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Conducting remote psychological assessments and interventions:
Summary of the available evidence and when I do and don't work remotely

Psychological assessments and interventions have been conducted remotely for several decades to increase access and engagement and became commonplace during the COVID-19 pandemic due to social distancing restrictions. Remote working – also called telemedicine, telehealth, telepsychiatry, and telemental health – confers several advantages, including reducing geographical barriers and travel time and costs, overcoming logistical challenges in attending healthcare appointments (e.g., due to caring responsibilities or an impairing health condition), and increased convenience for everyone.

A large evidence-base supports indicates that remote psychological and psychometric assessments and remote psychological therapy are generally comparable to working face-to-face in terms of outcomes (effectiveness), safety, and acceptability to clinicians and patients (Backhaus et al., 2012; Brunt & Gale-Grant, 2023; Gentry et al., 2018; Goldenson & Josefowitz, 2021; Greenwood et al., 2022; Gros et al., 2013; Hubley et al., 2016; Kirschstein et al., 2022; Kois et al., 2020; Lexcen et al., 2006; Rosen et al., 2020; Schlief et al., 2022; Shigekawa et al., 2018), including for posttraumatic stress disorder specifically (Bongaerts et al., 2021, 2022; Jones et al., 2020; Litwack et al., 2014; Olthuis et al., 2016; Taknint et al., 2023; Thorp et al., 2012; Turgoose et al., 2018; Wild et al., 2020).

Meta-analytic syntheses of the literature have concluded that remote psychological interventions produced treatment effects that were largely equivalent to in-person delivered interventions (Batastini et al., 2021), and remote psychological assessment in the criminal justice system, including the assessment of mental health symptoms, therapeutic processes, program engagement and performance, and service satisfaction, were largely equivalent to in-person services for criminal justice and substance-abusing defendants (Batastini et al., 2016).

There is evidence demonstrating that people often disclose more during remote psychotherapy than face-to-face sessions (Tachakri & Rajani, 2002; Thorp et al., 2012; Wootton et al., 2003). The literature has not documented any adverse outcomes and the general message stated is that remote working is an equally feasible and useful alternative to face-to-face contact and clinical discretion and individual preference should be the determining factors in choosing between modalities.

More specifically with regards my own way of working, I consider the appropriateness of conducting expert witness assessments remotely on a case-by-case basis, in collaboration with instructing parties and the client(s), taking account of any contraindications to remote working (e.g., poor digital access and awareness, cognitive difficulties, auditory or visual impairments, severe mental health problems, high levels of risk). Clinical need and ethical rights are always prioritised. Remote assessments are typically perfectly acceptable and appropriate for personal injury, clinical negligence, immigration, and Occupational Health assessments, and for adults in family law assessments; I almost always assess children and young people in-person in family law assessments and always observe contact in-person.

At all times I adhere to professional practice guidelines regarding remote clinical working, which emphasise the importance of personal choice, privacy, confidentiality, robust clinical governance, safety, the therapeutic relationship, and being able to access a private and confidential space and reliable internet connection and understand the technology. I ask people I assess to ensure they have access to a quiet, confidential space for the duration of the assessment, do not record any of the assessment, and show ID during their assessment.

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