The use of telepractice in the family and relationship services sector

CFCA PAPER NO. 57

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Child Family Community Australia | information exchange
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Summary

The use of telepractice as a service delivery method has increased in Australia since the start of the COVID-19 pandemic. This paper reviews the evidence for telepractice as a service delivery method in the family and relationship services sector. It describes the acceptability of telepractice as a service delivery option for both clients and practitioners, the enablers and barriers to uptake and implementation, and the current evidence on client outcomes. Evidence-informed implications of implementing telepractice for practice in this sector are also presented at the end of the paper.

Key messages

- Telepractice can be a satisfactory form of service delivery for clients and practitioners, when personal preferences and client circumstances are considered.

- Key enablers of telepractice include ensuring that service providers are sufficiently skilled in the use of virtual service delivery and that clients and organisations have access to, and the skills to use, the necessary technological resources.

- Key barriers to using telepractice include difficulties engaging clients, digital inequities and privacy risks, practitioner resistance and an organisational environment that is not set up to support telepractice.

- The benefits of telepractice compared to face-to-face services include improved access to services for certain populations and it can provide practitioners with insights into family life through video-conferencing technology.

- There is limited material comparing client outcomes from telepractice with client outcomes from face-to-face delivery.

- Some evidence suggests that telepractice may suit certain service areas (e.g. mental health related early intervention compared to other family and relationship services).
Introduction

As the COVID-19 pandemic began in 2020, many child, family and social services across Australia transitioned to online/telephone service delivery due to mandated physical distancing restrictions affecting traditional face-to-face service delivery. At the same time, services providing family and relationship support (such as child and family services, mental health and family law services) experienced a surge in demand due to an increase in family violence, unemployment, poor mental health, and financial hardship (Bowden & Johnson, 2020; Crime Statistics Agency, 2020).

The family and relationship services sector in Australia includes a variety of family and child related services. Those services aim to strengthen family relationships, prevent breakdown, support families through change, and ensure the wellbeing and safety of children, through prevention and early intervention strategies. The family and relationship services sector also includes services provided under the Australian Government’s ‘Families and Children’ Activity such as Family Law Services, Communities for Children (place-based) services, Children and Parenting and Adult Specialist Support.

Historically, the family and relationship services sector has under-used technology in service delivery compared to the medical and health care sectors (Lee, Flint, & McIntosh, 2017). Similar to these sectors, the family and relationship sector often works face-to-face with clients on a one-on-one (or one family to one practitioner) basis, providing tailored, evidence-based interventions that target specific or multiple needs (e.g. counselling, parenting interventions, early intervention for child development delays). The use of technology in medicine and health care has a relatively robust evidence base, with multiple large-scale reviews finding positive patient experiences associated with the use of telepractice (e.g. satisfaction with health outcomes, avoiding travel, having access to their preferred modality of service delivery and low cost) (Dods et al., 2012; Orlando, Beard, & Kumar, 2019). However, for the family and relationship service sector, evidence on the effectiveness, benefits or risks of telepractice as a service delivery model is not as clear. Family and relationship services operate differently to health and medical services; therefore, evidence from these sectors is not directly transferable.

What is telepractice?

Telepractice refers to the use of telecommunications technology – including voice calls, video conferencing or teleconferencing – to assess, triage and provide therapeutic and other supports to clients, enabling clients and service providers to meet despite being in different physical locations. Several terms are commonly used to describe this form of service delivery including telehealth and telemedicine. Telepractice provides a broad definition that encompasses services outside the health sector, including early intervention services, education and therapeutic or social services (Akemoglu, Muharib, & Meadan, 2020).

As Australia shifts into ‘COVID Normal’, services and their clients are adjusting to new ways of providing and accessing services, including the increased use of telepractice as a service delivery model. At the same time, traditional face-to-face models are being challenged on their ability to reach different types of clients with specific needs for the services they are accessing. Unlike the health and medical sector, the evidence on the effectiveness, benefits and risks of telepractice as a service delivery model is still emerging in the family and relationship services sector. For this reason, this paper will focus on telepractice services outside of health and medicine in an effort to capture evidence specific to the family and relationship sector.

This paper answers the research question: What evidence is there on the use of telepractice in family and relationship services? It describes the acceptability of telepractice as a service delivery method for practitioners and clients, implementation considerations and client outcomes. The paper also highlights key considerations for practice managers regarding the implementation or integration of telepractice into routine service delivery.
Methodology

A scoping review was undertaken due to the broad nature of the research question and the relatively small amount of evidence on the topic. This review methodology is also rapid and allows for consultation and engagement with key stakeholders to review findings. The methodology used in this review was informed by Arksey and O’Malley (2005) and the Joanna Briggs Institute’s Manual for Evidence Synthesis (Peters et al., 2020). CFCA would like to acknowledge Family and Relationship Services Australia’s (FRSA) contribution to shaping the research question for this paper.

Publications were included if telepractice was a replacement for one-on-one (one practitioner to one client or family member) face-to-face delivery, and if ‘family’ or ‘relationships’ were part of the intervention or outcome (see complete inclusion criteria in Appendix 1). Literature on health or medicine services, programs or interventions was excluded to ensure included evidence was more relevant to the family and relationship sector. Literature was searched across three types of publications: academic journals, online grey literature and reference lists of included publications. Articles published between 2015 and 2021 were identified through a range of databases (see Appendix 2 for the full list of databases). The date limit on publications was chosen to ensure that included articles were recent, due to rapid advances in technology.

Websites of key organisations in the family and relationship services sector in Australia were searched as part of the grey literature search (full list of organisation websites in ‘grey literature sources’, Appendix 2). Additionally, an advanced search on Google of .org and .gov domains captured international grey literature between 2015 and 2021.

The database literature search identified 1,777 publications. Twelve publications were added from the grey literature search and a further six from reference lists. Of those 1,795 publications, 30 publications were selected for review based on the inclusion and exclusion criteria (Appendix 3: PRISMA diagram). A full list of included publications and characteristics is presented in Appendix 4.

Data management

Publications were reviewed for the type of telepractice delivered, the type of family and relationship service for which it was used, and the benefits, limitations, barriers and enablers of telepractice (see Appendix 4). Publications focused on areas of practice within the family and relationship services sector; these practice areas are listed below, followed by the number of publications in this review that focused on that particular area of practice:

- development/behavioural therapy (8)
- early intervention (4)
- couple/family therapy (4)
- domestic/family violence (3)
- intimate partner violence (2)
- family law (2)
- mental health (2)
- parenting (2)
- family wellbeing (1)
- non-specific (1)
- parental conflict (1)

Target populations included children and young people (12), parents (9), partners/couples (8) and families (9). Telepractice mostly included video-conferencing techniques or a combination of video conferencing, telephone, emails and/or web-based platforms. Fifteen publications were published in 2020, which is likely due to the COVID-19 pandemic and widespread transition to online/telephone service delivery in the sector. While publications largely originated from the United States (19), around one-third were from Australia (9). Most publications sourced in this review were journal articles (20) including one systematic review and nine literature reviews.
What does the evidence tell us?

Acceptability of telepractice as a delivery method

Key findings

- In the publications reviewed, clients found telepractice an acceptable service delivery model when it is accessible and easy to use.
- One literature review and one primary research paper on parental education and counselling, found that approaches with a combination of face-to-face and telepractice service delivery are preferred by clients.
- Publications that assessed the acceptability of telepractice for practitioners found telepractice less acceptable compared to face-to-face service delivery, due to concerns regarding client privacy and rapport.

‘Acceptability’ was described in the publications in this review as the level of satisfaction for the use of telepractice as an alternative service delivery method to face-to-face services. Across the publications reviewed, telepractice was found to be satisfactory for clients across several areas including intimate partner violence prevention (Anderson et al., 2019), early intervention parent counselling (Owen, 2020), family counselling for treatment of challenging behaviour (Schieltz & Wacker, 2020) and domestic violence and sexual assault therapy (Gray et al., 2015; Steinmetz & Gray, 2017). Primary research investigating telepractice satisfaction in clients undergoing couple/family therapy (Burgoyne & Cohn, 2020) and parents receiving training to support their children with challenging behaviour (Ruppert, 2016) also found that telepractice was acceptable to these groups. Parents indicate a preference for a hybrid model, incorporating both telepractice and face-to-face service delivery, according to a literature review on technology assisted parental interventions and primary qualitative research on parental counselling (Hall & Bierman, 2015; Owen, 2020).

However, telepractice acceptance may be dependent on client characteristics such as income level and comfort in using technology. For example, one literature review showed that parents with higher incomes were more receptive to the delivery of interventions online (Hall & Bierman, 2015). While further research is required on why this is the case, the review indicated that it could be due to lower-income parents having limited access to technology and less comfort with using technology (Hall & Bierman, 2015).

The evidence suggests that practitioners find telepractice less acceptable as a service delivery model compared with face-to-face due to concerns regarding privacy and limitations in developing client rapport. For example, practitioners have described how the loss of visual cues affected communication and rapport with their clients (Pfitzner, Fitz-Gibbon, McGowan, & True, 2020). Practitioners seem to be more accepting of technology when provided with organisational support, online communication training, and through using techniques to protect client privacy; for example, by using headphones during consultations (Ghiara, 2020; Lee et al., 2017; Wrape & McGinn, 2019).

Implementing telepractice

Key findings

- While there is broad access to and acceptance of technology in Australia, limited access to the necessary equipment such as a computer and the internet is a barrier to telepractice.
- Other barriers to telepractice include difficulty engaging clients, poor organisational planning, inappropriate home environments, and privacy and safety risks.
- Positive practitioner attitudes towards telepractice and their skills and confidence in using technology aid telepractice uptake.
Enablers of telepractice

Enablers of telepractice are the mechanisms that support telepractice to work well in family and relationship services. Table 1 lists enablers identified in this scoping review. Examples from the research are given to provide more detail.

Table 1: Enablers of telepractice

<table>
<thead>
<tr>
<th>Enablers of telepractice</th>
<th>Examples from included publications</th>
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<tbody>
<tr>
<td><strong>Context and client considerations</strong></td>
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</tbody>
</table>
| Access to technology in Australia | - 98% of small and medium enterprises in Australia have internet-connected devices  
- 74% of Australians have smartphones |
| Client access to technology | - Access to necessary equipment to receive telepractice services or access to the provision of technology by the service (e.g. lending client a tablet)  
- Access to high-speed internet |
| Targeting a specific audience | - Having toys or strategies for virtual engagement with young children  
- Use of code words and safety procedures in telepractice with clients at risk of violence |
| Flexibility to accommodate client preferences | - Discussion of client preferences, needs, goals for treatment and intervention  
- Initial face-to-face meeting before telepractice  
- Flexibility to provide preferred model of telepractice (e.g. video conferencing, text messaging, multi-modal approach)  
- Options for appointment format/structure (e.g. client may prefer four short appointments rather than one longer one) |
| **Organisational factors** | |
| Organisational access to technology | - Access to secure platforms of service delivery  
- Availability of IT support for delivering telepractice  
- Availability of hybrid models for service delivery choice (both telepractice and face-to-face) |
| Organisational environment | - Ensure fidelity of programs when transitioning to telepractice  
- Develop a plan to address common barriers to telepractice (e.g. practitioner attitudes) |
| **Practitioner factors** | |
| Practitioner attitudes towards telepractice | - Confident in the benefits of telepractice  
- Avoid assumptions about client preferences |
| Practitioner confidence in telepractice | - Access to telepractice and video-conferencing training  
- Professional and peer support for using telepractice  
- Access to learning opportunities early in career (e.g. during university) |
| Practitioner skills in telepractice | - Ability to be flexible and prepared  
- Ability to develop strong partnerships with clients  
- Multi-modal telepractice abilities to reduce impact of technical difficulties (e.g. phone call if video conference cuts out) |

Acceptance, access and authorising environment for telepractice

Organisations and clients need access to the necessary digital resources to deliver and receive telepractice. Appropriate hardware with built-in or external audio-visual capabilities (e.g. laptop, computer, tablet, smartphone) aid with telepractice. A consistent, high-speed internet connection is also essential to facilitate telepractice service delivery for providers and clients. Where clients do not have access to appropriate equipment, one research paper suggests organisations provide equipment to facilitate service delivery and minimise digital inequity and access limitations (Gurwitch, Salem, Nelson, & Comer, 2020). Having access to technology support (such as a dedicated IT team) can allow for the smoother delivery of services (Pfitzner et al., 2020; Sourdin & Zeleznikow, 2020).
Competencies to deliver telepractice

The confidence, skill and adaptability of practitioners support the successful implementation of telepractice. Opportunities to practice using virtual service delivery methods helps to improve practitioner confidence in using the technology (Owen, 2020). Interactive peer meetings and training on video conferencing can help to increase practitioner skills (Owen, 2020). Several publications highlighted that upskilling practitioners in the use of technology facilitates telepractice (Cole, Pickard, & Stredler-Brown, 2019; Early Childhood Intervention Australia, 2020; Ghiara, 2020; Hall & Bierman, 2015; Owen, 2020; Ruppert, 2016). Supporting practitioners to understand the logistics (e.g. the technology required such as secure platforms for service delivery) and benefits of telepractice is also considered useful (Cole et al., 2019). Ensuring clients were prepared before beginning telepractice also aided delivery; for example, letting the client know what a session will entail so they can be prepared with resources (e.g. toys for a child during the session). Practitioner flexibility when planning a session was identified as an enabler; for example, working with the client to ensure a suitable intervention format (e.g. multiple shorter appointments might be preferred) (Schieltz & Wacker, 2020).

Flexibility to accommodate client preferences

Understanding and working with a client’s resources (e.g. digital resources and private space) to meet their needs and goals is another enabler of telepractice. A recent guideline produced by Early Childhood Intervention Australia, and in a recent report from the UK, recommends an initial face-to-face session to build rapport with the client and make sure they are comfortable, prior to using telepractice (Early Childhood Intervention Australia, 2020; Ghiara, 2020). Additionally, allowing clients to choose their preferred method of service delivery may facilitate better engagement (e.g. a hybrid approach with both in-person and telepractice appointments (Burgoyne & Cohn, 2020; Early Childhood Intervention Australia, 2020; Hall & Bierman, 2015; Owen, 2020).

Other enablers

Establishing a back-up plan for technology failures can improve telepractice and ensure a more consistent service delivery for clients. For instance, if the internet connection fails, delivery can continue on the phone (Steinmetz & Gray, 2017). Other enablers identified include being innovative by providing visual aids to assist client engagement and to cater to all levels of literacy (Hall & Bierman, 2015; Lee et al., 2017) and practical tips such as keeping the web layout for online platforms similar to paper forms (Lee et al., 2017).

Barriers to telepractice

Barriers are the challenges to accessing, implementing or successfully using telepractice in family and relationship services. Table 2 lists the barriers identified in this scoping review and provides examples from the research for more detail.

<table>
<thead>
<tr>
<th>Barriers to telepractice</th>
<th>Examples from included publications</th>
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<tbody>
<tr>
<td><strong>Practitioner and organisational factors</strong></td>
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</table>
| Attitudinal barriers from practitioners or service providers | • Reservations about the efficacy of telepractice, including assumptions about client preferences for treatment modes  
• Concern that telepractice would not be supported by the organisation  
• Lack of practitioner willingness to attend technical training sessions and time constraints often found in the not-for-profit sector |
| Risk to client engagement and rapport | • Telepractice platforms could hinder engagement (e.g. if clients need to download specific software to access a service)  
• Children not staying in the room or in sight of camera during an intervention (and the safety concerns of this)  
• Difficulty establishing rapport and establishing feelings of trust  
• Loss of non-verbal cues |
| Difficulty maintaining engagement over time | • Practitioners and clients often lose interest in telepractice over time due to poor interactivity/engagement online. This results in high numbers of drop-outs in telepractice services in the publications reviewed. |
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<thead>
<tr>
<th>Barriers to telepractice</th>
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<tbody>
<tr>
<td>Organisational issues</td>
<td>• Difficulty keeping up to date with research on best practice due to the rapid pace of new technology developments&lt;br&gt;• Inequity of physical home office spaces across practitioners&lt;br&gt;• Strain on practitioners with the constant adaption of services, known as ‘change fatigue’</td>
</tr>
<tr>
<td>Technology/Privacy/Environmental factors</td>
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<tr>
<td>Limited access to technology and limited skills in technology use</td>
<td>• Digital poverty and inequity&lt;br&gt;• Lack of internet or access to high-speed internet&lt;br&gt;• Necessity of clients to own technology suitable for telepractice&lt;br&gt;• Lack of technical skills in practitioner or client</td>
</tr>
<tr>
<td>Technical issues</td>
<td>• Internet connectivity issues&lt;br&gt;• Unreliable functionality (e.g. picture freezing, poor sound quality)</td>
</tr>
<tr>
<td>Inappropriate home environment</td>
<td>• Distractions in the home (e.g. pets, children)&lt;br&gt;• Day-to-day activities interrupting the session</td>
</tr>
<tr>
<td>Privacy and safety concerns</td>
<td>• Clients may not have access to a private space at home to participate in telepractice sessions&lt;br&gt;• Practitioner difficulty communicating with clients when they live with a perpetrator (e.g. for family violence service delivery)&lt;br&gt;• Concerns about video-conferencing or other online platforms storing data during (and/or following) consultations; concerns about the ethics of storing such data</td>
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Limits to digital technology and technical ability

Concerns over inequitable digital access, also known as the ‘digital divide’, ‘digital equity’ and ‘digital poverty’, were articulated across the publications in this review. Unequal digital access can impact clients who cannot afford the required equipment or technology, such as high-speed internet. Certain population groups may have more difficulty accessing telepractice services; for example, older adults who might be less familiar or comfortable with using technology (Emezue, 2020). Unreliable functionality of technology (e.g. poor internet connection, video freezing) is frequently reported in the literature as a barrier to telepractice (Cole et al., 2019; Early Childhood Intervention Australia, 2020; Emezue, 2020; Kohlhoff, Wallace, Morgan, Mauolo, & Turnell, 2019; Sourdin & Zeleznikow, 2020; Steinmetz & Gray, 2017).

Attitudinal barriers from practitioners or service providers

Practitioners’ attitudes towards telepractice can pose a barrier to virtual service delivery. Research showed that when practitioners had reservations about the capacity of telepractice to deliver client outcomes, or assumed their clients would prefer traditional face-to-face models of service delivery, telepractice was less likely to be offered (Cole et al., 2019; Lee et al., 2017). Practitioners were reluctant to use telepractice when working with clients who had complex needs (Wrape & McGinn, 2019). Similarly, telepractice was not considered by the practitioner if the practitioner believed there was no organisational support (Owen, 2020).

Risks to client engagement and rapport

Another barrier that practitioners delivering telepractice identified was the potential communication risk it poses to client engagement (Ruppert, 2016). Difficulty engaging clients could occur from the outset if there was significant investment required on the client’s behalf to set up the technology (e.g. needing to download software or learn a new platform) (Anderson et al., 2019). Practitioners were also concerned about the difficulty in building rapport with families or children over telepractice, with the loss of non-verbal cues and limited ability to establish trust (Burgoyne & Cohn, 2020; Sourdin & Zeleznikow, 2020). Practitioners expressed difficulty in being able to accurately assess clients or convey empathy via technology, which may be particularly problematic when working with clients from culturally or linguistically diverse backgrounds (Pfitzner et al., 2020).
Concerns about privacy and inappropriate telepractice environments

Concerns about privacy were also frequently identified. If unaddressed, this could create a significant barrier to telepractice, posing potential risks to professional codes of ethics and duty of care to clients (Lee et al., 2017; Rogers, 2020). Platforms used for telepractice need to be secure in terms of client confidentiality and data storage (Doss, Feinberg, Rothman, Roddy, & Corner, 2018; Early Childhood Intervention Australia, 2020; Emezue, 2020). Practitioners and clients may not have an appropriate space at home, without distractions, to participate in telepractice (Burgoyne & Cohn, 2020; Owen, 2020). One publication highlights how practitioners have minimum control over the treatment space when using telepractice, which poses potential safety risks if a child elopes from the treatment space (Kohlhoff et al., 2019). Privacy risks are magnified for victims of family and domestic violence, who require a private and safe space away from perpetrators to receive support from specialist services. Telepractice may also inadvertently provide perpetrators with an additional avenue to abuse their victims; for example, through digital tracking and impersonation, online stalking and surveillance (Emezue, 2020).

Perceived benefits of telepractice

### Key findings
- Publications in this review highlight perceived benefits such as the flexibility and convenience telepractice provides to clients and practitioners.
- Improved access to services for certain populations such as clients with a disability, rurally located clients or clients with complex needs was highlighted as a perceived benefit of telepractice.
- Telepractice can foster personal connections with clients by facilitating contact despite relocation and connecting families who are located separately.
- Video conferencing, as a form of telepractice, can allow practitioners to work with clients in their family home, providing unique insights into family life and family functioning, which may be beneficial for certain family and relationship services.
- Telepractice may help to reduce the stigma associated with certain services (e.g. rural mental health services where client anonymity is difficult to preserve).

Several publications in the review described how telepractice has been beneficial for clients and practitioners or described how telepractice is perceived to be beneficial for service delivery. Clients and practitioners in the family and relationship services sector appreciate the greater flexibility and convenience that telepractice provides. Benefits include parents’ attendance at appointments while caring for young children, reduced coordination efforts required to organise child care and reduced travel time to attend clinics (Kohlhoff et al., 2019; Pfitzner et al., 2020).

The evidence suggests that telepractice is perceived to improve access to services, particularly for:
- remotely located families who do not have access to local practitioners or find it difficult to travel long distances (Anderson et al., 2019; Burgoyne & Cohn, 2020; Cole et al., 2019; Comer et al., 2017; Gray et al., 2015; Kohlhoff et al., 2019; Steinmetz & Gray, 2017)
- clients with a disability or who are housebound (Burgoyne & Cohn, 2020; Hall & Bierman, 2015)
- clients undergoing domestic violence screening through providing visual aids online and reducing literacy burden (Lee et al., 2017)
- clients with complex circumstances, through greater ease of access to multiple professionals from different locations through group video conferencing (Early Childhood Intervention Australia, 2020; Pfitzner et al., 2020).

Telepractice can provide personalised and consistent connections with families; for example, by connecting family members who are physically separated (Wrape & McGinn, 2019) or providing continuity in care if a client moves location (Burgoyne & Cohn, 2020; Owen, 2020).

Practitioners can obtain unique and valuable insights into a family’s life, interactions and environment through telepractice. Practitioners can observe parenting skills in the context of the family’s life and provide tailored support (e.g. by understanding what toys are available at home) (Kohlhoff et al., 2019). In early interventions for children, telepractice allows parents to ‘take the lead’ in their interaction with their child during the session, because the practitioner is not physically present (Early Childhood Intervention Australia, 2020). Telepractice
may also facilitate sessions during non-traditional hours, giving access to important daily routines (e.g. mealtimes) and providing insight into family functioning (Cole et al., 2019).

Telepractice may be less intimidating and less stigmatising, compared to face-to-face service delivery, for clients obtaining certain services, such as mental health services (Comer et al., 2017; Doss et al., 2018; Wrapi & McGinn, 2019). This could be a valuable consideration for services operating in regional and rural locations, where client anonymity is more difficult to protect. Clients at an Australian domestic violence men’s service reported that using a telephone was less intimidating than face-to-face delivery (Pfitzner et al., 2020). Additionally, in a literature review on domestic and intimate partner violence, some survivors preferred tech-enabled interventions and online guided support because of the confidentiality it provided (Emezue, 2020).

Client outcomes from telepractice

Key findings

- There is limited evidence (few studies or poor-quality evidence) comparing client outcomes from telepractice to face-to-face delivery.
- No reviews found telepractice produced better outcomes than face-to-face delivery.
- Some evidence suggests that telepractice may suit certain service areas (e.g. mental health related family and relationship services).

The review showed that there was limited evidence on client outcomes for telepractice in the sector (few studies or poor-quality evidence). Five evidence reviews, including one systematic review, and one report reviewed the evidence that compared client outcomes from telepractice to face-to-face service delivery (Anderson et al., 2019; Caldwell, Bischoff, Derrig-Palumbo, & Liebert, 2017; Hall & Bierman, 2015; Lee et al., 2017; Martin et al., 2020; Schieltz & Wacker, 2020). Comparisons between telepractice and face-to-face services were evaluated in programs focused on intimate partner violence (Anderson et al., 2019), early interventions for children and young people across a range of areas including education, physical and mental health, substance misuse and so on (Martin et al., 2020), parenting (Hall & Bierman, 2015), couple/family therapy (Caldwell et al., 2017), parenting and child mental health (Lee et al., 2017) and functional assessment/function-based therapy (Schieltz & Wacker, 2020).

No reviews found telepractice produced better client outcomes than face-to-face delivery. The remaining evidence showed varying degrees and inconsistent levels of effectiveness between the two delivery methods. Two literature reviews and one rapid review suggest that when compared, client outcomes from interventions delivered via telepractice were poorer or equivalent to those delivered face-to-face (Lee et al., 2017; Martin et al., 2020; Schieltz & Wacker, 2020). There was some evidence to suggest that telepractice can produce comparable outcomes to face-to-face delivery for clients receiving mental health treatment (Lee et al., 2017) or mental health early intervention (Martin et al., 2020). Limited evidence exists for two specific services producing equivalent outcomes: early intervention programs targeting risky sexual behaviour or teenage pregnancy (Martin et al., 2020) and functional assessment/function-based therapy (Schieltz & Wacker, 2020). Some evidence suggests early intervention programs targeting substance use via telepractice may produce worse outcomes than traditional face-to-face service delivery (Martin et al., 2020).

Recent primary research studies suggest telepractice may be more effective compared to face-to-face delivery with specific interventions. An online family problem-solving therapy for adolescent dysfunction (Kurowski et al., 2020) and internet-delivered parent-child interaction therapy (Comer et al., 2017; Kohlhoff et al., 2019) showed better self-reported outcomes, improved child behaviour and symptoms compared to face-to-face delivery. This could be because the target group for the first study were adolescents, who may be more amenable to telepractice techniques due to their familiarity with online resources (Kurowski et al., 2020). In the second study, parents were able to participate in the parent-child interaction therapy in their natural home environment, which may be more effective than in an office environment (Comer et al., 2017). These interventions were highly specific; therefore, findings may be less applicable to other areas of practice, target groups or contexts. Some aspects of program delivery may need to be modified when using telepractice and only some programs may be suited to this type of delivery. However, the evidence is not yet clear and caution is required when using these findings in practice.
Evidence-informed implications for practice

This section provides evidence-informed implications, drawing on the findings from this scoping review. Given that research on telepractice in the family and relationship services sector is still in its infancy, strong recommendations cannot be drawn from the research available. Specifically, there is no conclusive evidence on whether telepractice produces better client outcomes than traditional face-to-face delivery. Comparatively, there is more research on the benefits and acceptance of telepractice in the family and relationship services sector. The following section may be of use to program or practice managers considering the implications of this research and telepractice implementation or scale-up in delivery.

Importance of considering local contexts

Main implications
Research suggests the need to:

- Consider client circumstances when deciding if telepractice is appropriate and beneficial as a service delivery method.
- Consider local context and which services may be more suited to telepractice; for example, mental health related family and relationship services, or services that will benefit from practitioner insights into family functioning through video conferencing.

For service and program managers, it is useful to consider the circumstances in which telepractice is acceptable for clients and practitioners, and for which clients it may be more suitable. Evidence shows that clients find telepractice to be acceptable (Anderson et al., 2019; Burgoyne & Cohn, 2020; Gray et al., 2015; Owen, 2020; Ruppert, 2016; Schieltz & Wacker, 2020; Steinmetz & Gray, 2017) and that technology is broadly accepted as a part of life in Australia today (Lee et al., 2017). Service providers can consider telepractice when face-to-face service delivery models are not meeting clients’ needs.

Busy parents with young children or multiple commitments may prefer telepractice as it can be accessed from home and can reduce the burden of planning and travel required with face-to-face visits (Kohlhoff et al., 2019; Pfitzner et al., 2020). This is true for both clients and practitioners (Pfitzner et al., 2020). This may also be helpful for clients with disability, living in rural areas or with complex needs requiring multiple interventions, where the logistical difficulty of organising frequent travel for appointments can be reduced (Anderson et al., 2019; Burgoyne & Cohn, 2020; Cole et al., 2019; Comer et al., 2017; Gray et al., 2015; Kohlhoff et al., 2019; Steinmetz & Gray, 2017). It may be useful for service and practice managers to plan the delivery of specific services via telepractice after gauging community and subpopulation preference and capacity (Ghiara, 2020).

Some family and relationship services may be more suited to telepractice than others. Mental health related services provided through telepractice (e.g. mental health early intervention programs) have shown positive impacts on client outcomes compared to other family and relationship services provided through telepractice (Lee et al., 2017; Martin et al., 2020). Family and relationship services that require insights into family life and relationships may benefit from telepractice. Video conferencing with clients in their homes can provide opportunities for observing, for example, the interaction of parents with children during important daily routines like mealtimes or assessing the availability of resources at home; for example, toys for children (Cole et al., 2019; Early Childhood Intervention Australia, 2020; Kohlhoff et al., 2019). Services that may be stigmatising for the client, such as men’s violence programs, may also be suited to telepractice due to the anonymity it provides (Pfitzner et al., 2020).

Hybrid approaches combining both telepractice and face-to-face service delivery were considered to be favourable in parent–child interventions (Hall & Bierman, 2015; Owen, 2020). The hybrid approach provides the option of telepractice, when it is suitable to the local context, but also provides an avenue to continue face-to-face delivery when common barriers such as digital inequity and privacy concerns cannot be resolved.
### Main implications

Research suggests the need to:

- Develop an organisational strategy to address common enablers and barriers of telepractice uptake.
- Create a supportive organisational environment for practitioners where flexibility is encouraged in order to address common barriers of telepractice according to client needs and circumstances.
- Develop practitioner knowledge and skills on the use of telepractice.

Common barriers to the implementation and uptake of telepractice often arise from inadequate organisational support, and not having structures in place to specifically address practitioners’ concerns about the use of telepractice. Practitioners may have concerns about the difficulty in building and maintaining rapport with clients online as well as privacy concerns associated with online delivery of services. ‘Change fatigue’ is a common barrier to any organisational change, including telepractice (Cook et al., 2019).

Factors that assist with overcoming organisational issues include:

- having a change management strategy to address known challenges, such as practitioners’ reluctance to use telepractice (Lee et al., 2017; Martin et al., 2020). This could mean identifying characteristics of the changes that are to take place and considering the risks of, and potential resistance to, these changes.
- ensuring organisational policies and procedures for telepractice are aligned with best practice and best available evidence (Rogers, 2020)
- ensuring program or intervention fidelity (or quality) is maintained when transitioning the service delivery model from in-person to virtual. Practice managers are encouraged to consider which programs already have good evidence to support delivery via telepractice (Martin et al., 2020). However, as this may not always be possible, practice managers are encouraged to use the best available evidence and stay abreast of new research.

Factors that assist in supporting practitioners could include:

- supporting practitioners to develop skills in delivering telepractice and ensuring they are informed about the benefits of virtual service delivery (Owen, 2020; Ruppert, 2016). This training could start early by training undergraduate students in universities on the use of telepractice (Gray et al., 2015).
- ensuring practitioners are aware of providing overt non-verbal cues, are alert to social cues and emotionality in clients, and are using a communication style appropriate for telepractice (e.g. asking more questions to avoid misinterpretations) (Martin et al., 2020)
- supporting practitioners to be flexible and have a plan for engaging clients through telepractice. This could involve providing clients with information ahead of time about accessing the online delivery system, or scheduling processes to ensure children are not overscheduled with telepractice appointments (Britwum, Catrone, Smith, & Koch, 2020; Burgoyne & Cohn, 2020; Wrape & McGinn, 2019) by offering shorter, more frequent appointments (Schieltz & Wacker, 2020).
- encouraging solutions to protect client safety concerns. For example, practitioners could wear headphones to protect client confidentiality, establish alternative ways to contact high-risk clients for safety planning, and become familiar with emergency resources and designated supports (Doss et al., 2018; Wrape & McGinn, 2019).
- encouraging regular team catch-ups where peer-to-peer support and debriefing takes place may also be beneficial. This can provide practitioners with an opportunity to better understand the benefits of telepractice or to troubleshoot any problems they may be experiencing with telepractice service delivery with their peers (Pfitzner et al., 2020).


Technology requirements

Main implications

Research suggests the need to:

- Consider the known barriers to digital access for both clients and practitioners and develop an organisational plan to address these.
- Invest in appropriate software and technology to safeguard quality of service delivery and protect client privacy.

Digital access and technology requirements for telepractice are key factors influencing the effectiveness of delivery for both practitioners and clients. Evidence shows that organisations and clients need access to the appropriate technology, internet and devices for telepractice to be considered viable (Pfitzner et al., 2020). Practice managers may need to consider the organisation’s scope to supply these resources to clients who have limited access to technology (Gurwitch et al., 2020). This may be more challenging in certain circumstances; for example, telepractice in remote communities may be restricted by a lack of availability of high-speed internet (Cole et al., 2019; Thomas, Barraket, Rennie, Ewing, & MacDonald, 2020). In this review, specific guidelines on what technology requirements are needed to facilitate telepractice in the family and relationship sector were not found. When implementing telepractice, it may be helpful to consider published guidelines from other sectors for information on how to support clients using technology and minimum requirements for technology set-up and use.

Clients that require family and relationship services often have social, financial and cultural circumstances that act as barriers to accessing services. Moving to online service delivery, therefore, may add to, or exacerbate, these access issues further (Thomas et al., 2020). For this reason, careful consideration and assessment of client circumstances must be made when offering telepractice to families.

Practical considerations to overcome these concerns and hurdles include:

- arranging for dedicated staff to provide technological support to clients and practitioners (Doss et al., 2018)
- providing tech-related resources to clients if feasible; for example, Bluetooth headsets, 4G Wi-Fi dongles, tablets (Gurwitch et al., 2020; Kohlhoff et al., 2019)
- investing in high-quality video equipment that is fit-for-purpose, able to meet contemporary needs and nimble in responding to future challenges (Sourdin & Zeleznikow, 2020)
- considering appropriate software packages to manage the risk of privacy and confidentiality breaches (Doss et al., 2018).

Limitations to using these findings

The findings and evidence-informed implications must be viewed in conjunction with the limitations of this review. There were several gaps in the evidence for the use of telepractice in family and relationship services (e.g. no publications reviewed telepractice in relation to elder abuse) suggesting the need for further research in this space. There were no specific papers that focused on or included information on sub-populations such as Aboriginal and Torres Strait Islander or culturally and linguistically diverse communities. Similarly, there were no best-practice guidelines on the use of telepractice for these populations. This could be because telepractice in health and medicine was excluded in this review. Evidence in that discipline may have further guidance on the use of telepractice with these, and other, sub-populations.

There was limited evidence on the impact on client outcomes from telepractice compared with face-to-face service delivery. There were no studies comparing the cost effectiveness of telepractice with face-to-face service delivery, despite several studies considering cost as a motivator for the implementation of telepractice (Anderson et al., 2019; Doss et al., 2018; Hall & Bierman, 2015; Lee et al., 2017; Owen, 2020; Wrape & McGinn, 2019). Systematic reviews are considered strong evidence; however, in this scoping review, only one systematic review (Anderson et al., 2019) and one report using rapid review methodology (Martin et al., 2020) were identified, which were specific to intimate partner violence and early intervention, respectively.

The publications in the review highlighted the need for more research comparing different types of technology using telepractice and comparing the use of telepractice across different types of family constructs; for example,
parent-and-one-child dyads and parent-and-multiple-children dyads (Ruppert, 2016). The importance of research that monitors the accessibility and suitability of telepractice across different populations was also emphasised (Gurwitch et al., 2020; Hall & Bierman, 2015). This may include sub-populations such as Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities. The high prevalence of publications from the United States suggests caution is warranted in applying findings to Australian service systems. The limited evidence in relation to telepractice in the family and relationship sector in Australia emphasises the importance of building evaluation mechanisms into services and programs implementing telepractice to capture evidence on what works.

This suggests that research about telepractice in family and relationship services is in its infancy and, therefore, robust conclusions should not yet be drawn. It also highlights the gaps in research, where future research could be directed.

Conclusion

This paper reviewed the evidence on telepractice as an alternative or complementary option to face-to-face service delivery in the family and relationship service sector. Research on telepractice for the family and relationship service sector is emerging, especially in response to the COVID-19 pandemic in 2020. According to this review, telepractice can be an acceptable mode of service delivery for clients but suitability to telepractice must be assessed based on individual context. There are several potential disadvantages to telepractice including privacy concerns, access, affordability and ease of use for certain user groups. To support practitioners, services may need to invest in developing the technological skills of practitioners and their understanding of the benefits of its use.

At present, there is limited evidence comparing the impact of service delivery via telepractice on client outcomes compared to face-to-face service delivery (not enough studies/poor quality) and there were no evidence reviews included in this review suggesting that telepractice produces better outcomes for clients compared to face-to-face service delivery. While the evidence is limited, there is some evidence to show that certain family and relationship services, such as mental health related services, may be more amenable to telepractice than others. Further research and evaluation would allow for improved insights into client outcomes.

Telepractice may provide unique benefits to the family and relationships service sector, including gaining insights into family life in the home. It may also improve access to services for clients, provide greater flexibility for clients and practitioners, and can be less stigmatising in certain family and relationship services such as family and domestic violence services. Telepractice provides benefits that work well as an addition to, and not a necessarily replacement of, face-to-face consultations. As the family and relationship services sector continues to adapt to changing circumstances as it moves into ‘COVID Normal’, telepractice may be a required part of the mix of service delivery methods in order to stay nimble and respond to client needs. This paper provides a starting point to understand the evidence in this space.

Authors and acknowledgements

All authors are employed by the Australian Institute of Family Studies. Anagha Joshi is a Senior Research Officer, Nicole Paterson is a Research Officer, Dr Trina Hinkley is a Research Fellow and Dr Nerida Joss is the Executive Manager of the Knowledge Translation and Impact Lab team. The authors wish to thank Amanda Coleiro for her guidance in producing this paper.

The authors would like to thank FRSA and Professor Kay Cook, Swinburne University, for their review and feedback on the paper.


## Appendix 1: Inclusion criteria

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Inclusion</th>
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</thead>
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<tr>
<td>Location</td>
<td>Australia or countries with comparable social care systems</td>
</tr>
<tr>
<td>Language</td>
<td>English</td>
</tr>
<tr>
<td>Publication date</td>
<td>January 2015–November 2020</td>
</tr>
<tr>
<td>Publication focus</td>
<td>The use of telepractice to support family and relationship services*</td>
</tr>
<tr>
<td>Intervention type</td>
<td>Services* delivered remotely, one-to-one practitioner/provider to individual/family, using video-conferencing or teleconferencing technologies</td>
</tr>
<tr>
<td>Publication type</td>
<td>Journal article, report, conference paper, thesis/dissertation, guideline or toolkit</td>
</tr>
<tr>
<td>Study type</td>
<td>Systematic reviews, narrative reviews, meta-analyses and original research using quantitative and/or qualitative methodology</td>
</tr>
<tr>
<td>Examples of keyword searches</td>
<td>telepractice; teletherapy; telecare; telehealth family/families; relationship; parent/ing; marriage; child/ren/s; teenager; adolescent; youth; young people; domestic violence; trauma; dispute resolution; social/work.</td>
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*Note: Services refers to services, interventions and programs*
## Appendix 2: Literature sources

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<tr>
<th>Databases</th>
<th>Grey literature sources</th>
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<td>A+ Education</td>
<td>Analysis and Policy Observatory</td>
</tr>
<tr>
<td>Academic Search Complete</td>
<td>Australia’s National Research Organisation for Women’s Safety</td>
</tr>
<tr>
<td>AGIS Plus Text</td>
<td>Australian Association of Social Workers</td>
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<tr>
<td>AiFS Library Catalogue</td>
<td>Australian Council of Social Service</td>
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<tr>
<td>Australia/New Zealand Reference Centre Plus</td>
<td>Australian Institute of Aboriginal and Torres Strait Islander Studies</td>
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<td>Australian Criminology Database</td>
<td>Australian Institute of Family Studies</td>
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<td>Australian Public Affairs – Full Text</td>
<td>Australian Institute of Health and Welfare</td>
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<td>British Library Document Supply Centre Inside Serials &amp; Conference Proceedings</td>
<td>Australian Research Alliance for Children and Youth</td>
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<td>Complementary Index</td>
<td>Child and Family Welfare Association of Australia Inc.</td>
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<td>Directory of Open Access Journals</td>
<td>CREATE Foundation</td>
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<td>EconLit with Full Text</td>
<td>Early Childhood Australia</td>
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<td>ERIC</td>
<td>Families Australia</td>
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<tr>
<td>Gale Academic OneFile</td>
<td>Family and Relationship Services Australia</td>
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<td>Gale Academic OneFile Select</td>
<td>Lowitja Institute</td>
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<td>Gale eBooks</td>
<td>Murdoch Children’s Research Institute</td>
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<td>Gale General OneFile</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
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<td>Informit Business Collection</td>
<td>National Disability Service</td>
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<td>Informit Families &amp; Society Collection</td>
<td>National Society for the Prevention of Cruelty to Children</td>
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<td>Informit Health Collection</td>
<td>Outcomes Practice Evidence Network</td>
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<td>Informit Humanities &amp; Social Sciences Collection</td>
<td>SNAICC</td>
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<td>JSTOR Journals</td>
<td>The California Evidence-Based Clearinghouse for Child Welfare</td>
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<td>SocINDEX with Full Text</td>
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<td>Women’s Studies International</td>
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Appendix 3: PRISMA flow diagram of the literature search

Records identified through systematic searching
\( (n = 1,777) \)

Records identified through grey literature search
\( (n = 12) \)

Records identified through handsearching reference lists
\( (n = 6) \)

Records after duplicates removed
\( (n = 1,647) \)

Records screened
\( (n = 1,647) \)

Records excluded
\( (n = 1,601) \)

Full text articles assessed for eligibility
\( (n = 46) \)

Full text articles excluded
\( (n = 15) \)

Articles included for analysis
\( (n = 30) \)

\( (n = 23 \) from systematic search)\n
\( (n = 3 \) grey literature)\n
\( (n = 4 \) handsearching)\n
### Characteristics of included publications

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<tr>
<th>First Author (Year)</th>
<th>Publication Type</th>
<th>Study design</th>
<th>Country</th>
<th>Type of telepractice/domain</th>
<th>Target population</th>
<th>Modality</th>
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<td>Anderson et al. (2019)</td>
<td>Report</td>
<td>Systematic review</td>
<td>USA</td>
<td>Intimate partner violence</td>
<td>Partners, families</td>
<td>Video conferencing, text messages, emails</td>
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<td>Ghara (2020)</td>
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<td>USA</td>
<td>Family violence, sexual assault</td>
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Table continued over page
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<th>First Author (Year)</th>
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<td>Martin et al. (2020)</td>
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<td>UK</td>
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<td>Children</td>
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Note:*Study design has been recorded when described in the publication.