DE-ESCALATING VIOLENCE IN HEALTH-CARE SETTINGS

TRAINER MANUAL
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FOREWORD

Health Care in Danger (HCiD) is an initiative of the International Red Cross and Red Crescent Movement (the Movement) led by the International Committee of the Red Cross (ICRC) that aims to address the issue of violence against patients and health workers, facilities and vehicles, and to ensure safe access to and delivery of health care in armed conflict and other emergencies.

As discussed in recent documents and guidance from HCiD, reactive violence committed by weapon bearers and civilians alike is a growing phenomenon affecting the delivery of health care in conflicts and other emergencies. Reactive violence is aggressive behaviour that occurs when someone is angry or otherwise emotional. It is distinct from premeditated violence and from the direct impact of hostilities: it arises from a combination of factors that can be analysed, predicted and controlled through training staff, changing attitudes among the health-care seeking population and changing health facilities.

One of the ways in which the health-care community has been responding to such violence is through training courses for people who work in health-care settings. The courses equip them with communication skills that can help break the cycle of escalation and contain a potentially violent situation before harm occurs. These skills foster a respectful environment conducive to the provision of health care, and they contribute to a better relationship between patients and staff.

The Movement has developed its own tools for managing and de-escalating violence in health-care settings: a manual developed by the Norwegian Red Cross on preventing interpersonal violence in health-care settings and training materials created by the ICRC’s delegation in Pakistan. This course draws on that material while also incorporating new content based on a literature review and feedback from people who had run similar training courses in their workplace. It is meant to be adaptable to different locations and circumstances to ensure training is effective while requiring few resources.

The training material was developed by John Bromley, a consultant who specializes in behavioural change, in dialogue with ICRC staff around the world. If you have feedback, we would love to hear from you – send an email to gva_hcid@icrc.org.

Maciej Polkowski
Head, HCiD Initiative
ICRC
SUGGESTED TIMING

<table>
<thead>
<tr>
<th>MODULE AND TOPIC</th>
<th>TIME</th>
<th>SLIDES</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module 1 – Setting the scene</td>
<td>40 min. total</td>
<td>2–14</td>
<td>Introductory module</td>
</tr>
<tr>
<td>Getting started</td>
<td>15 min.</td>
<td>4–5</td>
<td></td>
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<tr>
<td>Introductions and expectations</td>
<td>10 min.</td>
<td>6–7</td>
<td>Participants introduce each other and discuss their expectations</td>
</tr>
<tr>
<td>The Health Care in Danger initiative and violence against health care</td>
<td>15 min.</td>
<td>8–14</td>
<td></td>
</tr>
<tr>
<td>Module 2 – Understanding violence in health-care settings: Causes and effects</td>
<td>30 min. total</td>
<td>15–25</td>
<td>How violence impacts on the experience of working in health care</td>
</tr>
<tr>
<td>Violence in the workplace and how it affects people</td>
<td>15 min.</td>
<td>17–22</td>
<td>An introduction to what violence is, how it affects people and why it arises</td>
</tr>
<tr>
<td>Group discussion</td>
<td>10 min.</td>
<td>23</td>
<td>Reflection on how one’s own thoughts/feelings/behaviours contribute to tension</td>
</tr>
<tr>
<td>Rights and responsibilities of healthcare personnel</td>
<td>5 min.</td>
<td>24–25</td>
<td></td>
</tr>
<tr>
<td>Module 3 – Learning key behaviours for preventing and de-escalating tense situations</td>
<td>65 min. total</td>
<td>26–49</td>
<td>Learning and applying behaviours, part one</td>
</tr>
<tr>
<td>Triggers of violence and how we can learn to react to it</td>
<td>15 min.</td>
<td>28–30</td>
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<tr>
<td>A scene from the patient’s perspective</td>
<td>5 min.</td>
<td>31–32</td>
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<tr>
<td>Discussion</td>
<td>10 min.</td>
<td>33</td>
<td>Discussion of how participants would feel as patients</td>
</tr>
<tr>
<td>Key de-escalation behaviours</td>
<td>20 min.</td>
<td>34–45</td>
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<tr>
<td>Case studies</td>
<td>15 min.</td>
<td>46–49</td>
<td>Participants discuss how and when to apply techniques using concrete scenarios</td>
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<tr>
<td>Module 4 – Communicating and engaging with people</td>
<td>50 min. total</td>
<td>50–63</td>
<td>Learning and applying behaviours, part two</td>
</tr>
<tr>
<td>Further skills for improving communication with patients and carers</td>
<td>20 min.</td>
<td>52–57</td>
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<tr>
<td>Role play</td>
<td>30 min.</td>
<td>58–63</td>
<td>Participants practise using the techniques in pairs</td>
</tr>
<tr>
<td>Module 5 – Taking learning back into the workplace</td>
<td>20 min. total</td>
<td>64–73</td>
<td>Wrap-up</td>
</tr>
<tr>
<td>Recap, challenges and next steps</td>
<td>20 min.</td>
<td>66–73</td>
<td>Review and recommendations for continued learning</td>
</tr>
<tr>
<td>Entire course</td>
<td>205 min. (3 hr, 25 min.)</td>
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INTRODUCTION TO THE COURSE

The objective of the training course is to give participants the skills and confidence they need to de-escalate tense situations that could otherwise turn into violence. The course is based on the evidence for what works to de-escalate tension in health-care settings.

It has been designed and structured to facilitate participants’ understanding and practice of de-escalation skills. On a basic level, we are trying to change how participants behave, and behavioural theory states that the people remember and use new behaviours more effectively when:

- the behaviours have been developed after analysing people’s needs, ensuring that they are useful and applicable
- the behaviours provide direct benefits to them as well as others
- people get a chance to practise these new behaviours during training.

For the same reason, the course relies on repetition – many of the material in the different modules overlaps in order to reinforce the core skills being taught.

HOW PEOPLE LEARN BEST

People learn more effectively when the material is directly relevant to their needs and constraints. A little contextual analysis will improve how you teach.

People do not learn well when they are simply given lists of things to remember. Every behaviour that you are trying to instil should be presented with a context (when and where it should be done), a need (why it should be done), a technique (how it should be done) and an expected result (what will most likely happen if it is done).

People also learn new behaviours best when they can practise and discuss the material with others, so make sure that you provide sufficient time for discussions and practice.

Remember that the people you are training know the most about the situations that you will be helping them to deal with. Make sure that you listen and act when participants provide information that may be relevant to the course, such as:

- information about the types of violence that people are subject to in the workplace
- current coping strategies
- attitudes towards patients or the people accompanying them, like family or friends (referred to in this course as “carers”).

We will be asking participants to take the skills they have learned back to the workplace and demonstrate them to their colleagues. Teaching through demonstration works much more efficiently than simply taking leaflets or posters back to the workplace.

People adopt new behaviours when they can see a benefit to themselves.
To get participants to adopt new behaviours that help de-escalate tension, they need to feel that there is a direct benefit to them in doing so. It is essential therefore that during the course you emphasize how these new techniques will help them.

Participants should also realize that many of the behaviours being taught should be used every day to engage effectively with patients and carers.
SCOPE OF THE COURSE
It is critical that you understand and emphasize to participants that de-escalation behaviours can only be used to deal with certain kinds of violence in certain circumstances. You will need to spell out clearly when de-escalation should be attempted and when it should not.

EVALUATION
To find out whether the course has been worthwhile and useful to participants, we need to evaluate whether it has measurably improved their ability to de-escalate tension. To do so, participants will fill in a simple evaluation form in two parts: one to be completed before the course and one to be completed afterwards. The form is included at the end of this manual. Please print out enough copies to give one to each participant and write your name in the provided space at the end of the form.

PRE-TRAINING PREPARATION
Before you lead the training course, you will need to do a very basic analysis of the participants' place of work in collaboration with their managers or other key stakeholders. You will also need to understand your role in facilitating the course and be familiar with the material.

THE TRAINING MODULES
Discussions of the training modules will include the key points and objectives of each module, instructions on how to teach the content and notes on additional information that you should give participants.
SCOPE OF THE COURSE

Many of the course participants will be working in stressful environments with many operational challenges, such as lack of staff, equipment or medicines, as well as the strain placed on health systems by armed conflict and other emergencies. Difficulties might also arise when health responses are carried out without appropriate community engagement or when there are cultural differences between the health team and the larger community.

This may ultimately lead to tensions within the health-care environment, which could erupt into physical or verbal violence against staff. Such violence can disrupt the regular provision of health services and add pressure to already strained health systems.

The ICRC has developed a framework for the causes of violence in health-care settings through scientific research. There are three categories of causes: behavioural, institutional and socio-political. Behavioural causes include those inherent to the client and to the health-care provider. Apathy, negligence and gaps in communication from the health-care provider were identified as risk factors for violence.

Institutional causes relate to resource constraints, such as lack of equipment or medicines or understaffing. Sociopolitical causes include, for example, lack of awareness in society about the availability of services or poor law and order.

It must be made clear that the training course is not designed to deal with the underlying causes of violence: you will be teaching behaviours that help to de-escalate potentially violent situations. Nevertheless, this course not only helps staff to handle violence caused by the behaviour of patients and carers; it also addresses provider-related causes of violence against health care, specifically around communication, by teaching behaviours that will improve staff’s communication skills.

De-escalation techniques must not be used in situations of premeditated violence or when weapons are being used.

Participants must understand that de-escalation training has its limits: The behaviours taught in this course are strictly to be used in cases of reactive violence, i.e. when someone impulsively acts in a violent way owing to emotional distress. They cannot be used to manage proactive (i.e. premeditated) violence. And they cannot be used when weapons of any type are being used to threaten others, regardless of whether the violence is proactive or reactive.

There is a section in the course that clearly shows when de-escalation behaviours can be used and when they should not be used.

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1 ICRC, Violence against Health Care: Results from a Multi-Centre Study in Karachi, ICRC, Geneva, 2015.
### Causes of Violence

#### Client-related
- Reaction to adverse outcomes or serious conditions (25)
- Impatience (unwillingness to wait for turn/triage) (13)
- Lack of culture of respect/tolerance (11)
- Habit of creating chaos (7)
- High expectations of hospital (5)
- Vested interests (wrong reports) (2)
- Desire to gain staff's attention (1)

#### Provider-related
- Apathic attitude/negligence (11)

#### Capacity
- Low capacity leading to poorer quality of services/mishandled cases (24)

#### Resources
- Lack of equipment/medicines (23)
- Lack of staff/high workload (14)
- Lack of security (5)

#### Organization
- Delay in treatment/ambulance arrival (18)
- Overcrowding/easy access to attendants (19)
- Competition among ambulance services (8)
- Low incentives/strikes/protests (6)
- Misuse of resources (3)
- Lack of reporting of abuse (2)
- Lack of policies to deal with violence (1)

#### Institution-related
- Lack of education and awareness (37)
- Political indulgence in institutions (16)
- Poor law and order (15)
- Poverty/inability to pay high cost of care (13)
- Corruption/malpractice (13)
- Injustice and slow judicial system/no fear of punishment (12)
- Doctors as soft targets/spying on their income (11)
- Religious extremism (8)
- Influence of media/movies (7)
- VIP culture (7)
- Ethnic nationalism (6)
- General anxiety in society (5)
- Nepotism (4)
- Misconception of political affiliation of providers (4)
- Easy access to weapons (3)
- Change in demography (2)

**Figure 1:** Causes of violence (adapted from ICRC, 2015)
The course has two main behavioural objectives:
- to measurably increase staff’s confidence in their ability to deal with potential violence (verbal and physical) in the workplace
- to improve staff’s skills in engaging with patients and carers.

It is important that we measure whether training is successfully achieving these goals.

Before the course, participants will fill out the first section of an evaluation form to assess how confident they are when dealing with violence in the workplace.

After the course, they will complete the same evaluation, enabling us to see whether their confidence levels have improved, stayed the same or decreased as a result of training.

The form is included at the end of this manual. Please print out enough copies to give one to each participant and write your name in the provided space at the end of the form.
PRE-TRAINING PREPARATION

READ THE MATERIALS!
Before all else, ensure that you are familiar with this manual and the slide deck – they have the basic information you need to successfully run the course.

CONTEXTUAL ANALYSIS
To ensure your course is effective, you will need to do an initial contextual analysis of the health-care setting where the participants in your course work.

Discussing past incidents of violence can re-traumatize people, so you will need to be sensitive in your work.

We suggest that you talk to a senior member of the staff and ask the following questions:
- What are the types of violent situations (physical or verbal) that are affecting their workplace?
- What are the main needs in their workplace in terms of training to de-escalate tension?
- What are the main problems that staff have in communicating with patients and carers?

ADAPTING YOUR COURSE
Using the information gained through your analysis, adapt how you deliver the content, for example by creating more relevant scenarios for role play. The suggested timing for the course can also be adjusted to better suit the size and needs of the group.

Please note that some of the slides in the slide deck can or must be edited to better suit your course. The screenshots of the slides have a colour-coded border to indicate which slides must be edited before the course, which can be edited according to needs and which must not be changed:

- **Green-bordered slides must be edited.**
- **Yellow-bordered slides may be edited where necessary.**
- **Red-bordered slides should not be edited.**

UNDERSTANDING YOUR ROLE
The quality of the course depends a lot on how you run it. Your role will be to facilitate group discussions, ask open-ended questions and summarize reflections. The more the participants contribute and the more knowledge comes from them, the more everyone will learn.

With experience, you will learn to strike a balance between enough structure in how the material is delivered and enough flexibility for participants to give their own experiences and reflections.

As a facilitator, you need to:
- be a patient and active listener
- observe non-verbal cues and be responsive to individual and group needs
- encourage participation and facilitate interaction among participants
- ensure that people are being respected if they do not wish to talk about difficult experiences
- ensure that participants are not judgmental or discriminatory towards one another
- allow participants time to think and do not provide all the answers immediately
- get participants to elaborate on important topics
- summarize discussions and reflections
- express appreciation for all participants’ input
- share your own thoughts only when essential.
### THE DOS AND DON’TS OF FACILITATION

**DO**
- Arrive at least five minutes before the course starts.
- Position visuals where everyone can see them.
- Begin each module by outlining what will be covered.
- Speak clearly and loudly enough for everyone to understand.
- Avoid distracting mannerisms and eliminate distractions in the room.
- Maintain good eye contact.
- Manage time effectively.
- Check whether your directions have been understood.
- Encourage questions and get participants involved.
- Keep participants focused on the current task.
- Draw connections between the various modules.
- Give feedback.
- Finish each module by summarizing what has been covered.

**DON’T**
- Be late.
- Block visual aids.
- Talk to the flip chart or PowerPoint.
- Read from the training manual.
- Stand in one spot the entire time.
- Ignore participants’ comments or feedback (both verbal and non-verbal).
- Shout or lose your temper.
- Improvise and make up material not in the manual.

### THE ROOM

Set up the room in such a way that participants can sit together in groups of five. There must be enough extra space for them to work on the various activities (e.g. role play).

### MATERIALS AND SUPPLIES

- Computer, multimedia projector/overhead projector
- Permanent markers/transparency markers in different colours, flip charts and stands
- One participant manual and evaluation form for each participant (remember to fill in your name at the end of the evaluation form)
- Pens/pencils and looseleaf paper
- Water and disposable cups
USING PARTICIPANTS’ EXPERIENCES

During the course, people may want to talk through some of the violent situations they have experienced. They should never be required to disclose this information – state clearly that they should only talk about their experiences if they are comfortable and they should avoid talking about the experiences of others in the room, instead focusing on their own experiences and feelings.

There are advantages and disadvantages to people talking about their own experiences, which you as the facilitator will need to balance. Real-life events provide an excellent starting point for discussions and may lead to possible measures for improving such situations in the future. However, people may become distressed when reliving traumatic experiences or find it difficult to move on, which can also derail the course.

If someone is upset: Leave the room with the person, encouraging the other participants to carry on with the discussion. Talk to them, and see if they are able to carry on. Remind them that they do not have to share their experiences with others.

If someone is not moving on: During the next break, talk to the person and reassure them that it is OK to be very moved by a traumatic experience. Remind them that it might be helpful to speak with a professional for support. Gently suggest that it could be interesting to give others space to speak and hear their experiences and how they have managed them.

ROLE PLAY

Role play is a learning technique in which participants explore a given situation by acting out the roles of those represented in the situation. It is mainly used for changing attitudes and developing interactive knowledge and skills.

How to conduct a role-playing exercise:

• Inform the participants that there will be role play in the session.
• Share the scenario with the group and invite volunteers.
• Assign roles to the volunteers and show them their prompts.
• Ask observers to take notes on what went well, what did not and why.
• Once the role play is over, ask each player for feedback on how they felt about the roles.
• Ask the observers to comment on how the situation was handled: Should it be handled in this manner? Is there another way? How would they feel if they were in these roles?

Before the course begins, remember to have participants fill out the pre-training part of the evaluation form, found at the end of this manual. Print it out, write your name in the space at the end of the form and distribute it to the participants. At the end of the course, have them fill out the post-training part and hand it back to you.
MODULE 1
SETTING THE SCENE

KEY POINTS

In this module, after setting out the goals of the course, performing introductions and addressing participants’ expectations, you will discuss violence in health-care settings: its prevalence, risk factors and the two main categories of violence (proactive and reactive). It is critical that you emphasize that the behaviours participants will learn can only be used in certain circumstances – in cases of reactive violence when no weapons are present.

SLIDE 4: GROUND RULES

This slide sets out ground rules for the course.

Additional information to include:

- There is designated space in the participant manual where participants can take notes during the course.
- The manual is also intended to serve as a reference for reviewing important information once participants are back at work.

Note: Slides 1 to 3 introduce the course and module and should not be edited.

SLIDE 5: OBJECTIVES

Additional information to include:

- The objectives of the course are to help people working in health-care settings to:
  - understand the impact that violence towards health-care personnel can have on people in health-care settings and the provision of care
  - learn simple behaviours that will improve their confidence in their ability to de-escalate tensions in the workplace
  - further build their communication and listening skills with patients and carers, which can be used every day.
- The skills they will learn are evidence-based and have been proven to work.
- Through practising the behaviours at work they will improve not just their skills but also their colleagues’.
SLIDE 6: INTRODUCTIONS

This activity is an important icebreaker that will require participants to use their listening skills in order to introduce their neighbour effectively.

Directions:
- Explain that building listening skills is an important part of the course, and that this exercise will help them to practise.
- Have participants sit in pairs.
- Ask them to ask questions about their partner for two to three minutes each.
- Remind participants they will be expected to introduce their neighbour to the group.

SLIDE 7: EXPECTATIONS

It is very important that you find out what the participants expect of the training course before getting into the material.

Their responses will ensure that you can dispel any misconceptions about the course; it will also give you the opportunity to ask questions about the participants’ working environment.

Directions:
- Ask the participants what they expect to achieve or learn in the course.
- Write down their answers on a blackboard or sheet of paper.
- When everyone has finished, review each point and respond.
- Keep a list of these expectations somewhere so that you can review them at the end of the course.

SLIDE 8: HEALTH CARE IN DANGER (HCID)

In this section you will provide some basic information on the HCID initiative, its aims and how it is working to achieve them.

If you as a trainer would like to know more about HCID, you can visit HCID’s website (www.healthcareindanger.org) for reference documents and videos.
Additional information to include:

- HCID is an initiative of the Movement that aims to address the issue of violence against patients, health workers, facilities and vehicles, and ensures safe access to health care in armed conflict and other emergencies.
- It has three main activities:
  - advocacy and coalition-building – creating networks at the national level to bring together representatives of health-care providers and policymakers who can contribute to developing solutions
  - collecting an evidence base – partnering with local public health or research organizations to collect information so that prevention strategies can be based on an understanding of local patterns of violence
  - developing concrete, practical solutions – developing and implementing measures at both national and local levels. *The de-escalation training course falls into this category of support.*

**SLIDES 9–10: VIOLENCE AGAINST HEALTH-CARE PERSONNEL**

This slide discusses how people working in health-care settings are frequently the victims of violence when caring for or supporting the care of those in need.

Additional information to include:

- **VIOLENCE AGAINST HEALTH CARE IS A PROBLEM AROUND THE WORLD.** In 2020, the ICRC carried out a review of global patterns of violence against health care, examining 66 studies dating from 2007 to 2019, and found that between 15 and 97 per cent of health-care personnel around the world had experienced physical, sexual or psychological harm while performing their duties (as shown in the map). In addition, between 2015 and 2017, the ICRC documented 1,261 acts of violence against health care across 16 operations around the world. About 57 per cent happened inside a health facility.

- **VIOLENCE IN HEALTH-CARE SETTINGS DOES NOT JUST AFFECT DOCTORS AND NURSES.** In the studies examined, around 107,000 people working in health-care settings were asked about whether they had been subject to violence while performing their duties, including doctors, and nurses but also technicians, support staff, paramedics, pre-hospital emergency teams, midwives, personal caregivers, health management, ambulance drivers, nursing assistants and community health workers.

- **VIOLENCE COMES IN MANY FORMS.** The violence represented on the map includes not just pushing, kicking, slapping, beating, stabbing and shooting but also threat of physical force (with or without weapons present), verbal abuse, harassment and tribal penalties.

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VERBAL THREATS AND HARASSMENT SHOULD NOT BE CONSIDERED PART OF THE JOB.

At this point you will have participants watch a short video on violence in health-care settings, entitled “It’s a matter of life and death”. If you have problems playing it in the PowerPoint, you can also find it here, or at www.healthcareindanger.org/resource-centre, under “Campaign and audio–visual material”.

SLIDE 11: RISK FACTORS FOR VIOLENCE

You must explain clearly to participants that de-escalation training cannot deal with some of the underlying problems faced in many health-care settings around the world.

Additional information to include:

- Violence can be caused by individuals’ behaviour, institutional issues or sociopolitical factors.
- The course does not aim to prevent all violence – health-care personnel do not have control over institutional or sociopolitical matters, so de-escalation training focuses on behaviour, specifically that of staff.
- Among the listed risk factors for violence, only the last (“Lack of staff training and policies”) can therefore be addressed through de-escalation training.
- Apathy and negligence but also poor communication on the part of staff are risk factors for violence.
- The course will provide participants with skills and techniques that can help them in their working lives, both in how they deal with potentially violent incidents and in how they communicate on a day-to-day basis.

SLIDES 12–14: TYPES OF VIOLENCE AND WHEN TO USE BEHAVIOURS

In these slides, you will break down violence into two categories: proactive and reactive. After defining what each type is and giving examples, explain that de-escalation behaviours are only to be used in cases of reactive violence where no weapons are present. When weapons are present, and when proactive violence occurs, staff must activate security protocols.
MODULE 2
UNDERSTANDING VIOLENCE IN HEALTH-CARE SETTINGS

KEY POINTS
In this module you will explain how being exposed to violence impacts on people and why tension can sometimes escalate into violence.

The module will also provide an opportunity for participants to share some of their experiences of violence in the workplace and to reflect on how their own emotions can affect the way they treat patients and carers.

You should recommend that participants:
• choose the least painful experience they have had
• only share when they feel comfortable doing so – when in doubt, they should not share.

SLIDE 17: VIOLENCE IN HEALTH-CARE SETTINGS

This slide provides a brief overview of when and where violence occurs.

Note: Slides 15 and 16 introduce the module and should not be edited.

SLIDE 18: PARTICIPANTS’ EXPERIENCES OF VIOLENCE

Directions:
• Ask the participants to reflect silently on experiences of workplace violence that they have had or heard about and to identify possible triggers for the events.
• Remind them that they do not have to share if they are not comfortable doing so.
• Put participants into pairs to share their thoughts and collect their ideas in one list.
• Ask each pair to present their list on a flip chart to rest of the participants.
• Compile a master list on a flip chart or board.
• Ask participants to identify what types of violence have been mentioned – e.g. kicking, spitting, name-calling.
SLIDE 19: DEFINITION OF WORKPLACE VIOLENCE

Directions:

- Define violence for the participants – the World Health Organization defines violence as “the intentional use of physical force or power, threatened or actual, against oneself, against another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation”.

- Define workplace violence for the participants – the Joint Programme on Workplace Violence in the Health Sector (of the International Labour Organization, International Council of Nurses, World Health Organization and Public Services International) defines workplace violence as “incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health”.

- Explain that violence can either be physical or verbal:
  - Physical violence is the use of physical force against another person or group that results in physical, sexual or psychological harm. It includes beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching, among others.
  - Verbal violence (or emotional abuse) is the intentional use of non-physical power to inflict harm, including verbal abuse, bullying, harassment, threats, the infliction of mental pain, degrading treatment, humiliation in front of others or the compulsion to act against one’s will or conscience. This can have detrimental physical, mental, spiritual, moral or social effects.

- Discuss with participants the types of violence they identified in the previous exercise as compared to the definitions provided above.

- Emphasize the key points:
  - Unfortunately, threats, discrimination and humiliation are less frequently reported but nevertheless highly prevalent in many health-care settings – make sure participants include these forms of violence.
  - No form of violence should be part of the job.

SLIDE 20: THE EFFECTS OF VIOLENCE

The effects of violence can include a wide range of emotional, cognitive, behavioural, social and physical consequences. The effects can be immediate or delayed, and they vary between people in terms of how intense they are and how long they last. They may not occur at all.

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Additional information to include:
- Some studies mention that victims of violence avoid talking about their experience and, more importantly, that they may avoid even thinking about them or having feelings related to them. People who have experienced violence may therefore be relatively unlikely to seek help, which makes it more difficult for them to get needed legal or psychosocial support.

**SLIDE 21: BODILY REACTIONS TO VIOLENCE**

*Note:* After describing how the body reacts to violence, encourage the participants to read more about mental health and self-care in the participant manual (pp. 5–7).

**SLIDE 22: WHY TENSIONS ESCALATE INTO VIOLENCE**

Additional information to include:
- When someone attacks us verbally or physically, our first response may be to defend ourselves. We might feel stressed owing to a rush of adrenaline.
- We often do not realize that this is happening, and when we are already stressed or over-tired it can easily lead to tensions with a patient or carer escalating.

**SLIDE 23: SELF-REFLECTION**

In this section, participants will discuss in small groups how they deal with patients and carers.

The aim is for them to learn to be aware of their feelings and reactions in the moment; self-reflection may help them to reduce tension. This discussion prepares the participants for the following module, in which they will be asked to think about situations from the patients’ and carers’ perspectives.

The questions are phrased impersonally, but participants will likely talk about some of their own feelings and behaviours.

**Directions:**
- Explain to the participants that they will be discussing the questions on the slide in small groups.
  
  **Additional information to include:**
– To better understand and address potentially violent situations, we need a broader context, looking at the roles played by the environment, our own emotions and the other person’s story.
– That means that to defuse tensions we need to be aware of the role played by our own thoughts, feelings and behaviour.
– This discussion will shed light on the thoughts and feelings we have when faced with violence.

• Divide the participants into smaller groups, and have each group sit in a semicircle or circle so that all members can see each other.
• Give the participants a specific amount of time in which to have the discussion.
• Ask one member from each group to summarize the discussions that took place in their group.
• Summarize the important points presented by all groups.

SLIDES 24–25: RESPONSIBILITIES AND RIGHTS OF HEALTH-CARE PERSONNEL

These slides show the responsibilities and rights of health-care personnel. In particular, the slide on responsibilities is included in order to emphasize the key behaviours required of all health-care personnel around the globe.

You will not have a discussion on these responsibilities, but some participants may bring up issues or limitations associated with the expected behaviours. If that occurs, you will need to answer that these are expected behaviours and health-care personnel should always abide by them, unless their lives or the lives of others are endangered. This course cannot deal with some of the complexities and difficulties associated with health-care delivery.
MODULE 3
LEARNING KEY BEHAVIOURS FOR PREVENTING AND DE-ESCALATING TENSE SITUATIONS

KEY POINTS
In this module, participants will learn de-escalation behaviours and be given a chance to practise them. They will learn when to use them and what the expected results are when they are used effectively.

We open the module by looking at the problem of violence from the perspective of patients and carers. We also explore how tension can easily build into physical or verbal violence and some of the key frustrations that can cause patients and carers to become angry.

The objective of this process is not to apportion blame but to get participants to realize that patients and carers are in an environment that may feel threatening or frightening.

Finally the module introduces the various behaviours that can de-escalate violence in the workplace. You will emphasize that the behaviours need to be practised and repeated to ensure they become ingrained in everyday behaviour.

SLIDE 28: REVIEW

Here you will have participants briefly review what was covered at the end of the second module.

Note: Slides 26 and 27 introduce the module and should not be edited.

SLIDE 29: TRIGGERS IN PATIENTS AND CARERS

Note: You may adapt this slide to better fit the circumstances where you are giving the course.

Additional information to include:

- “Expectations not aligned with reality” refers to unmet expectations that patients or carers may have around the cost of medical care and/or the services offered.
- “Unexpressed questions and fears” refers to the fact that, often, patients and carers initially do not voice questions or concerns they have. This can lead to fear or frustration building up, especially in an emergency.
SLIDE 30: LEARNING NEW BEHAVIOURS

Additional information to include:
- When we repeatedly perform a behaviour, it becomes ingrained, and we no longer think about it. (Think about brushing our teeth: we usually do not think consciously about the activity – we just do it.)
- Approaching tense situations with calm and controlled behaviour and using de-escalation techniques needs to become a habit – something we do not consciously think about.
- To do this, we need to practise, repeating the behaviours until they become ingrained. If we do not practise, we will forget the behaviours and return to our old habits.

SLIDE 31: WHAT DO YOU THINK HAS HAPPENED HERE?

This slide shows an image of a patient or carer shouting at a nurse.

Directions: Ask participants what they think has happened – let them know that there is no right or wrong answer.

SLIDE 32: CASE STUDY 1

This slide provides the backstory to the previous slide. The objective of this slide is to show participants that many violent situations arise from frustration and anger that build up over time, perhaps starting even before the person arrived. They may be frightened and agitated and may not respond in a logical way.

Remember the discussion you had with senior staff as part of your contextual analysis (see page 13): instead of the scenario provided, you may use an incident that you heard about if it would better suit the audience. However, make sure you change the story enough so that the situation and people involved will not be recognized.

Directions:
- **Before the course begins**, it is important that you change the names on the slide from “Mr X” and “Mrs Y” to common names in the place you are giving the course.
- Explain that this slide contains the backstory to the previous one.
- Explain that this is when participants can use de-escalation behaviours to take the heat out of high-tension situations.
SLIDE 33: DISCUSSION ON TAKING THE CARER’S PERSPECTIVE

Directions:
- **Before the course begins**, change the name of “Mr X” to whatever you selected for the previous slide.
- Ask participants to discuss how they would feel in the carer’s position.

SLIDES 34–36: BE ALERT FOR WARNING SIGNS

In slides 34 through 45, you will be explaining in detail various behaviours for de-escalating tension. You should clearly explain how to use them.

Additional information on this behaviour to include:
- By recognizing the warning signs of elevated stress, we can resolve it before it escalates into something worse.
- When you present the warning signs, make sure you clarify that the signs on their own are not an indication of potential violence – they should be considered in context, just like when a doctor considers a patient’s symptoms before deciding on a diagnosis.

SLIDE 37: BE RESPECTFUL AT ALL TIMES

Directions:
- Emphasize that we must calmly communicate while sitting down and actively listening in order to show respect for the other person’s emotions and needs.
- When you mention active listening, tell participants that it will be addressed in the following slide.
- Ask the participants to think of a situation in which they were patients and they felt disrespected.
- Ask them why it is important to always respect people in health-care settings.
SLIDE 38: LISTEN ACTIVELY

Directions:
- Explain what active listening means (paying careful attention and demonstrating that you are listening through your behaviour), and emphasize why it is important (one of the main reasons why people become agitated is because they feel they are being ignored or their issues are not being taken seriously; by actively listening, you show that you are interested and concerned).
- Give the participants one or two culturally appropriate examples of non-verbal signals that can be used to show that you are listening. (In many places, this means nodding and/or slightly tilting one’s head to one side.)
- Ask a participant to tell you about something that they recently experienced or did.
- While they are speaking, look at your phone and over their shoulder.
- Ask them how they felt when you did this.
- Now ask them to repeat the story, and instead look at them while they are speaking and demonstrate active listening.
- Ask the participants what the differences are.

SLIDE 39: DEMONSTRATE INTEREST AND CHECK FOR UNDERSTANDING

Directions:
- Emphasize that this behaviour means telling the person what you’ve heard them say so as to show that you want to understand and to give them the opportunity to correct misunderstandings.
- Ask a participant to pretend they are sick and explain their symptoms to you, their doctor.
- While they are doing so, paraphrase some of the things the participant says.
- Ask the participants how this feels.

SLIDE 40: OFFER CHOICES

Directions:
- Explain that offering a choice shows the person that you are concerned and want to help.
- Emphasize that offering a choice is important, but the choice must be one that can be delivered on.
• Give an example of when you have been provided with information and a choice in a health-care setting, e.g. a choice of location (“Would you like me to explain this to you here, or should we go somewhere quieter?”). Other possible choices include:
  – Would you prefer to sit here or there?
  – Would you like to speak to me or to someone else?
  – Would you prefer to be called by a specific name?
  – Would you like me to ask someone else to be here with us?
  – Would you like some water?
• Ask participants how they feel when they have been given a choice.

SLIDE 41: AVOID JARGON

Note: You may adapt this slide to better fit the circumstances where you are giving the course.

Directions:
• Explain that using jargon and medical language puts up a barrier between us and the person we are speaking to, which can cause frustration or anger to escalate.
• Ask the participants to explain the jargon below in a simple way.
• Ask the participants whether they have ever had difficulties with abbreviations or other specialist language and which expressions they think are important to translate for patients and carers.

JARGON

- Peripheral oedema
- OR (or OT)
- ECG
- Triage
- Tachycardia
- Pre/post-op
- Hypertension
- ICU
- Referral
- Idiopathic
- Ischaemic heart disease
- NPO
- Paroxysmal nocturnal dyspnoea

SUGGESTED PLAIN LANGUAGE

- Ankle swelling
- Operating room/theatre
- Test to check the heart’s activity
- Prioritizing patients’ care by the severity of their condition; also the area in the facility where patients’ needs are initially assessed
- Fast heart rate
- Before/after an operation
- High blood pressure
- Intensive care unit (for patients who need particular attention)
- Direction to get further health care outside of the facility
- Of unknown cause
- Heart is not getting enough blood and oxygen
- Not receiving any food or liquids by mouth
- Waking up breathless
SLIDE 42: WATCH YOUR BODY LANGUAGE

Note: You may adapt this slide to better fit the circumstances where you are giving the course.

Directions:
- Note that when we wear face masks, which make facial expressions harder to read, we have to pay particular attention to the rest of our body language and pair it with clear verbal communication to ensure understanding.
- Emphasize that non-verbal behaviour, such as facial expressions, gestures and posture, make up a big part of how we communicate, so it is vital to ensure your body language is not threatening.
- Ask another participant to talk through an experience at work or at home.
- While they are doing so, cross your arms and then point at them.
- Ask them how they feel.
- Ask them to repeat the experience and instead uncross your arms and do not point.
- Ask the participants what the difference is.

SLIDE 43: CONSTANTLY EVALUATE THE SITUATION

Directions: Emphasize that, while using the other behaviours, participants should keep track of whether the tension is easing. If they sense that things are not normalizing, they should excuse themselves and ask a colleague to step in.

SLIDES 44–45: EXTRA TIPS

The final slides with extra tips contain other elements that can help to manage a tense situation.

Directions: Ask the participants if they have other ideas, and ask them to note these additional points in the participant manual.
At this point you will ask the participants to return to the initial case study and think about which behaviours could be used to improve the situation and how they could be used.

Directions:
- Before the course, be sure to change the names of the characters to the names you previously used.
- Before the discussion, ask participants to think through some of the behaviours that they have just learned – try to get participants to review and discuss the various behaviours.

Notes:
- Before the course, change “Mr Z” to a name that is common where you are.
- As with the previous case study, you may use an incident that you heard about if you think it would better suit the audience – but remember to change the details to ensure anonymity.
- Ensure that the participants discuss active listening, offering choices and body language.
COMMUNICATING AND ENGAGING WITH PEOPLE

KEY POINTS
In this module, participants will learn and practise other communication skills that complement the behaviours learned in Module 3. All of the skills are essential to not only de-escalating tense situations but to having successful interactions in one's working life.

Some of the points have been addressed earlier, while others are new; the objective is to reinforce some of the behaviours that they have already learned and supplement them with others. This provides an opportunity to reflect and to consolidate learning.

Most importantly, the module shows participants how important empathy and effective communication are in everyday working life. By using these simple skills all the time, participants will likely reduce the chance of tension leading to violence.

You will need to explain the basic principles and examples to participants. Invite them to give their own examples of these behaviours. Ensure that they know that they will have a chance to practise later in the module.

Note that the sections and corresponding slides on body language (“Look”, “Incline” and “Nod”, slides 56 and 57) may need to be adapted to fit the cultural norms where you are giving the course.

This module is based on Lowry, Lingard and Neal’s model for teaching communication skills in nursing education.5

BEFORE ANY ROLE-PLAYING:
• Ensure the scenarios are suited to the circumstances. Just like with the case studies, make sure the examples fit the service and the participants. You may adjust them and/or include other scenarios in the slides based on the contextual analysis you did in advance. There are a number of scenarios you can use:
  – long wait times
  – unavailable treatment
  – unaffordable treatment
  – delayed treatment
  – bad news to be broken.
• Go back to slide 53, which lists all of the behaviours covered in this module. Ensure that everyone knows them.
• Inform the participants that there will be role play in the session.
• Share the scenarios and invite volunteers.
• Assign the roles to the acting participants (e.g. the patient, family member, health-care personnel).
• Provide five minutes for preparation before role-playing begins.
• Direct the other participants to take notes on the situation and the roles as they are being played out, as well as notes on what went well, what did not and why.
• Once each role play is over, ask the actors how they felt about the roles.

• Have the observers comment on how the situation was handled. Should it be handled in this manner? Is there another way to manage it? How would they feel if they were in these roles?

ADAPTING THE MODULE
Some of the information and role-playing scenarios in this module may need to be adapted to ensure they are culturally appropriate and relevant.

Slides 56, 57 and 59 to 63 can be edited as needed.

The rest of the slides for the module should not be edited.
MODULE 5

TAKING LEARNING BACK INTO THE WORKPLACE

KEY POINTS

This module gives participants a chance to review the behaviours they have learned and discuss some of the challenges they have encountered in using them, reflecting on the successes and challenges participants had in the role-playing exercises.

They will also learn that, by using the behaviours in their workplace, they will show their colleagues how the behaviours can help lower tension and reduce violence.

Notes:
- Encourage participants to talk about which behaviours they found difficult and which they found easy to practise.
- Ask them if they understand what they can do in various situations.
- Ensure they clearly understand when these de-escalation behaviours can be used and when they should leave as quickly as possible and activate security measures.
- The following are common challenges or concerns, along with responses you can use:
  - I found it difficult to role play.
    Don’t worry, the more you practice using the techniques (even badly) the better prepared you will be to deal with violence in the workplace.
  - I don’t understand which behaviours to use.
    The most important behaviours are giving respect, actively listening, making sure your body language is positive and being non-judgemental. Try to treat others as you would like to be treated when you seek health care.
  - I am not sure when to try to de-escalate a situation and when to call for help and extract myself from the situation.
    Leave whenever you feel that you are losing control of the situation or the person is not responding to the behaviours you are using.
- You should explain to participants that only by practising de-escalation behaviours will they become confident using them in their daily lives. It is important that as soon as they get back to work they explain and demonstrate the behaviours to their colleagues, showing how they can be used to defuse tensions.
- Re-emphasize the key point of the training course: Effective communication techniques should not just be used in the face of potential tension; they should be used all the time to improve interactions with patients and carers. As shown in the examples, specific additional action and attention might be necessary when there's tension and the possibility of violence.
- At the end of the course, give participants the evaluation form to fill in. Use the results to find out whether participants now feel more confident in their knowledge of and ability to use de-escalation behaviours at work.

Note: None of the slides in this module should be edited.
EVALUATION FORM: DE-ESCALATING VIOLENCE IN HEALTH-CARE SETTINGS

We would be grateful if you could complete this short questionnaire so that we can find out how useful the course has been. You will receive this questionnaire before the training begins, but at this stage you should only complete the section entitled “Before the course”. Once the training has finished, complete the section “After the course” and then return the questionnaire to the trainer.

Name (optional): ______________________________________________________

BEFORE THE COURSE

On a scale of one to five, rate how confident you feel in the following statements, where one is not confident at all and five is very confident.

1.1 “I know when to try to de-escalate a situation and when to take other security measures.”

1  2  3  4  5

1.2 “I know what behaviours can be used to de-escalate potential violence.”

1  2  3  4  5

1.3 “I can defuse situations of potential physical or verbal violence in my work.”

1  2  3  4  5

AFTER THE COURSE

Your knowledge of de-escalation behaviours

On a scale of one to five, rate how confident you feel in the following statements, where one is not confident at all and five is very confident.

2.1 “I know when to try to de-escalate a situation and when to take other security measures.”

1  2  3  4  5

2.2 “I understand the de-escalation behaviours taught in the course.”

1  2  3  4  5

2.3 “I can defuse potential situations of physical or verbal violence in my work using the behaviours taught in the course.”

1  2  3  4  5
Trainer’s performance
On a scale of one to five, with five being the best, please rate your trainer on the following:

3.1 Knowledge of material

3.2 Presentation and facilitation style

3.3 Ability to transfer knowledge clearly

3.4 Enthusiasm and energy

General feedback

4.1 Overall, how satisfied are you with the course? (One is not satisfied at all; five is very satisfied.)

4.2 Which parts of the course did you find most useful?

4.3 Which parts of the course could be improved, and how?

4.4 Do you have any other comments about the course?

Thank you for completing this form. Please return it to your trainer.
REFERENCES


International Committee of the Red Cross (ICRC), Violence against Health Care: Results from a Multi-Centre Study in Karachi, ICRC, Geneva, 2015.


ICRC, Specialized Mental Health Care Annex, ICRC, Geneva, 2021. (Internal access only.)


Norwegian Red Cross, Training Manual on Interpersonal Violence Prevention and Stress Management in Health Care Facilities, Norwegian Red Cross, Oslo.


The ICRC helps people around the world affected by armed conflict and other violence, doing everything it can to protect their lives and dignity and to relieve their suffering, often with its Red Cross and Red Crescent partners. The organization also seeks to prevent hardship by promoting and strengthening humanitarian law and championing universal humanitarian principles.

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