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Telemedicine in Prisons: A *Crime in Mind* perspective

John Gunn^{1*}, *Pamela J Taylor*², *Andrew Forrester*³, *Janet Parrott*⁴, *Adrian Grounds*⁵

1* Address for correspondence: Professor John Gunn, Emeritus Professor of Forensic Psychiatry, Institute of Psychiatry, King's College, London SE5 8AF, UK, johncgunn2@gmail.com

2 Cardiff University, Cardiff, UK.

3 Greater Manchester Mental Health NHS Foundation Trust and University of Manchester, Manchester, UK.

4 Oxleas NHS Foundation Trust, UK.

5 Institute of Criminology, Cambridge, UK

www.crimeinmind.org.uk

Telemedicine, or telehealth, has been with us for some time and has progressed particularly well in countries when doctor and patient may be separated by long distances. It has become well established in relation to prisoners in such places as Australia (Sullivan et al 2008, Bradford et al., 2016), South Africa (Mars et al 2012) and the USA (Alverson et al., 2019). It has become increasingly sophisticated over time, to the extent that physicians can even undertake physical examinations of patients, provided a nurse is present and can make some of the necessary observations and place the apparatus - e.g. stethoscope or EEG electrodes – correctly (Tenforde et al., 2017). Of particular potential interest in relation to the COVID-19 crisis, it has been used successfully to combat spread of infections in prisons (Morey et al, 2019; Young et al, 2014), but it has been reported that the use most frequently reported in the literature is in relation to prisoner mental health (Senanayake et al, 2018).

It is recognised that the UK has rather lagged behind in the actual technology required; prison staff have no specialised training in telehealth and prisons are not

provided with top quality equipment (Sales et al, 2018). The coronavirus lockdown, however, has meant that not only businesses but also health services have suddenly increased their use of using video communications through a range of platforms such as *Zoom, Teams, Skype, FaceTime, WhatsApp* and so on, to enable the office workforce to stay home productively. In health, some general practitioners are delighting in what they regard as a new way of working to manage their workload. While it seems unlikely in forensic psychiatry that most clinicians will see such technology as anything but a necessary and temporary substitute for face to face work with patients in secure hospital units – generally their main base for work in the UK - it may be tempting to think that it could substitute for face-to-face assessments and even treatment in prisons.

The Parole Board in England and Wales has for some time had a system gathering prisoner, prison officers and offender managers together via a television link to assess the suitability of the prisoner's potential release. Some of us who have worked with this system have not been assured that an adequate assessment could be done this way. Perhaps the qualities of technology here have benefited so much during the Covid-19 pandemic that many of the technological concerns may be set aside. It is interesting and important that research has been set up alongside technological advances in Surrey (Edge et al, 2020), and this may be wide ranging. Our concern here is particularly that safe and appropriate use of telepsychiatry does not depend on technology alone.

Psychiatric examinations and treatments are about much more than asking questions and receiving answers; of course, this is important, just as reviewing written background material is also important, but the psychiatric interview aims to

develop and use rapport and empathy. A skilled assessor will pick up many nuances which are not transmitted well by video-link. Such interviews are intimate matters, best done in private settings; video-link interviews never feel private. The usual timescale of the psychiatric interview is at least one hour, which is insufficient to develop rapport and a trusting relationship at the best of times, but when technology intrudes it can be much more difficult. Just think of “Zoom fatigue”, which healthy, working people are complaining about during the lockdown, meaning that any lengthy interview will be sub-optimal on both sides. Best results are obtained if the patient is put at ease from the start, but this is difficult by video-link. If the patient has paranoid ideas, for example, the presence of electronic apparatus is likely to make them worse and certainly will not facilitate an accurate evaluation. Even without paranoid ideas many patients will feel that the interview is not confidential, a point that is particularly important in psychotherapy – and indeed it may not be. Feelings between patient and interviewer develop more quickly in a natural environment and the interviewer can test their own feelings, for example does the patient create a sense of fear and threat. Again, this is very much more difficult at a distance. A very simple example of what can go wrong is the interviewer posing the question "are you feeling anxious?" and receiving a negative response. Close to, it is easier to assess whether this is an accurate answer or simply a defensive one. A video-link makes it difficult to pick up the nuances of a frown or a brief smile. One of the difficult skills of a psychiatric interview is the use of silence, especially the interviewer's silence, just listening to what the patient says without interruption or judgement. Putting it simply it is not natural to be in a small room with a television camera and a stranger at the other end, and silence in that context may feel simply uncomfortable to everyone, without nuance.

Secure institutions are never natural environments but with a little bit of kindness and friendliness something more approximate to a natural environment can be produced by two people sitting together. To fully grasp the contrast between being with a patient and across a tele link, imagine trying to comfort someone who is dying, by using a video-link and being unable to touch them. Although in some circumstances prisoners have indicated they are accepting of video-link psychiatry Mekhjian et al (1999), it would be instructive to explore its meaning to them further and find out the extent to which they feel they can speak candidly and convey accurate emotions.

Likely limits on the development of a good working relationship arising from the barriers surrounding telehealth practices may encourage a view that the patient is an object presenting with a collection of signs and symptoms, rather than a human being. This accentuates the de-individuation that can be experienced in places of detention as part of the well-understood process of institutionalisation, which is opposite to the aims of forensic psychiatry. Also the medicolegal implications in secure health care are not yet fully established – for example, what are the implications in the event of a suicide, or a homicide, in cases when only a tele-assessment has been conducted, but a full, face to face assessment would have been possible?

The GMC's good medical practice guidelines state that doctors have a responsibility to make the care of their patient their first concern, and to “establish and maintain good partnerships with your patients...”. We argue that although the implementation of greater video-link working in forensic psychiatry within the context of the Covid-19 pandemic is understandable, it should not be extended beyond this temporary phase

without full review because it places limitations on the abilities of doctors to meet these two core obligations.

Our concern is that there will inevitably be pressure from administrators who will believe that a new way of saving money and time has fortuitously been demonstrated by the 'success' of working via telecommunications rather than face-to-face assessments. If the technology is state of the art, we should allow that there may be circumstances in which it could help – for example obviating the need for a sequence of four or five or more experts to visit in person before a hospital bed can be confirmed for someone who needs urgent transfer out of the prison rather than waiting weeks or months for this succession to be completed. There may indeed be other areas where we could put such technology to more use, but we need to do this according to evidence, true cost effectiveness and all the time being mindful of prisoners as people. We need to develop a research strategy to determine optimal adjunctive use of such facilities, in the meantime, we need to draft a working practice guideline, and to develop training modules in optimising ethical use of technology in such circumstances. Cheapest in the short term may be very costly over longer time. Governments, commissioners and other administrators may say that the new technology can supplant the need for doctors, other clinicians and assessors and therapists to visit prisoners in person. They should be disabused of this tempting idea.

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