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Promoting Personal Growth and Balancing Risk of Violence in Community-Based Mental Health Care: A Professional Perspective

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Abstract

The aim of this study was to investigate how municipal mental health care workers develop professional strategies, taking the risk of service user violence into account. Factors that professionals regard as hindering or furthering personal growth among the service users are particularly focused. Data were collected through focus group interviews. The analysis resulted in two main categories: working where the clients live their lives and focus on growth and development. Offering opportunities for restraint and growth for people with serious mental health disorders and risk of violence represents the basic factors for improving desirable processes. The health-promoting focus was managed through a resource-oriented and growth-oriented focus, where available services and workers' qualities and attitudes appear to be crucial.

Keywords

mental health care, violent behavior, community-based services, professional care, severe mental illness, risk management, social sciences, nursing, risk communication, psychology, humanism, approaches

Introduction

People with a severe mental illness, such as deep depression, bipolar illness, and schizophrenia[1] (Olsen et al., 2010), combined with problems connected to violence and violent behavior represent a minor group, which has, however, special needs for adopted health and care services (Helsedirektoratet, 2008).

This article focuses on the role of mental health care in regard to this group. Acts of violence among people with serious mental illness can be regarded as a failed and costly solution to inner, personal challenges rather than problematic actions that must be eliminated, even though the violent behavior in itself remains a real problem. Stable conditions of housing and continuous and predictable services seem to be, for the individual, central elements in preventing conflicts and in helping to further the user's development toward mastering his or her life situation (Helsedirektoratet, 2014). It appears that the mental ill-health should be treated in parallel with the problems of violent behavior—and drug addiction—through use of a holistic enquiry, setting preconditions for relevant support in the local community (Helsedirektoratet, 2014).

To help people with serious mental illness and a known risk of violent behavior to master their daily life, often after discharge from institutional treatment, is a complex and demanding task for both mental health care and the entire local community. As care and treatment should preferably be offered at the lowest possible level of service—normally within the local community—this could involve professional development and reflection on what the best practice in municipal settings could be.

This article reports on a study investigating how municipal mental health care workers use professional strategies, taking the risk of client violence into account. We focus in particular on factors that professionals regard as hindering or furthering personal growth among the clients.

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Research on Factors Connected With Violent Behavior and Mental Health Care in the Context of Risk of Violence

Previous research has shed some light on factors that are important for developing criminality, violence, and risk of violence. Toumborou et al. (2007) emphasized the importance of socioeconomic factors and living conditions, whereas de Vries Robbé, de Vogel, and Stam (2012) focused on how personality-related factors and conditions, such as mastery, empathy, work, and personal aims can protect the individual. With regard to factors connected to professional helpers, Lillevik and Øien (2010) show that crucial factors might be recognition of the clients' perspective and his or her own thought-through perspective, when meeting the client.

Acts of violence from people with mental health problems often receive a lot of attention from the media, and Norvoll (2013) points out that there could well be a difference between factual and public understanding of the risk of violence from this group. Risk of violence, in this context, is a multifaceted phenomenon, depending, among other things, on the person's own resources to live an active social life, with positive and constructive relationships with other people, and mental health care and support, making it easier for the person to find his or her place in the local context (Douglas, Hart, Webster, & Belfrage, 2013). Underlying this, subjective reasons behind previous acts of violence, and connected contextual factors, must be included in the assessment (Yang & Mulvey, 2012).

Knowledge of how to handle violent and aggressive behavior has predominantly been developed in special care units/institutions (Bøe & Thomassen, 2007); however, there is a need for further development of such knowledge when the clients in this category are increasingly being discharged from institutions to live their lives in the local community (Olsen et al., 2010). Regardless of whether the clients get help and support from special units, community-based services are offered to this group, even to those who do not want help (Schjødt, Hoel, & Onsøien, 2012).

Song, Hipolito, and Whitley (2012) have investigated factors contributing to processes of recovery in a local community context, for people with severe mental health problems. Their results show that recovery-oriented services can offer a refuge from poverty and homelessness, as well as social support for this group. Antonovsky (2012) expands the concept of health by focusing on the human need for experiencing a sense of coherence (SOC), where mastery, well-being, and health seem to be closely tied up to the concepts of understandability, mastery, and meaningfulness.

Stickley and Felton (2006) focus on the ethical challenge embedded in the ambition to, simultaneously, consider societal protection and the risk of violence and, at the same time, take into account the autonomy and freedom of people with severe mental health problems in mental health care. Professionals working with this group, they argue, should be focusing attention on this ethical challenge. To focus entirely on the risk aspect might cause acts of violence, whereas, at the same time, attention on growth, development, and improvement for those who receive help will get lost. Risk, in this context, means the likelihood that a potentially harmful act will take place in relation to the individual or to others (Stickley & Felton, 2006).

Krug, Mercy, Dahlberg, and Zwi (2002) showed how preventive efforts really work and should be taken into account, at international, national, and local levels, based on studies from 70 countries in total. Other researchers, such as Dorn, Volavka, and Johnson (2012), point out that the research on the potentially preventive effects of follow-up by a municipality-based mental health-care team to reduce the risk of violent behavior is incomplete. A study by Newbill et al. (2010) pointed in the same direction—health professionals seemed to ascribe episodes of violent behavior to clients' psychotic symptoms. This is in contrast to the clients themselves, who emphasized that it was the health personnel's interventions that led to acts of violence. Health professionals and clients in this study placed the responsibility on each other. So far, the research on risk of violence and actions of violence, committed by people with severe mental illness who are receiving help and support from health professionals in the local community, seems to be incomplete and to some extent contradictory.

Ethical Approval

Ethical research demands—voluntary nature, informed consent, confidentiality, and safe storage of the data—have been taken into account. The Norwegian Social Science Data Office (NSD) was contacted in advance and decided that this study did not need to be processed.

Method

Informants, Data Collection, and Data Analysis

The study was carried out in three Norwegian municipalities, differing in size (650,000, 13,600, and ca. 6,000 inhabitants, respectively). Educated professionals in municipal health and social care, with a minimum 2-year work experience and working in this field for at least 50% position, were invited to take part in focus group interviews after information about the study from the researchers was forwarded by their managers (Hummelvoll & Barbosa da Silva, 1996). A focus group consists of people sharing experiences around a given theme (Malterud, 2012), in which the group dynamic processes contribute to unfolding and deepening of this theme. The aim of using this method is to get deep and nuanced verbal descriptions of the informants' experience of a defined phenomenon (Kvale & Brinkmann, 2009). The informants had varied educational background and experience from the field of mental health care, however, most of them had

Table 1. Main Categories and Subcategories Describing Strategies in Community Mental Health Care for People Struggling With Serious Mental Health Disorders Who Show a Potential Risk of Violence.

Main category	Subcategory
To work where the clients live their lives	Handling the risk of violence
	A supportive collegial culture is needed
	Problematic cooperation with other services
Focus on growth and development	Growth-furthering factors
	Mobilizing resources

worked with in-bed patients who after dismissal from hospital get follow-up service from the municipalities. Some of the informants had deepened studies in mental health care. Rural as well as more urban areas were represented among the informants.

All in all, 20 informants (12 women and 8 men), almost equally distributed among three groups and one group with employees from each municipality, took part in the interviews, all of which were held in municipal locations. A semi-structured interview guide, containing four open questions on hindering and furthering factors in everyday work with the client group in the study, not only guided the interviews but also gave space for flexibility. The questions functioned as starting points for narratives and discussion among the informants and gave the interviewer room for follow-up questions. The questions were,

- Which experiences do you have from working with individuals with severe mental illness and a known-from-before risk of violent behavior?
- Which are your everyday experiences from working in the municipal health services, taken the mission to further the clients' mastery of their life situation into account?
- Which factors seem to further or limit the clients' ability to master their situation?
- What about the clients' hope for a better future? Is it, in meetings with the clients, taken into account by you as a professional?

Aside from the researcher (first author) who led the interviews, a co-moderator took part to follow the interview, sum up, and contribute to the discussion. The interviews were transcribed verbatim, and thereafter again, they were validated against the recorded interview. Data were analyzed qualitatively, following Graneheim and Lundman (2004): (a) After repeated reading, meaningful units were identified and coded (verbally labeled); (b) Meaningful units that appeared to have an inner connection were developed into categories and subcategories; (c) The categories and subcategories were ordered and related to each other; (d) Finally, the analysis resulted in two overarching categories: "To work where the clients live their lives" and "Focus on growth and development."

Results

The analysis resulted in two main categories and five subcategories. The relationship between categories and subcategories is shown in Table 1.

Each category and subcategory is described in depth below and illustrated using quotations from the focus group interviews.

To Work Where the Clients Live Their Lives

Handling the risk of violence. A "practice of security" was developed among the professionals, as part of a holistic thinking in relation to the clients. This meant that the security aspects were continually discussed and verbally brought to the fore among colleagues. Informants reported that there should also be good routines, allowing room to take action, that is, an assessment of the risk of violence made by an expert, before discharging from hospital to municipality housing. One informant said,

> I stick to the crisis plan that is decided and follow up on symptoms and signals, and act as is said in the crisis plan

Good and stable relationships with the staff, and enough time for clients to feel safe in their contacts with the services, decrease the risk of violent actions. One informant said,

> Developing good relations is alpha and omega for us, not least in relation to the risk of violence, to get a good relationship to them.

It is a matter of creativity to develop good relationships and alliances with the clients. Participants reported that when meeting them, professionals should be humble and honest and not have hidden agendas. Staff being clear in regard to the clients can make room for common actions and safety which can be transferred to clients, guided by a nonconfrontational style. Informants underlined the importance of being conscious about arrangements for increased security:

> I think that being aware of security aspects is one thing, but another is the distinct communication with the individual, not having a hidden agenda, but being concrete and not diffuse when communicating, as this might be understood as less threatening.

In this sense, the work aims to find a balance between caring and allowing freedom, although the complexity of the clients' problems will make it hard to foresee what will

happen next. This balance might imply a dilemma for the professional, with the risk of overstating the positive aspects of clients' situations, thereby not taking into account what can be really dangerous.

Participants reported that stable and flexible services and equal treatment from staff, including other areas of the caring services, will contribute to lowering the risk of violence and violent behavior. Many of the clients have experienced betrayal and broken relationships, making it hard for them to retain hope for a better future. Therefore, follow-up services, tailored to the individual as far as possible, are important.

A challenge for the staff is to understand clients' deterioration and acting out and to have the time needed to access methods of reaching the clients that will work in practice. The clients can, as an example, keep staff out of a situation in which they are in the greatest need of help; this leads to staff frustration and make it necessary for the staff to develop briefing routines:

> I don't think anyone will ever get used to behaviour of acting out, or being spat at, so the close follow-up that we have of each other, irrespective of position, is worth gold . . . .

A supportive collegial culture is needed. Working in an environment involving risk of violence and threats requires the establishment of an inclusive and supportive culture. It is important that staff can talk with each other about things that are experienced as hard, that it is easy to ask for help, and that there are options for debriefing when bad things happen. If not, the informants said, there could be a tendency for the opposite to develop—a kind of "macho-culture":

> It is really important that we take our feelings seriously, that we allow ourselves to be scared and to tell each other we are scared, or there might otherwise quickly develop a culture where it is fine to be tough, not to be scared, not to speak about it because this can be connected with a feeling of shame.

A safe working situation is a prerequisite for doing a good job. Supporting people with serious mental illness and violent behavior—in their own housing in the local community—is a relatively new task for municipalities, a task that raises new challenges for professionals. In addition to organizational arrangements, such as the opportunity to bring a colleague along when visiting some of the clients or debriefing after bad experiences, it is important to feel safe and be prepared to handle clients' unpredictability. It is also important not to transfer feelings of insecurity to the clients:

> . . . we shall not feel insecure when at work, because, if we are insecure, our "boys" will be insecure, they will notice this immediately . . .

Problematic cooperation with other services. Working in municipal mental health care involves meeting the clients in person and simultaneously cooperating further with other services, such as specialist mental health care social insurance authorities and general practitioners (GPs).

It is important to prevent fragmentation of the services because trying to relate to too many professionals, and the experience of lack of coherence among services, can lead to deterioration in clients' mental health and contribute to an increased risk of violence. Ideals and realities can differ in this regard, the informants made clear:

> In theory, it looks fine, but in the real life world, it is not always easy to follow up what has been decided.

Lack of knowledge and information about the clients, especially, about previous—and the risk of continued—acts of violence, will often challenge the opportunity to offer services tailored to the individual. This could be an assessment of the risk of violence, using the manually based mapping instrument Historical Clinical Risk Management-20 (HCR-20; Douglas & Reeves, 2010), which includes information on any previous history of use of violence. This is especially important, as one informant pointed out, when clients previous have used severe violence:

> We often ask for epicrisis and such things. I remember the most significant example, when we got a person who had committed murder, which is especially important for us to know; . . . we got no information, but found out via other sources . . .

At the same time, it is a tricky task to judge—taking into account that the clients can act differently when in hospital then they do in the local community.

The obligation to keep confidentiality can sometimes be experienced as hindering information exchange between staff in different services. The duty of exchanging information between different actors, for example, hospital and municipal authorities, should be used to ensure that information about dangerousness is more easily available. It is a problem if the possibility of giving good help to the client depends on whether he or she has released the professionals from their obligation to keep confidentiality when meeting and cooperating with other services to strengthen clients' options of support from social insurance authorities, GPs, and others. It is even more serious if it can be suspected that other interests play a role, as this quotation from an informant indicate,

> When we get people from specialist care institutions, . . . might call it a sort of "sell-out" when they want to get rid of people, . . . then it might happen that some things are underreported, especially if it has to do with violence.

To summarize, Staff working in the clients' homes have developed a "practice of security" by working for the best of

the clients, while at the same time, taking the risks of clients' violent behavior constantly into account. An important part of this practice is an open, supportive, and trustful relation between professionals and different services, as well as good practical routines for mutual help, when needed. However, the needed cooperation with other services is sometimes complicated due to formal and professional obstacles.

Focus on Growth and Development

Growth-furthering factors. Professionals' interaction with clients, including working toward creating trust and safety and being able to adapt to clients' stress levels as well as tolerating and accepting their rejection, can promote clients' sense of accomplishment and growth. These qualities require commitment and an ability to provide that little extra when it is needed. It also includes being able to work out with the "theoretical level" for a while. It involves having conversations with users about personal experiences and using theoretical knowledge alongside common sense:

> The guys feel like we are a bunch of weirdoes that live life one day at a time, but with dedication and commitment to their well-being . . . a lot of theoretical knowledge, but we use it wisely.

An important factor is that the service is easily accessible. It includes the necessity for boundaries for every individual, however, allowing them time and space for flexibility. Provision of sufficient time is an important quality in local health services. One informant compared this to the situation in hospitals:

> We spend 90–95% of our time with the patients in a working situation. In a hospital, one might spend 10%, and think that you are the best, which is wrong.

Promoting the individual person's value, and being a fellow human being when meeting the clients, is an important factor that can contribute to their growth and development. A part of this involves staff showing interest in the human being and recognizing the person for whom he or she is and having a nonjudgmental and accepting approach to that person, but not necessarily to all of his or her actions. Focusing on health, the small things in clients' everyday lives and working to make things as good as possible are also expressions of sensibility toward the person and the situation:

> The fact that we have a conscious view that enables us to separate the person from his or her action; . . . there are a lot that have done horrible things, . . . how we handle it, and how we are able to relate to the person, and not the action, it is essential that we are conscious of this when we meet the client . . . .

Mobilizing resources. An important part of furthering growth and development is to contribute to strengthening clients' own resources. Three aspects of this are particularly important. First, it is about creating stable boundaries for the clients, not least when it comes to practical assistance and basic human needs—realistic economies for everyday life and predictability when it comes to what the local health service can and cannot offer. Fixed, practical, basic arrangements have to be in place as a precondition for traditional treatment. One informant put it in a straightforward way:

> Several users say that they are tired of sitting down and talking to a psychologist, for example, or a psychiatrist; they do not feel that their life is improving, but being able to buy something at IKEA, a couch and a bed is very concrete . . .

Second, another aspect of mobilizing coping resources is about giving clients gradual increases in responsibility for their everyday lives. This involves staff acting professionally, by taking clients' expressed needs seriously and giving them increased opportunities to master their lives in the local community, but to an extent that matches clients' abilities. The clients' experience of handling their lives increases, but sometimes their expectations are unrealistic. It is important not to dismiss clients' wishes, but instead sometimes meeting them halfway. The third aspect involves the clients' hopes for a better life. The hopes and dreams of a better life can have a positive influence; it is important for staff in the municipal health services to take this seriously and also actively work to expand it. Specifically, this can be about giving the clients an experience of self-control and influence, safeguarding an individual plan, working toward small goals, providing trust, being available as helpers, and not giving up on them. The informants stated this clearly:

> If we do not have faith in them, if we show that we do not have faith in them somehow, I think they might deteriorate a lot, so we should give them the confidence, so they may be making decisions and determining . . . and that it is not we who are the commanders but them.

> Every human being should be allowed to have dreams and, where there are not so many, one must get help with that.

To summarize, important factors to further growth and development are the professionals being fellow human beings when meeting the clients and that there is flexibility in time and space. The clients' basic needs, such as economy and housing, have to be cleared out as a precondition for a good development. Factors contributing to growth and development are to stepwise increase the clients' self-determination and responsibility and to support their hopes and dreams for a better future.

Discussion

The results from this study show that there will be challenges with the health care professionals' and society's need for control and simultaneous desire to promote coping and

mastery, when the clients receive mental health services at the municipal/local level. A deliberate approach and a desire to create human well-being could move us toward a growth-oriented and resource-oriented focus for the client, creating the space needed for helping and productive relationships between staff and clients. The study's main categories and subcategories highlight work with clients being combined with several considerations. Parts of the result will here be discussed in relation to previous research and the authors' reflexions.

Balancing Growth and Risk Factors When Working in the Clients' Homes Is a Multifaceted Task

All the informants were practitioners in mental health care with a large part of their work taking place in the clients' homes, even though they also met with individual clients in their respective offices. The informants highlighted a conscious approach that acknowledges clients' expressed needs, symptom burden, and dynamic functioning as a central factor when meeting clients. Good help seems to be united through a balancing act that safeguards human autonomy, whereas risk factors such as substance abuse, marginalization, and deterioration of serious mental illness are taken into account with people who have previously used violence. These findings are compatible with the Norwegian government guidelines on how aid should, and can, be delivered to this client group (Helsedirektoratet, 2008, 2014; Olsen et al., 2010) and corresponding to what other researchers have found (Heiden, Holden, Alder, Bodke, & Boustani, 2017).

That professionals take into account what clients tell about factors related to growth and danger for themselves and others appears to be significant and is referred to by de Vries Robbé et al. (2012) as protective factors that focus on health and which can encourage positive communication between clients and staff. From a municipal health perspective, such information, based on clients' own descriptions, is knowledge that is important to consider before, during, and after a transfer to a lower level of service. People with serious mental illnesses can as a result have the opportunity to be met, understood, and taken care of in a dignified way. Schjødt et al. (2012) point out that a consequence of legislation and various government guidelines may be that the user becomes a shuttlecock' between different services, lacking clarity on which agency is responsible for what when it comes to the individual's follow-up. Some people with serious mental illnesses can then be transferred to a lower level of services, with inadequate planning and information exchange with those who manage the new services. This raises questions of the competence and resources needed in municipal health service.

There may be challenges associated with safeguarding the risk aspect and the observation of the early warning signs of a client's increased symptomatic burden when the individual is followed up in his or her own home. At the same time, Schjødt et al. (2012) highlights an optimistic view of this area of service and a realistic awareness of a nuanced perspective when meeting the clients. Stickley and Felton (2006) show that mental health workers must be aware of such a safeguarding risk perspective and work therapeutically with it. This can challenge the practice when health and social staff are forced to attend multiple perspectives simultaneously.

Support from colleagues in daily work is described by the informants as a decisive factor for managing secure relationships with the clients. Such support would entail the confidence to be honest and open in a practice that could challenge the helper's own values, and tolerance in the face of issues of violence and aggression. Judge and Bolton (2013) point out that health and social personnel must have the opportunity to discuss and process the emotions that arise if one is exposed to violent behavior at work. An organizational culture that fosters an atmosphere of trust between colleagues will be important to promote safety for staff. Where room for reporting on challenges and "close-call situations" is given, there is a willingness to improve practice and learn from each other (Cowman, 2006). Informants emphasized the importance of promoting support from colleagues, keeping a vivid dialogue, and advising and guiding each other. Such a culture can quickly become vulnerable if staff are not talking about what their experiences are at work. It stands out as essential to help prevent anyone feeling ashamed if they should indicate a horror of being involved in demanding situations.

Professionals Must Combine the Clients' Perspective and Different Professional Perspectives

Insight into a person's first-person perspective can bring useful theoretical and practical knowledge about dynamic risks for violence (Yang & Mulvey, 2012). Skjervheim (2001) describes this as an inside perspective, where one's own experience of health and ill-health is of relevance. Risk assessments performed at a specialist level, but also from the client's own perspective, must be taken into account. Assessments made by staff mainly reflect a professional point of view, which does not necessarily express the experience of the person who is the recipient of the services. This can be further questioned because people with severe mental illnesses do not, in all situations, seem able to take advantage of their own assistance programs. There might be different reasons behind this, for instance, clients experience cognitive difficulties or feel a risk of being stigmatized (Lauber, Nordt, Braunschweig, & Rossler, 2006). By being aware of the importance of this first-person perspective, professionals can promote further client involvement.

Informants had experience of follow-up measures designed via structured violence risk assessments and action plans involving other authorities such as the police and GPs. de Vries Robbé et al. (2012) show that a combination of work with positive protective factors and risk factors appears to reduce violence. Descriptions of increased emotional stress and contexts of vulnerability resulting in outward aggression and less serious violence should, according to the informants, be described in clients' journals, where there is no structured violence risk assessment of the individual.

Newbill et al. (2010) show that, when meeting people with severe mental health disorders, an approach characterized by cooperative discussions, which promote alternative ways of safeguarding human needs, can be significant. On the contrary, setting up boundaries that give the client a sense of being a victim of a system without proper care appears to increase client aggression levels (Newbill et al., 2010). To ensure clients' self-determination and self-assertion through providing opportunities for choice, we must draw parallels with the phenomenological perspective and try to understand the meaning of a phenomenon for the client who experiences it (Lillevik & Øien, 2010); professionals should be keen to bring this with them into their work. Professionals follow up people who have committed both less serious, and very serious, acts of violence. The measures around the clients seem to depend on the degree of prior violence. In light of the above reasoning, new questions related to the study's empirical findings have arisen. Can it be that we are facing a group of people who fall between the categories—such as people who have been discharged from hospital care but are not "sick" enough to ensure appropriate action?

Lack of Cooperation Between Service Levels Can Cause Problems

Hansen (2013) points out that cooperation between services raises questions about what information should be shared between professionals, and clients' rights to decide what information should be shared. An open question is whether there is a consensus between what the specialist health service considers necessary and the community health considers important in order to safeguard the user. The findings in this study clearly point at situations where the municipal professionals lacked information from other services that would have been useful in their daily contacts with the clients, sometimes even critical to prevent and avoid situations of violence. Lemvik (2006) points out that language shows what professionals look for and that people with mental disorders do not have more complex needs than others but will need several different services to meet their general needs, such as security, reputation, food, and rest. The client group can have challenges to play an active role in their own treatment program and in social arenas, so these areas deserve attention. Real and fruitful cooperation between service operators and users must contain concrete plans for what the cooperation should comprise.

Those who provide services and clients who are going to receive the services will be located between these issues (Dale, Ødegård, Nesje, Iversen, & Bjørkly, 2011). Olsen et al. (2010) describe transferable knowledge of the client being essential; this knowledge must be established when people with these types of challenges are transferred to a lower level of service. Meanwhile, the municipality has a responsibility as the coordinating unit for people who are in need of long-term services. Informants in the study have acquired valuable expertise on the challenges that the client may present with regard to issues of violence. The service levels must then retain a sensible dialogue that promotes safeguarding of clients' dignity and rights but, at the same time, provide the necessary information that might help to lower clients' violence risk related to themselves and others.

A Resource-Oriented and Growth-Oriented Focus Can Support Recovery and Hope

The informants underlined that facilitating the opportunities for the clients to cope with their mental health problems is the central task for mental health care. To promote safeguarding the basic needs can help to curb the disturbing element that could result in adverse consequences related to perceived stress and frustration, which some people with mental illness perceive as a large load. Toumborou et al. (2007) call for safeguarding livelihoods and socioeconomic status factors. Stickley and Felton (2006) show how networks, shelter, money, and work appear to be of great importance for an individual's life and improvement process. Promotion of recovery will involve further enhancement of human autonomy. Thus, safeguarding basic human needs will be a necessity for future work and to guard against the occurrence of violence.

A holistic approach to recovery for people who experience severe mental illness seems to be necessary (Song et al., 2012). The clients appear to be in need of services that extend from the fundamental need for contact and belonging to support for very specific things. Some people with severe mental illness will be in need of long-term follow-up at the municipal level, where recovery must be given space and time to gradually evolve. Municipalities participating in the study, brought to fore by the informants, can gain important knowledge for safeguarding people who are in need of complex care and assistance. To provide assistance and mobilize coping resources that contribute to clients' growth seem to depend on factors such as hope, mastery of venues, and the construction of a stable framework around the client, which can promote security and predictability. Song et al. (2012) talk of "recovery communities," where "recovery-oriented" offerings for people with severe mental disorders have been established. Factors such as social environment, service

environment, and physical environment are highlighted as key factors. A customized physical environment may appear to contribute to a reduction in the use of drugs and violence, where a social environment is trying to promote "a place to belong." Slade and Davidson (2011) refer to this as promoting human social identity as belonging; identity can be impaired in people who experience being trapped in a stigmatized social role, such as users of health care.

The findings in this study indicate that there should be more of what seems to work, helping people to cope with severe mental suffering, and assist clients to find alternative coping strategies to violence. Newbill et al. (2010) show that the alternative coping strategies and problem-solving skills must be developed in such a way that they are transferable and can be further developed into a social perspective to avoid further institutionalization of the user group. Fitzgerald (2010) points out that recovery in people with severe mental disorders may depend on, among other things, insights into their own suffering. An insight-oriented working method therefore appears to improve the long-term effect on improvement in people receiving health care when reduced insights can be one of the problem areas for severe psychotic breakthrough. In addition effects such as emotional discomfort, and loss of social and cognitive functioning, appear to be areas that have an influence, in addition to the symptoms that psychosis entails.

Langeland (2007) points out that the theory of salutogenesis promotes the client as a person, to which the identification of coping resources and their maintenance are central. To promote adequate responses to the environment and the realities in which one is found, a goal is to strengthen the SOC. Furthermore, it appears that humans will suffer damage if it is on an emotionally high voltage level over a longer period (Antonovsky, 2012). The study findings emphasize the former, where people who previously exercised violence allegedly lacked adequate coping strategies for dealing with life, and experienced large loads. Bengtsson, Brunt, and Rask (2005) note that the SOC will be of particular interest in the face of severe mental health disorders on the basis that much suffering could result in an absent SOC. The degree of the SOC will depend on internal and external stressors and influence "experienced." Emotions that seem to make a cognitive and motivational basis for action include hope (Antonovsky, 2012). This seems consistent with the informants' descriptions, which refers to the importance of promoting a meaningful everyday life for the future of the user, which could form the basis for turnarounds for people who have experienced hopelessness and defeat.

Hummelvoll (2012) shows that the attitude in the face of situations in which there is danger of violence should be characterized by an understanding of the client's world of experience and a comprehensive approach of humanistic grounding. Such an understanding will further require that staff work to put themselves into the client's situation. The study findings point out that use of the qualities, available services, and an attitude sensitive to the people who are in need of the described services can contribute to growth and increased coping outside institutional frameworks. Personal skills and an appreciative perspective in clients seem to be related to what Lillevik and Øien (2010) call a perspective selection from the helper.

Working in the clients's home can cause health and social workers to have several different roles. In this study, it was highlighted that this role can contribute to dissemination of hope, almost like a friendly, professional, and sometimes nearest relation, when the client may have a limited social network with many broken relationships. Scheyett, Deluca, and Morgan (2013) point out that health and social workers seem to have to keep a two-sided focus by maintaining a focus related to helping clients to realize their potential while safeguarding their challenges.

Mental health services also have to help ensure that people with mental health problems have a sense of belonging in the community and help them develop networks that can contribute to social integration (Granerud & Severinsson, 2006). What Granerud and Severinsson pointed out can be seen in the light of what Slade and Davidson (2011) describe as health-carers contribution to a recovery-oriented model, in which staff should search wider than just offering treatment. This means support for living in the social arenas—as important as curing suffering. The management of holistic services by the client will require its holistic aides, where staff willingly have to step into different roles with an awareness of the work complexity and a huge commitment for others' well-being.

To sum up. The study's findings and relevant previous research show a consensus on how violence risk management of good quality in practice may depend on several factors that have to be taken into account: a thought-through practice for security, good relationships that can protect against the occurrence of violence, and a conscious approach to professional quality that holds positive attitudes and compassion. Furthermore, safeguarding the individual's autonomy, while protecting the community, appears to be a complex task. Solutions adapted to the individual and flexible services were highlighted as key aspects to promote the safeguarding of people who need assistance in managing everyday coping in the community to promote recovery and increase clients' hope for a better future. In addition, the study finds that the professional's balancing act between getting and giving information challenges current practice. It seems to be problematic for professionals to experience having insufficient information when meeting people with these types of problems.

Implications for Practice

Work at a municipal health care level with people who experience severe mental health problems provides frameworks

other than a mental health hospital. This involves major contextual differences with regard to safeguarding a client's violence risk perspective and a coping perspective. The community has another challenge relating to the human right to privacy: autonomous choice and the simultaneous management activities of a risk perspective in some people with severe mental disorders. The study's findings show that this improvement can be resolved with professional knowledge used sensibly and a service that responds to users' expressed needs, and the human improvement process will not be forgotten along the way. An open and supportive culture among municipality-employed mental health care workers is a prerequisite for successful work, and so are good routines for sharing information between different service levels.

Conclusion

This study was undertaken in Norway, where community-based welfare services is an important and growing part of societal treatment and care for those who suffer from mental health problems. It shows the importance of a flexible, multiperspective approach from health and social personnel in municipal mental health care working with people with severe mental health problems and showing, or showing risk of, violent behavior to promote growth and recovery, while at the same time safeguarding the local community. An increased focus on what seems to work in practice every day for the clients may be necessary. This should be combined with the acquisition of knowledge about what people with the described challenges experience as good help. Factors contributing to growth for this small group of people can apparently be of great importance for the life of those concerned and lead to positive societal consequences. An open and collegial atmosphere among staff is an important factor to build a professional culture to handle situations where client violence is involved. Communication between service levels is sometimes problematic, in the worst case, causing dangerous situations for staff in municipal health care.

Further Research on This Subject Is Needed

This study highlights the need of deepened knowledge concerning a societal area of growing importance, as more and more welfare services are expected to take place in the local community. However, it is limited, not least when it comes to number of informants and to geographical and socioeconomic comprehension. Further research on this theme, from a social science perspective, is therefore needed. Dorn et al. (2012) point out that there should be more research on positive protective effects for people with mental health disorders who receive services at the municipal level, in relation to reduced violence. We strongly agree with Dorn et al. about the need for further research, also studies including active participation from clients, alongside with different group of professionals.

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Note

1. According to Olsen et al. (2010), severe mental illness comprises deep depression, bipolar illness, and schizophrenia. Some kinds of personal disturbances might be included, often in connection with drug abuse. The definition of what should be regarded as severe mental illness is not always quite clear.

References

Antonovsky, A. (2012). *Helsens mysterium. Den salutogene modellen* [The mystery of health: The salutogenic model]. Oslo, Norway: Gyldendal akademisk.

Bøe, D. T., & Thomassen, A. (2007). *Fra psykiatri til psykisk helsearbeid* [From psychiatry to mental health care]. Oslo, Norway: Universitetsforlaget.

Bengtsson, A. T., Brunt, D., & Rask, M. (2005). The structure of Antonovsky's sense of coherence in patients with schizophrenia and its relationship to psychopathology. *Scandinavian Journal of Caring Sciences*, *19*, 280-287. doi:10.1111/j.1471-6712.2005.00342.x

Cowman, S. (2006). Safety and security in psychiatric clinical environments. In D. Richter & R. Whittington (Eds.), *Violence in mental health settings: Causes, consequences, management* (pp. 253-271). Washington, DC: Springer Science + Business Media, LLC.

Dale, K. Y., Ødegård, A., Nesje, A., Iversen, H. P., & Bjørkly, S. (2011). Bygge ned og bygge annerledes. Endringer i psykisk helsetilbud for voksne i Nordmøre og Romsdal i lys av redusert døgntilbud og opptrappingsplanen [To dismantle and to build up in another way. Changes in mental health services for grown-ups in Nordmøre and Romsdal, in the light of reduced 24-hour services and the Norwegian psychiatric reform plan]. *Tidsskrift for psykisk helsearbeid*, *8*, 227-236.

de Vries Robbé, M., de Vogel, V., & Stam, J. (2012). Protective factors for violence risk: The value for clinical practice. *Psychology*, *3*(12A), 1259-1263. doi:10.4236/psych.2012.312A187

Dorn, R. V., Volavka, J., & Johnson, N. (2012). Mental disorder and violence: Is there a relationship beyond substance use? *Social Psychiatry and Psychiatric Epidemiology*, *47*, 487-503. doi:10.1007/s00127-011-0356-x

Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). *HCR-20V3: Assessing risk of violence—User guide*. Burnaby, British Columbia, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.

Douglas, K. S., & Reeves, K. A. (2010). Historical-Clinical-Risk Management-20 (HCR-20) Violence risk assessment scheme: Rationale, application, and empirical overview. In R. K. Otto & K. S. Douglas (Eds.), *International perspectives on forensic mental health: Handbook of violence risk assessment* (pp. 147-185). New York, NY: Routledge/Taylor & Francis Group.

Fitzgerald, M. M. (2010). Comparison of recovery style and insight of patients with severe mental illness in secure services with those in community services. *Journal of Psychiatric and Mental Health Nursing*, *17*, 229-235. doi:10.1111/j.1365-2850.2009.01498.x

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*, 105-112.

Granerud, A., & Severinsson, E. (2006). The struggle for social integration in the community—The experiences of the people with mental health problems. *Journal of Psychiatric and Mental Health Nursing*, *13*, 288-293. doi:10.1111/j.1365-2850.2006.00950.x

Hansen, G. V. (2013). Helhetlige tjenestetilbud med basis i bolig [Holistic services based in housing]. *Tidsskrift for psykisk helsearbeid*, *10*, 129-137.

Heiden, S. M., Holden, R. J., Alder, C. A., Bodke, K., & Boustani, M. (2017). Human factors in mental healthcare: A work system analysis of a community-based program for older adults with depression and dementia. *Applied Ergonomics*, *64*, 27-40.

Helsedirektoratet. (2008). *Mennesker med alvorlige psykiske lidelser og behov for særlig tilrettelagte tilbud. Vurdering av omfang og behov, samt forslag til tiltak* [People with severe mental illness and need for especially adopted services. Assessment of amount and need, and proposition for decision] (IS-1554). Oslo, Norway: Direktoratet.

Helsedirektoratet. (2014). *Sammen om mestring. Veileder i lokalt psykisk helsearbeid og rusarbeid for voksne. Et verktøy for kommuner og spesialisthelsetjenesten* [Together on mastery. Guidelines for local mental health care and addiction treatment for grown-ups. A tool for municipalities and special care units] (IS-2076). Oslo, Norway: Direktoratet.

Hummelvoll, J. K. (2012). *Helt—ikke stykkevis og delt. Psykiatrisk sykepleie og psykisk helse* [To view the whole—and not the parts. Psychiatric nursing and mental health] (7. utg). Oslo, Norway: Gyldendal Norsk forlag AS.

Hummelvoll, J. K., & Barbosa da Silva, A. (1996). Det kvalitative forskningsintervju som metode for å nærme seg den psykiatriske sykepleiers profesjonelle livsverden i kommunehelsetjenesten [The qualitative research interview as a method for approaching the professional life world of the psychiatric nurse in municipality health care]. *Vård i Norden*, *16*(2), 25-32.

Judge, J., & Bolton, J. (2013). Violence in primary care. *Primary Health Care*, *23*, 18-22. doi:10.7748/phc2013.12.23.10.18.e806

Kvale, S., & Brinkmann, S. (2009). *Den kvalitativa forskningsintervjun* [The qualitative research interview]. Lund, Sweden: Studentlitteratur AB.

Krug, G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *The Lancet*, *360*, 1083-1088. doi:10.1016/S0140-6736(02)11133-0

Langeland, E. (2007). *Sense of coherence and life satisfaction in people suffering from mental health problems: An intervention study in talk-therapy groups with focus on salutogenesis*. Bergen, Norway: University of Bergen.

Lauber, C., Nordt, C., Braunschweig, C., & Rossler, W. (2006). Do mental health professionals stigmatize their patients? *Acta Psychiatrica Scandinavica*, *113*, 51-59.

Lemvik, B. (2006). *Å skape gode livsvilkår. Psykisk helsearbeid i kommunen* [To create good conditions for living. Municipal mental health care]. Oslo, Norway: Kommuneforlaget AS.

Lillevik, O. G., & Øien, L. (2010). Kvaliteter hos hjelperen som bidrar til å forebygge trusler og vold fra klienter [Qualities of the helper that contribute to prevent threats and violence from clients]. *Nordisk Tidsskrift for Helseforskning*, *6*, 84-96.

Malterud, K. (2012). *Fokusgrupper som forskningsmetode for medisin og helsefag* [Focus group interviews as research method in medicine and health disciplines]. Oslo, Norway: Universitetsforlaget.

Newbill, W. A., Marth, D., Coleman, J. C., Menditto, A. A., Carson, S. J., & Beck, N. C. (2010). Direct observational coding of staff who are the victims of assault. *Psychological Services*, *7*, 177-189. doi:10.1037/a0020005

Norvoll, R. (2013). *Samfunn og psykisk helse. Samfunnsvitenskapelige perspektiver* [Society and mental health. Social science perspectives]. Oslo, Norway: Gyldendal akademisk.

Olsen, A.-K., Andersson, B. M., Lydersen, B., Gudmundsen, G., Mohm, G.-F. R., Guldebakke, H., . . . Vik, T.-G. (2010). *Drap i Norge i perioden 2004–2009* [Homicide in Norway 2004–2009] (NOU 2010:3). Oslo, Norway: Helse- og omsorgsdepartementet.

Scheyett, A., Deluca, J., & Morgan, C. (2013). Recovery in severe mental illnesses: A literature review of recovery measures. *Social Work Research*, *37*, 286-303.

Schjødt, B. R. H., Hoel, A. K., & Onsøien, R. (2012). *Psykisk helse som kommunal utfordring* [Mental health as a municipal challenge]. Oslo, Norway: Universitetsforlaget.

Skjervheim, H. (2001). Deltakar og tilskodar [Partaker and spectator]. In H. Skjervheim (Eds.), *Deltager og tilskodar og andre essayes* [Partakers and spectators and other essays] (pp. 71-78). Oslo, Norway: Universitetsforlaget.

Slade, M., & Davidson, L. (2011). Recovery as an integrative paradigm in mental health. In G. Thornicroft, G. Szmukler, K. T. Mueser, & R. E. Drake (Eds.), *Oxford textbook of community mental health* (pp. 26-33). New York, NY: Oxford University Press.

Song, E., Hipolito, M. M., & Whitley, R. (2012). "Right here is an oasis": How "recovery communities" contribute to recovery for people with serious mental illnesses. *Psychiatric Rehabilitation Journal*, *35*, 435-440. doi:10.1037/h0094576

Stickley, T., & Felton, A. (2006). Promoting recovery through therapeutic risk taking. *Mental Health Practice*, *9*(8), 26-30. doi:10.7748/mhp2006.05.9.8.26.c1910

Toumborou, J. W., Hemphill, S. A., Tresidder, J., Humphreys, C., Edwards, J., & Murray, D. (2007). Mental health promotion and socio-economic disadvantage: Lessons from substance abuse, violence and crime prevention and child health. *Health Promotion Journal of Australia*, *18*, 184-190.

Yang, S., & Mulvey, E. P. (2012). Violence risk: Re-defining variables from the first-person perspective. *Aggression and Violent Behavior*, *17*, 198-207. doi:10.1016/j.avb.2012.02.001

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