Table 3 – Studies on Conflict

Study	Setting: Country	Design	Total sample size (N)	Sample characteristics	Variables measured; outcomes measures; outcome tool	Primary finding (s)	Quality assessment score (%) and categorisation
Bowers et al. (2015)	Acute psychiatric wards within 15 hospitals (chosen at random) in the South East of England.	Cluster randomised control trial. Safewards compared to control group (staff physical health program).	N= 31 (wards)	Modal age group of staff was 40-49 years (33.7%), 59.4% of whom were female and 28.4% white British.	Total rates of conflict and containment, measured by the PSCC. APDQ; SHAS; WAS: SF	Relative to control, Safewards reduced rates of conflict events by 15% (95% CI 5.6-23.7%), p= <.01 No significant different in the rates of zero event shifts for conflict.	83% High
Dickens et al. (2020)	Eight adult mental health inpatient units from one large metropolitan local health district in Sydney, Australia.	Repeated measures within-subject design: pre and post. No control group.	N = 8 (wards)	Not provided	PCC-SR; VPC-14. Recording of ward characteristics including number of beds and ward function (acute versus non-acute service).	The mean (SD) reported conflict incidents per shift fell from 3.96 to 2.94 (4.22). Controlling for other variables, this represented reductions of 23.0%. Violence prevention climate ratings did not change. Conflict rates largely mirrored the acute/non-acute ward function, where rates of were higher on acute wards overall.	81% High
Fletcher et al. (2019a)	Inpatient mental health wards (adult, adolescent/youth, aged acute an secure extended care units) in Victoria, Australia.	Cross-sectional post intervention survey design. No control group.	N= 10 (wards)	Majority consumers were representative of adult inpatient wards, mean age = 40 years (range 18-78). 52% female. Average length of stay ranged from 1-4 weeks.	Bespoke online survey including demographic data followed by both quantitative and qualitative questions regarding the acceptability, applicability and impact of Safewards.	Quantitative results demonstrated that consumers felt Safewards had a positive impact on physical and verbal conflict, 25% of responses answering 'usually' or 'always'. No analysis of significance was conducted.	63% Moderate

Davies et al. (2020)	Acute assessment and treatment unit for people with intellectual disabilities in South Wales, UK.	Mixed methods design: repeated measures (pre and post) and qualitative feedback. No control group.	N = 15 (service-users)	Not provided	PCC-SR.	Significant reductions overall post-intervention for aggression (z= -6.526, p< 0.01), absconding (z = -2.171, p <0.05), and medication-relation behaviours (z= -2.085, p<0.01). Nine out of 31 sub-questions on the PCC-SR showed significant reductions between time one and time two. Qualitative feedback did not relate to the effectiveness of the model on conflict, containment or ward climate.	54% Moderate
Fletcher et al. (2019b)	Inpatient mental health wards (adult, adolescent/youth, aged acute and secure extended care); Victoria, Australia.	Cross-sectional postintervention survey design. No control group.	N= 103 (staff responses)	Majority female staff (68.4%), mean age of 43 years with each type of service represented. 55% of participants were in nursing in some capacity.	A bespoke online survey with both quantitative and qualitative questions designed to assess staff perceptions of acceptability, applicability and impact, analysed using thematic approach.	Overall quantitative results showed staff felt Safewards positively impacted physical and verbal conflict 'usually' or 'always.	54% Moderate
Maguire et al. (2018)	Male forensic medium-long term mental health ward in Victoria, Australia.	Mixed methods; repeated measures within subjects (pre and post). Retrospective comparison to TAU.	N = 28 (unique service users)	Mean age of 44.3 years. 100% were male. Primary diagnoses were schizophrenia and schizoaffective disorder. Average length of stay was 8.3 years. Mean age of staff was 47.8 years.	Incident data was retrieved from the Victorian Health Incident Management system (VHIMS) and compared with incident data from the year prior. Ward climate was assessed using the EssenCES. Content analysis used to evaluate free-text answers in the fidelity checklist to elicit patient and staff experiences of Safewards.	Reported conflict incidents (attempted absconding, substance use, self-harm, medication refusal, verbal aggression, physical aggression, property damage) reduced in the year in which Safewards was implemented, with 65 fewer events. No analysis of statistical significance was undertaken due to size of dataset. Qualitative data indicated that participants were of the view that Safewards improved conflict rates and that there were less incidents following the introduction of the intervention.	54% Moderate

Price et al. (2016)	Six wards within a regional medium secure forensic unit in the UK.	Service evaluation using a non-randomised controlled design, repeated measures between and within subjects. Control group received TAU.	N = 61 (service-users)	Intervention sample consisted of: One 16 bed male acute ward, one nine-bed female acute ward, and a four-bed female acute ward. Control wards comprised of: Two, ten-bed make acute wards and one 12-bed female acute ward.	PCC-SR was used to measure conflict and containment. Staff feedback was collected through individual and group meetings.	Between-ward analysis indicated no statistically significant benefit of Safewards compared to control wards. Conflict reduced in intervention wards (non-significant). A significant relationship was found between ward and conflict. Staff feedback was mixed- no formal analysis of feedback was conducted but the dominant view was that staff did not deem the Safewards interventions to be effective for conflict and containment rates on the male wards.	38% Low

PCC-SR = Patient Staff Conflict Shift Report; PSCC = Patient Staff Conflict Checklist (Bowers et al., 2005); APDQ = Attitudes to Personality Disorder Questionnaire (Bowers & Allan, 2006); SHAS= Self-harm Antipathy Scale (Patterson, Whittington, & Bogg, 2007); Ward Atmosphere Scale (Moos, 1996); SF-36v2 short form health survey (Ware Jr, 2000); EssenCES = Essen Climate Evaluation Schema Questionnaire (Schalast, Redies, Collins, Stacey, & Howells, 2008); VPC-14 = Violence Prevention Climate-14 (Hallett et al., 2018).