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Development of Custodial Staff Modifiers for Safewards Secure-Custodial Mental Health

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Correspondence: Tessa Maguire (tjmaguire@swin.edu.au)**Received:** 15 April 2026 | **Revised:** 28 August 2026 | **Accepted:** 30 September 2026**Keywords:** conflict | containment | forensic mental health nursing | mental health | prisons | Safewards

ABSTRACT

Safewards is a nursing model of care designed for acute mental health inpatient units. Since inception, the model has gained popularity in many countries and has been implemented in settings other than mental health. A version for bed-based mental health units within prisons has also been developed to assist nurses working in this complex setting called Safewards Secure-Custodial Mental Health. A previous study identified that modifiers (things staff can do to prevent conflict and containment) were needed for custodial staff to finalise the prison model. The aim of this study was to develop custodial staff modifiers for the adapted model known as Safewards Secure-Custodial Mental Health. To inform the modifiers a literature review was first conducted. A Nominal Group Technique was then used to seek feedback and reach consensus on the proposed custodial staff modifiers. Participants ($n = 15$) included custodial officers, forensic mental health nurses, allied health and lived experience workers. Consensus was reached on the custodial staff modifiers after suggestions from the NGT were incorporated. Data were thematically analysed and three themes were interpreted: (1) Complexity with clashes in paradigms (custodial versus clinical); (2) You are a 'Care Bear': Ostracised for demonstrating care and concern; (3) Meeting in the middle (to work collaboratively). There was support for the implementation of Safewards Secure-Custodial Mental Health. Future research should consider the interventions for the custodial model with reference to contextual factors in a prison setting.

1 | Introduction

Bed-based prison mental health units are designed to provide specialist forensic mental health (FMH) care in a prison setting and are staffed by clinical and custodial staff. This is a relatively unique approach, as many prisons tend to have in-reach mental health services provided by external forensic mental health service providers. Forensicare provides specialised, voluntary mental health care within Victorian prisons, providing services from mental health assessment on arrival to prison, acute care in dedicated mental health units, out-patient clinics, care in rehabilitation units, and support for

community transition (Forensicare 2026). It is important to note that by voluntary mental health care, this means that the person is not under mental health legislation, so they can refuse mental health treatment while in prison, and in order to be treated against their will, they would need to be placed under mental health legislation and transferred to a forensic mental health inpatient service to receive treatment. The service has a recovery-oriented model, which is intended to deliver care equivalent to community mental health services with a focus on early intervention, inpatient treatment, rehabilitation, and assisting people within the prison with serious mental illness to live meaningful lives and prevent recidivism.

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Under this model forensic mental health staff and custodial staff work together on the unit (Foreniscare 2026). There are unique challenges to the delivery of mental health care in a prison setting. These challenges are a mix of personal challenges for the individual (such as co-morbidity, psychosocial stressors and the psychological toll of being in the prison setting) and environmental challenges (related to lack of autonomy and freedom, the structure, legislative limits and inherent restrictions present within a prison; Mazher and Arai 2025; Simpson and Jones 2018).

Mental healthcare in prison needs to be provided in a way that facilitates a coordinated response to complex needs and be able to provide continuity of care as individuals transition to the community (Davidson et al. 2020). It is also important that clinical and custodial staff have a working partnership to ensure safe and effective delivery of care (Maguire et al. 2025). This, however, can be difficult in a custodial setting due to differences in priorities. Custodial staff are primarily focused on maintaining the 'good order' of the prison to maintain safety and security (Maguire et al. 2021; Schaefer 2018). Whereas clinical staff are primarily focused on the provision of therapeutic care. This can prove challenging for clinical staff as they must provide care within the boundaries of custodial restrictions and operational requirements (Calabrò et al. 2023). Working within a prison setting can also result in conflict for clinical staff between the role of providing care and the values and priorities of corrections (Cashin et al. 2010). This in turn can influence clinical staff's perceptions of caring and providing quality patient care (Cukale-Matos and Champion 2022). In this context, having a shared model of care that can assist in understanding the setting and challenges may enhance health and custodial staff working together in seeking to address some of the challenges.

1.1 | Safewards

Safewards was developed in the United Kingdom as a model of care designed to prevent and address conflict and containment in acute mental health inpatient units (Bowers 2014). In the model, conflict refers to events that occur in the inpatient setting that threaten the safety of staff and patients, such as verbal and physical aggression. Containment refers to the actions staff take to prevent or minimise the impact of conflict, including the use of restrictive practices such as seclusion (Bowers et al. 2015). The model contains six domains where conflict can arise (Regulatory framework, patient community, patient characteristics, outside hospital, physical environment and staff team domain). Each domain includes flashpoints (situations that can lead to conflict), staff modifiers (actions staff can take to reduce conflict) and patient modifiers (things patients can do that can reduce conflict; Bowers 2014). To assist with reducing conflict and containment, the Safewards Model has a set of interventions (calm down methods, know each other, discharge messages, clear mutual expectations, mutual help meeting, talk down, positive words, soft words, bad news mitigation and reassurance) designed to address the source of conflict and focus on developing a therapeutic milieu and empowering patients (Simpson and Brennan 2024; Ward-Stockham et al. 2024). Since the initial randomised controlled trial, Safewards has been

implemented across many different countries and implementation has resulted in reductions in conflict and containment (Simpson and Brennan 2024). It is also important to note that while Safewards has resulted in reductions in conflict and containment in some studies, these results have not been consistent across all studies investigating the implementation of Safewards (Finch et al. 2022).

1.2 | Safewards Secure

Safewards has also been implemented into secure FMH settings; however, the impact on conflict and containment is equivocal. Concerns were identified related to a lack of focus on inherent challenges in FMH settings (such as the presence of offending behaviour, long term admissions, transfer back to prison services, and long-term therapeutic relationships) which have resulted in the development of an adapted version for FMH services (Cabral and Carthy 2017; Karlsson et al. 2025; Maguire et al. 2025; Price et al. 2016). The adapted version, Safewards Secure, was developed by engaging FMH clinicians and the lived experience workforce who had knowledge of the Safewards model and cross-checking suggestions against evidence in the literature (Maguire et al. 2022, 2023). The evolution of the original model for FMH settings has led to consideration that an adapted version for prison settings might also be effective in reducing conflict and containment in bed-based prison mental health units. This resulted in the development of Safewards Secure-Custodial Mental Health, using a similar process to Safewards Secure. To develop this version, Maguire et al. (2025) recruited FMH clinical staff and lived experience experts to reach consensus on the features, flashpoints, staff modifiers, and patient modifiers for the six domains. It emerged from this study that Safewards Secure-Custodial Mental Health required the inclusion of custodial staff modifiers, given their role within the prison mental health units and the influence they have on the unit and patient care (Maguire et al. 2025). Against this background, the current study was designed to develop custodial staff modifiers for the Safewards Secure-Custodial Mental Health model.

2 | Methods

This study used the Nominal Group Technique (NGT) to engage nurses and allied health, members of the lived experience and peer workforce, and custodial staff to develop custodial staff modifiers for the Safewards Secure-Custodial Mental Health model. The NGT is a method that can be used to gain feedback and attain consensus (Søndergaard et al. 2018), and in this study consensus was being sought about the proposed custodial staff modifiers. Figure 1 provides an outline of the steps taken to reach consensus on the custodial staff modifiers for the Custodial Mental Health version of Safewards Secure. The current study uses EQUATOR network recommendations for qualitative research (Tong et al. 2007).

First a literature review using Boolean terms and MeSH headings was conducted to inform the custodial staff modifiers. Key search terms were used from the original Safewards study to determine the evidence for custodial staff modifiers in addition to the following search terms: (custodial staff) OR (correction*

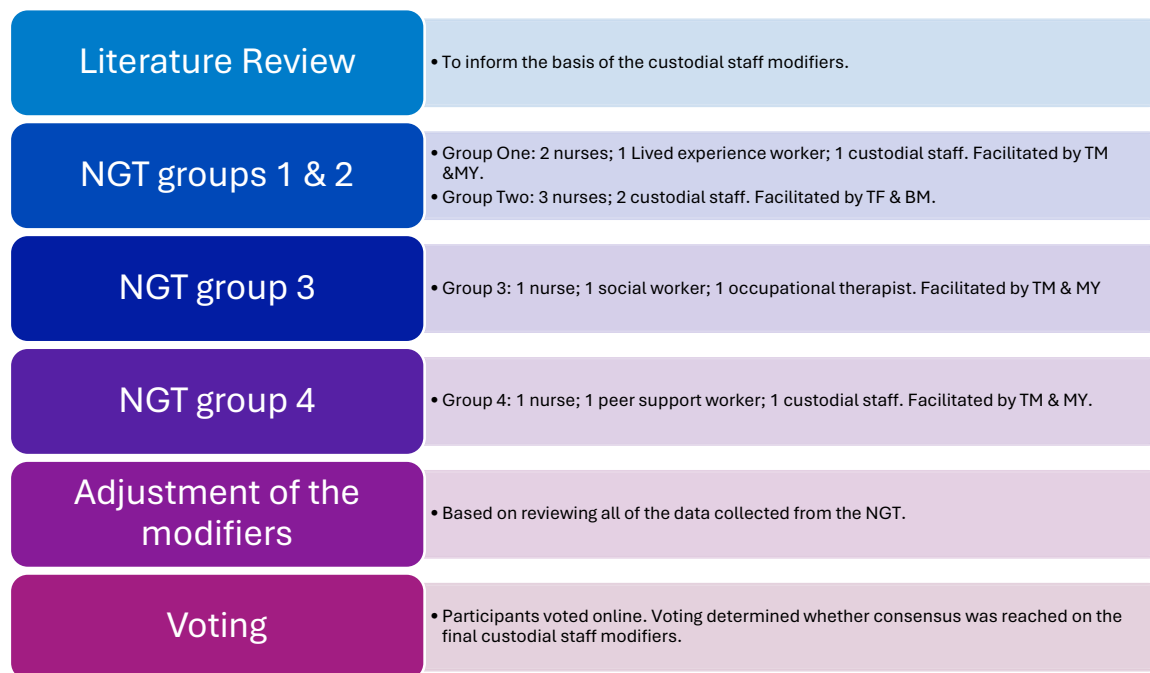


FIGURE 1 | Method.

staff) OR (prison staff) OR (prison guards) OR (custodial officer) OR (correction* officer) OR (prison officer) AND (conflict) OR (containment) OR (restrictive intervention) OR (aggress*) OR (suicid*) OR (self-harm) OR (abscond*) OR (seclusion) AND (prison mental health unit). A list of terms of interest was developed while screening abstracts and titles. Articles were downloaded based on abstract screening relevance. All full text papers were read, annotated and notes were taken. The evidence from the review was then summarised and tabled in a document supplied to participants in advance of the NGT and used to structure and guide data collection. Participants were requested to read the literature review summary prior to their NGT.

Although a NGT usually has four steps, some modifications to the process were made for this study as it was not possible to engage all the participants online at the same time. This was due to (1) the challenge of bringing together staff who work across two different organisations and (2) the need to limit the size and duration of the NGT (due to the limited time able to be devoted to involvement by custodial and clinical staff). The size of a NGT is typically around four to seven; however, there are some studies that report between two and fourteen (McMillan et al. 2016; Vahedian-Shahroodi et al. 2023).

The NGTs were run across four different groups of participants using three steps. The first large group was divided into two, and groups three and four were conducted separately at a time that suited the participants (see Figure 1). TM and BM are experienced FMH nurses and researchers. MY and TF are experienced researchers in FMH settings. All have extensive qualitative research experience, including experience conducting NGTs. Before the commencement of each NGT, an overview was provided to participants to explain the NGT process and a summary was given of how the draft custodial staff modifiers were developed, and the intent of the Safewards Secure-Custodial Mental Health model.

The three steps during the NGT were as follows: (1) the silent generation of ideas (participants were asked to type their thoughts about each custodial staff modifier into the direct message function on Zoom); (2) each participant then shared their ideas on each domain as the anonymous responses were read aloud and discussed as a group; and (3) clarification of the ideas. The NGTs all lasted approximately 1 h online using Zoom.

Written and verbal data were read, analysed and incorporated into the custodial staff modifiers before being presented back to all participants for voting. An online survey platform, Qualtrics, was used for the voting stage of the process. Participants were invited via email and asked to vote 'yes' or 'no' to whether they agreed with the inclusion of each custodial staff modifier in the final model.

2.1 | Setting

Zoom was used to connect with the participants in this study. The direct message chat function on Zoom was used to ensure that responses were anonymous. Participants directly messaged either MY (for groups one, three and four) or TF (group two). For each question in the NGT, MY and TF copied and pasted all responses onto a PowerPoint document. For stages 2 and 3 of the NGT, a PowerPoint slide (with all the anonymous responses) was shared with the group to facilitate discussion. When the participants were invited to vote, they were sent a link via email to a Qualtrics survey. Voting was also anonymous.

2.2 | Participants and Recruitment

Purposive sampling was used for this study. We sought to recruit custodial officers who had experience working with

people in prison who experience mental ill health (referred to henceforth as 'patients'). To ensure sufficient feedback about the proposed modifiers, nurses, allied health and lived experience staff from Forensicare who had 5 or more years' experience working in bed-based mental health prison units or were employed as peer support and/or lived experience workers and had some knowledge of Safewards or Safewards Secure, were also recruited. The 5 or more years of experience requirement was to ensure participants had ample experience working in a prison setting and a detailed understanding of the role of a custodial officer. It was considered important to include nurses, as the model was designed as a nursing model of care, however we also included the other staff as they also have an important role in bed-based mental health units working with nurses and custodial officers.

The custodial officers were sent an email about the study and were asked to email TM if they were interested in participating. A list of Forensicare staff who met the inclusion criteria was sent to TM by one of the senior nurses working across the prison services. TM then sent an email detailing the study and interested staff were asked to email TM to indicate their interest. Consent was provided using electronic consent forms and participants were asked to return signed consent forms by email to the researchers before the NGTs commenced.

2.3 | Data Collection

Data were collected via the NGT and voting. During the NGT, verbal and written text were collected. Each NGT was facilitated using the same question guide, which asked participants to reflect on the proposed custodial modifiers for each of the six domains. Stages two and three of all NGTs were audio-recorded and transcribed. All typed feedback during the silent generation of ideas was also collected; participant responses to each question were cut and pasted onto prepared PowerPoint slides with the corresponding question written at the top.

2.4 | Data Analysis

All data collected (verbal and text) were analysed using the six-stage approach recommended by Braun and Clarke (2019). In phase one (becoming familiar with the data), TM listened to the recordings several times to ensure the transcripts were an accurate record of the discussions, while simultaneously creating notes. In phase two, two researchers individually created codes by identifying similar statements and assigning appropriate codes. In phase three, TM and MY then searched for themes by producing thematic maps on a word document. Phase four comprised a review of the early themes by all members of the research team, which resulted in additional analysis and modifications. Phase five defined and named themes. This phase involved a team review and TM returning to the transcripts to make certain coding supported the suggested themes, which resulted in the final defining and naming of the themes. Phase six involved drafting the results included in this manuscript. Quantitative data from the votes was totalled by counting the votes received for each of the custodial staff modifiers.

2.5 | Rigour

To ensure rigour in this study, a reflexive and methodical study design was used. We sought participants who had appropriate experience working in the proposed setting for the model, to ensure they had the requisite knowledge to answer the research questions. The study was planned and carried out by experienced forensic mental health nurse researchers (TM, BM) in conjunction with researchers with experience conducting research in FMH settings and knowledge of Safewards. Revision of the NGT transcripts alongside the audio-recordings ensured the transcripts were an accurate reflection of the discussions in the NGT. This was also complemented with the text comments collected. Data analysis was conducted collaboratively.

2.6 | Ethical Considerations

Ethical approval to conduct this study was granted by the Swinburne University Human Research Ethics Committee; Project ID: 8399. Access to Forensicare and to include Forensicare staff was granted by the Forensicare Operational Research Committee. All ethical requirements were met by the researchers. Confidentiality was maintained via de-identifying data and appointing numbers to participants as identifiers. To differentiate verbal responses from text, the letter 'P' for participant has been used to code participants in the NGT, and the letter 'G' for group (one, two, three and four) was used to code text responses created in the silent generation of ideas.

3 | Results

A total of 15 people attended across the four NGTs. Seven of the participants were nurses, four were custodial officers, two were peer support/lived experience workers, one occupational therapist and one social worker. The NGT provided a systematic method to develop the custodial staff modifiers and reach consensus via voting. The data generated from the NGT were used to develop the custodial staff modifiers in the Safewards Secure-Custodial Mental Health model and three themes were interpreted from these data. Data are presented as themes generated from the NGT, outcomes of voting, and the finalised custodial staff modifiers.

3.1 | Themes

Three themes were interpreted from the data: (1) Complexity with clashes in paradigms (custodial versus clinical), (2) You are a 'Care Bear': Ostracised for demonstrating care and concern, and (3) Meeting in the middle (to work collaboratively).

3.1.1 | Theme One: Complexity With Clashes in Paradigms (Custodial Versus Clinical)

The first theme reflects the challenges faced by custodial and clinical staff while working in the same environment with different mandates. FMH staff work within a model of care that emphasises

holistic, person-centred care for patients with serious mental illness within the bed-based prison unit. In contrast, custodial staff are responsible for maintaining safety, security and order in the prison, while also contributing to rehabilitation efforts. However, the prioritisation of safety and security by custodial staff often supersedes other considerations, as illustrated in the following quote:

When it comes to the custodial side, it always falls back to the safety and security for us being paramount and the level of care then is taken over by the alternate side so it's clear and defined in that sense. There will never be a falter from the custodial side to lapse on security when we see the risk. So that'll always be a sticking point potentially.

(P1)

Participants acknowledged the differences in priorities and goals between custodial staff and FMH staff, and how these differences can have a negative impact on the working relationships within the environment.

When it comes to the custodial staff's goal. it's different, even though we all work towards the same goal, but it's slightly different. So, the trust, trust can be actually a tricky word in the space of custodial work and it can be used differently in that space.

(P1)

I often think there's a joint goal of improved safety on the unit, but the different perspectives on how to achieve this is the cause of tension between the two.

(G3)

The differences in paradigms were seen to result in confusion and tension at times between the two parties. Some of this tension is around what information clinical staff can and cannot share and differences in what is considered to be risk and safety depending on if you are clinical or custodial staff.

I guess about the shared definition of risk and safety in this space. Among the clinical and the custodial perspective, there can be a divergence. When we talk about working towards safety, sometimes that means something different between the two groups. I wonder how this can sometimes impact the working relationship as well.

(P3)

The clinical staff come with a different way of managing it (safety for patients) and that's where the correctional policies are a little bit different from the clinical. That can be a bit confusing sometimes.

(P4)

This is a real source of friction in the working relationship, around the sharing of risk information and not to be too abrupt, but I think sometimes it

comes across like it is very much a one-way street, with custodial staff informing and helping.

(P3 FMH staff member)

Differences were also highlighted in the relationships between custodial staff and patients and FMH staff and patients, and how these differences are viewed depending on your role. Participants spoke about the level of disclosure that was considered appropriate depending on your role and the prioritisation of maintaining boundaries to ensure safety within a bed-based prison unit.

Nurse patient relationship versus custodial officer and prisoner relationships are different. For example, sharing something personal may contribute to building a therapeutic rapport with a nurse, but maybe seeing a breach of security or safety for a correctional staff member.

(G1)

One participant gave an example that demonstrated the stark difference in the relationships, when a patient made 'a really innocent comment about my shoes' (P2) which resulted in her being cautioned by custodial staff, and told to document the incident in case they were being 'groomed'. The differences in the relationships left some participants pondering how and if, custodial staff would be able to change their limits in terms of self-disclosure with patients when implementing a model such as Safewards Secure Custodial Mental Health. These discussions highlighted the importance of having separate FMH staff and custodial staff modifiers, and that implementing a blanket approach to all staff would not be appropriate or safe in a prison setting.

This theme emphasises that although FMH and custodial staff in bed-based prison units work in the same environment and share some of the same goals, such as ensuring safety and providing care for patients, their roles remain distinctly different. This theme highlights the importance of having separate sets of custodial and FMH staff modifiers given the different paradigms and ways of working.

3.1.2 | Theme Two: You Are a 'Care Bear': Ostracised for Demonstrating Care and Concern

The expression of caring, empathy, and in some cases working to aid someone's distress are sometimes met with criticism by others within the custodial setting. This was true for custodial and FMH staff participating in this study. Participants reflected on times when they had tried to comfort and show compassion for patients when they were experiencing distress and how this was met with criticism and in some cases resulted in the staff member being ostracised:

Staff are also ostracised by fellow staff if they are showing that caring empathetic side to a person that's in high distress saying, oh my god, you're a Care Bear. Unfortunately, we've still got that.

(P5)

You're seen as going above and beyond for that person. Hang on, I'm just looking after that person as a human.

(P1)

As a peer worker. It is wild just how judged I get, because my boundaries are so, so, different. And the looks you get from custodial staff and even FMH staff.

(P6)

In some instances, demonstrating care when someone is in distress may be seen as going outside professional boundaries, as opposed to providing support for someone in genuine distress.

I got ostracised (FMH staff), I got talked about behind my back because there was a woman in distress and I'm like, it's okay. She was physically throwing up and I'm like, it's okay you can breathe through this, and I've got the doctors coming, but I was still ridiculed and ostracised because of my actions on that day. I had been perceived as overstepping my level of care for that individual when they were in great distress.

(P5)

Participants were cognisant that the Safewards Secure custodial staff modifiers are focused on a person-centred approach to everyday work within a bed-based prison mental health unit. This is a considerable shift from traditional officer practice, where the expression of care and concern is not accepted practice, as officers are trained to 'be very sensitive about any kind of personal conversations' (P2) with patients, and in this context the proposed modifiers may challenge custodial staff practice and be met with resistance.

3.1.3 | Theme Three: Meeting in the Middle (To Work Collaboratively)

The final theme reflects the optimism of the participants when thinking about Safewards Secure-Custodial Mental Health, in that there is a way forward which could be achieved by meeting somewhere in the middle to work collaboratively.

Some of the comments have prompted me to think there's some opportunities to bring custodial staff input into some of our assessment work and to value and respect their perspective on the basis they probably have more interaction and involvement with the people that we work with, than we do. I think there's a really nice opportunity here to demonstrate some respect and curiosity about their perspective in informing the work that we do.

(P4)

There was acknowledgment that enhanced communication and clarity around goals and treatment may assist the two parties to work together more effectively, which may be further assisted with working protocols on confidentiality.

There may be benefit of a formalized protocol around the way clinical and custodial staff work together, that would consider the limitations of confidentiality.

(P3)

Ensuring good communication of relevant information both ways between custodial and clinical staff, supports both teams to ensure a good standard of care. We don't often see things that custodial staff may observe in their work with patients, which can help inform our assessments and treatment.

(G3)

There was a sense that a lot of work is underway to work towards changing the culture in the prison setting, towards a more supportive manner of practice. As an example, there have been projects undertaken with custodial staff to focus on building rapport, being respectful and focusing on reinforcing positive behaviour, which aligns with the priorities and practices core to Safewards Secure-Custodial Mental Health.

Most of them [custodial staff modifiers] are completely relevant and connect to multiple areas of work that are currently underway.

(G1)

However, it was also acknowledged that 'It is achievable, but there is a mountain of work to have an entire workforce behind it in such a punitive environment' (G1). The responses from the NGT suggested that the custodial modifiers presented are appropriate, but a lot of work will need to be done to implement these modifiers, and the Safewards Secure-Custodial Mental Health model more generally. Specifically, how the model is presented at an organisational and individual level in custodial settings to achieve buy in and ensure successful implementation.

I wholeheartedly believe in all of the modifiers listed here, but I think there's something about how we build a culture of prioritising these modifiers that's not condescending or not us (FMH staff) taking some kind of higher ground... just being careful that we don't inadvertently suggest to custodial staff that they're kind of getting it wrong.

(G3)

It feels like a long game to me. There will need to be a cultural shift for a lot of the modifiers to be prioritised and adopted fully.

(G3)

TABLE 1 | Custodial staff modifiers: Pre and post NGT.

Pre NGT	Post NGT
Patient Community Developing positive interpersonal relationships to ensure safety and autonomy-supportive communication style	Developing positive interpersonal relationships to ensure safety and wellbeing. Using a communication style that establishes clear boundaries whilst acknowledging and validating the patient's feelings
Patient Characteristics Building trust, being respectful and focusing on reinforcing positive behaviour. Demonstrating emotional safety and well-being practices and communication skills during routine contact. Engaging in training to better identify signs of and work with suicidal or self-harm intent. Caring beyond a duty of care	Building rapport, being respectful and focusing on reinforcing positive behaviour. Listening to and validating patients' experiences. Being aware of signs of deterioration and suicidal or self-harm intent and working with FMH staff to address needs. Applying humanity within the limits of forensic responsibility and boundaries
Regulatory Framework Providing information and explanations about individual rights and the legal system to demystify the justice system, rules and boundaries and roles	Providing information and explanations about individual rights and the custodial system to assist in understanding rules, boundaries and roles, or providing referral to or contact with an appropriate professional who can (e.g., lawyer or Aboriginal liaison officer). This may involve providing information to family, carers and supporter
Staff Team Effectively communicating with clinical staff to ensure coherency in goals and priorities and continuity of care. Collaborating with clinical staff to contribute to assessment, monitoring and treatment of patients	Effectively communicating with FMH staff to ensure coherency in goals and priorities and continuity of care. Collaborating with FMH staff to contribute to assessment, monitoring and treatment of patients, whilst maintaining correctional policies
Physical Environment Provision of activities and opportunities that resemble outside living, to promote autonomy and responsibility	Provision of activities and opportunities that resemble outside living, to promote autonomy and responsibility as much as practicable within the setting
Outside FMH Unit Encouraging and assisting maintenance of relationships to family/children/carer/supporters outside prison	Encouraging and assisting maintenance of relationships with family/children/carers/supporters outside the FMH unit where appropriate. Facilitating engagement with culturally appropriate support

This final theme emphasises that whilst FMH and custodial staff have distinct roles and differing priorities, their work must complement one another to achieve unity within the setting. Participant responses suggest that rigidity within both groups can hinder collaboration, highlighting the importance of meeting in the middle.

3.2 | Finalising the Model

Table 1 contains the custodial staff modifiers for each of the six domains. The modifications were made based on the suggestions from the participants in the NGT and the suggestions were collected via verbal and written data. The first column is the modifier as it was presented to participants prior to the NGT, and the second column shows the final version of the modifier with participant suggestions implemented.

3.3 | Voting

Participants voted on the final custodial staff modifiers via an online Qualtrics survey. Participants were asked to 'Please read each of the six domains and vote 'yes' or 'no' to whether you agree with the inclusion of what is written in the Safewards Secure-Custodial Mental Health model'. Consensus for voting was set at 75%, and consensus was met for each of the domains. The results from the voting are presented in Table 2.

4 | Discussion

The aim of this study was to develop custodial staff modifiers for Safewards Secure-Custodial Mental Health, using empirical evidence and expert opinion, to complement the FMH staff and patient modifiers. Via a NGT, participants in this study were able to consider suggested custodial staff modifiers drawn from a literature review, make suggestions based on their experience working with people experiencing mental ill health in a prison setting, and vote on the custodial modifiers after suggested changes were made. This resulted in a finished version of the Safewards Secure-Custodial

Mental Health model (see Figure 2 for the simplified version of Safewards Secure-Custodial Mental Health and (Figure 3) for the technical version).

This study emphasises the clash in paradigms, where two groups of staff (custodial and FMH staff) work together with fundamentally different drivers. Although the goals may be similar, governing policies, underlying frameworks, and ways of working are inherently different. These findings are similar to identified tension between the provision of healthcare and maintaining security (Foster et al. 2013; Sainsbury Centre for Mental Health 2006), and the predominant philosophy in prisons that prioritises security over healthcare (Foster et al. 2013; Walsh and Freshwater 2006). This clash in paradigms is also complicated by FMH staff being considered as contracted staff. Although FMH staff have a duty of care to their patients, security needs are prioritised by custodial staff (Pont et al. 2018; Sundt et al. 2024). The findings of the current study concur with custodial staff perceptions that security will always take precedence, and that it is the role of custodial staff to be accountable for ensuring safety and security for everyone (Maguire et al. 2025; Walsh et al. 2013). This is where having a model such as Safewards Secure-Custodial Mental health could assist as the model highlights these tensions, has different modifiers for clinical staff, custodial staff and consumers and could be used to generate ideas to acknowledge and address these inherent tensions.

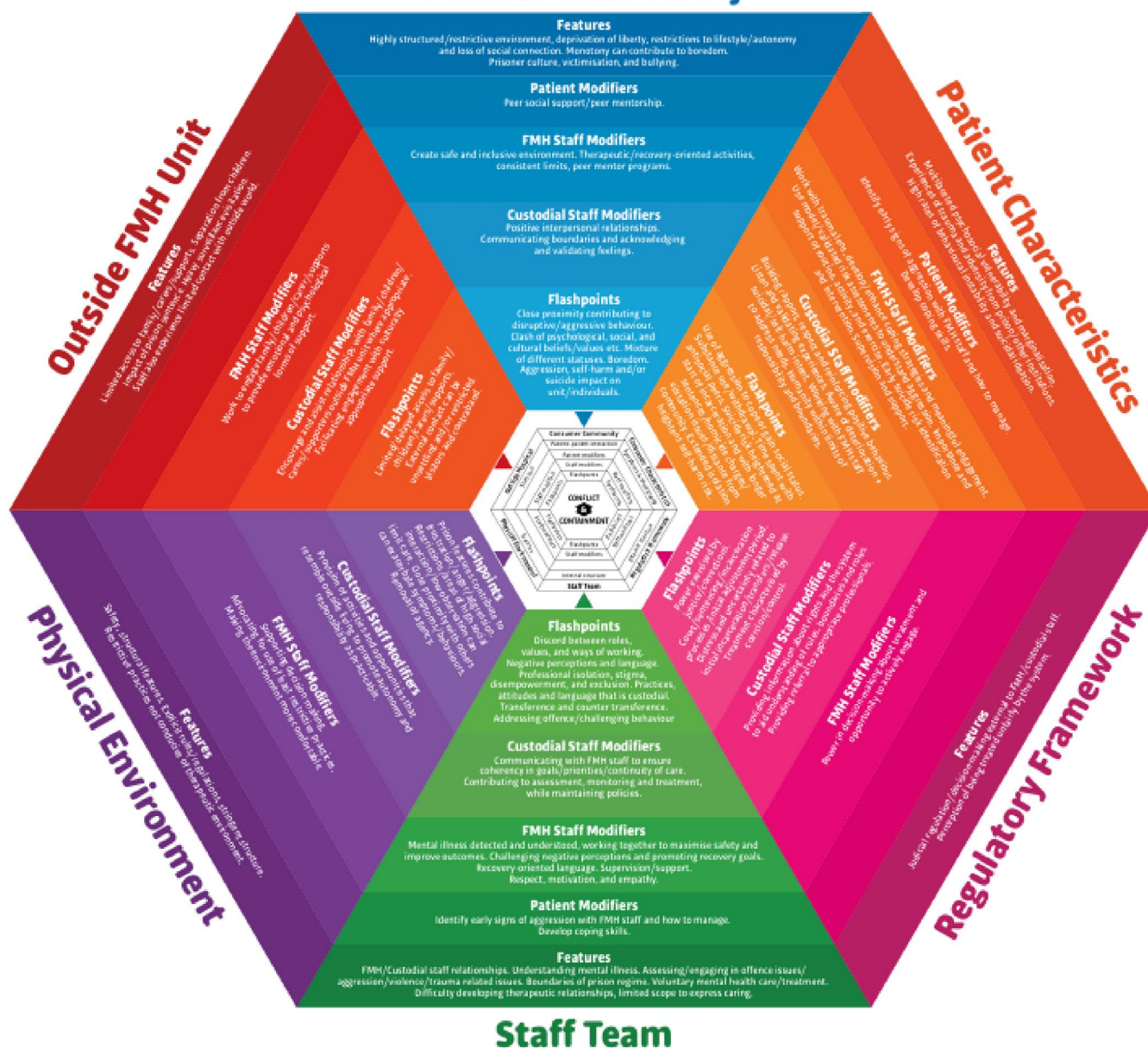
In practice, resolving the tensions between FMH and custodial staff will remain a challenge, and if Safewards Secure-Custodial Mental Health is to be realised, these challenges will need to be addressed. If such efforts are not made, any attempt to implement the model will be difficult and possibly met with resistance, similar to the Safewards implementation in FMH settings (Cabral and Carthy 2017; Price et al. 2016). An inability to overcome these challenges may be harmful for patients and FMH staff (Maguire et al. 2025). Previous studies have shown that resistance from staff in relation to Safewards may result in poor results and in some cases splits or ruptures in teams (Cabral and Carthy 2017). Introduction of Safewards Secure-Custodial Mental Health to a prison setting would benefit from using an implementation science framework to identify possible barriers and enablers, engage the right people and increase chances of success (Chu 2024).

Despite these tensions, this study reflected a genuine desire for FMH and custodial staff to collaborate to implement Safewards Secure-Custodial Mental Health. There were indications of steps undertaken by custodial teams to move away from a primary focus on custodial security, and to also consider patient safety and rehabilitation. These changes can be difficult to achieve in what can be described as a distrustful and sceptical environment (Crewe 2011). However, an environment that is less stressful for everyone (FMH staff, custodial staff, and patients) is more conducive to rehabilitation (Halsey and Deegan 2017; Lambert et al. 2014).

Another significant challenge is the culture within prisons that stifles attempts to engage with patients in a more humanistic or empathic manner. The prison environment and culture may actively restrict custodial staff's ability to work

TABLE 2 | Voting results.

Item	Yes (n)	No (n)	Yes (%)	No (%)
Patient community domain	15	0	100	0
Patient characteristics domain	15	0	100	0
Regulatory framework domain	15	0	100	0
Staff team domain	15	0	100	0
Physical environment domain	15	0	100	0
Outside FMH unit domain	15	0	100	0



One of the limitations in this study was the relatively small number of custodial staff that we were able to recruit. We had engaged with other custodial services to increase the number of custodial participants; however, despite a great deal of enthusiasm and support from people at an advisory level, a range

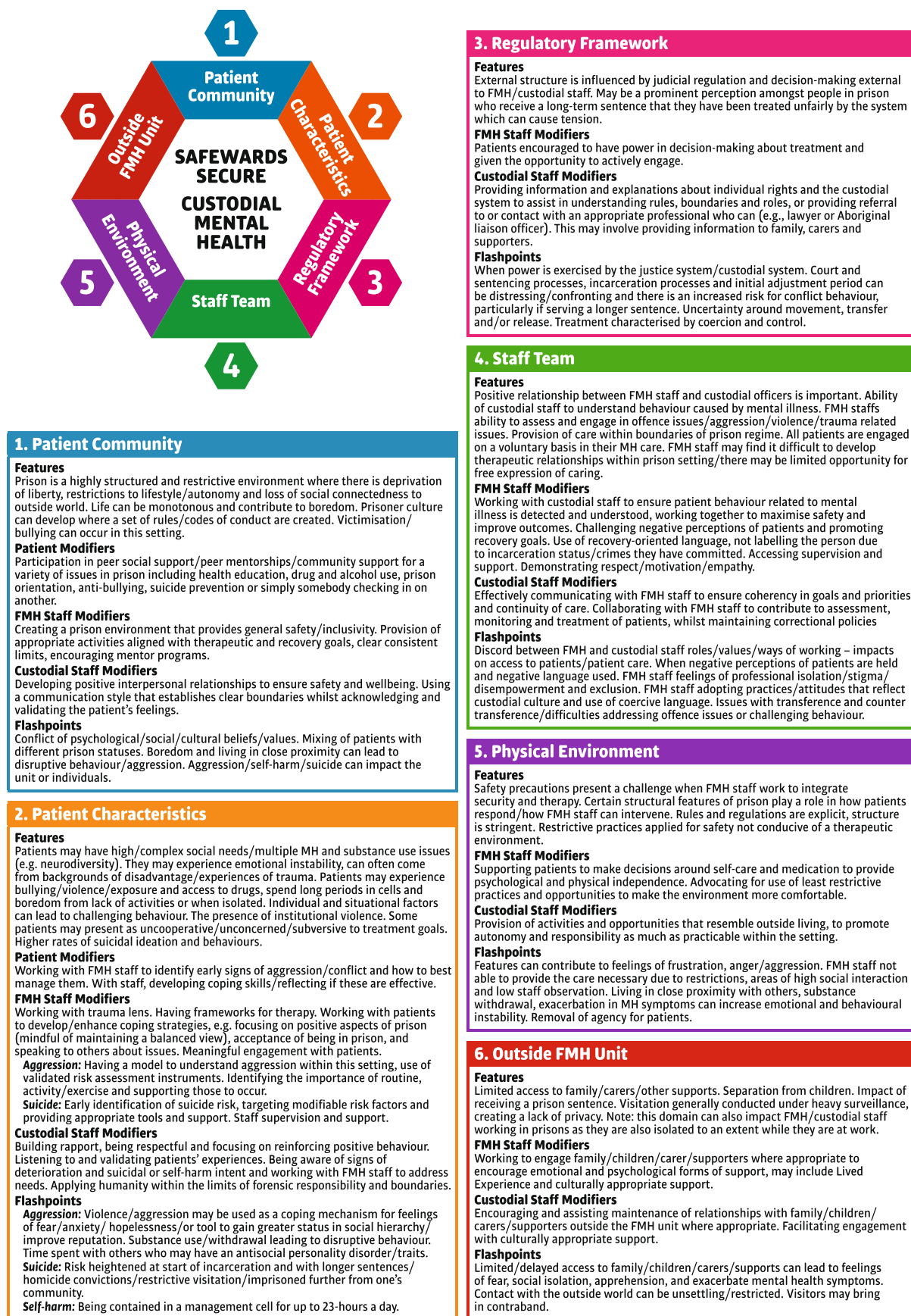


FIGURE 3 | Technical version of Safewards Secure-Custodial Mental Health.

of bureaucratic barriers were experienced that precluded involvement. Nevertheless, the FMH staff and peer workforce/lived experience workers we were able to recruit had experience working with custodial staff closely in bed-based mental health units within the prisons and also had knowledge of the Safewards model. Thus, they were able to engage in the NGT and consider the appropriateness of the suggested custodial staff modifiers. We also had a limited time to run the NGTs. Running smaller groups allowed time to go through the three steps of the NGT and ensure discussion occurred, despite this limitation. We were also able to collect a combination of verbal and written data which was rich in nature. The time between the NGTs and the voting allowed the researchers the opportunity to analyse all of the responses and suggestions for changes to the modifiers and then present the edited modifiers to the participants for voting.

5 | Conclusion

This study has finalised the custodial staff modifiers for the Safewards Secure-Custodial Mental Health model. There remains a need for research to examine if the ten commonly used Safewards interventions apply within a prison setting, before piloting Safewards Secure-Custodial Mental Health in its entirety. Evaluation would need to be applied to implementation to determine if this model could signal a beneficial shift in how care is provided in bed-based prison mental health units.

6 | Relevance to Practice

There have been calls to change how people in prison who experience mental ill health are treated. The focus requires a shift away from a punitive model to a therapeutic model that focuses on treatment and recovery. Safewards Secure-Custodial Mental Health offers a potential pathway to achieving an environment that is more therapeutic and offers better ways of working for FMH nurses, allied health/lived experience staff, and custodial staff. Implementation will need to be a joint effort between FMH nurses, other staff, custodial staff, and patients to ensure success.

Author Contributions

All authors listed meet the authorship criteria of the International Committee of Medical Journal Editors, and all authors are in agreement with the manuscript. All authors were involved with study concept and design. T.M., M.Y. and T.F. collected data. All authors were involved in data analysis and write up.

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Ethics Statement

To undertake this study permission was granted from the Swinburne University of Technology (Project ID: 8399). Access to Forensicare and

to include Forensicare staff was granted by the Forensicare Operational Research Committee. Ethical requirements were met by the researchers. Confidentiality of the participants was maintained by data de-identification and assigning participant numbers.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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