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Forensic Telepsychiatry in the United Kingdom

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Forensic telepsychiatry remains in its infancy in the United Kingdom. This article sets out to describe how it can be used within a community forensic service, and the future challenges ahead in the U.K. It looks at relevant academic, governmental, and legal resources and is designed as a scholarly reflection by clinicians rather than as a formal literature review. Copyright © 2008 John Wiley & Sons, Ltd.

Forensic telepsychiatry is defined by Merideth (1999) as ''the use of telecommunication technology to provide mental health services in a medicolegal context''. It provides opportunities for forensic evaluations, clinical consultations, and education in the context of forensic mental health. In addition its use may enable criminal justice agencies such as courts, prisons, and probation to have access to forensic expertise in a timely and efficient manner (Merideth, 1999). Although US clinicians have recognized the use of telepsychiatry as appropriate in forensic settings (APA, 1998), its use in such settings in the United Kingdom remains in its infancy (Khalifa, Saleem, & Stankard, 2007). This is despite the fact that secure video conferencing facilities are readily accessible from most courts, prisons, and secure hospitals in the U.K. The purpose of this contribution is to provide an overview of forensic telepsychiatry in the U.K., present a service model, highlight some practical considerations and offer recommendations for future practise.

THE MEDICOLEGAL CONTEXT OF THE U.K.

For the benefit of the many non-U.K. readers, it would seem useful to provide an overview of the criminal justice system (looking specifically at England and Wales, as

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Scotland has a separate legal system) and practise of forensic psychiatry in the U.K. before exploring forensic telepsychiatry.

The Criminal Justice System (CJS) is one of the major public services in the U.K. Within the CJS, agencies such as the Police, Crown Prosecution Service (CPS), Her Majesty's Court Service, National Offender Management Service (which incorporates both the prison and probation services), and Serious Fraud Office work together to deliver the criminal justice process. Broadly speaking, the police represent the point of entry to the CJS. The decision to charge a suspect or not is usually made through consultation between the police and the CPS. This decision is usually based on the evidential test and the public interest test. Once these tests are satisfied the suspect is formally charged. The CPS will then have to prepare a case and present it in court.

Virtually all criminal cases start in the Magistrates' Courts. The less serious (summary) offenses are dealt with entirely in Magistrates' Court. The more serious (indictable) offenses are passed on to Crown Court, to be dealt with by a judge and jury. Crown Court also deals with appeals from Magistrates' Court. Appeals from Crown Court are heard at the Criminal Division of the Court of Appeal. The House of Lords is the highest appellate authority in the U.K.

In cases where a defendant has (or is suspected of having) a mental disorder, the involvement of psychiatrists (particularly forensic psychiatrists) may be sought at any stage of the criminal justice process. Existing arrangements allow the diversion of mentally disordered offenders (under criminal or mental health legislation) to mental health treatment facilities at any stage of the criminal justice process. The vast majority of diversion schemes operate at the levels of the police and Magistrates' Court (Birmingham, 2000).

Forensic psychiatry is an established sub-speciality of psychiatry in the U.K. and comprises both clinical and medico-legal services. It also has an academic infrastructure represented by university departments in London, Nottingham, Cardiff, and Manchester. Clinical forensic services are primarily multidisciplinary, delivered at different levels of security and publicly funded through the National Health Service (NHS), which is free at the point of delivery. The level of risk posed by the patient determines the degree of physical, procedural, and relational security measures that will be required. Maximum secure care is provided at Broadmoor, Ashworth, and Rampton hospitals in England and Carstairs in Scotland. Historically these were the exclusive providers of secure hospital care until the 1970s. Lower levels of forensic care are provided within medium secure (also known as regional secure units) and low secure hospitals. The latter are often linked with community forensic services to provide for the needs of mentally disordered offenders who move into community settings. Forensic psychiatrists have traditionally provided psychiatric input to prisons either on ad hoc basis or as visiting psychiatrists. The last few years have seen the development of psychiatric inreach teams, which are the equivalent of community mental health teams in prisons (DoH, 2001).

In addition to a therapeutic role, forensic psychiatrists also provide expert testimony for the courts in both civil and criminal cases. Forensic psychiatrists also provide reports to the Home Office for those patients who are detained under the appropriate legislation and reports on patients who are appealing against detention under civil mental health law.

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The manner in which forensic services currently operate in the U.K. means that patients' movement or transfer between these multiple sites (for instance between prisons and secure hospitals, one level of security and another, and hospitals and community settings) is integral to the practice of forensic psychiatry. Interagency communication, liaison, and information sharing are, therefore, of paramount importance. This is where telepsychiatry has a pivotal role to play. It has the potential to facilitate interaction between the various components of the complex and multi-layered U.K. forensic service.

TELEPSYCHIATRY IN THE U.K.

Telepsychiatry in forensic mental health care in the U.K. has a recent history. By comparison, however, the criminal justice system had allowed the use of live television at preliminary court hearings since the Crime and Disorder Act of 1998. This piece of legislation paved the way for the introduction of video-link facilities, which were initially used for conducting remand hearings, but their use was later extended to include child testimony. Videolink facilities are now widely available in most courts and prisons in the U.K. For instance, in England and Wales there are 57 prisons linked up to 30 Crown Courts and 154 Magistrates' Courts (U.K. Parliament, 2004). Within the criminal justice system, these facilities are connected through a secure network and no recording of any type is allowed. Moreover, they are readily accessible (and available free of charge) to various professionals such as lawyers, probation officers, and parole board members.

Health care professionals were not initially considered as potential users of such facilities. However, in October 2005, the first author (Y. S.) first accessed the video link, and used it in subsequently for the purpose of forensic evaluations. As the practice became more usual, more forensic psychiatrists including trainees (equivalent to senior residents) within Nottinghamshire Healthcare NHS Trust (where the authors are currently working) began to use the video link to deliver mental health services in prisons. Over the last decade, video-link facilities have been established in most forensic units within the NHS. These can link to prisons and courts through the secure network.

The published literature on the use of forensic telepsychiatry in the U.K. is scarce, compared with the North American and Australian literature. Although the vast geographical nature of these latter countries makes the use of telepsychiatry particularly attractive (Khalifa et al., 2007), it is possible that the lack of U.K. papers suggests that telepsychiatry is underused. According to McLaren (2004), health-care professionals in the U.K. have only embraced telepsychiatry for meetings, supervision, education and administration rather than for clinical purposes. He concludes that there is a ''wariness'' among professionals, which is grounded in ''prejudice and professional defensiveness'' rather than ''objective assessment''.

Harley, McLaren, Blackwood, Tierney, and Everett (2002) used a telepsychiatry programme within the South London and the Maudsley NHS Trust (SLaM) to provide specialist mental health services to the Island of Jersey Health and Social Services. During the six-month pilot phase, a number of consultations, psychiatric assessments (including forensic), educational seminars, and case reviews were conducted via video link. The overall results suggested that videoconferencing was a

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feasible and acceptable mode of health-care delivery. Leonard (2004) described the development and evaluation of a telepsychiatry service for prisoners. The service linked a medium secure hospital (Ravenswood House) to a prison off the south coast of England (HMP Parkhurst). Saleem and Stankard (2006) described the use of video link to conduct psychiatric assessments, which also served as the basis for psychiatric court reports. Finally, the SLaM telepsychiatry programme (SLaM, 2007) examined the use of telepsychiatry to improve the quality of care for mentally disordered offenders (MDOs) in south London, and concluded that it is feasible to use videoconferencing for this group. Overall, all articles conclude that telepsychiatry is reliable, acceptable, and cost-effective in the forensic setting.

A SERVICE MODEL

Trent Tele-Psychiatry Service (TTPS) at North Nottinghamshire Community Forensic Service, Nottinghamshire Healthcare NHS Trust, is the model presented. The clinical team within the service is comprised of three social workers, five community psychiatric nurses, two psychologists, an occupational therapist, a consultant forensic psychiatrist, and a specialist registrar (equivalent to senior resident). The time investment by members of the team in delivering their clinical duties is significant. The team base is in Mansfield (a small town in North Nottinghamshire, with a population of approximately 100,000). In-patients of our service are in a low secure unit thirteen miles away (Nottingham). We provide psychiatric in-reach services to a prison 22 miles away (Ranby Prison). Our sister secure units are 43 (Arnold Lodge Regional Secure Unit), 33 (Wathwood Regional Secure Unit), and 25 (Rampton High Secure Hospital) miles respectively from the team base. This is notwithstanding the fact that our community caseload of patients lives in four small towns (Mansfield, Worksop, Retford, and Newark).

The service[Q1], which utilizes video-link facilities within a local Magistrates' Court, has established a system that allows all disciplines to assess those referred to the community forensic service (particularly prisoners) via video link. At first it was used only by the consultant, but currently nurses, social workers, psychologists, occupational therapists, and others are utilizing the service. A range of services is now being delivered using video link. These include

- performance of forensic evaluations that would serve as the basis for medico-legal reports (for Crown Prosecution Service, solicitors, and a range of other agencies)
- follow-up of community patients
- psychotherapy (cognitive analytic therapy and psychodynamic psychotherapy)
- care programme approach meetings (these are three or six monthly meetings, which consider the patient's care pathway, risk assessment, and future needs)
- mentoring forensic practitioners
- meetings (particularly medical management meetings within the Forensic Directorate)
- discharge planning.

In addition, the use of video link has enabled the clinical team to liaise with and obtain more background information from patients' carers, including family members.

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Looking at the broader U.K. perspective, there is a relatively small forensic work force in the U.K. (fewer than 300 consultant forensic psychiatrists in England, Wales, and Northern Ireland (RCPsych, 2005) covering multiple sites and across a large geographical area. The emphasis on a multidisciplinary and interagency approach to the management of mentally disordered offenders means that professionals have to liaise, co-work, and share care for these patients. For instance, discharge planning takes place after considerably prolonged inter-site (and at times inter-agency) exchange of information, assessments, and meetings. This process has until now relied entirely on conventional means of transport and communication. The use of telepsychiatry will assist and may potentially expedite these processes.

PRACTICAL & ETHICAL CONSIDERATIONS IN THE USE OF TELEPSYCHIATRY IN THE U.K.

Logistical Issues

Its is likely that the video-link equipment used is at least part owned and maintained by other agencies (for example, by Her Majesty's Court Service or Prison Service). This means that individual psychiatrists will have no jurisdiction over its integrity, though they would appear to remain clinically responsible for ensuring the confidentiality, circumstances, and outcomes of the interview itself. Some clinicians may feel uneasy about being accountable for variables that are outside their direct control.

The sustainability of a service such as TTPS relies on fostering relationships with key personnel in these agencies, often at a local level. At present these are based on goodwill. The challenge will be to formalize such arrangements in the future, and to potentially roll out such a project on a national scale. There is a limit to what can be achieved without dialogue involving senior central management within large governmental organizations. It can also be difficult to ensure that decisions taken then filter down to frontline staff in individual institutions.

Historically, Prison Service policies and operations are dominated by security considerations (see also 'risk management' below). This is enshrined in the Prison Service statement of purpose, and is in itself laudable. There are negative consequences though, and psychiatrists going into prisons will be able to recall anecdotal problems in doing so successfully. These can be in terms of gaining entry, booking appointments in appropriate interview environments (health-care clinics can have restricted capacity of interview rooms for non-regular visiting clinicians), where there are tightly restricted time slots allowed for interviews (the result of rigid prison regimes and movement restrictions) and where prisoners are relocated to other prisons without informing the assessing psychiatrist (relocation is commoner in the current overcrowded prison estate).

Although these concerns may seem petty at first, reading their implications can be more wide-ranging: inadequate clinical interviews, wasted clinical time, and reduced efficacy in the delivery of psychiatric health care and in facilitating the criminal justice process. Telepsychiatry may combat some of these problems.

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Willingness of Professionals to Use Telepsychiatry

Unwillingness of professionals to use telepsychiatry has been identified as one of the most significant barriers to its use (McLaren, 2004; Jones, Leonard, & Birmingham, 2006; Khalifa et al., 2007). McLaren (2004) argues that mental health-care professionals in the U.K. have only embraced telepsychiatry for meetings, supervision, education, and administration rather than for clinical purposes. He concludes that there is a ''wariness'' among professionals, which is grounded in ''prejudice and professional defensiveness'' rather than ''objective assessment''. This ''wariness'' may also be related to perceived usefulness and ease of use of video link (Hu, Chau, Liu Sheng, & Yan Tam, 1999); resistance to change; lack of experience or training; and concerns about the effect on communication, confidentiality (Jones et al., 2006), and therapeutic rapport (May et al., 2000).

Licensing and Competency

The scenario of a doctor potentially having to be credentialed and licensed in two different states if the doctor and the patient are in different parts of the country (Hayler & Gangure, 2004) does not arise within the United Kingdom. This is because doctors' practice throughout the U.K. is regulated by a single body, the General Medical Council (GMC). All medical practitioners must be registered with the GMC. This contrasts with the U.S. model of multiple state-level medical boards.

Professional Liability

This depends on the purpose for which the video-link assessment is performed. Psychiatrists employed by, and performing work on behalf of, the National Health Service are covered by NHS indemnity (DoH, 1996). In addition, doctors are advised to take out adequate insurance or indemnity cover for any part of their practice not covered by the NHS indemnity scheme. Such individual cover is offered by specialist medical defense organizations. For the most part, medico-legal psychiatric examinations are non-NHS work and are funded by solicitors or the Courts. While it is accepted that in using telepsychiatry ''the accountability and ethical duties of doctors and their ethical duties remain the same'' (British Medical Association, personal communication, 2006), the standards of care and extent of professional liability have yet to be tested in the courts.

Risk Management

During the interview concerns may emerge regarding risk to self or others. There needs to be consideration of procedures by which such concerns will be safely communicated to the appropriate personnel, and relevant clinical management plans put in place. This can be highlighted using a prison evaluation as an example. A prison officer (prison guard) will escort the prisoner to the interviewing booth, and may wait outside until the termination of the interview. If the psychiatrist is

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concerned about the health of the prisoner then this will be relayed to someone with limited skills in mental health care and the doctor will also seek to communicate remotely with specialist staff at the health-care wing of the prison. The doctor can feel in a more exposed position compared with being physically in attendance when seeking to impose immediate clinical management.

Guidance from Professional Bodies

There appears to be no U.K. guidance specifically looking at the use of telepsychiatry. The Royal College of Psychiatrists has not published anything on this subject. This may seem surprising to U.S. readers, who will be aware of the position statement from the American Psychiatric Association (APA, 1998).

The GMC's advice on the practise of remote prescribing (which can be extrapolated for telepsychiatry) recommends clear explanations to the patient, ensuring that they know of a doctor's identity, that there are appropriate follow-up arrangements, and that there is appropriate communication with other clinicians involved in the patient's care (GMC, 2006).

The British Medical Association points to existing European standards (Standing Committee of European Doctors, 1997). These relate to competency, the doctor–patient relationship, the responsible physician, quality, security, safety, ethics, consent, and confidentiality. It states that the use of telemedicine ''must not adversely affect the individual doctor–patient relationship . . . preferably, all patients seeking medical advice should see a doctor in a face to face consultation''.

Ethical, Privacy, and Confidentiality Issues

Telepsychiatry is a new form of practice in the U.K. and most agencies are unaware of it as a mode of service delivery. It is, therefore, imperative that the person carrying out the telepsychiatry interview informs and obtains permission from the referrer that a telepsychiatry consultation, as opposed to the conventional/standard face to face interview, is acceptable to them.

Clearly, informed consent is required prior to conducting an interview by video link. The interviewee should be informed of the risks associated with telepsychiatry and of limits of privacy and confidentiality. To an extent concerns regarding privacy can be allayed, as the communication line is secure. Court and prison video-link apparatus does not currently allow any recording to occur. Photocopying prison medical records may expose clinical data to non-clinical staff. However, the administrative staff who are likely to conduct this will often have access to other sensitive data such as criminal record print-outs, court depositions, and security intelligence files in their existing roles. They will thus be aware of the importance of confidentiality.

The Therapeutic Relationship

Medical teaching in the U.K. emphasizes the art of establishing therapeutic rapport with patients. Forensic psychiatrists have particular skills in eliciting complex and

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often sensitive histories, usually via face to face interview. Clinicians may, quite legitimately, be uneasy about the importance of this clinical skill being underestimated. Some may argue that video-link psychiatric interviews have an adverse effect on the rapport gained. Interviews may become stilted, less empathic, and diagnostically inferior.

There may also be a contribution from the current political climate, one in which traditional medical roles have passed to other health-care professionals. It may be felt that the extension of remote interviewing is a checklist, standardized approach rather than one of a person-centred clinical assessment.

There may be concerns that video-link interviews are offered as they suit the psychiatrist, rather than the patient. It is important, therefore, that the patient's best interests are always acted upon when deciding whether a video-link interview is appropriate.

Legal Issues

Psychiatric reports for Criminal Courts can be subject to scrutiny via the adversarial legal process. Psychiatrists need to be clear that information attained during interview will not be undermined by the legitimacy of video link as a means of interview. At present there is no guidance from the judiciary (Department for Constitutional Affairs) on this matter. There has not been any case law to date in which video link has been challenged. The Criminal Justice Act (2003) allows for live video testimony to be available for any witness in the interests of efficient or effective administration of justice (HM Government, 2003). It remains possible that medical evidence, including recommendations for compulsory hospitalization, may be challenged.

RECOMMENDATIONS FOR THE FUTURE

Enhanced information sharing on the practice of telepsychiatry amongst peers and related professionals

One of the authors (Y. S.) has been to several U.K. forensic psychiatric units giving an academic presentation that makes other professionals aware of telepsychiatry. The feedback received thus far has been mainly positive. While most professionals appreciate the advantages of interaction between multiple sites through video link (and indeed some express a desire to use it), some do have reservations regarding the practical considerations, for example, ownership of equipment, professional licensing and liability, and risk management.

It would be advantageous if identified, interested psychiatrists disseminated information at a local level. The potential formation of a special interest group or working party, perhaps within the Royal College of Psychiatrists, would allow for the exchange of experience and good practise between clinicians. This would also provide an interface with stakeholders and professional bodies. It might also lead to the production of a training document on telepsychiatry (as those currently using the system are largely self-taught) and provide competence standards, which

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could be interlinked with ongoing psychiatric training. Such a training document and agreed competencies should help to diminish professional wariness to telepsychiatry, as highlighted by McLaren (2004). A national survey could also be conducted to assess health-care professionals' views about the possible uses for forensic telepsychiatry.

Develop a dialogue with key stakeholders to facilitate clearer pathways for the use of telepsychiatry

It is to the benefit of several parties, namely hospitals, prisons, courts, and clinicians, that the process of psychiatric evaluation and clinical management occur as efficiently as possible. This requires a collaborative approach by each of these agencies (Department of Health, Department of Constitutional Affairs, and HM Prison Service). Protocols for the practical use of video-link technology could incorporate policies and procedures addressing key areas such as on risk management post-assessment, and remote access to inmate medical records.

There is recent evidence of such joint working in a recently circulated (October 2007) advice notice from the National Offender Management Service and Department of Health. This states that patients in secure hospitals are now permitted to plead and give evidence via video link to the courts, if appropriate, without requiring specific permission from a Government Minister. Indeed on 18 January 2008 both Y. S. (who gave expert witness testimony) and a patient appeared via video link to a Crown Court for trial and sentencing. This is the first occasion on which this has occurred in the U.K.

Development of guidance and position statements by professional bodies on the use of telepsychiatry

This concentrates on medical professional organizations but could also form a basis upon which other health professionals might design their own guidance. The GMC currently has no guidance relating to doctor–patient interaction via video link. Good practice advice relating to telepsychiatry needs to be developed urgently, as a protection to those who are currently using this apparatus. The BMA does not have a policy that is specific to the practice of telepsychiatry similar to the APA resource document. Speedy action in this regard is needed to bolster the confidence of individuals who wish to use telepsychiatry in their practice. The Royal College of Psychiatrists has traditionally provided guidance on various issues in relation to the practice of psychiatry in the U.K.; telepsychiatry should not be an exception.

The decision to engage in remote interviewing rather than face to face must bear in mind the clinical circumstances of the case. A doctor's core responsibilities in alleviating distress and doing no harm must be borne in mind when presented with circumstances that do not lend themselves to remote interviewing (such as, for example, acute psychotic illness, significant learning disability). It is important that this is incorporated into guidance documentation.

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CONCLUSIONS

Telepsychiatry in the U.K. is a relatively new concept. It has been an important tool by which the TTPS service is delivered, and is currently being pioneered in the U.K. Forensic psychiatrists in the U.K. sometimes ruminate upon whether there has been sufficient progress since the expansion of the sub-speciality since the 1970s. It could be that telepsychiatry is an opportunity to embrace innovation and take forensic psychiatry forward. It is the experience of the authors, as well as much of the U.K. research, that this could be the case.

It is important that proponents of telepsychiatry work to address the concerns raised by colleagues in order to achieve its full potential. There should be a framework for its use, at an operational and professional level. It is important that it can be used in appropriate situations as a helpful adjunct to forensic practise.

CONFLICT OF INTERESTS

None.

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