

BEFORE THE INCIDENT

*What communication skill can and cannot do about violence, complaints
and discord in health and social services*

59%

Of Canadian nurses experienced violence or abuse at work in the past year

A decision-maker's white paper

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Executive summary

In the Canadian Federation of Nurses Unions' 2025 national survey of 4,736 members, 59% reported experiencing violence or abuse at work in the past year. Of those, 82% reported verbal abuse from patients or families, 47% physical violence and 18% sexual abuse. Thirty-seven percent of nurses reported having received no workplace violence training at all.

The compensation data move in the same direction. Ontario's violence-related claims nearly tripled between 2012 and 2024, from 406 to 1,190. Manitoba's rose from 298 in 2015 to 812 in 2024. British Columbia recorded more than 1,800 health-care workplace violence claims in 2023.

This paper makes a deliberately narrow argument, because the evidence will not support a broad one: there is no randomized-trial evidence that de-escalation training reduces violent incidents—and that is true of every communication-based approach, including this one.

What the evidence does support is different and still useful. Practitioner behaviour measurably shapes client behaviour: in a meta-analysis of 36 studies and 3,025 participants, MI-consistent skills correlated with client change talk at $r = .55$, while MI-inconsistent behaviour correlated with sustain talk. A meta-analysis of 33 studies of psychological reactance found that freedom-threatening language reliably produces anger ($r = .21$), and that anger reliably reduces persuasion ($r = -.23$). Experimental work comparing an empathic with a confrontational counselling style found that the more the practitioner confronted, the worse the client's outcome a year later.

That is a mechanism, not an outcome study. The honest position for an executive is that autonomy-supporting communication is the upstream tier of a multi-tier violence prevention program—worth testing, worth measuring, and not a substitute for staffing, environmental design or security provision.

The practical conclusion

- Do not promise incident reduction. No training method—including de-escalation—has randomized evidence for it.
- Address the training gap first: 37% of Canadian nurses have had none.
- Position communication skill as the upstream tier, before formal de-escalation and security response.
- Expect and plan for the reporting artefact: better culture raises reported incidents.
- Do not present this as an alternative to staffing. Sixty-seven percent of nurses report their workplace regularly operates over capacity.

The numbers at a glance

Indicator	Latest defensible figure	Meaning for leaders
59%	Nurses experiencing violence or abuse in the past year	National survey, $n = 4,736$, 2025.
37%	Nurses reporting no workplace violence training	A coverage problem precedes any method debate.
1,190	Ontario violence-related claims, 2024	Up from 406 in 2012.
51%	PEI nurses who did not report their most recent incident	Incident counts are unreliable in both directions.
10.3%	CPSBC complaints categorized as unprofessional communication	A floor, not a total; 21.9% of all conduct complaints.

Indicator	Latest defensible figure	Meaning for leaders
67%	Nurses reporting their workplace regularly operates over capacity	The structural driver no conversation resolves.

1. The scale of the problem, measured carefully

Violence against health and social-service workers in Canada is well documented and worsening by most measures, but the figures are not directly comparable across provinces or sources, and a white paper that stacks them will be picked apart.

Provincial survey findings

Jurisdiction	Finding	Year
Canada (CFNU)	59% experienced violence or abuse; 47% physical	2025
Alberta	43% experienced physical violence, up from 37% in 2019; 70% non-physical	2024
Newfoundland and Labrador	86% of health care workers victims of workplace violence; 70% physical	2024
Prince Edward Island	88% experienced some violence; 36% more than five times; 51% did not report	2025
Nova Scotia	54.6% experienced violence or abuse; 83.3% verbal from patients or families	2025
British Columbia (BCNU)	50% experience physical violence at least monthly; 93% work short-staffed monthly	2024

Compensation claims

British Columbia’s accepted violence-related claims across all sectors rose 25% between 2018 and 2022, from 2,292 to 2,868. In health care specifically, BC recorded more than 1,800 claims in 2023: 649 among nurse aides, orderlies and patient service associates; 525 among registered and licensed practical nurses; and 471 among social and community service workers. Quebec recorded a 45.3% increase in violence-related injuries among health professionals between 2019 and 2023.

These series use different definitions—whole sector versus nursing occupations, all claims versus time-loss claims—and should be cited separately rather than combined.

The complaints picture

The College of Physicians and Surgeons of British Columbia opened 1,430 complaints in its 2025–26 year. Of these, 147 were categorized as unprofessional patient or team communication—10.3% of all complaints and 21.9% of conduct complaints. Ontario’s Patient Ombudsman received 4,886 new complaints in 2024–25, a 10% increase; emergency department complaints rose 40% since 2021–22, with recurring themes described as a lack of sensitivity, caring, courtesy and respect.

Ten percent is a floor, not a total. Communication failures are also embedded inside complaints recorded as clinical or access problems, and the Ombudsman’s emergency-department themes are communication failures filed under other headings.

2. Why the evidence here is weaker than the marketing

Any organization considering a communication-based approach to workplace violence should know what the systematic reviews actually say, because the same reviews apply to the incumbent approach.

De-escalation training: the reviews

Review	Scope	Conclusion
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Review	Scope	Conclusion
Cochrane (psychosis-induced aggression), 2017	345 citations screened; zero randomized trials found	“Appears to be accepted as good clinical practice but is not supported by evidence from randomised trials.”
Cochrane (non-psychosis aggression), 2018	One cluster-randomized study, rated very low quality	“Uncertainty remains around the effectiveness of de-escalation.”
AHRQ Comparative Effectiveness Review, 2016	Full evidence review	Strength of evidence for staff training to prevent aggression: insufficient.
Meta-analysis of training programs, 2025	10 studies	Training reliably improves staff confidence—an intermediate, self-reported outcome.
Systematic review, 2026	23 studies, 2020–2025	Integrative strategies work: training plus policy, environment, reporting and post-incident management.

The defensible framing is this: there is no randomized evidence that de-escalation training reduces violent incidents. What evidence exists supports structured risk assessment and multi-component programs in which training is one element. Training alone improves staff confidence, which is not the same as reducing harm.

That framing is not a weakness in the case for better communication. It levels the field. An MI-informed approach is not at an evidentiary disadvantage relative to the incumbent—both are supported by mechanism and practice consensus rather than by outcome trials.

3. The mechanism that is well evidenced

Where the evidence is genuinely strong is not in incident counts but in how practitioner behaviour shapes client behaviour. That research comes from motivational interviewing process studies and from experimental work on psychological reactance.

Discord is produced in the conversation, not brought to it

Motivational interviewing distinguishes sustain talk—language favouring the status quo—from discord, which is about the relationship itself and characteristically contains the word “you”: you’re not listening to me; you can’t tell me what to do. Both predict poor outcomes if they persist. Critically, both are interpersonal behaviour and highly responsive to practitioner style. Resistance can be raised or lowered by the practitioner within a single conversation.

What the process meta-analysis found

Relationship	Correlation	Interpretation
MI-consistent skills → client change talk	$r = .55$	What practitioners do strongly predicts what clients say
MI-consistent skills → sustain talk	$r = .40$	Skilled practice shapes both directions of client language
MI-inconsistent behaviour → sustain talk	$r = .16$	Directive, controlling behaviour elicits opposition
Sustain talk → worse outcome	$r = .19$	Opposition predicts failure
Change talk → better outcome	not significant	The lever is reducing discord, not manufacturing enthusiasm

Reactance is measurable

A 2026 meta-analysis of 33 independent studies and 146 effect sizes found that high freedom-threatening language produces anger ($r = .21$) and negative cognitions ($r = .17$). Anger in turn reduces persuasion ($r = -.23$). This is the empirical basis for a proposition that otherwise sounds like a matter of taste: telling people what they must do reliably makes them angrier and less cooperative.

Confrontation predicts worse outcomes

In a controlled comparison of an empathic versus a directive-confrontational therapist style with problem drinkers, the empathic condition elicited roughly twice as many problem-acknowledging statements and less arguing and interrupting. The more the therapist confronted—arguing, showing disbelief, being negative about the client—the more the client drank a year later.

Autonomy support has broad support in health contexts

A meta-analysis of 184 independent datasets found autonomy-supportive health care climates associated with basic need satisfaction, autonomous self-regulation and positive mental health, and inversely associated with negative mental health indicators. The authors describe autonomy support as both an ethical outcome in itself and a useful approach to patient welfare.

4. The honest gap

No study—Canadian or international—has directly tested whether MI training or autonomy-supportive communication training reduces workplace violence incidents, security calls or complaints in health or social services.

That gap should be stated plainly and treated as a reason to evaluate rather than a reason to hesitate. It is also the reason this paper recommends a measured pilot rather than a program.

5. Where a communication tier belongs

Workplace violence prevention in Canadian health care already has recognized tiers. The argument here is not to replace any of them but to occupy the one that is usually empty.

Tier	What it addresses	Where communication fits
Environmental and organizational	Staffing, design, working alone, security provision, flagging	Not a substitute; a legal and operational obligation
Risk assessment	Identifying likely escalation before it occurs	The only element with even low-strength evidence of effect
Upstream interaction	Discord produced by how requests, refusals and limits are delivered	This is where MI-informed practice operates
Formal de-escalation	Managing visible agitation	Existing protocols continue unchanged
Response and post-incident	Security, reporting, support, review	Communication shapes whether staff report and recover

The three moments worth training

1. Delivering a refusal or a limit. Most discord in service settings begins when someone is told no. Naming what is not negotiable, while offering a genuine choice within what is, reduces the freedom threat without softening the limit.
2. Responding to escalating language. The trained instinct is to defend or correct. The alternative—reflecting accurately, including the part that is true—removes the thing being pushed against.
3. Reopening after a rupture. Discord that is named and repaired does not compound. Discord that is ignored recurs at the next encounter, usually louder.

6. Designing and measuring a pilot

Because the outcome evidence is thin, the design has to be unusually careful about what it claims.

Suggested 90-day pilot

Period	Actions	Evidence produced
Weeks 1–2	Select one unit; baseline incidents, security calls, complaints and reporting culture	Baseline including a reporting-confidence measure
Weeks 3–4	Workshop on limit-setting, reflection and repair, using the unit's own scenarios	Initial skill assessment
Weeks 5–8	Apply in practice; coaching and debriefs after real encounters	Fidelity samples and identified escalation patterns
Weeks 9–12	Reinforce; review indicators with explicit reporting-artefact analysis	Pilot report and scale recommendation

Measurement hierarchy

Stage	Measure	Timing
Reach	Staff trained and participating; coverage of the 37% gap	Immediately
Learning	Observed limit-setting, reflection and repair behaviours	Pre/post and 30 days
Staff experience	Confidence, perceived safety, moral distress	30–90 days
Reporting culture	Proportion of incidents reported; confidence in reporting	Throughout — required to interpret everything below
Incidents	Security calls, code whites, aggression incidents, complaints	90–180 days, reported with the reporting caveat
Workforce	Sick time, turnover intention	Six months and beyond

In PEI, 51% of nurses did not report their most recent incident. An intervention that improves reporting culture will appear to increase violence. Any evaluation that cannot separate these two effects will produce a misleading answer in one direction or the other.

7. Risks and safeguards

Risk	What goes wrong	Safeguard
Incident reduction promised	Program judged against an outcome no method has demonstrated	Commit to staff experience and behaviour; report incidents descriptively
Blaming the worker	Staff hear that violence is a consequence of their communication	Frame as organizational capability; never as individual fault
Substituting for staffing	Training deployed instead of addressing capacity	State the structural drivers alongside the pilot
Reporting artefact misread	Better culture read as worsening violence	Track reporting confidence as a measure in its own right
Confidence mistaken for safety	Staff remain in situations they should exit	Pair with clear exit and escalation thresholds
Resource-depleted setting	Complex intervention cannot be implemented at all	Choose a unit with capacity to participate, not the worst-hit one

8. Recommendations for executives

1. Close the coverage gap first. Thirty-seven percent of nurses report no workplace violence training of any kind; that is a prior problem to any method debate.
2. State the evidence limits in the business case yourself, before someone else does.

3. Position the work as the upstream tier of an existing multi-component program, not as a replacement for any tier.
4. Choose a unit that has the capacity to participate. A workplace in a resource spiral cannot implement a complex intervention.
5. Measure reporting culture deliberately, and interpret incident counts only in light of it.
6. Ask staff what they were doing in the sixty seconds before the incidents that did occur. That is where the trainable behaviour lives.
7. Do not let this substitute for the employer's obligations on risk assessment, physical design, security and working alone.

Conclusion

Fifty-nine percent of Canadian nurses experienced violence or abuse at work last year. Claims are rising in every province that publishes them. And the systematic reviews say, without much ambiguity, that we do not have randomized evidence that any training method reduces the incidents.

That is an uncomfortable position for anyone selling training, and it is the reason this paper is narrower than it could be. What can be defended is a mechanism: discord is produced within conversations and is highly responsive to how the practitioner behaves; controlling language reliably produces anger; anger reliably reduces cooperation; and confrontation predicts worse outcomes a year later.

The proposition is modest. Some proportion of the incidents that reach a security call began as a refusal delivered badly, a concern dismissed, or a limit set in a way that left the person nothing to hold onto.

That proportion is unknown. It is also measurable, by one unit, over ninety days, with an honest reading of what the numbers mean. An organization that runs that test will know more than the published literature currently does—and more than it knows today.

References

1. Canadian Federation of Nurses Unions. (2025). CFNU National Nurses Survey. https://nursesunions.ca/wp-content/uploads/2025/03/CFNU-Member-Survey-Report_March-25_final-65.pdf
2. Canadian Federation of Nurses Unions. (2025). Violence Against Nurses in Canada: An Urgent Call to Action. https://nursesunions.ca/wp-content/uploads/2026/03/HMM25-WhitePaper_EN_Web.pdf
3. BC Nurses' Union. (2025). A Growing Crisis. Update Magazine, Spring 2025. <https://www.bcnu.org/news-and-events/update-magazine/2025/spring-2025/growing-crisis>
4. WorkSafeBC. (2023). WorkSafeBC reminds employers of their obligation to reduce violence in the workplace. <https://www.worksafebc.com/en/about-us/news-events/news-releases/2023/March/worksafebc-reminds-employers-their-obligation-reduce-violence-workplace>
5. Global News. (2024). B.C. logged more than 1,800 health-care workplace violence claims last year. <https://globalnews.ca/news/10897809/workplace-violence-healthcare/>
6. Association of Workers' Compensation Boards of Canada. (2023). National Work Injury, Disease and Fatality Statistics, 2020–2022. <https://awcbc.org/files/publications/National-Work-Injury-Disease-and-Fatality-Statistics-2020-2022.pdf>

7. SafeCare BC. (2026). Injury Statistics and Trends. <https://safecarebc.ca/topic/injury-statistics-trends/>
8. College of Physicians and Surgeons of British Columbia. (2026). Annual Report 2025/26. <https://www.cpsbc.ca/files/pdf/2025-26-Annual-Report.pdf>
9. CP24. (2025). Patient complaints on the rise in Ontario, ombudsman says. <https://www.cp24.com/local/2025/11/13/patient-complaints-on-the-rise-in-ontario-ombudsman-says/>
10. Patient Care Quality Review Boards (British Columbia). (2021). Annual Report 2019/21. <https://www.patientcarequalityreviewboard.ca/pdf/pcqrb-annual-report-2019-21.pdf>
11. Canadian Institute for Health Information. (2025). Health workforce: overtime and staffing challenges in hospitals. <https://www.cihi.ca/en/health-workforce-overtime-and-staffing-challenges-in-hospitals>
12. Statistics Canada. (2025). Canada's health workforce: regional vacancy trends, 2024. <https://www.statcan.gc.ca/o1/en/app/8775-canadas-health-workforce-regional-vacancy-trends-2024>
13. Du, M., et al. (2017). De-escalation techniques for psychosis-induced aggression or agitation. Cochrane Database of Systematic Reviews, CD009922. https://www.cochrane.org/evidence/CD009922_de-escalation-techniques-psychosis-induced-aggression-or-agitation
14. Spencer, S., Johnson, P., & Smith, I. C. (2018). De-escalation techniques for managing non-psychosis induced aggression in adults. Cochrane Database of Systematic Reviews, CD012034. https://www.cochrane.org/evidence/CD012034_using-de-escalation-prevent-violence-aggressive-people
15. Gaynes, B. N., et al. (2016). Strategies to De-escalate Aggressive Behavior in Psychiatric Patients. AHRQ Comparative Effectiveness Review No. 180. https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/aggression_research.pdf
16. Jaspers, S., Karlsen, I., & Aust, B. (2025). Workplace violence: a complex challenge demanding a systemic response. *Scandinavian Journal of Work, Environment & Health*, 51(5), 349–354. <https://www.sjweh.fi/article/4249>
17. Miller, W. R. (2023). The evolution of motivational interviewing. *Behavioural and Cognitive Psychotherapy*, 51, 616–632. https://motivationalinterviewing.org/sites/default/files/the_evolution_of_motivational_interviewing.pdf
18. Magill, M., et al. (2018). A meta-analysis of motivational interviewing process. *Journal of Consulting and Clinical Psychology*, 86(2), 140–157. https://www.appa-net.org/eWeb/docs/APPA/standards/A_Meta-Analysis_of_Motivational_Interviewing_Process.pdf
19. Miller, W. R., Benefield, R. G., & Tonigan, J. S. (1993). Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology*, 61(3), 455–461. https://findings.org.uk/PHP/dl.php?f=Miller_WR_6.txt
20. Li, Z., & Shi, J. (2026). Message effects on psychological reactance: meta-analyses. *Human Communication Research*, 52(1), 38–52. <https://academic.oup.com/hcr/article/52/1/38/8178818>
21. Ng, J. Y. Y., et al. (2012). Self-determination theory applied to health contexts: a meta-analysis. *Perspectives on Psychological Science*, 7(4), 325–340. https://selfdeterminationtheory.org/SDT/documents/2012-NgNtoumanis_PPS.pdf
22. Schwalbe, C. S., Oh, H. Y., & Zweben, A. (2014). Sustaining motivational interviewing: a meta-analysis of training studies. *Addiction*, 109, 1287–1294. <https://media.wcupds.wisc.edu/website-docs/wcupds/resources/motivational-interviewing/Sustaining-Motivational-Interviewing-A-Meta-Analysis-of-Training-Studies.pdf>

About the author

Brittany Godin works with health and social-service organizations on the communication skills that determine whether good intentions become completed care. Through Compassion Campus she teaches and coaches motivational interviewing as an operational capability—built through practice, observation and feedback rather than delivered as a one-time workshop—and helps leaders design pilots that test whether better conversations actually change what happens next.