International Practice Development Journal

Online journal of FoNS in association with the IPDC and PcP-ICoP (ISSN 2046-9292)

ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Managers' perceptions of competence and practice development following education in the prevention and management of staff-directed aggression: promoting person-centred practice

Erlend R. Maagerø-Bangstad*, Knut Tore Sælør and Ottar Ness

*Corresponding author: University of South-Eastern Norway, Drammen, Norway
Email: Erlend.rinke.maagero-bangstad@usn.no

Submitted for publication: 19th February 2020
Accepted for publication: 3rd August 2020
Published: 18th November 2020
https://doi.org/10.19043/ipdj.102.008

Abstract

Background: Staff-directed aggression and violence may have harmful implications for all parts of a mental health service organisation. In an effort to advance the development of competent practice in community mental health and substance abuse services in Oslo, the municipality has offered various courses in the prevention and management of staff-directed aggression and provided supportive tools for practice development.

Aim: To explore managers' perceptions of how participating in education and applying supportive tools have contributed to the development of competence and practice in their own services.

Method: Qualitative interviews with 11 managers working in homebased community mental health services were analysed, using qualitative content analysis.

Findings: The findings show education and application of tools contributed to: 1) increased awareness and understanding of the complexities of staff-directed aggression; 2) empowered and collaborative practice through negotiations of power relations; and 3) adjustment of perceived management responsibilities and assignments.

Conclusion: The findings indicate that managers not only felt their staff had become more knowledgeable and competent following education, but that participation in education also impacted on collaboration within and outside their own services, as well as directly influencing how they dealt with threatening situations in the workplace.

Implications for practice:

- Staff-directed aggression is a complex phenomenon and efficient practitioners are able to keep in mind a number of relevant aspects of practice simultaneously
- Collaboration in prevention and management of staff-directed aggression requires staff to acknowledge and accommodate service users' perspectives regarding practice
- A levelling of power differentials between community mental health services and specialist mental health services takes place when partaking in the same education and sharing vocabulary and conceptual frameworks regarding risk assessment and management

Keywords: Staff-directed aggression, managers, community mental health services, substance abuse services, competence development, qualitative research

Introduction

In mental health settings, staff-directed aggression and violence comprise various forms of physical attack, threats of violence and verbal abuse towards staff (Nolan et al., 1999; Fry et al., 2002; Fujimoto et al., 2017; Tonso et al., 2017). The aftermath of such actions can be severe and debilitating for the individual staff member (Büssing and Höge, 2004; Fujimoto et al., 2017; Tonso et al., 2017; Daniels and Anadria, 2019). Additionally, considerable fiscal costs (Beech and Leather, 2006), increased problems recruiting and retaining staff (Jackson et al., 2002), and reduced commitment to the workplace (Barling et al., 2001) occur after incidents of violence. This all puts additional strain on the healthcare organisation. Studies show staff-directed aggression impairs relationships between service users and the healthcare providers (Lanctôt and Guay, 2014), harms the quality of care (Arnetz and Arnetz, 2001; Gates et al., 2011), affects staff's performance of the interpersonal aspects of their roles (Barling et al., 2001), limits the frequency and duration of home visits (Galinsky et al., 2010) and is linked to negative patient outcomes (Roche et al., 2009). Due to the far-reaching impact of workplace violence in health settings, Beech and Leather (2006) argue for a 'total organisation response' with all levels of the organization sharing the responsibility for its prevention and management. Service users, however, are not given a role in this proposal.

Norwegian legislation gives employers substantial responsibility for providing staff with sufficient training and education to ensure safe working environments (Norwegian Ministry of Labour and Social Affairs, 2016). Staff members consider the development of competence in prevention and management of violence to be a requirement for building services that can address challenges related to staff-directed aggression (Svalund, 2009).

Since 2010, the Agency of Health in Oslo Municipality has, through a competence development project, devised and implemented various educational knowledge-based activities and tools in mental health and substance abuse services to prevent and manage staff-directed aggression. More than 3,500 participants have attended various courses and seminars as part of the project. The activities comprise general and specialised education and training, and seminars for managers and appointed 'resource persons'. The tools, including written material and e-learning content, help build individual and collective competence in the workplace and support safe service provision. A management appointment, the role of resource person was developed as part of the project, enabling municipal districts to enhance competence and promote practice change within their own services according to local requirements. Resource persons have a special responsibility for maintaining awareness among colleagues concerning staff-directed aggression and preventive measures. They can also have a responsibility for educating their colleagues and keeping themselves up-to-date on the topic.

The various activities and tools involved in the project are described in Table 1.

Table 1: Overview of competence development activities and supporting tools aimed at prevention and management of staff directed aggression in Oslo Municipality

Activity/tool/role	Description/content
One-day course: 'Basic course in management of threats and violence'*	• One of two general courses offered to staff employed in mental health and substance abuse services in Oslo (both municipal and specialist services) • Focus on situational risk assessment and management during service provision • Exemplification of in situ risk assessment through a simulation exercise
One-day course: 'Who am I in the encounter with the service user: phase-oriented prevention and management of threats and violence'*	• One of two general courses offered to staff employed in mental health and substance abuse services in Oslo (both municipal and specialist services) • Particular focus on how staff could contribute in de-escalating aggressive situations, and emphasis on disempowerment as reason for staff-directed aggression
One-day course: 'Continuing course in management of threats and violence'	• Course offered to previous participants in 'Basic course in prevention and management of threats and violence' • Includes an expansion and further deliberation on principles of situational risk assessment and management of staff-directed aggression • Simulation training is a central element during the course
Resource persons	• A staff role in mental health and substance abuse services in the municipal districts, aimed at facilitating continued practice and competence development. Services recruit resource persons from among staff members • These employees are offered additional in-depth education and training in prevention and management of staff-directed aggression
One-semester bachelor-level course: 'Continuing education in violence risk assessment' (VIVO I)	• A 15-ECTS (European Credit Transfer System credits) continuing education course hosted by the University College of Molde, covering theories and tools of violence risk assessment within mental health • Participants from specialist and community mental health services • Seven whole-day sessions over the course of one semester. Written group exams at the end of the semester • The Agency of Health, Oslo Municipality covers tuition fees for resource persons
One-semester bachelor-level course: Continuing education in violence risk assessment (VIVO II)'	• A 15-ECTS continuing education course hosted by the University College of Molde, on principles for treatment and management of risk in institutional and non-institutional settings within mental health. For participants who have completed VIVO I • Participants from specialist and community mental health services • Seven whole-day sessions over the course of one semester. Written group exams at the end of each semester • The Agency of Health, Oslo Municipality covers tuition fees for resource persons
Two-day seminars for resource persons and managers of municipal mental health and/or substance abuse services	• Held once or twice a year on various topics related to prevention and management of staff-directed aggression • Group work and plenary discussions have a central role in the activities
Municipal intranet pages with e-learning content on prevention and management of staff-directed aggression	• Web pages providing a summarised overview of knowledge on prevention and management of staff-directed aggression • Resources, tools and up-to-date knowledge for staff in the mental health services • Assignments developed for individual or collective reflection on prevention and management practices in the workplace • Tailor-made films promoting reflection and critical reappraisal of practice in aggressive encounters
Checklists and booklets regarding prevention and management of staff-directed aggression	• Readily available, shareable and printable written material aimed at raising awareness and preparing staff for prevention and management of challenging situations during service provision

** These general courses have recently undergone scientific evaluation and the findings have been made available by Maagerø-Bangstad et al. (2019).*

All educational development activities and tools were developed according to principles of disempowerment-sensitive (Lillevik and Øien, 2012), non-physical, de-escalation (Price and Baker, 2012), recovery-oriented (Davidson and White, 2007) and knowledge-based risk assessment perspectives (Bjørkly, 2006). The educational activities are devoted to viewing violence and aggression against mental health staff as situated within a power imbalance between service users and service providers (Kaplan and Wheeler, 1983).

Although education in the prevention and management of staff-directed aggression is a widespread and valued endeavour within healthcare (cf., Beech and Leather, 2006), there is little knowledge of how managers within community mental health services perceive the advantages of staff participation. Campbell (2017) describes research on violence and aggression in non-institutional, homebased settings as lingering in its 'infancy', and there is limited insight into the various dimensions of this topic.

Recovery, person-centredness and practice development

Recovery and person-centredness, having originated from, respectively, service-user and 'survivor' movements, and humanist-existentialist professional philosophies, have been found to be interdependent concepts in that the one presupposes the other (Hummelvoll et al., 2015). Both are 'about the person trying to find meaning and keep control over their life situation, with support for making informed decisions and for real partnerships with families and services' (Hummelvoll et al., 2015, p 2). In a Norwegian context, both recovery-oriented and person-centred principles inform national guidelines for mental health and substance abuse services (Norwegian Health Directorate, 2014). Additionally, the Agency of Health's work in relation to mental health and substance abuse services are founded on recovery-oriented principles. On these grounds, both perspectives have been chosen to constitute the ideological foundation for this study.

Within the person-centred perspective, development of healthful and encompassing relationships is ventured by a practice that is:

> *'Underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development'* (McCormack and McCance, 2017, p 20).

Thus, practice development is an iterative endeavour aimed at promoting person-centred workplace and learning cultures, supported by individual and collective engagement in critical reflection and active learning in practice (McCormack et al., 2011). McCormack et al. (2007) have further argued that collaboration, inclusion and participation are key methodological principles for practice development. This implies that thus conceived, it is a communal endeavour, founded on the establishing of a shared organisational purpose, engaging stakeholders (staff, service users and their families, managers and other collaborating partners) and incorporating their views and contributions in the process (Manley et al., 2013, 2014).

Theories of learning

In line with the above, person-centred practice development entails a critical reappraisal of self and the contexts of one's practice. This is deeply indebted to emancipatory and transformational depictions of adult education in the vein of Freire and Mezirow (McCormack et al., 2013). Thus, transformational adult learning is used as a framework for this study.

Adult learning can entail a perspective transformation resulting from experiencing a 'disorienting dilemma' – a significant experience that sheds light on, and questions formerly implicit and accepted assumptions of ourselves and our world (Taylor and Elias, 2012). Critical reflection may pave the way for the reformulation of our assumptions to allow 'a more inclusive, discriminating, permeable, and integrative perspective; and for making decisions about or otherwise acting upon these new understandings' (Mezirow, 1990, p 14). This suggests experiencing disorienting dilemmas followed

by critical reflection may be a prerequisite for transformative adult learning and for applying taught material in practice. Thus, transformative learning has considerable emancipatory potential through challenging prior assumptions regarding self and society (Brookfield, 2012).

Phenomenography is considered to be a relevant approach to exploring learning processes. It proposes that learning takes place 'by a change in something in the world as experienced by a person' (Marton and Booth, 1997, p 139). From this perspective, a central premise for learning is that learners employ their own awareness in constituting this phenomenal transition. By applying additional identified aspects of the phenomenon in the broadening of their conceptualisations, learners establish a more comprehensive understanding of the phenomenon (Marton, 2015). The increasing ability to simultaneously hold multiple relevant or critical aspects in one's awareness constitutes increasingly powerful ways of seeing and implies the learner's potential for more effective and proficient action during prospective encounters with the phenomenon (Marton, 2015). In phenomenography, the outcome of learning can be both individual and collective (Marton and Booth, 1997), which has relevance for the establishment of cultures of learning in workplaces (McCormack et al., 2011).

Aims and research question

Management is crucial for the development and continuation of practice development and the development of staff competence, knowledge and skills (Dewing, 2008). It is also important for fostering practice development in healthcare settings (McCormack et al., 2007). Thus, this study aims to explore and develop knowledge of how managers within mental health and substance abuse services view the contribution of participation in educational activities and the application of supportive tools for practice, and how they describe the perceived impact of these measures on workplace practices. The research question for this study is:

How do managers in community mental health and substance abuse services perceive the contribution to competence and practice in their own services of staff participating in education and training activities and applying supporting tools in the prevention and management of staff-directed aggression?

Method

Research design

This study is positioned within a social constructionist framework in terms of viewing knowledge development as being communally based, socially situated, relational and co-constructed between researchers and participants in a study (Gergen, 2011). Social constructionism refutes the modernist idea of research as uncovering 'undisturbed' and objectively true phenomena in the world, and instead focuses on communal meaning-making and the creation of 'the relational realities in which we live' (McNamee, 2010). Arguably, managers' perception of the impact of participation in competence development activities is a social phenomenon, stemming from various sources such as managers' contact with and observations of staff following participation in the activities and their own participation in such education and training – potentially moulded or reframed during interaction with an interviewer. We have thus chosen social constructionism as a suitable vantage point from which to reach knowledge about mangers' perceptions in the present study.

A reference group is included in parts of the study, both before data collection and in the final stages of analysis. It consisted of managers and staff from community mental health and substance abuse services, persons with service-user experience and a person with professional experience from a collaborating psychiatric service. Having experiential knowledge and familiarity with community mental health and substance abuse services and with the topic at hand, the group helped to construct an interview guide and to establish the credibility of the study's analysis and findings. The group contributed to the study from what Borg (2009) has termed an advisory position, determining neither its aims nor its methodology. However, discussions within the group were critical for developing the findings and providing analytical clarity in the process of delineating the content and coverage of the developed categories.

Participants and recruitment

Participants were recruited by applying a purposeful, criterion-based sampling method (Sandelowski, 1995). The inclusion criteria were: 1) management or advisory responsibilities for staff in community mental health or substance abuse services; 2) regular contact with staff; 3) employment in services that have participated substantially over time in various education and training initiatives in the municipality; and 4) municipal districts or services with one or more appointed resource persons. Variation in the sample was sought by ensuring participants represented a variety of services. Since the first author (ERM-B) has been engaged in developing and implementing the competence development activities described in this study, all participants were, in advance of being approached, known to meet the inclusion criteria. In total, 11 experienced managers (seven female and four male) were approached and all agreed to participate. They managed or supervised supported housing facilities, home-based community mental health or substance abuse services.

Data collection

Qualitative, semi-structured interviews were chosen as the method for generating data. All interviews but one took place in the participants' workplaces; the remaining one was conducted at the first author's workplace at the participant's request. The interviews took place from November 2017 to August 2018 and all were recorded. This study is part of a larger PhD project addressing the impact of various parts of the described competence development activities. Due to practical issues and general workload, it has regrettably taken longer than anticipated to write up the findings.

In line with the study's epistemological stance of knowledge being co-constructed, and respecting the participants' engagement with the topic, the interviewer (first author) emphasised an open style of interviewing, albeit using a semi-structured interview guide. The interviews aimed to explore different aspects of participants' experience with staff members' practice and competence in encounters with aggression in the workplace following participation in courses and education. The interviewer asked follow-up questions when additional clarification or more nuanced descriptions were required. Interviews ranged from one hour to over two hours.

Data analysis

The interviews were transcribed verbatim. Qualitative content analysis (Graneheim and Lundman, 2004) was chosen to analyse the data. This is an interpretative and epistemologically flexible method that is sensitive to variation in and between parts of texts (Graneheim et al., 2017). The process entails reducing data into descriptive categories or concepts of a phenomenon (Elo and Kyngäs, 2008). Analysis can involve mapping out either the manifest and descriptive or the latent and interpretative content of participants' expressions (Graneheim, et al., 2017). In conducting the collaborative analysis an inductive, data-driven approach was favoured, implying a movement from the data to a theoretical understanding (Graneheim et al., 2017).

As a first step, the first author carefully read the transcribed interviews several times. He then sorted segments of the transcripts dealing with the focus of the study into meaning units and coded the condensed material. Subsequently, the first and the second author (KTS) discussed the codes and reached a consensus. The first author then developed initial categories on the basis of the coded material. All three authors then discussed and refined the categories. Finally, the first author presented the developed categories to the reference group members, and then reassessed and further refined the categories according to recommendations from the discussions within the group. For instance, the meaning of staff empowerment and collaboration with specialised mental health services received greater focus following these discussions.

Dependability concerns the consistency of findings over time as well as the degree of 'alterations made in the researcher's decisions during the analysis process' (Graneheim and Lundman, 2003, p 110). The 'challenge of deciding which codes and supporting quotes form the original text are to be included in a category' is a matter of dependability, according to Graneheim et al. (2017, p 33). By reaching a

consensus among the researchers and, in this case, among the reference group regarding the codified meaning units to be included in each established category, dependability was achieved. The notion of dependability is contested (Marshall and Rossman, 1999), and consideration was also given to Sandelowski's (2011) warning that text can carry multiple meanings, yet Graneheim and Lundman (2004) have proposed dialogue among researchers as an appropriate way to reach internal agreement and elicit trustworthy results during analysis. Additional measures included member checking the findings (Guba and Lincoln, 1989) with the reference group.

Since the first author had played a part in developing and implementing the competence development activities and tools, it was necessary for him to reflect critically with the co-authors and the reference group on his own attitudes and preconceptions regarding staff-directed aggression and prevention and management practice, throughout the entire study.

Analysis resulted in the establishment of three categories outlining the contributions managers perceived from staff participation in education and training activities and the use of supportive tools developed in the original competence project. These categories are: 1) increased awareness and understanding of the complexities of staff-directed aggression; 2) empowered and collaborative practice through negotiations of power relations; and 3) adjustment of perceived management responsibilities and assignments.

Research ethics

The study was conducted in accordance with the Norwegian National Committee for Research Ethics' principles for ethical research. The Norwegian Centre for Research Data granted approval for this study (ref. 52044).

Before the interviews, all participants were informed participation in the study was voluntary and that withdrawal was possible without any repercussions. Written consent was obtained from every participant.

As managers of community mental health and substance abuse services, the participants are well known within their organisations. Identification would be likely to have an adverse effect on their ability to perform their role in the future and could also disrupt collaboration and relations with specialist psychiatric services and with higher management. Some of the participants voiced such concerns regarding anonymity, and this became an integral ethical consideration during analysis and when writing up the results of this study.

Findings

The findings portray different aspects of the perceived impact of education and supportive tools, as described by the participants. These range from changes in staff conceptualisations of practice to modification of power relationships in mental health and rearrangement of managerial responsibilities.

Increased awareness and understanding of the complexities of staff-directed aggression

The participants felt the educational activities and supportive tools improved understanding of staff-directed aggression among staff. Only a few said they had authorised educational activities in a deliberate effort to promote learning and practice development in their workplaces. Nevertheless, they believed these initiatives promoted shared understanding and communal practice within their teams and contributed to advanced levels of awareness among individuals. This, for some, involved a shift in the attitudes at the workplace regarding what staff could be expected to put up with at work:

> *'There has been an increase in awareness. That is what I believe has been going on here […]. The staff have really not been particularly focused on violence and threats. They have, so to speak, been accustomed to it being the way of things. They have sort of had an attitude of "Well, there is a lot we have to put up with"'* (Female manager 2).

Most participants said violent incidents occurred sporadically within their services, making staff more susceptible during calm periods to allowing levels of awareness to fall. Participants felt the competence activities and tools led to a more sustained focus on the threat of staff-directed violence and aggression. This awareness helped make staff, and the workplace, more prepared to deal with the issue.

Others who thought their staff already had good levels of awareness and competence said the activities helped remind the staff of the importance of being attentive to staff-directed violence and aggression and of keeping preventive and handling strategies and tools in mind.

Participants described the education and tools offered as different yet complementary, and said their staff had expanded their practical understanding of staff-directed aggression as a result:

> *'To learn how to think about safety and how to act according to what you observe. How you meet feelings relationally and in conversation. The way you interact with these service users'* (Male manager 4).

Participating managers said staff – and in some instances themselves – had gained a deeper understanding of violence and aggression as being deep-seated, complex and contextually dependent phenomena. They described staff's greater awareness of alternative ways to manage situations, and of their own role and responses during aggressive encounters with service users.

This led to a change in staff attitudes to the responsibilities and limitations of their role. Those who, before the education initiatives, might have lingered in potentially threatening situations or tried to solve situations on behalf of the service users, gained an increased understanding of their limitations in these situations and of their roles as mental health workers. This seemed to make withdrawal from perilous situations a more viable option, as effectively summed up by one of the participants:

> *'What has been achieved is an attitude change [among staff]. That you should think more about yourself, rather than stick it out just to help and guard the service user from harm and make sure the service user is okay and well. Instead, think more about yourself. The service user is probably caught in a line of thought we aren't going to be a part of anyway, so whatever we do it won't help. You'd preferably pull out instead'* (Female manager 5).

However, this did not entail abandoning the service user or neglect of efforts to prevent or manage situations. Rather, this seemed to concern staff's preservation of their own safety in particularly aggravated situations.

Empowered and collaborative practice through negotiations of power relations

Managers presented an overall view of their personnel as having become more capable, prepared, autonomous, confident and effective in dealing with staff-directed aggression. They described the competence development activities as empowering for both individual staff members and the team. This positively affected collaboration with service users and other collaborating parties, such as the specialist mental health services:

> *'ViVo [continuing education in violence risk assessment and management offered to resource persons] has been very important in relation to our staff gaining more confidence when meeting with the psychiatric services and in discussions concerning discharge. We have a much stronger say in the psychiatric services. Far more confidence, maybe, than earlier because we, to some extent, share their conceptual framework, and we are familiar with the tools they use' (Male manager 1).*

The competence development activities served as a theoretical foundation for staff who had previously relied predominantly on knowledge born of experience, and as confirmation and authentication of their existing competence. The confidence – and, for some resource persons, pride – of increased understanding also contributed to staff being more self-assured when making requests or when expressing their views about risk assessment of service users and contextual factors. This applied to communication with their own managers and with collaborating mental health services, resulting in more nuanced assessments of individual service users:

> *'Quite often, I notice that when they [specialist mental health services] realise that we are competent in something that is in their area of professional expertise… Because, occasionally, some specialists take pleasure in showing off their specialist competence and leave it with 'This is what we have done…'. When they realise that we understand, 'No, that does not work here'. Then, the outcome for the service user is different'* (Female manager 7).

Several of the participants said competence development allowed for more critical appraisal of risk assessments from psychiatry. Greater insight into formal risk assessment tools and frameworks meant staff were able to challenge existing assessments from psychiatric services and propose their own, more contextualised and nuanced assessments, derived from being closer to service users' everyday lives.

As a result, some participants reported increased recognition from collaborative partners, meaning their perspective was given greater attention:

> *'We can now actually phone them [the specialist mental health services] and present our opinion, and they act on it'* (Female manager 7).

Most of the participants concurred that the competence activities had helped balance inequalities in power relations between the community mental health and substance abuse services, and collaborating specialist mental health services. Partaking in further education alongside participants from psychiatric services promoted a more unified, appreciative and collaboratively receptive approach to addressing staff-directed aggression between the service levels.

Increased courage in the face of the hardship caused by staff-directed aggression was also reported. Some pointed out that dealing with this in mental health services was an issue fraught with stigma and apprehension. Competence development gave staff the resolve to talk about aggression with service users, and the '*courage to help people deal with the things that repeatedly alienate them from everything*' (Female manager 1). The result was more purposeful efforts to address indications of staff-directed aggression collaboratively with service users and cultivating a shared exploration of the underlying reasons.

Managers and resource persons were also empowered to develop training protocols and education activities within their own services by applying learning materials and tools developed in the project, sometimes in collaboration with other local services. This enabled access to wider perspectives on prevention and management from collaborative partners and during training with practitioners from other fields of practice.

On a more critical note, some participants expressed limited confidence that the change brought about by the education and training activities would be real and lasting in their services; they viewed the activities as being too theoretical and far removed from the practicalities of staff's day-to-day work. One participant viewed it as an easy way for higher management in municipal districts to discharge their obligations without further commitment to the cause:

> *'I think these courses are to some extent used by employers to document that things have been done. When suddenly an incident of whistleblowing regarding safety not being ensured appears, then they can report that staff has attended courses. The employers have done what they're*

supposed to. Professional supervision has been given. A lot is about documenting that things are in order. In that regard, these courses are very convenient' (Male manager 2).

This statement recalls the potential downsides of competence development, especially where there is a lack of support and organisational commitment.

Adjustment of management responsibilities and assignments

A third outcome from participating in education and the application of supportive tools was an shifting of management obligations to address staff-directed aggression. Some participants spoke of this change as a relief, in terms of being not solely responsible for staff training in a difficult area:

'To me, as a leader, it is alleviating. We are a small workplace, and we are somewhat isolated, right? We have our own personnel meetings and our own health and safety representative. We have our own 'total-thing' [i.e., complete and self-sufficient operation] going on in our corner here. So, to me, it has been alleviating and a relief that not everything concerning violence, threats, the interpretation of signals … That all that kind of training of staff has to go through me' (Female manager 1).

This perceived impact extended to responsibilities to staff and service users following incidents, and to cooperation with partners in other mental health and substance abuse services, as well as to establishing workplace routines and regulations. In Norway, employers are required by law to collaborate with staff-elected personnel who help develop and oversee workplace health and safety, and to ensure staff assignments and the workplace environment comply with regulations. One participant described an interaction with her local health and safety representative, who had returned from one of the courses, having acquired:

'A considerable urgency in making routines about "What do we do with violence and threats?" This was a workplace routine I was supposed to have developed. But, after returning from the course, the health and safety representative was all over me, all the time: "You have to put that workplace routine into writing!" In the end, she went and wrote it herself! That was very nice. I could just sign it, and then, we were done' (Female manager 2).

Participants noted an increase in staff autonomy following education, contributing to personnel taking more responsibility and giving managers the confidence to entrust their personnel with handling situations appropriately themselves.

Some participants disclosed their own strong reactions and emotional turmoil in response to incidents of staff-directed violence and aggression. They expressed concern about how these reactions could potentially muddle their ability to communicate appropriate principles of practice and balance their efforts at supervising and instructing their staff. Thus, the educational activities staff – and often managers themselves – had participated in were viewed as a better way to accommodate competent practice in their own teams, through 'proper' and pedagogical methods that were provided by skilled educators using coherent instruction.

Yet, an increased focus on staff-directed aggression resulted in all participants identifying multiple aspects of practice they perceived to be in need of review in the future.

'It's going to have implications for this team, to put it that way. Yes, I have great ambitions for changing… That is, to make routines for this' (Female manager 2).

The imperatives for action identified by the managers included, inter alia, the need to develop a more systematic, structured and collaborative way of working, both within the teams and when following

up with service users. This involved maintaining awareness and focus within teams by accommodating self-reflection and discussions. Providing employees with opportunities to practise and further develop knowledge and skills was considered vital by managers. This entailed a commitment to allow staff and resource persons wider involvement in more areas of practice. By facilitating discussions among colleagues and through day-to-day supervision, the resource person was ascribed particular prominence in supporting the managers' efforts in this respect.

A further implication of this approach was the need to provide staff and collaborative partners with timely and appropriate information about indications of a heightened risk of aggression in service users. This was suggested by some as means to enable incidents or potential situations to be dealt with more safely and effectively.

Several participants described themselves as role models for their staff and as facilitators of practice in their workplace. This meant taking a visibly serious and respectful approach, and adapting their own attitudes and conduct towards staff-directed aggression. Some spoke of encouraging staff to 'dig deeper' – to explore the underlying reasons for and meaning behind signs of aggression. Others sought to influence staff by overtly modelling ways to elicit information from collaborative partners regarding risk assessments. This was expressed by a manager when reflecting on his own and his local resource person's roles as models for their colleagues:

> *'I haven't noticed staff requiring more [information from specialist mental health services]. I don't think so. But, maybe we in some way are able to ask questions that some staff might overhear and might find relevant to ask or to reflect upon themselves'* (Male Manager 3).

This particular statement was somewhat ambivalent, as it arose from an experienced status as a lone 'carrier' of competence in prevention and management. This suggests the incorporation of competence and development of practice in workplaces can require considerable effort and commitment by several stakeholders, beyond just attending courses or telling, or even showing, colleagues how to act.

Discussion

This article aims to explore the perceptions of managers in community mental health and substance abuse services regarding the impact of staff undertaking competence development activities and applying supportive tools for the prevention and management of staff-directed aggression. The findings underline the importance of awareness and understanding in such situations, as well as addressing the distribution of power and level of cooperation in mental health and substance abuse work. Even though the activities and tools were not developed according to principles of a particular framework for person-centred practice (McCormack and McCance, 2017) or a model for person-centred practice development (Manley and McCormack, 2004), it is argued that the findings may have relevance for both person-centred practice development and recovery-oriented practices.

Aware and enabled practitioners

According to the participants, education gave learners insight into many factors relevant to staff-directed aggression, notably the idea that aggression is a multifaceted, deeply embedded, personal, contextual and relational phenomenon. Emphasis was also placed on an appreciation of the role of staff during aggressive encounters, on the ability to consider alternative actions depending on the situation, and on gaining a better understanding of the input of the workplace and of collaborative partners. According to the participants, increased understanding and awareness also resulted in heightened levels of service-user involvement and increased collaboration. These have been found to be prerequisites of recovery-oriented practice in encounters with aggression in mental health settings (Lim et al., 2019) and are key to person-centred frameworks (McCance and McCormack, 2017).

The participants in the courses and the various educational activities seemed from the managers' accounts to have experienced an opening of relevant 'dimensions of variation' of practice in encounters

with staff-directed aggression. According to Marton and Booth (1997), this is a basic premise for learning and promotes broader, more empowering notions of the phenomenon. Development of competence is comparable to staff acquiring more powerful ways of seeing practice and is contingent on learners being provided with opportunities to learn about the different aspects of a phenomenon and with opportunities to practice discerning these aspects through their own work. In this study, this seemed to have been achieved by a systematic and purposeful offering of general and in-depth education, as well as through the actual learning content of each course and seminar being tailored to portray phenomenal variation – that is, showing practice as consisting of various critically important aspects. Managers noted that greater proficiency in low conflict practice meant staff had not only become more effective and flexible in safe service provision but could also grasp a more 'holistic' notion of practice and the helping relationship (McCance and McCormack, 2017).

Critical deliberation of own practice

Being subjected to violent aggression from service users is frequently a disquieting experience for the victim. Such incidents are often perceived as 'part of the job' (Rippon, 2000, p 457) although, according to the participants in this study, they do not happen regularly. Nevertheless, threatening behaviour from service users could be interpreted as a breach in mental health care staff's expectations of reciprocity in relating to each other as fellow human beings in the helping relationship (Sandhu et al., 2015). This might well count as a disorienting dilemma (Mezirow, 1990) for the service provider. As suggested by Mezirow (1991), such experiences are incompatible with the way practitioners perceive the meaning structures of their work and, as such, represent an opportunity to revise earlier established assumptions regarding practice. Direct and indirect experiences with staff-directed aggression in the workplace provided avenues for staff to seek new perspectives and answers related to practice during participation in the competence-building activities.

In this study, participation in education and the application of tools supporting further competence and practice development seemed to precipitate critical deliberation regarding the practice of staff and managers, again fostering momentum for the revision of previous workplace practices and routines. Critical reflection such as this involves the learner engaging in '*challenging the validity of presuppositions in prior learning*' (Mezirow, 1991, p 12, italics in the original), questioning and examining the very bedrock of one's practice and supporting a deeper, more involved (and eventually, transformative) learning effort (Howie and Bagnall, 2015). With regard to person-centredness, such critical reflection is seen as a requisite tool for emancipatory practice development (Smith, 2016).

Roberts (2015) suggests that courage is a requirement for critical reflection in mental health practice. From this study's findings, this seemed to have importance for practice development at the participants' workplaces. Practice development at the various workplaces following the education initiatives was largely contingent on the willingness and courage of both the individual and the collective to address the issue at hand and to take deliberate action.

A shared understanding of practice in aggressive encounters

In gaining or regaining awareness of staff-directed aggression, a more deliberate effort seemed to have been achieved in teams. This seems to have paved way for a common reflective dialogue in the workplace, closer attention among staff to service-user communication and behaviours, and a commitment to a continued focus on developing practice able to prevent and manage staff-directed aggression. According to Marton (2015), learning, on a collective level, is achieved through changes in ways of seeing that come to be shared by a group, community or – as in this case – teams. Such changes in perspective could arguably be common outcomes of participation in education and training but can be further reinforced by continued reflection and elaboration of the phenomenon in the workplace. As managers in this study reported, participating teams seemed to have gained the ability to collectively explore alternate ways to handle situations and develop their own understanding of practice in aggressive encounters with service users. It could be argued that this development was initiated both

by an individual and a collective expansion of the conception of prevention and management practice within the teams. The development of practice and competence was achieved by attuning individual conceptual abilities to a more unified and shared understanding in the workplace.

Building on insights from both phenomenography and social constructionism, Sandberg and Targama (2007) put forth the notion that competence, on a collective level, consists of a 'shared understanding' and can be 'characterised by an interaction between several individuals in performing a specific task' (p 89). They continue by claiming that 'shared understanding is developed and maintained through the circular dialectics between the subjective and objective construction of reality and forms the basis for the competence developed and used within the organisation' (p 93). Competence development thus requires an interplay between an individual's understanding of work and the commitments and obligations towards the organisation that are shared by its members. In this study, these changes proved significant enough for some services to inspire them to develop own competence and practice development activities, in addition to restructuring expectations regarding the allocation of duties between managers and staff.

Enhanced understanding, as well as a more encompassing awareness, expressed by the participants in this study seem to support the development of more adept ways to handle aggressive encounters with service users, individually and collectively. Schat and Kelloway (2000) suggest that perceived control (in the form of staff perceptions of their ability to understand, influence and predict situations) during encounters with workplace aggression has a substantial impact on counteracting its potentially negative effects on staff. Furthermore, they propose education and training as a way to enhance staff perceptions of control in such instances (Schat and Kelloway, 2000). Thus, this article argues that the services taking on the education and supportive tools might have fostered more persistent and coherent service provision in the face of staff-directed aggression by contributing to an increasingly resilient and confident workforce.

Transformations of power and the advancement of collaborative partnerships

Participating in education not only increased the understanding and availability of risk assessment and management tools but also contributed to increased recognition from specialist mental health services of the relational and contextual knowledge held by community mental health services. The learning experienced in the community mental health teams did not entail an abandonment of their former knowledge base and perspectives, but enabled them to argue their position more convincingly and with greater credibility, due to a more encompassing understanding and bolstered self-confidence. Education also seemed to endorse managers' valuing of and trust in collaboration with service users in devising strategies to prevent and manage staff-directed aggression. From a transformational learning perspective (Mezirow, 1991), this study argues that what staff and managers might have experienced was a reassessment of their previous (distorted) assumptions about what constitutes a valid source of knowledge or information for practice. This reassessment contributed to new respect for contextual and relational competence, which was expanded by aspects of the technical-rational domain of psychiatric risk assessment and management. Schön (1991, p 42) differentiates between 'high-ground' practice, which comprises technically and theoretically manageable problems, and practice in the 'swampy lowlands', which, in contrast, comprises messy and confusing problems that defy technical solution. Although he accords the latter type with the greatest human importance, he concedes that 'high-ground' practice has superiority in the field of practice. The services portrayed in this study seemed to endorse a relational and contextually accommodating practice, lenient towards uncertainty and ambiguity in providing personalised care for service users – a type of practice often previously disregarded by their collaborating partners in the specialised mental health services.

As has been seen, McCormack et al. (2007) propose that the key methodological principles of practice development are collaboration, inclusion and participation. The scope of the competence development activities and tools has been established, along with how these have helped facilitate dialogue and

shared reflection at the workplace, to be in accordance with these principles. What further corroborates this is these findings' suggestion that outcomes of participation in the competence development activities included staff becoming more accommodating and attentive of service-user perspectives on workplace practices, more attuned to equal collaboration with other parts of the mental health system, and increasingly mindful of their own and colleagues' understandings of practice. This suggests that a more elaborate and communal foundation for practice development has been accomplished through partaking in the competence development activities.

Within the field of mental health, evidence-based, statistical and summative means for establishing a person's likelihood to behave violently, based on established knowledge of violent aggressors as a group, has enjoyed a longstanding hegemonic status (Godin, 2004). Baines (2004) claims that formal and technical competence of this type is often held in higher regard than the more relational, emotional and, often, tacit forms of competence that are also part of human care work. Godin (2004) shows that community mental health practices often reflect the latter form of competence, even though Carlsson et al. (2000) also demonstrate similar tacit forms of caring knowledge among 'floor-level' practitioners in inpatient psychiatric services. This suggests that proximity to service users has a significant impact on the way practitioners develop competence and their understanding of mental health and substance abuse care. This study's findings show that this idea manifests itself in managers' continued valuation of the contextual and situational knowledge of their staff and in their desire to promote its value to specialist services, bolstered by participation in education. Grant et al. (2015) criticise contemporary evidence-based healthcare for promoting cultural practices that privilege rational, quantitative, post-positivist assumptions of knowledge at the cost of knowledge based on service-user feedback and preference. Instead, Grant (2015) argues for mental health practice informed by a 'human paradigm' that is more attuned to the narratives and lived experiences of the people mental health care practitioners are engaged in helping. Brookfield (2012) underscores the critical structural and political potential of transformation theory, and the findings of this study seem to resonate with the view of community staff's competence versus that of the specialist psychiatric services. Interestingly, the status of the competence and forms of knowledge in the community services seems to have been heightened by adopting – yet never uncritically consenting to – the vocabulary of technical-rational conceptions of psychiatric risk assessment.

Limitations

Although we sought trustworthiness in this study in the ways described above, we concede that the findings might partially portray the contribution of education to the prevention and management of staff-directed aggression in the workplace. A different sample could conceivably have delivered different, yet equally meaningful representations of other participants' perceptions. This study is about specific educational activities, located within a specific context, in Norwegian community mental health and substance abuse services. We are unable to draw generalisations with other populations or with other educational settings. We do however argue that our findings contribute to the 'collective mind' (Marton and Booth, 1997) regarding research on education and training in the prevention and management of staff-directed aggression and violence in non-institutional mental health and substance abuse settings.

In the study, participants focused mainly on positive outcomes even though, as we have shown, some mentioned limitations and concerns regarding the potential for change. The predominantly positive focus among the participants could be a limitation in terms of any potential negative outcomes of the competence development activities. Even though the interviewer might have influenced participants because they knew him in advance through his long-time involvement in the competence development activities, we strived to mitigate this by endorsing as open style of interviewing as possible. Negative expressions were consistently followed up as an additional strategy for accommodating dissent.

Conclusions and implications for practice

In this study, we found the promotion of recovery-oriented and disempowerment-sensitive prevention and management of staff-directed aggression not only fostered increased awareness and understanding in the services, but also helped empower staff in encounters with such aggression. It also contributed to a levelling of existing power differentials between parties involved in service provision, thus making possible more authentic, recovery-oriented and ultimately, person-centred collaboration.

Education for person-centred practice is entangled in a complex array of contextual and systemic considerations and concerns, comprising the often diverging perspectives, values and conations of service users, colleagues and collaborating partners, as well as the practitioners' own. We argue that education in prevention and management of staff-directed aggression must take this complexity into account and promote more symmetrical, comprehensive and supportive versions of practice for the practitioners in the field, in line with person-centred and recovery-oriented principles.

We suggest that practice development could be effectively promoted if preceded by some sort of disorienting dilemma, including a sense of unease with practice, an intention to revise practice and a commitment to deliberate maintenance of staff competence using reflective discussions and emphasis on continued awareness. Maagerø-Bangstad et al. (2019) suggest that education and training in non-formal education settings should take into account the perspective of the participants' lifeworlds and incorporate their experiences with staff-directed aggression to make education both intelligible and relevant. Failing to target participants' disorienting dilemmas in a meaningful way, or making education over-technical and difficult to relate to their experiences, might hinder the efficient unpacking of critical aspects of the phenomenon. This result would predictably impede the ability to develop more powerful ways of seeing among participants and, as such, limit the potential contribution of education and training to the workplace.

With regard to the principles of recovery-oriented and person-centred research, we suggest that the perspectives and experiences of service users with competence and practice development endeavours should be included in descriptions of outcomes of education and training. A possible avenue of research into managers as facilitators of practice would be to inquire into how different management styles impact on staff practices in the prevention and management of staff-directed aggression in mental health and substance abuse services.

Finally, in line with Beresford (2016), we would like to point to the need to include service users in the development of social policies and practices, not least when deciding how aggression from service users is handled within mental health and substance abuse services.

References

Arnetz, J. and Arnetz, B. (2001) Violence toward health care staff and possible effects on the quality of patient care. *Social Science & Medicine*. Vol. 52. No. 3. pp 417-427. https://doi.org/10.1016/s0277-9536(00)00146-5.

Baines, D. (2004) Losing the 'eyes in the back of our heads': social service skills, lean caring, and violence. *Journal of Sociology and Social Welfare*. Vol. 31. No. 3. pp 33-50.

Barling, J., Rogers, A. and Kelloway, E. (2001) Behind closed doors: in-home workers' experience of sexual harassment and workplace violence. *Journal of Occupational Health Psychology*. Vol. 6. No. 3. pp 255-269. https://doi.org/10.1037/1076-8998.6.3.255.

Beech, B. and Leather, P. (2006) Workplace violence in the health care sector: a review of staff training and integration of training evaluation models. *Aggression and Violent Behavior*. Vol. 11. No. 1. pp 27-43. https://doi.org/10.1016/j.avb.2005.05.004.

Beresford, P. (2016) *All Our Welfare: Towards Participatory Social Policy*. Bristol: Policy Press. https://doi.org/10.2307/j.ctt1t88xgj.

Bjørkly, S. (2006) Psychological theories of aggression: principles and application to practice. Chp 2 *in* Richter, D. and Wittington, R. (Eds.) (2006) *Violence in Mental Health Settings: Causes, Consequences, Management*. New York: Springer. pp 27-46. https://doi.org/10.1007/978-0-387-33965-8_2.

Borg, M. (2009) Intet om oss uten oss [Nothing about us, without us]. Chp 2 *in* Borg, M. and Kristiansen, K. (Eds.) (2009) *Medforskning – å Forske Sammen for Kunnskap om Psykisk Helse [Co-operative Inquiry – to Inquire in Collaboration for Knowledge on Mental Health]*. Oslo: Universitetsforlaget. pp 29-41.

Brookfield, S. (2012) Critical theory and transformative learning. Chp 8 *in* Taylor, E. and Cranton, P. (Eds.) (2012) *Handbook of Transformative Learning: Theory, Research and Practice*. San Francisco: Jossey-Bass. pp 131-146.

Büssing, A. and Höge, T. (2004) Aggression and violence towards home care workers. *Journal of Occupational Health Psychology*. Vol. 9. No. 3. pp 206-219. https://doi.org/10.1037/1076-8998.9.3.206.

Campbell, C. (2017) Incident reporting by health-care workers in noninstitutional care settings. *Trauma, Violence and Abuse*. Vol. 18. No. 4. pp 445-456. https://doi.org/10.1177/1524838015627148.

Carlsson, G., Dahlberg, K. and Drew, N. (2000) Encountering violence and aggression in mental health nursing: a phenomenological study of tacit caring knowledge. *Issues in Mental Health Nursing*. Vol. 21. No. 5. pp 533-545. https://doi.org/10.1080/01612840050044276.

Daniels, J. and Anadria, D. (2019) Experiencing and witnessing patient violence – an occupational risk for outpatient therapists? *Psychiatric Quarterly*. Vol. 90. No. 3. pp 533-541. https://doi.org/10.1007/s11126-019-09648-x.

Davidson, L. and White, W. (2007) The concept of recovery as an organizing principle for integrating mental health and addiction services. *The Journal of Behavioral Health Services and Research*. Vol. 34. No. 2. pp 109-120. https://doi.org/10.1007/s11414-007-9053-7.

Dewing, J. (2008) Implications for nursing managers from a systematic review of practice development. *Journal of Nursing Management*. Vol. 16. No. 2. pp 134-140. https://doi.org/10.1111/j.1365-2834.2008.00844.x.

Elo, S. and Kyngäs, H. (2008) The qualitative content analysis process. *Journal of Advanced Nursing*. Vol. 62. No. 1. pp 107-115. https://doi.org/10.1111/j.1365-2648.2007.04569.X.

Fry, A., O'Riordan, D., Turner, M. and Mills, K. (2002) Survey of aggressive incidents experienced by community mental health staff. *International Journal of Mental Health Nursing*. Vol. 11. No. 2. pp 112-120. https://doi.org/10.1046/j.1440-0979.2002.00234.x.

Fujimoto, H., Hirota, M., Kodama, T., Greiner, C. and Hashimoto, T. (2017) Violence exposure and resulting psychological effects suffered by psychiatric visiting nurses in Japan. *Journal of Psychiatric and Mental Health Nursing*. Vol. 24. No. 8. pp 638-647. https://doi.org/10.1111/jpm.12412.

Galinsky, T., Feng, H., Streit, J., Brightwell, W., Pierson, K., Parsons, K. and Proctor, C. (2010) Risk factors associated with patient assaults of home healthcare workers. *Rehabilitation Nursing*. Vol. 35. No. 5. pp 206-215. https://doi.org/10.1002/j.2048-7940.2010.tb00049.x.

Gates, D., Gillespie, G. and Succop, P. (2011) Violence against nurses and its impact on stress and productivity. *Nursing Economics*. Vol. 29. No. 2. pp 59-66.

Gergen, K. (2011) *Relational Being: Beyond Self and Community*. New York: Oxford University Press. https://doi.org/10.1093/acprof:osobl/9780199846269.001.0001.

Godin, P. (2004) 'You don't tick boxes on a form': a study of how community mental health nurses assess and manage risk. *Health, Risk and Society*. Vol. 6. No. 4. pp 348-360. https://doi.org/10.1080/13698570412331323234.

Graneheim, U., Lindgren, B. and Lundman, B. (2017) Methodological challenges in qualitative content analysis: a discussion paper. *Nurse Education Today*. Vol. 56. pp 29-34. https://doi.org/10.1016/j.nedt.2017.06.002.

Graneheim, U. and Lundman, B. (2004) Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*. Vol. 24. No. 2. pp 105-112. https://doi.org/10.1016/j.nedt.2003.10.001.

Grant, A. (2015) Demedicalising misery: welcoming the human paradigm in mental health education. *Nurse Education Today*. Vol. 35. No. 9. pp e50-e53. https://doi.org/10.1016/j.nedt.2015.05.022.

Grant, A., Zeeman, L. and Aranda, K. (2015) Queering the relationship between evidence-based mental health and psychiatric diagnosis: some implications for international mental health nurse curricular development. *Nurse Education Today*. Vol. 35. No. 10. pp e18-e20. https://doi.org/10.1016/j.nedt.2015.07.033.

Guba, E. and Lincoln, Y. (1989) *Fourth Generation Evaluation*. Thousand Oaks, US: Sage.

Howie, P. and Bagnall, R. (2015) A critical comparison of transformation and deep approach theories to learning. *International Journal of Lifelong Education*. Vol. 34. No. 3. pp 348-365. https://doi.org/10.1080/02601370.2014.1000409.

Hummelvoll, K., Karlsson, B. and Borg, M. (2015) Recovery and person-centredness in mental health services: roots of the concepts and implications for practice. *International Practice Development Journal*. Vol. 5. Suppl. Article 7. pp 1-7. https://doi.org/10.19043/ipdj.5sp.009.

Jackson, D., Clare, J. and Mannix, J. (2002) Who would want to be a nurse? Violence in the workplace – a factor in recruitment and retention. *Journal of Nursing Management*. Vol. 10. No. 1. pp 13-20. https://doi.org/10.1046/j.0966-0429.2001.00262.x.

Kaplan, S. and Wheeler, E. (1983) Survival skills for working with potentially violent clients. *Families in Society: The Journal of Contemporary Social Services*. Vol. 64. No. 6. pp 339-346. https://doi.org/10.1177/104438948306400603.

Lanctôt, N. and Guay, S. (2014) The aftermath of workplace violence among healthcare workers: a systematic literature review of the consequences. *Aggression and Violent Behavior*. Vol. 19. No. 5. pp 492-501. https://doi.org/10.1016/j.avb.2014.07.010.

Lillevik, O.G. and Øien, L. (2012) Miljøterapeutisk praksis i forebygging av vold [Milieu-therapeutic practice in prevention of violence]. *Tidsskrift for Psykisk Helsearbeid [Journal of Mental Health Work]*. Vol. 9. No. 3. pp 207-217.

Lim, E., Wynaden, D. and Heslop, K. (2019) Changing practice using recovery-focused care in acute mental health settings to reduce aggression: a qualitative study. *International Journal of Mental Health Nursing*. Vol. 28. No. 1. pp 237-246. https://doi.org/10.1111/inm.12524.

Maagerø-Bangstad, E.R., Sælør, K.T. and Ness, O. (2019) Encountering staff-directed aggression in mental health and substance abuse services: exploring conceptions of practice following education. *International Journal of Mental Health Systems*. Vol. 13. Article 20. pp 1-13. https://doi.org/10.1186/s13033-019-0277-8.

Manley, K. and McCormack, B. (2004) Practice development: purpose, methodology, facilitation and evaluation. Chp 3 *in* McCormack, B., Manley, K. and Garbett, R. (Eds.) (2004) *Practice Development in Nursing*. Oxford: Blackwell. pp 33-50.

Manley, K., O'Keefe, H., Jackson, C., Pearce, J. and Smith, S. (2014) A shared purpose framework to deliver person-centred, safe and effective care: organisational transformation using practice development methodology. *International Practice Development Journal*. Vol. 4. No. 1. Article 2. pp 1-31. Retrieved from: fons.org/library/journal/volume4-issue1/article2. (Last accessed 15th September 2020).

Manley, K., Titchen, A. and McCormack, B. (2013) What is practice development and what are the starting points? Chp 3 *in* McCormack, B., Manley, K. and Titchen, A. (Eds.) (2013) *Practice Development in Nursing and Healthcare* (2nd edition). Chichester, UK: John Wiley and Sons. pp 45-65.

Marshall, C. and Rossman, G. (1999) Designing Qualitative Research. (3rd edition). Thousand Oaks, US: Sage.

Marton, F. (2015) *Necessary Conditions of Learning*. New York: Routledge. https://doi.org/10.4324/9781315816876.

Marton, F. and Booth, S. (1997) *Learning and Awareness*. New York: Routledge. https://doi.org/10.4324/9780203053690.

McNamee, S. (2010) Research as social construction: transformative inquiry. *Health and Social Change*. Vol. 1. No. 1. pp 9-19.

McCance, T. and McCormack, B. (2017) The person-centred practice framework. Chp 3 *in* McCormack, B. and McCance, T. (Eds.) (2017) *Person-centred Practice in Nursing and Health Care: Theory and Practice* (2nd edition). Chichester, UK: John Wiley and Sons.

McCormack, B., Dewing, J. and McCance, T. (2011) Developing person-centred care: addressing conceptual challenges through practice development. *Online Journal of Issues in Nursing*. Vol. 16. No. 2. pp 1-12. https://doi.org/10.3912/OJIN.Vol16No02Man03.

McCormack, B., Manley, K. and Titchen, A. (2013) Preface in McCormack, B., Manley, K. and Titchen, A. (Eds.) (2013) *Practice Development in Nursing and Health Care.* (2nd edition). Chichester, UK: John Wiley and Sons. pp x-xii.

McCormack, B. and McCance, T. (2017) Underpinning principles of person-centred practice. Chp 2 *in* McCormack, B. and McCance, T. (Eds.) (2017) *Person-centred Practice in Nursing and Health Care: Theory and Practice.* (2nd edition). Chichester, UK: John Wiley and Sons.

McCormack, B., Wright, J., Dewar, B., Harvey, G. and Ballantine, K. (2007) A realist synthesis of evidence relating to practice development: recommendations. *Practice Development in Health Care*. Vol. 6. No. 1. pp 76-80. https://doi.org/10.1002/pdh.213.

Mezirow, J. (1990) How reflection triggers transformative learning. Chp 1 *in* Mezirow, J. and Associates (Eds.) (1990) *Fostering Critical Reflection in Adulthood. A Guide to Transformative and Emancipatory Learning*. San Francisco: Jossey-Bass. pp 1-20.

Mezirow, J. (1991) *Transformative Dimensions of Adult Learning*. San Francisco: Jossey-Bass.

Mishler, E. (1991) *Research Interviewing: Context and Narrative*. Cambridge, US: Harvard University Press.

Nolan, P., Dallender, J., Soares, J., Thomsen, S. and Arnetz, B. (1999) Violence in mental health care: the experiences of mental health nurses and psychiatrists. *Journal of Advanced Nursing*. Vol. 30. No. 4. pp 934-941. https://doi.org/10.1046/j.1365-2648.1999.01163.X.

Norwegian Health Directorate (2014) *Sammen om Mestring. Veileder i Lokalt Psykisk Helsearbeid og Rusarbeid for Voksne. Et Verktøy for Kommuner og Spesialisthelsetjenesten. IS-2076 [Together in Coping. Guidelines in Local Mental Health Work and Substance Abuse Care for Adults. A Tool for Municipalities and the Specialist Health Services]*. Oslo: Helsedirektoratet.

Norwegian Ministry of Labour and Social Affairs (2016) *Arbeidsmiljøloven. Forskrift §23A. Arbeid som kan Medføre fare for å Bli Utsatt for Vold og Trusler om Vold [The Working Environment Act. Regulation §23A. Work that can Involve Danger of Being Subject to Violence and Threats of Violence]*. Oslo: Arbeids-og sosialdepartementet.

Price, O. and Baker, J. (2012) Key components of de-escalation techniques: a thematic synthesis. *International Journal of Mental Health Nursing*. Vol. 21. No. 4. pp 310-319. https://doi.org/10.1111/j.1447-0349.2011.00793.x.

Rippon, T. (2000) Aggression and violence in health care professions. *Journal of Advanced Nursing*. Vol. 31. No. 2. pp 452-460. https://doi.org/10.1046/j.1365-2648.2000.01284.x.

Roberts, M. (2015) *Critical Thinking and Reflection for Mental Health Nursing Students*. Thousand Oaks, US: Sage. https://doi.org/10.4135/9781526474087.

Roche, M., Diers, D., Duffield, C. and Catling-Paull, C. (2009) Violence toward nurses, the work environment, and patient outcomes. *Journal of Nursing Scholarship*. Vol. 42. No. 1. pp 13-22. https://doi.org/10.1111/j.1547-5069.2009.01321.x.

Sandberg, J. and Targama, A. (2007) *Managing Understanding in Organizations*. London: Sage. https://doi.org/10.4135/9781446212530.

Sandelowski, M. (1995) Sample size in qualitative research. *Research in Nursing & Health*. Vol. 18. No. 2. pp 179-183. https://doi.org/10.1002/nur.4770180211.

Sandelowski, M. (2011) When a cigar is not just a cigar: alternative takes on data and data analysis. *Research in Nursing and Health*. Vol. 34. No. 4. pp 342-352. https://doi.org/10.1002/nur.20437.

Sandhu, S., Arcidiacono, E., Aguglia, E. and Priebe, S. (2015) Reciprocity in therapeutic relationships: a conceptual review. *International Journal of Mental Health Nursing*. Vol. 24. No 6. pp 460-470. https://doi.org/10.1111/inm.12160.

Schat, A. and Kelloway, E. (2000) The effects of perceived control on the outcomes of workplace aggression and violence. *Journal of Occupational Health Psychology*. Vol. 5. No. 3. pp 386-402. https://doi.org/10.1037/1076-8998.5.3.386.

Schön, D. (1991) *The Reflective Practitioner*. Farnham, UK: Ashgate.

Smith, K. (2016) Reflection and person-centredness in practice development. *International Practice Development Journal*. Vol. 6. No. 1. pp 1-6. https://doi.org/10.19043/ipdj.61.012.

Svalund, J. (2009) *Vold og Trusler om Vold i Offentlig Sektor [Violence and Threats of Violence in the Public Sector]*. Report No. 30. Oslo: Fafo.

Taylor, K. and Elias, D. (2012) Transformative learning: a developmental perspective. Chp 9 *in* Taylor, E.W. and Cranton, P. (Eds.) (2012) *Handbook of Transformative Learning*. *Theory, Research and Practice*. San Francisco: Jossey-Bass. pp 147-61.

Tonso, M., Prematunga, R., Norris, S., Williams, L., Sands, N. and Elsom, S. (2017) Workplace violence in mental health: a Victorian mental health workforce survey. *International Journal of Mental Health Nursing*. Vol. 25. No. 5. pp 444-451. https://doi.org/10.1111/inm.12232.

Acknowledgements

The authors wish to thank Ellen Kobro and Grete Vedlog for their contribution and assistance in coordinating the research project of which this study is a part. We also wish to thank the participants in the study and the reference-group members for their invaluable contribution in developing the data and collaboration in providing insight into the findings.

Erlend R. Maagerø-Bangstad (MEd), PhD Candidate, Dept. of Health and Social and Welfare Studies, Faculty of Health and Social Sciences, University of South-Eastern Norway, Drammen, Norway.
Knut Tore Sælør (PhD, MSH, RN), Associate Professor, Dept. of Health and Social and Welfare Studies, Faculty of Health and Social Sciences, University of South-Eastern Norway, Drammen, Norway.
Ottar Ness (PhD, Cand. polit.), Professor, Dept. of Education and Lifelong Learning, Faculty of Social and Educational Sciences, Norwegian University of Science and Technology, Trondheim, Norway.