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Abstract

Internationally, clinical services are under pressure to reduce their use of restrictive practices. The aim was to explore how mental health nurses and nursing assistants perceive conflict and their use of restrictive practices with mental health inpatients in forensic mental health care. A total of 24 semi-structured interviews with forensic mental health staff were conducted and analysed using thematic analysis. The findings propose a dynamic model that explains how tolerance of potential conflict situations changes depending on individual staff members' perceptions of patients and colleagues, and their relationships.

Keywords: professional-patient relations; staff attitude; conflict; violence; qualitative research

Introduction

Internationally, there have been repeated calls for reduction of restrictive interventions in mental health service and particularly within forensic mental health (e.g. Hui, 2016; Steinert, 2016). Research to increase understanding of factors that influence staff interpretation of patient 'boundary violations' is essential (e.g. Johnson et al. 2016). In Denmark, The European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment strongly criticized the use of such interventions (CPT 2014). This prompted the Danish government to introduce a target of a 50% reduction in such measures by 2020. Six core strategies and 'Safe Wards' have been implemented widely in Denmark, but the targeted reduction has not been achieved yet (Stensgaard, Andersen, Nordentoft, & Hjorthøj, 2018). This article reports on findings from a qualitative interview study with mental health nurses and nursing assistants to investigate perceptions of staff-patient conflicts and possible links to the use of restrictive practices in forensic mental health inpatient settings.

Background

Restrictive interventions are defined as: 'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken' (Duxbury & Jones, 2017, p. 272). Such interventions include practices such as restraint, seclusion, rapid tranquilization and mandatory observation. These are identified as only to be used in last resort situations (Völlm & Nedopil, 2016), however, there is also international consensus that such restrictive practices are used too frequently and not just as last resorts (e.g. McLaughlin, Giacco, & Priebe, 2016; Raboch et al., 2010). Moreover their use carries

significant risks, including physical and psychological harm to both patients and staff (Johnson et al., 2018; Motamedi, Mahmoudi, & Motamedi, 2017; Renwick et al., 2016; McLaughlin et al., 2016; Steinert et al., 2013; Cusack et al., 2018; Edward et al.; 2016). Restrictive interventions are also costly in terms of increased staff absenteeism and litigation, as well as extra staffing resources required to implement them (Van Leeuwen, 2016; Renwick et al., 2016; Johnson et al., 2018). Thus, there is an international need for mental health services to reduce their use of restrictive practices (c.f. Hui, 2016; Steinert, 2016).

In mental health services, research has shown that the staff-patient relationship, social climate, patient factors and staff attitude play an important role in the occurrence of aggression (Robinson, Craig, & Tonkin, 2016; Bowers, 2014; Papadopoulos et al., 2012) and staff's subsequent use of restrictive interventions (Kuivalainen et al., 2017; Nedopil, 2016; Tomlin, Bartlett, & Vollm, 2018). However, forensic mental health is considered a unique setting; faced with similar, but also unique, challenges (Laiho et al., 2016). Two studies from Denmark have indicated no major differences in interactional elements when comparing forensic nursing care to nursing care in an acute mental health setting. In both studies, care based on 'trust and the staff-patient relationship' alongside 'behavioural and perceptional correcting care' was noted (Gildberg, Bradley, & Hounsgaard, 2013). Laiho et al. (2016) identified that the high incidence of violence or threats of violence, combined with forensic staff's knowledge of the patient's criminal history, impacted negatively on the care provided by nursing staff. However, there is limited forensic mental health research that details the characteristics of how staff perceive conflicts and their use of restrictive practices as a team and how it may or may not impact on the degrees of custodial care (Gildberg et al, 2010; Johnson et al. 2016).

It has been suggested that emphasis on the establishment and maintenance of trusting empathic relationships between staff and patients is pivotal, in order to de-escalate conflict situations (Nielsen et al., 2018; Price & Baker, 2012; Wright et al., 2014; Gerace et al.,2018). Internal, external and interactional etiological models have been devised (Dickens, Piccirillo, & Alderman, 2013; Pulsford et al., 2013), wherein social climate, staff modifiers and staff-patient relationships (Robinson et al., 2016; Bowers, 2014) or – more broadly – staff-patient interactions seem to be core factors in patient-staff conflict (Duxbury & Whittington, 2005; Papadopoulos et al., 2012; Price & Baker, 2012; Renwick et al., 2016; Greenwood & Braham, 2018). A recent study showed that nurses felt moderately safe dealing with conflicts and that containment methods were more likely to be used due to a lack of resources (Gerace & Muir-Cochrane, 2019).

A review of literature on patients' experiences and views of aggression situations by Gudde et al., (2015) found that patient experience the occurrence of aggression due to a combination of their own mental illness and an overload of negative structures. Patients experienced not being able to escape from negative situations, leading to a sense of being in custody rather than in a caring environment with involvement in clinical decision making. However, despite the development and implementation of interventions such as 'Six Core Strategies' (Huckshorn, 2004), 'Safewards' (Bowers, 2014) and other interventions to reduce the use of restrictive practices, prevalence remains high and difficulties in consistently implementing and evaluating interventions in forensic mental health have been repeatedly noted (Maguire, Ryan, Fullam, & McKenna, 2018; Price, Burbery, Leonard, & Doyle, 2016; Maguire, Young, & Martin, 2012; Stensgaard, Andersen, Nordentoft, & Hjorthøj, 2018; McLaughlin, Giacco, & Priebe, 2016; Kuivalainen et al., 2017; Nedopil, 2016; Tomlin, Bartlett, & Vollm, 2018; Flammer, Frank, & Steinert, 2020).

Eidhammer, Fluttert, and Bjorkly (2014) found, in a systematic literature review, that patient involvement in risk management programmes in forensic care seldom occurs. Fluttert et al. (2008, 2010) developed and studied the Early Recognition Method, in which patients and nurses collaborate in the identification and management of early warning signs of aggression. The results of their study suggested that a dialogue between nurse and patient with emphasis on early warning signs, contributed to a decrease of restrictive practices and the severity of aggression. Research by Johnson et al., (2016), within a forensic setting suggested that the frequency and perceived impact of patient boundary challenges were associated with a low propensity to trust colleagues, increased staff depersonalization, and negative and cynical attitudes towards patients. De Vries et al. (2016) studied how patients (n=154) and nursing staff (n=219) perceived their ward climate in terms of 'experienced safety', 'therapeutic hold' and 'patient's cohesion and mutual support'. 'Therapeutic hold', referring to interactions between nurses and patients focusing on the goals of treatment, targeted most of the staff's work and was rated higher among staff than among patients. Rask and Brunt (2007) interpreted patients' negative views of staff as an indication of experiences of repression and restrictive practices. Nevertheless, more recent studies found patients' levels of 'experienced safety' to be rated higher than those of the staff (de Vries, Brazil, Tonkin, and Bulten, 2016).

Also, Berring, Pedersen, and Buus (2015), in their discourse analysis of aggression in forensic health, found differences in staff's and patients' perceptions: in regards to the cause of aggression; staff referred to internal patient factors, while patients refer to staff responses as being provocative. In a recent single-case narrative Fluttert et al. (2020) explained by means of Self Psychology how nurses' relationship with a specific and very aggressive patient could be interpreted. However, there is still limited research that seeks to understand how staff interpret 'patient boundary challenges' and the dynamics within

clinical teams that influences decisions to use or not use restrictive interventions, particularly in forensic mental health inpatient settings (Laiho et al., 2016; Johnson et al. 2016). Consequently, this article reports on findings from a qualitative interview study with forensic mental health nurses and nursing assistants, exploring their perceptions of staff-patient conflicts and their link to the use of restrictive practices in forensic mental health inpatient settings.

Aim

To explore how forensic mental health nurses and nursing assistants report perceived conflict situations and use of restrictive practices with forensic mental health inpatients.

Method

This study used 24 semi-structured, explorative in-depth interviews (Guest, Namey & Mitchell, 2013; Spradley, 1979) and thematic analysis (Gildberg et al., 2015) rooted in the methodological approach described by Herbert Blumer by stressing the need for careful and disciplined examination of data (Blumer, 1986), in order to gain insight into how forensic mental health nursing staff perceived staff-patient conflicts.

Data collection

Semi-structured interviews were chosen to allow for an exploration of participants' perceptions. Interviews were semi-structured, with explorative questions deducted from research questions and topics on the subject inducted by participants' answers (Polit & Beck, 2008 pp. 394). The interview schedule was created from the following research questions:

(i) What characterizes mental health nurses' and nursing assistants' perceptions of conflicts with forensic inpatients in a forensic setting?

(ii) What meanings do forensic mental health nurses and nursing assistants ascribe to reasons for and characteristics of staff-patient conflicts with forensic inpatients?

Interviews were tested by conducting two test-interviews on participants. Subsequent questions and question-types were evaluated for the ability to produce rich data in relation to the research questions. The test-interviews and interviews were carried out by second and third author. Both supervised in one-on-one and team sessions and trained in interview technique through seminars, group exercises and by conducted interviews, which were monitored and evaluated through feedback continually during the process by a senior researcher (first author). Data were digitally recorded and transcribed verbatim. Fieldnotes were taken for follow-up questions and to provide sociodemographic data on participants. Debriefing and follow-up on potential participant distress were provided by second and third authors. This however was not requested nor detected. Interviewers and participants were not known to each other in advance of the study.

Data analysis

Research approach and thematic analysis, rooted in the basic requirements of an empirical science, as described by Herbert Blumer, were undertaken (Blumer, 1986; Gildberg et al., 2015). The specific thematic analysis was chosen because it provides a short-range preliminary model that, from a pragmatic perspective, could be further developed into an intervention strategy to address the problem area. With the intention of creating an overview of emerging themes, interview data were first read through and initial themes noted. Using the above research questions, the data were coded by reading through the data material. Opposite each original decontextualized text-piece an interpretation – along

with a marking of authenticity in a condensed form – were provided, thereby answering the research question. The specific condensation was subsequently labeled with an immediate subject heading. By sorting data subject headings – along with the specific condensed text – the data was categorized. Categories with similar or the same subject headings were tested against the original text, and inclusion and delimitations for said category were established and the text merged into coherent theme-text. Subsequently, the themes were subject to taxonomical grouping of theme headings using the semantic relation 'X is a part of Y' and tested against the original interview text to avoid skewed interpretations. Notes from first reading were used to avoid overlooking overriding textual structures and authenticity-markings to differentiate levels of interpretations. The markings were as follows: Marking 1 – Indicating quote-level; marking 2 – Containing both quotes and elaborations; and marking 3 – Abstract levels of interpretation (for a detailed describtion see Gildberg, 2015; Spradley, 1980). This was done using Microsoft Word and Excel. Data quality was monitored throughout the process of analysis. Data collection and analysis continued until data saturation (Morse et al. 2002).

Setting and sample

Two forensic wards were purposively selected at a large mental health hospital in Denmark. Forensic mental health nurses and nursing assistants were included based on their rich first-hand experience of interacting with forensic patients daily (Polit & Beck, 2008). Psychiatrists, ward sectaries and ward management were excluded. In total, 24 nursing staff employed on two wards volunteered – via emails and leaflets – to participate in the interviews. No participant refused or dropped out during the study. Reasons for not volunteering were not explored.

	Nurses (n=11)		Nursing assistants (n=13)		Total staff (n=24)
Measure	**Mean(sd)**	**Gender ratio**	**Mean(sd)**	**Gender ratio**	**Mean (sd)**
Age (years)	34.82(10.00)		39.53(10.42)		37.38(10.29)
Male / female		0/11		9/4	9/15
Years of experience in mental health	9.40(5.27)		13.63(8.55)		7.17(7.24)
Years of experience on the ward	0.65 (0.21)		0.65(0.28)		0.65(0.25)
Interview minutes	35.91(6.23)		47.85(18.75)		42.37(15.61)

Table 1 *Staff included in interviews*

A total of 11 forensic mental health nurses with a mean of 9.40 years of experience and 13 nursing assistants with a mean of 13.63 years of experience participated in the interviews, which lasted, on average, 42.37 minutes (Table 1). The academic qualification among the nurses was a bachelor's degree in nursing science and, for nursing assistants, education equivalent to level 3 in the International Standard Classification of Education system. The mean age of participating staff was 37.38 years. Nine male and 15 female staff participated. Written informed consent was obtained from participants. The one-on-one interviews took place on site in a nearby staffroom. Transcripts were not returned to participants and no repeat interviews were carried out.

Ethical approval was granted by the Regional Research Ethics Committee and the Danish Data Protection Agency. Data has been handled and stored in accordance with the EU General Data Protection Regulation by a GDPR certified data manager (first author).

Results

Analysis identified six interrelated and interdependent main themes (Figure 1.): 'Personal and collegial tolerance to conflict', 'conflict-tolerant strategies and competencies', 'safe/unsafe', 'patient-related factors', 'relationship, observation and assessment' and 'colleague-related factors'. These seemed to suggest a dynamic model which determined when and if staff tipped into using restrictive practices.

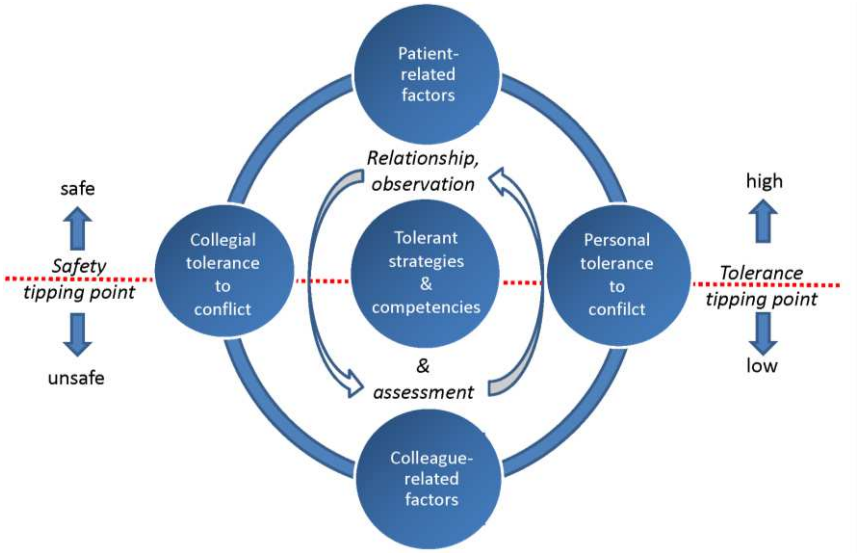

Figure 1. Dynamics model of conflict management

Personal and collegial tolerance to conflict

The concept of both personal and collegial 'tolerance to conflict' was perceived by staff as their own and their colleague's capacity to endure conflicts and was catagorised as high or low. With a higher tolerance appearing to be more accepting of 'patient-related factors' e.g., challenging behaviors, patients venting frustrations or anger in the form of

verbal assaults on staff or physical assaults on objects. Staff with higher tolerance appeared less likely to instigate restrictive practices and more likely to use high conflict-tolerant strategies e.g. informal talks, listening and containing. Staff with lower tolerance appeared more likely to instigate restrictive practices e.g. limitation setting, rule enforcement and shielding.

The analysis suggested that the collective approach to high or low 'conflict-tolerant strategies and competencies' were dependent on a combination of staff's perception of themselves, colleague- and patient-related factors (Figure 1). Patient-related factors were perceived and assessed through staff's perceptions of their 'relationship' with and 'knowledge' about the patient. The more staff perceived that they had a trusting relationship with and knowledge of the patient, the more they perceived that patient 'predictability' increased in their 'assessment' and 'observation'. This in turn impacted on staff's feelings of trust and therefore increased feelings of 'safety'. Consequently, the increased perception of safety impacted personal and collegial (staffs) 'tolerance to conflict' positively (i.e. high tolerance) and were associated with the use of high conflict-tolerant strategies and competencies and vice versa.

The analysis showed that, if a high degree of 'collegial tolerance to conflict' was perceived by the individual staff member during a shift, the staff member would, together with colleagues, deploy 'high conflict-tolerant strategies and competencies' when confronted with 'patient-related factors' in escalating situations. However, if a staff member perceived even one member of the team had low levels of tolerance to conflict, even though they considered themselves to have a 'high personal tolerance to conflict', they suggested that they would be more likely to instigate restrictive practices.

> "But it is what you show the patients, that we [staff] stand together and that we agree that this is the way it should be. It may be that you are not always

100% in agreement regarding the decision made, but you follow suit." SU_0110_91-95

The reason why is illustrated in the above quote. According to staff they required from each other that they follow suit with strategies and approaches used. According to the data, low or high staff tolerance to conflict was formed out of staff's perception of feeling 'safe/unsafe', in relation to perceived 'patient-related factors', 'relationship, observation and assessment' and 'colleague-related factors'. In the following sections, the above elements of conflict management dynamics will be described in detail.

Low 'personal and collegial tolerance to conflict'

Low personal or collegial tolerance to conflict was characterized by negative 'staff attitude & communication', the display of conflict-escalating attitudes and a tendency for staff to use 'low conflict-tolerant strategies and competencies' (Figure 2).

Staff's attitude & communication

The display of negative 'staff attitude & communication' was characterized by and tended to involve conflicts which were caused by staff interacting (towards patients) with the following characteristics: Arrogant, upset, power-abusive, know-it-all, controlling, preaching, patronizing, corrective, dismissive, ignoring, strict, confrontational, paternalistic, disrespectful, angry, commanding, inaccessible, tough or displaying provocative body language.

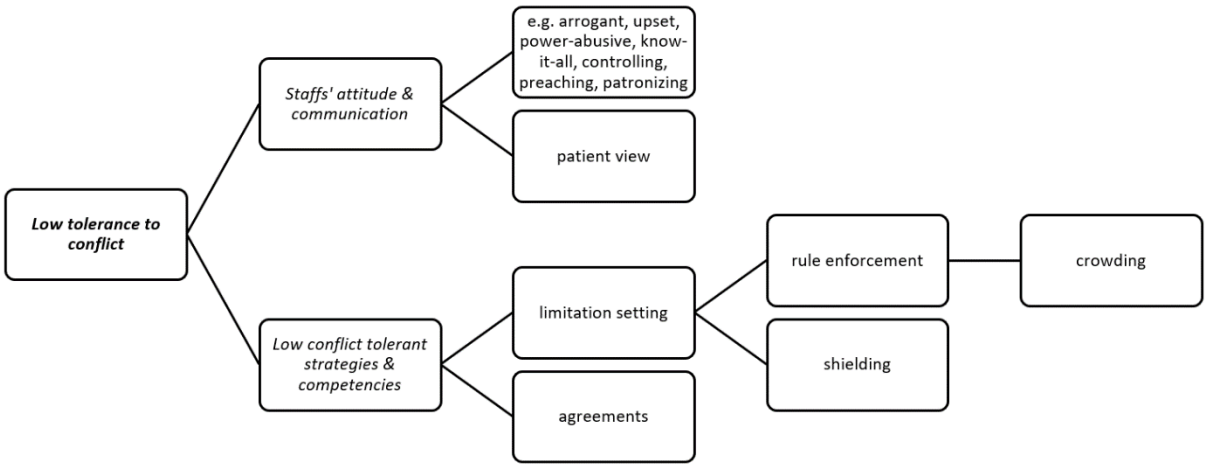

Figure 2. Low tolerance to conflict

Added to this, participants stated that conflicts typically arose if staff displayed a lack of empathy, understanding, situational awareness, time to listen, information sharing and explanations regarding the deployment of 'low conflict-tolerant strategies and competences.

> "Well, meanwhile he is told to stay in his room ... and minimize calling and quieten down and so on. You could say it is in order for him to figure out that there is no more of mother's breast right now." GU_0210_574-582
>
> "It's on a daily basis. It could be, that somehow it's a victory for the patients because often they are cunning and good at playing staff off against each other." PU_1510_373-87
>
> "This way [by keeping the patient under constant observation instead of using mechanical restraint] he could really feel it on himself. 'It is actually crap what I have done, and I am sorry, and I can feel that I regret it' and things like that. So that he noticed the natural process of consequence in regard to the things he had done, right?" G_0110_539-546

As the above example illustrates, negative 'staff attitude & communication' was linked to a characteristic 'patient view' (staff's way of perceiving or looking at patients). A small proportion of participants suggested that, on a daily basis, patients would actively test staff boundaries, play staff off against each other, seek conflicts, spot staff weaknesses, or shout and make demands, in order to get their own way.

Low conflict-tolerant strategies and competencies

The 'low conflict-tolerant strategies and competencies' were characterized by staff's preference for restrictive practices, such as 'limitation setting', 'rule enforcement', 'shielding', 'crowding' and 'agreements', as ways of controlling conflict situations.

> "Yes, he [the patient] was a part of our team and it was me and John and another from the team who took the lead on this. We said that he had to hand over the TV. I understand that it sucks and tried to explain it to him. He became very hostile, shouting and screaming and slamming the doors. Very hostile." GU_0810_102-115
>
> "You can easily be swallowed by it and find yourself in situations where you can't break through the patient's psychotic world without raising your voice and tell them to stop." BU_0110_148-50
>
> "Because some of them when they are not here ... Some of them are practically living on the streets, right? They don't get food. So it's a bit ... and that should be understood positively ... a bit like animals, if there is food, they just want food. […] They are unaware of the fact that there are 14 other patients that must share this food. 'No, if I could empty it all onto my plate and eat it until I puke that would be ok.' They have no sense of it and that is our job to try to help them." BUI_ 2909_232-242

As illustrated in the above quotes, ‘low conflict-tolerant strategies and competencies’ was characterized by the engagement of staff in for example verbal or physical ‘limitation setting’. This was characterized by, e.g., stopping or restricting patient behaviour, liberties, requests or physical whereabouts. This practice took the form of ad hoc corrections, e.g., asking the patient to postpone needs or denying patient requests, or as ‘rule enforcement’, e.g., enforcing formal ward rules and regulations, or as ‘shielding’, e.g., following, observing and correcting the patient’s behaviour or whereabouts.

> “If a person cannot cooperate, we have to limit the person by shielding in order to calm things down.” RU_ 0210_60-66
>
> “He was really nice and friendly as long as you gave him what he wanted, and he could do whatever he wanted. When you began limiting him or correcting his behavior, he would get very upset right away. It was like hitting a switch. He was so friendly and nice until ... But you knew that every time you pushed him just a little, he would ignite.” GU_ 0810_50-56
>
> “Well we have a rule that says that patients are not allowed to visit each other in their rooms and there was this patient that wanted to talk with a fellow inpatient. I confronted him with the fact that that [talking in the patient’s room] was against house rules. That this is not allowed here. That we have rules about not visiting each other. That is what I told him, and it created a minor conflict because they were just talking and did not do anything. And that may very well be the case, but it is a rule that should be kept because that rule was made.” LBU_0110_34-41

According to participants the above subthemes would frequently result in conflicts, because the patient felt unfairly treated, put down or simply rejected. Staff also reported that they would use staff numbers to physically outnumber the patient ('crowding') in high conflict situations. This was used as a tool to enforce rules, by outnumbering the patient, but it was often also a reason for conflict escalation. Closely connected to these subthemes is the enforcement of 'agreements'.

> "He was told that if his behavior was good he would be allowed a bit more time in the common areas and of course if you go down to him in order to correct him then you also tell him that he should keep in mind to keep the agreement [good behavior] because that will give you more time out in the common areas." YU_254-68

This theme was characterized by staff entering into formal agreements with the patient regarding the establishment of limits, e.g., staff would make an agreement with the patient to stay in his room or limit cigarette smoking to one cigarette per hour. This was perceived as a reason for conflict, whenever staff did not hold up their end of the agreement or the agreement was perceived by patients as one-sided, or as neglecting patient involvement. Staff perceived these 'low conflict-tolerant strategies and competencies' as the most frequent reason for subsequent conflicts.

High 'personal and collegial tolerance to conflict': 'Staff's attitude & communication'

Central to the staff's perception of high staff tolerance to conflict and the typical 'attitude and communication' associated with this was a belief that any further reduction in a patient's freedom and liberties without care and caution within the already restricted environment would increase patient conflicts.

> "But I think that we are good at letting them [the patients] react, if you can put it like that. All the shouting, screaming and scolding and badmouthing and things like that … As long as it's only verbal threats and shouting and stuff, they are allowed to blow off steam. But the second they get physical … we tell them 'now we stop.'" GU_0810_447-451
>
> "Because, as I said, the patient is frustrated. Maybe it is a psychotic one [patient] but it is still a frustration. They are just like us." BU_ 1510_696-709
>
> "It's ok to scold, be angry. Get it all out, you may be threatening but don't threaten me. But you can be mad and threaten in the sense that you think that it's all crap and you that would like to trash it all. That's ok, we can take it." GI_0210_779-82

As illustrated in the above examples, staff also suggested that a patient's freedom to express emotions and vent frustrations should not be considered as dangerous conflict behaviour that would require restrictive practices, but human behaviour requiring space and subsequent dialogue. High tolerance to conflict was characterized by staff's display of wide conflict-response boundaries. This included allowing for, tolerating and making efforts to understand patients' needs and rights to display and vent frustrations in various forms – if it did not involve physical harm. Staff referred to high personal or collegial tolerance to conflict as a question of attitude, e.g., respecting patient autonomy and management of own freedom within the confines of their involuntary admission. Staff who advocated 'high personal tolerance to conflict' saw it as their job, within said boundaries (apart from harm being caused to self or others), to contain these patient

frustrations and outbursts using ‘high conflict-tolerant strategies and competencies’, with a view to deescalating conflicts and avoiding the use of restrictive practices (Figure 3).

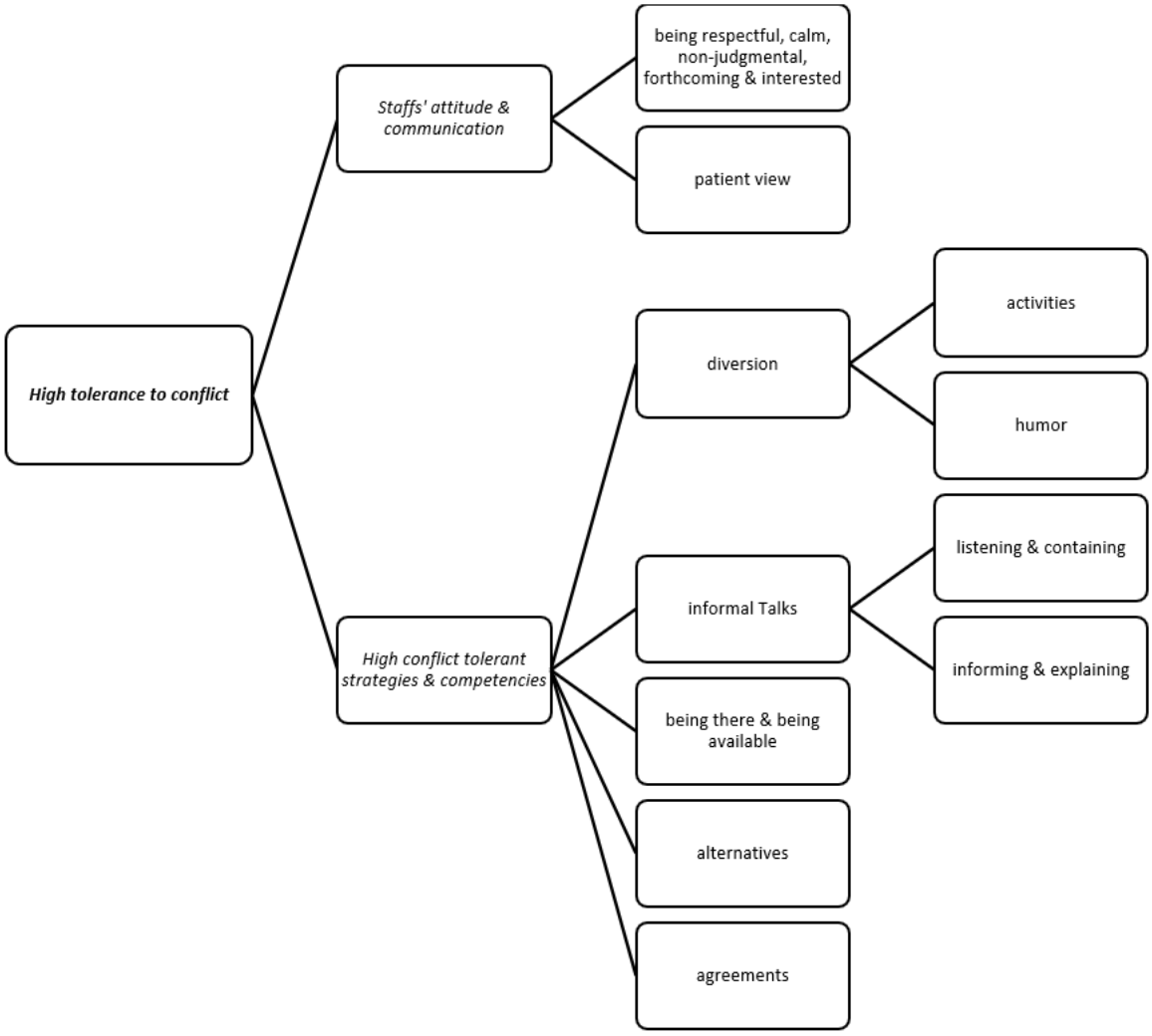

Figure 3. *High tolerance to conflict*

High conflict-tolerant ‘attitude and communication’ was characterized by ‘respecting’ the above-stated rights to express emotions, ‘contain anger and frustrations’ without taking them personally and to interact ‘calmly, and be non-judgmental, forthcoming and interested’ regarding the patient, conflict issues and solutions.

High conflict-tolerant strategies and competencies

These attitudes were associated with ‘high conflict-tolerant strategies and competencies’, characterized by staff’s use of ‘diversion’, ‘activities’, ‘informal talks’, ‘listening & containing’, ‘informing and explaining’, ‘humor’, ‘agreements’, ‘alternatives’ and ‘being there and being available’.

> “Maybe a yard-walk. Well. It may sound a bit illogical to offer a patient who is really behaving unwell a walk in the yard. But sometimes it is enough to get fresh air and blow off steam and, in that sense, it can help. However, it requires that … you know the patient well. We would never offer that to a newly admitted patient because we don’t know what that person is like … But for patients who have been here a long time, we learn their rhythm and know that it is usually a good way of dealing with a conflict before it escalates.” YU_0810_381-388
>
> “Okay, now he is a bit upset, well okay, it normally works if we get down there and have a cigarette, right? Then that is what we do and that’s the way you divert.” G-516-17
>
> “I use myself by changing scenes. For example, if a person is upset it may be that they want to talk about something else; talk about something else than the thing that upsets the patient, do something else, divert their attention so that they get distance from what was going on” OI 316-20

‘Diversion’ as a theme was linked to ‘activities’, e.g., going for a walk, games, TV or physical activities, with an underlying intention of calming the patient by shifting focus and/or setting from a conflict-prone activity/setting to a non-conflict-prone one. As shown in the above example, ‘high tolerance to conflict’ staff would offer a yard-walk outside the conflict-prone setting and allow the patient to vent his or her frustrations verbally. Or, in the early stages of conflict management, they would offer the

abovementioned ‘activities’ or ‘alternative’ solutions or suggestions to a problem, along with ‘informal talks’, to change focus or resolve conflict.

It was not the aim of ‘diversion’ to resolve the problem but was a strategy to divert the patient’s attention from the issue. However, ‘diversion’ was not always possible, and it depended on whether they had developed a ‘relationship’, which through dialogue would allow access to patient conflict management preferences. Using ‘alternatives’, such as de-escalation, was characterized by staff as fending off or gaining control of the conflict situation by offering alternatives.

> “It’s all about creating a setting that makes them see scopes of action. That they do not feel pushed up and into a corner, that they have other options than the back against the wall … That they feel that there is a way around the thing that puts pressure on them. They see a possibility to do something appropriate for the other patients and themselves of course.” BN_0110_117-121

> “It can be small things like getting a radio in, so that you can listen to music. Or a TV-set for one hour before dinner and one hour after dinner and in the evening. These are some of the things that I think calm things down.” BU 354-58

> “It is not all about rejecting people all the time. You must guide them to something else and there are different ways of doing that. You could meet them by saying ‘here is a glass of lemonade but you cannot smoke right now’.” BU_198-203

The rationale was, as illustrated above, that any further restriction to patient scope of action served only to increase the risk of conflict. However, if staff were not able to meet patients’ demands, they believed that staff actions should follow with a broadening of the

patient's scope of action, offering 'alternative' possibilities, thereby reducing the risk of conflict. According to the participants, high conflict-tolerant strategies are characterized by communicational skills and competencies, such as the above, together with 'informal talks', 'listening and containing', and 'informing and explaining' – all with the purpose of deescalating conflict situations.

> "Well, I use myself by spending time with the patients, if I feel that something is brewing or if a patient is latently angry, I'll sit down and talk with them or go to their room and have a cup of coffee; to draw them away from the other patients and start some small talk. I think it makes a difference, just a little talk about what is going on. Try to calm them down." GI_0301_273-278
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> "If they are very agitated I'll draw the person away or out somewhere to create a quiet setting for the patient where we can chat. Mainly because too many patients together creates too much disturbance. But if I draw them away and they can vent frustrations … they will calm down and we can talk about why and what happened in the situation. I have avoided a lot of conflicts using that strategy, I think." GN_3009_14-20
>
> "Just to calm the patient down. Sometimes they are all upset and then you sit and small talk and have a cup of coffee or a cigarette or something. I find that it calms the patients down so that is what I do even if the patient is very upset" LGI_0301_ 280-83

The use of 'informal talk' and the above, related subthemes, according to the interviews, aimed to allow the patient to vent frustrations and do so without sanctions. It was used with the intention of letting the patient's point of view be heard and acknowledged. In deploying 'informal talk', staff would gain an insight into and an understanding of the

situation from the patient's perspective. Secondly, it provided staff with the opportunity to share information that could shed light on or explain the conflict-causing situation. 'Informal talk' also provided an opportunity to mediate when there were differences. This is linked to the subtheme 'alternatives', as a creative way of figuring out other solutions to the problem and/or enter into a bilateral 'agreement'.

'Humor' could also sometimes be used, depending on the relationship and development of trust between staff and patient, to prevent a potential conflict; e.g., staff would sometimes use humor when delivering a message or information that they thought could result in a conflict situation. Humor is perceived by staff as being linked to the theme 'diversion' and comes with a caution about situational and relational sensitivity. The above themes are connected to staff's 'patient views' and should, according to interviews, be reflected on interactionally by clear, respectful, forthcoming, calm, non-judgmental and interested staff communication. This was because of staff's belief that patients would 'mirror' their behaviour. For the above to happen, staff underline the need to 'be there and be available'. Being present among the patients and being available for contact not only provided staff with 'observations' and 'assessments', but also reduced the number of conflicts, because it allowed for early conflict detection and intervention.

'Safe or unsafe'

According to the analysis, low or high tolerance to conflict as a theme was formed out of staff's perception of safety, clearly this related to perceived 'patient-related factors', 'relationship' and 'colleague-related factors' (See Figure 4). According to the participants, the perception of being 'safe or unsafe' as a theme was pivotal to their level of conflict tolerance.

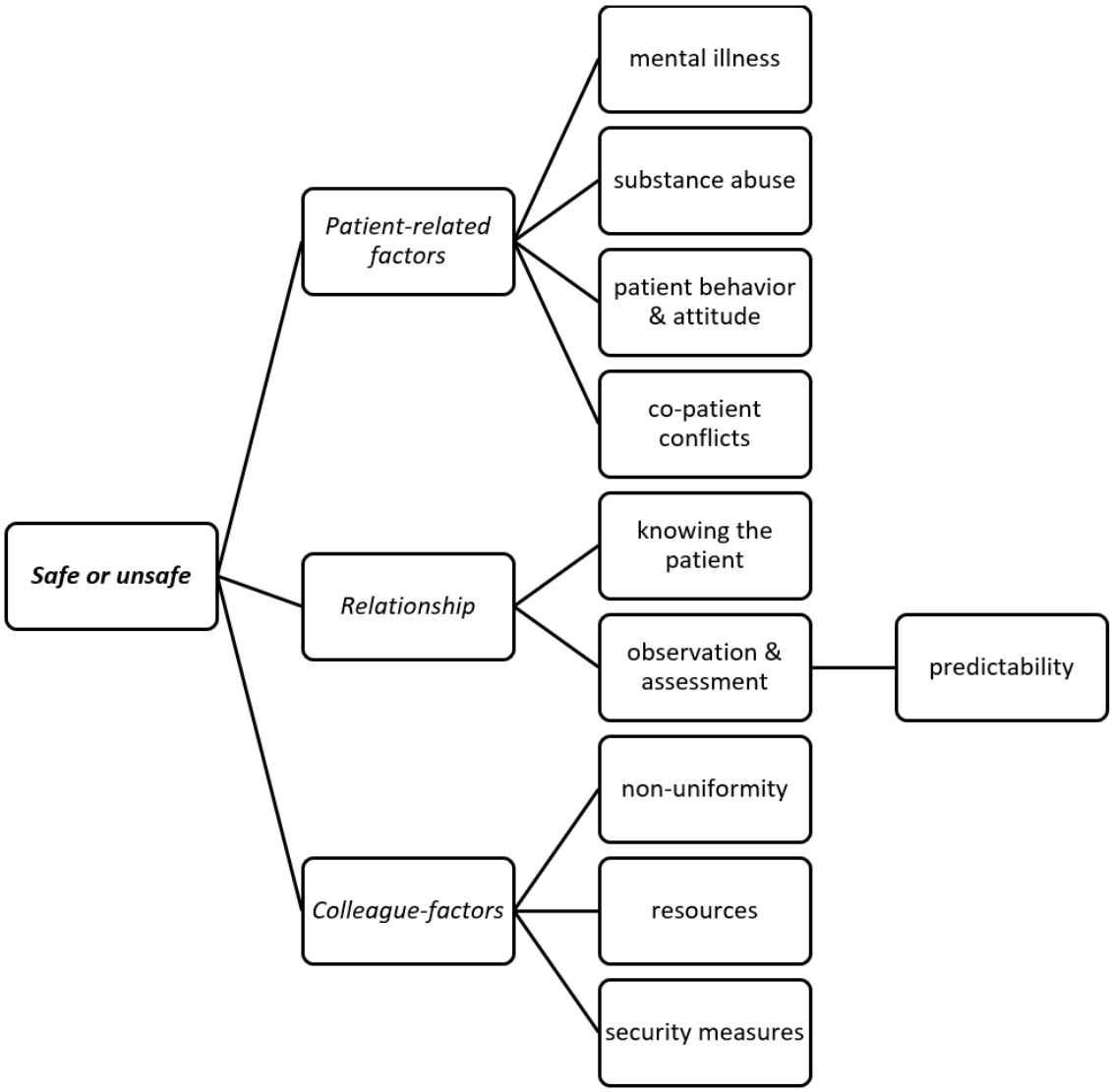

Figure 4. *Safe or unsafe*

Patient-related factors

'Patient-related factors' were a central element in and reason for patient-staff conflicts and violence – as perceived by the staff. These factors were characterized by staff's perception that patients behaved unpredictably, and that patients lacked cooperation and insight regarding treatment and care.

> "It is not really his behavior but his illness that is sneaky. When he is well, he comes across as friendly… but suddenly, spontaneously you must be in it [a psychotic episode] together with him and contain him … He would

> come out of his room and yell at me violently, go back inside and then suddenly it is all over and he will come out and say: 'Oh, I was really unwell, you should not be afraid of me. I'll not hurt you'. So, it is not specific to a situation, but like a 'jack-in-the-box' that just pops up." YI_0810_159-169

The patient-related factors and the subsequent unpredictability were perceived by the staff to be caused by their 'mental illness', e.g., psychosis, paranoid beliefs or 'substance abuse', which had led to changes in their perception of reality. According to the participants, 'mental illness' and 'substance abuse' caused misinterpretations and misunderstandings of social situations, and a lack of insight into treatment needs, e.g., regarding medication, or unacceptable 'patient behavior & attitude', such as violation of personal boundaries, e.g., physical proximity, violent or threatening behavior, shouting, bad language or assaults, any of which could trigger conflicts and evolve into violence. Furthermore, staff also reported 'co-patient conflicts', caused by boundary violations, issues relating to perceived hierarchy, and invasion of privacy, as a source of conflict.

> "It is relationship, relationship, relationship … that is what is needed in order to prevent conflicts, because that way we always have something to cling on to … because you get to know the patient well and you know what is going to work." BU_2909_759-767/833-836
>
> The participant is asked what 'relationship' is all about:
>
> "Yes, we'll find out where we stand with the patient and the patient should know where we stand. We need to uncover the patient's triggers that escalate [conflicts] … BN_0110_70-71
>
> "If you do not have trust and a good relationship, then they [the patients] do not trust their contact person and you will have conflicts all the time

between the two and it will spread throughout the wards." PI_0610_377-380

'Patient-related factors' as a theme was linked to the themes 'relationship', 'observation & assessment', 'predictability' and 'knowing the patient'. Patient conflict actions and reactions and the corresponding staff approach to conflict management were, according to the analysis, assessed and addressed through staff's perceived knowledge of and 'relationship' with the patient. The 'observation and assessment' of the patient conflict actions and reactions depended on staff's development of relationships and trust.

'Patient-related factors', combined with not 'knowing the patient' or being unsure of the staff-patient 'relationship', would reduce staff's perceived patient 'predictability'. This would then lead to increased staff fear of violence and reduce their tolerance to conflict. It would impact conflict management, by giving rise to a tendency to use 'low conflict-tolerant strategies'. According to staff, the converse was also true: A staff-patient relationship perceived to include a high level of knowledge about the patient, together with 'patient-related factors' that were personalised in regard to the patient, together with perceived trust, would increase staff's perceived patient predictability. These would then positively impact staff's perceived safety and increase their tolerance to conflict. According to the interviews, this was associated with a tendency to use 'high conflict-tolerant strategies.

Colleague-related factors

According to the staff, perceived lack of safety among colleagues was related to the following factors: (1) 'Resources' to handle intensity of staff-patient contacts, (2) 'non-uniformity' in rule enforcement and staff-patient agreements, and (3) 'security measures' to handle frequent boundary violations by patients. This appeared to be an underlying

reason for ‘low tolerance to conflict’ and negative ‘staff attitude & communication’, along with negative ward atmosphere, misunderstandings and disagreements between colleagues and patients regarding patient-related decisions.

> “If you loosen up on some of the rules. If a rule is considered unimportant by one staff member and another staff member enforces the rule, then there will be splitting, and the patient will be very confused about what is going on and that can quickly turn into conflicts”. YU_0110_8-11

Especially non-‘uniformity and loyalty’ in staff’s enforcement or implementation of staff-patient ‘agreements’ and ‘rule enforcement’ were a major source of collegial and staff-patient conflicts and perceived lack of safety. According to participants, non-uniform ‘rule enforcement’, i.e. the ad hoc bending of rules or ‘agreements’, was perceived as an act of disloyalty toward colleagues and would lead to confusion, lack of safety and perceived unfair discrimination among patients, resulting in staff-patient conflicts.

Staff lack of ‘resources’, such as staff numbers, time needed to talk, listen or help created situations wherein patient requests would be postponed or rejected. According to the interviews, these factors gave rise to daily conflicts.

> “If I’m on a shift where I know that if she [a staff member] goes out here right now he [the patient] will explode. That is not safe!” BI_0101_102

> “I experienced that someone [a staff member] suddenly made herself scarce. […] ‘this is tough’. And you think: ‘Where are they at?’… It could be that I one day find myself paralyzed or make myself scarce because it gets so wild that I do not dare be in it.” RI_0210_801-806

The perceived daily levels of conflict, along with ‘security measures’, such as low staff numbers or non-supportive collegial conflict participation, e.g., being left alone, colleagues behaving passively, being frightened or inexperienced in the conflict situation,

impacted staff's perceived safety by increased fear of violence and subsequent reduction in conflict-tolerance (Figure 1). On the other hand, if colleagues engaged in post-conflict dialogue with other staff members, this was highly appreciated and regarded a factor that reduced feelings of lack of safety (unsafe).

Discussion

This study proposes a dynamic model of conflict management (Figure 1) which seeks to explain how tolerance to conflict situations changes depending on individual staff, and their perception of colleagues, patients, and their relationship with the patients. It also appears that individuals may exert an influence over the use of restrictive practices and the team's tolerance to this, although this requires further research. Central to the above-presented findings is the perception of feeling safe or unsafe – which is perceived by staff to impact on their tolerance and subsequently their collective engagement in high or low conflict tolerant strategies. A recent study on newly graduated nurses' (NGN) transition into forensic mental health confirms that staff's feelings of safety are linked to how they perceive support from experienced colleagues, but also that a lack of theoretical knowledge and support from management and training in conflict management, among other factors, influenced perceived safety (Sorensen, Tingleff, & Gildberg, 2018). The same study points out a clash between what NGNs perceive as custodial care with similar elements, as in the above-presented Low conflict tolerant strategies and their own patient approach. However, a direct relationship between patient-related factors and feelings of lack of safety was not found, contrary to the present findings and existing literature (de Vries et al., 2016). Conflict management in this study seems to be related to patient-related factors, such as, e.g., anger or violent or threatening behaviour. Staff appeared to value their relationships with and knowledge of the patients in order to understand patient-related factors and to get a sense of safety while being with the patients. Similar

findings on the central importance of personal relationship or alliance based on perceived trust, safety and knowing each other have been shown throughout the existing literature in the field (Bowers, 2005; McCann & Baker, 2001; Nielsen et al., 2018; Price & Baker, 2012; Salzmann-Erikson, 2011; Scanlon, 2006; Wright et al., 2014). It has also been suggested, however, that an exacerbation in a patient's symptoms can have a negative impact on staff-patient alliance (Nielsen et al., 2018) in the same way that negative social climate, limiting patient freedom, staff attitude and interactions play very central and important roles in the occurrence of aggression (Duxbury & Whittington, 2005; Papadopoulos et al., 2012; Price & Baker, 2012; Robinson et al., 2016). In the light of this, the above findings seem to suggest some truth to the saying, that "what you fear you create" – in the sense that the synergistic effect of perceived patient-related factors and negative colleague-related factors impacts staff trust and safety within staff-patient and collegial relationships. This would give way to negative assessments and low conflict-tolerant strategies, which in turn could increases negative patient response and – according to the current study – leads to colleagues engaging in the same modus operandi and brings staff full circle, by increasing their sense of a lack of safety.

The more unsafe nurses felt, the greater was the indication of observation and assessment. Nurses with low tolerance to conflict tended to act in a more restrictive manner and emphasized the rules and limiting patients' freedoms. In nurses with high tolerance to conflict, more emphasis was placed on 'understanding the patients', being non-judgmental and calm and having informal talks. Such elements in nursing care and their perceived positive or negative impacts on staff-patient relationships have been noted in the existing literature (Gildberg, Elverdam, & Hounsgaard, 2010). However, the notion that these interactional elements could be attributes linked to profiles of tolerance and strategies, safety and its lack, relationship and assessment (Figure 1) has received very

little attention until now. Nursing theorists, for example, Tanner (2006), have previously emphasized the importance of 'knowing the patient' and his or her typical pattern of responses. Tanner (2006) argued that, by knowing a patient's pattern of responses, nurses can determine the aspects of it that are salient, what is typical for the patient and that which allows for individualized responses and interventions. These are referred to as so-called 'clinical judgments' and 'clinical reasoning' (ibid). The findings in the current study show a resemblance to these concepts. However, whereas the nurses in this study characterized their attitudes of 'knowing the patient' mainly by means of an informal approach, in the field of forensic mental health nursing it is acknowledged that a more structured approach is effective in assessing and gaining insight into forensic patients' risk (de Vries et al., 2016; Douglas, Ogloff, & Hart, 2003; Ray & Simpson, 2019). By means of a structured approach, nurses' efforts in the assessment and judgment of patients' (violence)-risk are based on structured instruments and strategies. Apart from the seemingly rather unstructured informal attitudes mentioned in this study, in the field of forensic mental health it is argued that risk formulation and the use of structured strategies contribute to effective deescalating and stabilizing interventions and positive outcome of patient behavior, accordingly (Bjorkly, Eidhammer, & Selmer, 2014; F. Fluttert et al., 2008; Martin et al., 2013). Especially in cases of low-tolerance attitudes of staff towards conflicts, a proactive, structured risk management with risk-formulation dialogues could be a tipping point from low to high tolerance to conflicts and positive attitudes, accordingly (Figure 1). In this study, the participants responded that they value observations and assessments to allow for 'early conflict detection and intervention'. Risk management strategies specifically designed for this focus within forensic nursing, such as the Early Recognition Method (Fluttert et al., 2008; Fluttert et al.,2013), resonate with this 'early conflict detection' and could contribute to staff-patient collaboration. Then,

the focus would not be on restrictive conflict management but on proactive management of patients' *early* warning signs. Within these kinds of strategies, patients' autonomy and self-management are acknowledged in order to contribute to patients' awareness and management of their own role in conflict situations. Then, nurses' attitudes, such as being non-judgmental and interactional and their efforts towards a structured assessment and 'knowing the patient' would be preferred, similar to those of high tolerance to conflicts (Ray & Simpson, 2019).

Limitations

The data used in this study originated from two Danish forensic wards that were purposively selected (Polit & Beck, 2008) and sample size was determined by data saturation (Morse et al. 2002). The study findings could reflect local Danish perspectives on forensic staff-patients conflicts and should be considered alongside variations in culture, preferences and policies. Alternative sampling strategies, such as recruiting from other forensic sites, thereby countering the local perspective, were considered but were not possible at the time. On the same note, generalizations drawn from these findings should be made with caution, since the presented theory should be falsified or further developed by renewed empirical testing (Blumer, 1986) – preferably in other forensic settings. As noted in Table 1, the total years of experience on the ward was a mean of 0.65 (sd.25), whereas the total experience within mental health was 7.17 (sd.7.24) years. This should be carefully considered because it could indicate that staff were new to each other, which in turn could impact group dynamics and feelings of safety within the group. However, such issues were not reflected in the interview and experience was only mentioned regarding participants' total number of years of experience within mental health. Future studies should, however, challenge the issue.

The use of interview as a method is limited by what the participants want to share and, due to the nature of the topic in this study, could have resulted in a lack of institutional self-critique and to self-glorification. It was evident in the data that most participants were able to pinpoint and critically reflect on, e.g., low conflict tolerant behavior or attributes by ascribing it to their colleagues. There were only a few participants who directly stated that they, themselves, displayed low tolerance to conflict. To strengthen the study design, interviews were carried out by second and third author overseen and adjusted by first author. The analysis, however, was primarily carried out by first author due to the massive amount of data and low work-hour-resources available. Although the whole author team were involved in discussions regarding the analysis and findings, this should be considered (Whittemore, Chase, & Mandle, 2001).

Relevance to clinical practice

The study of staff interactions and characteristics in the management of conflict situations has received minimal research attention, when compared to studies focusing on patient factors. From the data presented in this paper, it appears that the nature of the staff team on duty may influence how and when restrictive practices are used. Further studies could aim to modify tolerances and understand how much individual staff members can influence the ward milieu and dynamics of conflict situations.

Conclusion

This study provides an insight into the day-to-day management of conflict situations in a forensic mental health inpatient setting and seeks to explain how tolerance to conflict situations changes depending on individual staff, their perception of others, and the relationship with the patients, by proposing a dynamic model of conflict management. The development of such a model of conflict – which could be modifiable via future

interventions – could result in fewer conflict situations. Future research needs to understand whether the ideas presented here are reflected by the views of patients, and staff in other forensic settings.

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Tables

	Nurses (n=11)		Nursing assistants (n=13)		Total staff (n=24)
Measure	**Mean(sd)**	**Gender ratio**	**Mean(sd)**	**Gender ratio**	**Mean (sd)**
Age (years)	34.82(10.00)		39.53(10.42)		37.38(10.29)
Male / female		0/11		9/4	9/15
Years of experience in mental health	9.40(5.27)		13.63(8.55)		7.17(7.24)
Years of experience on the ward	0.65 (0.21)		0.65(0.28)		0.65(0.25)
Interview minutes	35.91(6.23)		47.85(18.75)		42.37(15.61)

Table 1 *Staff included in interviews*

Figure legends

Figure 1. Dynamics model of conflict management

Figure 2. Low tolerance to conflict

Figure 3. High tolerance to conflict

Figure 4. Safe or unsafe