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Making the Case for Videoconferencing and Remote Child Custody Evaluations (RCCES): The Empirical, Ethical, and Evidentiary Arguments for Accepting New Technology

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The COVID-19 pandemic and its requirements for social distancing and limited, if any, in-person contact have forced the child custody community to consider remote child custody evaluations (RCCES) conducted through videoconferencing. CCEs are perhaps the most complex of all forensic evaluations, requiring complex, multifaceted assessments of multiple parties and their relationships in order to address the best interests of the child. Attempting these evaluations via videoconferencing should be done carefully and only after consideration of numerous factors, including whether this alternative can be safely and reliably accomplished. This article outlines the conceptual approach used by the child custody community for determining the foci of the evaluation, tailoring data collection via multiple methodologies, and analyzing the data. The article reviews the empirical literature demonstrating that professional relationships and various clinical and forensic processes have reliably and successfully used videoconferencing with adults, children, and different clinical and forensic populations. The article also outlines how evaluators conducting RCCES must comply with the ethical demands of their discipline or profession, as well as ethical demands unique to remote service delivery. Finally, the article addresses how evaluators can prepare for challenges to their work that are based upon the standards for admissibility of expert witness testimony. The limitations of videoconferencing, including limitations specific to the demands of RCCES, are also reviewed.

Keywords: remote child custody evaluations, videoconferencing, telemental health, ethics in telepsychology

The impact of the COVID-19 pandemic on the child custody evaluation (CCE) community has been astounding and immediate. In March, April, and May of 2020, state and local governments and courts began issuing safe-at-home and social distancing proclamations. Provision of in-person mental health services was discouraged as unsafe (Chenneville & Schwartz-Mette, 2020). These pronouncements required evaluators to quickly learn what technology could be used and how to use it to finish incomplete evaluations or meet the demands of court orders for new evaluations. While the capability of providing behavioral health services

with telecommunication technologies has been extended to virtually all clinical aspects of behavioral and mental health practice, such as assessment, consultation, psychoeducation, and treatment (Luxton, Nelson, & Maheu, 2016), utilizing these technologies in parenting plan evaluations had not been a serious topic prior to the COVID-19 pandemic. That has changed. This article examines the feasibility of remote child custody evaluations (RCCES) both during the pandemic and beyond.

The COVID-19 pandemic has pushed an entire professional community to consider whether videoconferencing (VC) can be paired with custody methods and procedures to produce valid, reliable, and trustworthy results. For each component methodology of a comprehensive CCE that would usually require in-person contact, the best practices for using VC and the available empirical research are used to illustrate when VC is acceptable and when it is not. In a completely remote CCE, VC is used to conduct interviews of the adults and children, to conduct psychological testing (to the extent possible), and to conduct parent-child observations. RCCES retain elements of in-person CCEs such as document retrieval and review and contacts with third-party collaterals—usually by telephone. In order to conduct an RCCE, an evaluator must be competent in both VC use in a professional relationship and in the methodological demands of properly conducting a CCE. However, not every task can be delivered via VC, not every case is appropriate for remote evaluation, not every party or child will agree to using the technology, and not every evaluator

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will embrace this new approach. Yet progress in a professional specialty like child custody, that looks to science for guidance, is often about generalizations where conclusions obtained in a laboratory or slightly alternative setting are developed, then transported and applied elsewhere in environments that may differ from that in the laboratory or alternative setting (Pearl & Bareinboim, 2014). This is an opportunity to do just that.

This effort is not an attempt to fundamentally alter current CCE processes but to extrapolate and accept the lessons learned about VC use in other areas of psychology in the CCE context. Using VC can enable RCCEs to be viewed as an alternative with an array of possible applications, including situations where COVID-19 or other issues require social distancing, as well as situations where other factors (e.g., access to justice, financial considerations, and resource availability) otherwise limit the choices available to families and the court. It is also possible that a family could choose to have their evaluation conducted remotely using VC for reasons entirely their own.

These issues are of interest to evaluators making decisions about whether to use VC and to conduct RCCEs. These issues are of interest to attorneys as they advise and represent their clients in various contexts including but not limited to litigation. These issues are also of interest to courts and judges who must decide whether an RCCE will help the court, under what circumstances this approach may or may not work, and how to weigh the data generated via VC. Finally, these issues are also of interest to the parties—and ultimately their children—as they weigh the considerations and factors associated with various dispute resolution alternatives and, when necessary, their access to the authority of the court for problem solving.

A Conceptual Model for RCCEs

Child custody evaluation may be the most complex and difficult type of forensic evaluation. In contrast to most examinations in which one person is evaluated, in the typical child custody evaluation, the mental health professional examines a number of persons (e.g., mother, father, child or children, and potential or actual stepparents). Additionally, given the expansive nature of the underlying psycholegal issues (i.e., the best interests of the children and the ability of the parents to meet those interests), the examinees must be assessed regarding a variety of behaviors, capacities, and needs. Finally, because the stakes are so significant (i.e., residential placement of the children and decision-making authority with respect to their welfare), emotions in cases of contested custody typically run high, further compounding what is an already complicated evaluation process. (Otto, Edens, & Barcus, 2000, pp. 312–313)

Competent child custody evaluators, both those conducting in-person CCEs as well as those performing RCCEs, must operationalize the best interests task and objectives, understand how multiple methods are used to gather data on factors and psycholegal questions, and know how to use the multitrait-multimethod matrix interpretation principles of data analysis. The behaviors of the parties and their children and their relationships usually have multiple determinants. There may be few, if any, linear or simple cause-and-effect relationships.

Complex custody disputes almost always involve not just one theory or question but multiple questions and competing theories about highly disputed facts (Dale & Gould, 2014). For the evaluator, these factual disputes require formulating, hypothesizing, and

developing opinions to numerous series of questions that are often subsumed under multiple main questions.

Determining what is in the best interests of the child involves answering numerous subquestions about child factors, interfamilial and parenting factors, parent factors, and extrafamilial factors (citation omitted). Each of these factors is composed of subfactors that address separate factual questions about how the age of the child, the child's gender, and the child's cognitive and emotional development will affect current and future parent-child interactions and functioning (Krauss & Sales, 1999, p. 96).

In addition, evaluators must recognize any CCE is an assessment of multiple moving targets; people, their circumstances, and their situations may be in a constant state of change in response to the separation or other aspects of the ongoing dispute. Articulating a conceptual lens is necessary because of how much the evaluator must adapt the methodological elements as the evaluation proceeds. The evaluator manages a process that must assess and investigate required topics, be responsive to opportunities for additional details—which may emerge at any point in the process—and adjust inquiries as the data confirms or disconfirms various hypotheses.

The process of any evaluation, whether conducted in person or via VC, is dependent upon a perpetual adaptation of the evaluator's ability to operationalize best interests considerations and questions, the evaluator's competence in the use of each of the multiple methods of data collection, and the evaluator's ability to integrate large amounts of data into a comprehensive understanding of the issues in the case. While there are scientific principles to guide portions of the work, a CCE is still a fact-intensive inquiry and investigation using multiple methods to seek an individualized answer. Diligently applying the conceptual model, the multitrait-multimethod data analysis, and the investigative mindset is the evaluator's best defense against missing something, against challenges of possible biases, or against performing a less than adequate evaluation.

Scope of a CCE: Best Interests Factors and Case-Specific Psycholegal Questions

In CCEs, evaluators collect data and facts that are used to develop opinions about relevant factors or psycholegal questions, including opinions about the ultimate issues of custody, residency, and parenting time. In making a best interests determination, courts must consider all the factors that may be identified by statute or case law, as well as any relevant factors raised by the parties. If offering an opinion on the ultimate issues of custody and parenting time, evaluators are also expected to consider these factors, and when possible and appropriate, evaluators may use social science research to support their choice of methods, inferences, and opinions.

Evaluators are also encouraged to develop case-specific psycholegal questions to guide their inquiry. "The relevance of the information gathered in the evaluation is directly tied to the clarity and scope of the questions that guide the investigation" (Gould & Martindale, 2009, p. 1). "Clearly defined questions lead the evaluator to choose methods of assessment that measure behaviors directly relevant to questions of concern to the court" (Gould & Martindale, 2007, p. 101). By including specific questions in court

orders or stipulations, judges and attorneys increase the likelihood that evaluators will stay on course, investigate the issues of concern, and, in preparing their reports, provide information that bears directly upon the issues before the court (Gould & Martindale, 2009). This process requires considerable pre-evaluation preparation.

Child custody evaluators are often asked to evaluate allegations of risky and/or abusive behaviors such as domestic or intimate partner violence, child sexual abuse, various forms of child maltreatment, or claims of parental alienation or alienated children, as well as a multitude of other behaviors believed to place children at risk for harm, neglect, or adjustment problems. Efforts to assess the historical truth of an allegation, for example, usually involve interviewing all of the involved parties and combining this data with information from relevant records or information from other third-party informants.

Multiple Methods of Data Collection: Five Types of Data Collection

In conducting comprehensive child custody evaluations, evaluators apply theory, research, and scientific methodology (Drozd, Oleson, & Saini, 2013). Evaluators seek information from five types of independent data sources: (a) document or record review; (b) interviews, including individual interviews of the parties and, when appropriate, the children, as well as joint and group interviews, when appropriate; (c) psychological testing; (d) direct observations of parent-child relationships via home or office visits; and (e) contacts with collateral sources or witnesses. VC can be used to collect information from several of these data sources, including interviews, observations, and, in some instances, psychological testing.

Before proceeding, it is important to recognize that agreement about these types of data collection does not always translate into agreement about the actual methodologies that are used. Different evaluators collect different data, and different evaluators may assign different weight to data (Gould, Kirkpatrick, Austin, & Martindale, 2004, p. 39). Some evaluators may rely differently on different portions of the evaluation in developing their hypotheses and opinions. For example, nonpsychologists are less likely to include psychological testing in their evaluation procedures. These evaluators must answer the same questions but may use records, interviews, observations, and contacts with collaterals to address the questions for which a psychologist uses testing. Evaluators unable to effectively use one methodology (e.g., testing) will be expected to develop ways to investigate issues using tools within their competence. The shortcomings of any individual data collection tool require the evaluator to design methods of investigating the relevant issue in other ways. The evaluator's approach throughout the evaluation process involves choices. For each important issue or data point, does the evaluator immediately query and follow up or accept an answer in order to move on? Does the evaluator compare data or a fact to a claim or hypothesis and again query and challenge, or do they accept and move on?

Conducting in-person interviews, observations, or psychological testing does not guarantee that the evaluator will produce a valid, reliable, or trustworthy work product. Poorly conducted interviews, psychological testing, or observations will likely result in unreliable results. In fact, there often exists as much disagreement

as agreement about how each of these methods should be used in evaluations that are conducted in person. Evaluators may differ on how much historical data they collect or on how to weigh this information. With respect to interview techniques, for example, there may be agreement concerning the essential objectives of interviews with parents and with children, but there are disagreements about the degree that these interviews should be structured, with some claiming superiority of structured or semistructured interviews over unstructured interviews (Martindale & Gould, 2004). While many trumpet the importance of parent-child observations, there is no agreed-upon technique or procedure for how to do these observations in CCEs, a fact that raises serious questions about the ecological validity of any inferences based upon any individual evaluator's parent-child observation procedures (Saini & Polak, 2014). In addition, in response to claims about the inappropriate use of psychological testing in CCEs, the response of a group of evaluators acknowledged problems yet outlined how properly conducted psychological testing can make unique, relevant, and reliable contributions in custody disputes (Rappaport, Gould, & Dale, 2018).

The record keeping of evaluators can become an issue. Some have claimed forensic evaluators have a heightened duty to document their work. Some evaluators take copious notes, while others contemporaneously type questions and answers into a computer during interviews. Some evaluators audio record interviews, and others do not. Currently, evaluators who choose to record must have written permission of the parties. It is unclear, however, whether the parents could provide permission for the evaluator to record a child or whether an attorney or some other kind of representative would be needed to assist a child in making the decision about consent to the evaluator recording such contacts. While the forensic interviews of small children in child protection cases are routinely video and audio recorded, this is not standard practice in CCEs. In other areas of the law, evaluators have generally not been required to record forensic interviews without a showing of exception circumstances (see *Holland v. United States*, 1988 for a review of the case law regarding this issue in Rule 35 examinations). In addition, in order to avoid unequal treatment of evaluators, any requirement to record RCCEs would probably require that all CCEs, including face-to-face evaluations, be recorded. For a myriad of reasons that are beyond the scope of this article, we view such a proposition as highly unlikely.

The Multitrait-Multimethod Matrix: Data Analysis and Interpretation

In managing their data collection, constructing hypotheses, and developing conclusions or opinions about the factors and psychological questions, evaluators have applied the multitrait-multimethod matrix, triangulation strategies, and the concepts of convergent and discriminant validity. In CCEs (and RCCEs), the multitrait-multimethod matrix refers to use of multiple data collection methods and a process for analyzing the data (Campbell & Fiske, 1959). This method recognizes that the behaviors and competencies of individuals are multiply determined (Wälder, 1936) and that the study of complex phenomena requires an active process of developing possible hypotheses and inferences from an evolving data set. Within this process, evaluators seek to avoid bias by maintaining even hovering attention to these multiple hypotheses

(Freud, 1912), remaining vigilant to established methods and protocols that they have established, and adjusting the hypotheses as new data and issues are collected. Any deficiency in data collection in one area can be remedied by additional inquiry or by applying a different methodology to get that information. The multitrait-multimethod approach is the evaluator's best defense against claims of bias or overreliance on simple answers to complex questions (Neal & Brodsky, 2016).

Data analysis strategies using the multitrait-multimethod matrix heavily rely upon triangulation (Austin & Kirkpatrick, 2004). Triangulation involves using more than one approach or more than one data source to study, in this instance, a factor or question. Triangulation enhances reliability and validity by cross-checking or cross-referencing data or by combining different perceptions of the same event to provide a more robust and holistic picture (Vidovich, 2003). Triangulation also includes cross-checking data from multiple methods, sources, theories, and/or data types in order to get a more detailed and balanced picture of the situation (Altrichter, Feldman, Posch, & Somekh, 2008). The term "convergent validation" is used to describe when data from independent procedures support or validate the same conclusion or opinion, and the term "discriminant validation" is used to describe when data from independent procedures fail to support the same conclusions or opinions (Campbell & Fiske, 1959). There also may be times when evaluators must explain seemingly divergent data.

CCEs also usually involve one or more hypothesis or theory about the meaning of various facts and events in the case. "Forensic practitioners ordinarily avoid relying solely on one source of data, and corroborate important data whenever feasible" (American Psychological Association [APA], 2013b, p. 15). In addition, while unique facts can be disclosed or discovered during any part of a CCE, there is generally no one-to-one correspondence between any single evaluation methodology and any best interests factor or psycholegal question. This is especially true when evaluating various kinds of competencies (e.g., parenting competence), where data from multiple sources are relevant.

Evaluating each hypothesis or theory involves a combination of scientific and clinical thinking (Milchman, 2015). The scientific method calls for testing alternative hypotheses or theories and collecting evidence that confirms or disconfirms either an individual hypothesis or unifying theory. Coherence-based reasoning also applies to the evaluator's data analyses as one attempts to integrate numerous, complex, and sometimes contradictory inferences into a coherent theory about the case (Charman, Douglass, & Mook, 2019). Understanding the implications of any particular hypothesis or theory and the interrelationships between the data and facts of the case is central to determining whether any fact confirms, disconfirms, supports, or disproves that particular hypothesis or theory.

Child custody evaluators attempt to combine two sets of skills that are often presented as opposite extremes: the empirically minded psychometrician and the self-aware clinician. The extremes of this artificial and largely academic debate are captured in the following quote:

In psychometric testing the examiner is seen as a source of error or bias, therefore his role is standardized and minimized, if not eliminated. By contrast, in clinical testing the role of the examiner is maximized: the examiner's skill, judgment, and intuitive sensitivity

are not only valued but are also regarded as the most sensitive and perceptive clinical tools available. The variety of interactional reactions that arise in the patient-examiner relationship are neither avoided nor acted upon; rather, they are identified and observed and then used as valuable aids in bringing greater meaning and understanding to the patient's behavior and attitudes. Clinicians should at all times be able to point to the data from which they draw their conclusions and also to trace out explicitly the chain of inferences that led to those conclusions. (Lerner, 1976, p. 7)

In sum, each evaluator must design a study of the best interests factors and the psycholegal questions that are relevant to each case. There are both common elements to every CCE and unique, case-specific elements to every CCE. The approach is not totally experimental. Whereas scientific experiments seek to eliminate or minimize experimenter bias through methodological design, the custody evaluator's task is to manage a dynamic process while remaining balanced, objective, and as free as possible from bias.

The Substitutability of VC: Process Considerations

Demonstrating the substitutability of VC for face-to-face procedures can be done through comparisons of two interpersonal process variables and two outcome variables. The two process variables central to CCEs are empathic accuracy and the working alliance. The two outcome variables are positive therapy outcome (e.g., task completion) and studies demonstrating the equivalence of telemental health services provided by VC with those provided face to face.

Empathic Accuracy and the Primary of Auditory and Visual Behaviors Over Nonverbal Cues

Many evaluators are concerned that using VC and conducting RCCEs will result in a reduction in what has been termed "empathic accuracy." Empathic accuracy is "the ability to perceive accurately how another person is feeling" (Levenson & Ruef, 1992, p. 234). Empathic accuracy is commonly operationalized as the correspondence between the thoughts and feelings people report experiencing and the thoughts and feelings that perceivers infer from the target's behaviors (Ickes, Bissonnette, Garcia, & Stinson, 1990). Empathic accuracy is a relevant process variable because it is central to effective service delivery in both clinical and forensic psychology. It is an indication of emotional intelligence, and it is a clearly desirable skill for forensic evaluators (Brodsky & Wilson, 2013; Franklin, 2013). Even those with concerns about the uses of expressive empathy by evaluators agree that "empathic understanding" is an important element of forensic assessment (Greenberg & Shuman, 1997, p. 53). Certainly, some level of empathy is necessary for completion of a thorough assessment. While one research study found no significant differences in evaluatee disclosures or uses of impression management (e.g., lying) when evaluators actively used expressive empathy versus when evaluators did not use expressive empathy (Vera et al., 2019), evaluators who come across as cold and callous risk discouraging evaluatees from being thorough and honest (Franklin, 2013). Many have argued that the internal reaction of forensic evaluators may provide valuable information, if properly used (Erard & Pickar, 2008; Mulay, Mivshek, Kaufman, & Waugh, 2018; Pickar & Erard, 2008).

Empathic accuracy generally depends on visual, auditory, and semantic information—a great deal of which is available through a VC interview. While it is certainly true that people express much of their emotion life in nonverbal behavior (Mehrabian, 1970; Mehrabian, 1981), the proper response in a forensic evaluation to potentially relevant nonverbal behavior is verbal inquiry into possible explanations of what has been observed, not interpretations that are uninformed by an appropriate query. The forensic evaluator's focus on accuracy should lead to follow-up inquiry into observations of potentially relevant nonverbal behavior with the goal of making explicit potentially relevant emotions, their meaning, and their relevance to the legal questions being investigated.

Studies have found that verbal and contextual cues have more value than nonverbal cues, a fact that supports the necessity of inquiry into possible emotional states associated with nonverbal cues identified by evaluators. Studies of empathic accuracy as an interpersonal process have explored the types of informational cues (i.e., facial expressions or semantic information) that lead others to be able to “read” their emotional expressions (Zaki, Bolger, & Ochsner, 2009). When contextual information is available, empathy accuracy has been shown to be primarily dependent upon verbal and contextual cues rather than nonverbal cues (Gesn & Ickes, 1999; Zaki et al., 2009). Immediate contextual cues (the verbal and nonverbal behaviors that precede each reported thought or feeling) and the cumulative contextual cues (the emergent meaning context that develops as a function of the temporal nature of an interaction) allow one to infer the specific content of a target person's successive thoughts and feelings (Gesn & Ickes, 1999). Studies have also found that nonverbal expressive people are more “readable” than nonverbal, nonexpressive people (Zaki et al., 2009). Empathic accuracy increases when perceivers have access to both auditory and visual information rather than only auditory or only visual information (Zaki et al., 2009). In RCCEs, evaluators who observe nonverbal behavior should inquire as to the possible thoughts and emotions that the nonverbal behavior reflects.

The desire to actually observe and see all nonverbal behavior is related to concerns about deception and “truth bias.” Truth bias refers to the fact that many individuals believe they can detect deception (Hancock, Woodworth, & Goorha, 2010). Every time new technologies are developed that allow people to communicate at a distance, from the telephone to the telegraph to the invention of the alphabet, the public has registered concerns about increases in lying (see Hancock, 2007). The “cue-availability heuristic” refers to the notion that when there are fewer cues, people might lie more often (Toma & Hancock, 2012). This notion asserts that people might lie more often because there are no nonverbal cues to be detected, and therefore, they are less likely to be discovered than they are in face-to-face interactions (Hancock & Woodworth, 2013). Unfortunately, studies have shown that very few people are good at detecting deceit in interpersonal interactions (Porter, Woodworth, & Birt, 2000). As previously described, inquiry into nonverbal behaviors and the disciplined use of the procedures in the conceptual model are designed to address these concerns to the extent that this is possible.

Indeed, one small study of the effects of telepsychology format on empathic accuracy and therapeutic alliance found no significant differences on these variables in a comparison of VC, telephone, and face-to-face psychotherapy (Reese et al., 2016). Because the clients in this study received only one session of psychotherapy,

these results must be considered preliminary, but they are encouraging. However, because we view empathy accuracy as a principle component of successful therapy, the evidence for successful teletherapy also should be viewed as evidence that empathy accuracy is possible through VC. This research is reviewed in this article.

Working Alliance: Maximizing Data Gathering and Completing the Tasks of the Evaluation

The use of empathy in professional relationships is closely connected to the concept of a working alliance. The use of empathy in forensic evaluations may have varying levels of appropriateness, depending upon the nature of the evaluation and the setting in which the evaluation occurs. To the extent it is realistic, an assessment-based working alliance that fosters openness and acceptance should improve the assessment product (Mulay et al., 2018). While there are differences between the working alliance in therapy and in forensic assessment, we again assert that the research on the effectiveness of telemental health procedures should be viewed as evidence that forming a working alliance through VC is possible and achievable.

There may be differences in the working alliance in therapy and the working alliance in CCEs, but there are also numerous similarities. In therapeutic relationships, the working alliance concept includes the emotional bond between the client and therapist, the quality of the client and therapist involvement in the tasks of therapy, and the amount of concordance on goals between the therapist and client (Bordin, 1979). In therapeutic relationships, the working or therapeutic alliance is a central “causal ingredient of change” (Henry, Strupp, Schacht, & Gaston, 1994, p. 485).

In studies of the effectiveness of teletherapy that have found positive and equivalent outcomes, it seems safe to assume the therapists were able to develop successful working and therapeutic alliances. The ability for therapists to establish a working alliance via VC was also demonstrated in a study directly comparing the working alliances of the therapy processes and outcomes of clients randomly assigned to face-to-face, telephone, and VC. This study found no differences on either the working alliance or the outcome variables between the clients receiving services in different ways (Day & Schneider, 2002). In addition, this same study also found that client participation was significantly higher in distance modes (e.g., VC and telephone) than when face to face with their therapists. The researchers speculated that clients in the distance modes made more of an effort to communicate, that they took more responsibility for the interaction, or that distance made openness seem safer (Day & Schneider, 2002).

The working alliance in a forensic CCE is different, but it still involves developing a working alliance. There is a consensus that forensic evaluators should refrain from developing or creating the impression of a helping or therapeutic relationship. The evaluator's job is to help the court, but this is impossible to do without attending to and developing the evaluator-examinee relationship enough to achieve the goals of learning each party's parenting plan proposal and investigating the factors or questions that have been identified for evaluation. Whether one argues against empathy in forensic evaluations in the interest of objectivity (e.g., Shuman, 1993) or for moderate empathy in the interest of objectivity (e.g., Brodsky & Wilson, 2013), evaluations involve gathering information from multiple sources. At a minimum, conveying respect for

the other person and behaving in a culturally competent, ethical, polite, and professional manner remains a necessary aspect of any evaluator's behavior (Brodsky & Wilson, 2013). Evaluators who keep a substantial interpersonal distance may be likely to receive truncated information (Jourard, 1971).

A certain level of cooperation is particularly important in RCCEs. Using VC technology for RCCEs is likely a more valid and reliable procedure when the parties agree to its use. Generally, the validity of any psychological assessment is modulated by the degree to which the person being assessed accepts (i.e., is willing to participate in) the context of a given assessment including the setting and the manner in which the assessment is conducted. An individual's acceptance of a particular type of assessment is a multifaceted construct that depends on an individual's physical and emotional state, motivation, attention, personality, and temperament (Luxton et al., 2016). Poor acceptance has been cited as a factor that reduces compliance and the motivation to engage in mental health assessments (Rogers, 2001). Inadequate acceptance of telemental health by either the patient or practitioner can therefore be expected to have a negative influence on the validity and reliability of psychological assessments (Luxton, Pruitt, & Osenbach, 2014, p. 28).

Some level of cooperation from the parties is necessary to do an RCCE because elements of the evaluation occur in unsupervised settings.

Provision of telemental health services in professionally unsupervised settings requires that the patient take a more active and cooperative role in the . . . process than in in-person settings. Determining whether a patient [interviewee, added] can handle such demands may be more dependent on the patient's organizational and cognitive capacities, than on diagnosis. (Turvey et al., 2013, p. 10)

To help assure the validity and reliability of remote assessment, it is necessary to make sure the environmental conditions at the remote location are conducive to the assessment procedures. Ideally, the room would be set up according to the foci of the session (Gloff, LeNoue, Novins, & Myers, 2015, p. 518).

Many patients and families report high satisfaction with telemental health. Reasons for this include (a) conveniently finding high-quality services close to home, (b) decreasing time away from both work and school, (c) decreasing costs associated with traveling miles for care, (d) decreasing stresses of travel with a child with a behavior disorder and siblings, (e) decreasing worries about navigating unfamiliar health care settings, (f) allowing additional supporters to attend and work together to coordinate care, and (g) decreasing stigma by connecting to child-friendly settings such as schools (Gloff et al., 2015; Nelson, Cain, & Sharp, 2017). These same dynamics might apply to the participants in RCCEs.

The Substitutability of VC: The Empirical Outcome and Equivalence Evidence

The use of technologies in mental health and psychological practice has steadily increased over the last decade (Luxton et al., 2014) because studies of the technology demonstrate it can be effectively used to achieve positive, equivalent outcomes. The principles and procedures used for psychological assessment and evaluation during treatment services (i.e., diagnosis and symptom assessment) are pertinent to other remote assessment and testing

applications including neuropsychological and cognitive testing, forensic risk assessment, and occupational testing (Luxton et al., 2014). This section reviews the evidence base for telemental health procedures across adult and child populations, assessment and treatment tasks, and numerous clinical and forensic conditions. The authors assert that the consistently positive outcomes and demonstrated equivalence found in these studies support the notion that child custody evaluators, like therapists and other clinical and forensic evaluators, can develop empathic accuracy and working alliances sufficient to produce valid, reliable, and trustworthy child custody evaluations for the courts.

VC in Psychotherapy With Adults

The consensus at this point is that there is sufficient data of efficacy of telepsychology and a lack of data that it is inferior that there is no basis for overriding the choice of an informed client and competent therapist that this is an acceptable alternative under the right circumstances. (Harris, 2019, slide number, 47)

Numerous reviews of the existing research document the feasibility of using VC in psychotherapy with adults. In a systematic literature review of 65 studies across psychotherapy modalities regarding the use of VC psychotherapy (VCP), 10 questions were addressed, including what therapeutic types/formats have used VC, in what populations VCP has been used, the number and types of publications related to VCP, and available satisfaction, feasibility, and outcome data related to VCP (Backhaus et al., 2012). The results indicate that VCP is feasible, has been used in a variety of therapeutic formats and with diverse populations, is generally associated with good user satisfaction, and is found to have similar clinical outcomes to traditional face-to-face psychotherapy (Backhaus et al., 2012). Another review of 26 studies of VC and cognitive-behavioral therapy concluded that the majority of the studies supported the effectiveness of using VC to deliver psychotherapy (Gros et al., 2013).

Recent large randomized controlled trials demonstrate effectiveness of telemental health, with many smaller trials also supporting this conclusion. Regarding specific subgroups, such as patients with psychotic or phobic disorders, one review found no evidence for inferiority of VC telemental health for patients with psychosis (Sharp, Kobak, & Osman, 2011). Another study with psychotic patients compared in-person versus VC interviews and concluded that even patients with delusions pertaining to the TV appropriately responded to VC and did not incorporate their experiences into their delusional system (Dongier, Tempier, Laliniec-Michaud, & Meunier, 1986). A small study comparing in-person versus VC-based treatment for panic disorder with agoraphobia found equal effectiveness (Bouchard et al., 2004).

VC in Forensic Settings: Clinical, Civil Commitment, and Competence Assessments

VC has been used for psychiatric and forensic assessments in corrections environments around the world. In a study of 72 inpatients at a maximum security forensic unit of a state hospital in Washington found good to excellent reliabilities when comparing in-person with VC administrations of the Brief Psychiatric Rating Scale-Anchored Version and the MacArthur Competence Assessment Tool-Criminal Adjudication (Lexcen, Hawk, Herrick, &

Blank, 2006). A study of 21 forensic psychiatric inpatients comparing live interviews to VC interviews using the Georgia Court Competency Test found high levels of agreement between the interviewers (Manguno-Mire et al., 2007). In a study of 190 youth in juvenile detention, telemental health services were found to be associated with youth attaining goals and improving family relations during their incarceration (Fox, Connor, McCullers, & Waters, 2008).

VC has been used to provide forensic opinions in court on mentally disordered offenders in Western Australia (Sullivan, Chapman, & Mullen, 2008) and in involuntary commitment proceedings in rural Australia (Yellowlees, 1997). VC has been used by psychiatrists in the United Kingdom to conduct gate-keeping assessments, prepare psychiatric court reports, and provide courtroom testimony for the criminal and civil courts (Khalifa, Saleem, & Stankard, 2008, pp. 6–8).

VC in Neuropsychological Assessments

Much of the research on the use of VC in test administration originates in neuropsychology (or what is now termed “teleneuropsychology”; Grosch, Gottlieb, & Cullum, 2011). A meta-analytic review of 12 studies of VC-delivered neuropsychological tests found “support for the use of videoconferencing technology in the remote administration of neuropsychological tests, particularly those that rely upon verbal responses from participants” (Brearly et al., 2017, p. 184).

Neuropsychological tests relying upon verbal instructions and responses are particularly well suited to VC administration, and good agreement between VC and face-to-face testing has been found in a number of studies. For example, one study of VC-based neuropsychological assessment versus in-person assessment of subjects with or without cognitive impairment (i.e., dementia) found no significant differences and concluded VC-based neuropsychological testing is a valid and reliable alternative to face-to-face assessment using selected measures (Cullum, Hynan, Grosch, Parikh, & Weiner, 2014). Other research groups comparing clinical diagnostic interviewing conducted via VC and traditional face-to-face conditions has suggested generally good agreement in diagnosing a variety of conditions including dementia (Barton, Morris, Rothlind, & Yaffe, 2011) and Alzheimer’s disease (Loh, Donaldson, Flicker, Maher, & Goldswain, 2007).

VC in Remote Psychological Personality Testing: No Research, But New Guidance

There is currently no known empirical research on remote administration of measures of personality. In response to the COVID-19 pandemic, however, test publishers quickly developed methods for remote administration of numerous measures used by evaluators. Tests now available for remote administration include but are not limited to the Minnesota Multiphasic Personality Inventory (MMPI) instruments, the Millon inventories, and the Personality Assessment Inventory. For other psychological tests such as the Rorschach, remote administration procedures have also been developed. Remote administration is also possible for instruments like the Behavior Assessment Scale for Children or the Connors Rating Scales, which typically have been given to parents for completion at home.

Given these parameters, VC can be used in remote psychological testing in two ways. First, some research investigations, particularly with some of the cognitive and neuropsychological tests that were previously discussed, have demonstrated that psychologists can use VC to administer certain psychological tests. Some but not all psychological tests lend themselves to remote administration. Remote psychological testing also may be possible with the assistance of monitors or proctors who, in partnership with the psychologist, assist in the administration of the test items and tasks.

Second, VC can be used to allow a monitor or the psychologist evaluator to monitor test administration. Remote administration of psychological tests must consider the potential impact of remote administration procedures on the validity and reliability of the results (Corey & Ben-Porath, 2020). Therefore, “although these professional practice guidelines provide little practical instruction on how to ensure adherence to applicable ethical standards when administering psychological tests remotely, they do highlight an issue that is fundamental to understanding the challenge in remote psychological testing” (Corey & Ben-Porath, 2020, p. 200). Guideline 7 states,

When a psychological test or other assessment procedure is conducted via telepsychology, psychologists are encouraged to ensure that the integrity of the psychometric properties of the test or assessment procedure (e.g., reliability and validity) and the conditions of administration indicated in the test manual are preserved when adapted for use with such technologies. (APA, 2013a, p. 798)

The emphasis when using VC is on preserving the conditions of administration outlined in the test manual, whether this is in direct test administration or monitoring of someone completing a self-report instrument. For example, in a section titled “Testing Conditions,” the MMPI-2 manual describes the following:

The typical testing situation for administering the MMPI-2 requires adequate space at a table to lay out the test booklet and answer sheet, good lighting, a comfortable chair, and quiet surroundings free of intrusions and distractions. However, it is often not possible to provide an ideal testing environment. For example, the hardcover version makes it possible to take the test in a waiting room or while sitting up in a bed in a hospital ward. In such settings. Precautions must be taken to ensure that the person taking the test is not bothered by others in the room or offered gratuitous advice by fellow patients. It is generally permissible to let the individual take the test in several shorter sessions over a limited period of time, say before or after an interruption for routine procedures. (Butcher et al., 2001, p. 9)

A Case Example of Remote MMPI-2 Administration

In the initial VC CCE interview between the evaluator, Father (at home in city 60 miles from evaluator), and Mother (at home in city 180 miles from evaluator), the evaluator reviewed the court order and evaluation procedures. The court order included a provision allowing the evaluator to use VC. The parties and their attorneys agreed to this order.

After the evaluator’s initial joint interview with Father and Mother conducted via VC (using GoToMeeting, which is HIPAA compatible and securely encrypted), Father and Mother were directed to remain at their respective computers (where there is adequate lighting and a comfortable chair) with no one else around or in the room (e.g., distraction-free environment) to await an

e-mail with a link to the portal through which they could complete the psychological testing. On his computer, the evaluator logged onto Pearson Q global and sent Father an e-mail, confirmed Father's receipt of that e-mail, and confirmed that Father was able to connect to the Pearson website via the link in the e-mail in order to take the test. Father began the test. The evaluator and Mother went through the same procedure until Mother was connected to the Pearson website and taking the test.

The evaluator remotely monitored Father and Mother via VC while they were taking the test. The evaluator silenced his audio input and intermittently closed the ability of Father and Mother to see him. However, Father and Mother were prohibited from shutting down their audio or visual inputs. Through this continuous supervision, the evaluator confirmed that Father and Mother took the test without any outside assistance or distractions. At the end of taking the test, Father and Mother each signed off the Pearson portal, and their test responses were sent to Pearson.

The evaluator logged onto Pearson again, located the respective test protocols, and generated an MMPI-2 Extended Score Report for each test taker. In order to conduct the critical item review with Father, Mother was excused from the VC connection. She signed off. The evaluator and Father stayed connected, and the evaluator conducted his critical item interview. When this was completed, Father was instructed to sign off and did so. Mother was contacted by cell phone and instructed to sign back on to the conference. When she did, the evaluator completed a critical item interview with her.

Telemental Health Evidence Base for Use of VC With Children and Adolescents

Today's youth comfortably communicate with peers and family members using information and communication technologies such as Skype, WhatsApp, FaceTime, Facebook Messenger, and a host of others (Saini & Polak, 2014). Telemental health may be especially suited for youth who frequently use the technology and may positively respond to the personal space and feeling of control allowed by VC. Videoconferencing may also offer advantages in working with adolescents, including less self-consciousness, increased personal space, and decreased confidentiality concerns as the provider is outside of the local community (Myers et al., 2017).

VC Use in Therapy With Children and Adolescents

To be included as a feasible accommodation in an RCCE, evaluators interviewing children using VC must be able to establish rapport with the child, develop adequate cooperation, and develop an alliance sufficient to gather data and information on a wide variety of topics. Interviews of the children in custody disputes are a central, essential, and often required element of child custody evaluations (Ackerman & Pritzl, 2011; Bow & Quinnell, 2004). There exists a substantial literature on interviewing children in custody cases (Saywitz, Camparo, & Romanoff, 2010; Warshak, 2003). Information from these interviews informs the evaluator on several important issues. State statutes often have several child-related best interests factors that must be considered by the court. These factors include but are not limited to the child's preferences, the child's adjustment, and the parent-child relationship. The perspectives of children are also crucial to an assessment of the children's needs, the parental capacities for

meeting these needs, and the resulting fit (APA, 2010). While the use of children as witnesses can stir controversy, their accounts of events in the home or in the life of the family or various family members, as well as accounts of the behaviors of others, can be helpful to understanding various allegations, claims, and stories. While children do not normally expect to make the custody decisions, many children, particularly older children, want to be heard on the issues that affect them (Cashmore & Parkinson, 2008).

Support for using VC interviews with children and adolescents in CCEs comes from multiple sources. In 2017, the American Telemedicine Association (ATA) developed the "Practice Guidelines for Telemental Health for Children and Adolescents" (CATMH) regarding use of Internet-based and telephone-based VC. The guidelines focus on interactive VC with the goal of providing the same level of service delivery that is provided in person. CATMH programs involving clinical evaluation and treatments have been successfully implemented in multiple diverse settings such as pediatric clinics (Myers, Sulzbacher, & Melzer, 2004), community mental health centers, rural schools, urban daycare, corrections (Myers, Valentine, & Melzer, 2008), and independent practice (Grady et al., 2011). CATMH has been applied to diverse populations such as African American, Hispanic, Hawaiian, Native American, and Alaska Native youth (Myers et al., 2017).

The professional and research literature documents the ability of mental health professional to use VC to successfully fulfill professional roles and complete professional tasks. "Child and adolescent telemental health has been practiced successfully across underserved settings with diverse youth, for most psychiatric disorders, and across development" (Nelson et al., 2017, p. 77). Development of a therapeutic alliance is a robust predictor of positive outcome in mental health treatment and is particularly important when working with children and adolescents.

The single most effective means of establishing an alliance with young people is conversation (Gloff et al., 2015). Experienced teleclinicians and preliminary research suggest that clinicians and patients can, and do, establish a therapeutic alliance during telemental health treatments (Goldstein & Glueck, 2016). Satisfaction studies demonstrate the ability to develop a therapeutic alliance with youth and families through telemental health (ATA, 2018). Only occasionally do children and adolescent patients rate alliance, or rapport, as significantly lower for telemental health versus the in-person modality.

The feasibility of delivering psychotherapy through VC has been demonstrated for agoraphobia, attention-deficit/hyperactivity disorder, bulimia nervosa, depression, obsessive-compulsive disorder, panic disorder, and posttraumatic stress disorder (Nelson et al., 2017). It also has been shown to be effective in working with children with autism and other developmental disorders (Szeftel, Federico, Hakak, Szeftel, & Jacobson, 2012).

VC Use in Forensic Interviews of Children Regarding Possible Child Abuse

In response to the COVID-19 pandemic, child protective service agencies across the country have turned to what are being called "tele-forensic interviews" in cases of possible child abuse and neglect. These interviews utilize synchronous VC while interviewing young children in cases involving suspected child abuse, sexual abuse, or neglect. In March 2020, a team from the National Children's Alliance, Montclair State University, and Central Mich-

igan University developed an extensive protocol for “Emergency Tele-Forensic Guidelines.” These guidelines include detailed instructions for choosing to do the interview as well as how to conduct it (National Children’s Alliance, 2020). In their training webinar, one presenter reported on a yet-to-be published research project comparing interviews conducted by VC with interviews conducted in person. The research involved interviews of 230 children who were 4 to 8 years old in actual clinical cases where child sexual abuse had been alleged. Preliminary results indicate there were no differences between the accuracy of reports gathered by VC as compared to in-person interviews. There were no differences between true and false reports and no differences with source monitoring problems. While there were age differences showing that younger children were less talkative, there were no indications that children were more suggestible in the VC interviews (National Children’s Alliance, 2020).

A separate experimental research project studied the memory reports of 100 children between the ages of 5 and 12 and found that “video-feed interviewing was just as effective as face-to-face interviewing in terms of the accuracy and informativeness of children’s accounts” (Hamilton, Whiting, Brubacher, & Powell, 2016, p. 260). The children were interviewed by experienced interviewers 1 to 2 days after they participated in an innocuous event.

VC in Parent–Child Therapy, Parent–Child Observations, and Family Therapy

The central purpose of conducting observations of parent–child interactions is to provide an important source of information for assessing parent–child connections and dynamics, to focus on each parent’s ability to respond to the needs of the child, observe a child’s response to each parent, and to consider potential risks and concerns within the parent–child relationship or contextual factors that may impede or facilitate these relationships. (Saini & Polak, 2014, pp. 185–186)

Many are concerned that use of VC for parent–child observations may not be feasible or might yield less helpful or less reliable information than in-person observations. This is already a concern about in-person CCEs. The available research on observations during evaluations shows considerable variability between evaluators, which suggests that evaluators may not be systematically studying the same dimensions of parenting (Saini & Polak, 2014). Whether or not a parent–child observation is valid and reliable depends upon how the task is introduced, how the task is interpreted by the parent and child (or children), and what happens when performing the task.

If properly used, it is possible that synchronous VC technology could enhance the ecological validity of the parent–child observations (Comer, Furr, Kerns, et al., 2017). Several studies have found VC as effective as in-person service delivery in addressing parent–child interactions. For example, remotely conducted parent–child interaction therapy (PCIT) has been shown to be feasible and to have comparable outcomes to clinic-based treatments with several small subgroups of children with anxiety-related conditions (such as obsessive–compulsive disorder; Comer, Furr, Kerns, et al., 2017) and externalizing youth (Comer, Furr, Miguel, et al., 2017).

In-office PCIT uses real-time, in-session parent coaching where the therapist monitors family interactions from an observation room and provides live, individualized coaching via a parent-worn

bug-in-the-ear device (Crum & Comer, 2016, p. 230). Internet PCIT simply changes the location of the therapist from behind a screen in another room to feedback from a remote location through a Bluetooth earpiece. In addition, behavioral parent training for parents and their children with attention-deficit/hyperactivity disorder found similar effectiveness rates among those who received the services online versus those who received services face to face (Dupaul et al., 2017). Obviously, there is a need to adequately capture the parent–child interaction via VC in order for this process to work.

In addition, the use of videos for a broad spectrum of consultation, research, and therapy purposes has been well documented. For example, video observations have been central to research on attachment and early parent–infant relationships (Gridley, Bywater, & Hutchings, 2018; Rusconi-Serpa, Sancho Rossignol, & McDonough, 2009; Steele et al., 2014).

Logistical problems increase as the number of people in the VC increases. There is no data on family therapy by VC. Critical issues specific to family-based telemental health care include (a) navigating varying levels of technological literacy across generations of participants, (b) deciding which family members to include, (c) ensuring the safety of participant, (d) optimizing therapeutic alliance and engagement of all participants, (e) navigating logistical concerns in conducting sessions, and (f) ensuring privacy (Crum & Comer, 2016). These developments demonstrate that such technological innovations can be used to overcome many traditional barriers to effective care (Comer et al., 2015), but no research on these issues is currently available.

The Ethics of Using VC in RCCEs

The practice of telemental health, including VC, involves consideration of ethical standards, legal requirements, telecommunication technologies, and individual practitioner policies and procedures that must be balanced with any other external constraints or demands of the particular professional context (APA, 2013a). The same ethical standards for delivering in-person services apply to professionals providing services using VC. It is the professional’s responsibility to maintain and enhance their level of understanding of their professional ethics, the concepts specific to VC service delivery (APA, 2013a), and to integrate any unique demands using VC might have on their work into their policies, practices, and procedures.

The goal of most telemental health services is to approximate the same best practices of in-person service delivery (APA, 2013a). Generally, the same liabilities, risks, and ethical issues encountered during in-person practice apply to telemental health. The APA Telepsychology Task Force provides eight telepsychology-specific guidelines for practitioners (see Table 1; APA, 2013a). These guidelines address issues of competence, standards of care in the delivery of telepsychology services, informed consent, confidentiality of data and information, security and transmission of data and information, disposal of data and information and technologies, testing and assessment, and inter-jurisdictional practice.

However, the geographical distance between the provider and service recipient and the use of technology as the medium of service provision introduce additional risks and considerations that extend beyond those of conventional in-person services

Table 1

Eight Guidelines for Practice of Telepsychology (APA, 2013a)

Competence

Guideline 1. Psychologists who provide telepsychology services strive to take reasonable steps to ensure their competence with both the technologies used and the potential impact of the technologies on clients/patients, supervisees, or other professionals.

Standards of care in the delivery of telepsychology services

Guideline 2. Psychologists make every effort to ensure that ethical and professional standards of care and practice are met at the outset and throughout the duration of the telepsychology services they provide.

Informed consent

Guideline 3. Psychologists strive to make every effort to ensure that ethical and professional standards of care and practice are met at the outset and throughout the duration of the telepsychology services they provide.

Confidentiality of data and information

Guideline 4. Psychologists who provide telepsychology services make reasonable efforts to protect and maintain the confidentiality of the data and information relating to their clients/patients and inform them of the potentially increased risks of loss of confidentiality inherent in the use of the telecommunication technologies, if any.

Security and transmission of data and information

Guideline 5. Psychologists who provide telepsychology services take reasonable steps to ensure that security measures are in place to protect data and information related to their clients' patients from unintended access or disclosure.

Disposal of data and information and technologies

Guideline 6. Psychologists who provide telepsychology services make reasonable efforts to dispose of data and information and the technologies used in a manner that facilitates protection from unauthorized access and accounts for safe and appropriate disposal.

Testing and assessment

Guideline 7. Psychologists are encouraged to consider the unique issues that may arise with test instruments and assessments approaches designed for in-person implementation when providing telepsychology services.

Interjurisdictional practice

Guideline 8. Psychologists are encouraged to be familiar with and comply with all relevant laws and regulations when providing telepsychology services to clients/patients across jurisdictional and international borders.

(Luxton et al., 2016). In its guidelines for informed consent when using video-based technology, the ATA identified several situation-specific conditions that must be addressed as part of ethical telemental health practice (see Table 2; Turvey et al., 2013, p. 11).

Evaluators using VC to conduct RCCEs must meet the ethical standards of their respective disciplines and apply these ethical standards to the virtual task. Evaluators using VC must establish appropriate verification, confidentiality, and security parameters consistent with the CCE and the privacy interests of the parties (Shore et al., 2018). This includes taking care to verify the identity of those being interviewed or observed, using procedures to protect the privacy of those being interviewed, and using technology with adequate security protections. Evaluators also must provide use technologies that provide quality audio and video images for the interviews or observations.

Another ethical issue reflects allegiance to the principles of evidence-based or evidence-informed practice. In the context of CCEs, evaluators expect that, when providing opinions and testimony based on novel or emerging principles or methods, they make known the status and limitations of these principles and methods (APA, 2013a, p. 9). Standard 9.02 ("Use of Assessments") of the Ethics Code is particularly relevant when consid-

ering an alternative method of assessment, be this an alternative interviewing technique or test administration:

9.02(a). Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

9.02(b). Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation. (APA, 2017)

Best Practice Guidelines for VC

Evaluators who use VC must competently and reasonably adapt the best practice guidelines that have been developed for VC and other telemental health service deliveries to the CCE context. Like the detailed provisions of the conceptual model outlined earlier, best practice guidelines emphasize consistent practices and are

Table 2

American Telemedicine Association Guidelines for Informed Consent and Preparation for Sessions

* Confidentiality and the limits to confidentiality in electronic communication

* An agreed upon emergency plan, particular for those in settings without clinical staff immediately available

* A process by which patient information will be documented and stored

* The potential for technical failure

* Procedures for coordination of care with other professionals

* A protocol for contact between sessions

* Conditions under which telemental health services may be terminated and a referral made for in-person care

designed to reduce practitioner errors. It is important to assume competent use of VC in considering its use. Many opposed to using VC cite fears and problems that are often easily remedied with adequate planning and forethought. For example, some have noted concerns about the identity of the person being interviewed or that another person might be present in the room coaching the interviewee, either adult or child, about how to answer certain questions. These concerns can be dispelled by scanning the room prior to or even during interviews. The value of use of VC should be judged on the “steel man argument” (what is likely when competent practices are followed) rather than a “straw man argument” (where those using VC are characterized as making silly mistakes that reflect incompetence in the evaluator rather than problems in the technique).

The acceptance of use of VC technology in clinical practice, as shown by numerous professional theory and evidence-informed best practice guidelines, is undeniable. For psychiatrists, the American Psychiatric Association has recognized VC as a legitimate service delivery mechanism since 1998 and, in 2018, together with the ATA, promulgated a statement, “Best Practices in Videoconferencing-Based Telemental Health” (Shore et al., 2018). The American Academy of Child and Adolescent Psychiatry (2008) introduced its guidelines, “Practice Parameter for Telepsychiatry With Children and Adolescents,” in 2008. For psychologists, the APA issued “Guidelines for the Practice of Telepsychology” in 2013. The APA guidelines were presented as informed by professional theories, evidence-based practices, and definitions in an effort to offer the best guidance in the practice of telepsychology (APA, 2013a). For social workers, a group of professional organizations (National Association of Social Workers, Association of Social Work Boards, Council on Social Work Education, & Clinical Social Work Association, 2017) created the “Standards for Technology in Social Work Practice” in 2017.

In addition, telepractitioners are developing their own professional identity and have promulgated additional evidence-based best practice guidelines. The ATA, an interdisciplinary professional group, has published multiple practice guidelines. These include (a) “Evidence-Based Practice for Telemental Health” in 2009 (published in 2011), (b) “Practice Guidelines for Videoconferencing-Based Telemental Health” in 2009, (c) “Practice Guidelines for Video-Based Online Mental Health Service” in 2013 (Turvey et al., 2013), (d) “A Lexicon of Assessment and Outcome Measures for Telemental Health” in 2013 (Shore et al., 2014), and (e) “Practice Guidelines for Telemental Health with Children and Adolescents” in 2017 (Myers et al., 2017).

Deviations from the guidelines may be acceptable, but departures from customary protocols must be justified.

If circumstances warrant, a practitioner may responsibly pursue a course of action different from the guidelines when, in the reasonable judgment of the practitioner, such action is indicated by the condition of the patient, restrictions or limits on available resources, or advances in information or technology subsequent to publication of the guidelines. Nonetheless, a practitioner who uses an approach that is significantly different from these guidelines is strongly advised to provide documentation, in the patient record, that is adequate to explain the approach pursued. (Turvey et al., 2013, p. 5)

Practical Considerations Regarding Using VC in Assessments and Therapy

Parties agreeing to an RCCE must be functionally capable of using the technology. While no studies have specifically identified any patient subgroup that does not benefit from, or is harmed by, mental health care provided through remote VC (Turvey et al., 2013), professionals using VC must determine that interviewees are intellectually, emotionally, physically, linguistically, and functionally capable of using the technology (Luxton et al., 2016). “Other key telepractice elements include assessment of the impact of culture on the client/patient’s (a) overall comfort/socialization with the behavioral health system; (b) comfort and familiarity with the technology; (c) communication, rapport, and trust; and (d) perceptions of confidentiality” (Luxton et al., 2016, paragraph 1758).

“Working via technology, then, also requires an understanding of how technology alters a professional clinical relationship and how to compensate for such alterations” (Luxton et al., 2016, paragraph 149). Establishing rapport and an alliance in the provider-interviewee relationship is as important in interactive VC as it is in in-person contact. Rapport allows for the interviewee to be more forthcoming with past and current history and cognitive and emotional experiences. While using VC, interviewers may need to flexibly and creatively adjust how they can communicate things such as understanding or empathy (Grady et al., 2011, p. 136). Verbal communications may be more deliberate to adjust for any auditory lags related to technology use and to clearly indicate when the teleprovider has finished speaking in order to facilitate reciprocity in communication (Nelson et al., 2017, p. 77).

Possible Limitations

There are limitations to use of VC, both in general and within RCCEs. “The lack of physical presence may limit the range of information available or how it can be observed” (Luxton et al., 2014, p. 28). Nonverbal information is useful for determining the patient’s emotional state and, in some cases, risk behaviors. For example, olfactory sensory information can provide clinically relevant information regarding hygiene as well as the use of alcohol or other substances. The observation of psychomotor and other medical symptoms is also important to observe during psychological assessments. VC assessments may be influenced by camera angle, screen size, room characteristics, or other technical factors that prohibit the observation of all behaviors. The lack of physical presence, however, may limit the range of information available, how it can be observed, or how the patient presents (Luxton et al., 2014). This is not, however, an insurmountable obstacle.

Home-based telemental health services may not be appropriate if there is a serious concern for patient safety (Gloff et al., 2015). “Certain high-risk families, such as families with maltreatment histories, may be inappropriate for remote telemental healthcare” (Comer & Myers, 2016, p. 299). Patients with a history of adverse reactions to treatment (e.g., severe panic attacks) or those who are at high risk of harm to self or others (e.g., family members in the case of home-based telemental health) may not be appropriate for telemental assessment (Luxton, O’Brien, McCann, & Mishkind, 2012).

Providers are expected to consider geographic location, technological competence (both psychologist and client/patient), medical con-

ditions, mental status and stability, psychiatric diagnosis, current or historic use of substances, treatment history, and therapeutic needs that may be relevant to assessing the appropriateness of the services offered. Prior to engaging in remote assessments, it is wise to review the patient's clinical history to determine potential clinical, cognitive, and/or sensory deficits that could impair their ability to use telehealth technology (APA, 2013a). While telemental health developed out of a need in underserved rural population areas, patients in densely populated areas also have benefitted from decreased travel times caused by high traffic volumes that make traveling even short distances a problem.

Defending VC in RCCEs in Court: The Evidentiary Argument

Evaluators choosing to use VC in RCCEs may face challenges in court about whether their methods meet the legal standards for admissibility of expert testimony found in the Daubert trilogy and/or the Frye case for admissibility of expert testimony (Flynn, 2019). To successfully defend their work product, evaluators must demonstrate that they qualify as an expert with competencies in CCEs and the technology that was used and that they have properly and reliably collected sufficient relevant data and facts to support their inferences, conclusions, and opinions.

The position espoused here is that the uniqueness of a child custody evaluation is found in the conceptual model for the evaluation that informs the collection of data and facts and in the manner in which the analysis of the data and facts is conducted, not in the data collection methods themselves. That is, both clinical and forensic evaluations involve gathering information from documents, interviews, observations, and testing in order to address the presenting problem(s) or situation. These contextual considerations are, of course, very important, but RCCEs should be independently considered based on their scientific and empirical merit rather than on general acceptance among like-minded members of some guild (Faigman, 2013, pp. 908–909). In each instance, there are requirements to establish rapport, elicit cooperation with the data collection task, and objectively collect data and facts about the presenting problem(s) and situation. In both clinical and forensic settings, evaluators are expected to apply the same intellectual rigor to the tasks (*Kumho v. Carmichael*, 1999). Accuracy and objectivity are always important, whether informing treatment of a patient or helping the court in a legal dispute. By following these principles, evaluators performing RCCEs can produce valid and reliable reports that will help courts in their efforts to resolve custody disputes.

Conclusion

The COVID-19 pandemic has at least temporarily and perhaps permanently changed the landscape of mental health service delivery, including the conduct of child custody evaluations. Currently and into the foreseeable future, some CCEs must be remotely done via VC to ensure the safety of the parties and the evaluators. The learning curve for using these technologies in this context is a steep one. There is a lot to learn and a need to learn and apply it quickly. VC can become the lens through which data and facts are collected (J. W. Gould, personal communication, June 20, 2020). Evaluators must use technologies that provide high-quality audio and video images for the interviews and observations. Evaluators need to be prepared to pro-

vide information regarding the technology they used, why they chose that technology, and how that technology worked during the data collection interviews or observations. They must establish that they used appropriate verification, confidentiality, and security parameters consistent with the CCE and the privacy interests of the parties (Shore et al., 2018).

Family courts that were overwhelmed prior to the pandemic are likely to be even more overwhelmed when they reopen. There likely will be many changes, but the need for the help of experts, including custody evaluators, is likely to remain a priority. For evaluators who conduct RCCEs, the new competence requirements will encompass both CCE and telemental health methods. In these evaluations, evaluators must think through, individualize, and adapt methodologies to help the court answer the questions that were the foci of the dispute.

This article articulated a conceptual model illustrating a dynamic, flexible process-oriented approach to creating and defining the scope of the evaluation and collecting data and facts from multiple sources, as well as a process that combines scientific and investigative principles for analyzing this information via comparisons with hypotheses and theories about the case. Regardless of whether a CCE is conducted in person or remotely via VC, evaluators must be able to describe and explain their choices of how they investigated the relevant factors and the psycholegal questions that were the foci of the evaluation and the ways analysis connects the data and facts to their conclusions and recommendations.

This article details the growth of the telemedicine and telemental health communities over the past 10 to 15 years from an alternative to reach underserved populations to an alternative within the mainstream mental health professions. This growth is mainly a story of successful applications across people of different ages, different clinical and forensic populations, and different clinical and forensic tasks. In the absence of a vaccine for COVID-19, it is difficult to think of safe mental health service delivery without accommodations. Properly conducted RCCE may be a necessary safe substitute for in-person processes. There are limitations and situations where VC may not be a safe alternative, but the child custody community—for example, courts, attorneys, evaluators, and families—should accept RCCEs as a valid alternative that, when properly done, can help resolve custody disputes.

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