

STANDARDS RESEARCH

Workplace Violence and Harassment Prevention and Management: A Focus on the Health Care Service Sector in Canada

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Executive Summary

Workplace violence and harassment (WPVH) is a persistent problem across Canada's health care sector, affecting workers in every care setting, at every level of the system, and at every stage of their careers.

This report examines the WPVH landscape across six distinct health care settings: medical care settings and rehabilitation centres; emergency medical services or paramedics; home and community care; long-term care and assisted living; mental health settings; and substance use and withdrawal services.

The central research question guiding this project was: What are the gaps, challenges, best practices, and opportunities for developing standards-based solutions to address WPVH in the Canadian health care service sector?

A mixed-methods approach was employed, comprising an environmental scan of 92 documents across all Canadian jurisdictions; a literature review of 593 peer-reviewed and grey literature sources (2019–2025); an online survey completed by 897 participants across all six settings; and key informant interviews with 20 participants from six provinces and the national level. Findings were integrated thematically to generate evidence-based recommendations.

All provinces and territories have legislative requirements governing WPVH across health care settings; however, the environmental scan identified significant variation in both depth and enforcement. Several jurisdictions have developed comprehensive sector-specific frameworks.

The literature review identified eight cross-cutting themes reflecting challenges present in all six health care settings:

- Definitional inconsistencies
- Under-reporting and normalization
- Insufficient organizational and managerial support
- Training gaps
- Staffing and work environment
- Inadequate post-incident support
- Vulnerable populations and intersectionality
- Systemic and cultural barriers

The literature review also identified six cross-cutting themes focused on best practices and opportunities for standards development:

- Comprehensive multicomponent prevention programs
- Staff education and training programs

- Leadership commitment and organizational culture
- Risk mitigation strategies
- Support systems and post-incident care
- Areas for improvement and emerging priorities

The survey findings revealed a significant gap between policy and practice. While most participants understood which behaviours should be reported (88.4%) and felt their organization had a clear WPVH definition (74.2%), confidence in organizational prevention and response systems was far lower: only 45.7% felt management takes reported incidents seriously, fewer than one-third trusted their workplace policies to protect them (27.6%), and only 22.2% believed perpetrators would be held accountable. Critically, 83.0% agreed that national standards are needed, and 84.1% agreed their workplace would benefit from dedicated resources to improve WPVH issues.

Key informant interviews reinforced these themes, with participants identifying the normalization of WPVH, chronic staffing pressures, inconsistent leadership engagement, lack of meaningful accountability, and inadequate reporting and measurement as the most significant barriers. There was enthusiastic support for the development of an actionable, setting-specific, and enforceable national standard.

Five priority areas for national standards development emerged from integrated findings across all research components:

- **Leadership commitment and organizational support:** Mandate visible, sustained commitment to WPVH prevention and response; timely and transparent post-incident follow-up; and non-blaming, trauma-informed organizational responses.
- **Education and training:** Establish standardized frameworks with setting-specific content; emphasize practical de-escalation and prevention from pre-service through ongoing professional development.
- **Risk assessment and mitigation:** Support standardized, ongoing risk assessment processes addressing environmental, organizational, and system-level factors alongside individual patient/client behaviours.
- **Post-incident response and psychological support:** Require structured, equitable, and trauma-informed post-incident protocols for all staff that include debriefing, counselling, peer support, and leadership follow-up.
- **Reporting, monitoring, and continuous improvement:** Adopt harmonized definitions, streamlined reporting systems, and standardized indicators to support surveillance, benchmarking, and evidence-informed improvement.

This report provides comprehensive evidence that WPVH is highly prevalent and deeply embedded across all six Canadian health care settings examined. While legislation and many organizational programs are in place, findings consistently demonstrate that current efforts are fragmented, inconsistently applied, and insufficient to fully address the problem. The normalization of violence as an occupational inevitability remains a significant cultural challenge.

At the same time, promising practices across jurisdictions and settings demonstrate that meaningful progress is achievable. The development of a national standard built around the five priority areas and grounded in the realities of each health care setting offers a significant opportunity to protect health care workers, strengthen the workforce, and enhance sustainability of care delivery across Canada.



"Canadian researchers have recently found that over 70% of employees in Canada have experienced Workplace violence and harassment."

1 Introduction

Workplace violence and harassment (WPVH) is a significant concern in Canada. In 2023, the Government of Canada ratified the first-ever global treaty on ending WPVH, underscoring the seriousness of this issue [1]. Moreover, Canadian researchers have recently found that over 70% of employees in Canada have experienced WPVH [2]. A recent review conducted by Ferron and Kovacs established the extent of WPVH in Canada and the actions that need to be taken to prevent and manage it [3]. Included in these recommendations is the need for sector-specific guidance. The health care sector, with known high rates of violence and harassment [4], is an essential one to address.

A recent systematic review found that 58.7% of health care workers reported exposure to some form of workplace violence [5]. Workers in health care settings are five times more likely to be injured than workers in other settings [6]. The World Health Organization estimates that between 8% and 38% of health care workers will suffer physical violence during their careers [7]. Exposure to and experiences of WPVH can have profound physical and psychological impacts on health care workers, including post-traumatic stress disorder (PTSD), major depressive disorder, generalized anxiety disorder, burnout, and suicide [8], [9].

This research project focused on WPVH prevention and management specific to the health care service sector and six health care settings within it:

- medical care settings (e.g. hospitals, nursing clinics, doctor outpatient departments, clinical labs) and rehabilitation centres
- emergency medical services or paramedics
- home and community care environments
- long-term care homes and assisted living settings
- mental health settings
- substance use and withdrawal services centres

There are many definitions of WPVH. Indeed, the existence of varying definitions and conceptual inconsistencies was one of this report's findings. In this report, WPVH is defined in accordance with Ontario's *Occupational Health and Safety Act* [10] as follows:

- **Workplace violence:**
  - "The exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker;
  - an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker;
  - a statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker."
- **Workplace harassment:**
  - "Engaging in a course of vexatious comment or conduct against a worker in a workplace, including virtually through the use of information and communications technology, that is known or ought reasonably to be known to be unwelcome"; or workplace sexual harassment.

- **Workplace sexual harassment:**
  - "Engaging in a course of vexatious comment or conduct against a worker in a workplace, including virtually through the use of information and communications technology, because of sex, sexual orientation, gender identity, or gender expression, where the course of comment or conduct is known or ought reasonably to be known to be unwelcome;
  - making a sexual solicitation or advance where the person making it is in a position to confer, grant, or deny a benefit or advancement to the worker and the person knows or ought reasonably to know that the solicitation or advance is unwelcome."

This research project was guided by the following overarching question: What are the gaps, challenges, best practices, and opportunities for developing standards-based solutions to address violence and harassment in the Canadian health care sector?

This objective of this research project was to examine the current landscape of policies, programs, and tools addressing WPVH across six health care settings while identifying key gaps, challenges, and opportunities for improvement. It also sought to develop evidence-informed recommendations for national standards tailored to diverse care contexts, informed by broad engagement with key informants, experts, and participants across the health care settings.

2 Methods

A comprehensive research approach was undertaken to arrive at well-informed and justified recommendations for national standards-based solutions to address WPVH issues, both in the health care service sector in general and specific to each of the six health care settings. A mixed-methods approach was utilized, allowing for the triangulation of both quantitative and qualitative data to inform final recommendations. The research project included four components: an environmental scan, a literature review, an online survey, and in-depth key informant interviews. Data was collectively integrated and analyzed to inform the resulting recommendations. Research ethics board approval was obtained through the Queen's University Health Sciences Research Ethics Board.

2.1 Environmental Scan

The environmental scan aimed to identify existing legislation, regulations, standards, programs, strategies, and support tools at the provincial, territorial, and national levels in Canada. This included a search of publicly available data from non-academic sources. The following data was extracted from included documents: general citation information, jurisdiction/

Figure 1: Four components of the research project utilized to arrive at final recommendations



scope, relevant health care sector(s), focus/aim/objective, definition of WPVH, and findings of interest. Extracted data was reviewed and analyzed thematically with respect to differences and similarities across jurisdictions. Additionally, data was analyzed critically to identify gaps in existing legislation, regulations, standards, programs, strategies, and support tools that could be addressed through standards.

2.2 Literature Review

A literature review was conducted to identify needs, gaps, challenges, best practices, and areas of improvement related to WPVH prevention and management in the health care service sector. The review included both peer-reviewed and non-peer-reviewed publications. The Medline (OVID), EMBASE, CINAHL, and PsycINFO electronic databases were searched from 2019 to May 2025. Retrieved citations underwent title/abstract screening to determine inclusion eligibility. Full texts were retrieved for citations that passed screening, and inclusion/exclusion criteria were applied to the full texts to arrive at the final set of included articles. The following data was extracted from the included articles: general citation information, jurisdiction, relevant health care sector(s), study population, definition of WPVH, strategies used to combat WPVH, gaps and challenges in preventing WPVH, and additional findings of interest. A thematic analysis was conducted to identify needs, gaps, challenges, and areas for improvement as well as best practices, solutions, and support tools.

2.3 Online Survey

The purpose of the survey was to elicit participants' perspectives on existing needs, gaps, and challenges that could be addressed through national standards. Additionally, participants had the opportunity to share any best practices, initiatives, and solutions they were aware of that could inform the development of standards for WPVH prevention and management in the health care service sector.

The survey questions were developed based on preliminary results obtained from the literature review and environmental scan. The survey consisted of 11 demographic questions, 21 closed-ended Likert-type questions, and three open-ended questions. It was administered online, in both English and French, using Qualtrics survey software. Hard copies were available upon request, though none were requested.

Participant recruitment employed a snowball sampling methodology. An initial comprehensive contact list of professional associations, regulatory colleges, labour organizations, health service delivery organizations, government and policy bodies, research organizations, and key informants working in the six health care settings was developed. Contacts were invited to both complete the survey and distribute it to their networks. Additionally, social media channels and paid social media advertisements were also employed to assist in recruitment.

Quantitative data (demographic and closed-ended survey responses) was analyzed with descriptive statistics reported as appropriate. Data was also analyzed using SPSS software to identify correlations. Open-ended survey questions were analyzed by content and thematic analysis as appropriate, identifying best practices, initiatives, and solutions and exploring issues, gaps, and challenges.

2.4 Key Informant Interviews

The purpose of the key informant interviews was to seek a richer understanding of the needs, gaps, challenges, and areas for improvement with regard to WPVH in the health care service sector, and to collect best practices and solutions. A semi-structured interview guide was developed, consisting of 10 questions. Participant recruitment was conducted using the same methodology as the online survey. All interviews took place virtually via the Zoom meeting platform. Interviews were recorded and transcribed using OtterAI software. All interviews were conducted in English, as no participants requested an interview in French.

Data was analyzed in accordance with thematic analysis methodology. Transcripts were reviewed and coded by two members of the research team, who conducted an iterative comparison and grouping of codes to arrive at emergent themes. These themes were refined and merged as needed to arrive at the final set of confirmed themes.

3 Results and Discussion

3.1 Jurisdictional Scan of Existing Canadian Frameworks

The environmental scan included a total of 92 documents, with the provincial/territorial and national breakdown as follows:

- National: 13 documents
- Alberta: 8 documents
- Atlantic provinces: 12 documents
- British Columbia: 13 documents
- Manitoba: 7 documents
- Ontario: 19 documents
- Quebec: 7 documents
- Saskatchewan: 8 documents
- Territories: 5 documents

3.1.1 National Legislation, Regulations, Programs, and Strategies

Canada's health care system is composed of several layers, where the outermost layer with macro-level influence is made up of international bodies, the federal government, provincial and territorial governments, pan-Canadian organizations, agencies, and research funding bodies [11]. Each organization in the outermost layer has a specific role in the workplace violence ecosystem [11], such as leading, delivering, or providing accountability for specific actions.

Canada's legal framework for preventing WPVH in health care settings is made up of a combination of federal and provincial/territorial legislation. The federal government and each province or territory has its own occupational health and safety (OHS) legislation, which facilitates an internal responsibility system (IRS) in the workplace. IRS means that maintaining a safe workplace is the joint duty of employers, supervisors, and workers [3]. The various OHS acts and regulations require employers to develop and implement comprehensive policies and programs to protect their workers from violence, conduct risk assessments, and establish clear procedures for reporting and investigating incidents [12].

Under provincial/territorial OHS legislation, workers have three fundamental rights: to know about workplace hazards, to participate in safety decisions, and to refuse dangerous work [13].

Federal legislation that protects health care workers from WPVH is included in the *Criminal Code* [14]. In late 2021, *An Act to amend the Criminal Code and the Canada Labour Code* was passed to provide enhanced protections for health care workers and those accessing health care services [14]. The amendments to legislation created a specific offence of intimidation to further protect health care workers and made it illegal to use threats and bullying to stop a health worker from providing care to patients. This could include threats or other forms of violence that are intended to provoke fear, to interfere with the duties of a health care worker, or to impede a person from receiving health care services. The specific offence of obstruction or interference with access prohibits obstructing any person from intentionally accessing health facilities, but does not apply where a person is peacefully protesting or communicating information, such as on a picket line outside a health facility. The amendment also introduced aggravating sentencing factors, which require courts to consider more severe penalties for offenders who target health care workers or impede access to services [14]. It should be noted that not all health care workers are captured by this protection; for example, paramedics are considered public safety personnel and not health care workers in the context of this legislation.

The *Canada Labour Code* (CLC) is an important part of the federal legislative landscape, specifically Part II of the CLC, which governs occupational health and safety for workers in federally regulated workplaces [15]. Generally, provinces and territories are responsible for their own health care systems; however, some health care professionals are employed by the federal government (e.g. in federal prisons, Indigenous health services, or on military bases) and are regulated by the CLC [16]. In 2021, amendments to the CLC through Bill C-65 strengthened and expanded the prevention of violence framework [17]. Specifically, changes were made to prevent incidents of harassment and violence from occurring, respond effectively

to incidents when they do occur, and support victims, survivors, and employers in the process.

The *Canadian Human Rights Act* [18] and its provincial/territorial counterparts prohibit harassment based on race, age, and gender identity. Canadian legislation places a significant responsibility on health care employers to proactively prevent, respond to, and investigate all forms of WPVH. Employers have a duty to provide a safe work environment through clear, written policies, regular risk assessments, trained security, and adequate staffing levels [3]. For some health care providers, organizations must provide robust support for victims of violence, including counselling, critical incident debriefing, and second victim support programs [19].

Health Canada supports policy-making in health care settings by funding targeted projects and pan-Canadian research about WPVH. An example is the evidence-based assessment conducted by the Canadian Academy of Health Sciences [11]. This research determined possible pathways forward to ease the health workforce crisis in Canada. It identified five priority pathways and 26 evidence-led policies and practices for early implementation. Six of those policies and practices speak to WPVH prevention and management.

Health Canada also supports continuous investments in organizations such as the Canadian Institute for Health Information (CIHI) to facilitate comparable and actionable health data and information across provinces and territories. Workplace violence has a negative impact on delivery of care, as it results in staff shortages due to injuries, high burnout rates, and workplace stress, which all affect quality of care and increase costs to the health care system [20]. The House of Commons Standing Committee on Health made nine recommendations for a pan-Canadian framework to prevent violence in health care settings that could be supported by CIHI [20]. For example, funding CIHI to develop standardized definitions for workplace violence and collect provincial/territorial statistics would amplify its contributions to improving health systems [20].

Several pan-Canadian programs and strategies support WPVH prevention and management. The *Canadian Centre for Occupational Health and Safety Act* (CCOHS) [21], established in 1978, is a pan-Canadian organization governed by a council representing government, labour, and employers. The CCOHS promotes workplace health and safety across all sectors by providing essential, unbiased education and training resources, management tools, and solutions to encourage attitudes and methods that improve workers' physical and mental health.

A national standard related to occupational health and safety, CAN/CSA Z1003 *Psychological Health and Safety in the Workplace—Prevention, Promotion, and Guidance to Staged Implementation* [22], provides a framework to help organizations create and maintain a psychologically healthy and safe workplace. The standard addresses factors like organizational culture, psychological protection, and workload management. It is designed for any size or type of organization looking for a systematic approach to mental health. While the CLC and provincial/territorial occupational health and safety regulations do not explicitly name the standard or mandate psychological health programs, workplaces across Canada, including the public sector and health care organizations, have implemented it as a best practice to mitigate and manage mental health risks [23].

3.1.2 Alberta

Alberta Health Services (AHS) has a comprehensive framework to prevent and address harassment and violence in the workplace, with layered policies that apply across hospital and community settings. At the core is the Respectful Workplaces and the Prevention of Harassment and Violence Policy [24], adopted in 2009 and updated in 2019. This policy applies broadly to all AHS workers, including employees, medical and midwifery staff, students, volunteers, contracted providers, patients, families, and visitors. The intent is to foster a safe, inclusive, and respectful organizational culture in which harassment, bullying, and violence are explicitly recognized as occupational hazards. All forms of violence, including domestic or relationship violence, are explicitly covered. AHS requires every incident or concern to be reported

in good faith, investigated promptly, and met with appropriate corrective actions. Workers are protected from reprisal and may also pursue complaints under other legislation such as the *Occupational Health and Safety Act*. Managers and leaders carry heightened responsibilities to model safe behaviour, investigate concerns fairly, and support affected individuals. All workers must complete violence prevention training and adhere to established safety controls.

Building on this framework, AHS has also created the Type II Procedure [25] to specifically address patient-to-worker harassment and violence. This detailed protocol guides staff in responding to risks that arise from patients, families, or visitors, acknowledging the heightened risks of aggression in clinical environments. Type II incidents are recognized as workplace hazards and must be reported through AHS's safety reporting system, MySafetyNet. Preventive strategies include risk assessments, tailored care planning, and the use of emergency codes such as Code White or Code Black for violent or weapons-related events. Investigations, corrective actions, and ongoing supports, including psychological services and staff debriefs, are required after every incident.

Complementary to these efforts is the Restraint as a Last Resort Policy [26], which connects directly to safety and violence prevention by addressing how and when restraints may be used in clinical care. Restraints may only be applied after all alternatives have been attempted and when other methods of de-escalation have failed. Clinical staff are expected to carefully document assessments, ensuring patient behaviours, medical symptoms, and environmental interventions have been considered before resorting to this measure.

The *Workplace Violence and Abuse Manual* [27], produced via a partnership between the United Nurses of Alberta (UNA), the Alberta Union of Provincial Employees (AUPE), and the Health Sciences Association of Alberta (HSAA), provides a worker-centred guide for identifying abuse, bullying, harassment, and systemic issues. The manual reinforces obligations under the *Occupational Health and Safety Act* to conduct workplace hazard assessments, implement zero-tolerance policies, and



provide mandatory training. It also acknowledges the lived experiences of frontline staff. The manual highlights that abuse often occurs in a climate of fear, with managers sometimes minimizing or overlooking incidents, and stresses that employees have the right to a safe workplace, independent investigation, and appropriate follow-up care.

Implementation of these policies is further reinforced in emergency departments and urgent care settings through the Prevention of Harassment and Violence Program [28], which focuses on provincial-level interventions in high-risk clinical environments, emphasizing collaboration between workplace health and safety teams and operational leaders. The aim is to create safer environments, increase staff confidence in navigating hazards, and build shared organizational accountability for violence prevention.

Concerns around violence and workplace conditions extend strongly into Alberta's pre-hospital system. The Parkland Institute's report "Lights and Sirens: The Critical Condition of Emergency Medical Services in Alberta" [29], released in 2023, documents the voices of paramedics and frontline emergency medical services professionals. Workers describe the system as "toxic" and "broken," citing staff shortages, mandatory shift extensions, a culture of fear, and high rates of burnout. The report positions these

challenges as forms of structural violence and moral injury, where systemic factors prevent workers from delivering care they know is needed. Sick time in emergency medical services has risen dramatically, and staff feel abandoned by policy-makers. The report makes 15 recommendations, including piloting a 30-hour work week, reconfiguring shifts, implementing trauma-informed workplace practices, and enhancing mentorship and training programs.

Related to emergency medical services operations, the Alberta Emergency Medical Services Dispatch Review completed by Price Waterhouse Coopers in 2022 [30] studied the province's centralized ambulance dispatch model. While the model was intended to improve efficiency, study participants reported concerns about delayed ambulance responses, communication silos, and inadequate cultural sensitivity in patient transfers, particularly for Indigenous communities. The review highlighted inefficiencies such as a lack of interoperability between communication systems, which causes delays between the EMS provider and fire/police communication, creating safety concerns. Recommendations included integrating computer-aided dispatch systems across police, fire, and emergency medical services; developing standardized provincial metrics; embedding patient data into dispatch processes to better detect or prevent patient violence; improving coordination with first responders; and strengthening frontline violence prevention elements.

It should be noted that since the time of the Dispatch Review, Alberta has experienced a restructuring of its health care system, including an organizational shift that resulted in emergency health services residing as a provincial health corporation within Acute Care Alberta. The impact of this restructuring, and specifically its impact on WPVH prevention, remains to be seen.

Taken together, Alberta's legislative and policy framework reflects both compliance-driven obligations under human rights and occupational health law and practice-driven adaptations to the lived realities of health care workers. At the organizational level, AHS enforces strong policies against harassment and violence, integrates worker protections into patient care practices, and supports staff through reporting, investigation, and training requirements. From the union and worker perspective, however, systemic pressures and under-resourced systems continue to foster environments where violence and disrespect flourish, particularly in emergency medical services. Independent reviews and research reports call for deeper reforms, ranging from workload and shift redesign to cultural change within dispatch and emergency medical services.

3.1.3 Atlantic Provinces

In **Nova Scotia,** safety in the workplace is protected by the *Occupational Health and Safety Act* and specifically the *Workplace Health and Safety Regulations* [31], which provide guidance on assessing risk, creating prevention plans, training employees, reporting incidents, and conducting investigations.

Nova Scotia Health (NSH) developed a comprehensive Violence in the Workplace policy (AD-OHS-010) specifically for health care workers. This policy came into effect in April 2023 [32] and is designed to implement legislative requirements for preventing and managing workplace violence. NSH acknowledges violence as an occupational health and safety hazard that can cause physical and psychological harm and negatively affect patient care, morale, and productivity. The policy states that staff and leaders are required to be aware of their legal obligations, potential hazards, and available policies, and must participate in education and training to prevent and manage violence. Any act of violence, including near-miss situations, must be reported. The policy also provides guidance on reporting and post-incident debriefing.

Health **Prince Edward Island** (Health PEI) has a Provincial Violence Prevention and Reduction Steering Committee, a multidisciplinary team focused on fostering a safe environment, minimizing workplace violence risks, and ensuring compliance with occupational health and safety legislation [33]. The committee aims to reduce risks, create a robust safety culture, raise awareness, recommend measures, select control measures (policies, signage, communication), support education program development and evaluation, and monitor WPVH statistics and trends.

Further, Health PEI has a Respectful Workplace Policy focused on resolving conflicts and addressing disrespectful behaviour [34]. Employers, employees, and staff are expected to be familiar with and abide by the policy. Health care workers must notify their supervisor of all WPVH incidents, even if no physical injury occurs. All WPVH incidents must be investigated and control measures implemented to prevent recurrence.

In 2019, under its *Occupational Health and Safety Act,* the Government of **New Brunswick** established the Respectful Workplace Policy, which states that all employers must establish a violence and harassment policy that includes a description of types of violence that may take place in the workplace setting. Employers must conduct risk assessments, have plans to implement the policy, train staff, and have follow-up procedures should an incident occur. In alignment with the policy, the Nursing Home Workplace Violence Prevention Working Group, a collaboration between the New Brunswick Nursing Home Association (NBANH), the New Brunswick Nurses Union (NBNU), WorkSafeNB, and the New Brunswick Continuing Care Safety Association (NBCCSA) developed the New Brunswick Nursing Home Violence Prevention Toolkit [35], [36], which promotes the message "Violence is NOT part of the job" and includes roles and responsibilities documents for boards, management, workers, and residents. It also provides conduct agreements, flow charts for incident steps, and risk assessment tools. Violence prevention training is also included in NBANH's offerings.

Under **Newfoundland and Labrador's** occupational health and safety legislation, employers have a responsibility to implement tools and procedures to identify and control workplace violence risks. Additionally, employers must conduct risk assessments and develop and implement prevention plans.

Across Atlantic Canada, WPVH prevention and management are governed by occupational health and safety legislation, but each province has developed its own complementary frameworks to strengthen protection for workers. Nova Scotia, Prince Edward Island, New Brunswick, and Newfoundland and Labrador all require employers to assess risks, implement prevention plans, train staff, and investigate every incident, including near misses. Collectively, the Atlantic provinces reinforce a unified message: violence is a serious occupational hazard, and creating safe, respectful environments demands coordinated prevention efforts, clear reporting expectations, and strong organizational commitment.

3.1.4 British Columbia

British Columbia has developed a wide-ranging set of policies, programs, and regulatory mechanisms aimed at preventing WPVH in all health care settings, recognizing it as both a growing crisis and a core occupational health and safety issue. The British Columbia Nurses' Union (BCNU) has been a leading voice in drawing attention to this issue. In 2019, BCNU made a submission to the House of Commons, stressing that "violence is not part of any nurse's job" [37]. The union highlighted systemic risk drivers, including understaffing, heavy workloads, poorly trained or absent security personnel, and unsafe physical environments. A subsequent BCNU brief presented to the Senate of Canada in 2024 noted a legal gap in protections, calling for amendments to the *Criminal Code* of Canada that would recognize assaults against health care workers as aggravating factors in sentencing, in the same way similar provisions protect transit operators or police officers [38].

The BC Women's Health Foundation's "Invisible No More" report detailed how women health care workers (who make up the majority of the workforce) face compounded stressors, from inadequate personal protective equipment during COVID-19 to denied personal days, inequitable compensation, and dismissal of their mental health needs [39]. Violence, harassment, and exhaustion were described as invisible burdens that fuel burnout. Recommendations from this report focused on sustainable staffing, equitable pay, proactive wellness supports, and training grounded in real-life clinical scenarios and cultural context.

British Columbia's *Workers Compensation Act* and Occupational Health and Safety Regulation (B.C. Reg. 296/97) set out firm requirements for violence prevention in all settings [40]. Employers must conduct workplace-specific risk assessments and ensure workers are informed about risks. Employers are further required to provide training in recognition, prevention, de-escalation, emergency procedures, and reporting. Written violence prevention programs must be implemented, reviewed at least annually, and supported by joint health and safety committees. Workers maintain a right to refuse unsafe work if they believe violence poses a serious risk or to decline to enter a scene until appropriate controls are in place.

At the program level, B.C. has invested in the Provincial Violence Prevention Curriculum (PVPC), developed in 2010 and updated in 2015 [41]. This curriculum is the cornerstone of health care worker training and emphasizes that prevention is everyone's responsibility, both individually and organizationally. Evaluations of the PVPC, particularly in emergency departments, have shown that its effectiveness improves when training is tailored to clinical realities, delivered by credible trainers using live scenarios, and reinforced by a non-blaming reporting culture. A 2022–2024 needs analysis led by SWITCH BC confirmed the importance of updating the PVPC by adding continuous refresher training, cultural safety content, mental health resiliency strategies, and team-based scenario practice [42]. SWITCH BC led the update of the PVPC's online violence prevention education modules, which were launched in February 2026.

Interior Health's Violence Prevention Program (VPP), introduced in 2003 and updated in 2024, builds compliance with WorkSafeBC regulations into a comprehensive framework of violence risk assessments, policies, procedures, worker training, incident reporting, and annual program reviews [43]. Code White drills for violent situations and Code Silver responses to active attackers are mandatory in all Interior Health facilities. Workers are trained to complete point-of-care risk assessments for every patient interaction, and managers are accountable for ensuring identified risks result in updated behavioural care plans and are communicated to all staff. Violent incidents (including attempted assaults or verbal threats) must be reported promptly through the Provincial Workplace Health Contact Centre, investigated, followed up with corrective measures, and communicated back to affected teams. Workers are supported with access to debriefing, counselling, and employee assistance services, and they retain the right to refuse unsafe work in dangerous conditions.

Complementary tools, such as WorkSafeBC's Health Care Violence Inspection Checklist and its guidance on risk communication, reinforce these requirements by providing practical compliance frameworks and clarifying employer duties to share relevant information (such as triggers and histories of aggression) across care teams and sites [44]. Doctors of BC has also contributed physician-focused guidance through its violence prevention policy papers and Violence Prevention Guide for Community Clinics, which urges physicians to incorporate team planning, exit strategies, and violence prevention roles into every clinic practice [45].

Taken together, the approach in British Columbia reflects a multi-layered response to workplace violence in health care, combining regulatory requirements, union advocacy, targeted prevention and response training, and system-level program implementation. Legislated employer duties under the *Workers Compensation Act and Occupational Health and Safety Regulation,* as well as standardized training through the Provincial Violence Prevention Curriculum and operational accountability within regional health authorities, have demonstrated an attempt by the province to embed violence prevention into both policy and daily practice. While ongoing updates and cultural shifts remain necessary, particularly to address gendered impacts and reporting culture, British Columbia demonstrates how coordinated legal, organizational, and frontline strategies have the potential to position workplace violence prevention as a core component of health system quality, worker safety, and patient care.



3.1.5 Manitoba

In Manitoba, legislation related to violence in the workplace falls within Section 11 of the *Workplace Safety and Health Act* [46]. This legislation requires employers to assess the risk of violence to staff, in consultation with a violence prevention committee or representative within the workplace. Additionally, employers must develop and implement violence prevention policies, train workers and ensure workers comply with the policy. If an incident occurs, it must be reported and an investigation carried out to understand how to reduce the risk of violence in the future.

Health care workers in Manitoba face significant risks of encountering verbal, physical, or psychological violence. Between 2018 and 2022, there were over 3,500 documented acts of violence or assaults on health care workers [47]. Only 28% of nurses feel safe at work daily [48]. In 2013, the Violence Prevention Program for Health Care Workers in Manitoba was established within the *Workplace Safety and Health Act* [49] and aims to "mitigate, eliminate or reduce all forms of violence in workplaces where health care services are provided." The policy defines violence as "any act that results in injury or threat of injury, real or perceived, by an individual, including but not limited to: acts of aggression, verbal or written threats, vandalism of personal property [49]." It also acknowledges that in some health care environments it may not be possible to eliminate the risk of violence and, as such, actions and measures are created to control and report the risk.

In addition, the Winnipeg Regional Health Authority (WRHA) developed Primary Health Care Operational Guidelines in accordance with Accreditation Canada required organizational practices and the *Workplace Safety and Health Act* and regulation [50]. The guidelines help to ensure the implementation of risk assessment tools, measures to reduce risks, patient screening practices, and documentation practices. Specific plans are developed by primary care site leadership and health care teams, and cover staff and patients within the clinic environment and at patients' homes in the case of home visits. A number of tools have been developed to support workplace violence prevention within WRHA, such as the Safety Assessment Form, the Safe Visit Plan tool, and a communication plan [50].

Manitoba's framework reinforces the broader Canadian approach to WPVH legislation. Organizations have a duty to assess risks, implement prevention policies, train staff, and investigate every incident. Local and provincial health authorities support these requirements through sector specific programs, operational guidelines, and practical tools.

3.1.6 Ontario

In Ontario, the overarching legislation addressing WPVH is the *Occupational Health and Safety Amendment Act* (OHSA), which was importantly amended in 2009 by Bill 168 [51]. Bill 168 received royal assent in December 2009 and amended the OHSA to strengthen protections for Ontario workers regarding WPVH.

In addition to the OHSA, the Ontario government released a guide entitled "Workplace violence prevention in health care: A guide to the law for hospitals, long-term care homes, and home care" [52]. Though this guide can assist organizations in these settings with OHSA implementation, it stops short of addressing implementation in other health care service sectors. Similarly, Health Quality Ontario released "Quality Improvement Plan Guidance: Workplace Violence Prevention" [53], a guide meant to help hospitals, primary care, long-term care, and home or community care settings meet expectations related to workplace violence and prevention through their quality improvement plans. It includes several recommendations for organizations, such as building interdisciplinary teams, using data analysis tools, conducting risk assessments and identifying contributing factors, suggested implementation strategies, and data details on a mandatory indicator (number of workplace violence incidents). Ontario's Public Services Health and Safety Association has also released several toolkits focused on risk assessment for acute care [54], risk assessment for long-term care [55], and bullying in the workplace [56].

Professional associations in Ontario have also demonstrated an increased focus on WPVH prevention and management and the provision of supports and tools for their members. The Ontario Medical Association provides guidance on their website regarding physicians' obligations under the OHSA and physician safety issues [57]. They also reference the College of Physicians and Surgeons of Ontario, which has a policy on Human Rights in the Provision of Health Services [58]. Freedom from WPVH is included as a human right.

Both the Ontario Nurses' Association (ONA) and the Registered Nurses Association of Ontario (RNAO) have developed several resources for their members and the public. In 2024, the ONA released an infographic entitled "Workplace violence is NOT a part of your job," which highlighted the rates of violence experienced by nurses and aimed to shift the culture of under-reporting and normalization of violence [59]. The ONA also developed tip sheets focusing on identifying and communicating the risk of violent behaviour [60], follow-up after a workplace violence incident [61], workplace violence prevention training [62], and a workplace violence safety plan checklist [63]. In 2019, the RNAO released a best practice guideline focused on preventing violence, harassment, and bullying against health workers [64]. It included three priority recommendation areas: use of validated risk assessment tools, the importance of education and training, and implementation and evaluation of multicomponent strategies. That same year, the RNAO made a submission on violence faced by health care workers to the Standing Committee on Health [65].

The Association of Ontario Midwives has also developed OHSA guidance for its members [66]. It includes recognition that midwives are at risk and highlights the legal framework and employer duties. Additionally, it discusses risk tracking and reporting as well as safety planning.

The Canadian Union of Public Employees (CUPE), which includes health care workers such as personal support workers (PSWs), released a report in 2022 highlighting poll findings which demonstrate the surge in violence experienced by hospital workers during the COVID-19 pandemic [67]. Extrapolating the poll's findings to the Ontario health care workforce, 85% of whom are women, there would be 155,610 physical assaults per year, of which 61,379 would be racially motivated, and 88,920 sexual assaults per year. Their recommendations included zero tolerance for violence and provincial funding to increase staffing so that workers are not left alone. Similarly, a working group at Peel Regional Paramedic Services released a report entitled "External Violence in Paramedicine" [68]. It highlights that paramedics frequently experience verbal harassment, intimidation, sexual harassment or assault, and physical assault. The report outlines several key initiatives and innovations that can help

to prevent and mitigate violence and harassment. These include the implementation of an external violence incident reporting system, described in greater detail in section 3.2.2.1 of this report; a zero-tolerance position statement; collaboration with their local police force; a public awareness campaign; and advocacy for legislative change.

In summary, the OHSA provides overall legislative guidance across the province of Ontario for health care workers regarding workplace violence prevention and management. This is complemented by implementation guides published by government organizations such as Health Quality Ontario. Several professional associations within Ontario have developed guidance based on the OHSA for their own membership. In addition, many of the publications highlight gaps that continue to exist and recommendations for addressing WPVH prevention and management.

3.1.7 Quebec

In March 2024, the National Assembly of Quebec enacted Bill 42: *An Act to prevent and fight psychological harassment and sexual violence in the workplace* [69]. It is meant to strengthen protections for workers in Quebec across all sectors, not just health care. The bill introduced system-wide legislative changes (including provisions in eight other major acts), provides stronger legal and procedural protections, enhances labour standards, recognizes psychosocial and sexual risks, and includes medical and insurance provisions. Also in 2024, Quebec enacted the *Act Respecting Occupational Health and Safety,* which is meant to "eliminate, at the source, the dangers to health, safety, and physical and mental well-being of workers [70]." It includes employer obligations such as knowledge of risk, preventive measures and programs, and the employee's right to refuse work.

Specific to the health care sector, the Federation Interprofessionnelle de la Santé du Quebec released a report entitled "Towards Well-being at Work: A Policy to Fight Violence" [71]. The report identified contributing factors such as work overload, lack of autonomy, and cultural and structural concerns. It recommends a shift from reactive to preventive approaches for psychological health, improvement in leadership styles, investment in health promotion, better governance, and encouraging a cultural shift that values psychological well-being.

Similar to Ontario, professional associations have also aimed to address WPVH through reports, tools, and recommendations. The Association des infirmières et infirmiers d'urgence du Québec (AIIUQ) released a report on the realities and struggles of nursing, particularly with regard to violence [72]. The report identifies high rates of violence and its increasing normalization leading to psychological effects (e.g. PTSD, depression, anxiety) and systemic effects (e.g. absenteeism, decreased productivity). The report recommends improving public sector working conditions, offering opportunities for mixed public and private practice, exploring alternative models of care, and expanding the role of nurse practitioner-run clinics to reduce strain on the emergency sector. This could help to reduce nursing staff shortages, which both contribute to and are a result of WPVH.

These challenges are also experienced by health care workers in other sectors. Dessercom, the largest ambulance and medical transportation company in Quebec, launched a zero-tolerance campaign to counteract violence against medical workers [73]. It included messaging in patient care areas and the introduction of XDCuff restraints, which aim to improve both safety and comfort. The campaign also advocated for policy and legislative changes, including calling on the Ministry of Health to train paramedics in administering chemical restraint tools and seeking support for an amendment to the federal government's Bill C-321 that would afford paramedics and other uniformed medical responders the same legal protections as peace officers.

Lastly, the Institut nationale de santé publique du Québec published a report focused on preventing domestic violence in the workplace [74]. It recommends that workplace initiatives to prevent and counter domestic violence include strengthened collaboration between organizations delivering the initiatives and

workplaces, domestic violence support services, and occupational health and safety organizations. The target audiences of these initiatives should include perpetrators, colleagues, and employers. The report also suggests all workplace members actively participate as witnesses and allies in preventing domestic violence.

In summary, similar to other provinces and territories, Quebec has passed its own legislation focused on workplace violence prevention and management, albeit more broadly across various sectors and not specifically focused on health care. However, health care-specific government publications do exist and can serve to guide application of the legislation in the health care sector. Additionally, professional associations have provided guidance and recommendations for their members.

3.1.8 Saskatchewan

Saskatchewan's legislation and regulations mandate that all workplaces develop policies and prevention plans to address violence and harassment. Under the *Saskatchewan Employment Act* and *Occupational Health and Safety Regulations* [75], violence is defined as any threatened or actual conduct likely to cause injury. While not specific to health care settings, the Act protects all employees, supervisors, and any dependent and independent contractors, students, or volunteers who are being trained or permitted by the employer to perform work or services. The Act also regulates the responsibility of employers, supervisors, and workers to maintain a violence-free environment. In 2022, the Act was amended to require all employers to develop a written policy statement and prevention plan (PSPP). These need to be tailored to the risks identified for a particular workplace, and high-risk workplaces such as hospitals, long-term care homes, and the home care service sector are required to continue to have a violence policy statement and plan in place [75]. The policy must define harassment, commit the employer to taking corrective action, and explain the complaint process while protecting confidentiality [76]. Both the violence and harassment policies must be reviewed every three years to ensure effectiveness. This aligns with the WorkSafe Saskatchewan Fatalities and Serious Injuries Strategy, which uses a data-driven approach to address serious injuries from growing issues like violence and mental health [77].

A violence prevention plan must be developed in consultation with occupational health committees and made available to all employees [78]. It must outline the employer's commitment to minimizing risk, identify at-risk worksites and positions, and establish procedures for reporting and investigating any violent incident. The plan must also include a mandatory training program that teaches workers to recognize and respond to violent situations. For health care staff, specialized training like Workplace Assessment and Violence Education (WAVE) is recommended to improve de-escalation and personal protection skills [79].

Overall, Saskatchewan's approach to preventing and managing workplace violence and harassment is informed by legislation and regulation, which states that all employers must have a PSPP tailored to the risks of the workplace. These comprehensive plans must incorporate formal procedures for reporting and investigating incidents alongside mandatory training, such as the specialized WAVE program, to ensure workers can effectively recognize and respond to potentially dangerous situations. To support long-term effectiveness and alignment with provincial safety strategies, formal policy reviews are required every three years.

3.1.9 Yukon, Northwest Territories, and Nunavut

In **Nunavut**, prevention of workplace violence is addressed through both legal resources and departmental policy manuals. The *Nunavut Safety Act* is the primary legislative framework governing occupational health and safety [80]. It establishes the general duty of employers to maintain workplaces in a manner that protects workers' health and safety and provides more detailed requirements under the *Occupational Health and Safety Regulations* [81]. Additionally, the *Nunavut Human Rights Act* [82] prohibits discrimination and harassment in areas including employment and the provision of goods, services and facilities, making it directly applicable to the health service sector. Health care employers

cannot discriminate against workers on protected grounds, such as race, disability, sex, pregnancy, religion, age, sexual orientation, gender identity or expression, and family status, and also have a duty to accommodate employment-related needs unless doing so would cause undue hardship [82].

The Law Society of Nunavut's 2020 *Prevention of Harassment and Violence in the Workplace* manual provides broad legal guidance, clarifying that harassment may involve repeated or isolated acts and that workplace violence can stem from personal or domestic disputes that spill into the workplace [83]. Employers are legally obligated to take every reasonable step to prevent and stop harassment, while workers retain the right to refuse unsafe work if an unusual danger exists. Employers must maintain written policies outlining prohibitions, reporting and investigation procedures, disciplinary expectations, and methods of informing staff about risks, including relevant histories of violent individuals, provided disclosure is limited to the minimum information necessary for protection. This legal framework explicitly recognizes health care workplaces as environments with heightened risk.

The Nunavut Department of Health's nursing policy manual includes a Community Health Nursing policy that applies to nurses, doctors, staff, volunteers, and contractors in community health centres [84]. It requires that all violent incidents, including near misses, be reported and reviewed by supervisors within one business day. The Department commits to a "just culture" approach, balancing worker accountability with system responsibility to encourage open reporting without fear of reprisal. Comprehensive incident management requirements include immediate disclosure to patients and families when harm occurs, timely supervisor reviews, and staff access to critical incident stress management programs and counselling resources. Together, Nunavut's legal and departmental frameworks emphasize due process, reporting accountability, and post-incident support.

In the **Northwest Territories,** the *Safety Act* outlines the duties of the employer and employees, who are defined as persons engaged in work for an employer, whether working with or without pay [85]. This includes individuals working in the health care sector. In long-term care settings, Northwest Territories' Long-Term Care Standards require policies for resident rights, training on preventing violations, emergency plans for catastrophic events, and adherence to national long-term care safety guidelines [86]. Both the survey findings and long-term care standards highlight systemic stress and the need for structural supports to stabilize the workforce and uphold safe care environments.

In **Yukon,** the foundation of WPVH prevention is set out in the territory's Workplace Health and Safety Regulations: Part 19—Violence and Harassment Prevention, which came into effect in 2006 and received major updates in 2020 [87]. These regulations require every employer to have a written policy prohibiting violence and harassment and affirming workers' rights to safe workplaces and freedom from reprisal when bringing complaints. Employers must conduct risk assessments, develop preventative measures, document and investigate all incidents, and share investigation findings with involved parties. Importantly, Yukon's legislation requires employers to take reasonable precautions where domestic violence may affect the workplace, which is a recognition of the blurring of personal and employment risks in small and remote communities. Confidentiality protocols require that only essential personal information be disclosed in reporting or response processes, balancing safety with privacy.

Overall, across the North, workplace violence prevention is grounded in clear legal duties, formalized reporting structures, and recognition of the unique realities of small, remote communities. In Nunavut, there is an emphasis on due process, written policies, rapid incident review, and post-incident supports within both its legal framework and Department of Health policies. The Northwest Territories integrates staff safety into long-term care standards, linking workforce stability and emergency preparedness to quality of care. In Yukon, comprehensive workplace health and safety regulations require proactive risk assessment, documentation, investigation, and protections related to domestic violence



"The World Health Organization (WHO) advocates for comprehensive prevention efforts, including risk assessment, specialized staff training, clear organizational policies, and collaboration with law enforcement to safeguard health care workers and enhance patient care quality."

spillover. This reflects the interconnected nature of personal and workplace safety in smaller jurisdictions. Together, the territories demonstrate a regulatory and policy-driven model that prioritizes accountability and worker support while adapting violence prevention frameworks to the operational challenges that can exist in Northern health systems.

3.2 Jurisdictional Scan of International Frameworks

WPVH presents critical challenges in the global health service sector, severely impacting worker safety, organizational culture, and the delivery of quality care. International frameworks such as the International Labour Organization's violence and harassment convention of 2019 (No. 190) set foundational standards by defining violence and harassment broadly, including physical, psychological, and gender-based forms, and by collectively calling on member states to implement legislation, policies, and preventive measures to establish safe and respectful workplaces [88]. The convention requires employers and governments to ensure effective prevention, reporting mechanisms, and remedies, highlighting the vital importance of protecting health workers who may face unique occupational risks.

The World Health Organization (WHO) underscores this concern by identifying health care settings as high-risk environments for verbal abuse, physical assault, and psychological harassment, often perpetrated by patients or visitors. WHO advocates for comprehensive prevention efforts, including risk assessment, specialized staff training, clear organizational policies, and collaboration with law enforcement to safeguard health care workers and enhance patient care quality [89].

Similarly, the United Nations identifies workplace violence elimination as integral to achieving Sustainable Development Goal 8 (which promotes decent work for all and safe working environments), while UN Women stresses the disproportionate impact of gender-based violence on women in workplaces, who comprise the majority of the health care workforce globally [90].

In other countries, sectoral reports highlight the alarming reality of workplace violence in health care. In England, a 2024 NHS report reveals that over half of health workers who experience harassment or bullying fail to report these incidents, and almost 30% of physical violence cases are similarly unreported, with bullying and harassment costing an estimated £2.3 billion annually [91]. In response, NHS England's *Violence prevention and reduction standard* provides practical guidance promoting risk assessment, workforce training, clear reporting channels, and a commitment to zero tolerance [92]. The Royal College of Nursing (UK) similarly advocates rigorous policies to protect health and social care workers from violence [93]. In Ireland, the Health and Safety Authority outlines employer responsibilities for managing workplace violence risks through risk identification, prevention strategies, training, and post-incident support [94].

Similar principles are echoed by Australasian organizations. The Australasian College for Emergency Medicine documents violence as an ongoing occupational hazard, calling for urgent legislative reform and safer workplace environments, particularly in emergency departments where violence is escalating rapidly [95], [96]. Reports from New Zealand parallel these concerns, with the New Zealand Nurses Organisation and Worksafe New Zealand emphasizing violence prevention frameworks and employer obligations to assess and mitigate risks in the health care sector [97], [98].

Collectively, these international and regional documents emphasize multidimensional approaches to mitigating workplace violence in health services. Effective strategies require clear legal definitions and policies, organizational commitment to risk assessments, thorough staff education, reliable reporting and monitoring systems, and a workplace culture that does not tolerate violence or harassment. Particular focus is placed on the health care context's unique risk factors, including interactions with potentially violent patients and the prevalence of gender-based violence, as well as the need for collaboration among employers, workers, unions, regulators, and law enforcement agencies. Addressing barriers such as under-reporting, stigma, and power imbalances is central to an effective response. Further, sustainable impact depends on robust enforcement mechanisms and accessible support and resources for affected workers.

3.3 Synthesis of Literature Review Findings Across Health Care Settings

The literature search retrieved 6,513 citations, of which 2,508 were determined to be duplicates. Following title and abstract review of the remaining 4,005 citations followed by full-text screening, we arrived at a final sample of 593 articles included in the literature review. The majority of the articles took place in multiple health care settings, with many covering all the settings included in this research.

Eight cross-cutting themes were identified as needs, gaps, and challenges, while six were identified as best practices, support tools, and areas for improvement. These themes are discussed below in the context of each health care setting.

3.3.1 Needs, Gaps, and Challenges Identified in Literature Review

3.3.1.1 Definitional and Conceptual Inconsistencies

One of the persistent challenges in evaluating and preventing WPVH in health care is the lack of consistency and clarity in how WPVH is defined and categorized across studies, organizations, and jurisdictions. Some sources define WPVH narrowly as physical or verbal assaults, while others adopt broader definitions that also encompass bullying, harassment, incivility, intimidation, sexual assault, discrimination, or even reputational harm, creating difficulties with measurement and comparison [99], [100], [101]. Existing policies often only address physical violence, leaving out bullying and intimidation, which results in significant gaps in both the monitoring and response systems for these types of incidents. This variability extends to the international context, with some frameworks distinguishing between "horizontal" (peer-to-peer) and "vertical" (leader–subordinate) violence or classifying incidents as Type I–IV depending on perpetrator relationships, while others do not use these typologies consistently [102], [103], [104]. Such inconsistencies have led to widespread under-reporting across all sectors, as workers are often uncertain about what behaviours "count" as violence, and some staff tend to normalize verbal abuse or patient-initiated aggression as "part of the job" rather than reportable events [105], [106], [107].

Conceptual ambiguities are compounded by the recognition that certain acts, including aggression from patients with dementia or delirium, may be unintentional, further complicating whether they are documented or classified as violence [107]. The result is that these definitional inconsistencies limit our ability to measure the true scope of WPVH, constrain comparability across settings and countries, and hinder the development of standardized, evidence-based prevention strategies [108], [109].

The **medical care and rehabilitation** literature also emphasizes a lack of standardized definitions and terminology regarding WPVH, both within medical settings (i.e. between hospital departments) and across settings (i.e. between different hospitals, outpatient clinics, and other settings), with terms like bullying, incivility, violence, and harassment used interchangeably or inconsistently [110], [111], [112], [113], [114]. This variability has been found to hinder research, policy-making, and cross-institutional data comparisons, directly contributing to ongoing challenges in prevention, response, and support in this setting [113], [115], [116].

In a recent qualitative systematic review of intensive care unit (ICU) settings, "workplace violence" encompassed a broad array of events, from physical assaults to harassment and intimidation; however, the study noted a lack of consistent definitions within and across medical settings [117]. This lack of clear and consistent definitions also results in confusion by frontline hospital staff over what constitutes workplace violence and what kinds of incidents should be reported, documented, or escalated [110]. This confusion directly hinders accurate comparisons of WPVH rates between units (e.g. emergency versus medical–surgical), between organizations, or over time within the same system.

Similarly, the **emergency medical services** sector could also benefit from a standardized definition of WPVH. The lack of such a definition has been found to complicate the calculation of prevalence rates and risk assessments [118]. It has been suggested that multiple data sources are needed in order to approximate the true burden of WPVH [119]. However, to do so, data sources must collaborate to harmonize their methods and data dictionaries [119]. A systems-level approach is needed, though efforts to standardize the definition and concept of WPVH have often omitted the emergency medical services sector [118].

Home and community care settings have also faced tremendous challenges in the absence of a universal definition for WPVH [120]. Researchers, home care agencies, and community health organizations have not agreed on common definitions or classifications of the different types of WPVH, which complicates data collection and prohibits alignment of evidence to inform best practices [120]. The issues posed by a lack of common definition extend to home care workers themselves, who often face difficulty defining what is considered WPVH and reporting those incidents [121]. Home care providers, for example, may not perceive certain forms of harassment, such as racial or sexual harassment, as reportable WPVH [122].

An important challenge within home and community care is associated with the subjective nature of interpreting behaviour and the individual's assessment of whether an incident meets the definition of WPVH. As such, a standard definition of violent behaviour can be difficult to develop and implement, as one person may assess a given incident to be WPVH while another may not. WPVH in the home care sector has considered the WHO definition "incidents where employees are abused, threatened, assaulted or subjected to other offensive behaviour in circumstances related to their work" to be somewhat limiting [123]. Given the variation in work sites for home care workers, some research includes robberies, property thefts, and vandalism within their definition of WPVH [124]. Others argue that unintentional WPVH perpetrated by cognitively impaired care-dependent people is not captured within the typical WPVH definitions used in health care settings [120], [125]. Inconsistent language describing aggressive behaviour by persons with dementia toward home and community care workers includes "challenging behaviour," "behaviour that challenges the professional caregiver," "behavioural and psychological symptoms of dementia," or "neuropsychiatric symptoms" [125]. Notably, "challenging aggressive behaviours" may include verbal aggression (e.g. yelling, insulting), workplace aggression (e.g. threatening behaviour), and workplace violence (e.g. pushing, choking) [126]. Recognizing the barriers to defining WPVH a priori, researchers have requested that home care workers describe situations they perceive to be personally threatening, challenging, or violent [127].

In **LTC homes and assisted living facilities,** WPVH is also poorly defined, making it difficult for organizations to educate staff and community, create policies, and accurately report occurrences [128],

[129], [130]. The understanding of WPVH within LTC homes needs to extend beyond just physical assault to include verbal abuse, bullying, sexual harassment, and microaggressions, both perpetrated by patients and between staff [131]. The most common form of WPVH in LTC and assisted living settings is violence or harassment against an employee by a resident or family member [132]; however, employee-to-employee WPHV does occur and also needs to be defined. New forms of violence, such as cyberbullying, also require specific attention and support mechanisms [133].

Likewise, in **mental health settings,** inconsistent definitions make research and direct comparisons of workplace violence interventions across studies difficult [134]. A recent Canadian study pointed out discrepancies in definition at the global level (World Health Organization), at the level of provincial legislation, and the definitions of Code White at a provincial level versus their own organization [135]. Not only do definitions differ, but so do expected responses [135]. Clinically, existing metrics do not always adequately capture WPVH [136]. This can hinder evaluation, prevention, and improvement efforts, and can result in underestimation of violence rates, as there is a heavy reliance on self-reported outcomes and subjective measures [136]. The literature in the mental health space emphasizes a need for standardized and validated frequency measures that include intensity of incidents [137] and well-defined quality indicators [135], [136]. The Canadian study led by Sethi et al. developed a set of 17 indicators through a consensus process that includes seven structural, six process, and four outcome indicators [135]. These are fed into a dashboard that provides real-time data on each indicator. This provides one example of how consistent definitions and the identification of explicit, standardized metrics and indicators can be utilized to address WPVH.

3.3.1.2 Under-reporting and Normalization of Violence

The pattern of silence and under-reporting is a consequence of an organizational culture across health care settings that implies WPVH is an inevitable component of health care work. It is widely known that health care workers are exposed to WPVH at a rate higher than any other sector. This high risk and frequency of exposure, compounded by the lack of organizational response and perceived futility of reporting, has resulted in negative physical and psychological outcomes among the health care workforce. Across sectors, decisions not to report WPVH incidents are shaped by personal, employer, and system-level factors.

Medical care settings recognize WPVH under-reporting as a significant issue affecting their workforce. A primary reason is the normalization of violence as an expected aspect of the job. Qualitative research identified that decisions not to report WPVH that takes place in the emergency department are complex and often shaped by individual judgments about the incident, such as its severity, legitimacy, patient factors (e.g. mental health crises, intoxication, dementia), and whether the violent event was expected [138].

A Canadian study in one of the largest emergency departments in the country noted that accepting WPVH as inevitable is reinforced by the routine occurrence of violent incidents, including Code White events, which can go unreported and may never be formally recognized [139]. Verbal abuse, in particular, was described as so pervasive that it was perceived as inevitable, leading to desensitization among emergency department health care providers to the violence they regularly experience in the workplace [139]. The lack of organizational follow-up or debriefing further perpetuates a culture in which WPVH is minimized rather than addressed as a serious occupational hazard [116], [117], [138], [140], [141], [142], [143], [144]. Another deterrent to reporting is that the process is perceived as both time-consuming (e.g. detailed forms, interviews, follow-up) and unlikely to result in change due to lack of response from hospital leadership [138], [142], [145]. These findings underscore the complex interplay of health care providers, patients, and organizational-level factors that challenge the development of effective reporting practices.

The **emergency medical services** sector also suffers from WPVH being widely under-reported and normalized [146], [147]. It is estimated that at

least 60% of WPVH incidents go unreported [8]. Despite this, data shows that emergency medical services workers face higher odds of occupational violence than other high-risk professions, such as firefighters [148]. Systemic under-reporting is largely due to violence and harassment being considered a routine component of the work; the ability to "brush off" incidents was framed as a competency in some cases [8], [118], [149]. Less serious incidents are more likely to be under-reported [149], and consequently there is a lack of evidence on non-physical violence [119], [149]. As reported in the medical care setting, emergency medical services research also indicates that decisions around whether to report WPVH are influenced by the perceived severity of incidents [8], a lack of meaningful consequences for perpetrators [146], and the belief that no action will be taken if a report is filed [8]. Further, the subjective motivation for reporting is also influenced by the health status of the perpetrator, as many of them experience mental health and substance issues [146]. This confluence of factors has influenced the organizational culture of this sector to normalize exposure to WPVH and has stigmatized reporting [147], [150].

The prevalence of WPVH in the **home and community care** sector is also considered to be significantly underestimated due to under-reporting [121], [122], [124], [151]. Once again, a primary reason for the low reporting rate is that workers normalize violent experiences, viewing them as an expected and unavoidable component of the work [121], [151]. This is a direct result of both inadequate awareness of which behaviours constitute WPVH and a tendency to rationalize violent actions as a symptom of a client's condition [121], [152]. Home care workers often minimize WPVH incidents as "no big deal," feeling that only the most egregious events, such as physical assault, warrant a formal report [121]. Further, home care workers often work alone, which means incidents occur in private dwellings where there are rarely witnesses or other corroborating evidence. Other reasons for under-reporting include lack of trust, shame, embarrassment, and lack of consequences [153].

This culture of normalization in the home and community care sector is compounded by systemic



barriers and a profound lack of confidence in reporting systems [154], [155]. Workers frequently cite a fear of negative consequences, including job loss, as a significant barrier to reporting [121], [153], [155]. This fear is often well-founded, as management is frequently unresponsive to safety concerns. A further complication is the difficulty workers face in defining and reporting incidents. The research suggests that home care workers lack clear guidance on when to report and may not perceive certain forms of harassment, such as racial or sexual harassment, as reportable WPVH [121], [156]. This is exacerbated by the absence of an agreed-upon definition of WPVH across the health care sector and a lack of a gold standard measurement tool for WPVH, which complicate data collection and make it hard to understand the scope of the problem [120], [157].

Under-reporting and normalization of workplace violence is also a widely recognized issue within **long-term care and assisted living facilities** [131], [132], [158]. The normalization of WPVH is due to the perception by staff that it is an intrinsic component of the work [131]. Within LTC settings, aggression from residents, particularly those with cognitive impairments or mental health conditions, is often accepted because staff believe the resident doesn't know better or doesn't mean to do it [132]. In a study by Brophy et

al. [132], one staff member said "Oh, they always do that, they always pinch me, they always grab [me]... when I am doing care," highlighting that this behaviour is accepted and even tolerated in this setting.

The under-reporting of WPVH in LTC and assisted living facility settings stems from several factors, including the high frequency of incidents (e.g. "it happens every day"), fear, lack of recognition that an incident is reportable, and lack of support from leaders [128], [132]. In some cases, leaders have discouraged reporting and often ask frontline staff what they have done to trigger the resident, placing blame on the staff member [132].

Under-reporting and normalization of violence is also a pervasive challenge in **mental health settings** [9], [115], [116], [134], [159], [160], [161], [162], [163], [164], [165]. Mental health workers believe violence is "part of the job" [9], [159], [160], [166], an unpleasant but unavoidable part of their work [167], or something that "comes with the territory" as part of "earning their stripes [162]." This has also been shown to be true in situations involving racism [168]. Additionally, mental health workers may not report incidents of violence due to a belief that nothing will be done [159], the feeling that reporting is a "waste of time" [159] and burdensome, or a perceived lack of follow-up at the organizational and managerial levels [115], [160]. In some instances, mental health workers also reported fearing retaliation from management or colleagues if they were to report incidents [9], [115], [165]. This further reduces trust in administration, supervisors, and coworkers. As in LTC and assisted-living settings, the patient population mental health workers care for is a contributing factor to under-reporting. Many workers report feeling that patients or perpetrators cannot be held accountable due to their mental status or potential cognitive impairments [116], [165]. Mental health workers are also less likely to report verbal incidents, including those involving racism [168], minimizing them compared to physical assaults.

The **substance use and withdrawal services** sector is also subject to a long-held belief that exposure to WPVH is an inevitable part of working with patients in treatment [169]. Published data indicate that 73% of nurses believed assault is "just part of the job" [170]. Consequently, WPVH is under-reported [169], [170], [171], with only more severe physical assaults being reported [172]. Additionally, health care workers have stated that they do not report assaults due to fear of retaliation [170] or the belief that nothing will be done [169], [170].

Under-reporting and normalization of violence is a concern with experienced staff, but it is also prevalent among trainees. A recent study found that nearly half of trainees surveyed did not report abuse or assault because they found it unnecessary and one-fifth of those surveyed indicated they believed reporting was futile [173]. Lack of institutional support, shame, and guilt were also cited as reasons for not reporting violent incidents [173]. Additionally, trainees felt unable to report incidents if their supervisors or managers were the perpetrators [174]. This data indicates a significant shift is needed to change the organizational culture of the current and future workforce.

3.3.1.3 Insufficient Organizational and Managerial Support

Across various health care settings, a persistent lack of organizational and managerial support for health care workers affected by WPVH has been widely reported. Staff frequently encounter inadequate responses from management, insufficient follow-up or support after incidents, and a sense of being undervalued or even blamed for the violence they experience. This problem is compounded by issues such as leadership inaction and the discouragement of reporting, which fosters a culture where violence is tolerated. There is a perception that leadership prioritizes patient/resident/family member satisfaction and institutional reputation over worker safety, leading to mistrust in the organization and in leadership. Specific challenges include insufficient reporting systems, fear of reprisal, and policies that are either ineffective or not implemented.

Medical care settings frequently lack robust support mechanisms for those affected by WPVH. There are many examples in the literature where staff report inadequate management responses, insufficient follow-up or support after incidents, and a sense of being

unvalued or blamed for violence they have experienced [117], [141], [142], [175], [176], [177]. Leadership inaction, organizational silence, and discouragement of reporting can undermine morale and perpetuate a culture in which violence is tolerated [115], [141], [142], [176]. Staff often feel that hospital leaders make patient satisfaction and institutional reputation a higher priority than the safety of workers. This weakens workers' trust in organizational commitment to safety and discourages open dialogue regarding WPVH issues [115], [141], [176]. Workers also cite a lack of clear processes for reporting to law enforcement, insufficient legal repercussions for assaults, and inconsistent application of policies at the organizational or legislative level [129], [141], [178], [179].

Insufficient organizational and managerial support has also been reported in the **emergency medical services and paramedics** setting. Workers have reported a lack or perceived lack of co-worker and supervisor support when reporting WPVH incidents [8]. There is also a documented lack of organizational or managerial follow-up [146]. Additionally, workers have reported that organizations implementing zero-tolerance policies have not supported these policies through their actions [180]. There have been calls for prevention efforts to shift from individual responders to the organizational level [118]. Strong organizational leadership and managerial support is imperative to support prevention efforts, as is consistent and mandatory reporting and follow-up [118].

The absence of specific policies and practices to prevent abuse in **home and community care** is a foundational problem [181]. Even when organizations do have policies in place, there is often a disconnect between policy and practice. An analysis of home care agency policies found that policy documents primarily benefitted clients while offering very little protection to workers [182]. This imbalance highlights the need to recalibrate protections for home care workers and their clients. Few home and community care workers submit reports after WPVH incidents because they lack confidence in the reporting systems and fear reprisal [155]. When reporting is completed, home care workers do not receive timely follow-up from managers [121]. The perceived unresponsiveness of management leads workers to feel unheard, which ultimately causes them to keep future incidents to themselves [121]. This problem is further compounded by what one study describes as an "employer customer-service mentality," where home and community care agencies may be reluctant to take action against a perpetrator, thereby implicitly prioritizing client satisfaction over employee safety [154]. This dynamic creates a vicious cycle: workers stop reporting because they believe nothing will change; management, seeing low reporting numbers, may inaccurately conclude that the problem is minor. The result is a culture of silence that perpetuates the problem, undermining the goal of providing a safe workplace.

The literature also highlights a significant lack of organizational and leadership support in addressing WPVH in **long-term care and assisted living settings.** Staff experience inadequate support and accountability from leaders following incidents, including acknowledging the incident, conducting investigations, and providing post-incident support [131], [132]. Workers feel discouraged from reporting incidents for fear of being blamed or fired or that no follow-up will happen [183]. Research shows that due to unsupportive management, frontline staff feel WPVH is just an expected component of the work [131], [132]. Furthermore, inadequate policies, unclear reporting processes, understaffing, and a lack of training and education create an organizational culture where staff feel unsupported and are unsafe [161], [184].

Health care workers in **mental health settings** have reported insufficient organizational and managerial support for WPVH prevention and management. Workers have reported a lack of policies, ineffective policies, and policies that are not put into action by leadership, who "turn a blind eye" [134], [177], [185]. Management-oriented reporting procedures may result in adverse reactions [177], with reports of post-event debriefs being used as opportunities to place blame [9]. Supportive resources are said to be limited [160] or insufficient [177]. These issues have been reported at both the staff and trainee levels [173].

Similar to the mental health sector, health care workers in **substance use and withdrawal services** settings also felt organizational and managerial support was lacking, particularly in the context of reporting violent incidents [160], [170], [173].

3.3.1.4 Insufficient Training and Preparedness

Across health care settings, insufficient training and lack of preparedness remain consistent challenges in addressing WPVH. Workers frequently report that training is either absent, generic, or overly focused on self-defence rather than on prevention, de-escalation, and communication. Educational initiatives are often theoretical rather than practical, failing to account for the unique risks of different care environments. As a result, staff—particularly students, early-career workers, and those in high-pressure settings—are left without the skills or confidence needed to safely manage violent or aggressive incidents.

Health care workers frequently report inadequate training and a lack of preparedness to effectively manage WPVH in **medical care settings,** especially in high-stress and high-risk environments such as emergency departments and inpatient wards [111], [117], [134], [141], [186], [187], [188]. This is particularly common among general nurses in high-pressure environments, students, and early-career staff [111], [117], [134], [141], [186], [187], [188]. Many educational programs focus mainly on theoretical knowledge rather than practical skills, and training is often non-tailored or generic, failing to address the specific challenges of clinical environments [111], [117], [188]. On the positive side, one American study describes an educational initiative that incorporates practical simulation and evidence-based curricula focused on the early recognition and de-escalation of violent behaviours. While this program was demonstrated to increase staff confidence, challenges remain with generalizability and ensuring consistent application across various units [188].

Insufficient training and preparedness is also a serious concern in the **emergency medical services** sector. Research has found that existing violence-prevention training and programs are often generic and not tailored to this sector's unique environment [118]. Moreover, available training tends to focus on self-defence rather than prevention [118]. The best practices section of this report (section 3.3.2.2) pertaining to emergency medical services highlights some successful examples of training and preparedness.

Research suggests that many **home care** workers do not complete WPVH prevention training, either at the time of hire or during their employment [124], [189]. One barrier to receiving appropriate training is the variation in home care workers' employment status [154]. Many are employed on a part-time or casual/per diem basis and work for more than one agency at a time. Logistically, working irregular hours for more than one employer makes it difficult for employees to complete training modules. It becomes even more challenging when their time spent doing so is not compensated. Home care workers are predominantly personal support workers (PSWs), an unregulated group of health care providers without uniform competency requirements. This variation in competencies across the home and community care workforce underscores the importance of ensuring that all staff, irrespective of status, complete training necessary to prevent and manage WPVH.

Training can be irrelevant to the home care setting when it focuses only on generic self-defence rather than the nuanced, relational skills required in a client's home [121], [154], [189]. For example, training content frequently lacks crucial elements such as effective de-escalation techniques, self-protection skills, client screening, and understanding hazardous neighbourhood characteristics [154], [189], [190]. Further, training is often deficient in procedures for seeking psychological care after a WPVH incident [154], [189].

Research highlights insufficient training and education as a significant factor contributing to workplace violence and harassment and a major barrier to its effective prevention and management in **LTC and assisted living settings** [131], [132], [191]. Specifically, frontline staff such as nurses and PSWs express feeling inadequately prepared to deal with resident aggression [132]. This highlights the specialized training needed in these settings. In a study by Brophy *et al.* [132], staff highlighted the absence of training related to identifying and de-escalating violent behaviour, a necessary skill when dealing with residents who may have cognitive impairment and/or mental health conditions. In the same study, staff also indicated that more in-depth, hands-on crisis intervention training



would be helpful. This type of training, usually available in hospital settings, would provide practical skills and specific interventions that could be effective in reducing WPVH [132]. Timely and sufficient training for new hires within LTC is also needed, as some may have not worked with the specific population and are unprepared to deal with resident aggression [191].

Health care workers in **mental health settings** have also experienced insufficient training and preparedness. A persistent lack of staff awareness and training in communication and engagement skills has been documented [192]. Consequently, staff lack the ability to manage conflict effectively, leading to misunderstandings and escalating tensions [192]. Training is needed in communication skills, de-escalation techniques, empathy and trauma-informed care, cultural awareness, and self-care [192]. Moreover, educators have a duty to ensure trainees are prepared to identify escalating situations and manage potentially violent situations [134]. It should be noted that training alone has been found to be insufficient; it should be part of multicomponent prevention programming, as will be discussed later in this report [193].

Similarly, insufficient training and preparedness are prevalent concerns in the **substance use and withdrawal services** sector [173], [191]. Limited de-escalation training has been identified as a factor leading to escalation of violent behaviours [191]. Additionally, a recent study identified the need for specific training on care-resistant behaviour warning signs and effective mitigation strategies, such as person-centred care [191]. Promoting person-centred care and team-based training approaches can ensure health care workers are equipped with the appropriate communication skills to help prevent violent incidents [191]. Training in this sector should also focus on behaviour management and de-escalation techniques specific to active withdrawal [191].

3.3.1.5 Impact of Staffing and Work Environment

Staffing levels and the broader working environment play a critical role in the risk of WPVH across all health care settings. Chronic understaffing, heavier workloads, and long wait times across the system all contribute to heightened patient frustration and aggression [99]. The literature frequently cites that inadequate staffing leaves nurses and other frontline staff feeling unsafe and unable to provide the quality of care that patients and caregivers expect, thereby increasing the risk of WPVH [99], [194], [195], [196]. Additionally, the literature describes instances of worker-on-worker WPVH, which, although less frequent, is a major issue across all health care settings and professions [197].

Hierarchical structures within health care settings have been found to contribute to WPVH involving lower-paid healthcare workers, such as registered practical nurses (RPNs), who perform similar tasks to higher-paid registered nurses (RNs) but have less decision-making power and greater social inequalities related to gender, race, and class [198]. This combination of heavy workloads, low autonomy, low status, and rigid routines (i.e. "structural violence") not only causes suffering but also limits the quality of care workers can provide [198].

Within **medical and rehabilitation centres,** and in particular within hospitals, health care workers report that stressful work environments, especially those characterized by high patient volume, noise, and chaotic atmospheres, contribute to both the occurrence of WPVH and difficulty managing it [99], [199]. This is particularly apparent in emergency and critical care units where staff must frequently manage agitated or vulnerable patients with complex psychosocial needs in an overcrowded environment [117], [199]. These conditions have been found to fuel patient frustration, extend the duration and frequency of staff–patient interactions, and contribute directly to burnout and decreased staff retention [141], [145], [199], [200]. One Canadian study by Brophy et al. [198] on occupational stress among hospital workers in Ontario described how chronic understaffing and the resulting increased workloads in recent years have severely compromised staff safety, contributing to rising WPVH incidents and deteriorating mental health among health care workers. Participants in this study reported that reduced numbers of staff, combined with high patient acuity and hospital overcrowding, left workers vulnerable to frequent aggressive encounters with patients and family members. These challenges contribute directly to a vicious cycle in which violence leads to staff burnout, mental health issues, and high turnover, which in turn worsens staffing shortages and the quality of the work environment [145], [198], [199].

Lateral or worker-on-worker violence is also an issue within this setting, with the literature suggesting that WPVH by peers is associated with lower levels of work engagement and higher levels of burnout [200]. When facing bullying in the workplace, health care workers may experience higher levels of anxiety, distraction, and feelings of isolation. These feelings are especially troubling because they may lead to increased medical errors or omissions in patient care, as well as decreased professional joy and job satisfaction, strained relationships with coworkers and leadership, social isolation, and increased risk of suicide [201]. Research indicates that RNs are often identified as perpetrators of WPVH, reflecting a persistent culture of disrespect and misuse of hierarchical power within nursing [134]. Despite professional expectations to mentor junior staff, aspects of this role have sometimes contributed to WPVH, perpetuating patterns described as "nurses eating their young" [134].

Emergency medical services workers and paramedics work in dynamic, high-risk environments [146], often requiring complex scene management [202]. Consequently, they experience a risk of injury from violence that is over five times higher than the general population, nearly seven times higher than firefighters, and 60% higher than nurses [203]. The changeable and often uncontrolled work environment exposes workers to a heightened level of vulnerability [204], with staffing and resources at the scene often limited [149]. Paramedics face additional risks from the possibility of patient access to weapons [149]. Paramedic uniforms may also be confused with police uniforms by patients, contributing to further risk [204]. Calls involving substance use, mental health problems, or homelessness contribute to an increased risk of violence [118], [204]. Workers report feeling a tension between their own safety and that of the patient's during mental health calls [204]. They have reported feeling moral distress from the conflict between their duty of care and staging or refusal of care to protect themselves [204]. In addition to the impact of these staffing and environmental factors, stressors like long shift durations, lack of rest, and high call volumes further contribute to negative mental and physical health outcomes for emergency medical services workers and paramedics [118].

Access to **home and community care** is a growing preference among Canada's aging population, who want to age in place rather than move into a long-term care or assisted living setting [205]. While this offers numerous benefits, it also exposes the home and

community care workforce to a high risk of WPVH. The home care setting presents fundamental challenges that distinguish it from a controlled institutional environment like a hospital or medical clinic. The most significant is that the home care worker has no control over their work environment, a factor that is a primary driver of WPVH risk [189], [206]. Home care workers are exposed to a host of hazards, including the potential presence of weapons, second-hand smoke, hostile animals, or high-crime neighbourhoods [154], [155], [207]. The unpredictable and dynamic nature of the home environment, often without clear escape routes, intensifies the high-risk work context and can be difficult to navigate [154]. Although home care agencies are required by regulation to ensure the health and safety of their employees, there are limitations on what employers can do when the patient's home is the workplace [206]. The home setting also blurs professional boundaries, which has been found to contribute to a higher tolerance for violence among home care workers [121]. This ambiguity makes it unclear what is appropriate behaviour and can lead workers to feel obligated to continue care despite experiencing abuse [121], [156].

A defining characteristic of working in the home care sector is isolation. Home care workers work alone; travel to multiple, often unpredictable, and sometimes high-risk locations; and operate without the immediate on-site support of colleagues or security personnel [121], [189], [207], [208]. This isolation makes them acutely susceptible to physical and verbal abuse from clients and their family members, who are the primary perpetrators of violence in this sector [121], [124], [206], [209]. Provision of phones to workers for safety purposes can be inconsistent [154] and workers report feeling abandoned by their organizations [121].

The home environment is a regulatory black box for health care provision. The isolated nature of the work, coupled with the absence of control over the physical setting, creates a context where incidents occur without witnesses, standard procedures, or immediate support. Under Ontario's OHSA, legal enforcement is complicated by the fact that an inspector's entry into a private dwelling often requires the resident's consent or a court order, which can hinder investigations and interventions in home care settings [210]. Moreover, home environments make objective data collection and tracking far more complicated than in hospitals, preventing an accurate understanding of the scope of the problem [154], [207]. This lack of reliable data, in turn, contributes to a lack of robust policy, which then fails to address the unique environmental risks, thereby reinforcing the conditions that make effective data collection impossible. This cycle ensures that the problem remains invisible and unaddressed at a systemic level.

Workplace violence in **long-term care settings** is significantly under-reported, often due to staff feeling guilty and fearing judgment by supervisors [132]. This under-reporting of WPVH is more significant with the chronic understaffing usually experienced in LTC and assisted living settings and a lack of management support [131]. The physical layout of long-term care and assisted living facilities and the absence of adequate security contribute to safety concerns and increase the risk of workplace violence [131]. Racialized frontline workers, particularly nurses and PSWs who often work in long-term care and assisted living facilities, also face racialized violence, which often goes unreported [158].

Workers in **mental health settings** were also found to experience increasingly challenging situations with fewer resources, heavier workloads, and difficult work environments [211]. WPVH is a major concern, with reported one-year prevalence in psychiatric hospitals reported at over 80% [212]. Staffing and work environment are significant contributing factors. Staffing levels in mental health settings have been widely documented as insufficient [141], [162], [167], [213]. This can make it difficult for individuals to effectively apply de-escalation techniques. Increasing violence has also been linked to staff cuts, not only among health care workers but also among security personnel, who may be insufficient in number, inadequately trained, or even nonexistent [159].

The physical environment in mental health settings has traditionally not been conducive to risk mitigation. A study conducted in Western Canada by Hiebert *et al.* [159], found that acute care units are often poorly designed, outdated, and overcrowded. They also

note that the configuration of patient rooms may be such that staff have difficulty hearing attacks. Additionally, the design of nurses' stations can be problematic, particularly if there are single or limited entry points that patients could barricade. The same study also found that charting rooms may be separate or distant from nurses' stations, which would impair the ability to see or hear attacks. They also noted that the layouts of units may create places where staff could be cornered and, while the use of cameras can help to mitigate risk, it is important to ensure that they are placed strategically to avoid blind spots.

The mental health environment is also unique in that health care workers find themselves faced with providing a therapeutic environment for patients while also needing to exercise control and surveillance over them, which could further perpetuate trauma and violence [211]. Workers in mental health settings may feel caught between balancing patient needs with their own and that of the organization [211].

The **substance use and withdrawal services sector** also experiences high rates of WPVH, due in part to staffing challenges and the work environment [191]. Treatment centres may include patients with a history of violence and/or psychopathology, which are risk factors for increased violence [171]. Health care workers in these settings have reported difficulties caring for patients in drug and alcohol withdrawal, with some reporting inconsistent implementation of protocols [214].

3.3.1.6 Gaps in Post-event Support and Psychological Impact

The physical risks of WPVH in health care are well-recognized; however, often there are considerable psychological and emotional consequences that are not addressed. Across health care environments, the literature points to a paucity of organizational support for workers affected by WPVH. The gaps in post-incident support systems are attributable to poor policies and practices, which become an additional burden shouldered by organizations in the form of decreased morale and higher rates of absenteeism, turnover, and even workforce attrition. Conversely, supportive work environments can foster resiliency and self-worth among health care workers. The often-overlooked impacts of WPVH on the mental health and well-being of these workers underscore the urgent need for structured, responsive, and compassionate post-incident support.

The literature pertaining to **medical care settings** consistently reports a notable gap in post-incident support for victims of WPVH, particularly in terms of mental health care, debriefing, peer support, and other psychological interventions [116], [142], [215], [216]. Persistent exposure to violence is associated with increased burnout, anxiety, and post-traumatic stress disorder (PTSD), erosion of staff morale and productivity and, ultimately, declining quality of patient care [115], [142], [199], [217]. Despite the profound emotional toll resulting from exposure to violence, many organizations lack structured, formal post-incident interventions. In a Canadian integrative review, nurses perceived post-incident support as lacking or ineffective [177]. Many expressed a desire for emotional input from managers, formal debriefings, and accessible counselling services, which are critical to mitigate the long-term psychological effects of WPVH. Likewise, a qualitative systematic review involving nurses from multiple countries, including Canada, observed that psychological support after violent events is often informal or absent, leaving affected staff vulnerable to unresolved trauma and prolonged distress [177]. Nurses expressed a need for accessible, non-judgmental psychological services and recognized peer support as a vital but underdeveloped resource. Many institutions rely on informal support or limited resources, but lack comprehensive, institutionalized programs such as trauma-informed counselling, critical incident stress debriefings, or systematic peer support [116], [177], [215].

Evidence indicates that **emergency medical services** personnel experience high rates of work-related mental illness, including PTSD, major depressive disorder, generalized anxiety disorder, burnout, and suicide [8]. In fact, there are a number of cases where emergency medical service workers have been seriously harmed and even killed by their patients [8].

Prevalence of PTSD in emergency medical service workers is estimated at greater than 20% [118]. It is not uncommon for workers to find themselves in recurrent violent situations. WPVH has been identified as the leading cause of stress for emergency medical services workers, is associated with increased levels of fear and anxiety, and is one of the reasons workers consider leaving the profession [118].

WPVH is a leading cause of burnout and turnover in the **home and community care** sector, and exposure to verbal abuse alone can lead to psychological and emotional trauma, stress, and sleep problems [154], [189]. Training and policy frameworks often lack procedures for seeking psychological care after an incident [121], [154]. A small percentage of home care workers reported receiving training on post-incident processes; however, they often describe the support provided to them as inadequate [121]. When a home care worker experiences a traumatic event and receives no timely support, they learn that their well-being is not a priority. To demonstrate peer support for home care workers, there is a need for continued conversations around the value of reporting and its follow-up, even when a challenging situation has been managed [155]. Silence after a WPVH incident exacerbates personal trauma and reinforces the belief that reporting is futile.

Like other health care settings, WPVH has profound psychological impacts on health care workers in **long-term care** homes [132], [183], [218]. These workers report frequently experiencing unaddressed emotional trauma, distress, fear, anxiety, depression, and burnout [218], [219]. Beyond these immediate emotional responses, the process by which workers manage and regulate their emotions and emotional displays during violent encounters can become problematic, leading to emotional dissonance, burnout, guilt, depression, detachment, depersonalization, and exhaustion [218], [219]. Additionally, WPVH is consistently linked to fear, decreased job satisfaction, higher nursing absences, and increased turnover, negatively impacting nurse retention. For some, this emotional exhaustion can become so overwhelming that it drives them to switch occupations entirely [131], [132], [219], [220]. LTC compensation systems are criticized by many for



their lack of support, including inadequate time off to recover following incidents involving residents [132].

Another key challenge in LTC and assisted living settings is the absence of administrative support and lack of concern from management for staff safety and well-being after an incident [161], [220]. One study showed that nurses and other frontline staff who reported incidents often saw no action from leadership, and felt that leaders supported patients and family members more than their own staff in these situations [161]. When formal support is inadequate, health care workers frequently resort to personal coping mechanisms or elect to leave the profession altogether [132]. Moreover, staff report fearing job loss or breach of confidentiality when they do file reports. The lack of post-incident support within the workplace is further compounded by a broad lack of public awareness about WPVH [132].

Workers in **mental health settings** experience psychological, physical, emotional, financial, and social consequences of WPVH, impacting both care provision and job satisfaction [221]. Workers may suffer from insomnia, decreased appetite, social isolation, stress, frustration, anger or irritability, fear, anxiety, self-blame, guilt, headaches, nightmares, flashbacks or recurring thoughts of assault, poor concentration,

poor substance use choices, hypervigilance, and relationship issues following a violent event [9], [159], [160], [167], [222], [223]. Witnessing or experiencing assaults regularly, as is common in mental health settings, can have both immediate and long-term effects such as PTSD [9]. Professionally, workers may find it difficult to form therapeutic relationships with patients and may be reluctant to work with violent patients, providing basic care only [159].

Post-event support is also lacking and inadequate in mental health settings [134]. Workers in these settings have reported difficulty navigating and accessing support systems [9]. Stigma is also a barrier to seeking help [9]. A recent study found that 28% of staff did not receive effective support from any source after an assault [223]. The study also found a reluctance among staff to attend formal work-based support groups after assault and noted that staff who feel unsupported or disconnected from support may have given up or feel numb due to trauma [223]. The psychological impacts of WPVH, coupled with a lack of post-event support in mental health settings, are a gap that needs to be addressed.

Similar to mental health settings, those working in **substance use and withdrawal services** centres find themselves at particular risk of negative psychological impacts [221]. WPVH among health care workers leads to negative psychological, physical, emotional, financial, and social consequences [221]. These impacts can negatively affect their lives outside of their work environment as well as their job satisfaction, care provision, and job recruitment and retention [191], [221]. Post-event support is an important factor in mitigating the psychological effects of WPVH.

3.3.1.7 Vulnerable Populations and Intersectional Challenges

The literature consistently highlights that while WPVH can affect any individual, certain populations are disproportionately vulnerable to both experiencing violence and harassment and facing additional harm like discrimination or bias after reporting. These groups include students, new graduates, women, racialized minorities, sexual and gender minorities, and those in more junior positions, all of whom often encounter unique barriers to reporting and support. Additionally, individuals with significant physical and cognitive impairments experience increased violence and harassment in health care settings. This heightened vulnerability is pervasive across all health care sectors, and factors such as gender-based discrimination, racial stereotyping, and a lack of organizational support significantly increase the risks and challenges faced by these workers. This section highlights unique intersectional social and systemic factors across different health care settings.

While the literature demonstrates that WPVH can happen to anyone at any time, some groups within the **medical care and rehabilitation sector,** including students, new graduates, women, racialized minorities, sexual and gender minorities, and those in more junior positions, have been identified as more vulnerable to both WPVH and the additional harm of discrimination or bias after reporting [111], [161], [174], [224], [225], [226]. These populations have been found to face unique barriers to reporting and support, such as fear of retaliation, lack of trust in organizational systems, and intersectional stigma [111], [161], [174], [224], [225], [226]. One study in the UK demonstrated that people from ethnic minority backgrounds experienced higher rates of bullying, with 26% experiencing discrimination based on religion and 35% experiencing discrimination based on race at least monthly [227].

Although the literature on health care workers with disabilities is scarce, one study that examined the mistreatment of physicians with disabilities reported that these physicians experienced racially or ethnically offensive remarks from both patients (21.3%) and coworkers (33.3%), a higher percentage than for non-disabled physicians (11.8% from patients, 28.4% from coworkers) [228].

The research literature on intersectional challenges and vulnerable populations in the **emergency medical services** sector was very limited. However, data from a study in Ontario showed that 18% of external violence incidence reports were found to describe violence against paramedics on the basis of gender, 9% because of race, and 2% because of sexual

orientation [149]. The research literature also explored the challenges experienced by women in this sector, which historically has been primarily staffed by men [229]. Women are at increased risk for adverse mental health outcomes, such as anxiety, depression, and PTSD, exacerbated by stressful occupations [229]. Additionally, women experience unique stressors such as gender-based discrimination or bias, pregnancy, and child or familial demands. Gender-based discrimination or bias includes negative attitudes regarding a women's physical ability to do the job and having their occupational abilities questioned [229]. This can also lead to a lack of opportunities for advancement and mentorship. Sexism, harassment, and bullying also disproportionately affect women. Harassment includes physical, verbal, and sexual harassment from patients and co-workers. There is a documented lack of support from leadership and administration and issues not being taken seriously. Consequently, women may experience fear and anxiety about making formal reports of harassment. Additionally, almost 40% of women working in this sector who were surveyed said they delayed or reconsidered family planning due to their occupation [229]. The impacts of WPVH in the emergency medical services sector are so significant that 61% of women from that same study reported reconsidering their career.

The **home and community care** workforce resembles many other health care settings in Canada, in that it is feminized and racialized. For instance, 89% of health care aides (HCAs) in Alberta and up to 90% of PSWs in Ontario identify as women [230]. Across Canada, gender stereotypes place immigrant, migrant, and undocumented women in low-income home care positions [231]. It is well-understood that health care practitioners' experiences of racism and discriminatory microaggressions are more prevalent among Asian, Black, and other ethnic minorities [11]. Moreover, health care workers in the home and community working with patients who have addictions or mental health conditions are more likely to experience violence [232].

The employment status of these workers is often precarious; in Alberta, 60% of HCAs were part-time or casual employees, even though more than half of them reported working over 37 hours per week [230]. PSWs are unregulated direct-care workers who are paid low wages and offered little structural power [155]. The employment patterns in this sector contribute to their vulnerability. This precarious, racialized, and feminized workforce intensifies workers' fear of job loss, which prevents them from reporting incidents of WPVH [155].

In long-term care and assisted living settings, both residents and staff often face heightened risks of WPVH exacerbated by intersecting social and systemic factors. Residents in LTC are particularly vulnerable due to social and cognitive impairments [128]. Over 90% of residents have some level of cognitive impairment, 40% suffer from mood disorders, and one-third are severely impacted by these conditions [132]. Aggression on the part of these individuals is often interpreted by staff as a symptom of their condition rather than intentional behaviour [132]. Although these responsive behaviours are a symptom of some forms of dementia, residents are often triggered by something in the environment, and violence is rarely intentional [132]. Furthermore, patients with high physical needs or dependencies, such as those confined to beds or wheelchairs, are vulnerable during provision of personal care tasks, which is also a frequent trigger for violence [132], [218]. A gendered dimension of WPVH among residents is noted, with men disproportionately acting as perpetrators against staff in LTC settings. One study indicated that in resident-to-staff WPVH incidents, 71% involved male residents as the perpetrator [191]. On the other hand, residents who are physically or cognitively vulnerable may be unable to report or respond to abuse by staff or other residents or may lack awareness that abuse is occurring [128].

Working conditions in LTC and assisted living settings also present challenges that increase vulnerability to WPVH for health care workers. Women comprise most health care personnel, including nurses, PSWs, and RPNs, and are at a higher risk of violence, notably sexual harassment [132]. This risk is amplified for women in precarious, lower-paying jobs, as experienced in some LTC sectors across Canada [132]. Additionally, racialized and immigrant nurses are particularly susceptible to WPVH and experience higher levels of physical

assault, verbal aggression, racial stereotyping, discrimination, and sexual harassment from patients, families, and colleagues [132]. Racialized workers are over-represented in frontline roles such as PSWs. Research indicates that racism is often overlooked in studies and that patients or families may exhibit a preference for "white" nurses [161].

These intersectional vulnerabilities are compounded by systemic and organizational factors such as understaffing, underfunding, and inadequate organizational support, which may contribute to aggression by staff, residents, and family members [132].

Cultural and race-based violence and harassment have been documented in the research literature as significant concerns in **mental health settings.** This is despite underestimation of violence rates due to under-reporting [233]. Mental health workers are less likely to report racial discrimination due to their belief that nothing will change or for fear of repercussions [225], [234]. Workers also report a lack of safe and effective harassment reporting mechanisms [234]. Black health care providers, in particular, experience higher levels of discrimination, bullying, and harassment [235], with some expressing that racism has been normalized and consequently they do not report it [225]. Mental health workers have shared that racially motivated incidents can be hard to prove and it can be difficult to get organizations to take racism seriously [225]. Although Black and minority staff are often over-represented in lower-paying roles, these trends are seen across health care worker groups including physicians [174], [235]. Another challenge that must be addressed in order to reduce race-based violence and harassment is improving a documented lack of literacy in equity and diversity [234].

The literature on vulnerable populations and intersectoral challenges in the **substance use and withdrawal services** sector focused predominantly on gender differences and, in particular, the challenges faced by women working in this sector. Research was extremely limited on genders other than women and men. Women often reported feeling that their concerns were dismissed, which further exacerbated their vulnerability [174]. One review found that 64% of studies reported higher prevalence of all forms of workplace violence for women, compared to 17% for men [174]. As a result, women experienced changes in their mental health and social behaviours, dissatisfaction, burnout, and even changes in their career goals [174]. Individuals were even more likely to experience violence if they were younger, less experienced, had lower professional status, or were part of an equity-deserving group [174]. Power structures played a significant role in exacerbating incidents of WPVH [174].

3.3.1.8 Systemic, Structural, and Cultural Barriers

WPVH in health care is reinforced by systemic, structural, and cultural barriers that cut across care settings. Inconsistent definitions and fragmented policies undermine accurate measurement and coordinated prevention efforts, while chronic underfunding, staffing shortages, and inadequate managerial support leave workers vulnerable and underprepared. Organizational cultures that normalize violence as intrinsic to the role, combined with fear of retaliation and ineffective post-incident supports, silence reporting and perpetuate unsafe conditions. These dynamics are further compounded by gender inequities, discrimination, and the marginalization of racialized and equity-deserving groups. Together, these entrenched barriers sustain environments where violence is tolerated rather than addressed, undermining both worker safety and the quality of patient care.

WPVH in **medical care settings and rehabilitation centres** is not merely the result of individual incidents but is deeply embedded within systemic, structural, and cultural factors that impede effective prevention and response measures [114], [141], [217], [224], [225], [226], [236], [237]. These entrenched barriers manifest in organizational silence, hierarchical power imbalances, lack of diversity and inclusion in leadership roles, and tolerance of bullying and discrimination, all of which sustain unsafe work environments and make meaningful change challenging [115], [141], [145], [236], [237]. Workplace cultures that tolerate bullying, harassment, and discrimination contribute



"Training is often generic and poorly adapted to the realities of work in this sector, while organizational policies tend to emphasize individual responsibility rather than system-wide prevention."

directly to the normalization of a hostile environment, and bullying behaviours often go unpunished due to fear of retribution, inadequate grievance processes, or tacit managerial endorsement [114], [224], [236]. In addition, Canadian and international studies note that staff who report violence or discrimination may face punitive responses, such as professional isolation or formal investigations that discourage future reporting [141], [225], [237]. The "Nurse leaders' experiences of upwards violence" qualitative systematic review from Canada revealed that nurse managers face significant challenges managing violence directed toward them from various organizational levels, undermining their leadership effectiveness and perpetuating a hostile work climate [237]. Likewise, in the "Running on empty" study, Ontario hospital workers described a workplace culture in which speaking up about violence is discouraged due to fear of retaliation, weak leadership responses, and rigid systems that make it difficult to implement effective prevention or support after incidents [198].

WPVH prevention and management in the **emergency medical services** sector is subject to several systemic, structural, and cultural barriers. At a systemic level, the sector is hindered by inconsistent definitions of violence and harassment, which complicates data collection, prevalence measurement, and risk assessment [118], [119]. Training is often generic and poorly adapted to the realities of work in this sector, while organizational policies tend to emphasize individual responsibility rather than system-wide prevention [118]. Critical gaps also exist in post-event psychological supports, with high rates of PTSD, depression, anxiety, and burnout documented among workers, particularly women, who also face inequities. Structurally, there is insufficient organizational and managerial follow-up and a lack of accountability in response to reported incidents [8]. Resource and staffing shortages, long shifts, and high call volumes add to physical and psychological strain, while unpredictable work environments further increase vulnerability [8]. Culturally, violence has become normalized as an expected aspect of the work. Reporting is stigmatized, reinforcing silence and leaving less severe but still harmful incidents unacknowledged. Gender-based discrimination and harassment continue to exist [229]. Violence is not tolerated but also not addressed, as implemented policies are often not meaningfully enforced. Together, these barriers reinforce one another, leaving workers vulnerable, unsupported, and at heightened risk of physical and psychological harm.

The most notable characteristic of **home and community care settings** is the private nature of the workplace, which leads to a unique power dynamic for workers [238]. Upon entering a client's home, workers are frequently viewed as guests and their professional authority is challenged, creating a barrier to imposing organizational WPVH policies [238]. As such, the home environment blurs how professional

boundaries are set and interpreted. This is especially true for incidents of sexual harassment, which can be particularly insidious in the isolated and intimate environment of a private residence [238], [239].

Systemic failures, such as fragmented policies and a lack of funding, lead to weaknesses across the system that make home care providers susceptible to WPVH [11], [240], [241]. Underinvesting in home care has resulted in chronic understaffing and heavy workloads for these vulnerable, low-wage frontline workers [20]. These structural problems create an environment where workers are overstretched and no longer have the time or resources to build rapport and effectively manage clients' complex needs [20], [242]. Gender-based power dynamics can lead to the normalization and under-reporting of violence, as WPVH disproportionately affects women health care workers who operate in environments with high gender inequity [243]. The isolated nature of the home care environment further exacerbates these risks, making the worker uniquely vulnerable to the physical and psychological toll of the work [238], [239].

The continuous exposure to violence in this under-supported environment fosters a culture of acceptance where violence is viewed as an unavoidable element [119], [242]. A contributing factor is the cultural norm among health care providers that a person must be strong after a violent or harassing event [11]. This mindset, combined with a fear of reprisal and a lack of belief that reporting will lead to action, results in a high rate of under-reporting across the home and community setting, made worse by a lack of resources for employees (e.g. community workers lacking computer access to file reports) [11], [242].

The increased complexity of tracking WPVH in home care settings further contributes to the true scale of the problem being hidden from official data, preventing policy-makers and health authorities from adequately addressing the systemic and structural issues [120]. This feedback loop ensures that the conditions that lead to violence are perpetuated. The cycle of burnout and staff attrition worsens the staffing shortage, further increasing the risk for those who remain [242].

Workplace violence in **LTC and assisted living settings** is influenced by a range of systemic, structural, and cultural barriers. Systemically and structurally, persistent understaffing and underfunding are root causes, leading to increased workloads, job dissatisfaction, and burnout. This often leads to inadequate safety measures, including a lack of specialized training and critical resources like behavioural specialists for residents with cognitive impairments [132]. Additionally, insufficient policies, unclear reporting processes, and lack of leadership support for WPVH are widespread in LTC [184]. Poor physical work environments, including inadequate security measures, lack of personal alarms, and facility designs, further exacerbate staff vulnerability [132].

Culturally, WPVH is often normalized and minimized in LTC settings, with many frontline staff viewing it as intrinsic to their roles [131]. This is reinforced by a culture of fear and blame, where staff avoid reporting due to concerns about negative consequences, retaliation, or being blamed for provoking residents [184]. In LTC settings, "resident rights" can be misinterpreted as "the customer is always right" and unintentionally contribute to an environment where residents and families harass frontline workers [218]. Additionally, within LTC settings, there are many PSWs and nurses from diverse backgrounds who disproportionately experience discrimination, racial stereotyping, physical assaults, and questioning of their competence by residents and families [218]. This creates an environment where WPVH is not only prevalent, but also deeply challenging to address, due to rooted systemic and cultural issues.

Mental health settings face systemic, structural, and cultural barriers that perpetuate WPVH. Systemically, definitional and conceptual inconsistencies across organizations, legislation, and clinical practice undermine accurate measurement, evaluation, and prevention, while reliance on self-reports contributes to underestimation of incidents [134],[135], [136]. Structurally, insufficient policies, inadequate managerial support, limited training, poor staffing, and unsafe physical environments leave workers underprepared and vulnerable, while post-event supports remain fragmented and stigmatized [134], [159], [160],

[167], [173], [177], [211]. Culturally, violence is often normalized as "part of the job," which discourages reporting, compounded by fears of retaliation, perceptions of futility, and minimization of verbal and race-based incidents [9], [168]. These challenges are magnified for workers from racialized groups, who face additional barriers due to systemic racism, lack of safe reporting mechanisms, and organizational inaction [225]. Together, these systemic, structural, and cultural barriers not only perpetuate cycles of under-reporting and insufficient response, but also deepen the psychological toll on mental health workers and compromise safe, therapeutic care environments.

The **substance use and withdrawal services** sector also faces systemic, structural, and cultural barriers that perpetuate WPVH. Culturally, violence has been normalized, with many staff and trainees viewing assaults as commonly associated with their line of work, leading to widespread under-reporting fueled by fear of retaliation, futility, and lack of institutional support [169], [170], [173]. Structurally, organizations often fail to provide adequate managerial assistance or effective post-incident support, leaving workers vulnerable to ongoing psychological, physical, and professional harm [169], [191]. Systemic issues are further reinforced by insufficient training and preparedness, including limited de-escalation education and inadequate strategies tailored to withdrawal-related behaviours [191]. Staffing shortages and challenging work environments heighten risks, while inequities—particularly those affecting women, younger or less experienced staff, and equity-deserving groups—are compounded by power imbalances that silence reporting and reinforce vulnerability [174]. Collectively, these barriers reveal a deeply rooted problem that requires sector-wide cultural change, stronger organizational supports, and systemic reforms to improve safety and equity.

3.3.2 Best Practices, Support Tools, and Areas for Improvement

3.3.2.1 Comprehensive Multicomponent Prevention Programs

The implementation of multicomponent WPVH prevention programs is consistently highlighted in the literature as one of the most effective approaches to reduce violence across all health care settings, primarily because they address the issue across individual, organizational, and policy levels [99], [101], [107], [109], [195], [244], [245], [246]. These programs integrate clear policies, strong leadership commitment, staff education, environmental and security enhancements, systematic reporting procedures, and post-incident support, with the aim of preventing violent episodes and mitigating their effects when they do occur [101], [107]. Strong leadership engagement and organizational culture change, including zero-tolerance policies, shared governance, and interdisciplinary committees, help to foster environments where staff feel supported, empowered, and more willing to report incidents, which improves both prevention and accountability [101], [107].

Multicomponent programs are particularly effective when they couple staff-focused interventions like de-escalation and resilience training with environmental and system-level strategies such as risk assessments, security technology, alarm systems, and legislative frameworks, ensuring that both root causes and acute incidents are addressed [99], [109], [195], [244]. Evidence shows that these layered, system-wide interventions not only improve worker safety and reduce the frequency and severity of workplace violence, but also enhance staff morale, retention, and ultimately the quality of patient care [107], [195].

Within the **medical care and rehabilitation settings,** there are several examples of multicomponent prevention programs that have been successfully implemented. One notable Canadian example is Ontario's Life Cycle of a Code White framework, a structured quality-improvement initiative designed specifically for hospital settings [247]. This program incorporates governance committees involving senior leadership and clinical experts, 12 quality improvement initiatives, and 17 measurable indicators. The framework has enabled Ontario hospitals to systematically collect data, monitor trends, and coordinate responses to WPVH incidents, deepening the evidence base for intervention and fostering organizational accountability [247].

As part of their WPVH prevention strategies, many Canadian hospitals have adopted validated risk assessment tools and environmental safety measures

tailored to their settings, which have contributed to improved detection of violent behaviours and safer care environments [248], [249]. Risk assessment tools such as the Broset Violence Checklist (BVC) [250] and the Dynamic Appraisal of Situational Aggression (DASA) [251] have proven effective in predicting violent behaviour in this setting, enabling proactive management of at-risk patients.

Environmental interventions are also pivotal within medical settings. Well-designed care spaces with sightlines for natural surveillance, improved lighting, secure access controls, and physical separation have been found to minimize violence triggers in the hospital setting [252]. A few studies describe how Canadian hospitals have invested in redesigns of emergency departments and psychiatric units to decrease overcrowding and reduce stressful stimuli, which are recognized contributors to WPVH [199], [248], [249]; however, much more work needs to be done in this area.

The deployment of specialized Behavioural Emergency Response Teams (BERTs) or Code White Teams (multidisciplinary rapid-response groups trained to manage escalating violent situations) has been found to be one of the most used techniques to be deployed [253]. These teams have been shown to provide timely on-site support and reinforce staff confidence in managing WPVH incidents, as observed in several Canadian hospital programs [247], [254], [255].

Literature specific to the **emergency medical services** sector has also demonstrated that comprehensive multicomponent prevention programs are effective. Interventions were more likely to be effective if they are evidence-based, co-designed, and address all levels of health care [146]. This extends beyond interventions focused solely on emergency medical service workers to encompass the patients they treat. Increased funding and support for community-based rehabilitation services for individuals with mental health or substance abuse issues can help decrease the risk of WPVH for emergency medical services workers [146]. At a policy level, there is a need for increased accountability for perpetrators, which was found to help in shifting the culture away from one of under-reporting due to lack of accountability and follow-up [146].

Policies and procedures for reporting should also be clear, simple, and time-efficient [146]. A recent study in Ontario developed a novel reporting process that showed significant success [8]. The External Violence Incident Report (EVIR) was developed with the involvement of paramedics to overcome reporting barriers and was implemented as part of a multicomponent program that included comprehensive prevention policies, a public-facing statement of zero tolerance for violence against paramedics, and new restraint equipment. The EVIR was embedded into the electronic patient care record, allowing workers to quickly and easily file a report at the point of event. The system also prompts the paramedic to fill out the report if they experience violence during an interaction. Paramedics' willingness to report more than doubled following implementation of the EVIR. They cited the accessibility of the reporting process, the belief that reports led to meaningful change, the prompt actioning of reports by supervisors, and encouragement from peers and supervisors as motivating factors [8]. The EVIR serves as a prime example of how a co-designed, comprehensive intervention can address several of the needs, gaps, and challenges identified in the emergency medical services sector.

The **home and community care sector** cannot rely on a single intervention to improve the prevention and management of WPVH [207], [243]. As in other settings, multicomponent interventions are necessary to tackle the deep-seated, normalized culture of under-reporting and accepting violence and harassment as expected occupational hazards. Home and community care work environments transcend public and private spaces where the unpredictable nature of the work environment means no single tool or resource can mitigate all potential risks [189]. According to Canadian reports, effective programs for preventing WPVH include components such as written policies, risk assessments, hazard recognition and control measures, and training [3], [11].

A Canadian pilot study in a large home care agency recently demonstrated the acceptability and impact of a layered intervention that combined policy changes, a pre-visit screening tool, education, and a brief digital

end-of-visit reporting form on WPVH [155]. This multicomponent intervention fostered a shift toward greater confidence in navigating WPVH incidents and began to shift the organizational culture toward greater openness and shared accountability. Nevertheless, the study emphasized that creating a culture of safety requires ongoing dialogue, reinforcement, and a sustained commitment to collective responsibility for prevention and reporting [155].

Within **long-term care and assisted living** environments, comprehensive multicomponent prevention programs have been much more successful than single strategies, which are often insufficient [132], [161], [219]. The need for a comprehensive approach is driven by the fact that different types of WPVH, including patient-initiated and employee-initiated violence, require tailored interventions [219]. Studies consistently recommend a range of strategies, including formal reporting systems, addressing staff shortages, risk assessments, administrative support, employee education and training, post-incident support, and public awareness campaigns [128], [132].

Comprehensive multicomponent prevention programs have also been shown to be effective in **mental health settings.** A scoping review of guidelines and systematic reviews in health care settings, including mental health settings, found that prevention programs should include clear and adaptable goals, education and training as a central component, evidence-based risk assessment tools, environmental modifications, multidisciplinary rapid response teams, easy-to-use reporting systems, and active leadership involvement [171]. A more recent integrative review, specific to psychiatric hospitals, also determined that a multicomponent approach is needed [256] and suggested a number of components: involvement of administrators, care providers, and patients in strategy development; environmental modifications; training and education; leadership and organizational commitment to safety; building of respectful staff–patient relationships; use of communication strategies; and targeting unmet patient needs [256].

One Canadian example of a multicomponent prevention program is the Behavioural Optimization and Outcomes Support Team (BOOST) [166]. This is a proactive, nurse-led program that uses data from electronic medical records to identify high-risk patients. Previous patient behaviours may trigger a psychiatric consultation without requiring a physician referral. The BOOST could help to develop behavioural care plans and model behavioural techniques. The presence of BOOST members on a unit helped build staff mental health expertise and made them feel safer, more supported, and less burdened. BOOST was also found to improve timely access to psychiatric intervention and increased risk identification.

Recent pilot studies from the United States also exhibited successful multicomponent prevention programming. The first study utilized multidisciplinary team implementation of the Broset Violence Checklist to predict violence [222], which leads to high-scoring patients receiving psychiatric consultations. The programming also included training focused on recognizing escalating behaviours and learning key de-escalation techniques. The training was continuously offered and interdisciplinary collaboration was fostered through safety huddles. Real-time feedback was received from nursing staff. This program resulted in a 17.6% reduction in nursing restraint use and a 60% reduction in calls to public safety services [222].

The second pilot study utilized a behavioural management model that included primary, secondary, and tertiary prevention strategies [257]. Primary prevention entailed proactive training of hospital staff, while secondary prevention included behaviour management consultation services provided by a clinical psychologist for patients exhibiting behaviours that raised concerns for escalation. Tertiary prevention entailed consultation by the clinical psychologist for patients who had already experienced a behavioural emergency. Staff reported feeling more confident with this prevention program in place, and this model led to a 50% decrease in calls to the BERT [257].

The literature from the **substance use and withdrawal services** sector has also shown that comprehensive multicomponent prevention programs are more effective than isolated interventions [171]. Programs should include a combination of organizational



changes, such as simple-to-use reporting systems, environmental changes to workplace design, and training in prevention and management strategies [171]. Programs should also be adaptable to the changing conditions in this sector. Though the literature for this sector is limited, there are published examples of successful multicomponent interventions. In California, the Behavioural Evaluation and Addiction Management (BEAM) team is an evidence-based, comprehensive program [214] that employs a nurse-led team trained in substance use disorders to proactively round on at-risk inpatients and respond to behavioural escalations. The team is trained in de-escalation techniques and also provides real-time staff education on alcohol and opioid withdrawal protocols and medication management. Evaluation of the program showed that BEAM improved patient management and reduced unnecessary transfers. It also decreased the workplace injury and Code Grey rates while increasing staff comfort in caring for these patients from 13.5% to 48.25% [214].

3.3.2.2 Staff Education and Training Programs

Education and training programs are the cornerstone of effective WPVH prevention and management. Across Canada's health care system, there is compelling evidence that targeted, context-specific training is associated with increased staff preparedness, confidence, and safety. Nevertheless, the current landscape of training offered and completed by health care providers is insufficient with respect to its content, level of oversight, and completion rates. As new training modalities emerge, there is an opportunity to offer trainees, early-career workers, seasoned employees, and those working in high-risk or isolated roles with innovative, tailored modules to complement established training practices. Understanding the unique training needs of each health care sector is an integral first step to equipping health care workers with the skills and knowledge they need to prevent, manage, and recover from WPVH incidents.

Health care workers in **medical care settings and rehabilitation centres r**equire continuous, context-specific training to recognize early warning signs of aggression and manage violent behaviour safely and effectively. Nursing students in Canada have indicated they receive insufficient preparation for managing WPVH during clinical placements, underscoring the need for integrative university–hospital collaborations to enhance training and support [111], [134]. Training programs in Canada, such as the Management of Aggressive Patient Situations, incorporate practical simulation exercises and emphasize trauma-informed care, de-escalation tactics, communication skills, and

cultural competence [188], [258]. It is recommended that training be recurring and tailored to the specific demands of clinical environments and roles, including nursing students, early-career nurses, support staff, and security personnel [134], [259], [260].

To be effective, the literature notes that WPVH training must extend beyond theoretical lectures to include role-playing and immersive experiences that build confidence and practical skills [170], [259], [261]. Innovative methods like virtual reality simulations are emerging as effective tools for experiential learning, allowing staff to practice responses in realistic scenarios without risk, a promising practice gaining interest in Canadian health care education [170], [262].

The literature also highlights the need to integrate cultural competency and bias awareness training into WPVH training and educational programs [228], [263]. Given the well-documented over-representation of racialized, gender minority, and marginalized staff among WPVH victims, training that promotes inclusion and sensitivity is necessary to mitigate conflicts arising from misunderstood behaviours or systemic inequities [224], [225]. The literature also notes that training should be provided to prevent microaggressions and bullying between staff [227], [263].

Staff education and training programs also play a critical role in prevention and risk mitigation in the **emergency medical services** sector. A systematic review of educational training interventions on WPVH found that training improves knowledge, attitude, confidence, and coping capabilities [264]. Modules to be included in education and training programs include de-escalation techniques, risk assessment, communication skills, worker responsibility, post-incident procedures, and legal aspects. The review examined a variety of delivery modes, including computer-based learning, role play, and lecture and discussion [265].

A more recent study of occupational hazards in emergency medical services found that de-escalation training was associated with lower odds of experiencing violence [148]. Conversely, restraint training was not. It has also been suggested that level of worker certification or training may correlate with better de-escalation. Paramedics were significantly more likely to make an adequate de-escalation attempt (59%) compared to other emergency medical service responders with lower levels of certification, such as emergency medical technicians (32%) and advanced emergency medical technicians (36%) [266]. It should also be noted that education and training programs must be tailored to the emergency medical services sector. Universal training that employs one-size-fits-all approaches has not been successful [204].

Home and community care settings also consider context-specific curriculum for WPVH prevention to be an essential element of education and training [189]. While training is a foundational tool, it must be designed specifically for the realities of home care, where workers often operate in isolation and face unique risks [125], [189]. In addition to being tailored to reflect the specific challenges of working alone, serving vulnerable clients, and navigating private home environments, training for home care workers should be mandatory upon hiring and repeated annually [3], [121], [124]. Comprehensive programs should go beyond verbal de-escalation and self-protection to include guidance on duress code procedures, accessing psychological support, screening clients and families, recognizing early warning signs, using reporting tools, and maintaining clear communication with the agency [20], [125], [189]. Training for home and community care workers must also consider employment status and the impact it has on delivery and completion of training sessions. Since many PSWs hold part-time or casual roles with multiple employers, it can be difficult for them to attend scheduled group sessions. Additional barriers include geographic dispersion, reliance on public transit, and frequent last-minute changes in client needs that can override scheduled training [155]. Flexible, accessible training formats such as modular asynchronous options are needed to ensure participation without compromising care delivery.

Incorporating innovative approaches, such as intergenerational mentorship models, into training and education can improve outcomes. This approach pairs inexperienced staff with experienced mentors to foster confidence and build rapport with clients,

and may also reduce the likelihood of aggression from clients [181]. This is especially important given that young and early-career home care workers are at greater risk of experiencing WPVH [181], [120]. Additionally, staff who support clients with dementia should be required to complete specialized training in communication and recognizing unmet needs, since these are key strategies for preventing escalation and managing challenging behaviours [125], [127].

Long-term care homes and assisted living settings view education and training as critical strategies for preventing and managing WPVH [171], [259]. Verbal de-escalation training is among the top recommendations to manage aggression, in both staff-to-staff and patient-to-staff incidents [259]. De-escalation techniques should be tailored to the population being served within the specific setting [131]. Jones *et al.* [267] highlighted the importance of de-escalation training for managing patient aggression in long-term care homes, a population that experiences high patient aggression due to cognitive changes among residents.

Training programs should start immediately upon hiring and be refreshed frequently to ensure staff are well-educated [259]. Multimodal, targeted training has been shown to increase staff confidence in de-escalating verbal harassment [259]. More recently, other training methods like virtual reality and simulation are mentioned as effective strategies to enhance training experiences for health care providers and staff [261], [268].

Similar to the aforementioned sectors, **mental health settings** rely on staff education and training programs as central components of effective multicomponent interventions to address WPVH prevention and management. The literature identifies training founded on empathy, trauma-informed care, cultural awareness, and self-care as important in mental health settings [141], [269]. Further, education and training should focus on prevention of escalation rather than solely reactive strategies, as this has been shown to be critical in impacting the occurrence of dangerous behaviours [257]. Other critical topics for mental health care education and training programs are risk recognition, early recognition of escalating behaviours, strategies to prevent or diffuse volatile situations, patient-centred care and relationship building, interpersonal communication skills, self-protection, and management of aggressive patients [114], [141], [167], [265], [270].

Education and training can be delivered through a variety of modalities. Though even traditional didactic training has been shown to be effective [265], hands-on training and simulation-based activities provided opportunities for trainees to model strategies and behaviours and to role-play situations they may encounter [270], [271]. Trainees can also work through aggressive scenario examples and videoclips illustrating techniques [270]. Recent studies have also made use of virtual reality for training purposes. Virtual reality training in verbal de-escalation techniques was found to increase confidence and provided trainees in mental health settings with an experiential training opportunity [170], [265].

The **substance use and withdrawal services** sector identified staff education and training as a critical factor in WPVH prevention and management. Training topics should include types of violence, risk factors, facility-specific processes, legal issues, psychosocial methods to avoid or minimize restrictive interventions, and de-escalation techniques [170], [171]. Training should also include experiential components, such as peer facilitation and role-play or simulations [170]. A Canadian randomized control trial compared behavioural skills training (BST) for teaching safety skills compared to "training-as-usual" (TAU) [221]. TAU involves description, demonstration, and doing, while BST includes instruction, modelling, practice, and feedback [221]. BST provided significant improvements in observed performance of self-protection and team control skills, with both methods resulting in improved skills and confidence. However, both training methods also showed a decrease in skill performance at follow-up, suggesting the importance of providing opportunities to refresh learnings and practice skills [221].

3.3.2.3 Leadership Commitment and Organizational Culture

Strong leadership engagement and a robust organizational culture are foundational to the effective prevention and management of WPVH across diverse health care settings. These elements are critical for fostering an environment that reduces WPVH,

encourages reporting, and ensures staff feel supported. A fundamental shift away from the normalization of violence is essential, requiring leaders to actively enforce policies, provide clear expectations, and ensure that all reports of WPVH are taken seriously and addressed promptly. Responsive management practices, including timely follow-up, empathetic engagement, and transparent communication, are key to building the trust necessary for staff to report incidents without fear of retaliation. Ultimately, creating systems that workers can trust involves removing current barriers, promoting inclusive leadership, and prioritizing worker safety as a core value, moving beyond the perception that violence is simply embedded in the nature of the work.

Within **medical care settings and rehabilitation centres,** strong, visible leadership engagement has been found to play a critical role in fostering a culture where violence is not tolerated, reporting is encouraged and protected, and staff feel supported. Leadership must actively enforce policies, provide clear behavioural expectations, and ensure that reports of WPVH are taken seriously and addressed promptly [141], [142].

Canadian hospitals that have adopted governance models similar to the Code White Governance Committee show how multidisciplinary leadership can effectively coordinate strategies for preventing and responding to WPVH. These committees provide forums for data review, policy refinement, staff feedback incorporation, and ongoing quality improvement [247].

Shifting organizational culture away from silence and normalization of violence requires dismantling hierarchical barriers and power imbalances that suppress reporting and perpetuate unsafe environments. Inclusive leadership that reflects workforce diversity ensures that policies are equitable, relevant, and sensitive to the experiences of all staff. Addressing organizational culture is particularly critical given the ample evidence that women, new graduates, racialized employees, and LGBTQ+ individuals disproportionately suffer violence and discrimination within health care workplaces [224], [225], [237].

Simplified, user-friendly, and accessible reporting mechanisms substantially increase incident reporting, improving data collection and enabling effective interventions. However, such systems must be matched with feedback and visible corrective action to maintain staff trust and participation [142], [143].

Leadership commitment and organizational culture play a critical role in WPVH prevention and management in the **emergency medical services** sector. For example, supervisors actioning reports promptly and closing feedback loops has been a contributing factor to increasing reporting rates among paramedics, as has fostering an organizational culture that promotes reporting rather than stigmatizing it [8]. A supportive organizational culture has also been documented as having psychosocial benefits for emergency medical services workers [8]. This is particularly important in a sector where the psychological impacts of the work can be severe.

Leadership commitment is a critical enabler of WPVH prevention in the **home and community care** sector. When leadership is disengaged, fails to model appropriate behaviour, or demonstrates organizational deafness (a pattern of unresponsiveness to staff concerns), it can contribute to a culture where violence and harassment are tolerated or normalized. This risk is heightened in home care, where workers often operate independently and are physically distant from supervisors. In this context, visible leadership support and consistent follow-up on reported incidents become even more essential. As noted in a federal report, the deeply embedded culture of acceptance of violence within health care systems is a significant barrier to progress [20].

Responsive management practices, such as timely follow-up, empathetic engagement, and transparent communication, foster trust and encourage workers to report incidents [121], [122]. WPVH policies must be supported by a work culture that actively works to de-normalize violence and challenge the perception that it is "part of the job" [121], [155], [243]. Leadership also plays a key role in preventing bullying. Strengthening leadership training enables managers to identify and respond to biased, discriminatory, and bullying behaviours before they escalate [272].

A fundamental shift in organizational culture is needed to build systems workers can trust. This includes establishing confidential reporting

mechanisms, ensuring protection from retaliation, and reinforcing that worker safety is a core value, not subordinate to client satisfaction [153], [155].

Organizational culture and committed leaders play a crucial role in WPVH prevention in **LTC and assisted living settings.** The safety of health care workers, staff, and patients/residents needs to be prioritized to create a positive work and living environment. Organizations should establish and enforce zero-tolerance policies for violence, abuse, and incivility [132]. In order to transform organizational culture from one that normalizes WPVH to one that prioritizes safety, the organization's strategies and policies need to be flexible and setting- or context-specific, not one-size-fits-all [273].

Similarly, leadership commitment and organizational culture can have a significant impact on WPVH prevention and management in **mental health settings.** Effective leadership can profoundly impact the work environment [114], so individuals selected for leadership positions should possess emotional intelligence [114] and address violence in a timely manner [168]. Policy and strategy development aimed at fostering a positive organizational culture should directly involve mental health workers. A recent study examining the roles of nurses suggests they should be involved in decision-making that impacts the clinical setting and patient care, and can also co-develop prevention strategies and highlight existing barriers to implementation [159]. Leadership should listen to staff suggestions and co-create or collaborate on policies whenever possible [213].

In 2022, the Joint Commission in the United States released a new standard focused on workplace violence prevention in hospital settings, including mental health settings. Key components of this standard reflect what has been identified in the research literature and include organizational and management support, fostering a strong violence prevention culture, and engagement of interested parties [165]. Organizational and managerial support should include a commitment to protecting both staff and patients through open, non-blaming communication and using incidents as learning opportunities [165]. Fostering a strong



violence prevention culture can be achieved by enacting prevention-focused policies, implementing non-punitive reporting systems, and providing resources for staff, such as education and training and environmental safety measures [165]. Lastly, engagement of interested parties should encompass active engagement of staff and unit managers, permitting autonomy and flexibility in prevention efforts [165].

Leadership commitment and a shift toward an organizational culture of prevention and management have also been found to be important in the **substance use and withdrawal services** sector. Research shows that leaders should be actively involved in preventing and addressing violence and harassment, reinforcing policies, and providing mentorship and role modelling [171]. Leadership commitment should focus on creating a workspace that prioritizes respect, inclusivity, support, and provision of skills and training [171].

3.3.2.4 Risk Mitigation Strategies

Across health care settings, a range of risk mitigation strategies have been developed to prevent and manage WPVH. Common approaches include proactive risk identification through flagging systems, electronic health record alerts, and risk assessment tools, as well as environmental modifications.

Communication and coordination among staff, leadership, and organizations are emphasized alongside practical preparedness approaches. Together, these strategies highlight the importance of combining data-driven tools, environmental safeguards, organizational support, and individual readiness to reduce risks and foster safer workplaces.

Effective WPVH mitigation in **medical care settings** requires a comprehensive, multi-level approach. Organizations must establish and enforce robust WPVH prevention programs led by designated individuals and multidisciplinary teams, ensuring engagement from all parties [274], [275]. Many of the reviewed studies emphasize that it is absolutely essential in the medical care setting, and especially in hospitals, to adopt clear policies reinforcing the message that violence is not an acceptable or inevitable aspect of health care work [141], [184], [276], [277]. Compliance with legislative and regulatory standards and efforts to improve staffing levels are also seen as essential to reduce risk [277], [278]. Equally important is the cultivation of an organizational culture that prioritizes civility, respect, and psychological safety through leadership commitment, employee involvement, and non-blaming reporting environments [141], [184], [276]. Standardizing definitions and reporting processes, integrating them into electronic health records, and ensuring usability of reporting tools further enable consistent data collection, monitoring, and accountability [278], [279]. Complementary strategies include patient codes of conduct, specialized WPVH committees to oversee prevention initiatives, and continuous reinforcement of organizational commitment to staff safety.

Beyond policy, effective mitigation also depends on equipping staff with the skills and resources necessary to prevent, de-escalate, and respond to violence. Comprehensive training in de-escalation, recognition of risk factors, communication, and specialized approaches to bullying, lateral violence, and microaggressions help to foster preparedness and resilience [277], [280]. Environmental and security measures, such as improved access control, weapon detection, and surveillance systems, have been suggested as preventative in some studies [281], [282]; however, other studies have found that such measures, and specifically wearable alarms, may not actually be effective in preventing WPVH [283]. Thoughtful design of physical spaces (e.g. noise reduction, safe furniture placement, clear signage) may also help to minimize aggression triggers [284]. Patient-centred approaches, including the use of validated risk assessment tools, behavioural flags in electronic health records, individualized care plans, and proactive communication about delays and expectations, address root causes of aggression while balancing concerns about stigmatization [171], [177], [285].

To sustain workforce well-being, organizations must prioritize immediate and ongoing support for affected staff through debriefing, counselling, and legal or psychological services, while also addressing systemic contributors such as understaffing and workload-related stress [177]. Finally, specialized interventions, including BERTs [254], AI-assisted violence prediction, and VR training [262], represent innovative, context-specific solutions that require further research.

A number of risk mitigation strategies have been identified that could help to prevent and manage WPVH in the **emergency medical services** sector. Hazard flagging is a frequently cited strategy to mitigate risk, not only at the scene of the emergency, but in clinical handover between professions and from EMS/paramedics to acute care settings. Patients with a history of violence are flagged to trigger a modified response plan [202], [203], [293]. Paramedics can also be alerted to the possibility of violence based on address or phone number, in addition to patient history [286]. Data from previous violent incidents can be used in a number of ways to mitigate future risk. For example, the EVIR system developed in Ontario feeds data from received reports into a real-time situation awareness dashboard that can serve to identify potential risks [8].

As previously stated, emergency medical services are typically administered in an uncontrolled environment. Therefore, strategies to help ensure scene safety are critical. These include: communication between organizations such as police, dispatch, and EMS/paramedics [204]; organizational or managerial

support for refusal of care or staging outside a patient's home until police arrive [204]; and use of restraints or sedation if necessary [204]. Finally, there is an increasing trend toward the use of body-worn cameras in emergency medical services. The implementation costs are considerable and limited research currently exists as to their effectiveness in risk mitigation and prevention of violence and harassment [287].

In addition to formal training, **home and community care** workers can adopt proactive, situational strategies to reduce the risk of WPVH, especially when working alone [20]. One such strategy is utilizing a Preparation, Awareness, Alertness, and Prevention (PAAP) mindset [207]. Mental preparation is a key component. Workers can reduce their exposure to risk by reviewing client histories, checking for any known safety concerns, and consulting local crime statistics prior to visits [3], [207]. These steps help staff anticipate potentially volatile situations and make informed decisions about personal safety.

Practical strategies further enhance on-the-ground safety. These include ensuring phones are fully charged and pre-programmed with emergency contacts, wearing non-restrictive clothing that cannot be easily grabbed, and having a designated communication plan with their agency [3], [288]. In high-risk or uncertain situations, the use of pre-established duress words or codes can serve as a critical safety measure to discreetly signal for help [189]. When embedded within organizational protocols and reinforced through training and supervision, these individual-level strategies serve as vital components of a broader violence prevention approach, which recognizes the unique vulnerabilities of working in clients' homes and communities.

Long-term care and assisted living facilities can also employ several risk mitigation strategies to reduce WPVH. Addressing understaffing and underfunding is critical to mitigate risk through improved staffing ratios and creation of multidisciplinary teams, including behavioural management specialists to support persons with responsive behaviours [132]. Comprehensive, context-specific education and training in LTC settings, including de-escalation techniques, simulations, and early recognition of behavioural warning signs, can help to reduce risk [264]. Additionally, enhancing physical safety measures such as controlled entries, video surveillance, presence of security staff, and personal alarms is critical [131], [289].

With a focus on the main population served within LTC settings, which includes older adults with cognitive impairment or individuals with mental health conditions, there are several care strategies to reduce risk. These include specialized therapies (i.e. music or pet therapy) for residents, playing music during bathing to reduce agitation, and maintaining a ratio of two or more workers to one resident to support care [290].

There are also a number of risk mitigation strategies that could be implemented in **mental health settings** to reduce WPVH. First, environmental risk factors should be evaluated and addressed [168]. This may include controlled access doors, panic buttons [291], video monitoring, available and well-trained security [159], access to rapid response teams, ensuring rooms have accessible exits, and in some instances even the use of bullet-resistant glass and metal detectors in high-risk areas [141]. Additionally, electronic health records should be utilized to identify risks and document violent incidents for future treatment and discussion [168]. An Ontario-based study utilized risk-flagging in the electronic medical record system to support risk communication [292]. This resulted in an overall decrease in incidents for most risk-flagged patients. The study authors did caution, however, that individuals must be cautious of alert fatigue that can result from longstanding alerts for patients and may minimize staff's diligence with regard to risk [292]. Lastly, a number of risk assessment tools exist (e.g. Broset Violence Checklist, STAMP framework, Aggressive Behaviour Risk Assessment Tool, Violence Assessment Tool). Organizations should review these tools and consider implementation of the most appropriate measures for their setting.

Several risk mitigation strategies have been identified in the **substance use and withdrawal services** sector. First, environmental modifications can help to reduce risk. These include locked doors, cameras, alarms, and specialized behavioural rooms [171].

The use of multidisciplinary response teams, such as aggression management teams, has also been effective [171]. Evidence-based risk assessment tools and strategies can also mitigate risk. Tools such as the Broset Violence Checklist and the Dynamic Appraisal of Situational Aggression can help predict inpatient violence [171], thereby reducing the risk of future incidents. The Violent Event Severity Tool (VEST) assesses six types of violence (physical assault, sexual harassment, physical threat, verbal threat, written threat, verbal abuse) with four grades of severity [172]. Data reported and collected through VEST can proactively identify potentially violent patients [172]. Finally, incorporation of patient history of violence and notifications delivered through the electronic patient health record can also mitigate the risk of WPVH [172].

3.3.2.5 Support Systems and Post-Incident Care

Support systems and robust post-incident care are consistently emphasized across the literature as essential to protecting the psychological well-being, retention, and performance of health care workers across all care settings following WPVH. Having structured debriefing sessions after violent events helps staff process trauma, reduces psychological effects, and strengthens confidence [293]. Supportive management practices, including immediate follow-up, transparent and timely investigations, and access to counselling or EAPs, help to validate health care workers' experiences and prevent normalization of violence as a routine part of the work [294].

Providing comprehensive, trauma-informed support to health care workers following WPVH incidents in **medical care settings and rehabilitation centres** has been found essential to mitigating long-term psychological effects such as PTSD, anxiety, and burnout [215]. Peer support, professional counselling, structured debriefings, and EAPs constitute core elements of effective post-incident care [142], [215], [216].

The literature suggests there are notable gaps in the availability, accessibility, and consistency of post-incident support within medical settings, with many workers reporting feelings of isolation and inadequate organizational follow-through after violent episodes [177]. The "Running on empty" study in Ontario highlights how hospital austerity measures and staffing shortages exacerbate these deficits, leading to deteriorating mental health among hospital staff exposed to WPVH [198]. Strengthening these support frameworks to make them culturally sensitive and inclusive is crucial, particularly for vulnerable groups facing compounded marginalization [174], [224], [225]. Structured peer support programs have been well-received by health care workers within the hospital setting and provide important avenues for emotional validation and shared recovery, but they do require formalization and sustained institutional backing to be effective [215].

Given the profound psychological impacts of WPVH on workers in the **emergency medical services** sector, support systems and post-incident care are necessities. Peer supports and supportive partners can help to manage workplace stressors [229]. One recent study highlighted how tailored interventions that include adaptive coping mechanisms such as therapy, cognitive reframing, and exercise are able to protect and improve well-being [229]. As previously described in the context of prevention programs, multicomponent programs with a focus on support and post-incident care are needed. These should include a combination of education, policy, and actionable strategies that support emergency medical services workers [229].

The literature suggests that comprehensive WPVH prevention plans in the **home and community care** sector must also include mandatory post-incident support protocols. These should ensure timely access to formal psychological counselling, structured post-incident debriefings, and peer support programs [121]. The need for robust, accessible support systems is critical. Home care workers frequently report feelings of isolation and abandonment following WPVH incidents, particularly when working alone in clients' homes. Without appropriate post-event care, the psychological toll of these incidents can compound, leading to long-term impacts on mental health and job retention [121]. Research from the United States shows that post-incident debriefing offers a safe and supportive environment for reflection,



discussion, referral, and feedback, which is especially important for workers without immediate access to colleagues or supervisors [288]. In tandem, peer support networks and professional counselling services provide vital outlets for processing traumatic events and restoring a sense of safety and connection [121].

The consequences of insufficient support are far-reaching. WPVH has been linked to increased burnout, stress, injuries, and staff shortages, all of which compromise continuity and quality of care [20], [295]. Leaders in the home care sector must also prioritize equitable access to mental health and well-being resources, particularly for staff with intersecting social identities who may face greater barriers to care [208]. When combined with clear reporting mechanisms and accountability structures, post-incident support systems play a vital role in both addressing the human cost of WPVH and reinforcing an organizational culture that prioritizes worker safety and well-being [121], [207].

Similarly, good post-incident support for health care workers experiencing WPVH in **LTC and assisted living** settings is crucial for mitigating psychological trauma, preventing burnout, and improving overall well-being and retention [132]. Most importantly, health care workers in LTC settings need timely and appropriate support. This includes multi-faceted post-incident support that focuses both on response to the immediate incident and planning for improvements to prevent future WPVH incidents. Post-incident support can include debriefing sessions, which could be informal with co-workers or facilitated by a clinical educator, and access to individual counselling with qualified mental health professionals [131], [161]. Peer support and social networking have been cited as important coping mechanisms in this setting, especially for frontline staff who represent minorities. These social networks can foster safer work environments and decrease feelings of isolation. Additionally, some may also find support through religious activities such as prayer or church attendance [161].

Policies and practices in LTC homes should include appropriate time off to recover from assaults and allow for emotional healing, including sick-time benefits for part-time staff, who may not typically have paid sick time [132]. Leadership should demonstrate compassion and follow up with staff after the incident. In accordance with appropriate WPVH policies, investigations should take place to look for opportunities to improve the setting and reduce the risk of future WPVH incidents [132].

Several types of support systems and mechanisms for post-incident care have also been found to be effective in **mental health settings**. As with the other settings, peer support in particular has been heavily cited in the research literature [9], [141], [177], [185] and has even been found to be a

protective factor in preventing burnout [296]. Social support from supervisors and coworkers has also been associated with better physical and mental health, improved sleep quality, and reduced anger following incidents [223]. Access to specialized and confidential trauma-informed mental health services and immediate debriefing following violent incidents are also important in this setting [9], as are long-term professional mental health support and counselling services [177]. Education and training can also serve in a post-incident care capacity, with a focus on enhancing workers' knowledge of risks and risk mitigation strategies and building competencies [177].

Though the literature is limited in the substance use and withdrawal services sector, post-incident debriefing and personal and emotional support after violent incidents have been found to be important [171]. Further work is needed to determine whether there are specific types of supports or post-incident care that are most effective in this setting.

3.3.2.6 Areas for Improvement and Emerging Priorities

As described in the sections above, the Canadian landscape of WPVH prevention and management in health care settings needs system-wide transformation. Each health care setting is plagued by contextual factors that complicate the implementation of a blanket solution. However, key areas for improvement have emerged as strategies grounded in clear definitions, consistent and reliable data collection, strengthening and enforcement of existing policies, and robust role- and setting-specific training and education offerings. Across sectors, there is growing recognition of the need for national coordination of reporting and implementation of tailored, evidence-based policies and interventions. It is clear, as outlined below, that meaningful improvements in the health and well-being of Canada's health care workforce will require significant cultural shifts in how trainees, staff, management, leadership, and all involved parties prevent and manage WPVH.

A primary challenge for **medical care settings and rehabilitation centres i**s the absence of a standardized, universally accepted definition for WPVH, one that differentiates bullying, incivility, harassment, and violence. Without consensus on a definition, efforts to collect, report, and compare data to develop effective policies remain stymied. Harmonizing these definitions locally, nationally, and internationally is a complex task, but one that is urgently required to build robust evidence and guide consistent practice [113], [129].

Under-reporting is another persistent barrier, fueled by the normalization of WPVH, fears of retaliation, skepticism about the utility of reporting, and cumbersome reporting systems. Targeted interventions are imperative to stimulate meaningful culture change across medical care settings [116], [138], [143].

Addressing systemic workforce and environmental factors such as chronic understaffing, high workloads, long patient wait times, and inadequately designed care spaces is also pivotal. Canadian research links austerity-driven staffing shortages to elevated violence and staff burnout, highlighting the urgency of investments in safe staffing models and optimized, patient-centred physical environments to prevent precipitating factors for WPVH [141], [198], [200], [249].

Legal and policy frameworks have strengthened criminal and occupational health and safety laws to better protect health care workers. Nonetheless, gaps in enforcement, broad coverage, and institutional compliance remain, necessitating enhanced oversight and implementation [129].

There is an opportunity to embrace technological advances, including AI-driven aggression risk assessments, wearable panic alarms, and digital alerts integrated into electronic health systems, to prevent and manage WPVH. While these require careful ethical evaluation, privacy considerations, and efficacy testing, they represent important frontiers for enhancing safety in Canadian health care settings and beyond [258].

Research on WPVH in the **emergency medical services** sector highlights data collection as a persistent challenge: because the definition of WPVH remains inconsistent across studies, its prevalence is difficult to determine [118], [119]. Emergency medical services personnel face elevated risks of injury and repeated exposure to violence, with significant impacts

on their mental health [8]. Organizational responses are often inadequate: incidents are normalized, reporting is discouraged or stigmatized, and managerial follow-up is limited [8], [118], [146], [149]. Gender-related inequities are especially concerning [229].

Promising practices are beginning to emerge, such as hazard-flagging systems and co-designed interventions like EVIR, which doubled reporting rates by embedding streamlined tools into patient records [8]. However, to meaningfully address this issue, priorities must include standardized definitions and data collection, comprehensive prevention strategies, sector-specific interdisciplinary training, stronger organizational leadership, and integrated post-incident supports that recognize the profound personal and professional toll of workplace violence on emergency medical service workers and paramedics.

Workers in the **home and community care** sector face substantial risks of both physical and psychological harm, often from clients, their families, and members of the public. Despite growing awareness of this issue, WPVH remains under-reported and inconsistently addressed. There is an urgent need for a common definition and universal language for describing WPVH. A shared nomenclature would allow for consistent application of research questions and the development of clear, enforceable workplace policies [3], [120], [181].

Culture change among health care workers will begin with organizations adopting WPVH policies that are accompanied by established, transparent, and accountable reporting systems with a clearly defined chain of command and timely follow-up procedures to support affected individuals [121].

Evidence suggests that standalone training programs have limited effectiveness. Instead, there is a growing call for comprehensive multicomponent interventions tailored to the realities of delivering care in private homes and community settings [243].

Currently, Canada's fragmented and inconsistent approaches to workplace safety highlight the need for a pan-Canadian framework or national standard for violence prevention in home and community care [3], [297]. Identifying a leading organization to establish a standardized and centralized data collection system is essential and would enable a more accurate understanding of the prevalence and patterns of WPVH and help identify high-risk populations and behaviours [120], [207].

Continued challenges and gaps in addressing WPVH in **LTC and assisted living settings** hinder effective prevention and management. A lack of universally agreed-upon definitions for violence and aggression, coupled with wide variation in measurement approaches, makes it difficult to compare prevention efforts and understand the true scope of the problem [298]. Additional challenges such as under-reporting of WPVH, driven by fears of negative consequences, retaliation, victim-blaming, and the perception that reporting is useless or that violence is to be expected, further exacerbate the problem [131], [132]. Organizational culture presents significant barriers, with WPVH frequently minimized and normalized and staff experiencing a lack of management support and accountability following incidents [218]. Insufficient organizational policies and post-incident support are also evident in the literature [184]. Additionally, current patient rights legislation often lacks language holding patients and families accountable for uncivil behaviour, which accounts for a high number of WPVH incidents in LTC and assisted living settings.

Understaffing, poor staff-to-resident ratios, and underfunding are cited contributors to WPVH, leading to increased workload, reduced quality of care, and an inability to provide the relational care needed to prevent agitation of residents [132], [161], [183]. There are also a high number of racialized and immigrant nurses working in LTC settings who disproportionately experience physical assaults, verbal aggression, racial stereotyping, and discrimination from patients, families, and colleagues [161]. Inadequate violence prevention and de-escalation training is also a widespread issue, with frontline staff feeling unprepared to manage aggression, particularly in specific LTC populations or situations [191].

There is an urgent need to address these identified gaps to better prevent and manage WPVH in long-term care and assisted living settings. Several emerging

priorities provide a clear direction for strengthening WPVH prevention and management in LTC and assisted living settings.

For example, the adoption of standardized definitions, indicators, and reporting approaches could improve recognition of WPVH, support consistent measurement, and enable meaningful comparison and monitoring over time. Stronger organizational policies and visible leadership accountability are also needed to challenge the normalization of violence and establish clear expectations that WPVH will be taken seriously and acted upon. An additional emerging priority is addressing workforce and system-level conditions, including staffing levels, workload, funding, and opportunities to provide relational and person-centred care. Finally, multifaceted interventions that include comprehensive education and training, resident care strategies, reporting processes, and post-incident support are critical priorities in mitigating and preventing WPVH. Together, these priorities emphasize a shift from primarily responding to individual incidents toward creating organizational and system conditions that proactively prevent WPVH and support a sustained culture of worker safety.

The **mental health sector** faces persistent challenges in preventing and managing WPVH, including inconsistent definitions and metrics [134], normalization of violence [9], [162], under-reporting [9], [159], [168], limited managerial support [134], [160], [177], inadequate training [134], [164], [192], unsafe environments [159], [167], [211], [212] and gaps in post-incident care [9]. These challenges are compounded by systemic racism and inequities that disproportionately affect racialized staff [225]. Emerging priorities centre on developing standardized definitions and indicators, fostering leadership commitment to a culture of safety, and implementing comprehensive multicomponent prevention programs that integrate staff training, environmental modifications, risk assessment tools, and rapid response systems [166], [171], [222], [256]. Strengthening ongoing education—grounded in empathy, trauma-informed care, cultural safety, and de-escalation—alongside adequate staffing and safer facility design is essential [141], [170], [257], [259], [271]. Together, these actions represent critical opportunities to shift from normalization of violence toward proactive prevention and a culture of safety, equity, and support in mental health settings.

The **substance use and withdrawal services** sector faces persistent WPVH challenges, driven by a culture that normalizes violence [169], [170] under-reporting fueled by fear and futility [170], [171], [173], insufficient organizational support [169], and limited training specific to withdrawal-related behaviours [191]. High-risk patient populations and inequities that affect women, trainees, and equity-deserving groups further compound the risks and impacts of WPVH, which often extend beyond the workplace [171], [174], [191], [214], [221]. Emerging priorities include fostering sector-wide cultural change led by strong leadership and organizational accountability [171] and implementing comprehensive multicomponent prevention programs [171], [214], [290]. Expanding use of evidence-based risk mitigation tools [171], [172], improving post-incident supports, and addressing systemic inequities are also critical to building safer work environments.

3.4 Findings from Interested and Affected Parties Engagement

3.4.1 Online Survey Results

3.4.1.1 Demographics

The survey was accessed by 966 participants, 949 of whom consented to completing the survey, and was completed by 897 participants. Their demographic information is presented in Table 1. Survey participants had a mean age of 54.3 years. Most respondents identified as women (n = 727), straight or heterosexual (n = 745), and white (n = 655). Participants were geographically diverse, although by far the largest proportion came from British Columbia (n = 478), followed by Ontario (n = 64) and Nova Scotia (n = 31), with most respondents residing in urban settings. A smaller proportion of respondents identified as persons with disabilities (n = 121). The sample also included representation from several equity-deserving groups and Indigenous communities, including First Nations participants (n = 35), although these groups were comparatively smaller in number.

Table 1: Survey participant demographics (n = 897)

Age (years)	
Range	18-76
Mean	54.3
Median	58

Gender	
Woman	727
Man	141
Non-binary	3
Other	3
Prefer not to answer	23

Sexual orientation	
Bisexual	47
Gay or lesbian	22
Other	15
Straight or heterosexual	745
Prefer not to answer	67

Identify as person with disability	
Yes	121
No	732
Prefer not to answer	44

Racial or ethnic identity (participants may check all that apply)	
Black	12
East Asian	23
Indigenous	58
Latin American	10
Middle Eastern	6
South Asian	37
Southeast Asian	52
White	655
I don't know	3
Other	14
Prefer not to answer	65

Racial or ethnic identity (participants may check all that apply)	
First Nations	35
Inuk/Inuit	35
Métis	31
None	789
I don't know	6
Prefer not to answer	36

Geographic location	
Alberta (n = 77)—Rural/remote	7
Alberta (n = 77)—Not specified	1
Alberta (n = 77)—Urban	69
British Columbia (n = 478)—Rural/remote	51
British Columbia (n = 478)—Urban	427
Manitoba (n = 7)—Rural/remote	3
Manitoba (n = 7)—Urban	4
New Brunswick (n = 3)—Rural/remote	0
New Brunswick (n = 3)—Urban	3
Newfoundland & Labrador (n = 83)—Rural/remote	24
Newfoundland & Labrador (n = 83)—Urban	58
Newfoundland & Labrador (n = 83)—Not specified	1
Nova Scotia (n = 31)—Rural/remote	14
Nova Scotia (n = 31)—Urban	17
Ontario (n = 64)—Rural/remote	8
Ontario (n = 64)—Urban	56
Quebec (n = 6)—Rural/remote	0
Quebec (n = 6)—Urban	6
Saskatchewan (n = 25)—Rural/remote	13
Saskatchewan (n = 25)—Urban	12
Yukon (n = 1)—Rural/remote	0
Yukon (n = 1)—Urban	1

Survey participants represented all six of the studied health care settings as well as additional general settings such as environmental services, administration, protective services, government/regulation, and health care unions. Figure 2 shows the distribution of participants among the studied health care settings. The majority of participants worked in medical care settings, followed by long-term care and assisted living, home and community care, mental health settings, other settings, EMS/paramedics, and substance use and withdrawal services. It should be noted that participants could select more than one setting.

Similarly, survey participants represented a broad range of roles within the health care settings. The largest participant groups were PSWs, RNs, and HCAs or assistants. A detailed breakdown of participant roles is available as a supplementary file.

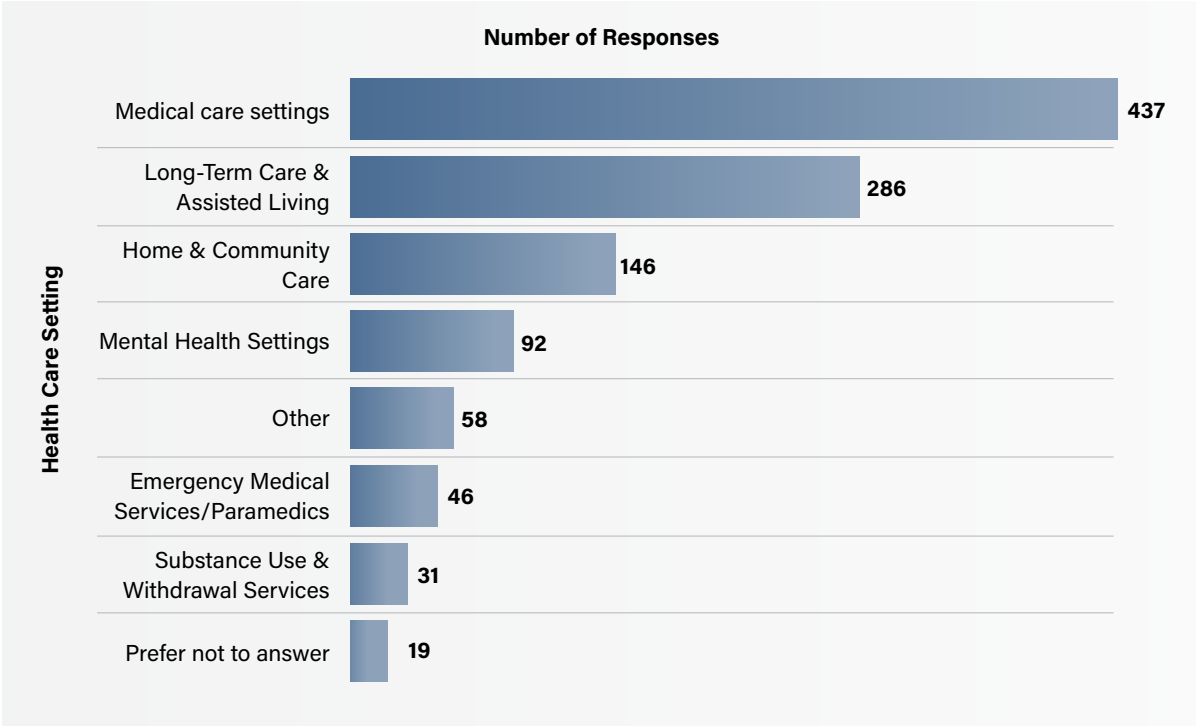
Nearly half of participants (44%) had been working in the health care sector for 16 years or longer, followed by 22% between five and 10 years and 17% between 11 and 15 years. Eighty-seven percent of participants reported that their role is unionized, while 11% indicated it is not. One percent indicated that they did not know and 1% preferred not to answer.

3.4.1.2 Quantitative Survey Responses

Closed-ended survey questions were developed and grouped into the following categories: definitions and awareness; reporting practices; organizational management; training and preparedness; risk mitigation strategies; workplace culture and normalization; systemic and structural barriers; emerging priorities and improvements.

Regarding definitions and awareness, 74.2% of participants agreed or strongly agreed that their organization provided a clear definition of WPVH. Similarly, 88.4% of participants indicated they understand what types of behaviours should be reported as WPVH. These data indicate participants believe they have a clear understanding and awareness of WPVH.

Figure 2: Distribution of participants among health care settings



However, participant responses regarding reporting practices showed greater variation. Just over half of participants (55.9%) indicated agreement or strong agreement with feeling comfortable reporting incidents of WPVH, and only 53.6% agreed or strongly agreed that reporting practices in their workplace were clear and straightforward.

In terms of organizational management, less than half of participants (45.7%) agreed or strongly agreed that management in their workplace takes reported incidents of WPVH seriously, while more than a third (37.5%) disagreed or strongly disagreed. Moreover, only 29.5% of participants agreed or strongly agreed that they received adequate follow-up and feedback after reporting an incident. Post-incident support, such as debriefing and counselling, was also found to be lacking, with only 30.0% of participants agreeing or strongly agreeing that their organization provides sufficient support.

Regarding training and preparedness, approximately half of participants (49.6%) felt they have received sufficient training on preventing and managing WPVH. However, only 43.0% of participants agreed or strongly agreed that the training they receive is updated regularly, and only about one-third (33.5%) agreed or strongly agreed that the training is practical and prepares them to handle real-life situations.

Risk mitigation strategies such as risk assessments, procedures for responding to violent situations, and physical environment risk-mitigation features were explored in the survey. Only 34.8% of participants agreed or strongly agreed that risk assessments are conducted regularly in their work environments. Conversely, half (50.4%) of participants agreed or strongly agreed that clear procedures are in place for responding to violent situations and that their workplace physical environment includes risk mitigation features (52.3%).

In terms of workplace culture and normalization of WPVH, the survey data shows room for improvement. When asked whether verbal abuse is recognized as a serious incident, 38.0% of participants agreed or strongly agreed, while 47% disagreed or strongly disagreed. Similarly, 39.1% of participants agreed or strongly agreed that they felt comfortable speaking up about harassment and bullying from colleagues and supervisors, while 44.6% disagreed or strongly disagreed.

Data regarding systemic and structural barriers showed concerning results. Approximately one-third of participants agreed or strongly agreed that leadership in their organization models a zero-tolerance approach to WPVH. However, only 27.6% of participants agreed or strongly agreed that they trust their workplace policies to protect them against WPVH, while more than half (52.4%) disagreed or strongly disagreed. Furthermore, only 22.2% of participants agreed or strongly agreed that perpetrators of WPVH are held accountable in their organization, while 55.6% disagreed or strongly disagreed.

There was overwhelming agreement in survey responses to questions about emerging priorities and improvements. Overall, 68.9% of participants agreed or strongly agreed that standardized reporting systems across Canada would improve prevention and response, while only 7.7% disagreed or strongly disagreed. Regarding standards, 83.0% of participants agreed or strongly agreed that national standards are needed to improve prevention and management of WPVH in the health care sector, while only 3.1% of participants disagreed or strongly disagreed. Similarly, 84.1% of participants agreed or strongly agreed that their workplace would benefit from more resources dedicated to preventing and managing WPVH, while only 4.4% disagreed or strongly disagreed.

3.4.1.3 Sub-group Analyses

Sub-group analyses were also conducted to determine whether there were significant differences in responses between participants in the following demographic variable groups: health care setting, gender, years worked, urban versus rural setting, sexuality, disability, and indigeneity. No significant differences were found between groups with regard to urban versus rural setting and indigeneity variables. The results are presented in Table 2.

Table 2: Sub-group analysis of quantitative survey responses with significant difference

Note: *p*-value lower than 0.05 indicates statistically significant difference; + indicates comparison group with more agreement with the survey question.

Variable	Survey question	Comparison groups	*p*-value
Health care setting	National standards are needed to improve prevention and management of WPVH in health care.	▪ Medical care settings ▪ Home and community care+	0.025
		▪ Medical care settings ▪ Emergency medical services/paramedics+	0.037
	My workplace would benefit from more resources dedicated to preventing and managing WPVH.	▪ Medical care settings ▪ Long-term care settings+	0.004
		▪ Medical care settings ▪ Home and community care+	0.001
		▪ Medical care settings ▪ Emergency medical services/paramedics+	0.000
		▪ Medical care settings ▪ Substance use/withdrawal services+	0.007
Gender	The training I receive is practical and prepares me to handle real-life situations	▪ Non-binary individuals+ ▪ Women	0.026
	My workplace physical environment includes risk mitigation features such as surveillance cameras, alarms or panic buttons, clear lines of sight, multiple escape routes, controlled entry and exit points, and security services.	▪ Men+ ▪ Women	0.027
	I feel comfortable speaking up about harassment or bullying from colleagues or supervisors.	▪ Non-binary individuals+ ▪ Women	0.01
	Standardized reporting systems across Canada would improve prevention and response.	▪ Men ▪ Women+	0.029
		▪ Men ▪ Non-binary individuals+	0.003
	National standards are needed to improve prevention and management of WPVH in health care.	▪ Men ▪ Women+	0.004
		▪ Men ▪ Non-binary individuals+	0.000
	My workplace would benefit from more resources dedicated to preventing and managing WPVH.	▪ Men ▪ Women+	0.007
		▪ Men ▪ Non-binary individuals+	0.000

Variable	Survey question	Comparison groups	*p*-value
Years worked	Management in my workplace takes reported incidents of workplace violence and harassment seriously.	▪ 11–15 years ▪ 16+ years⁺	0.012
	I receive adequate follow-up and feedback after reporting an incident.	▪ 11–15 years ▪ 16+ years⁺	0.035
		▪ 11–15 years⁺ ▪ <1 year	0.047
	My organization provides sufficient post-incident support (e.g. debriefing, counselling, peer support).	▪ 11–15 years ▪ 16+ years⁺	0.006
	I have received sufficient training on preventing and managing workplace violence and harassment.	▪ 11–15 years ▪ 16+ years⁺	0.005
	Leadership in my organization models a zero-tolerance approach to workplace violence and harassment.	▪ 11–15 years ▪ 16+ years⁺	0.025
Sexuality	My organization provides sufficient post-incident support (e.g. debriefing, counselling, peer support).	▪ Gay or lesbian⁺ ▪ Straight or heterosexual	0.046
Disability	National standards are needed to improve prevention and management of WPVH in health care.	▪ Identifying as having a disability⁺ ▪ Not identifying as having a disability	0.030

3.4.1.4 Qualitative Survey Responses

Participants were asked the following three open-ended survey questions:

1. What gaps/challenges/barriers should be addressed to enable the prevention and management of workplace violence and harassment?
2. Are you aware of any standards, best practices, models, or solutions focusing on workplace violence and harassment prevention and management that you could share?
3. Please share any other comments you may have that you feel may be helpful.

Thematic and content analyses were conducted for each question as appropriate.

3.4.1.5 Identified Gaps, Challenges, and Barriers

The gaps, challenges, and barriers identified in the survey responses fell into eight main themes, as follows:

- Management and leadership issues
- Reporting systems and processes
- Workplace violence and harassment by patients and visitors
- Training and education
- Staffing and resource shortages
- Workplace culture and psychological safety
- Accountability and consequences
- Sector-specific challenges

These themes further reinforced the findings of the literature review and environmental scan.

Management and leadership issues included a lack of accountability and follow-up when staff report incidents of WPVH. Many participants indicated that management and leadership do not take reports seriously, fail to follow up on them, or dismiss complaints entirely. Participants also expressed that they find it challenging to communicate this feedback to management and fear retaliation. A participant working in medical care and mental health settings shared that power imbalances can make it hard to communicate incidents and feedback on WPVH to managers without feeling like they are making themselves a target.

Fear of retribution was a sub-theme that was also evident in the main theme of **reporting systems and processes**. Participants reported fear of retaliation after reporting. Additionally, they expressed that complex, slow, and non-confidential reporting processes discourage them from reporting. One participant indicated that reporting structures should be simplified and training implemented so that reporting becomes second nature. Participants felt that neutral bodies or anonymous channels for reporting, outside of immediate management, could help to facilitate reporting. Moreover, participants wished to receive reports or outcomes of investigations and to see consequences and follow-up to reporting.

Workplace violence and harassment by patients and visitors also emerged as a theme in participants' responses. Participants expressed that there is a need for clearer policies and rules for patients and visitors. These should include zero-tolerance policies, visible signage, and public education. Participants also expressed that policies should include consequences, as currently, many participants feel that patients and visitors rarely face disciplinary measures even after abuse or assault. Violence from patients and visitors is normalized, particularly when patients are cognitively impaired. Numerous survey participants, especially those from the long-term care and mental health sectors, experienced challenges with patients exhibiting behavioural symptoms due to dementia or resulting from psychosis and substance use.

Many participants expressed that **training and education** about WPVH requires significant improvement. Training was found to be insufficient, generic, or available online only, with little practical application. Staff preferred regular, in-person, and contextual workshops rather than occasional online modules. Participants indicated that they need better training on de-escalation techniques, crisis intervention, trauma-informed care, and cultural and language competencies. Several participants also shared that training gaps extend to management and security personnel working in the health care sector.

Staffing and resource shortages were frequently cited as a barrier to WPVH prevention and management. Participants described staffing shortages as a chronic issue, resulting in higher workloads that reduced participants' capacities to report incidents, follow protocols, or intervene when incidents arise. A lack of security staff was also reported, particularly by participants working in smaller or rural settings. Participants also reported a lack of physical resources, such as panic buttons, locking doors, or secured units, which could help mitigate some of the risks they face in the workplace.

Workplace culture and a lack of psychological safety were discussed extensively by participants in their responses. Normalization and a culture of acceptance or minimization of aggression toward health care workers were expressed. Additionally, many participants shared that they were made to feel blamed or that they must do better in order to prevent WPVH. They expressed feeling a lack of support, not only in instances of WPVH perpetrated by patients or visitors, but also in instances of staff-to-staff WPVH. Participants indicated that staff-to-staff harassment is common and under-addressed. Moreover, they felt that, many times, peer perpetrators of violence were shielded through union protections. Consequently, participants feared reporting this type of WPVH, as they felt it could result in isolation, retribution, or further bullying.

The lack of **accountability and consequences** following WPVH was a considerable challenge expressed by participants across health care settings. Participants indicated that perpetrators rarely face consequences, particularly if they are



"The lack of accountability and consequences following WPVH was a considerable challenge expressed by participants across health care settings."

patients or clients. Moreover, if WPVH policies were enforced, it was often done in an inconsistent manner, with enforcement varying by role, ethnicity, or relationships. Many participants wished for zero tolerance with immediate discipline. They also cited a need for legal and external involvement. This included police, standards, and legislative changes.

Finally, several **sector-specific challenges** were brought up by participants. Participants providing care to older adults, such as those working in long-term care and assisted living, home and community care, or medical care and rehabilitation settings, expressed challenges managing WPVH when perpetrated by individuals with cognitive impairment. They expressed a need for specialized approaches and resources. A similar need was expressed by participants working in mental health settings and in substance use and withdrawal services. Home and community care workers also said they face unknown risks when visiting clients' homes, adding an additional challenge in preventing WPVH. Similarly, emergency medical services workers and paramedics expressed that working in uncontrolled environments adds a layer of risk and poses a challenge that still needs to be addressed with regard to WPVH prevention and management.

3.4.1.6 Standards, Best Practices, Models or Solutions

Approximately 100 participants provided responses to the second open-ended question. The standards, best practices, models, or solutions identified by participants fell into the following categories:

- Formal policies (e.g. zero-tolerance policies, respectful workplace policies)
- Training and education modules or programs (e.g. violence prevention training, nonviolent crisis intervention, Code White/Code Purple drills)
- Reporting mechanisms (e.g. anonymous reporting, third-party investigations, incident reporting)
- Risk assessment tools and protocols (e.g. behavioural safety programs, violence and aggression screening tools)
- Leadership and accountability models (e.g. leadership training, accountability for management)
- Environmental and structural solutions (e.g. safe rooms, staffing ratios)
- Union and external organization involvement and advocacy (e.g. union policies, workplace safety associations, provincial programs)
- Psychological safety and trauma-informed care approaches (e.g. psychological safety frameworks)
- Security measures (e.g. panic buttons, police involvement, security presence)

3.4.1.7 Additional Comments

Approximately 150 participants left meaningful comments to the third open-ended question (i.e. did

not leave it blank or a simple response such as "okay"). Responses ranged from brief statements to detailed personal experiences. Overall, comments supported the previously identified themes in the survey. Participants once again stressed the need for leadership and accountability, including strengthening training, external oversight, and clear consequences. They reiterated the need for safe, anonymous, transparent, and independent reporting systems. More broadly, participants expressed that training and education need to be role-specific, ongoing, and include communication style, diversity, and inclusion topics. Participants also voiced the need for support from a variety of perspectives, including mental health services and post-incident supports, increased staffing and resource supports, and legislative and policy supports. Finally, they commented on the urgent need for a cultural shift from one where WPVH in the health care sector is normalized to one that promotes respectful workplaces, zero tolerance for WPVH, and trust among staff and leadership.

3.4.2 Key Informant Interview Results

3.4.2.1 Demographics

Twenty individuals participated in the key informant interviews: 12 women and eight men. The following provinces were represented in the sample: Alberta (n = 3), British Columbia (n = 8), Manitoba (n = 1), New Brunswick (n = 1), Ontario (n = 4), Saskatchewan (n = 1). One individual represented a national perspective in their interview. Fifteen of the 20 participants worked in roles that covered the entirety of their provinces, including urban and rural regions. Four individuals represented regional perspectives, with three representing urban areas within their region and the remaining individual working in a rural setting. Interviews ranged from approximately 23 to 43 minutes in length, with an average length of 32 minutes and 49 seconds. The majority of participants worked or had jurisdiction across multiple health care settings.

3.4.2.2 Thematic Analysis of Interview Results

3.4.2.2.1 Presentation of WPVH

Participants were asked to share how WPVH typically presents in the settings where they work. As most participants worked across health care settings, they spoke broadly to the presentation of WPVH in the health care sector. Participants also mentioned additional, setting-specific WPVH presentations.

In general, WPVH was described as pervasive, multifaceted, and increasing in both frequency and complexity, occurring **across all care settings** and involving multiple perpetrators, most commonly patients and their families, but also coworkers and external individuals. Participants shared that WPVH could range from forms of verbal abuse, such as yelling, swearing, discriminatory remarks, and sexualized comments, to more severe incidents, including physical assault (e.g. hitting, biting, spitting), sexual assault, stalking, and threats with weapons. The majority of participants stated that the more an individual was involved in direct patient or client care, the greater their risk of WPVH. Participants also stated that WPVH was also often linked to patient-related factors such as cognitive impairment, mental health conditions, substance use, or distress. Moreover, system-level pressures like long wait times and resource constraints heightened frustration and aggression, making patients or clients more likely to lash out at care providers. At the same time, workplace dynamics contributed to harassment, including bullying, cyber harassment, and discrimination rooted in racism, sexism, and power imbalances, with certain groups, such as those in roles requiring less training or education, experiencing disproportionate exposure.

WPVH was also found to be present in **setting-specific** ways, with heightened risks in environments where health care workers may be isolated or have limited control. This included emergency medical services or paramedics, as well as those working in the home and community care sector. One participant shared that home and community work creates a power imbalance, as workers are usually not in a neutral or employer-owned space, but in the client's space. Moreover, if instances of WPVH occur and the worker chooses not to report it, there are typically no other individuals present who might report the incident.

Health care workers in settings with exposure to patients under the influence of alcohol or other substances, such as emergency medical services, substance use and withdrawal services, and mental health services, were likely to experience WPVH

or aggressive behaviours by patients. In long-term care, health care workers face the unique challenge of working with patient populations that have a large proportion of cognitively impaired individuals. Participants shared that health care workers in these settings may experience physical and non-physical abuse, not out of malicious intent by the long-term care residents, but due to responsive behaviours beyond the residents' control. One participant also shared that long-term care residents who may have grown up in homogenous neighbourhoods can sometimes react aggressively toward staff of colour or diverse backgrounds. This is a concern that has increased as long-term care workforces become more diverse.

3.4.2.2.2 Current Gaps, Barriers, and Areas for Improvement

Several sub-themes emerged under the theme of current gaps, barriers, and areas for improvement.

The first of these sub-themes was the need for better **education and training** that is comprehensive, practical, and consistent. Participants repeatedly identified significant gaps in both foundational and ongoing training, noting there is a complete lack of training in certain techniques, such as de-escalation, and that current approaches are inadequate for preparing staff to handle real-world situations (e.g. watching a 10-minute video). Participants suggested practical, experiential learning, with calls for scenario-based and interdisciplinary training where staff can rehearse realistic scenarios and develop applied skills. Moreover, several participants suggested that education and training should begin before health care workers enter the workforce, through integration of WPVH prevention into post-secondary curricula. This would allow workers to enter the field with realistic expectations and skills. Overall, participants underscored that health care workers require stronger, more practical, and standardized education that spans pre-entry, onboarding, and continuous professional development in order to effectively prevent and respond to WPVH.

Participants highlighted persistent **leadership, organizational, and system-level gaps** that act as barriers to effective WPVH prevention and management. At the leadership level, there is a lack of clear direction, accountability, and prioritization, with participants emphasizing the need for clear leadership from the top and noting that resource allocation for understanding and addressing violence is a leadership responsibility. However, leadership engagement is often inconsistent, with a tendency to focus on immediate responses to extreme incidents while failing to address more routine forms of harm in a meaningful way. Organizationally, policies and systems frequently fail to translate into action, and efforts are often reduced to "tick box" exercises rather than substantive change. Participants also expressed concerns with weak use of existing structures, such as occupational health and safety committees, and a lack of follow-through on incidents. At the system level, participants shared challenges including fragmentation, unclear expectations, and competing priorities, as well as structural issues like staffing shortages and overcrowding that contribute to the risk of WPVH. These challenges were further compounded by a tendency to default to reactive approaches rather than adopting a systems-based approach to prevention. Overall, participants identified a misalignment between leadership intent, organizational practice, and system design, with a need for coordinated, proactive, and system-wide strategies.

Participants frequently cited a **lack of accountability and meaningful consequences** in addressing WPVH, which consequently allowed harmful behaviours to persist. They repeatedly emphasized that when there are no consequences, WPVH continues, pointing to a system where policies exist but lack enforcement. Even when incidents were reported, participants said they were often ignored or inadequately addressed, with one person sharing that they had found a report in a garbage can. Others shared that their reports were sometimes met with resignation from leadership who receive too many complaints to act on them. Participants also underscored the absence of consequences for perpetrators, noting that staff often endure repeated abuse with no repercussions faced by the person who continues to abuse them. One participant shared a compelling comparison, describing how if someone were to walk into a bank and punch a teller in the face, the perpetrator would likely be



charged, escorted from the premises, and potentially not allowed back in that bank ever again, whereas in health care, a patient may punch a health care worker in the face and still receive care, likely from the very individual they assaulted. A lack of accountability and meaningful consequences was a significant barrier to addressing the subsequent sub-theme of reporting.

Reporting and normalization of WPVH were brought up by most interview participants. A dominant issue was pervasive under-reporting, driven by beliefs that violence is an expected component of working in health care and that incidents are "not a big deal," leading many workers to normalize harmful behaviours and therefore not report them. Participants shared health care workers' fears of negative consequences, which further suppressed reporting. They said workers worry they will be blamed, judged, or seen as incapable of performing their duties properly. Practical barriers also impede reporting, including difficult, lengthy, or burdensome processes, complex multi-step forms, and systems that require reporting only during business hours (e.g. via telephone between certain hours) that are misaligned with shift work. The previously stated lack of follow-up also undermined trust and reinforced workers' perceptions of the futility of reporting. Additional structural challenges, such as concerns about confidentiality, inconsistent definitions of harassment, and disincentives like loss of income or removal from work, further discouraged reporting.

Collectively, these barriers contribute to significant gaps in reporting and, as one participant shared, if reporting does not happen, then changes cannot be made.

Participants' responses highlight a clear need for a fundamental **culture shift** in how WPVH is understood and managed in the health care sector. Participants indicated that a persistent cultural norm frames violence as inevitable, with health care workers often told this is just what happens or to toughen up, reinforcing the belief that violence is inherent to the work and therefore not worth reporting. This normalization contributes to under-reporting and complacency, with participants emphasizing the need to shift the culture away from WPVH being acceptable.

At the same time, participants shared that there is a deeply ingrained expectation that health care workers prioritize patient care over their own safety, with many workers more concerned about their patients' well-being than their own and making their own safety a "secondary thought." Changing this mindset requires reinforcing that WPVH is not part of their job. Participants also highlighted a "blame-oriented culture" that requires a shift from individual responsibility to system-level accountability, which would in turn foster environments where reporting is supported, not stigmatized. Additionally, several participants felt that the desired cultural shift should not be unrealistic (e.g. eliminating all violence

completely, as they recognize that some violence will always occur), but rather one that ensures WPVH is never ignored and always responded to, and that prevention and support are invested in.

Participants repeatedly commented on **staffing and resource shortages** as a key barrier to effectively preventing and managing WPVH. Participants emphasized that resources and staffing levels are "huge" issues, with many settings operating with a skeleton staff that is rushed from patient to patient. This chronic understaffing contributes directly to unsafe conditions, as participants described being short in every way possible and calling the system broken. One participant said they have seen situations when only half the number of required staff are working. This strain is further compounded by workforce attrition, as organizations are losing many staff due to early departures, in many cases due to violence and harassment. Beyond staffing, gaps in material resources, such as insufficient security presence, lack of panic buttons, and inadequate infrastructure, further heighten risk, with some participants reporting facilities that lack basic safety features like accessible alarms. Together, these shortages create an environment where health care workers are overextended, under-supported, and less able to respond effectively to violent incidents, underscoring the critical need for sustained investment in both staffing and safety resources.

Finally, several participants highlighted a clear and ongoing need for stronger **measurement and evaluation** frameworks in WPVH prevention and management. Participants expressed uncertainty about how incidents are tracked and acted upon, and also pointed to inconsistencies in defining and responding to serious or critical incidents. More broadly, measurement efforts were described as sparse and inconsistent, with limited data at higher levels and under-reporting creating a significant unknown when measuring WPVH levels. Participants emphasized that measurement must go beyond simple data collection, calling for an emphasis on analysis, reporting, and evaluation that is directly tied to interventions, outcomes, and intended impacts. One participant stated that without clear purpose and guidance, organizations either collect data but don't know why or fail to collect anything at all. This participant reinforced the need for standards that ensure meaningful, consistent, and actionable evaluation practices.

3.4.2.2.3 Impact of COVID-19

All participants found that the **COVID-19 pandemic had an impact** on WPVH in the health care sector, though not always in the same way. Several participants consistently described how the pandemic amplified existing stressors in the system, including lack of staffing and resources. Several participants indicated there was heightened stress among patients, families, and staff, which contributed to increased incidents, while health care workers themselves were worn down with reduced capacity to cope. Restrictions such as limited visitation and masking further escalated tensions, with one participant reporting that it led to more aggressive responses. A couple of participants commented on the shift away from appreciation of health care workers early in the pandemic toward increased harassment and a sense that people were "allowed" to be abusive and demanding. The pandemic also disrupted formal prevention mechanisms as some employers halted joint committee engagement on WPVH, which weakened coordinated responses.

A few participants did comment that certain COVID-19 measures, such as controlled entry into health care facilities and restricted entries, resulted in a reduction in WPVH levels. This reduction was temporary, however, with several participants sharing that they feel WPVH has increased and has not returned to pre-COVID-19 levels. Moreover, participants reported that the psychological impacts of the COVID-19 pandemic on health care workers have been long-lasting, which has resulted in a heightened sensitivity to WPVH in the post-pandemic context.

3.4.2.2.4 Innovations, Successful Strategies, and Best Practices

Participants shared several innovations, successful strategies, and best practices for preventing and managing WPVH. The initiatives shared emphasized comprehensive, system-level approaches that integrate training, risk assessment, reporting, and supportive workplace culture.

One of the key strategies shared by participants was the implementation of standardized, evidence-based education, such as provincial curricula that teach de-escalation and are mandatory for all health care workers, alongside more advanced, simulation-based training for high-risk areas and interprofessional team training in "high-fidelity, high-stress" scenarios. Participants stated that these efforts are strengthened by embedding broader principles, such as trauma-informed care, cultural safety, and EDI, into training and by ensuring ongoing refreshers.

Effective prevention models shared by participants also prioritized proactive risk identification and tailored responses, including validated screening tools to detect pre-violence indicators, dynamic and individualized care approaches where procedures are adjusted to the individual, and dedicated roles or systems to continuously assess and communicate patient risk. Participants also shared technological and process innovations that further support prevention, such as AI weapon detection (which reduced weapons incidents by 82% according to one participant), hazard-flagging systems, integrated reporting tools, and QR code-based reporting that allows staff to report incidents at their convenience, which increased reporting rates.

Participants also highlighted the importance of clear policies, accountability, and multi-level coordination, including formal partnerships with police and Crown prosecutors to ensure incidents are taken seriously. Communication and deterrence strategies, such as "harassing client letters" shared by one participant that clearly outline unacceptable behaviour and legal expectations, reinforce accountability.

At the organizational level, participants shared practices that engage frontline staff in solution design, implement environmental modifications (e.g. secured entrances, calming spaces), and use data dashboards to monitor trends over time. Participants also described supportive and preventive measures, including safety huddles, public awareness campaigns like "Violence is not part of the job," and innovative staffing models such as community hosts or plainclothes security personnel who build rapport and help de-escalate situations.

Finally, several best practices that were shared extended beyond immediate prevention to include secondary supports such as mental health resources, critical incident stress programs, and violence prevention frameworks that integrate psychological health and safety. Overall, sustained success was found to depend on moving beyond pilot initiatives to continually managed and replicable models with adequate staffing, leadership engagement, and system-wide accountability.

3.4.2.2.5 Priority Areas for Standards Development

Analysis of participant data revealed a comprehensive set of interrelated themes that participants felt should inform the development of a national standard on WPVH prevention and management in the health care service sector. Several participants noted that the standard should be developed in a setting-specific manner with tailored guidance. All but one of the participants felt there was a need for the development of this specific standard, with the lone other participant suggesting revisions to an existing standard.

Education and training emerged as foundational, with participants emphasizing the need for standardized national approaches and early integration into professional education, including scenario-based learning and training on de-escalation and recognition of pre-violence indicators. They said training should include a variety of modalities, including simulation and role play, and should also incorporate interdisciplinary training. However, participants stressed that training alone is insufficient without strong **leadership and organizational support,** including clear roles and responsibilities throughout all organizational levels, accountability for action, and better preparation of leaders to respond empathetically and effectively following incidents.

Participants recommended the inclusion of **proactive risk assessment and mitigation** in a future standard. They called for approaches that identify conditions that could put health care workers at risk, thereby enabling early intervention to support safer care delivery. Participants also highlighted the critical role of **post-incident response and psychological support,** noting that supports are often delayed or insufficient. Their recommendations included timely

critical incident support, peer-based programs, and proactive mental health screening to mitigate longer-term impacts. As well, participants said post-incident responses and psychological supports must employ worker-centred and trauma-informed approaches, including non-blaming investigative practices; be mindful of unintended consequences of reporting (e.g. loss of income); and incorporate equity-informed practices such as cultural safety, anti-racism, and individualized care planning.

Participants emphasized a broader **culture shift** as a priority area for standards development, including reframing WPVH as a core occupational health and safety issue rather than a private human resources matter. The aim would be to address the normalization and stigma that continue to shape responses to WPVH.

Finally, participants underscored the importance of **measurement, evaluation, and continuous improvement** in the proposed standard. This was felt to be a significant current gap. It was suggested that the standard include meaningful indicators that are clearly linked to interventions, outcomes, and intended impacts rather than superficial compliance measures.

In general, participants noted that standards must move beyond aspirational "best practice" statements to encompass actionable, enforceable guidance that is clearly differentiated across the system, organizational, and frontline levels. There was a call for stronger integration of system-level actors (e.g. ministries, public engagement) and better use of existing structures to ensure sustained change.

Collectively, these themes point to the need for a national standard that is technically robust but also context-sensitive, prevention-oriented, and grounded in cultural change, leadership accountability, and continuous improvement.

3.5 Overall Outlook for Workplace Violence and Harassment Prevention in the Canadian Health Care Service Sector

The overall outlook for WPVH prevention and management in Canada's health care service sector reflects a complex and evolving landscape characterized by strong legislative foundations, growing awareness, and increasing policy attention, but also persistent and systemic gaps in implementation, consistency, and effectiveness. Across jurisdictions, Canada has established a robust legal and regulatory framework grounded in federal, provincial, and territorial occupational health and safety legislation, human rights protections, and recent amendments to the *Criminal Code,* such as Bill S-233. Bill S-233 proposed additional legal recognition of violence against health care workers and first responders by requiring courts to treat the fact that the victim was a health care worker or first responder as an aggravating factor in sentencing [299]. These legislations and policies clearly position WPVH as a critical occupational hazard and places responsibility on employers to assess risks, implement prevention measures, and respond to incidents. Complementary programs, policies, and tools, which have been developed by governments, health authorities, and professional associations, demonstrate a widespread commitment to addressing WPVH and improving health care worker safety.

Despite this strong foundation, the current state of WPVH prevention and management is marked by significant fragmentation and inconsistency across jurisdictions, sectors, and organizations. Variability in definitions and conceptualizations of WPVH limits the ability to measure prevalence, compare data, and implement standardized approaches. This lack of consistency extends to policies, reporting systems, and training programs, resulting in uneven application of prevention strategies across health care settings. While some jurisdictions and organizations have implemented comprehensive and integrated approaches, others continue to rely on partial or reactive measures, highlighting a lack of consistency in how WPVH is addressed.

A pervasive and deeply rooted challenge across all health care settings is the normalization and under-reporting of violence and harassment. Organizational cultures that frame WPVH as "part of the job," combined with burdensome reporting processes, lack of follow-up, and limited confidence in organizational responses, contribute to widespread under-reporting. This, in turn, obscures the true scale of the problem and undermines prevention efforts. Compounding

this issue are persistent gaps in organizational and managerial support, where workers frequently report insufficient leadership engagement, inadequate post-incident support, and a disconnect between policy and practice. These challenges are further exacerbated by insufficient and inconsistently delivered training that is often lacking in practical, context-specific, and prevention-focused components.

At the same time, there is clear evidence of promising practices and opportunities for advancement. Jurisdictions and organizations that have implemented comprehensive, system-level approaches integrating risk assessment, standardized training, clear reporting mechanisms, and supportive workplace cultures demonstrate the potential for meaningful progress. International frameworks and pan-Canadian initiatives further reinforce the importance of coordinated, multi-level action, including standardized definitions, data collection, and collaboration.

Overall, while Canada has made important strides in recognizing and addressing WPVH in the health care service sector, the outlook underscores a critical need for greater standardization, stronger implementation, and sustained cultural change to ensure that prevention efforts translate into safer and more supportive workplaces.

4 Gap Analysis and Evidence-Informed Recommendations for Standardization

4.1 Identified Gaps, Needs, and Challenges for Each Health Care Setting

4.1.1 Medical Care Settings and Rehabilitation Centres

Key gaps and challenges identified in medical care settings include:

- Inconsistent definitions and variability in how violence, harassment, and related behaviours are conceptualized
- Under-reporting linked to confusion among staff regarding what should be reported and how incidents should be categorized



- Limited ability to track trends or evaluate interventions across departments and organizations
- Desensitization to violence in high-risk environments such as emergency departments
- Reporting processes perceived as burdensome and ineffective
- Limited follow-up, organizational response/accountability, post-incident care and support for staff
- Training that is inadequate, overly theoretical, or not tailored to specific clinical contexts

Together, these gaps and challenges undermine trust in organizational processes and leave staff feeling underprepared to prevent and manage WPVH effectively.

4.1.2 Emergency Medical Services and Paramedics

Key gaps and challenges identified in emergency medical services and paramedic settings include:

- Lack of standardized definitions of WPVH
- Difficulty accurately measuring prevalence and conducting risk assessments
- Fragmented data systems that limit understanding of WPVH trends and patterns

- Fragmented communication systems (e.g. between dispatch and responders or between responders and police or other disciplines)
- A workplace culture that normalizes exposure to aggression
- Under-reporting of incidents, particularly non-physical forms of WPVH
- Lack of feedback or follow-up after incident reporting
- Disconnect between stated zero-tolerance policies and actual practice
- Training programs that not tailored to paramedic work environments and over-rely on self-defence training rather than prevention and de-escalation approaches
- Staffing shortages and operational inefficiencies that compound workplace risks

Together, these challenges and gaps highlight the need for system-level approaches that strengthen organizational accountability, improve reporting and data systems, and provide tailored training and supports for emergency medical services and paramedic health care workers.

4.1.3 Home and Community Care Environment

Key gaps and challenges identified in home and community care settings include:

- Limited organizational oversight in home-based care environments
- Workers operating alone without immediate support
- Increased risk of unreported incidents
- Difficulty identifying and documenting incidents due to subjective interpretation of behaviours
- Challenges recognizing WPVH when care recipients have cognitive impairments
- A culture that normalizes WPVH as intrinsic to working in the setting
- Fear of reprisal and lack of trust in reporting systems
- Minimal managerial follow-up after incidents are reported
- Organizational practices that prioritize client needs over worker safety
- Training that is inconsistent, inaccessible, or not tailored to home care settings

These gaps highlight the need for home and community care-specific training and supports, stronger reporting and response mechanisms, and greater organizational accountability.

4.1.4 Long-Term Care Homes and Assisted Living Settings

Key gaps and challenges identified in LTC homes and assisted living settings include:

- Inconsistent recognition of and response to verbal abuse, bullying, and sexual harassment
- High rates of resident-to-staff aggression, particularly involving individuals with cognitive impairments
- A workplace culture that normalizes violence as unavoidable and simply part of the work
- Under-reporting driven by fear of blame and lack of leadership support
- Inadequate follow-up, limited accountability, and insufficient organizational responses after incidents occur, which further discourages reporting or places responsibility on staff
- Understaffing and resource-related pressures
- Unclear reporting processes
- Insufficient training related to WPVH prevention and response

Together, these gaps contribute to workplace environments where workers feel unsupported and unsafe, highlighting the need for stronger leadership engagement and system-level interventions.

4.1.5 Mental Health Settings

Key gaps and challenges identified in mental health settings include:

- Inadequate metrics that heavily rely on self-reported data and fail to capture the frequency, intensity, and full spectrum of violent incidents; limiting the ability to assess and improve prevention efforts
- A workplace culture that normalizes violence as an unavoidable component of work

- Under-reporting driven by perceptions that reporting is futile or time-consuming and fear of negative consequences, including retaliation or blame, following reporting
- Limited follow-up after incidents and limited access to support resources for workers
- Insufficient training and preparedness related to managing high-risk interactions, resulting in lack of worker confidence and skills to effectively respond to complex situations

Together, these gaps contribute to work environments where mental health workers may feel unsupported and underprepared to prevent and respond to WPVH effectively.

4.1.6 Substance Use and Withdrawal Services Centres

Key gaps and challenges identified in substance use and withdrawal services settings include:

- A workplace culture that normalizes violence, including among both experienced staff and trainees
- Under-reporting of WPVH, particularly verbal abuse and non-physical harassment; severe incidents are often the only ones reported
- Fear of retaliation following incident reporting
- Lack of confidence that organizational response processes will result in meaningful change
- Insufficient organizational and managerial support related to reporting and follow-up

Together, these challenges highlight the need for cultural change, stronger organizational accountability, and improved reporting and support mechanisms to address WPVH effectively in these settings.

4.2 Priorities for Evidence-Informed Guidance and Standardization

Drawing on findings from the environmental scan, literature review, online survey, and key informant interviews, this research project identified a range of gaps, challenges, best practices, and opportunities for improvement related to WPVH prevention and management across the health care service sector.

While there was considerable overlap in the priority areas identified across the six health care settings, important setting-specific distinctions also emerged. Collectively, the findings demonstrate that standards development can play an important role in addressing existing gaps, promoting consistent approaches to WPVH prevention and management, supporting implementation of evidence-informed practices, and strengthening organizational accountability across the sector. Based on the integrated findings of this research project, five priority areas for standards development were identified:

- Leadership commitment and organizational support
- Education and training
- Risk assessment and mitigation
- Post-incident response and psychological support
- Reporting, monitoring, and continuous improvement

The following sections discuss each of these priority areas broadly across the health care service sector while also highlighting setting-specific considerations and nuances where appropriate.

It should be noted that a common thread identified across all health care settings and throughout each of the priority areas for standards development was the normalization of WPVH within the health care sector. This represents a significant cultural and systemic challenge that cannot be addressed through a single intervention or organizational change. Rather, it requires a coordinated, multi-pronged approach that addresses the underlying factors contributing to this issue. The five priority areas identified for standards development collectively provide a foundation for addressing these underlying factors. Through standards development, there is the potential to shift the culture away from acceptance and normalization of WPVH and toward prevention, accountability, safety, and psychological well-being.

4.2.1 Leadership Commitment and Organizational Support

Leadership commitment and organizational support emerged as foundational elements of effective WPVH prevention and management across health care settings.

The following recommendations identify opportunities for evidence-informed guidance and standardization to strengthen organizational responsibility, enhance psychological safety, and support sustained improvements in WPVH prevention and response:

- Establish organization-wide leadership accountability mechanisms that clearly define responsibilities for WPVH prevention, incident response, investigation, communication, and staff support at all organizational levels.
- Require leaders to demonstrate visible and sustained commitment to WPVH prevention through measurable actions and ongoing engagement.
- Implement standardized processes for timely follow-up after WPVH incidents to ensure concerns are addressed promptly and consistently.
- Develop transparent communication practices that inform staff about incident outcomes, corrective actions, and organizational responses.
- Monitor and evaluate organizational performance related to WPVH prevention and response on an ongoing basis.
- Require organizations to demonstrate how WPVH policies are operationalized within day-to-day practices, workflows, and organizational culture.
- Establish regular policy review and evaluation processes to ensure WPVH procedures remain effective, current, and consistently applied.
- Create formal staff engagement mechanisms that allow frontline workers to provide input into WPVH prevention strategies, policies, and organizational improvements.
- Integrate WPVH prevention activities into broader organizational quality improvement and occupational health and safety initiatives.
- Ensure organizational responses to WPVH incidents are supportive, trauma-informed, and non-blaming rather than blame-oriented.
- Implement safeguards that protect workers from retaliation, dismissal, stigma, or reprisal related to incident reporting.
- Promote leadership approaches that are transparent, responsive, and adapted to the operational realities of different care environments.
- Require accessible support resources for workers affected by WPVH, including debriefing processes, counselling services, peer support, and psychological supports.
- Promote organizational cultures that prioritize worker safety alongside patient care and service delivery.
- Support continuous improvement approaches aimed at reducing normalization of WPVH and strengthening prevention, responsiveness, and transparency across health care settings.

4.2.2 Education and Training

Education and training were consistently identified as critical components of a comprehensive approach to WPVH prevention and management in health care settings. The following recommendations are based on evidence-informed guidance focused on education and training:

- Develop standardized WPVH education and training requirements that apply across all health care organizations and worker groups, which define consistent core competencies for WPVH prevention and management.
- Require organizations to adapt training content to setting-specific operational realities, workplace risks, workflows, and patient or client populations.
- Promote team-based and practice-oriented training approaches that reflect real clinical situations and operational pressures through scenario-based learning and simulation exercises.
- Include training on early recognition of escalating behaviours and warning signs, as well as require competency development in de-escalation techniques and environmental awareness.
- Integrate communication strategies and trauma-informed approaches into all WPVH training programs.
- Emphasize prevention-focused interventions rather than passive or compliance-based training models.

- Within training programs, frame WPVH as a preventable workplace safety issue rather than an unavoidable occupational hazard.
- Support coordinated organizational prevention strategies through standardized training expectations.
- Integrate WPVH education into pre-service curricula prior to workforce entry.
- Require ongoing refresher training and regular competency reinforcement for all workers.
- Establish continuous learning opportunities to address evolving workplace risks and realities.
- Develop dedicated WPVH education and training programs for leaders and managers focused on their organizational responsibilities, consistent incident response, prevention responsibilities, and worker support practices, in order to strengthen organizational accountability.
- Support training approaches that improve worker confidence, preparedness, and early intervention capacity.
- Promote education and training strategies that contribute to broader organizational and cultural change related to WPVH prevention.

It should also be noted that several setting-specific nuances emerged regarding training needs and implementation considerations:

In **medical care settings,** particularly emergency departments, intensive care units, and acute care environments, workers highlighted the need for frequent simulation-based training that reflects high-acuity situations, rapidly escalating behaviours, and interdisciplinary team responses.

In **emergency medical services and paramedic settings,** training approaches must account for dynamic field environments, isolated work conditions, mobile care delivery, and interactions occurring in uncontrolled community settings. Training should also emphasize the importance of situational awareness, communication with law enforcement and dispatch systems, and trauma-informed approaches to patient interactions in pre-hospital environments.

In **home and community care settings,** standards development should support training related to dynamic risk assessment, personal safety planning, boundary-setting, and communication strategies specific to home-based care delivery.

In **long-term care homes and assisted living settings,** training should include responding to responsive behaviours associated with dementia, cognitive impairment, and mental health conditions, while avoiding normalization of resident aggression toward staff. Standards could support training approaches that balance compassionate, person-centred care with worker safety and violence prevention principles.

Similarly, in **mental health and substance use settings,** specialized training related to trauma-informed care, crisis intervention, therapeutic communication, behavioural assessment, and de-escalation in environments where staff regularly care for individuals experiencing acute psychological distress, substance use crises, or cognitive impairment would be beneficial.

4.2.3 Risk Assessment and Mitigation

Risk assessment and mitigation were identified as essential components of a proactive and prevention-focused approach to WPVH in health care settings. The following recommendations aim to strengthen risk identification, improve communication and coordination, and support comprehensive mitigation strategies:

- Develop standardized, evidence-based WPVH risk assessment processes that can be applied consistently across health care organizations and settings.
- Require risk assessment to be implemented as an ongoing and continuous process integrated into organizational operations, clinical workflows, and routine care delivery.
- Ensure risk assessments are workplace-specific and adaptable to the unique hazards, patient/client populations, staffing models, and operational realities of different care environments.
- Expand risk assessment frameworks beyond individual patient/client behaviours to include environmental, organizational, and system-level contributors to WPVH.



- Incorporate assessment of environmental hazards, staffing levels, workload pressures, communication challenges, physical layout issues, and organizational culture factors into WPVH risk assessment standards.
- Promote the use of point-of-care risk assessments integrated directly into routine clinical workflows and care processes.
- Encourage the implementation of structured, practical, and scalable approaches to dynamic risk assessment.
- Support the use of standardized screening tools to identify and assess WPVH risks consistently across care settings, while ensuring tools are adapted to the unique contexts and workflows of each setting.
- Establish standardized communication protocols and mechanisms to ensure WPVH risk information is shared effectively among staff and care teams, including team members across multiple organizations caring for common clients/patients, to reduce fragmented communication, inconsistent documentation, and gaps in continuity of prevention efforts.
- Implement patient/client behavioural alert systems to improve awareness of potential risks during care delivery.
- Encourage interdisciplinary care planning processes that incorporate WPVH risk prevention and mitigation strategies.
- Require organizations to implement coordinated mitigation strategies that address environmental, organizational, operational, and clinical risk factors simultaneously.
- Strengthen physical and environmental safety measures through improvements in facility design, secure workspaces, visibility, controlled access points, communication systems, alarm technologies, and access to trained security personnel where appropriate. It should be noted that environmental safety measures may be less feasible to implement in non-institutional settings.
- Emphasize that environmental safety interventions must be accompanied by broader organizational and systemic improvements to effectively reduce WPVH risk.
- Address systemic contributors to WPVH by implementing strategies to reduce staffing shortages, workload intensity, burnout, overcrowding, and inadequate organizational resources.
- Promote interdisciplinary and system-wide approaches to WPVH risk mitigation across all levels of health care delivery.
- There are also a few setting-specific nuances for standards development related to risk assessment and mitigation.

In the **emergency medical services and paramedical** setting, standards development should support improved integration of communication systems, enhanced information-sharing processes between dispatch, law enforcement, and health services, and structured scene safety assessment protocols.

In **home and community care** settings, standards should support individualized and dynamic risk assessment processes that incorporate environmental scanning, safe visit planning, communication protocols, and mechanisms for reassessing risks over time as patient/client circumstances change.

In **long-term care homes and assisted living** settings, standards development could support more consistent implementation of behavioural assessment tools, interdisciplinary care planning approaches, environmental modifications, staffing supports, and communication systems designed to reduce triggers and prevent escalation.

Mental health and substance use settings standards development should consider the importance of balancing therapeutic care approaches with proactive safety planning, particularly during crises, involuntary care situations, or periods of acute psychological distress.

4.2.4 Post-incident Response and Psychological Support

Effective post-incident response and psychological support are critical to mitigating the impacts of WPVH on health care workers and promoting recovery following incidents. Follow-up after an incident should not be viewed as optional for leadership and organizations. The evidence highlights the importance of timely, coordinated, and trauma-informed organizational responses that recognize both the immediate and longer-term consequences of WPVH exposure. The following recommendations focus on strengthening post-incident care, enhancing psychological safety, and reinforcing organizational accountability across health care settings:

- Develop standardized post-incident response protocols that clearly define organizational responsibilities following WPVH incidents.
- Establish post-incident response processes as a core component of worker psychological safety, organizational accountability, and recovery support.
- Provide immediate debriefing opportunities for workers following incidents.
- Ensure access to psychological counselling services after incidents occur.
- Implement peer support mechanisms for affected workers.
- Provide access to employee assistance programs (EAPs) following incidents.
- Offer ongoing mental health supports based on worker needs and recovery trajectories.
- Integrate trauma-informed approaches into all post-incident response and support processes, which embed principles of psychological safety, empathy, confidentiality, non-retaliation, and organizational learning into post-incident practices.
- Recognize and accommodate varying psychological responses to incidents based on severity, frequency, nature, and cumulative exposure.
- Address barriers to reporting by reducing fear of stigma, shame, blame, and professional repercussions.
- Establish clear expectations for managerial communication following incidents, that require timely follow-up according to defined standardized response timeframes.
- Implement consistent documentation processes for post-incident follow-up and support activities.
- Create clear support pathways to guide workers toward appropriate services and resources after incidents.
- Ensure post-incident response processes are supportive, equitable, and consistently applied across all staff groups, including part-time, full-time, casual workers, and across all care settings.

Several setting-specific considerations emerged regarding post-incident response needs and implementation approaches.

In **medical care settings**, workers described situations in which they were expected to continue providing care immediately following violent incidents without adequate recovery time, support, or follow-up. Standards in these settings should therefore support structured post-incident debriefing protocols, interdisciplinary support approaches, and leadership accountability for timely follow-up after incidents.

In **emergency medical services and paramedical** settings, workers highlighted the unique psychological burden associated with repeated exposure to violence in unpredictable and uncontrolled field environments, often compounded by operational stress, fatigue, and isolation. Post-incident response approaches in this setting should account for the cumulative nature of trauma exposure and support timely access to peer support, trauma-informed counselling services, and operational follow-up processes.

In **home and community care** settings, standards may need to emphasize accessible remote support systems, timely organizational communication, and clear follow-up responsibilities after incidents.

Long-term care and assisted living standards development could support more consistent post-incident review processes that recognize the complexities associated with dementia-related responsive behaviours while still reinforcing worker safety and organizational accountability.

Similarly, in **mental health and substance use** settings, workers emphasized the importance of balancing compassionate, trauma-informed care approaches toward patients with equally strong trauma-informed support processes for staff affected by WPVH.

4.2.5 Reporting, Monitoring, and Continuous Improvement

Robust reporting, monitoring, and continuous improvement systems are essential for understanding the scope of WPVH, informing prevention efforts, and strengthening organizational accountability. The evidence indicates that meaningful progress depends on the consistent collection, analysis, and use of data to identify patterns, evaluate interventions, and support ongoing learning across health care settings. The following recommendations are aimed at improving data quality, enhancing organizational responsiveness, and supporting continuous improvement at the organizational, sectoral, and system levels.

- Establish clear, standardized definitions of WPVH and reportable incidents across all health care settings.
- Adopt harmonized terminology and classification frameworks that include physical violence, verbal abuse, threats, harassment, bullying, discrimination, sexual harassment, racism, and other forms of non-physical violence. Be cognizant of potential subjective interpretations and differences between health care settings when determining terminology and definitions.
- Implement streamlined, user-friendly reporting mechanisms that are accessible, efficient, confidential, and integrated into existing organizational workflows to reduce administrative burden and encourage reporting across all worker groups.
- Introduce electronic reporting platforms to facilitate reporting, data collection, and interconnectivity with other health care workers.
- Simplify documentation requirements to improve reporting compliance and efficiency.
- Establish standardized reporting pathways to support consistency across organizations and care settings.
- Implement mechanisms that support timely submission and review of incident reports.
- Design reporting systems to foster organizational trust, psychological safety, and meaningful organizational action.
- Define organizational accountability and establish clear post-reporting procedures, including timely investigation processes, documented follow-up actions, and communication with affected workers.
- Explicitly encourage reporting of all forms of WPVH, including verbal abuse, threats, harassment, racism, sexual harassment, bullying, and other non-physical incidents.



"Legislative and policy frameworks exist across jurisdictions, and many organizations have implemented programs, training, and reporting mechanisms."

- Reinforce through standards that all forms of WPVH are occupational health and safety concerns requiring documentation, review, and prevention efforts.
- Develop and adopt standardized WPVH indicators that include structural, process, and outcome measures.
- Implement measurement systems that include standardized indicators and frameworks capable of monitoring prevention efforts, organizational responsiveness, worker safety, and system performance over time to support benchmarking, evaluation, and quality improvement activities.
- Ensure monitoring systems capture both physical and non-physical forms of violence.
- Collect data on incident frequency, severity, location, as well as contextual contributing factors and require organizations to regularly analyze incident data to identify trends and contributing factors.
- Evaluate the effectiveness of WPVH interventions and prevention strategies on an ongoing basis.
- Integrate WPVH findings into broader organizational quality improvement and occupational health and safety processes.
- Support implementation of real-time data tools, dashboards, and integrated monitoring systems where feasible.
- Provide timely WPVH data and reporting information to leaders, managers, and frontline teams.
- Support national-level data harmonization and standardization efforts for data collection, classification, and reporting across jurisdictions, organizations, and health care settings.
- Use harmonized data systems to support evidence-informed policy development, benchmarking, accountability, evaluation of prevention and intervention strategies over time, and to strengthen surveillance capacity.

5 Conclusions

This report provides a comprehensive, evidence-informed examination of WPVH across the Canadian health care service sector, drawing on an environmental scan, literature review, pan-Canadian survey, and key informant interviews. Together, these data sources highlight that WPVH is both highly prevalent and deeply embedded across all six health care settings examined. Legislative and policy frameworks exist across jurisdictions, and many organizations have implemented programs, training, and reporting mechanisms. However, findings consistently demonstrate that these efforts remain fragmented, inconsistently applied, and insufficient to fully address the scope and complexity of WPVH.

Across all lines of evidence, several key cross-cutting challenges emerged. These include persistent definitional and conceptual inconsistencies, widespread under-reporting and normalization of violence, insufficient organizational and managerial support, and gaps in training and preparedness. These challenges are not isolated to specific settings, but instead reflect systemic issues that affect medical care settings, long-term care and assisted living, home and community care, emergency medical services and paramedics, mental health, and substance use settings alike. At the same time, the report identifies promising practices, including comprehensive training programs, risk assessment approaches, standardized reporting processes, and organizational policies that emphasize prevention, accountability, and support for health care workers.

The significance of this work lies in its clear demonstration that, despite existing legislation and initiatives, there is a critical need for coordinated, sector-specific, and standardized approaches to WPVH prevention and management. Key insights from this report underscore that effective WPVH prevention requires a systems-level approach. This includes clear and consistent definitions, standardized data collection and reporting, comprehensive and context-specific training, strong leadership and organizational commitment, and integrated support systems for workers affected by WPVH. Importantly, shifting workplace culture away from normalization and toward recognition of WPVH as a preventable occupational hazard is central to meaningful progress.

Looking ahead, future directions should focus on the development and implementation of national standards that are adaptable across diverse health care settings while maintaining core consistency. These standards should prioritize the five key areas identified in this report. Continued collaboration among governments, employers, professional associations, and frontline workers will be critical to advancing these efforts and ensuring that standards translate into meaningful improvements in practice.

In conclusion, this report highlights both the urgency and the opportunity to address WPVH in Canada's health care sector. By building on existing knowledge and addressing identified gaps through coordinated standards-based solutions, there is significant potential to improve health care worker safety, strengthen the health workforce, and enhance the quality and sustainability of care delivery across the country.

5.1 Study Limitations

This report is subject to several limitations. The environmental scan relied on publicly available documents, which may not fully capture all relevant policies, programs, or emerging practices across jurisdictions. The literature review, while comprehensive, was limited to studies published between 2019 and May 2025 and may not reflect earlier foundational work or more recent developments. The online survey used a snowball sampling approach, which may introduce selection bias and limit the generalizability of findings. Moreover, survey sample sizes and responses indicate that some settings may have been under-represented. Similarly, key informant interviews reflect the perspectives of those who participated and may not represent all views across diverse health care settings. Finally, variations in definitions and reporting of WPVH across sources posed an added challenge when conducting comparisons and synthesis of findings.

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