

## **EXPERT REVIEW OF MENTAL HEALTH AND WELLBEING SUPPORT FOR YOUNG PEOPLE IN CUSTODY**

### **Context**

In accordance with Section 7(2)(d) of the Prisons (Scotland) Act 1989, the Cabinet Secretary for Justice instructed Her Majesty's Chief Inspector of Prisons for Scotland (HMIPS) "to investigate specific matters connected with prisons or prisoners which have been referred to the Chief Inspector by the Scottish Minister".

Following the recent tragic deaths of Katie Allan and William Lindsay (also known as William Brown) at HMP& YOI Polmont ("Polmont") and in collaboration with the Deputy First Minister and Minister for Children and Young People, the Cabinet Secretary for Health & Sport and Minister for Mental Health, the Cabinet Secretary for Justice instructed HMIPS to undertake, with a mental health expert, a time-limited review into mental health provision for young people entering and in custody.

The principal aim will be to review arrangements for young people, both untried and convicted, with mental health and wellbeing needs, entering and in custody, including:

- the information available to the SPS prior to entering custody;
- reception, screening and assessment arrangements
- health and wellbeing culture linked to on-going support and supervision;
- treatment and interventions during their time in custody and:
- arrangements by SPS for their return to the community.

The review will be assisted by Dr Helen Smith, Consultant Forensic Child and Adolescent Psychiatrist at NHS Greater Glasgow and Clyde.

The project management of the review will be supported by a short life working group to include representation from :

- Social Work Scotland
- Centre for Youth and Criminal Justice
- Scottish Children's Reporter Administration
- SPS
- HMIPS
- Healthcare Improvement Scotland
- Barnardo's Scotland
- Scottish Association for Mental Health
- NHS Forth Valley

The review will focus specifically on young females and males in custody. It will not consider the specific circumstances or details of recent cases which are the subject of current or future mandatory Fatal Accident Inquiries.

### **Scope and Terms of Reference**

The specific methodology of the review is at the discretion of HMIPS but will involve consideration of:

- An evidence review of mental health and wellbeing support for young people in custody including any areas of best practice;
- Identifying and reviewing the processes for the identification of wellbeing and mental health needs for young people at the point of reception to custody;

- An investigation of information sharing practices and flows to inform the provision of information to SPS (including from other agencies out with the justice system such as health, education, social work 3rd sector agencies; and including any relevant factors arising from their experience prior to entering the custodial system) and whether the information can be better utilised to assess and act upon identified risk factors or specific vulnerabilities whilst in custody;
- The views and lived experience of staff, young people and their families with identified mental health and well-being needs at Polmont both currently in custody and those with lived experience of custody;
- Reviewing the processes for mental health and wellbeing assessment and referral processes in custody including the management of the risk of self-harm or suicide or other complex vulnerabilities.
- Reviewing the governance and decision-making arrangements for implementation of the Talk2Me process in custody including the evidence for its implementation, operational procedures, staff training and awareness;
- Review of:
  - staff training and awareness of mental health and wellbeing needs
  - the risk assessment process on reception,
  - the provision of wellbeing and mental health support in custody,
  - the treatment and interventions in custody and
  - the arrangements for continuity of care post release.
- Review of the DIPLAR process arrangements when it's an apparent suicide;
- Make recommendations for changes or improvements to Scottish Ministers which they can pursue with other relevant agencies and bodies as required.
- Should anything of immediate concern be identified these should be escalated to the respective bodies via Scottish Ministers;
- Suggest any further reviews that arise out of the investigation.

This investigation and review recommendations are to be presented to the Deputy First Minister, Cabinet Secretary for Health and Sport and Cabinet Secretary for Justice in Spring 2019 at the same time as the publication of the routine inspection findings of Polmont undertaken on 29 October -1 November 2018.