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Developing Safewards Secure for Mental Health Prison Units Using a Nominal Group Technique

Tessa Maguire[1,2,3] | Maicee Young[1,2] | Monica Najda[2] | Hannah Jackson[2] | Jo Ryan[2] | Trentham Furness[1,2] | Brian McKenna[1,4,5]

[1]Centre for Forensic Behavioural Science, Swinburne University of Technology, Melbourne, Victoria, Australia | [2]The Victorian Institute of Forensic Mental Health (Forensicare), Melbourne, Victoria, Australia | [3]Institute Health and Wellbeing, Federation University Australia, Melbourne, Victoria, Australia | [4]Auckland University of Technology, Auckland, New Zealand | [5]Auckland Regional Forensic Psychiatry Services, Auckland, New Zealand

Correspondence: Tessa Maguire (tjmaguire@swin.edu.au)

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ABSTRACT

The introduction of Safewards has resulted in the reduction of conflict and containment in general mental health units, and an adaptation has been developed for secure hospitals in forensic mental health services. Forensic mental health nurses working in bed-based prison mental health units could benefit from having a model to assist conflict and containment reduction in their unique context. The aim of this study was to develop a version of Safewards for bed-based prison mental health nurses. A literature review was conducted to identify relevant features of bed-based prison mental health units including flashpoints, and staff and consumer modifiers. A summary of the review was presented to participants prior to a Nominal Group Technique (NGT) with nurses and other disciplines (working in bed-based prison mental health units) ($n = 12$). The NGT was used to elicit feedback about the proposed model and achieve agreement on several questions related to the proposed version. Data collected were analysed thematically. Two themes were interpreted: (1) 'Square peg, round hole': the stark difference between custodial and Forensic Mental Health staff values and aims; and (2) nothing can happen without custodial staff support. Consensus was reached on all suggested changes/additions to the model. Findings support the need for an adapted version of Safewards (Safewards Secure-Custodial Mental Health) to assist nurses working in this setting. However, modifiers for custodial staff require development and collaboration with Correctional services will also be essential for successful implementation in this setting.

1 | Introduction

Prisons were never intended to serve as facilities for mental health care and treatment (Melnikov et al. 2017). However, due to the nature of the prison environment and the demographics of people who engage in offending behaviour, it has become imperative to acknowledge and address mental health needs of people in prisons worldwide (McClelland et al. 2023; Melnikov et al. 2017). The World Health Organisation in 2007 promulgated the 'Statement on Prisons and Mental Health', which emphasised the rights of people in prison to have appropriate mental health care. The Statement cited that,

> Without urgent and comprehensive action, prisons will move closer to becoming twenty-first century asylums for the mentally ill, full of those who require treatment and care but who are held in unsuitable places with limited help and treatment available. The

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> mental health of prisoners cannot be left as an issue only for prison authorities
>
> (p. 3).

In 2015, the United Nations adopted the 'Standard Minimum Rules for the Treatment of Prisoners', which granted people in prison the same standards of health care as those in the community and stipulated that people in prison requiring specialised treatment should be transferred to specialised institutions or hospitals (United Nations 2015).

To address the mental health needs of people in prison, forensic mental health (FMH) nurses provide a range of assessments and treatments within prisons including within bed-based services (McKenna and Sweetman 2021). FMH nursing is a subspecialty of mental health nursing. FMH nursing practice is the assessment, formulation, planning, implementation and evaluation of nursing care and treatment within a therapeutic relationship with people experiencing mental illness who are involved in criminal justice processes (Martin et al. 2012).

There are a variety of models of service delivery for those in prison experiencing mental illness; one is the use of bed-based services within prisons staffed 24 h a day by FMH nurses. A range of other clinicians also work in these settings, such as psychologists, social workers, consultant psychiatrists, consumer and peer workers, and custodial officers, who offer recovery-oriented FMH services providing mental health treatment and care for people who are mentally unwell while in the prison system. This type of model requires partnership between clinical and custodial staff (Forensicare 2024). Consumers in a bed-based prison service are on remand or have been convicted of an offence and sentenced to prison. In comparison, consumers in a FMH setting (secure hospitals) may have been found not guilty by reason of mental impairment, be on remand, or sentenced and transferred to the inpatient setting for assessment and treatment, and then return to prison.

The containment of a person in custody is inherently coercive and restrictive, which poses challenges to how nurses interact with consumers and their ability to form therapeutic relationships (Carroll et al. 2021; Dickinson et al. 2017). FMH staff, in particular nurses, play a key role in mental health service delivery within prisons (Maguire et al. 2021). When working within a FMH setting, nurses are required to carefully work therapeutically and maintain security to ensure safety for all (Dickinson et al. 2017). Maintaining security encompasses adhering to the policies and procedures, practices, physical structures and technology that ensure consumers do not escape or abscond, and/or cause injury to themselves or others in the environment (Maguire and McKenna 2024).

FMH nurses working in prisons are faced with additional challenges and differences in their provision of care as compared to nurses working in mental health settings or even secure forensic hospitals (Maguire et al. 2021). Care within a prison is dictated by order, routine, regulation and control (Carroll et al. 2021). Nurses often rely on custodial staff to access and assess consumers, and the planning of care will often require approval from custodial officers before implementation. Nurses and other FMH staff must work around protocols and procedures developed and implemented by correctional services that are outside of their control, such as planned and unplanned lockdowns (where people are not allowed to freely enter, leave, or move around in a building or area), which might limit access to consumers. There are also issues with lack of privacy, limits to maintaining confidentiality, lack of integration between services (such as health and corrections) and shortcomings in ensuring continuity of care between prisons and upon release into the community (Carroll et al. 2021).

Entering a prison can be an extremely dehumanising experience; often, people will feel overwhelmed, hopeless and fearful (Popovic 2020). The experience is often characterised by separation from family, supports and familiar environments, which causes uncertainty and despair and can involve victimisation and exposure to violence (Popovic 2020; Scott et al. 2023). Other stressors might include withdrawal from alcohol or substances, uncertainty around legal proceedings, and the experience of boredom due to a lack of purposeful activity in prison (Scott et al. 2023). This is especially true for people in prison with mental health challenges or mental illness, and these individuals often have more difficulty adjusting during their period of incarceration (Popovic 2020).

People experiencing mental illness residing in prisons are up to eight times more likely to be victims of sexual assault; they typically serve longer sentences; commit more rule infractions; and are often subject to more disciplinary actions (Canada et al. 2022; Melnikov et al. 2017; Popovic 2020). Furthermore, the prison environment and processes can have a further detrimental effect on a person's mental health, and prisons are often unsuitable places to carry out mental health assessment and treatment (Scott et al. 2023). Living in prison can also result in a loss of autonomy, self-worth and self-esteem (Canada et al. 2022).

1.1 | Conflict and Containment

People in prison may develop defence mechanisms in response to the deprivations they experience as a means to cope, including engaging in misconduct, aggression, violence, drug use, self-harming behaviours and suicide (Canada et al. 2022; Perrin 2018; Popovic 2020). Violent and aggressive behaviour presents numerous challenges for staff, other people in prison, daily routines, the milieu and the rehabilitative aims of therapy (Maguire et al. 2021; Popovic 2020). People in prison may act out in a violent or aggressive way in response to the deprivations of prison life or to maintain or build social status to ensure their safety (Popovic 2020).

Mental health nurses are often at the forefront of preventing and managing aggressive and violent behaviour, and this is also true for nurses working in prison settings (Maguire et al. 2021). In prisons, people who engage in aggressive or violent behaviour are often subject to restrictive conditions as a form of punishment (Popovic 2020). This can include segregation and extended periods of solitary confinement.

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Health care staff, including nurses, have very little or no say in the use of restrictive interventions as a form of punishment (Popovic 2020).

Similarly, it is common practice to place in solitary confinement people in prison who engage in self-harm behaviours or express suicidal ideation (Carroll et al. 2021). For people who are mentally unwell, this form of containment might not act as a deterrent, and instead further exacerbate underlying symptoms of mental illness (Popovic 2020). Restrictive practices, such as restraint and seclusion, are generally perceived by people who experience mental illness as emotionally disempowering and are generally considered counter-therapeutic, even traumatic (Carroll et al. 2021).

In a prison setting, FMH nurses are seldom involved in employing restrictive practices; instead, custodial staff are responsible for maintaining the order of the prison, security and the use of physical restraint (Corrections Victoria 2019). However, this does not mean that FMH nurses working in this setting have no role in addressing aggressive behaviour and understanding the function of aggression (Maguire et al. 2021). Therefore, having a framework to understand violence, aggression, self-harm and suicide in a prison setting is necessary. This includes the need to consider and influence how containment can be prevented and/or reduced.

1.2 | The Safewards Model

The Safewards model was developed as a nursing intervention framework to understand the relationship between conflict (events that threaten staff and consumer safety such as aggression, self-harm and suicide) and the use of containment (things staff do to prevent or minimise the impact of conflict such as extra medication, close observation, restraint and seclusion); and to reduce conflict and containment within mental health units (Bowers et al. 2015). Safewards also aims to generate ideas for change that have the potential to reduce conflict and containment. The model consists of six domains in which conflict originates. These are: the physical environment, the staff team consumer characteristics, events occurring outside the hospital, the consumer community and the regulatory framework (Ward-Stockham et al. 2022). Within these domains 'flashpoints' defined as social and psychological situations preceding conflict, can arise. Staff modifiers (features within staff control) and consumer modifiers (features within consumer control) influence the frequency of conflict and containment (Bowers et al. 2015). Interventions in Safewards are designed to act on flashpoints to reduce conflict and containment, and they include: clear mutual expectations, soft words, talk down, positive words, bad news mitigation, know each other, mutual help meetings, calm down methods, reassurance and discharge messages (Bowers et al. 2015).

1.3 | Safewards Secure

Despite success within general mental health settings, the limited studies investigating Safewards within FMH settings (secure hospitals) suggest implementation has been challenging; including staff resistance to implementation and limited impact on conflict and containment rates (Cabral and Carthy 2017; Maguire, Garvey, et al. 2022; Maguire, Ryan, et al. 2022). While there are some similarities between forensic and general mental health nursing, there are also significant differences, such as the locked and secure nature of the units, the intersection between a criminal justice response and therapeutic care, and the length of stay (Whitmore 2017). For this reason, Safewards Secure was developed to address the perceived gaps for Safewards in a secure hospital context (Maguire et al. 2023; see Figure 1). Safewards Secure was developed by deriving evidence from the literature to identify missing features, flashpoints and modifiers, as well as additions to the interventions, and was verified by experts in FMH and Safewards. The model can be used to emphasise the knowledge, skills and attitudes required of nurses who work in FMH settings and encourage working in more collaborative ways with consumers and their families, carers and supporters (Maguire et al. 2023).

FMH nurses working within bed-based settings within prisons may also benefit from a model such as Safewards, given the presence of self-harm, suicide and aggression in this setting. However, there is currently no bespoke framework to support the use of Safewards within prison bed-based mental health units. Given the differences between FMH units and bed-based prison mental health units, the aim of this study was to develop a version of Safewards for nurses working in bed-based prison mental health units by conducting a literature review to determine the possible features, flashpoints and modifiers for the model and seeking feedback from staff who have experience working in bed-based prison mental health units.

2 | Methods

To inform the model, a literature review was undertaken to locate the evidence for potential features, flashpoints and modifiers in the bed-based prison mental health unit setting. The literature review was conducted using Scopus and Google Scholar with Boolean methods and MeSH heading. Google Scholar was used for identifying suitable literature, as this database has been shown to have equivalent coverage compared to combined searches in other independent databases (Gehanno et al. 2013). The search terms were: 'prison'; 'conflict & containment'; 'restrictive practices'; 'mental illness'; 'aggression'; 'substance use or dependence'; 'suicide or self-harm'; 'mental health care'; 'mental health beds'; 'prisoner'; 'challenges'; 'characteristics'; 'environment'; 'interaction'; 'disputes'; 'family and carers'; 'pro-social supports'; 'FMH nurses'; 'correctional staff'; 'security'; 'privacy'; 'activities'. Articles were screened and included if they presented a potential feature, flashpoint and/or modifier specific to a mental health prison setting.

The literature was summarised for participants taking part in a Nominal Group Technique (NGT) and sent to them prior to the day of the event, along with a description of the original Safewards model (Bowers et al. 2015) and Safewards Secure (Maguire et al. 2023). A NGT discussion guide was also developed, which consisted of the proposed flashpoints, features and modifiers as identified from a literature review (see Data S1). For

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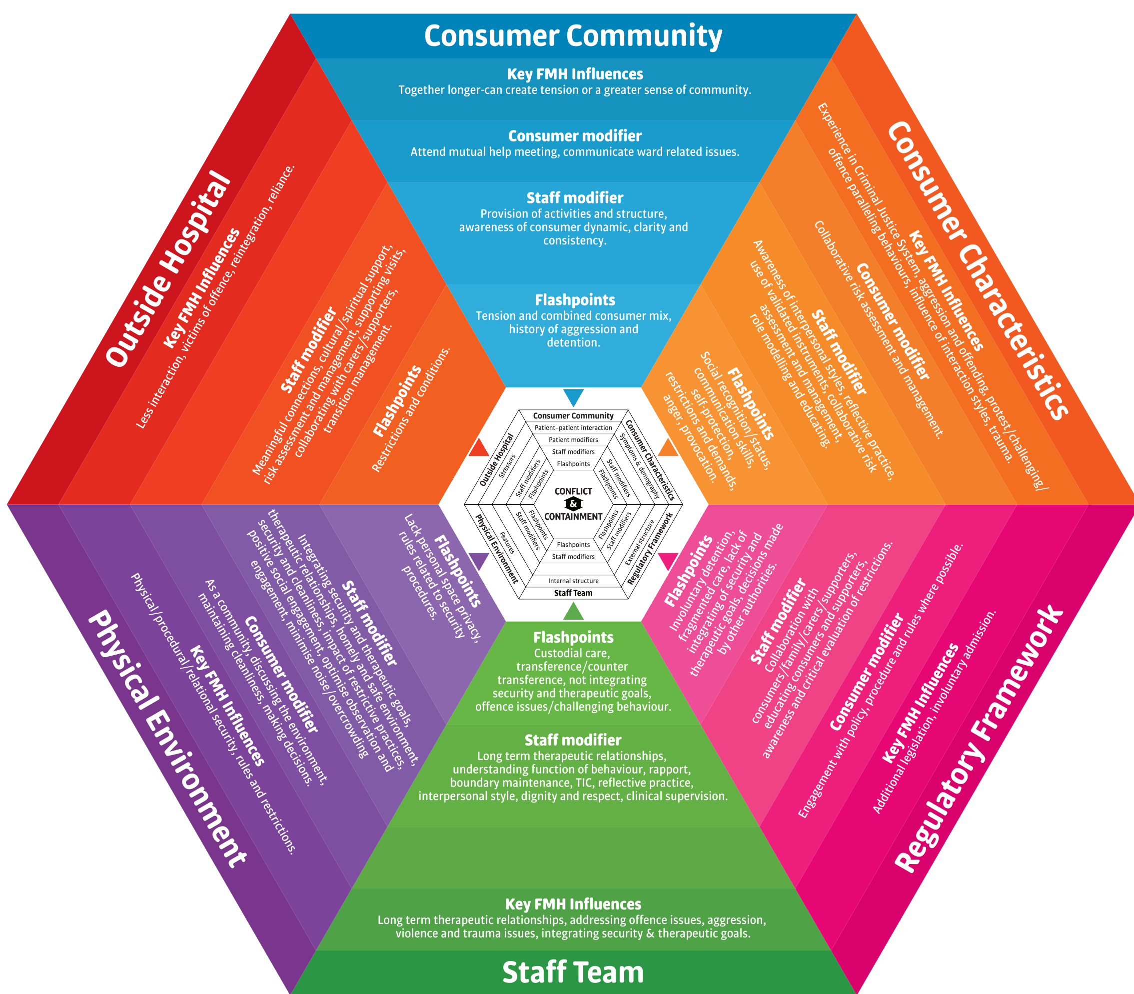

FIGURE 1 | Safewards Secure Simple version Maguire et al. 2023.

an overview of potential flashpoints, features and modifiers specific to a mental health prison setting (see Data S2).

A NGT can be used to define, develop and assess a phenomenon through group consensus (Fisler et al. 2019). The NGT provides a structured technique, which is a variation of a small-group discussion designed to reach group consensus. An NGT collects information through individuals' responses to a series of questions asked by a moderator and then explores ideas with all group members. The method allows contribution from all participants and avoids domination by a single person (Vahedian-Shahroodi et al. 2023). Outcomes of a NGT can be used to change clinical practice and policy (Harvey and Holmes 2012).

2.1 | Setting

This study was conducted at Forensicare, a statewide FMH service located in Australia. Currently, Forensicare provides specialist FMH services across 12 of 14 public and private prisons. Services include mental health nursing reception assessments, clinical support for dedicated units for the care and treatment of people experiencing mental illness within the prison, as well as outpatient care. Forensicare prison services also provide suicide and self-harm prevention assessment services. For all Victorian prison-based specialist mental health services, participation in care and treatment is voluntary (e.g., consumers can refuse medication). It is important to highlight that the provision of care within a prison setting, while voluntary, is complex, as the very nature of being in prison can be perceived as 'coercive', where consumers may feel they have limited choice or ability to refuse treatment.

2.2 | Participants and Recruitment

A purposive sample from the service was recruited to the NGT with the following inclusion criteria: (1) experience in FMH working within prisons for a period of 6 months or more and/or (2) FMH experience in using or implementing Safewards. A purposive sample can be used when specific knowledge of participants is needed to meet a study aim (Portney and Watkins 2014). For recruitment, TM (an experienced nurse researcher) emailed staff who work in the prison bed-based services across Forensicare. The email introduced the study and included the information and consent form. Interested staff were asked to respond to the email to indicate their interest. Interested participants were then sent an electronic invite to attend the NGT. Participants either emailed back signed consent forms prior to the day or handed in a signed paper copy on the day of the NGT.

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A total of 12 people attended the NGT representing the disciplines of nursing ($n=6$), social work ($n=3$), psychology ($n=1$), occupational therapy ($n=1$) and the peer work force ($n=1$).

2.3 | Data Collection

The NGT followed four steps: (1) The silent generation of ideas: members of the NGT listed individually and without engaging in discussion, their thoughts on each of the items contained in the NGT guide. Responses were written on post it notes by participants and grouped around each item. (2) A 'round robin' was facilitated, where group members presented their ideas. This process was repeated until all items on the NGT guide had been answered. All ideas were displayed so all participants could see them. (3) Clarification occurred, where there was a structured discussion of the ideas from the participants. (4) Private voting was then held involving each participant and the outcome discussed.

To conduct this NGT, the participants were split into three groups for steps 1 and 2 and 3 (to allow enough time for each group to work through the items) and then returned as one large group for steps 4. Researchers HJ, JR and MN are employed by the service so are known to the participants. For this reason, they were each paired with an academic employed by a different service and not involved in consumer care, to mitigate perception of coercion. Data generated in the NGT were written data from the generation of ideas (the ideas written on post it notes); verbal data, which was collected from the group discussions and transcribed; and the results of the voting.

2.4 | Data Analysis

The qualitative data were analysed according to the six-stage method recommended by Braun and Clarke (2019). The first stage involved one researcher from each group listening to the audio file and checking it against the transcript.

The second phase occurred when TM and MY independently developed codes from the transcripts and post it notes. The third phase consisted of TM and MY searching for themes by establishing thematic maps on a word document, followed by an initial review of the suggested themes by the research team, resulting in consensus on the themes identified. Finally, this manuscript was written.

Quantitative data from the voting were analysed using scoring and ranking methods during the NGT to identify group preferences regarding the potential additional features, modifiers and flashpoints. Consensus was set at 80% agreement.

2.5 | Rigour

To ensure rigour, a reflexive approach was used by the researchers. Participants were invited for this study based on their knowledge and experience of working within a bed-based prison setting and/or their knowledge of Safewards implementation. Researchers TM, JR, MY and TF have Safewards research experience, and TM, TF, MY, JR and FMH have research experience. The process of checking audio files and post-it notes against the transcribed data was a safeguard to confirm the accuracy of the transcriptions and to familiarise the researchers with the data. The researchers also engaged in the data analysis in a collaborative manner.

2.6 | Ethical Considerations

The study received clinical approval from the Forensicare organisational research governance committee and ethical approval from the Swinburne University of Technology HREC (Project ID: 7430). Confidentiality of the participants was maintained by data de-identification and assigning participant numbers (P) or, when writing on post-it notes, by group number (N). Data were collected in May 2024. The study is reported using the Standards for Reporting Qualitative Research (SRQR; O'Brien et al. 2014).

3 | Results

The NGT served two purposes. The first was to refine the proposed model and to reach consensus on potential via working through the steps and voting. This resulted in the Safewards Secure-Custodial Mental Health (SS-CMH) model. The second purpose was to generate themes from the data, which reflected participants thoughts about the suggested model. Two themes were interpreted from the data analysis. The first theme was '*Square peg, round hole*: the stark difference between custodial and FMH staff values and aims'; and the second theme was 'Nothing can happen without custodial staff support'.

3.1 | Theme One: '*Square Peg, Round Hole*: The Stark Difference Between Custodial and FMH Staff Values and Aims'

Participants described a distinct difference between custodial staff and FMH staff values and aims that can result in practice challenges for FMH staff. Participants in this study reflected on the inherent challenges experienced when working in a correctional setting. These include procedural restrictions and the design of the physical environment due to security requirements. Furthermore, the aims of the prison are to contain and, where possible, eliminate risk, which are at odds with the aims and values of FMH staff, which are to provide mental health care and treatment. These differences are evident in the following quotes.

> Treatment is characterised by need to manage risk rather than treat drivers of risk
>
> (G2)

> It's that balance of we are working in a punitive correctional environment…how do you marry the two when one is supposed to be recovery-oriented
>
> (P7)

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> If you want to do things differently, the amount of work you need to do to get that signed off by the right person at the right level, and in the meantime what harm is being done by the application of the restrictive response. It's this focus on containing risk and managing risk instead of treating risk, and that's embedded in the environment and regulations you then have to overcome
>
> (P5)

Further to the focus on managing and containing risk, participants reflected on how the setting is often considered to be untherapeutic and at times harmful for people experiencing mental illness.

> Its (prison) not just, not therapeutic, its actively depriving
>
> (G1)

> Corrections Act mandates processes that are untherapeutic and harmful, e.g., strip searching, urinalysis, observation cells, management unit
>
> (G2)

The environment can also limit the ability of FMH staff to respond in a person-centred manner and may also be at odds with a Safewards approach.

> There is a contradiction between correctional risk, adverse approach and the therapeutic environment and approach Safewards would recommend
>
> (G3)

> What do you do when someone's really, really unwell and can't reason, can't focus or can't attend to their needs at that time. There's always that other side that we do have to struggle with in the present system
>
> (P9)

The quotes above reflect some of the complexities FMH staff face when trying to work with consumers who are, in terms of their mental health care, voluntary in nature and where FMH staff are essentially a guest in the prison setting.

3.2 | Theme Two: Nothing Can Happen Without Custodial Staff Support

Participants in this study were of the opinion that a collaborative approach between FMH and custodial staff would be needed to ensure the divergent perspectives of the two would be met in implementing a Safewards approach in prisons. Acknowledging the different perspectives and working together was seen as key to success.

> Our focus is on the therapeutic side of things, but there is a safety and security element to be considered … So, if we can work collaboratively with officers to think about how we can implement this model that both meets their needs and our needs, then it's more likely to be positive implementation
>
> (P9)

While there was the desire for change, the support and endorsement from Corrections was seen as so important, that without this, implementation could not only be unsuccessful but may in fact be harmful for FMH staff and consumers.

> If we don't have the buy-in then I think trying to implement it will be harmful to our staff and then to our consumers … because it will just increase conflict, frustration, distress
>
> (P5)

Furthermore, participants were of the opinion that 'nothing can happen without their [custodial staff] support' (G1) in regard to introducing Safewards. However, there was a sense of optimism that if engagement and collaboration was to occur, there could be a way to proceed.

> It'd be good to have that included with the correctional staff initially too, really build it together so they feel a part of it, it would take off a lot easier
>
> (P12)

> If there's an engagement very, very, very early with the assistant commissioners of custodial operations across all of the locations that have bed-based services to engage … Then that filters down into everything from pre-service training and the way that we train also in the way that we onboard and orient our own staff
>
> (P5)

3.3 | Voting

Three yes/no questions were developed by the researchers for voting from the stepped process of the NGT. These questions related to participant responses to the items on the NGT guide, where initial consensus was not achieved. For voting results see Table 1.

TABLE 1 | NGT voting results.

Item	Response yes (%)
Should outside FMH unit also be a feature for staff	83.3
Should outside hospital be changed to outside FMH unit	97.1
Should there be a custodial staff modifier	100

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Stage one: Literature review undertaken to explore the 6 domains (including flashpoints, staff and consumer modifiers and features)

Stage two: The research team compiled the literature for each domain and developed items for the NGT guide

Stage three: A summary of the literature review was emailed to willing participants one week prior to the NGT

Stage four: The NGT was held with participants in person (see study design for the steps in the NGT)

Stage five: The research team met in person on two occasions over a five-hour period after the NGT to go through the voting and suggestions gathered from the NGT.

Stage six: Any additional suggestions mentioned in the NGT were then checked against the the Safewards model and the peer reviewed literature to ensure there was evidence for inclusion and no repetition.

Stage seven: All members of the research team reviewed the model and the wording before finalising the model.

FIGURE 2 | Sequence of the development of Safewards Secure- Custodial Mental Health.

3.4 | Finalising the Model

Figure 2 provides a flow chart visual of the steps taken to finalise the model.

Table 2 contains the final features, flashpoints, and modifiers as suggested by NGT members and supported by the literature in relation to the six Safewards domains in which conflict originates.

4 | Discussion

The aim of this study was to identify additional features, flashpoints, and modifiers present in bed-based prison mental health units to develop SS-CMH to assist FMH nurses and other staff working in prison settings. The additions were based on evidence from the literature and discussed in the NGT with people who have experience working in bed-based prison mental health units across Forensicare. In the NGT, the participants were able to explore the suggestions for the model derived from the literature review and consider the use of such a model in their setting. The final model has two versions: see Figure 3 for the simple version (a brief summarised version), and Figure 4 for the technical version (an expanded version for full reference to the model).

Findings from this study emphasise the fundamental differences between, not only general mental health inpatient units, but also forensic secure inpatient settings, as compared to bed-based prison mental health settings. FMH nurses can experience conflict between a duty to care for their consumers and duty to follow the rules of prison management, whereby, prisoners are not in the first instance considered primarily consumers (Pont et al. 2018). FMH staff are also often considered to be a 'guest' in prison settings in relation to maintaining security and the 'good order' of the prison. Custodial staff are ultimately responsible for the security, management, and order of the prison, and this is a responsibility taken very seriously, as both prisoner and staff welfare is at stake (Foster et al. 2012; Walsh et al. 2013).

The differences also arise from working in a setting that is oriented towards punishment and seeks to contain and eliminate risk (Glorney et al. 2020; Volker and Galbraith 2018). Whereas FMH nurses work in a recovery paradigm that supports positive risk taking, person-centred, recovery-oriented care. This requires nurses to work with consumers to identify and implement educational, cognitive, and supportive interventions to assist consumers to address and manage their risk behaviours (Martin et al. 2012). These differences provide support for the careful development of an addition to the original Safewards model that includes the unique aspects of this setting.

This subsequent model can inform work required to make this setting a more positive place, and to work towards reducing conflict and containment. While there might be a desire to transport models that have proved effective in other settings, it is necessary to make workplace-specific modifications, as conflict and containment events in each setting are complex and unique to that setting (Jaspers et al. 2019; Maguire et al. 2023).

As can be seen by the results from the NGT, staff are also impacted by working in a bed-based prison mental health unit as they are also subject to a range of restrictions in this setting for the duration of their working day (e.g., they cannot take in a mobile phone, and the limited possessions they can bring in must be contained in a clear see-through bag). Staff are also limited in terms of access to consumers and have very little or no say in the use of restrictive interventions in this setting. While staff appreciate the reasons as to why this is the case, they feel it is important to acknowledge the impact on models of care such as SS-CMH.

The challenges in this setting also underline the importance of collaboration with custodial staff to ensure effective

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TABLE 2 | Features, flashpoints and modifiers suggested by NGT members and supported by literature.

	Features	Flashpoints	Staff modifiers	Consumer modifiers	References that support the inclusion in the model
Consumer Community	Prison is a highly structured and restrictive environment where there is deprivation of liberty, restrictions to lifestyle and autonomy and a loss of social connectedness to those in the outside world. Life can be monotonous and contribute to boredom. Prisoner culture can develop where a set of rules and codes of conduct are created. Victimisation and bullying can occur in this setting.	Conflict of psychological, social, or cultural beliefs or values. **Mixing of consumers with different prison statuses**. Boredom and living in close proximity can lead to disruptive behaviour and aggression. Aggression, self-harm and/or suicide can impact the unit or individuals.	Creating a prison environment that provides general safety **and inclusivity**. Provision of appropriate activities **aligned with therapeutic and recovery goals**, clear and consistent limits, and encouraging mentor programs.	Participation in peer social support/peer mentorship/community support for a variety of issues in prison including health education, drug and alcohol use, prison orientation, anti-bullying, suicide prevention or simply somebody checking in on another.	**Flashpoint:** the mixing of protection and non-protection prisoners (Ricciardelli et al. 2024).

(Continues)

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TABLE 2 | (Continued)

	Features	Flashpoints	Staff modifiers	Consumer modifiers	References that support the inclusion in the model
Consumer Characteristics	Consumers may have high and complex social needs, multiple co-existing mental health and **substance use issues (e.g., neurodiversity)**. They may experience emotional instability due to **a range of reasons**, can often come from backgrounds of disadvantage, and experiences of trauma. Consumers may experience bullying and violence, exposure and access to drugs, spend long periods in cells and boredom from lack of activities or when isolated. Individual and situational factors can lead to challenging behaviour. The presence of institutional violence. Some Consumers may present as uncooperative/unconcerned/subversive to their treatment goals. Higher rates of suicidal ideation and behaviours.	Aggression: Violence or aggression may be used as a coping mechanism for feeling of fear, anxiety, and hopelessness, or a tool to gain greater status in the social hierarchy or improve reputation. Substance use/withdrawal leading to disruptive behaviour. Time spent with others who may have a diagnosis or symptoms of antisocial personality disorder. Suicide: Risk heightened at start of incarceration and with longer sentences/homicide convictions/restrictive visitation/imprisoned further from one's community. Self-harm: Being contained in a management cell for up to 23 h a day.	Conducting work with a trauma lens. Having frameworks for therapy. Working with consumers to develop/enhance coping strategies, such as focusing on the positive aspects of prison **(mindful of maintaining a balanced view)**, acceptance of being in prison, and speaking to others about issues. Meaningful engagement with consumers. Aggression: Having a model to understand aggression within this setting, use of validated risk assessment instruments. Identifying the importance of routine, activity, and exercise and supporting those to occur. Suicide: Early identification of suicide risk, targeting modifiable risk factors and **providing consumers with appropriate tools and support**. Staff seeking supervision and support.	**Working with FMH staff to proactively identify early signs of aggression or conflict and how to best manage them. With the help of staff, developing coping skills and reflecting on if these are effective**.	**Features:** Specific mention of neurodivergence/neurodiversity in prisoner populations (Allely 2015; Vinter et al. 2023). **Staff modifier:** Maintaining a balanced/realistic view of the custodial environment/system (Molleman and van der Broek 2014).

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TABLE 2 | (Continued)

	Features	Flashpoints	Staff modifiers	Consumer modifiers	References that support the inclusion in the model
Regulatory Framework	**The external structure is influenced by judicial regulation and decision-making external to FMH and custodial staff**. There may be a prominent perception among people in prison who receive a long-term sentence that they have been treated unfairly by the system, which can cause tension.	**Moments when power is exercised by the justice system/custodial system. Court and sentencing processes**, incarceration processes and the initial adjustment period can be **distressing** and confronting and there is an increased risk of conflict behaviour, particularly for those that are serving a longer sentence. **Uncertainty around movement, transfer and/or release**. Treatment **that is** characterised by coercion and control.	Consumers are encouraged to have power in decision-making about their treatment and given the opportunity to actively engage in this.		**Flashpoints:** Court and sentencing processes, incarceration processes and the initial adjustment period can be distressing (Atkins et al. 2023) **Flashpoint**: Distress experienced by people in prison when approaching release (Thomas et al. 2016). **Flashpoint:** Uncertainty around movements (Maier and Ricciardelli 2019).
Staff Team	A positive relationship between FMH staff and custodial officers is important. Ability of custodial staff to understand behaviour caused by mental illness. **FMH staff's** a**bility to assess and engage in offence issues, aggression, violence and trauma related issues**. Provision of care within boundaries of the prison regime. All consumers are engaged on a voluntary basis in their mental health care. FMH staff may find it difficult to develop a therapeutic relationship within a prison setting and there may be limited opportunity for free expression of caring.	Discord between FMH and custodial staff roles, values and ways of working which then impacts on access to consumers and consumer care. **When** negative **perceptions** of consumers are held **and negative language is used**. FMH staff feelings of professional isolation, stigma, disempowerment and exclusion. FMH staff adopting practices and attitudes that reflect the custodial culture and use of coercive language. **Issues with transference and counter transference/difficulties addressing offence issues or challenging behaviour**.	Working with custodial staff to ensure consumer behaviour related to mental illness is detected and understood, working together to maximise safety and improve outcomes. Challenging negative perceptions of consumers and promoting recovery goals. Use of **recovery-oriented** language, not labelling the person due to incarceration status or crimes they have committed. Accessing supervision and support. Demonstrating respect, motivation and empathy.		**Flashpoint:** Negative language from both clinical and custodial staff (Tran et al. 2018). **Staff modifiers:** Challenging negative perceptions of consumers (Molleman and van der Broek 2014). **Staff modifier:** Use of recovery-oriented language (Tran et al. 2018).

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TABLE 2 | (Continued)

	Features	Flashpoints	Staff modifiers	Consumer modifiers	References that support the inclusion in the model
Physical Environment	Safety precautions present a challenge when FMH staff work to integrate security and therapy. Certain structural features of prison play a role in how prisoners **respond**, and how FMH staff can intervene. Rules and regulations are explicit, and structure is stringent. Restrictive practices applied for safety are not conducive of a therapeutic environment.	Features of prison can contribute to feelings of frustration, anger and aggression. FMH staff not being able to provide the care necessary due to restrictions, areas of high social interaction and low staff observation. Living in close proximity with others, substance withdrawal, exacerbation in mental health symptoms can increase emotional and behavioural instability. Removal of agency for consumers.	Supporting consumers to make decisions around self-care and medication to provide psychological and physical independence. **Advocating for use of least restrictive practices and opportunities to make the environment more comfortable**.		**Staff modifier:** Advocating for use of least restrictive practices and opportunities to make the environment more comfortable (Goomany and Dickinson 2015; Kucirka and Ramirez 2019).
Outside **FMH Unit**	**Limited** access to family, carers and other supports. **Separation from children**. The impact of receiving a prison sentence. Visitation is generally conducted under heavy surveillance creating a lack of privacy, **Note that this domain can also impact FMH and custodial staff working in the prisons as they are also isolated to a certain extent while they are at work**.	Limited/**delayed** access to family/children/carers/supports can lead to feelings of fear, social isolation, apprehension, and can exacerbate mental health symptoms. Contact with outside world can be unsettling **and/or restricted**. Visitors may bring in contraband.	Working to engage family/children/carer/supporter where appropriate to encourage emotional and psychological forms of support, **this may include Lived Experience and culturally appropriate support**.		**Feature:** Separation from children/parenting role (Dargis and Mitchell-Somoza 2021). **Staff modifier:** inclusion of lived experience workers (Bagnall et al. 2015). **Staff modifier:** The importance of cultural supports (Strauss-Hughes et al. 2022).

Note: Bold Text: Text added to the model in line with suggestions made by NGT participants. Text removed from the model in line with suggestions made by NGT participants.

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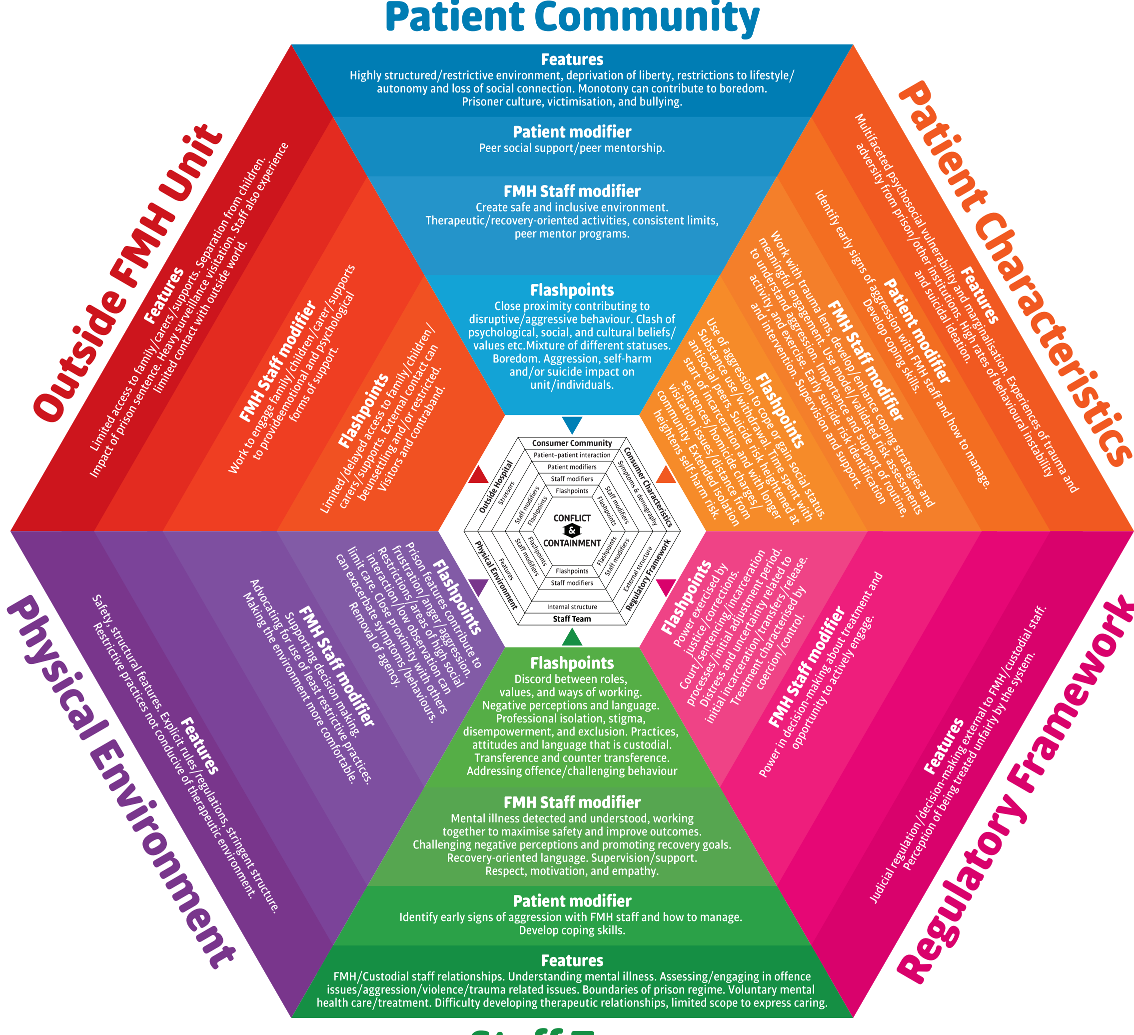

FIGURE 3 | Safewards Secure Custodial Mental Health Simple Version. The model uses the term patient; however, services should use the term that best describes the population they serve.

implementation of SS-CMH. Collaboration to provide service delivery has been shown to be effective in studies reviewing mental health care in prisons. Organised systems and structures, good communication between teams (e.g., FMH nurses and custodial staff), and positive relationships with custodial staff are seen as important in the early identification of risk and in the delivery of a range of interventions (Glorney et al. 2020). Essential aspects of mental health service provision are therefore reliant on a workforce that is enabled through systems and processes, and who feel practically and emotionally supported in their role (Glorney et al. 2020). Interestingly, in this study, inclusion of custodial staff was seen as so important that participants wanted to see the development of custodial modifiers to be included in SS-CMH.

Custodial officers can be effective members of the multidisciplinary treatment teams for people in prisons experiencing mental illness when provided with a basic understanding of mental illness (Brooke 2023; Melnikov et al. 2017) and including custodial officers within the multidisciplinary team could foster a more positive relationship between custodial officers, FMH staff and consumers (Brooke 2023). Custodial officers are also often well placed to inform FMH nurses' assessments, as they are typically the first to observe significant changes in a consumer's routine or mental status. Therefore, information from custodial officers can contribute to nurses' risk assessment and treatment. Regular meetings and discussion between officers and nurses are critical to ensure coordinated and consistent care (Appelbaum et al. 2001). It is also important however to highlight the tension between health information sharing expectations with custodial staff and the consumer's right to confidentiality (Adshead 2015; Elger et al. 2015).

Just as in the original Safewards model, some of the interventions may be more focused on FMH staff, others more towards consumers, and in the custodial mental health version, some may be more focused on custodial staff. The development of custodial modifiers will be the next step in the refinement of SS-CMH, and this will be done with custodial staff who have experience working in bed-based mental health units within prisons.

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1. Patient Community

Features
Prison is a highly structured and restrictive environment where there is deprivation of liberty, restrictions to lifestyle/autonomy and loss of social connectedness to outside world. Life can be monotonous and contribute to boredom. Prisoner culture can develop where a set of rules/codes of conduct are created. Victimisation/bullying can occur in this setting.
Patient modifier
Participation in peer social support/peer mentorships/community support for a variety of issues in prison including health education, drug and alcohol use, prison orientation, anti-bullying, suicide prevention or simply somebody checking in on another.
FMH Staff modifiers
Creating a prison environment that provides general safety/inclusivity. Provision of appropriate activities aligned with therapeutic and recovery goals, clear consistent limits, encouraging mentor programs.
Flashpoints
Conflict of psychological/social/cultural beliefs/values. Mixing of patients with different prison statuses. Boredom and living in close proximity can lead to disruptive behaviour/aggression. Aggression/self-harm/suicide can impact the unit or individuals.

2. Patient Characteristics

Features
Patients may have high/complex social needs/multiple MH and substance use issues (e.g. neurodiversity). They may experience emotional instability, can often come from backgrounds of disadvantage/experiences of trauma. Patients may experience bullying/violence/exposure and access to drugs, spend long periods in cells and boredom from lack of activities or when isolated. Individual and situational factors can lead to challenging behaviour. The presence of institutional violence. Some patients may present as uncooperative/unconcerned/subversive to treatment goals. Higher rates of suicidal ideation and behaviours.
Patient modifiers
Working with FMH staff to identify early signs of aggression/conflict and how to best manage them. With staff, developing coping skills/reflecting if these are effective.
FMH Staff modifiers
Working with trauma lens. Having frameworks for therapy. Working with patients to develop/enhance coping strategies, e.g. focusing on positive aspects of prison (mindful of maintaining a balanced view), acceptance of being in prison, and speaking to others about issues. Meaningful engagement with patients.
Aggression: Having a model to understand aggression within this setting, use of validated risk assessment instruments. Identifying the importance of routine, activity/exercise and supporting those to occur.
Suicide: Early identification of suicide risk, targeting modifiable risk factors and providing appropriate tools and support.
Staff supervision and support.
Flashpoints
Aggression: Violence/aggression may be used as a coping mechanism for feelings of fear/anxiety/ hopelessness/or tool to gain greater status in social hierarchy/ improve reputation. Substance use/withdrawal leading to disruptive behaviour. Time spent with others who may have an antisocial personality disorder/traits.
Suicide: Risk heightened at start of incarceration and with longer sentences/ homicide convictions/restrictive visitation/imprisoned further from one's community.
Self-harm: Being contained in a management cell for up to 23-hours a day.

3. Regulatory Framework

Features
External structure is influenced by judicial regulation and decision-making external to FMH/custodial staff. May be a prominent perception amongst people in prison who receive a long-term sentence that they have been treated unfairly by the system which can cause tension.
FMH Staff modifiers
Patients encouraged to have power in decision-making about treatment and given the opportunity to actively engage.
Flashpoints
When power is exercised by the justice system/custodial system. Court and sentencing processes, incarceration processes and initial adjustment period can be distressing/confronting and there is an increased risk for conflict behaviour, particularly if serving a longer sentence. Uncertainty around movement, transfer and/or release. Treatment characterised by coercion and control.

4. Staff Team

Features
Positive relationship between FMH staff and custodial officers is important. Ability of custodial staff to understand behaviour caused by mental illness. FMH staffs ability to assess and engage in offence issues/aggression/violence/ trauma related issues. Provision of care within boundaries of prison regime. All patients are engaged on a voluntary basis in their MH care. FMH staff may find it difficult to develop therapeutic relationships within prison setting/there may be limited opportunity for free expression of caring.
FMH Staff modifiers
Working with custodial staff to ensure patient behaviour related to mental illness is detected and understood, working together to maximise safety and improve outcomes. Challenging negative perceptions of patients and promoting recovery goals. Use of recovery-oriented language, not labelling the person due to incarceration status/crimes they have committed. Accessing supervision and support. Demonstrating respect/motivation/empathy.
Flashpoints
Discord between FMH and custodial staff roles/values/ways of working – impacts on access to patients/patient care. When negative perceptions of patients are held and negative language used. FMH staff feelings of professional isolation/ stigma/disempowerment and exclusion. FMH staff adopting practices/ attitudes that reflect custodial culture and use of coercive language. Issues with transference and counter transference/difficulties addressing offence issues or challenging behaviour.

5. Physical Environment

Features
Safety precautions present a challenge when FMH staff work to integrate security and therapy. Certain structural features of prison play a role in how patients respond/how FMH staff can intervene. Rules and regulations are explicit, structure is stringent. Restrictive practices applied for safety not conducive of a therapeutic environment.
FMH Staff Modifiers
Supporting patients to make decisions around self-care and medication to provide psychological and physical independence. Advocating for use of least restrictive practices and opportunities to make the environment more comfortable.
Flashpoints
Features can contribute to feelings of frustration, anger/aggression. FMH staff not able to provide the care necessary due to restrictions, areas of high social interaction and low staff observation. Living in close proximity with others, substance withdrawal, exacerbation in MH symptoms can increase emotional and behavioural instability. Removal of agency for patients.

6. Outside Hospital

Features
Limited access to family/carers/other supports. Separation from children. Impact of receiving a prison sentence. Visitation generally conducted under heavy surveillance, creating a lack of privacy. Note: this domain can also impact FMH/custodial staff working in prisons as they are also isolated to an extent while they are at work.
FMH Staff Modifiers
Working to engage family/children/carer/supporters where appropriate to encourage emotional and psychological forms of support, may include Lived Experience and culturally appropriate support.
Flashpoints
Limited/delayed access to family/children/carers/supports can lead to feelings of fear, social isolation, apprehension, and exacerbate mental health symptoms. Contact with the outside world can be unsettling/restricted. Visitors may bring in contraband.

FIGURE 4 | Safewards Secure Custodial Mental Health Technical Version.

4.1 | Strengths and Limitations

Participants in this study were very experienced in working in a wide range of public and private prisons in the state of Victoria. However, because Safewards is not currently being used in prisons, there was less experience among the group in terms of Safewards knowledge. To assist in reducing this knowledge gap, information was provided to give an overview of the original model and the Safewards Secure version. Because the focus of this study was on bed-based mental health prison units, this limits the generalisability to other parts of the prison that may function very differently. We would have liked more time to conduct the NGT but were limited to the time we could take staff away from the clinical setting (especially nurses). The advantage of the NGT was the rich data collected via notes and the group discussions. This study only gained the perspective of clinical staff, and

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there is a need for further research which highlights the views of custodial staff, which is part of our ongoing research.

5 | Conclusion

The first version of SS-CMH has been created, and future work will focus on the development of the custodial modifiers and the interventions. This model has been purposely developed for nurses working in bed-based FMH services within prisons and derived from the literature and verified by experts who work in this setting. This model could be employed to draw attention to the knowledge, skills, and attitudes required of FMH nurses who work in these settings and encourage them to work in collaborative ways with custodial staff, consumers, and their families, carers, and supporters.

6 | Relevance to Practice

SS-CMH could also be used to draw attention to some of the challenges faced by mental health nurses working in this setting and assist in supporting thinking around how to best support FMH nurses and consumers to work together to reduce conflict and containment within the confines of the prison regime. Engaging consumers will also be important in the next steps to ensure input and guidance regarding the model development.

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. T.M., M.Y., T.F., J.R. and B.M. were involved with the study concept and design. T.M., H.J., M.N., J.R. and B.M. collected data. T.M., M.Y., H.J. and M.N. were involved in data analysis, and all authors were involved in the write-up.

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Ethics Statement

To undertake this study, permission was granted from the Swinburne University of Technology (Project ID: 7430). 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 deidentification and assigning participant numbers.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Research data are not shared.

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