Asset Map

Workplace Violence Training/Education Programs

May 2017

Nova Scotia Health Research Foundation

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Introduction

Workplace violence is recognized as a serious safety and occupational health concern, specifically in health care and community services settings (Arbury, Hodgson, Zankowski, & Lipscomb, 2017; Beech & Leather, 2006; Farrell & Cubit, 2005; Livingston, Verdun-Jones, Brink, Lussier, & Nicholls, 2010). There are varying definitions of workplace violence, but the majority mention physical assault and verbal threats. The definition can be further broadened to include bullying and sexual harassment (Beech, 2008). According to Beech and Leather (2006) a widely used, comprehensive and inclusive definition of workplace violence is "incidents where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health"(p. 28). A survey from the Health Services Advisory Committee in the United Kingdom indicates that violence is a factor in all areas of health care, with the vast majority of health care professionals at risk for workplace violence at least once during their time in the sector (Smith-Pittman & McKoy, 1999). Further, Ramacciati et al. (2016) highlighted that a recent study found that more than two-thirds of physicians experience work-related violence, while approximately one third of nurses experience some form of physical and/or psychological workplace aggression (Heckemann et al., 2015).

The National Institute for Occupational Safety and Health (NIOSH) Guidelines from the United States list five "building blocks" for developing an effective and efficient workplace violence prevention initiative: 1) Management commitment and employee participation, 2) Worksite analysis, 3) Hazard prevention and control, 4) Safety and health training, and 5) Recordkeeping and program evaluation. The asset map outlined in the current report focuses on the fourth block (safety and health training) while also considering the importance of program evaluation. There has been rising interest in the notion that training/education programs for health care staff may help reduce, prevent and manage violent incidents. Evidence suggests training could reduce risk to staff (Farrell & Cubit, 2005), improve their effectiveness in the workplace setting (Beech & Leather, 2006; Livingston et al. 2010), reduce restraints and seclusion (Livingston et al., 2010), and decrease costs (Beech & Leather, 2006).

There are numerous commercial workplace violence training and education programs from a range of organizations (Lipscomb & El Ghaziri, 2013), yet there is a lack of evidence to understand the effectiveness of these programs comprehensively (Farrell & Cubit, 2005). Training and education are an essential part of an effective and comprehensive initiative to reduce workplace violence in the health care setting, but the content and frequency of training, as well as how and by whom it is delivered, are critically important as well (Arbury et al., 2017).

Purpose

The purpose of this asset map is to identify some of the key training/education programs that exist to address workplace violence in health care and community services settings, as well as outline what evidence is available to support the effectiveness of these programs. In regards to violence as a health and safety issue, researchers have classified workplace violence into four categories; 1) Criminal, 2)

Customer/client (including patients, clients, and residents (patients) in health care and community services), 3) Co-workers, and 4) Personal Relationships (Arbury et al., 2017). This asset map emphasizes programs that focus on reducing and preventing violence in the patient to staff relationship, but the majority of these programs also apply to other kinds of workplace violence relationships. A future iteration of the asset map may consider other programs that specifically focus on other forms of workplace violence (e.g., staff to staff). The scope of this work was defined in collaboration with members of the Workplace Safety Action Plan for Nova Scotia's Health and Community Services Sectors' Project Team.

Methodology

Searching Strategy

The project was supported by a scan of peer reviewed and grey literature. Snowball sampling of review articles was also used, whereby references of articles were hand searched and included in the review of the literature.

Peer reviewed literature was found through searches of the following sources: CINAHL, PubMed, Embase and Google Scholar. Key search terms included, but were not limited to: "workplace violence", "training", "program", "health care", "homecare", "long-term care" and "patient". The search was filtered to only include articles published from 2000 forward, English language, and from predominately English speaking countries (i.e. United States, Canada, Australia, United Kingdom). Due to hand searching of reviews, some articles that were published outside of these countries and published prior to 2000 were included based on relevancy.

Grey literature was sought using the Google Advanced Search and 211 Nova Scotia (http://www.ns.211.ca/) using similar search terms. In addition, program websites were scanned for peer-reviewed and grey literature.

Due to the high number of workplace violence programs available including commercial, customized, and programs developed for research purposes, the timeframe of the project and the advice of the Project Team, the asset map concentrated primarily on commercial programs. Priority focus was placed on these programs as they have been developed and disseminated by multiple vendors and large organizations, can easily be adopted and were deemed the most appropriate based on stakeholder needs.

After title and abstract were reviewed, relevant articles were exported to Mendeley reference management software and duplicates were detected and deleted.

Interpretation of Evidence

Evidence of program effectiveness should be interpreted with a critical eye as the level of rigor across studies and evaluation reports can vary based on numerous factors including the population under investigation, sample size, study/evaluation design, data collection/analysis and interpretation of findings. The asset map displays the scope of evidence available for each program, but does not report on the quality of each study and/or evaluation finding. The asset map was prepared based on a search of information within a short timeframe and is not meant to reflect the entire body of evidence on the topic.

Asset Map

The asset map includes twelve workplace violence prevention programs currently being implemented in Nova Scotia, across Canada and/or internationally. The map outlines the program's provider, area/region, a brief program description, program structure, the available evidence of the program's effectiveness, and a website link for further information. Though most programs can be adapted to multiple populations and context, the asset map is broken down into four program groupings to assist with accessibility:

1) **General Training Programs** – Programs that can be adapted to an array of human service settings, health care sectors including long-term care, homecare, and community services sectors including mental health care settings, etc.
2) **Training Programs in Long-term Care and Residential Care** – Programs that specifically focus on workplace violence in the long-term care and residential care settings including working with older adults with complex diseases, such as dementia.
3) **Training Programs in Psychiatric Care** – Programs that specifically focus on workplace violence in a psychiatric setting including working with individuals with severe mental health illnesses.
4) **Other Training Programs** – Programs focusing on other distinct populations including children with Autistic Spectrum Disorder, learning disabilities, etc.

Asset Map of Workplace Violence Training/Education Programs		
General Training Programs		
Program Name:	**Nonviolent Crisis Intervention®**	
Provider:	Crisis Prevention Institute	
Area/Region:	USA	
Population:	The program is designed for a variety of human service settings (health care facilities, correctional facilities, and schools).	
Program Description:	The program focuses on educating staff on strategies to reduce anxious, hostile and aggressive behaviours at the preventative stage. Strategies aid in diffusing the risk of injury, complying to legislative mandates, meeting accreditation standards, increasing staff retention, and minimizing issues with liability. The goal of the program is to increase staff knowledge and self-efficacy about defusing potentially violent incidents and preventing assaults.	
Program Structure:	A four-day course focusing on four core topics: 1) Prevention techniques 2) Team approach 3) Physical Intervention 4) Post-intervention There are three training options to choose from: 1) Introductory Course (One-Day): Emphasis on early intervention and prevention strategies for managing and responding to disruptive behaviours. 2) Foundation Course: (Two-Day): Building on the one-day course, reinforces preventative strategies and allows participants to practice a wide range of non-harmful holding skills. 3) Instructor Certification Program (Four-day): Building on the introductory and foundation course, the trainee will master intervention techniques, as well as gain the strategies and confidence necessary to adapt the program to the context of their work environment.	
Study and/or Evaluation Evidence:	Morrison (2003)	• Evaluation on aggression management programs in a psychiatric setting considered the program to have moderate effectiveness in staff injury, restraint and violence rates.
	Calabro, Mackey, and Williams (n.d.)	• Primary study conducted on the effectiveness of the program indicated significant short-term perceived improvement in knowledge, attitude, and self-efficacy of mental health care workers in an acute psychiatric hospital in the Southern United States.

		• Reported positive influence on respondent's willingness to use learned strategies and techniques, as well as indicated a decrease in injuries by patient assaults.
	Schindel-Martin et al. (2003)	• Significant improvement in staff's skill and knowledge to manage long-term care residents' potential violent behaviours after implementation of an adapted Non-violent Crisis Intervention program. • Positive improvement of staff's confidence in working with residents, but the indicator was not statistically significant. • Qualitative analysis suggests an improved organizational culture that tolerates, accepts and respects residents who are cognitively impaired and may express physically violent behaviours.
	Livingston et al. (2010); (Jonikas, Cook, Rosen, Laris, & Kim, 2004; McCue, Urcuyo, Lilu, Tobias, & Chambers, n.d.).	• Significant decrease in patient assaults, restraints and seclusion based on the implementation of the Non-violent Crisis Intervention program in various health care settings.
Website:	https://www.crisisprevention.com/Specialties/Nonviolent-Crisis-Intervention	
Program Name:	**The Mandt System®**	
Provider:	The Mandt System®	
Area/Region:	USA	
Population:	The program originally was developed to support staff working in residential facilities to manage individuals affected by intellectual disabilities and/or mental illnesses that may have uncooperative or aggressive behaviours. It has now expanded to an array of human service sectors; specific training is offered for practitioner, leadership, service users, and direct care professionals.	
Program Description:	The aim of the program is to develop healthy relationships among all stakeholders in the human service setting where new behaviours can be learned, formed and developed, while reducing behaviours that are deemed "challenging". The program is comprehensive and uses integrated approaches to prevent, reduce and intervene when behaviours pose a threat to the self and other individuals.	

Program Structure:	Four different levels of training are offered: 1) Relational Level (Two-Day Attendance - does not include physical techniques): 1) Building Healthy Relationships, 2) Building Communication, and 3) Building Healthy Conflict Resolution. 2) Relational/Conceptual Level (Two-Day Attendance - does not include physical techniques): Includes all chapters of Relational level plus: 4) Trauma Informed Services, 5) Positive Behaviour Support, 6) Liability and Legal Issues. 3) Relational/Conceptual/Technical Level (Four-Day Attendance: includes physical techniques): Includes all Chapters from Relationship and Conceptual Levels plus: 7) Assisting and Supporting Skills, 8) Separating Skills, 9) Restraining Skills – Standing. 4) Relationship/Conceptual/Technical/Advanced Level (Four-Day Attendance + Recertification of Relational/Conceptual/Technical): Includes Relationship/Conceptual/technical Recertification plus Advanced Technical Training broken up into two chapters aiming to further educate and teach people strategies and techniques to reduce incidents of violence when working with people with severe (violent) chronic problems).	
Study and/or Evaluation Evidence:	Bowen, Privitera and Bowie (2011)	• Outlines integrated models and best practices to reduce and manage workplace violence, but limited information on the effectiveness of program. • The company's website (http://www.mandtsystem.com/) posts resources on the The Mandt System®, however there is little independent confirmation of its benefits.
	Morrison (2003)	• Evaluation on aggression management training in a psychiatric setting indicated that the program had low effectiveness, such that research efforts and/or evaluation data on the program showed limited evidence on decreases in restraints, and reduction in patient and/or staff injuries and violence.
	Livingston et al. (2010)	• A review of the effectiveness of aggression management training programs for psychiatric hospital staff indicated that prior research efforts did not find significant reduction rates in aggression and staff injury.
Website:	http://www.mandtsystem.com/	
Program:	**Therapeutic Options Inc. (TO)**	
Provider:	Michael Partie, Therapeutic Options, Inc.	
Area/Region:	USA	
Population:	The program is used across the human service setting, including the health care sector (group homes, hospitals, classrooms, rehabilitation centers and community service settings).	
Program Description:	The program employs the concepts and methods of applied behavioral analysis within a person-centered approach. It focuses on stress management and learning of alternative adapted skills to support individuals in difficult situations rather than violence.	

Program Structure:	Two options are offered for program training: 1) Training – (Two-day course): PowerPoint presentations of conceptual and preventative material. Instructors receive a manual and a teaching guides to both the preventative (verbal) and physical skills curriculum. 2) Instructor Certification (Four-day course): Train-the Trainer course includes two days of curriculum demonstration, and two days of structured practice teaching, coaching and feedback from a Certified Instructor.	
Study and/or Evaluation Evidence:	Morrison (2003)	• An evaluation of four programs considered Therapeutic Options Inc. (TO) to have moderate effectiveness, yet scores were high in all other areas including the content, feasibility, the psychological comfort of the staff, and cost. • An evaluation conducted on a center-wide initiative to increase staff safety in a residential centre primarily attributed decrease in injuries, assaults, work-time lost and back injuries post one-year of training to the TO program.
Website:	http://www.therops.com	
Program:	**CALM – Crisis Agression Limitation Management**	
Provider:	CALM Training Services Ltd.	
Area/Region:	United Kingdom	
Population:	The program is developed for general users of the human services sector, while training is customized to the individual services based on best practice and need.	
Program Description:	Crisis Aggression Limitation Management (CALM) programs are noted to be grounded in the literature and place emphasis on supporting positive organizational cultures, environments and practices. CALM takes a holistic approach to reducing and preventing violence by understanding that there are various organizational variables that can influence the level of challenging behaviours and safety in a human service setting. CALM employs a public health approach where the focus is geared more to preventative solutions rather than crisis management.	
Program Structure:	CALM consists of two modules: 1) Theory in the management of critical incidents and challenging behaviours, and 2) Physical intervention. Each of these modules can be delivered in three different forms: 1) Direct Delivery: Modules 1 and 2 can be delivered within agencies by training staff 2) Mixed Delivery: Module 1 delivered by training staff, and Module 2 delivered by agency in house instructor 3) In house Delivery: Module 1 and module 2 delivered by agency in house instructor.	

Study and/or Evaluation Evidence:	CALM Training Services Ltd (2008); (Paterson, Leadbetter, & Steele, 2011; Paterson, McKenna, & Bowie, 2014)	• The CALM program has a wide array of evaluation and peer-reviewed literature indicating positive effects, specifically in decreasing restraint incidences (http://www.calmtraining.co.uk/evaluations.php). • Available evaluations currently are focused on sectors outside the health care context, yet publications examining the usefulness of the model in the health professions (e.g., mental health, & residential care) are available.
	Child Welfare League of America (2004)	• Large evaluation conducted over 3 years in 5 site facilities serving children and youth by the US congress found that the program obtained the lowest injury rates across the training models under investigation.
	Perkins and Leadbetter (2002)	• Evaluation in a special education school indicated an increase in confidence and reduction of stress in staff members. • Reduction of major violent incidence and crisis intervention by management, as well as an increase in verbal de-escalations techniques was found.
	Farrell and Cubit (2005)	• Authors note the program is more limited in scope than typical workplace prevention program as it has 5 of the 13 categories recommended by key leaders and professions as suggested content area for an effective training program.
Website:	http://www.calmtraining.co.uk/index.php	
Program:	**Kirkpatrick's Model Programs**	
Provider:	The One and Only Kirkpatrick® Company	
Area/Region:	USA	
Population:	General population, but is applied in various health care settings, including staff who work in homecare, long-term care, and with children or individuals with mental health illness and learning disabilities.	
Program Description:	Customized programs are developed in collaboration with the One and Only Kirkpatrick® Company consulting team to aid in building valid content that is grounded in theory and will ensure that what is learned can be utilized and elicit behavioral change. Programs designed based off the Kirkpatrick Model distinguish evaluation topics that can help with program construction and planning. Programs that use the Kirkpatrick Model® are measured across four evaluation categories to examine efficiency and effectiveness of the program; 1) Reaction – initial response of participants after training program, 2) Learning: Increase of knowledge that can be attributed to the program, 3) Behaviour – Extent to which participants apply their learned knowledge, and 4) Results: Changes at the organizational level.	

	In the content area of workplace violence, the consultation team works with researchers and/or organizations to develop training programs that fit the needs of the individuals implementing the program. For instance, a homecare organization worked with the consultation team to developed an aggression management training program to cope with violence in a health care setting (Oostrom & van Mierlo, 2008). The training program design was based on applicable methods and theory of the Kirkpatrick Model® and included three components to be evaluated; 1) Insight into assertiveness, aggression and recognition of violent behavior, 2) Insight into the interaction with aggressive persons and the effects of interactions, and 3) To provide participants with techniques and skills to aid in preventing a potential threatening situation from occurring (Oostrom & van Mierlo, 2008).	
Program Structure:	The company offers a variety of in-person and online training opportunities to learn the Kirkpatrick Model® evaluation methodology including certificate programs, workshops, keynotes and webinars. The main certificate programs are outlined: 1) Kirkpatrick Four Levels® Evaluation Certification Program – Bronze Level: 2 days or 5 online sessions – Create evaluation plan • Provides an understanding and breakdown of the four levels of training evaluation, as well as provides examples of tools and templates to adapt to your own customized evaluation and program plan. 2) Kirkpatrick Four Levels® Evaluation Certification Program – Silver Level: 1 day or 3 online sessions, plus formal presentation – Execute plan and report results • Provides the structure and support to successfully execute a complete program evaluation plan, as well as concludes with the development of customized actions plans for program execution. 3) Kirkpatrick Four Levels® Evaluation Certification Program – Gold Level: Presentation or Publication • Open to those who have attained silver level certification. Consists of presenting or publishing your program evaluation process, results or best practices in a way that assists other training professionals.	
Study and/or Evaluation Evidence:	Beech and Leather (2006); Beech (2008); Oostrom and van Mierlo (2008).	• Customized programs for an array of populations and context specific interventions use the Kirkpatrick Model® to develop effective training tools. • Using training techniques supported by the Kirkpatrick Model® are shown to change perceived knowledge and behaviours months after the program is implemented.
	Oostrom and van Mierlo (2008)	• A training program designed to help homecare workers cope with aggressive clients found significant improvement in assertiveness, reduction in aggression and increased ability to cope with hostile work situations. • The evaluation may have not capture participants overall change in behaviours overtime, but rather their perceived change in their beliefs, learning and knowledge.

	Beech (2008)	• A program for nurses that was supported by the Kirkpatrick Model found positive effects in staff's confidence in the areas of personal safety, prediction, and prevention were found. • Follow-up after three-months post training indicated increase reports of self-rest for nurses who underwent program.
Website:	http://www.kirkpatrickpartners.com/Our-Philosophy/The-Kirkpatrick-Model	
Training Programs in Long-term Care		
Program Name:	**P.I.E.C.E.S.™**	
Provider:	Ontario's Strategy for Alzheimer Disease and Related Dementias (ADRD)	
Area/Region:	Ontario, Canada	
Population:	Training to provide health care professionals the skills and knowledge to assist older individuals living with complex chronic diseases (e.g., neurocognitive disorders and/or mental health disease & associated behavioral changes). Originally developed for a long-term care setting, but has been adapted and implemented across an array of health care sectors and services.	
Program Description:	Physical, Intellectual, Emotional, Capabilities, Environment, Social (P.I.E.C.E.S™) program is an initiative focused on developing the knowledge and skills of frontline workers in long-term care settings that work with older adults with complex diseases. The program's framework focuses on targeting change at varying levels and takes into consideration numerous factors that influence behaviours and associated risks including people's physical and emotional strengths, as well as the social and physical environment. There are four cornerstone components of the P.I.E.C.E.S™ framework that provide a common set of values, knowledge, approach and language that support a person-cared approach including; 1) Shared solution finding, 2) Enhancing and translating knowledge, 3) Validating, and 4) Acting together. Currently in Nova Scotia, the P.I.E.C.E.S™ program is one component of the province's Challenging Behaviour Program that aims to enhance the quality of care to older adults experiencing cognitive/mental health and behavioural challenges.	
Program Structure:	The P.I.E.C.E.S™ framework is offered across Canada and is adapted based on provincial context and need, therefore the program structure varies widely. In Nova Scotia, two learning and development programs are offered; 1) 24-hour Learning and Develop Program, and 2) Leadership and Performance Improvement Program.	
Study and/or Evaluation Evidence:	McAiney et al. (2007); Speziale, Black, Coatsworth-Puspoky, Ross, and O'Regan (2009)	• Significant findings found an increase in staff's knowledge to understand challenging behaviours and mental health problems • The program was found to enhance staff's ability and use of assessment tools.
	Canadian Foundation for Healthcare Improvement (2014).	• Six-month improvement project to improve the lives of patients at a personal care home in Winnipeg, Manitoba. • Program resulted in a reduction in patients' anti-psychotic medications without an increase in behavioral challenges and physical restraints.

	Hagen and Slayer (1995)	• Evaluation to examine the effectiveness of the educational program on incident rates of physical aggression in a long-term care facility found the framework reduced physical aggression from elderly residents by 50%.
	McAiney and Service (2005)	• Evaluation of 25 training sessions in Ontario indicated that individuals who took part in the training reported increased confidence in their assessment skills and ability to assess physical health, intellectual capacity, emotional and spiritual health, functional capabilities, environmental factors, and social and cultural factors. • Participants suggest that ongoing education, training, further time to conduct assessments, access to assessment tools and supportive marterials are essential resources to ensure long-term sustainability of the training teachings.
Website:	http://pieceslearning.com	
Program Name:	**U-first!**	
Provider:	Alzheimer Society of Ontario	
Area/Region:	Ontario, Canada	
Population:	Individuals working with patients/clients with dementia and designed for staff working in community care, acute care and long-term care services.	
Program Description:	A training program for caregivers to improve and enhance the quality of their relationships with people living with Alzheimer's disease or other forms of dementia. The program focuses on dialogue and uses a case-based approach to ensure trainees have the confidence and skillset required to work with people who have dementia. U-first program uses concepts of the P.I.E.C.E.S program in its training.	
Program Structure:	Offered as a one day format or as two half days and broken up into three subject topics: 1) Demonstrate sensitivity and respect for the individuality of the person with dementia, their family and other team members. 2) Understanding the person living with dementia & associated behavioral changes. 3) Collaborate with the team to ensure individualized support strategies are developed that recognize and response to information gathered using U-First!	

Study and/or Evaluation Evidence:	Ryan (2009)	• An evaluation completed across the province of Ontario, Canada surveyed Administrators and/or Directors of Care from each long-term facility on their perceptions of the program. • Respondents reported increased understanding of the meaning of behaviours, increased availability of strategies for managing challenging behaviors, improved care planning, • Reduction of incidents of violent injury to staff and perceived the program as comprehensive approach for thinking through problems. • Perceived barriers to the effectiveness of the U-First! program including limited training staff, financial issues, and that additional training to enhance the uptake and adoption of the framework and common language was needed.
	McAiney & Service (2005)	• Evaluation of 25 training sessions in Ontario indicated that most participants who took part in the program reported that they were successful in using the U-First tool and P.I.E.C.E.S. framework to work through challenging issues, and rated the program as "fairly successful".
Website:	http://u-first.ca	
Program Name:	**Gentle Persuasive Approach**	
Provider:	Advanced Gerontological Education (AGE) in conjunction with educational initiatives that were part of the Ontario Canada's Alzheimer Strategy	
Area/Region:	Ontario, Canada	
Population:	Frontline care workers across health care professions working with individuals who have dementia.	
Program Structure:	A person-centered care approach to dementia care education designed to ensure staff respond in an effective, respectful and safe manner to verbal and physical behaviours (Speziale, Black, Coatsworth-Puspoky, Ross, & O'Regan, 2009) . The curriculum considers how unique personal history of each patient has a direct connection to their actions and behaviours (Speziale et al., 2009).	
Program Approach:	The program includes a 7.5-hour training course offered over a 3-month period. Four modules focused on: 1) Person-centered care 2) Impact of dementia on the brain 3) Interpersonal, environmental & communication strategies 4) Overview of body containment principles.	

	Speziale et al. (2009)	• Evaluation of the effectiveness of program found a significant improvement in staff's response to challenging behaviour and understanding of how brain changes of individuals impact behaviour. • A decrease in physical aggression rates over a six-month period following training, but could not indicate a change on occupation injury rates. • Proposed that the GPA program could potentially be extended to patients with diagnosis other than dementia, yet the research on this is limited.
	Martin and Dupuis (2005)	• Evaluation reported an increase in self-perceived competence, but suggests that the exposure to the curriculum may not be enough to permanently change behaviours, attitudes and values of employees who underwent training
Website:	https://www.ageinc.ca/research-hub/age-research-gpa-evaluation-service/	
Training Programs in Psychiatric Care		
Program:	**INTACT Aggression Management Program**	
Provider:	Developed by Dr. Olga Ilkiw-Lavalle	
Area/Region:	Australia	
Population:	Specifically targeted towards staff working in psychiatric care facilities	
Program Description:	An aggression management that was developed by Dr. Olga Ilkiw-Lavalle is based on a combination of past literature and extensive experience in the aggression management training and clinical care setting of psychiatric inpatients. The program includes specific components including legal issues, the characteristics of aggression, prediction of aggression, management of aggression, guidance on report incidents and self-care following aggression. The program also takes a preventative approach and emphasizes the importance of being aware of the potential aggressor and triggers of challenging behaviours.	
Program Structure:	The program training is conducted over a two-day period and incorporates group work, role-plays and practice of self-defense. Each participant will complete an illustrated aggression management manual.	
Study and/or Evaluation Evidence:	Ilkiw-Lavalle, Grenyer, and Graham (2002)	• Evaluation examining the effects of the program on a wide-range of occupation groups, as well as aimed to understand the value of training on staff who had received prior aggression management training from another program and/or educational forum. • Staff had a significant increase in knowledge of the components taught in the program, though staff who had not had previous training had less knowledge acquisition than those who did have prior training. • Evaluation focused primarily on the knowledge retained from the training and did not measure change in behaviours based on program implementation.

	Farrell and Cubit (2005)	• Comparison of aggression management programs indicated that the INTACT program included 10 of the 13 categories recommended by key professional and industrial organizations that are considered to be ideal content areas for workplace violence programs.
	Wang, Hayes, and O'Brien-Pallas (2008)	• INTACT training program is specifically directed at a targeted group of staff working in psychiatric care with no work mentioning the dissimination of this program to other health care settings.
Website:	Not Available	
Program:	**Prevention and Managing Crisis Situations (PMCS) and Creating a Respectful Environment**	
Provider:	New York State Office of Mental Health	
Area/Region:	USA	
Population:	Staff working in psychiatric hospitals	
Program Description:	The New York State Office of Mental Health developed a new aggression management staff training curriculum for use in state-operated psychiatric centers. The program put emphasis on increasing staff sensitivity to violent situations, and applying de-escalating and other non-coercive strategies. This training strategy is novel compared to past programs in the psychiatric units, which have primarily focused on safely applying restraint or seclusion. An additional part of the training was added to educate staff on interpersonal respect issues and is entitled "Creating A Respectful Environment."	
Program Structure:	Not Available	
Study and/or Evaluation Evidence:	Livingston et al. (2004)	• Evaluation of research efforts examining the effects of the program showed significant results – lowered use of (?) restraints and seclusions. • Authors suggested the study design and data collection methods used to examine effectiveness of program were weak.
	Fisher (2003)	• Research conducted in a large psychiatric hospital to examine the effectiveness of the training program showed a decline of restraint and seclusion rates up to 67% in a 2-year span.
Website:	https://www.omh.ny.gov/omhweb/dqm/restraint-seclusion/pmcs.pdf	
Program Name:	**Omega**	
Provider:	Health & Social Services section of the Agency for Health & Safety at Work	
Area/Region:	Montreal, Canada	
Population:	Employees in Psychiatric Hospital	
Program Description:	Aims to prevent and reduce workplace aggression towards health care workers by improving knowledge, attitudes, and skills of participants when facing verbal and physical aggression by patients.	
Program Structure:	Not Available	

Study and/or Evaluation Evidence:	VISAGE (2017)	• Limited evidence on the effectiveness of the Omega program, yet an evaluation of the program at the Institut universitaire en santé mentale de Montréal was conducted and available in French (http://www.equipevisage.ca/en/outils/3199/). An executive summary of the findings in English can be found here: http://www.equipevisage.ca/wp-content/uploads/2014/12/Résumé_rapport_anglais_SHJ.pdf
	Guay, Goncalves, and Boyer (2016)	• Longitudinal study collected data at three different time points show the impact of the program on those who underwent training. • Significant improvements for perceived levels of exposure to violence, a decrease of psychological distress for staff who completed the program, as well as an increase in confidence with coping with patient aggression over time.
Website:	Not Available	
Other Training Programs		
Program Name:	**Low Arousal Approach**	
Provider:	Autism Awareness Inc. in partnership with Studio-III UK	
Area/Region:	Canada and United Kingdom	
Population:	Originally the program was developed for staff working in services that focus on intellectual disabilities, but has now been modified for other sectors including individuals working with people with Autistic Spectrum Disorder (ASD), and in the mental health setting, and child & adult services.	
Program Description:	The program takes a person-centered philosophy and is designed to educate staff on how to focus on reducing arousal in crisis situations, while avoiding physical interactions. The purpose of the training course is to provide "effective, safe and socially valid methods to manage challenging behaviours" (Unwin, 2012). Particularly for health professionals working with individuals with Autistic Spectrum Disorder (ASD), the program assists in understanding what actions should be taken based on the "situation" by identifying numerous trigger warnings and educating individuals on a range of behavioral management strategies to reduce stress, and aim to prevent aggression.	
Program Structure:	Three-day training course for care staff now offered by the training organization Studio-III. The training program includes five key elements: 1) Reflective Practice 2) Demand Reduction in Crisis 3) Restrictive Practices (Restrict Physical Interventions) 4) Service Use Consultation 5) Organizational Approach	

Study and/or Evaluation Evidence:	Unwin (2012)	• A book review conducted on the *Managing Aggressive Behaviours in Care Settings: Understanding and Applying Low Arousal Approaches* states that there is thorough information provided on the effectiveness of the Low Arousal Approach and the applied framework. • Developer suggests that the techniques and strategies designed can be relevant in a range of health care settings, including children with Autistic Spectrum Disorder (ASD), children with learning disabilities, in a mental health care setting, and with the general child and adult population.
	McDonnell et al. (2008)	• Evaluation completed by the developer of the approach measured the effectiveness of a three-day training program using low arousal approach techniques. • A significant increase was found in confidence of the staff who were part of the program, but no significant findings were shown for staff coping, or perceived control of patients challenging behaviours.
	Allen and Tynan (2000)	• Evaluation findings of program showed enhanced confidence of individuals to manage challenging behaviours and work with aggressive individuals, as well as increased knowledge on behaviours management.
Website:	https://autismawarenesscentre.com/studio-3-canada/	

Conclusion

Workplace violence is increasingly becoming a safety concern in the health care and community services settingd, with severe negative consequences (Birgit Heckemann, Breimaier, Halfens, Schols, & Hahn, 2016), including physical and verbal aggression, as well as bullying and sexual harassment (Beech & Leather, 2006). Staff training programs are identified as an effective initiative to reduce and prevent violent incidents occurring in the workplace, especially within the health care sector (Livingston et al., 2010).

The asset map outlines key programs currently implemented in Canada, and/or internationally, as well as gives an overview of the available evidence their effectiveness. The asset map placed priority focus on commercial programs that aim to enhance patient to staff relationships, however future iterations of the asset map will expand to include other forms of workplace violence relationships (e.g., staff to staff).

The programs reviewed differ in their objectives, design and scope of evidence, yet there are similarities noted in the philosophy of the program's, as well as their potential effectiveness to reduce workplace violence. The majority of programs place emphasis on a patient/care-centered approach, educate on the signs and characteristics of challenging behaviours, consider organizational and environmental factors, as well as provide knowledge on the legal and liability issues associated with workplace violence. The structure of the programs are relatively alike and most of the programs consist of a number chapters and/or modules taught over a short-time frame.

In accordance with past literature (Beech & Leather, 2006; Livingston et al., 2010), the evidence on the effective of the workplace violence and aggression programs mainly show increase in staff's knowledge, understanding and techniques to manage challenging behaviours of their patients and/or residents, as well as the reduction in violence, restraints and seclusions.

The asset map will be able to assist stakeholders in deciding what programs could be adopted and implemented to reduce and prevent workplace violence in the health care sector.

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