SUPPLEMENTARY MATERIALS 2

Work package 1, qualitative study 1: A Theoretical Domains Framework-informed qualitative investigation of barriers and facilitators to the de-escalation of conflict in adult acute mental health inpatient and psychiatric intensive care settings

SM2.1 Direct participant quotes

Q1	***'They were angry. They were shouting at me. I felt like the nurse in charge should have remained calm, she was getting angry and aggressive. My parents told me you cannot argue with a fool because people might not notice the difference, so I'm going to be quiet and let you do the shouting…I said, listen to yourself, you're even shouting, do you need to take medication? That's when she realised that I was right, because I levelled with her. A lot of patients in here cannot speak for themselves… I always need to know is it (enforced medicines) justified, why are you doing this? Do you think it's necessary now? I felt through the way I talked and defended myself they realised I was being reasonable. I created reasonable doubt. I made them feel me, to be in my shoes. How many patients can do that though?'*** **(Female Patient 1, Acute Ward).**
Q2	***'They're big women*** **(referring to capable de-escalators),** ***they can hold their selves, you don't want to mess with them… But they're beautiful women inside and they're so loving and caring and they come into work and they're dead joyful and as soon as they walk in we all smile because we love them...they've got the thing of intimidation, not in a scary way but a way of I'm not going to mess with you… But they've got that loving side to them as well, not threatening… loving.'*** **(Female Patient 1, Acute ward)**
Q3	***'MVA (Management of Violence & Aggression) starts from the moment that a person walks through the door… I'll always greet them with a handshake, it's an instant mark of respect… And it's constant, seeing how they are, I come in on a morning and…greet them, before you go, see you tomorrow.'*** **(Male Nursing Assistant 1, PICU)**
Q4	***'I'm not bothered whether they come across nervous, I'll calm down to that because I see them as a vulnerable person. I'm not a bully... if they're passive, that's fine.'*** **(Female Patient 2, Acute Ward)**
Q5	***'Sometimes, you kick off because, if you actually were being honest, all you wanted was a hug, you wanted some sort of physical contact, and if you'd have been able to go to one of them and say, can I have a hug, you might not have kicked off at all. But the only way you could get any physical contact was to kick off and be restrained'*** **(Female Carer, Carer Focus Group 1).**
Q6	***'At < deleted place name > I was restrained… injected several times… When staff come running in I stand back ready for a fight… because I've had it done to me as a child with my mother, my mum was a beater… This time around (the current admission) they sit me down and go; what's the problem… go for a walk, go for a cig, just go to the shop. One of the staff… she'd make me go into the bedroom, she'd make me lay on the bed with my hands on my belly… that really calmed me down… and she stroked my hair and she reminded me of my mum…That's twice, three times we've done it now and I've not had PRN for I'd say about a month.'*** **(Female Patient 3, Acute Ward)**
Q7	***'How he handled it was really good, he was just command this, command that, and I want this and I want that….he started raising his voice, this patient, at him, and he got right in his face and he (the staff member) just said, listen, I'm not dancing to your f****** tune…but it wasn't inappropriate, do you know what I mean? To swear, it worked really well, and the next thing he went, oh, alright then, I won't do this, whatever, and the next thing… …from him saying that it was like, I've listened to you for about ten minutes now, I've been trying to get to the bottom of this…let's concentrate on what we want, and then he got what he wanted'*** **(Female Nursing Assistant 1, PICU)**
Q8	***'I would tend to try to deal with the distress, again, rather than, sort of, actually, dealing with necessarily the actions of what he's doing, looking at the distress side of things.'*** **(Female Carer 1)**
Q9	***'Hearing voices… that's a challenge… We've got a lady at the moment… she gets so aggressive… really… distressed. And nothing you say to her, will help calm her down… The more you talk to her, the more she wants to hit you. And we do have to just leave her. And as long as we make sure the area's safe, we leave her be. And it's the best form of de-escalation we've found. Because whatever she's experiencing in her thoughts, is obviously that disturbing for her. No amount of our voices help.'*** **(Female Staff Nurse 1)**
Q10	***'In terms of my role, occupational therapist, I got told when I first came onto this ward that you are to try and stay away from de-escalation at all costs because it would affect the therapeutic relationship with the patient.'*** **(Female Occupational Therapist 1, Acute Ward)**
Q11	***'What you have to be really careful of when you work with people who can become very unwell, is that they become experts at reading body language. And, I've noticed this when I've been to community support groups, someone might come in the door, and they won't say anything, but the people already there, somehow, have this sixth sense that this persona isn't quite how they normally are. So, they don't say, well, what's up with you, you look like you've lost five pound and found a fivepence, there's none of that. It's, like, oh, you've just ,come at the right time, because we're just brewing up, what are you having, and that is someone reaching out, but it's a very subtle way.'*** **(Female Carer 2)**
Q12	***"And I think staff burnout was through the roof. I've had staff tell me that they've had sleepless nights, they've dreaded coming onto shift. Also, an avoidance of certain service users where they***

	know there's potentially going to be that flashpoint. Almost giving up on, like, what's the point in trying to de-escalate, we know where this is going, we know where it's going to end, it's ended in the same situation for the last X amount of weeks, let's just accept it and get on with it." **(MDT Focus Group 1)**
Q13	*'There are posters up everywhere saying… "Care assistants, respect us." Well, I drew my own poster saying "Respect service users"… They don't like it. I was told to put it away'* **(Female Patient 5, Acute Ward).**
Q14	*'Some are just, that's the rule, that's the way it is. The girls were watching a film last night… Nurse X came in and turned the telly off at dead on midnight and the film didn't finish until quarter past twelve… she went, "That's the rule, it goes off at twelve"… And so she had three people ready to strangle her…'* **(Female Patient 5, Acute Ward)**
Q15	*'You can only get people to take responsibility if you calm them down enough to distract them by talking about something else first… There's a fine line between what people can and can't take responsibility for in terms of behaviour when they've got a mental health disorder.'* **(Carer Focus Group)**
Q16	*'They* **(staff)** *don't listen too much to patients when they know that someone is starting getting physical, they… take the most negative side possible, and blow it out of proportion. They say things like, "you're losing your leave" …they blackmail you, you know, "if you don't do this, you're not getting your leave". I think when it's emotional, your behaviour should be addressed individually. One staff, that's not a part of the problem, sits you down and speaks to you, without the things that you want to have be described to you, to make you behave, like a dog doing tricks for biscuits. It's not humane, it's not a way of addressing a problem either because you're not changing a problem, you're just behaving that way to get something in return.'* **(Male Patient 1, PICU)**
Q17	*'It's about knowing your diagnoses. Someone who's got a diagnosis of personality disorder doesn't warrant flexibility, because they're going to take the piss basically… If you know someone's got that sort of thing* **(personality disorder),** *be mindful of it when you're interacting with them, and don't give too much ground. Because it's all over NICE that a big part of managing personality disorder, an in-patient user, is boundary setting… Whereas someone who's say got schizophrenia, well, just the weird example, say they don't like to be seen eating as part of their delusion system. Say, right, okay, I'll come and sit with you while you eat something cold in your bedroom.'* **(Male Staff Nurse 1, PICU)**
Q18	*'Personality disorders, full stop… I've got my own opinions as far as personality disorder…I think that people with personality disorders should be in a unit by themselves, because you need to have a certain type of person who can deal with people with personality disorders.'* **(Male Nursing Assistant 2, PICU)**
Q19	*'When we talked to the staff, it was almost like, well, we can't tell you what we're doing. And I was always wondering whether they knew what they were doing or whether there was a legal reason why they couldn't tell us. So the communication wasn't that great. And they didn't ask us about the background… they didn't ask for anything, because it seemed like this was their job, they deal with all these kinds of people, and they knew best and they just got on with it.'* **(Male Carer 1)**
Q20	*'they're the leaders in their own care, they know themselves best. So, involve them in it, give them a chance to fix themselves. I think that builds insight. I know you could walk around this hospital and ask patients what they know about their medication, they wouldn't have a clue, they just know what they're on, some of them.'* **(Male Nursing Assistant 1)**
Q21	*'I've been here two years, I've never sat in a ward round… because a lot of the time patients come out of ward rounds highly agitated… we're trying to calm them down but we don't know what happens … they want to know about medication. They want to know about side effects… It's always, I'll get the nurse… but they've also got so much other stuff going on, paperwork… there must be some stuff that we can help them out with'* **(Female, Nursing Assistant 2, PICU)**
Q22	*'There is a protective culture… being open is a challenge, and people will only learn where they're being open. We need staff to be accountable but one of the concerns currently is there's this culture of staff are to blame and it just always allows them (incidents) to go under the radar every time… don't upset the apple cart… You get a lot of that going on – very protective…'* **(Team Leader, PICU)**
Q23	*'So we know co-produced care planning is important, we do something called 'My Mental Health', we've got PBS plans. But none of that is remotely accessible for a service user. You write this care plan with them and they'll say, where does it go? You say, we put it on the computer. So that's not theirs then is it, because it just goes off into an ether. If they could sit in front of a laptop, they'd type it in themselves, and it might help them take ownership of it. I think there is something about how our clinical system interfaces with service users.'* **(MDT Focus Group 1)**
Q24	*'What's problematic is people feel they have to intervene at every opportunity, like at any sight of any self-harm, people feel they have to do something there and then, whereas that's not always the case… It's about keeping responsibility and ownership with that person… we've had a few ladies, where self-harm is such a feature of their presentation, they feel like they need it to cope… We've had conversations around positive risk-taking and risk management but it's not something that the trust has kind of got its head around from a positive risk-taking perspective. One of our service users, she's been self-harming since she was 15, so it was said if you have any incidents, if you self-harm, then you won't be able to utilise that leave. And, actually she's coped up until going out on leave and then when she's come back, instead of just maybe superficially cutting, it's led to where she's ended up in hospital because she's done something. Like, it's built up, it's escalated and actually increased the risk.'* **(MDT Focus Group 1)**
Q25	*ECA* **(Extra Care Area)** *is good because seclusion is in ECA. When a patient is in ECA, they can see in seclusion, and they know they don't want to be in there, do you know what I mean. Just seeing it makes them think, you know, I'll calm down.'* **(Female, Nursing Assistant 2, PICU)**
Q26	*'I stood at the office door the other day and… and I'm waiting and I'm waiting and I'm waiting… I'm knocking… nine times waiting for some painkillers… and when they do come out it's "Don't talk to me, I've got stuff to do."… I think it's very rude and it gets my aggression up.'* **(Female patient 3, acute ward)**
Q27	*'At mealtimes, we have to lock it off the doors going into the day and night area, and count the cutlery in and out, all the patients are confined to one area, and if one person comes and eats dinner within five minutes, but another one takes twenty, they've got to wait for that patient to eat all of their meal. So that doesn't help in terms of de-escalation.'* **(Female Staff Nurse 2, PICU)**
Q28	*At certain times, you are not allowed to go to your room. I was complaining, why? If I don't want to be in the lounge with all these people, around TV and noise… I really didn't like that rule.'* **(Female Patient 6, Acute Ward)**

Q29	***'Trying to get male patients to put icing on fairy cakes isn't the one. Why can't we do how to de-escalate someone? Why can't we go through that with patients? Because they're sitting there, they're going to watch. And just go through it. Why can't we do that? Why can't we do interesting stuff?'*** **(Male Nursing Assistant 1, PICU)**
Q30	***'They need to have a proper relaxation room with like bean bags and these things, you know when you get disabled kids and they put them in this light room and they got like these towers of bubbles going up and there's relaxation and you can actually just lay down.'*** **(Male Patient 2, Acute Ward)**
Q31	***'I kick things and punch things when I'm angry... I go in the activities room and just kick the bean bags because I don't want to hit anyone because my voices to hit someone.'*** **(Female Patient 7, Acute Ward).**
Q32	***'That sense of normality is what helps… to know that you're a human being behind this shell that you put on us… with behaviour that we know isn't natural.'*** **(Male Patient, PICU)**
Q33	***'I'm not perfect by any means, and I agitate situations by being the wrong person to be there. And, because I am the staff nurse I have a duty to be there, when maybe I should just get the hell out of the way and let other people get on with it. We have some very good nursing assistants on the ward who are equally good at de-escalating people. But, because I'm the staff nurse on duty at a particular time, I maybe put my ore in too much sometimes when I shouldn't do with some patients, I should just leave it to them. So, don't let your ego get on top of it and come across as, I am a staff nurse and you will do as I say, which isn't good.'*** **(Male Staff Nurse 3, PICU)**
Q34	***'On the inpatient units, are young, female, and a lot of the patients… are…are older, males. The nurse… leading the de-escalation…may be young enough to be their daughter. It could be over cultural aspects, which I don't think we properly recognise. That's why things like saying I'm a nurse…ensuring that they see us as nurses rather than somebody who's younger or female.' (Male Ward Manager 1, Acute Ward)***

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1. Price O. *Development of an evidence-based training intervention for mental health staff in de-escalation techniques for the management of violence and aggression: evidence identification and theory development.* PhD, University of Manchester. 2016.