

Suggestions for mitigating challenges and improving the integration of telepsychiatry in correctional facilities

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INTRODUCTION

Telepsychiatry has become a key modality for delivering specialist mental health care to people in correctional facilities, where prevalence of severe mental disorders and substance use disorders is markedly higher than in the community and access to in-person care is structurally limited.

International evidence shows that video-based assessments can achieve comparable diagnostic reliability, high patient satisfaction and significant cost and time savings, but also reveals persistent concerns about privacy, therapeutic alliance, management of risk and unclear legal responsibilities in forensic contexts.

The rapid expansion of remote care during and after the COVID-19 pandemic has made these challenges more visible and underscored the need for structured, context-sensitive models that integrate telepsychiatry into routine prison mental health care rather than using it as an ad-hoc emergency solution.

AIM

To propose concrete, feasible strategies for mitigating logistical, ethical and clinical challenges and for achieving safe, sustainable and clinically credible integration of telepsychiatry in correctional facilities.

METHODS

- Narrative analysis of international literature on correctional telepsychiatry, with particular attention to barriers related to infrastructure, clinical practice, governance and ethical and/or legal regulation.
- Mapping of typical care pathways in prisons (intake, crisis care, routine follow-up, transfers, pre-release planning) to identify critical points where telepsychiatry can improve access or continuity of care.
- Development of a set of interlinked proposals addressing:
 - technological and security requirements,
 - clinical and organisational models of care,
 - workforce training and support,
 - ethical, legal and governance frameworks, and
 - financial planning and sustainability.
- Feasibility of each proposal is discussed in terms of resource needs, acceptability in forensic settings, and potential impact on both clinical outcomes and judicial processes.

RESULTS

Adoption of secure, encrypted video platforms explicitly certified for health-care and correctional use, with end-to-end encryption, role-based access and

detailed audit trails, reduces risks of data breaches while supporting forensic standards for documentation and confidentiality.

Creation of on-site “telepsychiatry hubs” with dedicated sound-insulated rooms, stable connectivity, tamper-proof hardware and basic panic-alert systems allows sessions to proceed without ad-hoc improvisation and supports both safety and privacy.

Standardised technical protocols (pre-session checks, contingency plans for connection failure, procedures for emergency escalation) minimise disruption and protect the evidentiary value of assessments.

Integrating telepsychiatry into standard prison intake, triage and periodic mental health reviews ensures prompt assessment and regular monitoring despite overcrowding and limited on-site staff.

Hybrid models in which high-stakes assessments (fitness to plead, risk evaluation, major diagnostic clarification) start with in-person contact, followed by remote follow-ups, preserve diagnostic depth while optimising scarce specialist time.

Telepsychiatry clinics can be scheduled for specific populations (women, adolescents, migrants, people with severe SUDs) to support tailored interventions and reduce waiting times for specialist consultation.

Structured pre-release and post-release teleconsultations facilitate continuity of care between prison services, community mental health teams and probation, reducing the risk of “care vacuums” during transition.

Targeted training for psychiatrists, psychologists, nurses and prison officers should cover:

- techniques for building rapport, reading non-verbal cues and managing dissociation or agitation via screen;
- risk assessment and de-escalation when the clinician is not physically present; and
- cultural competence and trauma-informed approaches in diverse inmate populations.

Simulation-based exercises and joint training with correctional staff can increase mutual trust, clarify roles during emergencies and reduce clinicians’ reluctance to use telepsychiatry.

Supervision and peer-discussion groups focused on telepsychiatric cases in regular intervals help maintain reflective practice and prevent “screen fatigue”

Clear clinical governance structures should include:

- minimum documentation standards for teleconsultations,
- mandatory peer review of selected forensic opinions issued remotely, and
- systematic monitoring of key indicators (no-show rates, incidents during or after sessions, transfers avoided).

Standard operating procedures for when telepsychiatry is suitable, when it must be complemented by in-person assessment and when it is contraindicated (e.g. acute delirium, severe cognitive impairment) protect both patients and experts in legal proceedings.

- Correctional-specific telepsychiatry guidelines should define:
- informed consent procedures adapted to custodial contexts;
- rules governing presence of officers or interpreters in the room; and
- safeguards for privacy, including limits on recording and data retention.

National or regional regulations need to clarify cross-jurisdictional licensing, liability when emergencies arise during remote sessions, and equivalence of telepsychiatric testimony with in-person expert evidence.

Cost savings from reduced prisoner transport, fewer external escorts, shorter waiting lists and less time lost for court-ordered evaluations should be systematically quantified.

Part of these savings can be earmarked for ongoing investment in infrastructure, maintenance, training and evaluation, turning telepsychiatry from a short-term project into a core, stable component of prison mental health services.

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