**Supplementary material**

**APPENDIX 1**

**Case scenario:**

A 38-year-old woman presents to hospital at 3am on Saturday after a life-threating large mixed overdose, including paracetamol which was taken between 12 to 36 hours previously. She is drowsy and unresponsive. She has previously received psychiatric care for depression and has a history of suicide attempts but is not currently under the care of mental health services. She lives alone and prior to the overdose had not seen a health care professional or family member for the last four weeks.

A relative brings in an advance decision printed on her lawyer’s headed paper. The document is signed by the patient and witnessed by the lawyer, her GP, and a family member. It clearly states that the patient does not want life-sustaining treatment (including CPR, intubation, investigations, intravenous fluids or specific antidotes) if she presents to hospital with a life-threatening overdose or other illness and lacks capacity.

The treating consultant judges that the advance decision is valid and applicable to the situation and a palliative approach to treatment is taken. The patient dies three days after admission.

**APPENDIX 2**

**Additional analysis information**

Thematic framework analysis was used to analyse the data because we had pre-determined questions to explore, but also because the approach enables themes to be developed from narratives of research participants.[1,2] Focus group data were analysed according to the five stages of the thematic framework analysis approach: (1) familiarisation, (2) identification of a thematic framework, (3) indexing, (4) charting, and (5) mapping and interpretation.[1,3]

In the *familiarisation* stage, LQ summarised the transcripts and wrote notes on non-verbal behaviour and context. LQ and RN then independently read the transcripts and conducted initial opening coding. Following this, in the *identification of a thematic framework* stage, a coding frame was developed deductively using the questions in the topic guide and the initial open coding. Preliminary categories and codes in the coding framework were discussed within the team (RN, LQ, SS, and NK) and revised accordingly. The transcripts were then re-read and the framework tested by SS and RN for two focus groups independently to ensure the codes adequately represented the data. The framework was further refined and revised following the testing.

Then, in the *indexing* stage the framework was applied to all transcripts using a qualitative data analysis management package[4] and categories and codes were assigned to the data. This was followed by a c*harting* stage, where the coded data was summarised and charted by each case (person and groups) and code. Three of the codes were independently charted by SS and compared with charts created by RN to ensure charting conducted was an accurate representation of the data. Finally, *mapping and interpretation* was conducted by summarising the data into a chart for each professional/lived experience group and code for comparative analysis. Thematic analysis of the summary charts was used to highlight themes that were reflective and narrative of summaries and was conducted by RN and SS independently. Emerging themes were refined and revised through discussion between RN, LQ and SS. Saturation was indicated when no further themes emerged from the charts and/or discussions.

**REFERENCES**

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4. NVivo qualitative data analysis Software; QSR International Pty Ltd. Version 10, 2012.