficult to implement in practice (Huo et al., 2023; O'Dwyer et al., 2021); their individual efforts to enact its principles may be undermined not by any ambiguity in the principles themselves, but by organisational structures that fail to support them. This distinction is not entirely conceptual; it points to where trauma-informed practice most needs to be present, not only in individual staff conduct but in whether the wider organisational process itself are legible and trustworthy. A distinction returned to in the clinical implications below.

Clinical implications and future research

The findings suggest several practical implications for MDT ward rounds, organised around the principles of TIC that structured this study and are summarised in Figure 3.

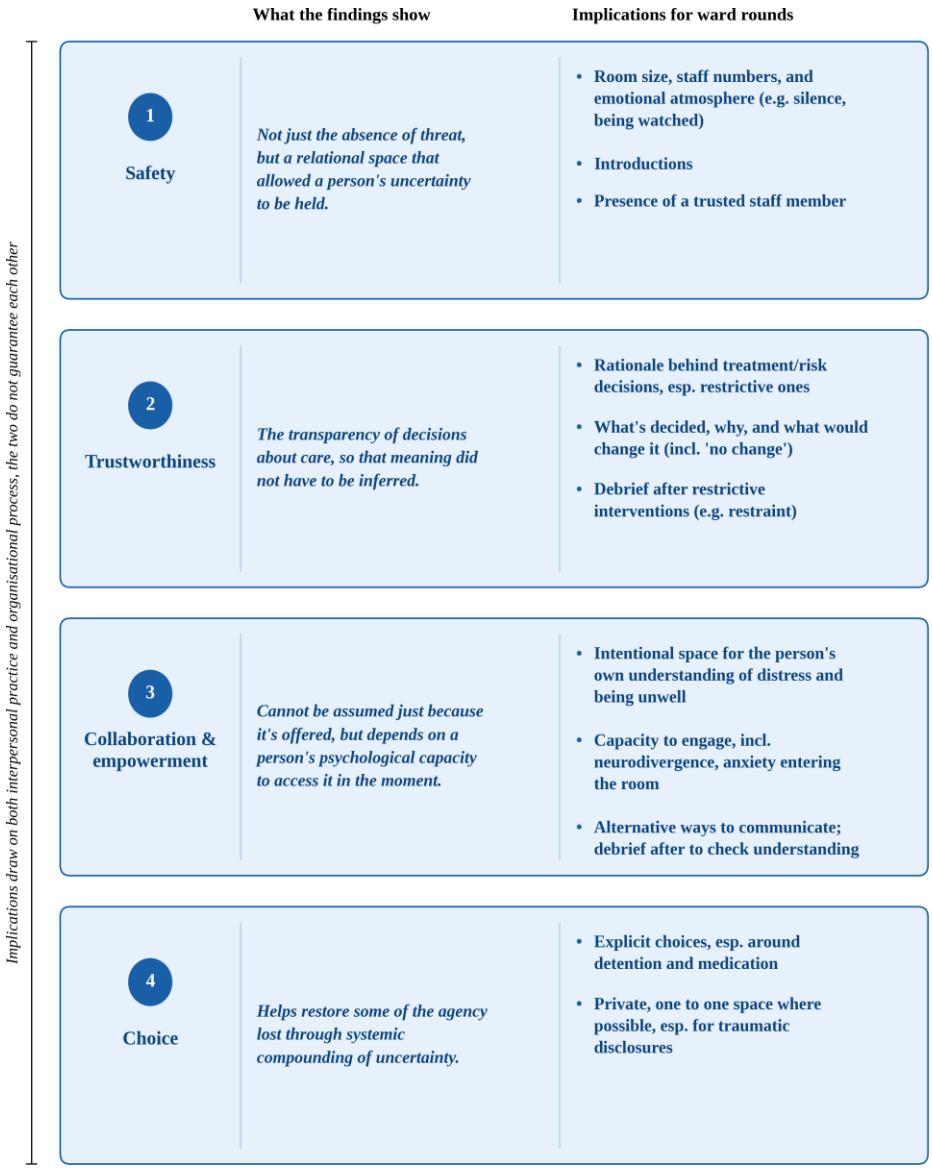


Figure 3. Findings mapped onto trauma-informed care principles and their implications for MDT ward rounds

For safety, participation should not be assumed simply because service users are present or invited to contribute; whether a space feels safe enough to speak depends on room size, staff numbers, and emotional atmosphere, including subtler factors such as silence or being watched. Clear introductions and the presence of at least one trusted staff member can support this.

For trustworthiness, participants did not always experience staff as deliberately withholding information; rather, the decision-making process itself could feel arbitrary or unclear, regardless of individual staff conduct. This was most acute around restrictive decisions, where the absence of a stated rationale, and of any debrief afterward, left meaning to be inferred rather than explained

For collaboration and empowerment, participation can break down before the point of speech itself, not only through a lack of opportunity to speak. Psychological capacity to engage, including neurodivergent processing and anxiety on entering the room, matters as much as the invitation to participate, and alternative ways of communicating distress may be needed when speech is not possible.

For choice, options were often felt to not have been made explicit in the first place; participants such as Peter described choices, including voluntary admission, that only became visible in retrospect as something that could have been offered.

These implications operate at two levels that do not guarantee one another. Warm, attuned individual relationships, of the kind found protective throughout this study, could not by themselves resolve uncertainty produced by an opaque or poorly understood organisational process; consistent with implementation literature (Goldstein et al., 2024; Huo et al., 2023), embedding TIC within MDT ward rounds therefore depends on organisational cultures and structures that prioritise safety, transparency and collaboration, not individual clinician practice alone, which is of particular importance given the Scottish policy context of this research.

Strengths, limitations and future research

A key strength of the present study is the congruence between the methodology and the phenomenon under investigation. IPA's double hermeneutic, whereby the researcher interprets participants' interpretations of their world, mirrors the interpretative task of clinical practice itself. The idiographic commitment of IPA, combined with a critical realist position, allowed for rich exploration of individual experiences within their broader relational and organisational contexts.

The findings should be interpreted within the methodological boundaries of IPA. The small sample, recruited from a single NHS service, was intended to achieve depth rather than representativeness, supporting theoretical transferability rather than generalisability. Recruitment may also have been shaped by clinical gatekeeping, since ward staff were involved in identifying individuals for whom participation was considered clinically appropriate; while this was necessary to ensure ethical recruitment and avoid approaching those too acutely unwell or lacking capacity to consent, it may have shaped the sample towards those perceived as more able to engage with the

research process. As a result, the experiences of those facing the greatest barriers to engagement, for whom questions of power, voice and participation may be most acute may be underrepresented.

Future research could investigate whether organisational-level interventions, such as structured decision-transparency practices, routine debriefing after restrictive interventions, or protected time for collaborative meaning-making, can support psychological safety and participation in ways that individual relational attunement alone could not.

Conclusion

Little was previously known about how service users themselves experience inpatient care as trauma-informed. The present study suggests that uncertainty is a central organising experience through which service users make sense of MDT ward rounds and their wider experience of care on inpatient wards. TIC's principles each pointed to different conditions determining whether that uncertainty was compounded or collaboratively held. This holding was not guaranteed by relational attunement alone; uncertainty could be held between a service user and an individual member of staff while remaining compounded by the organisational systems around them. Trauma-informed practice therefore needs to be present not only in individual staff interactions, but in whether the wider organisational process itself is legible and trustworthy. Addressing both levels together creates the possibility for uncertainty to be held rather than compounded.

References

Anstee, L., Chifamba, D., Loothfaully, W., Suleiman, S., Shah, C., Littlechild, B., & Zia, A. (2024). Stakeholder perspectives on continuous observation in inpatient psychiatric wards. Journal of Psychiatric and Mental Health Nursing, 31(6), 1133–1144.

Berry, L. L., Awdish, R. L., Letchuman, S., & Steffensen, K. D. (2021). Trust-based partnerships are essential—and achievable—in health care service. Mayo Clinic Proceedings, 96(7), 1896–1906.

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. Qualitative Research in Psychology, 5(3), 214–224. https://doi.org/10.1080/14780880802314304

Bion, W. R. (1985). Container and contained. In Group Relations Reader.

Callen-Davies, J., Weare, V., Griffey, T., Sereda, W., & Langon-Daly, J. (2025). Inpatient experiences of acute admission process: A qualitative service evaluation. Journal of Psychiatric Intensive Care.

Cappleman, R., Bamford, Z., Dixon, C., & Thomas, H. (2015). Experiences of ward rounds among in-patients on an acute mental health ward: A qualitative exploration. BJPsych Bulletin, 39(5), 233–236.

Care Quality Commission. (2017). The state of care in mental health services 2014 to 2017. Care Quality Commission.

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Community Connections.

Fiddler, M., Borglin, G., Galloway, A., Jackson, C., McGowan, L., & Lovell, K. (2010). Once-a-week psychiatric ward round or daily inpatient team meeting? A multidisciplinary mental health team's experience of new ways of working. International Journal of Mental Health Nursing, 19(2), 119–127.

Fonagy, P., & Adshead, G. (2012). How mentalisation changes the mind. Advances in Psychiatric Treatment, 18(5), 353–362.

Frank, A. W. (2013). The wounded storyteller: Body, illness, and ethics (2nd ed.). University of Chicago Press.

Gadamer, H.-G. (1989). Truth and method (2nd rev. ed., J. Weinsheimer & D. G. Marshall, Trans.). Continuum. (Original work published 1960)

George, C., Kaplan, N., & Main, M. (1985). Adult Attachment Interview. Unpublished manuscript, Department of Psychology, University of California, Berkeley.

Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. BMC Health Services Research, 8(1), 92.

Goldstein, E., Chokshi, B., Melendez-Torres, G. J., Rios, A., Jelley, M., & Lewis-O'Connor, A. (2024). Effectiveness of trauma-informed care implementation in health care settings: Systematic review of reviews and realist synthesis. The Permanente Journal, 28(1), 135.

Grossman, S., Cooper, Z., Buxton, H., Hendrickson, S., Lewis-O'Connor, A., Stevens, J., et al. (2021). Trauma-informed care: Recognizing and resisting re-traumatization in health care. Trauma Surgery & Acute Care Open, 6(1).

Hassall, R. (2024). Sense-making and hermeneutical injustice following a psychiatric diagnosis. Journal of Evaluation in Clinical Practice, 30(5), 848–854.

Hennessy, B., Hunter, A., & Grealish, A. (2023). A qualitative synthesis of patients' experiences of re-traumatization in acute mental health inpatient settings. Journal of Psychiatric and Mental Health Nursing, 30(3), 398–434.

Huang, M. (2024). Narrative modulations in patient-practitioner communication: Exploring attunement and misattunement in supported self-management. Language and Health, 2, 22–31. https://doi.org/10.1016/j.laheal.2023.11.002

Hultman, L., & Hultman, M. (2023). “Believe me, only I know how I feel.” An autoethnographic account of experiences of epistemic injustice in mental health care. Frontiers in Psychiatry, 14, 1058422.

Huo, Y., Couzner, L., Windsor, T., Laver, K., Dissanayaka, N. N., & Cations, M. (2023). Barriers and enablers for the implementation of trauma-informed care in healthcare settings: A systematic review. Implementation Science Communications, 4(1), 49.

Isobel, S., Wilson, A., Gill, K., & Howe, D. (2021). What would a trauma-informed mental health service look like? Perspectives of people who access services. International Journal of Mental Health Nursing, 30(2), 495–505.

Kira, I. A., et al. (2022). The direct and indirect impact of trauma types and cumulative stressors and traumas on executive functions. Applied Neuropsychology: Adult, 29(5), 1078–1094.

Köhne, A. C. J., de Graauw, L. P., Leenhouts-van der Maas, R., & van Os, J. (2023). Clinician and patient perspectives on the ontology of mental disorder: A qualitative study. Frontiers in Psychiatry, 14, 1081925.

Lewis, A., Lee, H. S., Zabelski, S., & Shields, M. C. (2025). Institutional betrayal in inpatient psychiatry: Effects on trust and engagement with care. Psychiatric Services, 76(3), 218–225.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. Qualitative Health Research, 26(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Mishel, M. H. (1988). Uncertainty in illness. Image: The Journal of Nursing Scholarship, 20(4), 225–232.

Mishel, M. H. (1990). Reconceptualization of the uncertainty in illness theory. Image: The Journal of Nursing Scholarship, 22(4), 256–262.

McGuinness, D., Murphy, K., Bainbridge, E., Brosnan, L., Keys, M., Felzmann, H., et al. (2018). Individuals' experiences of involuntary admissions and preserving control: Qualitative study. BJPsych Open, 4(6), 501–509.

Myklebust, K. K., & Bjørkly, S. (2019). The quality and quantity of staff-patient interactions as recorded by staff: A registry study of nursing documentation in two inpatient mental health wards. BMC Psychiatry, 19(1), 251.

NHS Education for Scotland. (2024, August 22). National Trauma Transformation Programme.

O'Dwyer, C., Tarzia, L., Fernbacher, S., & Hegarty, K. (2021). Health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings: A scoping review. Trauma, Violence, & Abuse, 22(5), 1057–1067.

O'Keeffe, D., Keogh, B., & Higgins, A. (2026). Meaning-making in psychotic experiences and its impact on meaning in life in first-episode psychosis. Irish Journal of Psychological Medicine, 43(1), 69–77.

Perkins, A., Ridler, J., Browes, D., Peryer, G., Notley, C., & Hackmann, C. (2018). Experiencing mental health diagnosis: A systematic review of service user, clinician, and carer perspectives across clinical settings. The Lancet Psychiatry, 5(9), 747–764. https://doi.org/10.1016/S2215-0366(18)30256-7

Pilgrim, D. (2014). Some implications of critical realism for mental health research. Social Theory & Health, 12(1), 1–21. https://doi.org/10.1057/sth.2013.17

Radwan, R. B., & Mallik, C. I. (2024). Improving patients' experiences of ward round in psychiatry wards. BJPsych Open, 10(S1), S257–S257.

Rapsey, S., Watson, R., & Dafforn, H. (2023). An equal seat at the table: Service users' experiences of ward rounds in secure care through the lens of trauma-informed care principles. Clinical Psychology Forum, 364, 38–44.

Ritunnano, R. (2022). Overcoming hermeneutical injustice in mental health: A role for critical phenomenology. Journal of the British Society for Phenomenology, 53(3), 243–260.

Ritunnano, R., Kleinman, J., Oshodi, D. W., Michail, M., Nelson, B., Humpston, C. S., & Broome, M. R. (2022). Subjective experience and meaning of delusions in psychosis: A systematic review and qualitative evidence synthesis. The Lancet Psychiatry, 9(6), 458–476.

Scottish Government. (2023). National trauma transformation programme: Progress and implementation update. Scottish Government.

Sigolo, B. D. O. O., & Casarin, H. D. C. S. (2024). Contributions of cognitive load theory to understanding information overload. RDBCI, 22, e024027.

Silva, B., Bachelard, M., Bonsack, C., Golay, P., & Morandi, S. (2023). Exploring patients' feeling of being coerced during psychiatric hospital admission: A qualitative study. Psychiatric Quarterly, 94(3), 411–434.

Smith, J. A., Flowers, P., & Larkin, M. (2022). Interpretative phenomenological analysis: Theory, method and research (2nd ed.). SAGE.

Spencer, L. J. (2025). Institutional epistemic isolation in psychiatric healthcare. Social Epistemology, 39(2), 215–228.

Stenhouse, R. C. (2011). They all said you could come and speak to us: Patients' expectations and experiences of help on an acute psychiatric inpatient ward. Journal of Psychiatric and Mental Health Nursing, 18(1), 74–80.

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. BJPsych Advances, 24(5), 319–333. https://doi.org/10.1192/bja.2018.29

Veale, D., Robins, E., Thomson, A. B., & Gilbert, P. (2023). No safety without emotional safety. The Lancet Psychiatry, 10(1), 65–70.

Verwijmeren, D., & Grootens, K. P. (2024). Shifting perspectives on the challenges of shared decision making in mental health care. Community Mental Health Journal, 60(2), 292–307.

Vogt, K. S., Baker, J., Kendal, S., et al. (2024). Safer, not safe: Service users' experiences of psychological safety in inpatient mental health wards. International Journal of Mental Health Nursing, 33(6), 2227–2238.

Vogt, K. S., Baker, J., Morys-Edge, M., et al. (2025). Staff perspectives on psychological safety in inpatient mental health settings. Journal of Psychiatric and Mental Health Nursing, 32(2), 276–287.

Williams, B., Olagunju, O., Richardson, S., & Jameson, G. (2024). How are inpatient psychiatric ward rounds understood in research literature? A scoping review. BJPsych Open, 10(S1), S69–S70.

Appendices

Appendix 1.1: PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	p8
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.	P11-13
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.	P14-16
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.	P16-17 Appendix 3
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Appendix 3
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.	P14, p16-17
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.	P14, p16-17
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.	P15 - 19
	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.	P15-19 Appendix 5
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.	P19-21
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)).	P15, p19-21 Appendix 4
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	P16 Appendix 6
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	P17-19, p21-22 Appendix 6
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe	P12-13, p15

		the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Appendix 7
	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.	n/a
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.	P15 Appendix 7
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.	P16-19
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	P16-17
Study characteristics	17	Cite each included study and present its characteristics.	P17-19 Appendix 5
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	P19-21
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.	P17-19 Appendix 5
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	P17-19
	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.	P21-22 Appendix 6
	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.	n/a
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	p33
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	n/a
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	P30-33
	23b	Discuss any limitations of the evidence included in the review.	p33
	23c	Discuss any limitations of the review processes used.	p33
	23d	Discuss implications of the results for practice, policy, and future research.	P33-34
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.	p13
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	p13
	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.	n/a
Competing interests	26	Declare any competing interests of review authors.	n/a
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 6

Appendix 1.2: ENTREQ Checklist

Item	Guide and descriptiion	Reported on page
Aim	State the research question the synthesis addresses	P13
Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	P12-13, p15
Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until theoretical saturation is achieved).	P13, Appendix 3
Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type).	P14-16
Data sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psychINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar), hand searching, reference lists) and when the searches were conducted; provide the rationale for using the data sources.	P13-14, p16-17 Appendix 3
Electronic search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research and search limits).	P13 Appendix 3
Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies)	P14-p17
Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	P17-19 Appendix 5
Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g. for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications t the research question and/or contribution to theory development).	P17
Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).	P14-15
Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI,	P14, p19-21 Appendix 4

	COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).	
Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	P14, p19
Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	P19-21
Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software).	P14-15
Software	State the computer software used, if any.	n/a
Number of reviewers	Identify who was involved in coding and analysis.	P15, p21
Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts).	P,15, p21
Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	P21 Appendix 6
Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.	P15
Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations or the author's interpretation	P22-29
Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	P30-34

Appendix 1.3: Database Search Strategies

Five databases were searched: Ovid MEDLINE and Ovid Embase (via the OvidSP interface); CINAHL and APA PsycInfo (via EBSCOhost); and Scopus. Each database-specific strategy below combines the qualitative filter with a psychiatric inpatient care, and a readmission concept block.

Ovid Medline

Search conducted: 21/11/2025

#	Search terms
1	Qualitative Research/
2	Nursing Methodology Research/
3	Questionnaires/
4	exp Attitude/
5	Focus Groups/
6	discourse analysis.mp.
7	content analysis.mp.
8	ethnographic research.mp.
9	ethnological research.mp.
10	constant comparative method.mp.
11	qualitative validity.mp.
12	purposive sample.mp.
13	observational method$.mp.
14	field stud$.mp.
15	theoretical sampl$.mp.
16	phenomenology/
17	phenomenological research.mp.
18	life experience$.mp.
19	cluster sampl$.mp.
20	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19
21	ethnonursing.af.
22	ethnograph$.mp.
23	phenomenol$.af.
24	grounded theory.mp.
25	(grounded adj (theor$ or study or studies or research or analys?s)).af. 18281 (life stor$ or women's stor$).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-
26	(life stor$ or women's stor$).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
27	(emic or etic or hermeneutic$ or heuristic$ or semiotic$).af. or (data adj1 saturat$).tw. or participant observ$.tw. 36363 (social construct$ or (postmodern$ or post-structural$) or (post structural$ or poststructural$) or post modern$ or post-modern$ or feminis$ or
28	(social construct$ or (postmodern$ or post-structural$) or (post structural$ or poststructural$) or post modern$ or post-modern$ or feminis$ or interpret$).mp.
29	(action research or cooperative inquir$ or co operative inquir$ or co-operative inquir$).mp.
30	(humanistic or existential or experiential or paradigm$).mp.

31	(field adj (study or studiesor research)).tw.
32	human science.tw.
33	biographical method.tw.
34	qualitative validity.af.
35	purposive sampl$.af.
36	theoretical sampl$.af.
37	((purpos$ adj4 sampl$) or (focus adj group$)).af. 114212 (account or accounts or unstructured or open-ended or open ended or text$ or narrative$).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word,
38	(account or accounts or unstructured or open-ended or open ended or text$ or narrative$).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
39	(life world or life-world or conversation analys?s or personal experience$ or theoretical saturation).mp.
40	lived experience$.tw.
41	life experience$.mp.
42	cluster sampl$.mp.
43	(theme$ or thematic).mp.
44	categor$.mp.
45	observational method$.af.
46	field stud$.mp.
47	focus group$.af.
48	questionnaire$.mp.
49	content analysis.af.
50	thematic analysis.af.
51	constant comparative.af. 4489 https://ovidsp-dc1-ovid-com.ezproxy2.lib.gla.ac.uk/ovid-new-b/ovidweb.cgi?&S=c632f893-e653-4ed0-9d10-82635bc9959f|main&clear+progress=1&C=_mai… 1/16 21/11/2025, 15:44 Ovid: Abstract Reference
52	discourse analys?s.af.
53	((discourse$ or discurs$) adj3 analys?s).tw.
54	(constant adj (comparative or comparison)).af.
55	narrative analys?s.af.
56	heidegger$.tw.
57	colaizzi$.tw.
58	speigelberg$.tw.
59	(van adj manen$).tw.
60	(van adj kaam$).tw.
61	(merleau adj ponty$).tw.
62	husserl$.tw.
63	giorgi$.tw.
64	foucault$.tw.
65	(corbin$ adj2 strauss$).tw.
66	(strauss$ adj2 corbin$).tw.
67	(glaser$ adj2 strauss$).tw.
68	glaser$.tw. 1186 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or
69	3670652 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or

70	findings.af.
71	interview$.af. or Interviews/
72	qualitative.af.
73	70 or 71 or 72
74	20 or 69 or 73
75	Mental Disorders/
76	Persons with Psychiatric Disorders/
77	*stress, psychological/
78	75 or 76 or 77 280002 ("mental disorder*" or "mental illness" or "mentally ill" or "mental disease" or "psychological problem*" or psychiatr* or "mental health problem*").ti. or ("mental disorder*" or "mental illness" or "mentally ill" or "mental disease" or "psychological problem*" or psychiatr* or "mental
79	("mental disorder*" or "mental illness" or "mentally ill" or "mental disease" or "psychological problem*" or psychiatr* or "mental health problem*").ti. or ("mental disorder*" or "mental illness" or "mentally ill" or "mental disease" or "psychological problem*" or psychiatr* or "mental health problem*").ab. or ("mental disorder*" or "mental illness" or "mentally ill" or "mental disease" or "psychological problem*" or psychiatr* or "mental health problem*").kw.
80	78 or 79
81	Patient Readmission/
82	"Continuity of Patient Care"/
83	81 or 82
84	("rehospitali*" or "readmission" or "revolving door" or "recurrent").ti. or ("rehospitali*" or "readmission" or "revolving door" or "recurrent").ab. or ("rehospitali*" or "readmission" or "revolving door" or "recurrent").kw.
85	83 or 84
86	74 and 80 and 85

Ovid EMBASE

Search conducted: 04/12/2025

#	**Search terms**
1	qualitative stud$.mp.
2	nursing methodology research.mp.
3	questionnaire/
4	attitude/
5	focus group$.mp.
6	discourse analysis.mp.
7	content analysis.mp.
8	ethnographic research.mp.
9	ethnological research.mp.
10	ethnonursing research.mp.
11	constant comparative method.mp.
12	qualitative validity.mp.
13	purposive sample.mp.
14	observational method$.mp.
15	field stud$.mp.
16	theoretical sampl$.mp.
17	phenomenology/

18	phenomenological research.mp.
19	life experience$.mp.
20	cluster sampl$.mp.
21	(S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15 or S16 or S17 or S18 or S19 or S20).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]
22	ethnonursing.af.
23	ethnograph$.mp.
24	phenomenol$.af.
25	grounded theory.mp.
26	(grounded adj (theor$ or study or studies or research or analys?s)).af.
27	(life stor$ or women's stor$).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]
28	(emic or etic or hermeneutic$ or heuristic$ or semiotic$).af. or (data adj1 saturat$).tw. or participant observ$.tw.
29	(social construct$ or (postmodern$ or post-structural$) or (post structural$ or poststructural$) or post modern$ or post-modern$ or feminis$ or interpret$).mp.
30	(action research or cooperative inquir$ or co operative inquir$ or co-operative inquir$).mp.
31	(humanistic or existential or experiential or paradigm$).mp.
32	(field adj (study or studiesor research)).tw.
33	human science.tw.
34	biographical method.tw.
35	qualitative validity.af.
36	purposive sampl$.af.
37	theoretical sampl$.af.
38	((purpos$ adj4 sampl$) or (focus adj group$)).af.
39	(account or accounts or unstructured or open-ended or open ended or text$ or narrative$).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]
40	(life world or life-world or conversation analys?s or personal experience$ or theoretical saturation).mp.
41	lived experience$.tw.
42	life experience$.mp.
43	cluster sampl$.mp.
44	(theme$ or thematic).mp.
45	categor$.mp.
46	observational method$.af.
47	field stud$.mp.
48	focus group$.af.
49	questionnaire$.mp.
50	content analysis.af.
51	thematic analysis.af.
52	constant comparative.af.
53	discourse analys?s.af.
54	((discourse$ or discurs$) adj3 analys?s).tw.
55	(constant adj (comparative or comparison)).af.
56	narrative analys?s.af.
57	heidegger$.tw.

58	colaizzi$.tw.
59	speigelberg$.tw.
60	(van adj manen$).tw.
61	(van adj kaam$).tw.
62	(merleau adj ponty$).tw.
63	husserl$.tw.
64	giorgi$.tw.
65	foucault$.tw.
66	(corbin$ adj2 strauss$).tw.
67	(strauss$ adj2 corbin$).tw.
68	(glaser$ adj2 strauss$).tw.
69	glaser$.tw.
70	(S22 or S23 or S24 or S25 or S26 or S27 or S28 or S29 or S30 or S31 or S32 or S33 or S34 or S35 or S36 or S37 or S38 or S39 or S40 or S41 or S42 or S43 or S44 or S45 or S46 or S47 or S48 or S49 or S50 or S51 or S52 or S53 or S54 or S55 or S56 or S57 or S58 or S59 or S60 or S61 or S62 or S63 or S64 or S65 or S66 or S67 or S68).mp. or 69 [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]
71	findings.af.
72	interview$.af. or Interviews/
73	qualitative.af.
74	71 or 72 or 73
75	21 or 70 or 74
76	Mental Disorders/
77	Persons with Psychiatric Disorders/
78	*stress, psychological/
79	76 or 77 or 78
80	("mental disorder*" or "mental illness" or "mentally ill" or "mental disease" or "psychological problem*" or psychiatr* or "mental health problem*").ti. or ("mental disorder*" or "mental illness" or "mentally ill" or "mental disease" or "psychological problem*" or psychiatr* or "mental health problem*").ab. or ("mental disorder*" or "mental illness" or "mentally ill" or "mental disease" or "psychological problem*" or psychiatr* or "mental health problem*").kw.
81	79 or 80
82	Patient Readmission/
83	"Continuity of Patient Care"/
84	82 or 83
85	("rehospitali*" or "readmission" or "revolving door").ti. or ("rehospitali*" or "readmission" or "revolving door").ab. or ("rehospitali*" or "readmission" or "revolving door").kw.
86	84 or 85
87	75 and 81 and 86

CINAHL (EBSCOhost)

Seach conducted: 12/12/2025

#	Search terms
1	DE "Qualitative Methods"
2	DE "Questionnaires"
3	DE "Attitudes" OR DE "Abortion (Attitudes Toward)" OR DE "Adolescent Attitudes" OR DE "Adult Attitudes" OR DE "Aged (Attitudes Toward)" OR DE "Aging (Attitudes Toward)" OR DE "Attitude Change" OR DE "Attitude Formation" OR DE "Attitude Similarity" OR DE "Caregiver Attitudes" OR DE "Child Attitudes" OR DE "Childrearing Attitudes" OR DE "Client Attitudes" OR DE "Community Attitudes" OR DE "Computer Attitudes" OR DE "Consumer Attitudes" OR DE "Cultural Attitudes" OR DE "Death Attitudes" OR DE "Disabled (Attitudes Toward)" OR DE "Drug Usage Attitudes" OR DE "Eating Attitudes" OR DE "Employee Attitudes" OR DE "Employer Attitudes" OR DE "Environmental Attitudes" OR DE "Explicit Attitudes" OR DE "Family Planning Attitudes" OR DE "Female Attitudes" OR DE "Gender Role Attitudes" OR DE "Health Attitudes" OR DE "Ideology" OR DE "Immigration (Attitudes Toward)" OR DE "Implicit Attitudes" OR DE "Male Attitudes" OR DE "Marriage Attitudes" OR DE "Obesity (Attitudes Toward)" OR DE "Occupational Attitudes" OR DE "Parental Attitudes" OR DE "Paternalism" OR DE "Political Attitudes" OR DE "Preferences" OR DE "Public Opinion" OR DE "Racial and Ethnic Attitudes" OR DE "Sex Role Attitudes" OR DE "Sexual Attitudes" OR DE "Socioeconomic Class Attitudes" OR DE "Sports (Attitudes Toward)" OR DE "Stereotyped Attitudes" OR DE "Student Attitudes" OR DE "Values" OR DE "Work (Attitudes Toward)" OR DE "World View"
4	DE "Focus Group"
5	TX "discourse analysis"
6	TX "content analysis"
7	TX "ethnographic research"
8	TX "ethnological research"
9	TX "ethnonursing research"
10	TX "constant comparative method"
11	TX "qualitative validity"
12	TX "purposive sample"
13	TX "observational method*"
14	TX "field stud*"
15	TX "theoretical sampl*"
16	DE "Phenomenology"
17	TX "phenomenological research"
18	TX "life experience*"
19	TX "cluster sampl*"
20	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19
21	TX ethnonursing
22	TX ethnograph*
23	TX phenomenol*
24	TX "grounded theory"
25	TX ((grounded w1 (theor* or study or studies or research or analys#s)))
26	TX ((("life stor*") or ("women's stor*")))
27	TX (emic or etic or hermeneutic* or heuristic* or semiotic*) or TI (data n1 saturat*) or AB (data n1 saturat*) or TI ("participant observ*") or AB ("participant observ*")
28	TX ((("social construct*" or (postmodern* or "poststructural*") or ("post structural*" or poststructural*) or ("post modern*") or "postmodern*" or feminis* or interpret*))
29	TX (("action research" or "cooperative inquir*" or ("co operative inquir*") or ("co-operative inquir*")))
30	TX ((humanistic or existential or experiential or paradigm*))

31	TI ((field w1 (study or studies or research)) OR AB ((field w1 (study or studies or research))
32	TI ("human science") OR AB ("human science")
33	TI ("biographical method") OR AB ("biographical method")
34	TX ("qualitative validity")
35	TX ("purposive sampl*")
36	TX ("theoretical sampl*")
37	TX (((purpos* n3 sampl*) or (focus w group*)))
38	TX (((account or accounts or unstructured or "openended" or ("open ended") or text* or narrative*))
39	TX ((("life world") or "lifeworld" or "conversation analys#s" or "personal experience*" or "theoretical saturation"))
40	TI ("lived experience*") OR AB ("lived experience*")
41	TX ("life experience*")
42	TX ("cluster sampl*")
43	TX ((theme* or thematic))
44	TX categor*
45	TX "observational method*"
46	TX "field stud*"
47	TX "focus group*"
48	TX questionnaire*
49	TX ("content analysis")
50	TX ("thematic analysis")
51	TX ("constant comparative")
52	TX ("discourse analys#s")
53	TI (((discourse* or discurs*) n2 analys#s)) OR AB (((discourse* or discurs*) n2 analys#s))
54	TX ((constant w1 (comparative or comparison)))
55	TX ("narrative analys#s")
56	TI heidegger* OR AB heidegger*
57	TI colaizzi* OR AB colaizzi*
58	TI speigelberg* OR AB speigelberg*
59	TI (van w1 manen*) OR AB (van w1 manen*)
60	TI (van w1 kaam*) OR AB (van w1 kaam*)
61	TI (merleau w1 ponty*) OR AB (merleau w1 ponty*)
62	TI husserl* OR AB husserl*
63	TI giorgi* OR AB giorgi*
64	TI foucault* OR AB foucault*
65	TI (corbin* n1 strauss*) OR AB (corbin* n1 strauss*)
66	TI (strauss* n1 corbin*) OR AB (strauss* n1 corbin*)
67	TI (glaser* n1 strauss*) OR AB (glaser* n1 strauss*)
68	TI glaser* OR AB glaser*
69	S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR S62 OR S63 OR S64 OR S65 OR S66 OR S67 OR S68
70	TX findings
71	DE "Interviews"
72	TX interview*

73	1,209,984 S73 TX qualitative
74	
75	S20 OR S69 OR S74
76	DE "Psychiatric Hospital Readmission"
77	TI (readmission* OR rehospitalization OR "re- hospitalization" OR "re- admission" OR rehospitalisation OR "re- hospitalisation" OR readmissions OR "revolving door" OR "recurrent") OR AB (readmission* OR rehospitalization OR "re- hospitalization" OR "re- admission" OR rehospitalisation OR "re- hospitalisation" OR readmissions OR "revolving door" OR "recurrent") OR KW (readmission* OR rehospitalization OR "re- hospitalization" OR "re- admission" OR rehospitalisation OR "re- hospitalisation" OR readmissions OR "revolving door" OR "recurrent")
78	S76 OR S77
79	(DE "Psychiatric Hospitals") OR (DE "Psychiatric Units")
80	TI ((psychiatric OR "mentally ill" OR "mental health hospital*" OR "mental health" OR (inpatient* N2 psychiatr*)) OR AB (psychiatric OR "mentally ill" OR "mental health hospital*" OR "mental health" OR (inpatient* N2 psychiatr*)) OR KW (psychiatric OR "mentally ill" OR "mental health hospital*" OR "mental health" OR (inpatient* N2 psychiatr*))
81	S79 OR S80
82	S75 AND S78 AND S81

APA PsycINFO (EBSCOhost)

Search Conducted: 04/12/2025

#	Search terms
1	DE "Qualitative Methods"
2	DE "Questionnaires"
3	DE "Attitudes" OR DE "Abortion (Attitudes Toward)" OR DE "Adolescent Attitudes" OR DE "Adult Attitudes" OR DE "Aged (Attitudes Toward)" OR DE "Aging (Attitudes Toward)" OR DE "Attitude Change" OR DE "Attitude Formation" OR DE "Attitude Similarity" OR DE "Caregiver Attitudes" OR DE "Child Attitudes" OR DE "Childrearing Attitudes" OR DE "Client Attitudes" OR DE "Community Attitudes" OR DE "Computer Attitudes" OR DE "Consumer Attitudes" OR DE "Cultural Attitudes" OR DE "Death Attitudes" OR DE "Disabled (Attitudes Toward)" OR DE "Drug Usage Attitudes" OR DE "Eating Attitudes" OR DE "Employee Attitudes" OR DE "Employer Attitudes" OR DE "Environmental Attitudes" OR DE "Explicit Attitudes" OR DE "Family Planning Attitudes" OR DE "Female Attitudes" OR DE "Gender Role Attitudes" OR DE "Health Attitudes" OR DE "Ideology" OR DE "Immigration (Attitudes Toward)" OR DE "Implicit Attitudes" OR DE "Male Attitudes" OR DE "Marriage Attitudes" OR DE "Obesity (Attitudes Toward)" OR DE "Occupational Attitudes" OR DE "Parental Attitudes" OR DE "Paternalism" OR DE "Political Attitudes" OR DE "Preferences" OR DE "Public Opinion" OR DE "Racial and Ethnic Attitudes" OR DE "Sex Role Attitudes" OR DE "Sexual Attitudes" OR DE "Socioeconomic Class Attitudes" OR DE "Sports (Attitudes Toward)" OR DE "Stereotyped Attitudes" OR DE "Student Attitudes" OR DE "Values" OR DE "Work (Attitudes Toward)" OR DE "World View"
4	DE "Focus Group"
5	TX "discourse analysis"
6	TX "content analysis"
7	TX "ethnographic research"
8	TX "ethnological research"
9	TX "ethnonursing research"
10	TX "constant comparative method"
11	TX "qualitative validity"
12	TX "purposive sample"
13	TX "observational method*"
14	TX "field stud*"
15	TX "theoretical sampl*"
16	DE "Phenomenology"

17	TX "phenomenological research"
18	TX "life experience*"
19	TX "cluster sampl*"
20	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19
21	TX ethnonursing
22	TX ethnograph*
23	TX phenomenol*
24	TX "grounded theory"
25	TX ((grounded w1 (theor* or study or studies or research or analys#s)))
26	TX ((("life stor*") or ("women's stor*")))
27	TX (emic or etic or hermeneutic* or heuristic* or semiotic*) or TI (data n1 saturat*) or AB (data n1 saturat*) or TI ("participant observ*") or AB ("participant observ*")
28	TX ((("social construct*" or (postmodern* or "poststructural*") or ("post structural*" or poststructural*) or ("post modern*") or "postmodern*" or feminis* or interpret*))
29	TX (("action research" or "cooperative inquir*" or ("co operative inquir*") or ("co-operative inquir*")))
30	TX ((humanistic or existential or experiential or paradigm*))
31	TI ((field w1 (study or studies or research)) OR AB ((field w1 (study or studies or research))
32	TI ("human science") OR AB ("human science")
33	TI ("biographical method") OR AB ("biographical method")
34	TX ("qualitative validity")
35	TX ("purposive sampl*")
36	TX ("theoretical sampl*")
37	TX (((purpos* n3 sampl*) or (focus w group*)))
38	TX (((account or accounts or unstructured or "openended" or ("open ended") or text* or narrative*))
39	TX ((("life world") or "lifeworld" or "conversation analys#s" or "personal experience*" or "theoretical saturation"))
40	TI ("lived experience*") OR AB ("lived experience*")
41	TX ("life experience*")
42	TX ("cluster sampl*")
43	TX ((theme* or thematic))
44	TX categor*
45	TX "observational method*"
46	TX "field stud*"
47	TX "focus group*"
48	TX questionnaire*
49	TX ("content analysis")
50	TX ("thematic analysis")
51	TX ("constant comparative")
52	TX ("discourse analys#s")
53	TI (((discourse* or discurs*) n2 analys#s)) OR AB (((discourse* or discurs*) n2 analys#s))
54	TX ((constant w1 (comparative or comparison)))
55	TX ("narrative analys#s")
56	TI heidegger* OR AB heidegger*
57	TI colaizzi* OR AB colaizzi*
58	TI speigelberg* OR AB speigelberg*
59	TI (van w1 manen*) OR AB (van w1 manen*)

60	TI (van w1 kaam*) OR AB (van w1 kaam*)
61	TI (merleau w1 ponty*) OR AB (merleau w1 ponty*)
62	TI husserl* OR AB husserl*
63	TI giorgi* OR AB giorgi*
64	TI foucault* OR AB foucault*
65	TI (corbin* n1 strauss*) OR AB (corbin* n1 strauss*)
66	TI (strauss* n1 corbin*) OR AB (strauss* n1 corbin*)
67	TI (glaser* n1 strauss*) OR AB (glaser* n1 strauss*)
68	TI glaser* OR AB glaser*
69	S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR S62 OR S63 OR S64 OR S65 OR S66 OR S67 OR S68
70	TX findings
71	DE "Interviews"
72	TX interview*
73	1,209,984 S73 TX qualitative
74	
75	S20 OR S69 OR S74
76	DE "Psychiatric Hospital Readmission"
77	TI (readmission* OR rehospitalization OR "re- hospitalization" OR "re- admission" OR rehospitalisation OR "re- hospitalisation" OR readmissions OR "revolving door" OR "recurrent") OR AB (readmission* OR rehospitalization OR "re- hospitalization" OR "re- admission" OR rehospitalisation OR "re- hospitalisation" OR readmissions OR "revolving door" OR "recurrent") OR KW (readmission* OR rehospitalization OR "re- hospitalization" OR "re- admission" OR rehospitalisation OR "re- hospitalisation" OR readmissions OR "revolving door" OR "recurrent")
78	S76 OR S77
79	(DE "Psychiatric Hospitals") OR (DE "Psychiatric Units")
80	TI ((psychiatric OR "mentally ill" OR "mental health hospital*" OR "mental health" OR (inpatient* N2 psychiatr*)) OR AB (psychiatric OR "mentally ill" OR "mental health hospital*" OR "mental health" OR (inpatient* N2 psychiatr*)) OR KW (psychiatric OR "mentally ill" OR "mental health hospital*" OR "mental health" OR (inpatient* N2 psychiatr*))
81	S79 OR S80
82	S75 AND S78 AND S81

SCOPUS

Search conducted: 19/12/2025

#	**Search terms**
1	ALL("discourse analysis")
2	ALL("content analysis")
3	ALL("ethnographic research")
4	ALL("ethnological research")
5	ALL("ethnonursing research")
6	ALL("constant comparative method")
7	ALL("qualitative validity")
8	ALL("purposive sample")
9	ALL("observational method*")

10	ALL("field stud*")
11	ALL("theoretical sampl*")
12	ALL("phenomenological research")
13	ALL("life experience*")
14	ALL("cluster sampl*")
15	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14
16	ALL("ethnonursing")
17	ALL("ethnograph*")
18	ALL("phenomenol*")
19	ALL("grounded theory")
20	ALL(grounded PRE/0 (theor* OR study OR studies OR research OR analys?s))
21	ALL("life stor*" OR "women's stor*")
22	ALL(emic OR etic OR hermeneutic* OR heuristic* OR semiotic*) OR TITLE-ABS(data W/1 saturat*) OR TITLE-ABS("participant observ*")
23	ALL("social construct*" OR "postmodern*" OR "post-structural*" OR "post structural*" OR "poststructural*" OR "post modern*" OR "post-modern*" OR "feminis*" OR "interpret*")
24	ALL("action research" OR "cooperative inquir*" OR "co operative inquir*" OR "co-operative inquir*")
25	ALL("humanistic" OR "existential" OR "experiential" OR "paradigm*")
26	TITLE-ABS("field" PRE/0 ("study" OR "studies" OR "research"))
27	TITLE-ABS("human science")
28	TITLE-ABS("biographical method")
29	ALL("qualitative validity")
30	ALL("purposive sampl*")
31	ALL("theoretical sampl*")
32	ALL((purpos* W/4 sampl*) OR (focus PRE/0 group*))
33	ALL(account OR accounts OR unstructured OR "open-ended" OR "open ended" OR text* OR narrative*)
34	ALL("life world" OR "life-world" OR "conversation analys?s" OR "personal experience*" OR "theoretical saturation")
35	TITLE-ABS("lived experience*")
36	ALL("life experience*")
37	ALL("cluster sampl*")
38	ALL(theme* OR thematic)
39	ALL(category*)
40	ALL("observational method*")
41	ALL("field stud*")
42	ALL("focus group*")
43	ALL(questionnaire*)
44	ALL("content analysis")
45	ALL("thematic analysis")
46	ALL("constant comparative")
47	ALL("discourse analys?s")
48	TITLE-ABS((discourse* OR discurs*) W/3 analys?s)
49	ALL(constant PRE/0 (comparative OR comparison))
50	ALL("narrative analys?s")
51	TITLE-ABS("heidegger*")
52	TITLE-ABS("colaizzi*")

53	TITLE-ABS("speigelberg*")
54	TITLE-ABS("van manen*")
55	TITLE-ABS("van kaam*")
56	TITLE-ABS("merleau ponty*")
57	TITLE-ABS("husserl*")
58	TITLE-ABS("giorgi*")
59	TITLE-ABS("foucault*")
60	TITLE-ABS(corbin* W/2 strauss*)
61	TITLE-ABS(strauss* W/2 corbin*)
62	TITLE-ABS(glaser* W/2 strauss*)
63	TITLE-ABS("glaser*")
64	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 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR S62 OR S63
65	ALL("findings")
66	ALL("interview*")
67	ALL("qualitative")
68	S65 OR S66 OR S67
69	S15 AND S64 AND S68
70	TITLE-ABS-KEY(readmission* OR rehospitalization OR "re-hospitalization" OR "re-admission" OR rehospitalisation OR "re-hospitalisation" OR readmissions OR "revolving door" OR recurrent)
71	TITLE-ABS-KEY(psychiatric OR "mentally ill" OR "mental health hospital*" OR "mental health" OR (inpatient* W/2 psychiatr*))
72	S69 AND S70 AND S71

Appendix 1.4: Critical Appraisal

Included qualitative studies were critically appraised using the CASP Qualitative Studies Checklist (Critical Appraisal Skills Programme). Current version available at: https://casp-uk.net/casp-tools-checklists/qualitative-studies-checklist/

Appendix 1.5: Full Table of Study Characteristics

Unabbreviated characteristics of all 13 included studies.

Study (Author, Year, Country)	Aim	Participants Characteristics	Recruitment	Data Collection and Analysis	Key Findings Relevant to Readmission
Martino et al. (2025), Switzerland	To explore understandings and experiences of psychiatric hospitalisation among patients who were hospitalised multiple times within a year.	n = 20 service users. Eight females and twelve males aged 21–64 years (mean 36.9). Diagnoses included psychotic disorders, mood disorders and personality disorders. Participants had experienced 3–8 psychiatric hospitalisations during the previous 12 months (mean 3.6). Both voluntary and involuntary readmissions were represented.	Criterion-based purposive sampling from a university psychiatric hospital in Switzerland. Eligible participants were identified by nursing teams and head nurses using administrative records and electronic files. Nursing staff initially approached potential participants before referral to the research team.	Semi-structured interviews with service users. Reflexive thematic analysis.	Why people return to hospital: psychic distress and external factors. Subthemes: hospitalisation due to overwhelming suffering, hospital as a therapeutic option, hospital as a source of safety and containment, constant nursing presence, and temporary escape from external pressures
Mlay et al. (2024), South Africa	To explore risk factors and strategies for relapse prevention from patients' and caregivers' perspectives.	n = 30 (24 service users, 6 caregivers). Service users had serious mental illness, including schizophrenia, schizoaffective disorder, psychosis and related disorders. Mean age = 34.8 years (range 19–79); 58% male; 88% Black African. Most had experienced readmission within the previous six months. Caregivers were predominantly female family members. High rates of unemployment and co-residence with family were reported.	Consecutive sampling of psychiatric inpatients receiving treatment at a specialised public psychiatric hospital in Durban, South Africa. Caregivers were subsequently recruited through participating service users and invited to complete separate interviews.	Face-to-face semi-structured interviews with service users and caregivers. Descriptive phenomenological analysis using NVivo and inductive thematic coding.	Risk factors for relapse: personal, family-related and health-system factors. Strategies for relapse prevention: personal, family-related and health-system strategies. Subthemes: medication adherence, motivation for treatment, family involvement, psychoeducation, community support, improved service accessibility and continuity of care.
Raluthanga et al. (2023), South Africa	To explore causes of relapse shortly after discharge from acute psychiatric units from caregivers' perspectives.	n = 18 caregivers. primary caregivers of mental health care users who had experienced readmission following discharge from acute psychiatric units. Conducted in Limpopo Province, South Africa. Demographic information was limited.	Convenience sampling of primary caregivers of mental health care users readmitted to acute psychiatric units in Limpopo Province, South Africa. Caregivers were identified through hospital records and approached following permission from service users.	Semi-structured interviews with primary caregivers. Inductive thematic analysis using NVivo.	Caregivers' perspectives on relapse and readmission: misconceptions about mental illness, barriers to supervision, beliefs about mental illness, treatment changes, and exposure to behaviours that worsen mental health. Subthemes: denial of illness,, refusal of caregiver supervision, living alone after discharge, attribution to witchcraft, use of alternative healing practices..
Phillips et al. (2022), United Kingdom	To explore service users' views of care from admission through to readmission in the context of psychosis.	n = 8 service users. Seven women and one man aged 31–58 years. All had experiences of psychosis and had been readmitted to an acute mental health ward within six months of discharge. Participants had between 3	Purposive sampling from two NHS Trusts in the North of England. Care teams and clinical records were used to identify eligible participants who had experienced readmission to an acute mental health ward within six	Semi-structured interviews with service users. Interpretative Phenomenological Analysis (IPA)	Experiences from admission to readmission: (1) quality of therapeutic relationships; (2) adjusting to sudden shifts in care; (3) struggling without the ward environment. Subthemes:

		and 17 previous psychiatric readmissions. All identified as White British except one participant who identified as Asian British.	months of discharge. Clinicians approached potential participants before referral to the research team.		compassionate versus dismissive care, empowerment versus disempowerment, unexpected discharge, absence of reliable support, unmet needs, perceived inevitability of readmission.
Ko and Park (2021), South Korea	To explore the experiences of individuals with long-term mental disorders following discharge and repeated readmission.	n = 11 service users. Five males and six females aged 31–61 years. All had schizophrenia; some also had alcohol use disorder or bipolar disorder. Participants had experienced multiple psychiatric readmissions (approximately 2–10 readmissions). Most lived with family members following discharge.	Convenience sampling through three community mental health centres in South Korea. Recruitment occurred via flyers and information provided by community mental health nurses. Interested participants either contacted the researchers directly or were referred by centre staff.	Individual in-depth interviews with service users. Thematic analysis.	Life after discharge and the revolving-door phenomenon: (1) suffering from social maladjustment; (2) loneliness and isolation; (3) shame and burden within the family; (4) difficulties managing mental illness. Subthemes: unemployment, economic hardship, stigma, dependency, social exclusion, medication burden, tension within family relationships.
Kassim et al. (2021), Brunei Darussalam	To explore psychiatric nurses' perceptions of reasons for readmission and their role in reducing readmissions.	n = 24 psychiatric nurses. Participants were aged 28–52 years and had between 3 and 20 years of psychiatric nursing experience. Recruited from a psychiatric department in Brunei Darussalam.	Purposive sampling of psychiatric nurses working in the primary psychiatric department in Brunei Darussalam.Nurse managers acted as gatekeepers and identified eligible participants, who were then invited to participate by the research team.	Five focus group discussions with psychiatric nurses using a semi-structured interview schedule. Thematic analysis following Braun and Clarke's six-step framework.	Preventing readmission: (1) significant role of family support; (2) value of psychoeducation.
Ådnanes et al. (2020), Norway, Finland, Italy, Austria, Romania and Slovenia	To explore psychiatric rehospitalisation from a service-user perspective, focusing on how readmission can be avoided.	n = 55 service users. Same participant sample as Ådnanes et al. (2018). Participants were recruited across Austria, Finland, Italy, Norway, Romania and Slovenia. All had received mental health services for at least one year and experienced multiple psychiatric hospitalisations. Age range 26–65 years; 60% female. Diagnoses included psychotic disorders, bipolar disorder, depressive disorders and anxiety disorders.Participants were counted once only in the overall review sample due to sample overlap with Ådnanes et al. (2018)	Convenience sampling through mental health organisations and activity/day-care centres across Austria, Finland, Italy, Norway, Romania and Slovenia. Recruitment was facilitated by organisational staff and local researchers.	Eight semi-structured focus groups conducted across six European countries. Systematic text condensation.	Strategies to avoid rehospitalisation: discharge planning and preparation, self-monitoring and coping strategies, follow-up by outpatient and community services, meaningful activities and social participation, peer support and family support. Subthemes: crisis plans, regular contact with services, flexible support, workshops and activities, online peer support, family involvement.
Dlamini and Shongwe (2019), Eswatini	To explore mental health nurses' perceptions of factors contributing to increasing psychiatric readmissions.	n = 9 mental health nurses. Mean psychiatric nursing experience = 7 years. No age or gender data reported.	Purposive sampling of mental health nurses employed at the National Psychiatric Referral Hospital in Eswatini. Nurses were recruited based on their experience caring for psychiatric patients with histories of readmission.	Individual in-depth interviews using an unstructured interview guide. Thematic analysis following Creswell's approach.	Factors contributing to psychiatric readmission: negative attitudes towards medication and illness, substance misuse, stigma and discrimination, low socioeconomic status, comorbidity, lack of family support, family belief systems, and

					administrative factors. Subthemes: alternative remedies, denial of diagnosis, non-adherence, transport barriers, poor outreach services, medication shortages, premature discharge.
Brännström et al. (2018), Sweden	To explore why some patients experience recurrent or prolonged psychiatric inpatient care.	n = 10 service users. Nine women and one man aged 22–61 years. All had affective disorders and histories of recurrent or prolonged psychiatric inpatient care. Seven participants also had personality disorder diagnoses. Participants varied in readmission frequency and length of inpatient stay.	Purposive sampling from an outpatient psychiatric clinic specialising in affective disorders in Sweden. Eligible participants were identified through the clinic based on experiences of recurrent or prolonged inpatient psychiatric care.	Semi-structured individual interviews. Inductive qualitative content analysis.	Patient perspectives on recurrent/prolonged inpatient care: (1) difficulties in affect regulation; (2) relational sensitivity; (3) resignation; (4) ambivalence towards responsibility. Subthemes: inadequate access to care, poor continuity, importance of supportive therapeutic conversations, passive inpatient care, unsatisfactory encounters, insufficient guidance and support.
Ådnanes et al. (2018), Norway, Finland, Italy, Austria, Romania and Slovenia	To understand the multifaceted nature of psychiatric rehospitalisation from the perspective of service users.	n = 55 service users. Participants were recruited across Austria, Finland, Italy, Norway, Romania and Slovenia. All had received mental health services for at least one year and experienced more than one psychiatric hospitalisation. Age range 26–65 years. 60% female. Diagnoses included psychotic disorders, bipolar disorder, depressive disorders and anxiety disorders.	Convenience sampling through mental health organisations and activity/day-care centres across Austria, Finland, Italy, Norway, Romania and Slovenia. Recruitment was primarily coordinated by designated contacts within participating organisations, who distributed study information and invitations.	Eight semi-structured focus groups conducted across six European countries. Systematic text condensation.	Experiences of psychiatric rehospitalisation: (1) less traumatising than first admission; (2) rehospitalisation as necessary and relieving; (3) rehospitalisation by default without progress; (4) rehospitalisation as part of recovery.
Duhig et al. (2017), Australia	To explain psychiatric readmission from the service-user perspective.	n = 13 service users. Eight males and five females. Participants had experienced psychiatric readmission within 28 days of discharge from an acute inpatient ward. Recruited from a public mental health service in Australia. Diagnostic information not reported in detail	Convenience sampling from three psychiatric inpatient wards within a metropolitan public mental health service in Australia. Clinicians identified service users who had been readmitted within 28 days of discharge and referred eligible participants to the research team.	Individual semi-structured interviews with service users. Inductive analysis informed by grounded theory techniques.	Readmission as a process: discordant discharge, stress and struggle in the community, inadequate relief from distress, readmission as sanctuary, and direct or indirect pathways back to hospital.
Nxasana and Thupayagale-Tshweneagae (2014), South Africa	To investigate nurses' perceptions of psychiatric readmission within one year of discharge.	n = 10 psychiatric nurses. Participants worked within a community psychiatric service in South Africa. Years of experience not consistently reported. No age or gender data reported.	Purposive sampling of psychiatric nurses working within a 72-hour community psychiatric service attached to Prince Mshiyeni Memorial Hospital, South Africa. Nurses were recruited based on their experience caring for individuals experiencing psychiatric readmission.	In-depth interviews with psychiatric nurses. Qualitative analysis using Tesch's method.	Factors contributing to readmission: medication management difficulties, lack of family support, alcohol and substance use, absence of community psychiatric follow-up, stigma, and cultural influences. Subthemes: poor insight, low educational attainment, medication dependence, side effects,

					geographical barriers, premature discharge.
George and Howell (1996), United States	To examine service users' and caregivers' perceptions of frequent psychiatric rehospitalisation and its effects.	n = 10 (5 service users, 5 caregivers). Service users had schizophrenia and histories of frequent psychiatric rehospitalisation. Mean age of service users = 37 years (range 24–42); caregivers mean age = 52 years (range 35–67). Service users included 3 Black males, 1 White male and 1 White female. All had multiple prior readmissions (range 3–56 readmissions) and had been readmitted within 90 days of discharge. Caregivers included family members and one community case manager.	Purposive intensity sampling from a large state psychiatric hospital in the United States. Service users were selected from adults with schizophrenia who had experienced readmission within 90 days of discharge. Caregivers identified by participants were also invited to participate.	Individual semi-structured interviews with service users and caregivers. Phenomenological analysis using a constant comparative approach.	Rehospitalisation as a multifaceted experience: (1) rehospitalisation as a safe place; (2) medication stabilisation; (3) renewal of hope; (4) frustration with the mental health care system; (5) reduced individual control.

Appendix 1.6: Audit Trail of Analytical and Descriptive Themes

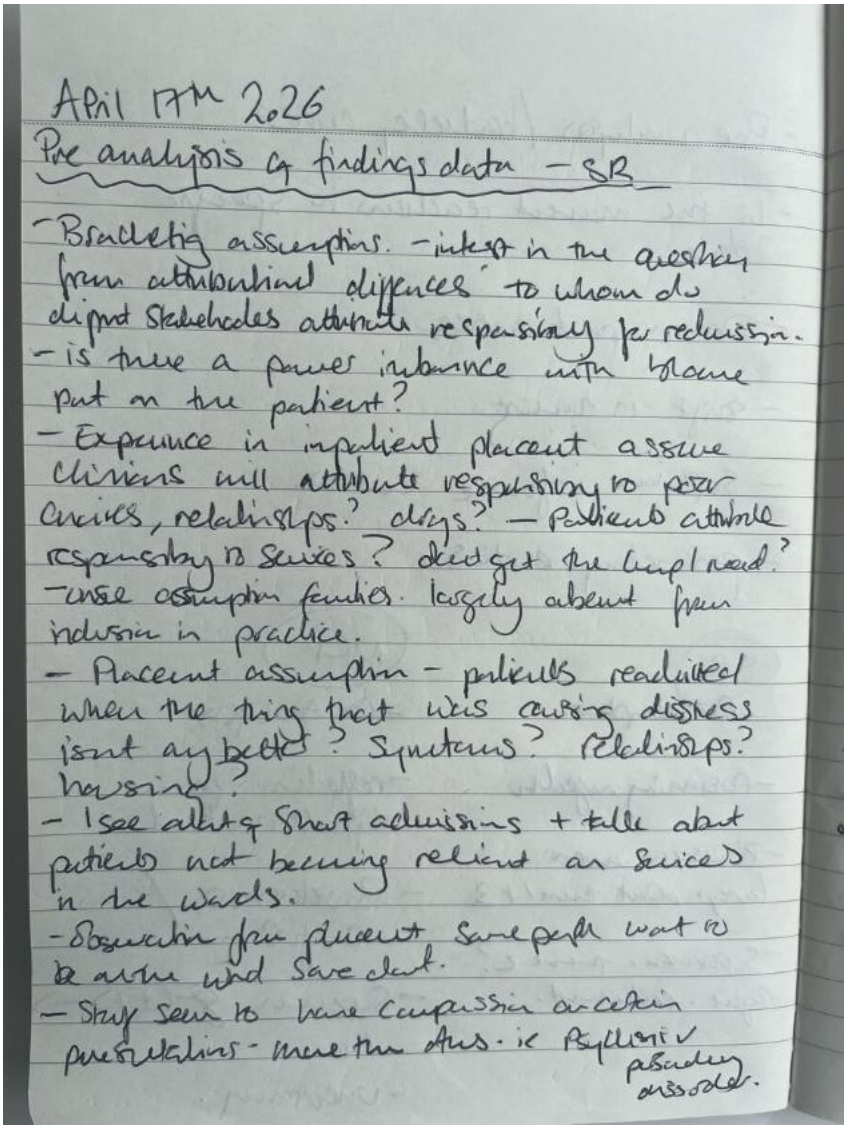
This table maps the 40 synthesised descriptive codes to the 13 included studies. A tick X indicates that the study contributed at least one initial descriptive code or quotation relevant to the synthesised descriptive code. Totals show the number of studies contributing to each synthesised code and should not be interpreted as quantitative weighting of theme importance.

Analytical Theme	Descriptive Theme	Synthesised Descriptive Code	Adn18	Adn20	Bra18	Dla19	Duh17	Geo96	Kas21	Ko21	Mar25	Mla24	Nxa14	Phi22	Ral23	Total
Readmission as a Failure of Containment Beyond Hospital	Escalating Distress Before Readmission	Progressive psychological deterioration	X	X	X	X	X	X	X	X	X	X	X	X	X	**13**
		Escalating psychosocial stress	X	X	X	X	X	X	X	X	X	X	X	X	X	**13**
		Diminishing coping capacity		X	X	X	X	X	X		X	X	X	X	X	**11**
		Delayed access to support	X	X	X	X	X		X		X	X	X	X		**10**
		Missed opportunities for early intervention		X					X		X	X	X	X		**6**
		Substance use contributing to deterioration				X	X	X				X	X		X	**6**
	Experiences of Discharge and Continuity of Care	Inadequate discharge preparation			X	X	X				X	X	X	X		**7**
		Fragmented continuity of care		X	X	X	X	X	X			X	X	X	X	**10**
		Limited community support	X	X	X	X	X	X			X	X	X	X		**10**
		Poor service coordination	X	X	X	X				X		X		X		**7**
		System capacity pressures	X	X	X	X	X	X	X		X	X	X	X		**11**
		Proactive discharge planning promotes stability		X	X	X	X	X			X	X	X	X	X	**10**
	Hospital as a Place of Safety During Crisis	Hospital as a source of safety	X	X	X		X	X			X		X	X		**8**
		Reliable therapeutic presence	X			X			X		X		X	X		**6**
		Readmission as a last resort	X	X	X	X	X	X	X		X	X	X			**10**
		Cycles of repeated readmission	X	X	X	X	X	X		X	X	X	X	X	X	**12**
Power, Responsibility and Competing Understandings of Readmission	Clinician Understandings of Readmission	Medication adherence	X			X		X	X	X	X	X	X		X	**9**
		Treatment engagement		X	X	X	X		X	X	X	X	X		X	**10**
		Family involvement in recovery		X					X	X		X	X	X		**6**
		Stigma affecting engagement	X		X	X			X	X			X		X	**7**

	Patient and Carer Experiences of Treatment Engagement	Medication burden						x		x	x	x	x			**5**
		Social disadvantage		x		x	x	x		x	x	x	x	x		**9**
		Social isolation	x	x	x		x	x		x	x			x	x	**9**
		Family relationships		x	x	x	x	x	x	x	x	x	x	x	x	**12**
		Caregiver burden						x	x			x			x	**4**
		Cultural accessibility				x	x	x	x			x	x	x	x	**8**
		Carers require support		x		x			x	x		x	x	x		**7**
	Experiences of Involvement and Decision-Making	Feeling unheard	x	x	x		x	x	x	x	x		x	x	x	**11**
		Exclusion from decision-making						x						x		**2**
		Powerlessness within services	x	x	x		x	x	x				x	x	x	**9**
		Shared decision-making promotes engagement	x				x	x	x	x				x	x	**7**
		Organisational constraints on collaborative care	x	x	x	x	x	x	x	x	x	x	x	x		**12**
The Paradox of Inpatient Care: Refuge and Exclusion	Experiences of Safety During Readmission	Therapeutic relationships		x	x		x	x	x		x	x		x		**8**
		Feeling psychologically safe	x	x	x	x	x	x	x		x	x	x	x		**11**
		Therapeutic structure promotes stability	x	x	x		x	x	x	x	x	x		x		**10**
		Developing coping skills		x			x	x	x			x	x	x		**7**
	Returning to Community Life	Loss of routine and purpose	x	x	x	x	x		x		x			x		**8**
		Challenges of community reintegration	x	x	x		x	x			x	x		x		**8**
	Community Participation and Belonging	Stigma and social exclusion			x	x	x		x	x		x	x	x	x	**9**
	Social and Relational Support for Recovery	Relational and community resources sustain recovery	x	x	x		x	x	x	x	x	x	x	x		**11**

Appendix 1.7: Reflective Journal Entries

The following extracts from the researcher's reflective journal are presented in chronological order to evidence reflexivity throughout the review process.

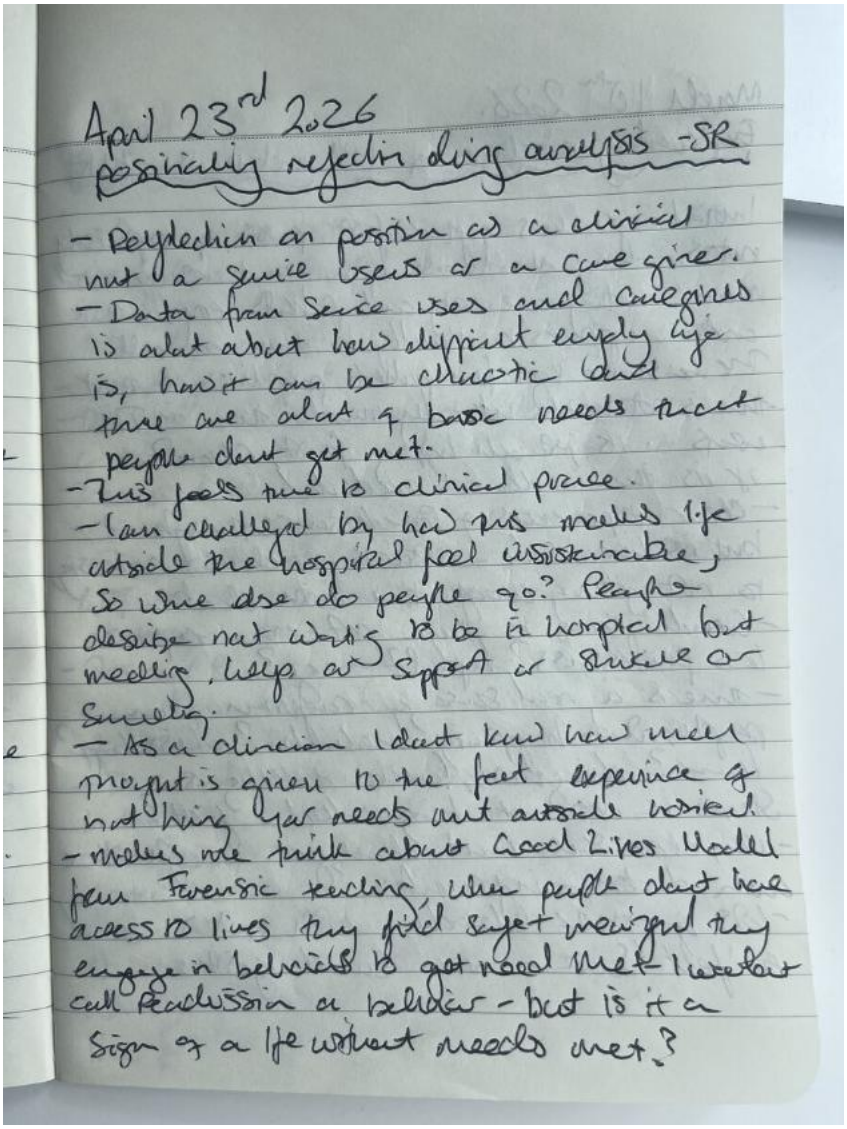


April 17th 2026

Pre analysis of findings data – SB

- Bracketing assumptions. - interest in the question from attributional differences to whom do dispat stakeholders attribute responsibility for reclussion.
- is there a power imbalance with blame put on the patient?
- Experience in inpatient placement assume clinicians will attribute responsibility to poor services, relationships? drugs? — Patients attribute responsibility to services? did get the help need?
- case assumption families. largely absent from inclusion in practice.
- Placement assumption - patients readmitted when the thing that was causing distress isn't any better? Systems? Relationships? housing?
- I see admit & short admissions + talk about patients not becoming reliant on services in the wards.
- Observation from placement some people want to be alive and save dead.
- Staff seem to have compassion on certain presentations - more than AMS - ie Psychiatric presentations - assaulted.

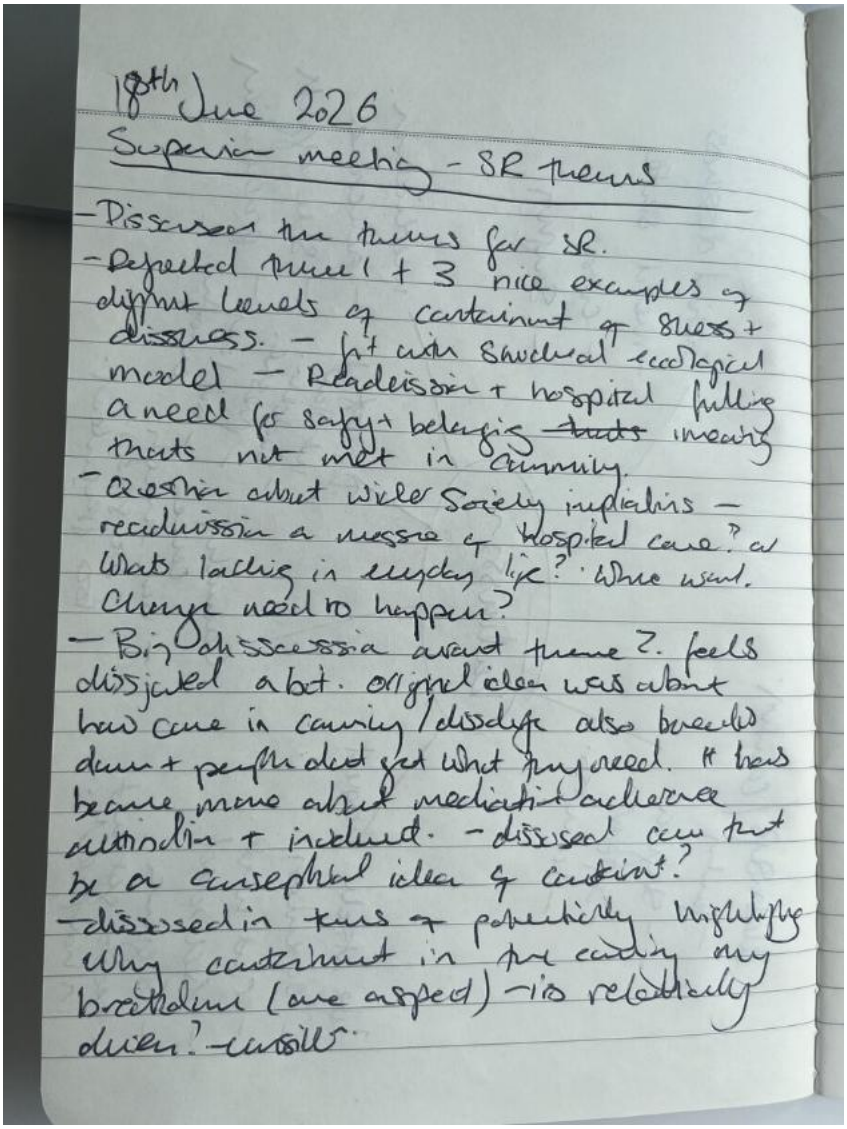
Reflective journal entry, 17 April 2026.



April 23rd 2026
possibility reflection during analysis -SR

- Reflection on position as a clinical not a service users or a care giver.
- Data from service users and caregivers is about about how difficult everyday life is, how it can be chaotic and there are about of basic needs that people don't get met.
- This feels true to clinical practice.
- I am challenged by how this makes life outside the hospital feel unbearable, so where else do people go? People describe not wanting to be in hospital but needing help or support or shelter or safety.
- As a clinician I don't know how much weight is given to the lived experience of not having your needs met outside hospital.
- makes me think about Good Lives Model from Forensic teaching when people don't have access to lives they find safe + meaningful they engage in behaviors to get need met I wonder could Reduction in behavior - but is it a sign of a life without needs met?

Reflective journal entry, 23 April 2026.



18th June 2026
Supervision meeting - SR themes

- Discussed the themes for SR.
- Reported theme 1 + 3 nice examples of different levels of containment of stress + distress. - fit with Socio-ecological model - Readmission + hospital filling a need for safety + belonging ~~needs~~ meaning needs not met in community.
- Questions about wider Society implications - readmission a measure of Hospital care? or What lacking in everyday life? Who need. Change need to happen?
- Big discussion around theme 2. feels disjointed a bit. original idea was about how come in crisis/distress also breaks down + people don't get what they need. It has became more about medication adherence attitudes + insight. - discussed can that be a conceptual idea of control?
- discussed in turns of potentially highlighting why containment in the community any breakdown (once stepped) - is relationship driven? - unsafe.

Reflective journal entry, 18 June 2026.

Appendix 2.1: COREQ 32-Item Checklist for Reporting Qualitative Research

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	p50
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	p1, p48
Occupation	3	What was their occupation at the time of the study?	p48
Gender	4	Was the researcher male or female?	p48
Experience and training	5	What experience or training did the researcher have?	p48
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	p49-50
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	p49
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	p48
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	p48
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	p49
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	p49
Sample size	12	How many participants were in the study?	p50
Non-participation	13	How many people refused to participate or dropped out? Reasons?	p50
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	p50
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	p50
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	p51-52
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	p50, App13
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	p50
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	p50
Field notes	20	Were field notes made during and/or after the inter view or focus group?	p50
Duration	21	What was the duration of the inter views or focus group?	p50
Data saturation	22	Was data saturation discussed?	p49
Transcripts returned	23	Were transcripts returned to participants for comment and/or	p50

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	p50-51
Description of the coding tree	25	Did authors provide a description of the coding tree?	p52-53
Derivation of themes	26	Were themes identified in advance or derived from the data?	p51
Software	27	What software, if applicable, was used to manage the data?	none
Participant checking	28	Did participants provide feedback on the findings?	p51
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	p53-63
Data and findings consistent	30	Was there consistency between the data presented and the findings?	p53-63
Clarity of major themes	31	Were major themes clearly presented in the findings?	p52-63
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	p54, p57

Appendix 2.2: Final Approved MRP Proposal

Protocol: https://osf.io/sqke7/files/9hcj2

Appendix 2.3: Project Approval Letters and Other Relevant Correspondence

Notification of Favourable Ethical Opinion (Email)

Appendix 2.3: Project approval letters and other relevant correspondence removed due to confidentiality issues.

Ethical Review Committee Favourable Opinion Letter (9 July 2025)

Ethical review committee favourable opinion letter removed due to confidentiality issues.

Ethical Review Committee Confirmation Conditions Met (6 August 2025)

Ethical review committee confirmation conditions met (6 August 2025) removed due to confidentiality issues.

NHS Lanarkshire Caldicott Guardian Approval (CG2699)

NHS Lanarkshire Caldicott Guardian Approval (CG2699) removed due to confidentiality issues.

NHS Lanarkshire R&D Management Approval (L25057)

NHS Lanarkshire R&D management approval (L25057) removed due to confidentiality issues.

NHS Lanarkshire Letter of Access (L25057)

NHS Lanarkshire letter of access (L25057) removed due to confidentiality issues.

Appendix 2.4: Participant Information Sheet, Privacy Notice and Consent Form

Participant Information Sheet: https://osf.io/sqke7/files/yfnpu

Privacy Notice: https://osf.io/sqke7/files/nj4s8

Participant Consent Form: https://osf.io/sqke7/files/ydt23

Appendix 2.5: Non-Standard Research Materials

Interview Guide: https://osf.io/sqke7/files/2fr6z

Recruitment Poster: https://osf.io/sqke7/files/8vykb

Appendix 2.6: Detailed Data Analysis Plan

Analysis Plan: https://osf.io/sqke7/files/5yfj9

Appendix 2.7: Detailed Record of the Data Analysis Process

Analysis Record: https://osf.io/sqke7/files/f7d23

Appendix 2.8: Data Availability Statement

The study data cannot be shared for important ethical and privacy concerns. The data is of a highly personal nature and participants have not given consent for the study data to be shared with third parties. Interested authors should contact the named author for any information pertaining to study data.