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Perceptions about Use and Effectiveness of E-Supervision for Clinical Social Work Candidates

Sponsor Report

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Background Information

Excerpt from grant proposal:

Every state in the United States and two Canadian provinces license social work practice at the clinical level. In addition to the expectation that a master's trained social worker will typically practice in an agency environment for 1-3 years before applying, most jurisdictions also require at least 100 hours of specialized supervision with a more experienced, clinically licensed, social work practitioner. Oftentimes, these clinical supervisors must be approved or qualified by the applicable state board(s) that licenses social workers.

Despite this common practice, little empirical evidence exists about the characteristics or commonalities of effective clinical supervision. Further complicating this fact, options for and ease of distance communication is having significant impacts on the provision of social work services, social work education, and social work supervision. Social workers, agencies, and institutions of higher education are all finding it challenging to stay abreast of emerging technologies. As with supervision in general, there is no consensus on the use of these new technologies in the training of new social work practitioners.

Data on social workers' experiences with electronic supervision would provide useful information to social workers both seeking and providing clinical supervision, as well as regulating bodies. Quality supervision benefits all these groups as well as the public, as consumers of the services clinical licensees provide. Is electronic supervision less than face-to-face contact? States that limit the number of supervision hours that can be fulfilled using this method would seem to imply that it is. And yet, the Council on Social Work Education (CSWE) now accredits bachelors and masters social work education programs offered entirely online. Those working toward clinical licensure have difficulty identifying preferred supervisors in some areas. Practitioners in rural areas or in areas with a paucity of clinical social workers to choose from may prefer distance supervision in order to gain access to a pool of more experienced, effective, or affordable supervisors. On what basis are regulating boards making the decisions about the provision of clinical supervision through electronic means?

The National Association of Social Workers (NASW, 2013) states that "supervision is an integral part of the training and continuing education required for the skillful development of professional social workers" and implies its purpose when it states that it "protects clients, supports practitioners, and ensures that professional standards and quality services are delivered by competent social workers" (p. 5). Beddoe, Karvinen-Niinikoski, Ruch, and Tsui (2016) agree stating "that supervision is seen as vital to meeting many professional demands: reflection, the continuing development of professional skills, retention and well-being of practitioners, the safeguarding of competent and ethical practice, and the oversight of casework" (p. 1569).

Social work supervision occurs in different contexts and by different people including during social work education by faculty liaisons and field supervisors, in agencies by professionals higher in the bureaucratic hierarchy, and by professionals outside the social worker's employment setting. It seems that a distinction between supervision that takes places in agencies as an employee and "clinical" supervision used to fulfill regulating board requirements for clinical level licensure is rarely made. While there seems to be a consensus that supervision is essential to the profession (Beddoe, Karvinen-Niinikoski, Ruch & Tsui, 2016), there is no such consensus on a preferred model or mode and "overall, the current state of supervision research is [only] foundational" (ODonoghue & Tsui, 2015, p. 626).

Researchers in the area regularly point out that "supervisory practice lacks a well-developed empirical base despite decades of theoretical and practice explication" (Bogo & McKnight, 2005, p. 59). The impact of supervision on workers appears best investigated. Bogo and McKnight (2005) identify components of the supervisory relationship that are valued including supervisor availability and knowledge, similar practice orientation, supportiveness, role modeling, and communication. Another metanalysis indicates findings that "task assistance", "social and emotional support" and "supervisory interpersonal interaction" (Mor Barak, Travis, Pyun, & Xie, 2009) were identified as most helpful to workers. Additionally, Kavanagh et al. (2003) found that frequency of contact, perceived impact on practice, and development of discipline-specific skills were most valued by supervisees in their sample.

While authors (Carpenter, Webb, Bostock, & Coomber, 2012) may bemoan the lack of research on social work supervision in general, even less research is available on the use of electronic means for this purpose. Munson (2012) states that e- supervision "will produce unique communication advantages and problems for supervision practice" (p. 89). Graf and Stebnicki (2002) examined the use of email instead of face-to-face supervision for rehabilitation practicum students and noted advantages of increased access to and more immediate responses from supervisor, as well as more relaxed communication. However, Danis, Black, and Woody (2013) compared face-to-face social work field liaison contact with communication by telephone and email and while their findings indicated that electronic contact offered some advantages including convenience and efficiency, the field faculty generally preferred face-to-face contact. Interestingly, this study excluded students from the examination as well as the use of videoconferencing. Videoconferencing was used in a study by Dudding and Justice (2004) for field contact in speech pathology and was found to differ "minimally from traditional models in terms of the supervisory relationship" (p. 148); they also noted other advantages of this e-supervision including allowing practicums to be arranged in locations without appropriate field faculty or at geographical distances, reduction in travel costs and time, greater flexibility in scheduling and the opportunity to increase the number of contacts between supervisors and students. Marrow, Hollyoake and Hammer (2002) examined videoconferencing for supervision in nursing. They suggest that this modality may offer more support for practitioners in remote areas as well as reducing stress and travel time to arrange face-to-face visits. However, as these relatively small investigations can hardly be considered conclusive; it appears that Beddoe, Karvinen-Niinikoski, Ruch, and Tsui's (2016) call for an increase in the research agenda on the effectiveness of supervision in social work should be applied to e-supervision techniques as well.

NASW (2013) does speak specifically to electronic supervision, dictating that

> When using or providing supervision by technological means, supervisors and supervisees should follow standards applied to a face-to-face supervisory relationship. Supervisors should demonstrate competency in the use of technology for supervision purposes and keep abreast of emerging technologies. Supervisors should be aware of the risks and benefits of using technology in social work practice and implement them in the learning process for supervisees (p. 23).

While this sounds perfectly reasonable, following standards for practice when there is no consensus on what constitutes best practices for supervision, whether face-to- face or electronic, will be difficult to achieve. However, there has been some attempt to establish guidelines for this area of practice.

Munson's (2012) expertise in clinical supervision is well-established. He identifies five characteristics of good supervision including that it is structured, regular, consistent, case-oriented, and evaluated (p. 12) as well as activities including keeping up with emerging knowledge, writing reports and other documents, observing supervisees, listening to them, and discussing clinical topics (p. 15). Munson also offers a measurement scale of satisfaction with supervision (p. 579).

The American Board of Examiners in Clinical Social Work (2004) clearly separates clinical supervision from general supervision (as it does clinical from general practice) and suggests that it shares commonalities regardless of model and should cover four domains, including clinical supervision of direct practice, treatment collaboration, continued learning, and job management (p. 11). The report goes on to list and explicate the knowledge and skills involved in nine competencies in which "advanced" clinical supervisors should be proficient. These competencies include: creation of a supervision contract; supervision of the processes of intake, assessment, and diagnosis; supervision for treatment planning; creation of supervision plan; supervision process; supervision of appropriate professional impact; evaluation of practice outcome; evaluation of supervision outcome, and consultation, teaching, and writing.

In a similar but expanded fashion, the Association of Social Work Boards (2009) created a task force that labeled six domains of social work supervision, including: supervisory relationship and process; supervision of practice; professional relationships; work context; evaluation, and life-long learning and professional responsibility. Multiple practice competencies were categorized under each of these domains and then the ASWB task force went on to identify the knowledge, skills, and abilities (KSAs), needed for each explicated competency. Taking the analysis further, each of these KSAs were rated on their importance for effective supervision, frequency of use, criticality (a combination of importance and frequency of use), and difficulty of acquisition, creating ranking of sorts. This "work of the ASWB Supervision Task Force is the first detailed, professionally organized analysis of the work of providing supervision for social workers for purposes of licensure" (p. 9). The report goes on to suggest that "now that the analysis has been done, supervision has a foundation aside from custom or anecdotal evidence of what works and does not work" (p. 9).

While perhaps a natural place to begin, it does not appear as yet that any of these explications of supervision tasks and processes have been used in a large-scale evaluation of the quality of supervision. In our study, we hope to contribute to the knowledge base in two gap areas: (1) information regarding the use of electronic supervision towards clinical social work licensure, specifically the use of videoconferencing, and (2) perceived quality of supervision towards clinical social work licensure, specifically a comparison of face- to-face and videoconferencing.

Study Methods

Texas Tech University's Human Research Protection Program, the institutional review board (IRB) for research with human subjects, reviewed and approved the procedures for this research (IRB2016-980). The initial approval was granted in December 2015 and modifications were approved in June 2017, November 2017, January 2019 and April 2019. The participants in this project were provided with information about the research as well as their rights as human subjects involved in research and they were given contact information for the TTU IRB.

This study primarily used quantitative research methods to explore and describe attitudes toward and experiences with e-supervision. A small number of qualitative interviews were also conducted with supervisors experienced with e-supervision to give additional insight into these issues.

<u>Sampling</u>. The research targeted two groups: 1) individuals who had relatively recently been issued a clinical social work license (referred to as LCSWs in this report) for the first time and 2) individuals who had provided clinical supervision to candidates working toward a clinical social work license. Anticipating that they would more clearly recall their experience of clinical supervision and would be more likely to have used electronic methods (telephone, email, or videoconferencing) for some of their clinical supervision hours, social workers who had been issued a clinical license relatively recently were sought. Additionally, individuals who had provided clinical supervision to candidates working toward a clinical social work license, whether through face-to-face or electronic delivery methods, were identified. For the qualitative interviews, we solicited supervisors with experience delivering supervision for the purpose of clinical licensing through electronic means.

Using information provided on public websites for social work regulation boards in the United States and Canada, states/jurisdictions allowing some of the required clinical supervision hours to be delivered electronically were identified. Rules and procedures for releasing information about licensees varied widely. Some states reported that they did not release contact information for licensees, some provided lists at no cost, and some charged a fee for this information. Some required review of the research proposal before approval could be issued. Following procedures as dictated, the research team contacted state boards, made requests for access, and submitted information about the project and/or fees. Of those states that eventually consented, most provided in Microsoft Excel files with names, street addresses, license type and issue date for their licensees. A very few states included email addresses or telephone numbers with the information provided.

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We were able to obtain lists for 13 states, including Alaska, Arizona, Iowa, Kansas, Kentucky, Minnesota, Missouri, New Mexico, Oregon, Virginia, Texas, Washington and Wyoming. [1] However, most states reported that they did not maintain a list of clinical supervisors and so we were only able to target members of that group in Minnesota, Oregon, and Texas. Each list provided by state boards were filtered to individuals issued a clinical license after 2014. The lists of supervisors were not filtered. Each name was assigned a random number, the lists sorted by that number, and then individuals selected from the top of each list, according to the total number desired from each state. All survey recipients were contacted via their postal addresses, as most states were not able to provide email addresses or telephone numbers.

In late 2017, the first stratified random sample of 1180 recent licensees was selected to receive the survey invitation. This sample included 100 individuals from each of the identified states, with two exceptions. Only 79 were identified on the list for Wyoming and no Texas licensees were included in this first round. In addition to these recent licensees, 300 clinical supervisors were sent the survey, evenly split between Oregon and Minnesota. A total of four contacts were made with this sample, which included two complete survey packets and two post-card reminders. Hoping to increase the number of respondents with e-supervision as well as the overall sample size, invitations were sent to a new sample of 1000 in spring of 2019. One-hundred names of recent licensees were chosen from those states with more liberal e-supervision policies, which included Arizona, Kansas, Missouri, New Mexico, Oregon, and Virginia. With the idea that they might be more likely to participate in research originating from an institution in their own state of residence, 100 names of recent licensees in Texas were added to the sample. To target additional clinical supervisors, 150 new names from Oregon, 25 from Minnesota (the only remaining names on the list), and 125 names from Texas were selected. Each valid address in this round received four contacts from the research team, including two complete survey packets and two reminders. Similar to the first round of mailings, the research team received a number of contacts notifying us that addresses had moved or other information on the mailing (names, etc.) was incorrect.

Several attempts were made to solicit participation of supervisors experienced with e-supervision methods for qualitative interviews. Letters of inquiry were sent to one-hundred randomly selected individuals identified as supervisors from the distribution lists in Oregon and Minnesota. Additionally, posts were submitted to the NASW state chapters' Facebook pages of Alaska, Arizona, Iowa, Kansas, Kentucky, Minnesota, Missouri, New Mexico, Oregon, Virginia, Washington, Wyoming, and Texas. Not all state chapters approved the posts. Five social workers from Texas and two from New Mexico volunteered to be interviewed by phone for 30-45 minutes. The interviews took place in the summer of 2018.

Sample-size and Response Rate. While additional completed surveys will likely continue to trickle in during the coming weeks, 344 respondents had completed surveys by the writing of this report. Given the number of addresses rejected by the NCOA system, mail returned as undeliverable, and direct contacts from individuals about misdirected mailings, it is clear that a good percentage of the information received from state licensing boards was incorrect or

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[1] Initially, the research team excluded their own state of residence, Texas, from consideration. However, with a low response rate, we added Texas licensees and supervisors during the second round of invitations.

incomplete. Assuming that ten percent of the selected individuals never received the request, the response rate would be about 15%, which is low.

<u>The Survey.</u> The quantitative survey was constructed in both web-based and paper formats. Twenty-one items assessed attitudes toward e-supervision, 20 items inquired about supervisor competencies, and 9 items asked about personal and professional characteristics. Qualtrics® was used for the web-based version; the paper survey was eight pages in length.

The selected individuals from the sampling frame were first mailed a cover letter, research information sheet, survey (see Appendix), and business-reply envelope. The cover letter described the research and requested their participation. They were provided with a web address and/or a QR code to complete the survey online or they were invited to return the paper version of the survey in the BRM envelope. With a few weeks delay between, the initial invitations were followed by reminder postcards/letters, a second survey packet, and a final reminder postcard/letter.

<u>Data Analysis</u>. IBM's SPSS 25.0 was used to compile, clean, and analyze quantitative data from the surveys. In addition to descriptive statistics used to describe the data, independent t-tests and ANOVA analyses were used for tests of inference. An alpha of .05 was used to determine statistical significance.

Quantitative Results

Of survey respondents, there were 151 whose answers indicated that they had been licensed for fewer than eight years. One-hundred and sixty respondents indicated that they had provided clinical supervision. There were 24 more respondents who fit neither category, never having provided clinical supervision and holding their license for 8 or more years.

The survey included questions about demographic characteristics, including gender, age, ethnicity, and education. Seven respondents, about 2.1% of the sample, either skipped these questions or indicated that they preferred not to answer; frequencies are displayed in the Table 1 for the other participants. As can be seen there, the majority of the sample was female, white, and held an MSW degree. Not surprisingly, the newly licensed clinical social workers were significantly younger, overall, than the clinical supervisors.

Table 1: Demographics for Total Sample and by Role

Demographic Characteristics	Total sample Valid % (n)	New LCSW Valid % (n)	Supervisor Valid % (n)
Gender identity			
Male	17.6% (59)	16.4% (24)	18.4% (29)
Female	82.4% (277)	83.6% (122)	81.6% (129)
Ethnic identity*			
White	90.4% (300)	92.4% (133)	90.4% (141)
Hispanic/Latino	7.8% (26)	9.7% (14)	7.1% (11)
Black/African-American	2.7% (9)	1.4% (2)	2.6% (4)
American Indian or Alaska Native	2.4% (8)	4.2% (6)	1.3% (2)
Asian	1.5% (5)	0.7% (1)	1.9% (3)
Native Hawaiian or Pacific Islander	--	--	--
Middle Eastern or North African	0.6% (2)	0.7% (1)	--
Other ethnic identity	1.3% (4)	--	1.9% (3)
Age category			
26-35 years	22.0% (74)	40.4% (59)	7.6% (12)
36-45 years	25.3% (85)	32.9% (48)	17.1% (27)
46-55 years	22.6% (76)	17.1% (25)	26.6% (42)
56-65 years	20.8% (70)	8.9% (13)	31.0% (49)
65+ years	9.2% (31)	0.7% (1)	17.7% (28)
Education			
BSW	13.6% (46)	16.2% (24)	11.3% (18)
MSW	97.9% (332)	98.6% (146)	97.5% (155)
*respondents could choose multiple ethnic identities			

The new clinical social workers had been licensed between 1 and 7 years previous, with a mean of 3.8 years (SD=1.3). Those respondents who reported that they had acted as a clinical supervisor to other professionals received their first clinical licensure between 2 and 40 years

previous (M=17.4, SD=10.4) and had between 0 and 44 years of experience as a supervisor (M=12.8, SD=9.7).

EXPERIENCE WITH E-SUPERVISION

The survey asked respondents about their use of different modalities for delivery of clinical supervision; the proportion of respondents with experience for each type are displayed in Figure 1. As can be seen, all respondents who answered these questions had used face-to-face meetings for some portion of the clinical supervision hours they had received (new LCSWs) or provided (supervisors). Far fewer had used telephone, videoconferencing, or email options.

While a significantly larger proportion of the supervisor group had utilized each alternative than had the newly licensed, this might be expected as they could be considering many more hours of supervision total than were the newly licensed group[2].

Figure 1: Experience with Supervision Delivery Formats for the Total Sample and by Role
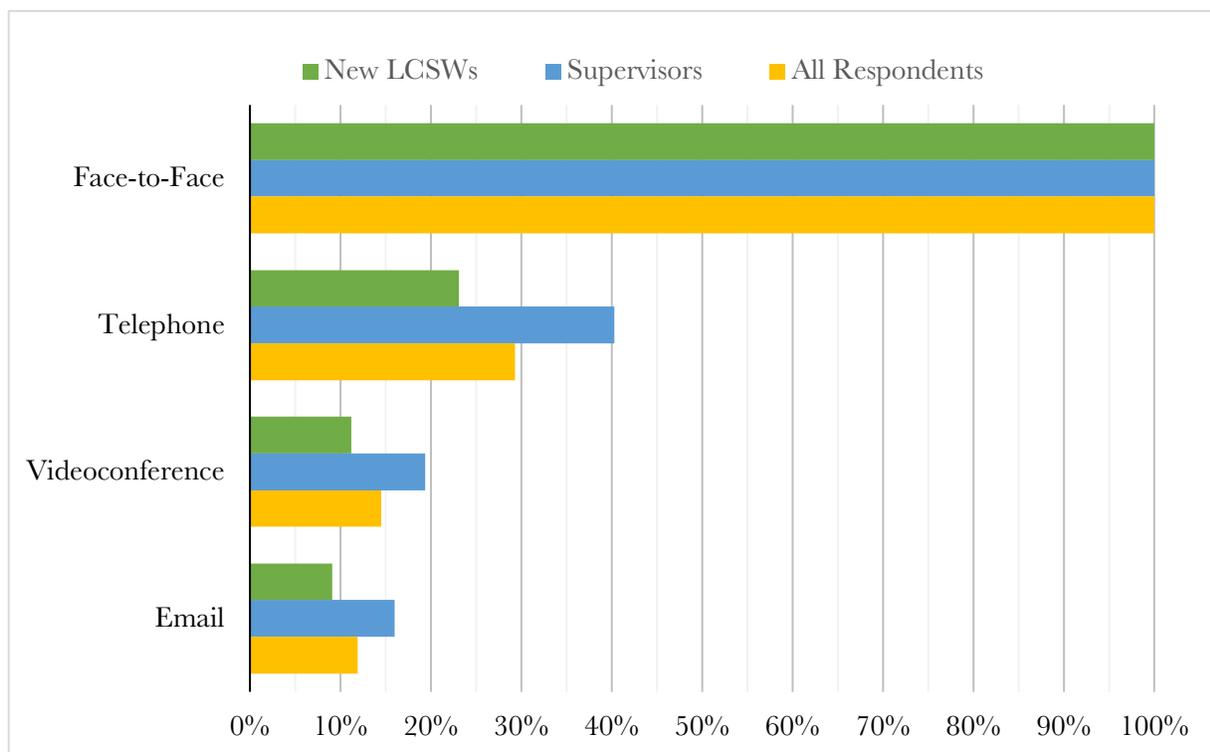
To consider the extent of experience with the different delivery methods, respondents were asked to indicate what proportion of clinical supervision hours were delivered in each way. Not only had every respondent utilized face-to-face meetings for some portion of clinical supervision, the

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[2] LCSWs were asked to consider the hours of clinical supervision they received while working toward clinical licensure to determine these proportions, while the supervisors were asked to consider the hours they had provided during the past 3 years.

majority (61.7%) of the total sample *only* had experience with face-to-face supervision. In other words, 100% of their clinical supervision hours, whether received or provided, had been conducted via face-to-face meetings. Considering only those respondents who had utilized an alternative, most did so for only a small portion of their total hours (see Figure 2).

Figure 2:   Proportion of Total Hours Delivered Electronically among Participants with Any E-Supervision Experience
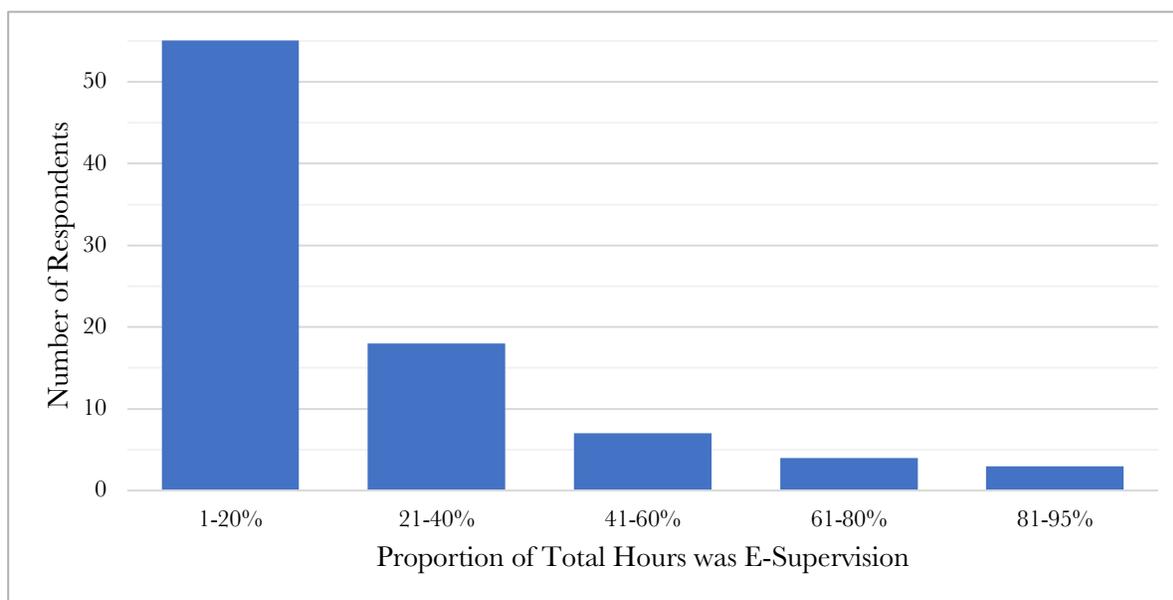
Videoconferencing best approximates face-to-face contact and is increasingly used for meetings in different settings, including telemedicine. Nevertheless, only 14% of the total sample reported using this technology for clinical supervision; 10% of the new LCSWs and 19% of the supervisors. Further, most of those who did use this alternative did so for only a small proportion of their total hours of supervision. In fact, only 5 supervisors and 3 new LCSWs reported that at least half of their clinical supervision hours had been delivered via videoconferencing.

ATTITUDES TOWARD E-SUPERVISION

Twenty-one questions exploring attitudes toward e-supervision were placed at the beginning of the survey and were presented to all participants. Respondents were asked to rank e-supervision on a 5-point scale between each of eleven pairs of adjectives with opposite meanings, referred to as semantic differential scales. Ten additional items presented declarative statements about e-supervision and asked respondents to rate their level of agreement with each, using Likert-type response options on 5-point scales. The analysis began with an examination of frequencies for these items.

Semantic Differential Attitude Items. Respondents were asked to indicate their beliefs about e-supervision by choosing a numbered point between each of the adjective pairs presented; results

are shown in Figure 3. The number 1 indicates a belief that the adjective listed first in the pair best describes e-supervision, the number 5 indicates that the second adjective is more applicable. Number 3 represents a neutral response. As can be seen, the sample tended somewhat more towards positive descriptors overall, though proportionately, more respondents described e-supervision as "detached" and "disliked" rather than their opposite adjectives of "personal" and "preferred."

Figure 3: Proportion of Respondents Choosing Numbered Options between Adjective Pairs
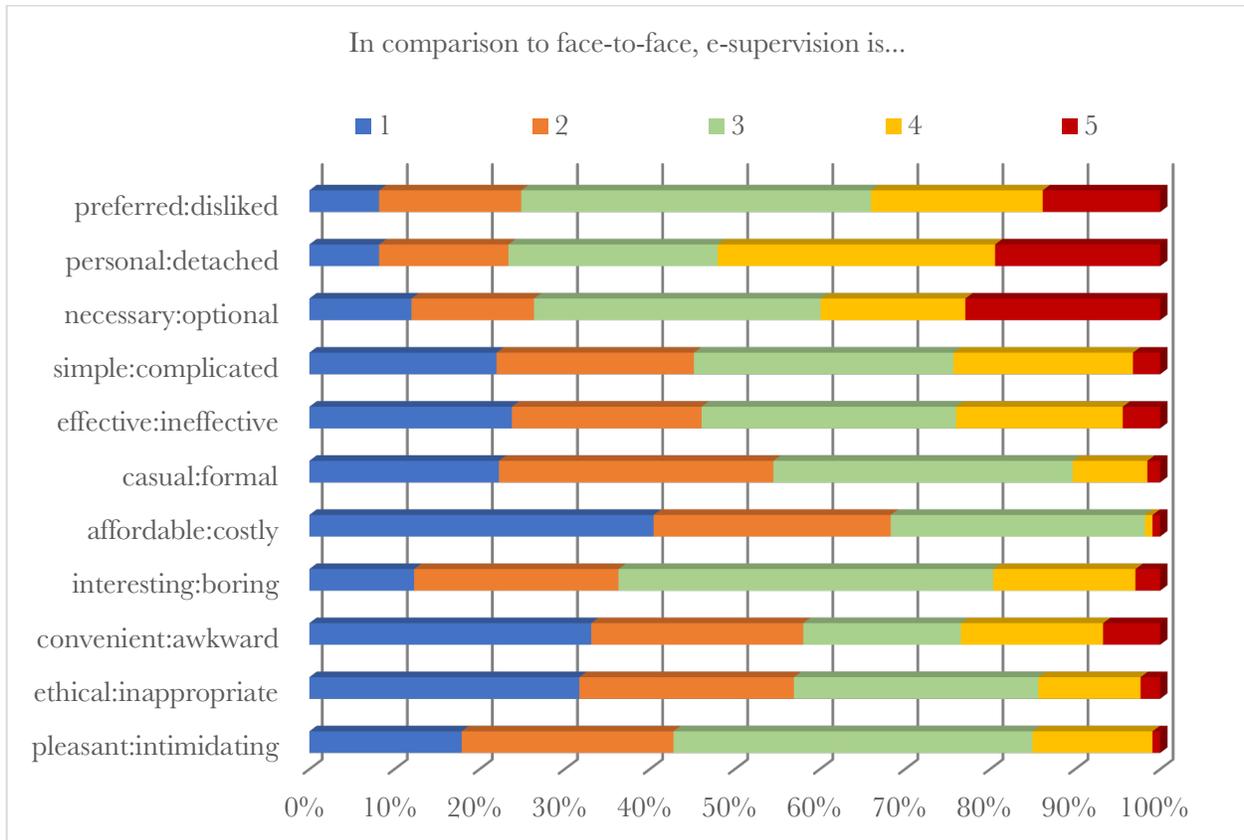
Likert-type Attitude Items. Additional survey questions asked the respondents to rate ten declarative statements about e-supervision on a 5-point Likert scale ranging from strongly agree to strongly disagree. Frequencies for the full sample are displayed in Table 2.

In the overall sample, more respondents thought that e-supervision should be allowed as an option and offers users ease of scheduling as well as more options for fulfilling licensing requirements. Most did not seem to be overly put-off by software or technology issues and did not believe that maintaining confidentiality during e-supervision is more difficult. However, they also believed that boards should limit how many hours of clinical supervision can be filled in this way, special training should be required for using this delivery method, and that relationships are better developed through face-to-face to meetings.

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Table 2: Statements about E-Supervision & Percent Choosing Likert-type Response Options

Declarative Statements	Response Options*				
	SA	A	N	D	SD
E-supervision requires users to own & use complicated software.	2.1%	21.0%	19.5%	43.4%	14.1%
It is easier to schedule e-supervision meetings than face-to-face meetings.	18.9%	40.7%	25.7%	13.8%	0.9%
Clinical supervision should not be delivered via electronic methods.	5.7%	15.3%	23.1%	29.9%	26.0%
E-supervision provides more options to fulfill requirements for licensing/credentialing.	33.2%	45.5%	12.9%	6.6%	1.8%
It is more difficult to maintain confidentiality using e-supervision methods.	5.4%	31.4%	24.0%	29.0%	10.2%
It is easy to share materials, such as an article or Eco-map, in an e-supervision meeting.	12.0%	32.6%	28.1%	24.0%	3.3%
E-supervision meetings are frequently interrupted by bad audio/video connections.	7.2%	28.7%	40.1%	22.2%	1.8%
Regulating boards should limit the number of clinical hours attained through e-supervision.	19.5%	33.2%	15.3%	21.0%	11.1%
Relationships with supervisors are best developed through face-to-face meetings.	28.7%	37.7%	18.0%	13.5%	2.1%
Special training should be required for clinical supervisors who use e-supervision.	24.6%	41.6%	18.6%	13.8%	1.5%
*SA=Strongly Agree; A=Agree; N=Neutral; D=Disagree; SD=Strong Disagree					

E-Supervision Attitude Scales. To more simply examine relationships between attitudes toward e-supervision and other variables, analysis was conducted to consider the two sets of survey items for use as summed scales. A reliability analysis of the eleven semantic differential items indicated that two of the adjective pairs, casual-formal and necessary-optional, did not fit well with the others. Excluding these from the scale resulted in a reliability alpha of .899. Therefore, sum scores for the other eight items were calculated for respondents and the new scale called "E-Sup Attitudes 1." Possible scores on this scale range from 8-40, with lower scores indicating more positive attitudes towards e-supervision. Actual scores among all the respondents in the sample (n=341) ranged from 8 to 37 (M=21.7, SD=6.9).

The ten declarative statements about e-supervision with Likert-type response options were also considered as a scale. This analysis resulted a reliability alpha of .836. Item analysis did not indicate that deleting items would improve its reliability. Negatively worded statements were reverse-coded and a sum score calculated for each respondent. The new scale, labeled "E-Sup Attitudes 2," had possible scores ranging from 10-50, with lower scores indicating more positive attitudes towards e-supervision. In our total sample (n=334), the actual scores on this scale ranged from a minimum of 11 to a maximum of 46 with a mean score of 29.0 (6.8).

Correlation Analysis. As expected, analysis indicated that these e-supervision attitude scales were strongly and positively correlated (r =.78, p=.000). As the majority of the sample reported that all their supervision experience occurred in a face-to-face setting, the distribution of a continuous variable measuring level of exposure to e-supervision methods (the sum of percentages reported

for supervision that occurred by telephone, email, or videoconferencing) showed extreme skew and kurtosis. However, we suspected that attitudes toward e-supervision and the extent of experience with these methods might have a linear relationship. Therefore, a correlation analysis among only those respondents with exposure that was greater than 0% was conducted. Results indicated that the more e-supervision a respondent reported, the more positive their attitudes, as measured by the E-Sup Attitudes 1 [r =(-).37, p=.000] and the E-Sup Attitudes 2 [r =(-).42, p=.000] scales. While statistically significant, these coefficients are no more than moderate in strength, explaining less than 18% of the variance. However, these relationships may be obscured by the fact that most respondents reported a low proportion of their clinical supervision being delivered electronically.

Group Comparisons. Data analysis continued with comparison of mean scores on the e-supervision attitudes scales between groups using independent sample t-tests and analysis of variance techniques (see Tables 3 & 4). No significant differences were found between respondents based on gender, ethnic status, or age. Additionally, respondents who had acted as clinical supervisors did not significantly differ in their attitudes when compared with those who had not provided any supervision.

Table 3:   E-Sup Attitudes 1 Scale Group Comparisons

	Mean (SD)	n	Statistical Comparison
Gender			t=1.42, p=.158
Male	22.9 (6.0)	59	
Female	21.5 (7.1)	275	
Ethnicity			t=0.46, p=.643
White	21.8 (6.9)	295	
Any non-dominant	21.2 (6.6)	35	
Age			$F_{(4,329)}$=0.56, p=.690
26-35 yrs	22.5 (6.9)	74	
36-45 yrs	21.4 (7.3)	85	
46-55 yrs	21.3 (6.8)	76	
56-65 yrs	22.0 (6.7)	69	
65+ yrs	20.6 (6.6)	30	
Professional Status			$F_{(3,329)}$=0.49, p=.690
LCSW =< 7 yrs	21.8 (7.3)	151	
LCSW > 7 yrs	21.0 (6.4)	24	
Supervisor <5 yrs	22.7 (5.9)	48	
Supervisor >5 yrs	21.4 (6.9)	110	
E-Supervision			t=2.93, p=.004*
No e-sup	22.7 (6.9)	191	
Any e-sup	20.4 (6.6)	118	
Videoconference Use			t=2.35, p=.019*
No Videoconference	22.2(6.8)	264	
Some Videoconference	19.6 (6.8)	45	
* statistically significant test			

Using independent sample t-tests, the attitudes of respondents who had only utilized face-to-face meetings for clinical supervision hours were compared with those reporting any use of electronic methods. While the mean scores on both measures were lower among those with the e-supervision experience, only the mean difference on the E-Sup Attitudes 1 measure reached statistical significance.

While we defined e-supervision as including clinical supervision that occurred by any electronic means for this study, videoconferencing is more typically considered a true substitute for in-person contact. As previously noted, relatively few respondents (n=45) indicated that they had used videoconferencing for any portion of their clinical supervision hours. Nevertheless, independent sample t-tests indicated that those with videoconferencing experience had significantly more positive attitudes toward e-supervision on both the attitudinal measures.

Table 4: E-Sup Attitudes 2 Scale Group Comparisons

	Mean (SD)	n	Statistical Comparison
Gender			t=0.70, p=.485
Male	29.5 (5.7)	59	
Female	28.8 (7.0)	268	
Ethnicity			t=-0.91, p=.389
White	28.9 (6.7)	292	
Any non-dominant	30.0 (7.1)	31	
Age			$F_{(4,322)}$= .232, p=.921
26-35 yrs	29.3 (7.6)	73	
36-45 yrs	28.5 (7.8)	83	
46-55 yrs	29.1 (5.5)	72	
56-65 yrs	28.8 (6.2)	68	
65+ yrs	29.6 (6.1)	31	
Professional Status			$F_{(3,329)}$=1.10, p=.350
LCSW =< 7 yrs LCSW	28.7 (7.1)	151	
LCSW > 7 yrs LCSW	31.4 (6.8)	24	
Supervisor <5 yrs	28.9 (6.9)	48	
Supervisor >5 yrs	28.9 (6.2)	110	
E-Supervision			t=1.66, p=.099
No e-sup	29.5 (6.9)	191	
Any e-sup	28.2 (6.6)	118	
Videoconference Use			t=2.81, p=.005*
None	29.5 (6.6)	264	
Some	26.42 (7.0)	45	
* statistically significant test			

QUALITY OF CLINICAL SUPERVISION

All respondents were asked about twenty competencies identified in the literature as central to quality supervision. New LCSWs were asked to consider whether the individual providing their required clinical supervision hours had demonstrated the competencies, while supervisors were asked to evaluate their own performance with supervisees over the past three years.

Perceptions of Supervisor Competence among the Newly Licensed

Response options on the 20 competencies for the newly licensed were limited to "yes," "no," or "unsure." As can be seen in Table 5, overall this group believed that their clinical supervisors had met the competency expectations. While positive evaluations clearly dominate the perceptions of those receiving supervision, there were a few competencies of which they were less certain. Almost 16% of the group indicated that their supervisor had not addressed *thoughts, feelings, and*

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behavior between them, close to 18% could not say that their supervisor had monitored and addressed *impact of their relational dynamics*, and more than 10% weren't sure if their supervisor had maintained *appropriate documentation* for their eventual clinical licensure.

Table 5: New LCSW's Perceptions of Clinical Supervisor

Competencies	yes	no	unsure
Were aware of their own personal & professional strengths & limits	92.5%	3.4%	4.1%
Were aware of their own professional knowledge & competency	98.0%	0.7%	1.4%
Appropriately maintained documentation	85.0%	4.8%	10.2%
Were up-to-date about best practices, laws, & regulations	91.8%	2.7%	5.4%
Developed environments that facilitated communication	97.9%	1.4%	0.7%
Effectively managed conflict/disagreement between them	91.8%	3.4%	4.8%
Developed environments that reflected working alliances	98.0%	0.7%	1.4%
Established & maintained appropriate boundaries between them	93.9%	4.1%	2.0%
Monitored & addressed relational dynamics between them	82.3%	10.2%	7.5%
Addressed thoughts, feelings, & behavior between them	80.3%	15.6%	4.1%
Asked for feedback & responded appropriately	92.5%	7.5%	--
Effectively managed power & authority between them	94.6%	3.4%	2.0%
used reflection, analysis, & case attributes to integrate experiences	93.8%	4.8%	1.4%
helped advance knowledge in assessment, case planning, & intervention, & evaluation	89.8%	6.8%	3.4%
followed up on cases, such as reflecting on & revising plans	90.5%	6.8%	2.7%
Addressed issues of personal safety & risk	96.6%	2.0%	1.4%
Assessed supervisees' strengths & areas for improvement	93.1%	4.8%	2.1%
provided constructive feedback that validated & offered support	95.9%	2.7%	1.4%
evaluated & provided recommendations about performance	91.8%	6.8%	1.4%
guided/directed toward ethical practice within regulations & laws	97.9%	2.1%	--

Overall Competency Scores. In order to make comparisons between groups, a sum score was created for these 20 questions. "No" responses received a score of 0, "unsure" a score of 1, and "yes" a score of 2; therefore, higher scores would indicate superior supervisor competency. The minimum possible summed score was 0 and the maximum 40. Table 6 displays group means of the summed totals for the supervisor competency items among the newly licensed respondents.

Table 6: Group Comparisons of New LCSWs Summed Ratings of Supervisor Competencies

	Mean (SD)	n	Statistical Comparison
Gender			t= (-)0.23, p=.824
Male	37.5 (4.1)	23	
Female	37.7 (4.4)	116	
Ethnicity			t= (-)0.32, p=.747
White	37.6 (4.4)	124	
Any non-dominant	38.0 (3.7)	14	
Age			$F_{(4,134)}$= 0.41, p=.800
26-35 yrs	38.0 (4.3)	58	
36-45 yrs	37.1 (4.2)	45	
46-55 yrs	37.5 (5.0)	24	
56-65 yrs	38.5 (3.4)	11	
65+ yrs	40 (--)	1	
* statistically significant test			

Actual scores among the new LCSWs ranged from 20-40, with a mean of 37.7 (SD=4.3). Statistical comparisons revealed no significant differences between demographic groups. Further, new licensees who received some e-supervision did not rate their supervisor's competency differently than those who had only face-to-face meetings.

Perceptions of Competence among Clinical Supervisors

Respondents who had provided clinical supervision to other professionals working towards clinical licensure were asked to evaluate themselves on the same twenty competencies, but this group chose responses from 5-point Likert-type options, which ranged from "strongly agree" to "strongly disagree" or from "always" to "never." Frequencies are presented in Tables 7.

As a group, the clinical supervisors rated their own performance very highly. Not a single supervisor ever chose "strongly disagree" or "never" for a response, which would have indicated that they had not met a competency. In fact, less than 12% of the responding supervisors *ever* indicated that they did not "always" or "usually" meet the criteria; only a very few respondents ever broke this pattern.

Table 7: Clinical Supervisor's Self-Evaluation of Competencies

Competencies	Agree	Neutral	Disagree
were aware of own personal & professional strengths & limits	99.4%	--	0.6%
were aware of own professional knowledge & competencies	100.0%	--	--
appropriately maintained documentation	95.0%	4.4%	0.6%
were up-to-date about best practices, laws, & regulations	92.5%	6.9%	0.6%

	Always or Usually	Sometimes	Rarely
used reflection, analysis, & case attributes to integrate experiences into practice	93.7%	6.3%	--
helped advance knowledge in assessment, case planning, intervention, & evaluation	89.9%	10.1%	--
followed up on cases, such as reflecting on & revising plans	88.7%	10.1%	1.3%
addressed issues of personal safety & risk	88.1%	11.3%	0.6%
assessed supervisees' strengths & areas for improvement	95.0%	5.0%	--
provided constructive feedback that validated & offered support	96.9%	3.1%	--
evaluated & provided recommendations about performance	90.6%	8.8%	0.6%
guided/directed toward ethical practice within regulations/laws	99.4%	0.6%	--
developed environments that facilitated communication	99.4%	0.6%	--
effectively managed conflict/disagreement between them	94.3%	5.7%	--
developed environments reflecting working alliances between	96.9%	3.1%	--
established & maintained appropriate boundaries between	99.4%	0.6%	--
monitored & addressed impact of relational dynamics between	96.2%	3.2%	0.6%
openly addressed thoughts, feelings, & behavior between	89.2%	10.8%	--
asked for feedback & responded appropriately	91.1%	8.9%	--
effectively managed power & authority between	94.3%	5.7%	--

While less pronounced, the supervisors indicated less confidence in their performance on some of the same competencies that were highlighted by the newly licensed group. A smaller proportion thought that they usually openly addressed thoughts, feelings, and behaviors in the supervisory

relationship. At least 10% indicated that they only sometimes or rarely helped facilitate the supervisees' acquisition of advanced knowledge in different phases of practice, followed up on cases previously discussed, or addressed issues of personal safety. About 9% did not usually ask for feedback or respond well when it was provided. So, while overall these supervisors were confident about their competence, these results may indicate some areas of weakness in supervisory relationships.

Overall Self-Rated Competency Scores. In order to make comparisons between groups, these 20 questions were summed into an overall self-rating of competency. Answers of "strongly agree" received a score of 1, "agree" a score of 2, "neutral" a 3, "disagree" a 4, and "strongly disagree" a 5. Therefore, lower total scores indicate more positive perceptions of competency. The minimum possible total score was 20 and the maximum was 100; the actual scores among the supervisors ranged from 20-58 and had a mean of 30.7 (SD=6.7). Group means and comparisons are presented in Table 8.

Table 8: Group Comparisons of Summed Self-Rated Competencies among Supervisors

	Mean (SD)	n	Statistical Comparison
Gender			t= 1.27, p=.207
Male	32.0 (8.1)	29	
Female	30.2 (6.4)	124	
Ethnicity			t= 1.55, p=.123
White	30.9 (6.8)	137	
Any non-dominant	28.0 (5.5)	14	
Age			F(4,148)= . 79, p=.53
26-35 yrs	31.1 (6.1)	12	
36-45 yrs	29.5 (6.3)	26	
46-55 yrs	32.1 (7.9)	40	
56-65 yrs	29.9 (6.6)	47	
65+ yrs	30.3 (5.8)	28	
Supervision Experience			t= .18, p=.859
new supervisor	30.8 (6.7)	44	
> 5 yrs experience	30.5 (6.8)	110	
* statistically significant test			

No significant differences were found between supervisor subgroups based on demographic characteristics or level of experience. Further, supervisor's self-rated competency scores were not related to years of licensure [r=(-).042, p=.609], years of providing supervision [r=(-).02, p=.831] nor number of supervisees[3] served in the previous three years [r=(-).175, p=153].

Competency and E-Supervision

Finally, analysis was conducted to explore any possible relationships with e-supervision. Independent sample t-tests were used to test for difference between mean competency scores between those who did or did not use electronic methods during clinical supervision. No significant differences were indicated, either in how the newly licensed social workers rated their

[3] On this variable, two responses were identified as outliers, being at least 3x larger than any other case, and were therefore excluded from this analysis.

supervisor's competency [t=(-)0.39, p=.695] or how supervisors rated their own competency [t=1.29, p=.207].

Among the supervisors who had provided more than 0 hours of e-supervision in the past three years, a moderately weak and inverse relationship [r=(-).314, p=.008] was found between their self-rated competency scores and how much they had used e-supervision methods. In other words, supervisors using more e-supervision tended to rate their own competency slightly higher. Level of e-supervision use had no relationship with how new LCSWs with any experience rated the competency of their clinical supervisors [r=.233, p=.123].

Qualitative Results

Seven individuals participated in short qualitative interviews about their experiences providing clinical supervision via electronic methods. These supervisors resided in New Mexico and Texas and had provided between 10 and 600 hours of e-supervision for between 1 and 30 supervisees. Their supervision experience ranged from less than one year to 15 years.

In addition to basic information about their role as supervisor and experience with e-supervision, the interview schedule included questions about their perceptions regarding strengths of and barriers to using e-supervision, what they enjoyed or disliked about it, their personal preferences for delivery alternatives, and how they would evaluate e-supervision overall.

Most of the respondents mentioned how e-supervision is more affordable and/or convenient in many situations. It eliminates the need for either party to travel, which requires both time and expense. It may also give those working toward licensure access to better qualified supervisors or to supervision provided free of cost within an employment system. Multiple respondents also noted that e-supervision can provide continuity of supervision during "*life's interruptions*" such as illness, traveling, and geographical moves of either party. Another respondent noted how e-supervision offered supervisees the opportunity for quick check-ins or consultations with their supervisor between scheduled meetings.

> *"You just push a button and you're there. I always find that helpful. It is just more customer friendly."*

Respondents pointed out that e-supervision allows access to qualified supervisors outside a social worker's own locality. Those living in rural areas were specifically identified by multiple respondents as a high need group in this sense.

> *"It is also helpful for people living in rural areas. It is one of the only ways they can get the supervision they need—using e-supervision. We have limited public transportation in the* [regional area] *so e-supervision opens the door for them to have clinical supervision."*

In addition to reducing the time/cost burden on those working toward licensure in remote areas and increasing their possibility of obtaining supervision at all, it was also remarked on that e-supervision can ultimately increase the number of providers in previously underserved areas. For some supervisors, this seems to add an extra layer of benefit to using e-supervision; in a way, it may serve to be an act of social justice.

> *"I enjoy e-supervision because I feel like I am addressing a larger issue of shortage of mental health care."*

> *"For areas that struggle with lack of clinical mental health services, it is a great way to address a shortage of providers. It is easy to implement and low cost. It provides that professional upward mobility for the*

> *social workers that they would not get otherwise. You are going to lose people in our profession if supervision is not offered in an accessible way."*

While the respondents primarily spoke about the benefits of e-supervision for those receiving the supervision and their communities, they also noted advantages for themselves.

> *"It is so helpful in our situation where the distance is such a problem... It saves time that we would lose with patients and saves us having to find someone to cover for us."*

> *"It is easier not to travel back and forth. Most of our clinics are at least 45 minutes away, some are up to 3 hours, so it is much easier not to worry about transportation issues, obtaining the government vehicle, so e-supervision is just more convenient."*

In addition to reducing the burden of travel and time away from the office, supervisors may have the opportunity to work with supervisees with whom s/he would not otherwise be involved.

> *"It is so great to hear about their practices in different areas of the state. Our state is large and diverse, so I hear about regional issues, diversity issues, that I would not learn about otherwise."*

The most commonly mentioned barriers or disadvantages to e-supervision methods were tech issues, such as broadband connections or dropped calls, secure software for videoconferences, or access to space with required equipment. The following quote explains how these issues can impact interactions with supervisees:

> *"Well, sometimes there is a delay in the technology that causes an awkward pause, especially with VTEL... It wasn't instantaneous. Sometimes you lose that one-on-one human connection that you would have being there with them in the moment. It is just a little different… You may be missing out on kinda the emotional aspect of what is going on…"*

Other respondents mentioned difficulty "reading" supervisees during telephone interactions. One respondent noted *"I think that I don't know them well enough to read their tone, their manner, to really get them, on the phone."* Another commented on a situation in which s/he was very concerned about a supervisee:

> *"I felt limited. I felt like if I could have seen her, I think that would have been helpful. But some supervisees may be less inhibited over the phone about discussing their feelings."*

A couple of respondents drew sharper distinctions between videoconferencing and speaking by telephone.

> *"Well, when I used phone calls only with no video, I couldn't read the supervisees body language. Also, when we were just using the phone, it seemed like supervisees could get distracted looking at computer screen, walking the dog, taking care of kids…but if video was involved, we had to stare at each other and there weren't as many distractions."*

> *"I have learned to really enjoy using video-conferencing, I think I can be totally present, still seeing expression, affect, if they are stressed. I wouldn't be in favor of just doing it by phone without seeing the person. I don't think that would be very good."*

Most respondents' overall thoughts about e-supervision emphasized the need and necessity for e-supervision and/or that these methods are simply the way the world is moving and as a profession, we must accept that fact. The following comments exemplify these ideas.

> *"I would recommend it to other supervisors and supervisees. It might not be perfect, but younger people are comfortable with technology and I think we have to move in that direction as a profession."*

> *"… we need to do this to strengthen our profession. We are suffering from a shortage of LCSWs in many areas… we've got to make it easier for people to get clinical supervision. Video-conferencing is one way we can do this."*

> *"Initially I would be one of those people who would say—face-to-face only… but the reality is that we are working with people that the technology is so much a part of their lives, that we have to be open to it."*

> *"Our profession has to keep moving with the times—the technology is out there. I see it as a way to strengthen our profession by having more people with clinical licensure. Young people are expecting us to be more flexible with our clinical licensure rules and video-conferencing is a way we can do that."*

Discussion

The results of this exploratory study suggest that individuals working towards a clinical license in social work are currently utilizing electronic methods of communication at very low rates. Of the newly licensed social workers surveyed, only just over 11% had received any of the required clinical supervision hours via videoconferencing, 23% via the telephone, and 9% via email. Only slightly higher proportions of clinical supervisors reported using these methods. Sixty-two percent of the overall sample *only* had experience with face-to-face supervision, whether received or provided. Of those with some exposure to these methods, most had used electronic delivery for a very small proportion of their overall hours. Less than 3% of this sample had used videoconferencing for at least half of their hours of clinical supervision. Therefore, while technology for distance communication, such as videoconferencing, has become widely available in the U.S. and is being used for social work education and for service provision to consumers, we are not, for the most part, currently taking advantage of these methods for clinical supervision toward licensure.

Many of the participants in this study appeared to feel uncertain about e-supervision. While more believed that e-supervision offers some advantages such as cost and convenience and can be effective and ethical as well, they also viewed in-person meetings as more personal and better for establishing or maintaining supervisory relationships. Attitudes toward e-supervision primarily varied by level of personal experience, rather than personal characteristics, such as age or gender. The more the respondents had used e-supervision methods, the more positive their view of its use in general. Attitudes were further differentiated between types of e-supervision methods. Those who had received or provided e-supervision via videoconferencing held more positive views towards e-supervision, in general, than those who had not. Those with videoconference experience were also less likely to indicate a preference for in-person meetings or suggest that regulating boards should limit the number of e-supervision hours.

Regarding quality, the participants in this study evaluated their clinical supervision relationships very highly, at least in terms of competencies identified as most important for clinical supervision in the literature (ASWB, 2009). Recently licensed social workers viewed their supervisors as highly competent; most believed that their supervisors had fulfilled all the identified behaviors. Similarly, the majority of responding supervisors claimed that they "always" or "usually" exhibited these competencies during their work with licensees. While we might prefer to interpret the results as indicating that those providing clinical supervision for the purpose of licensure are overwhelmingly competent, we suspect that this might be untrue. While it is generally agreed that clinical supervision is necessary (Beddoe, Karvinen-Niinikoski, Ruch & Tsui, 2016), expectations and qualifications for those providing it vary. For example, different jurisdictions have very different rules for supervisors; some have no particular preparation requirements beyond clinical licensure, while others require specialized training, certification, or demonstrated experience in the same field of practice as the supervisee. With no accepted standards of practice for this function (ODonoghue & Tsui, 2015), it is difficult to believe that most all current

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supervisors are providing excellent service and/or are equally competent. For example, another recent research effort considering the question of how to evaluate supervision quality found that their small sample of UK social workers rated their supervisor's skills considerably higher than did the researchers observing a single simulated session. (Wilkins, Khan, Stabler, Newlands, & Mcdonnell, 2018).

Comparisons of the quality ratings in our sample indicated that neither the new LCSWs ratings nor the supervisor's self-evaluations differed by personal or professional demographic characteristics. Those respondents using videoconferencing as well as other electronic methods of delivery, evaluated the quality of their supervision similarly to those using in-person meetings alone. These results are hopeful at least, indicating that traditional and e-supervision models of delivery may not produce significantly different results.

Study Limitations

This research did have several limitations. The sampling frame from which potential participants were selected was a largely unexpected challenge. Some of the distribution lists received from state boards contained many errors in names and addresses. From interactions during this research and other experiences, it seems clear that numerous state offices dealing with social work licensure operate with limited staff, limited financial support, and with outdated systems for maintaining records. In addition, few states maintain lists of clinical supervisors, which would seem problematic for those seeking supervision, as well as our research team.

While perhaps related in part to this issue, the response rate for this study was another limitation. A common concern with survey research, low response rates can significantly impact the results of research. It is possible that those individuals who chose to respond to the survey were more interested in the issue; their attitudes toward e-supervision may be different from the general population of licensed social workers. The response rate was particularly troublesome given the very limited experience with e-supervision that the sample reported. Too few respondents had enough experience with e-supervision methods to make truly distinctive comparisons between those who had and had not used e-supervision.

There may have been response bias and/or measurement validity issues in the research. It is generally known that when individuals "like" their therapists, they tend to rate the services and their satisfaction highly. It is possible that this same issue could impact the way that new licensees evaluate their clinical supervisors, especially following the desired outcome of successfully securing a clinical license. It is also possible that specific supervisor behaviors (or lack thereof) were not altogether salient for respondents and therefore their judgments may have not been accurate. Finally, given the lack of variation in data regarding supervisor competence in this study, the approach used to measure supervisor quality may be inadequate.

Conclusions

Currently in the United States, there are not uniform requirements for licensing clinical social workers, but most jurisdictions stipulate graduate education from a CSWE-accredited institution, practice experience beyond the graduate degree, and hours of supervision specific to clinical practice with a more experienced and licensed social worker. While the qualifications of and expectations for clinical supervisors vary by jurisdiction, there is very limited research information about the nature, impact, or effectiveness of these widely-prescribed relationships. The current policies of state regulating boards, which often exclude or limit the number of clinical supervision hours that can be awarded from e-supervision, seem to imply that in-person clinical supervision is preferable and that e-supervision is somehow "less-than."

Electronic communication in general is common in the U.S. and many other parts of the world today. Through the internet, email, telephone, and more recently, synchronous videoconferencing, individuals, groups, and organizations have increasing levels of and relatively easy access to one another for a variety of purposes, both personal and professional. Affording participants real-time visual and audio interaction, including the opportunity to observe body language and other unspoken communication messages, videoconferencing is often viewed today as a close approximation to in-person meetings. In addition to purely social interaction and employment- or education-related purposes, electronic communication is being used increasingly for the delivery of both physical and mental health services. Further, these methods are not only being used as a last resort, when participants are unable to access local providers, but as routine alternatives. In fact, both private and government-sponsored health insurance providers are increasingly encouraging consumers to access health providers through telehealth services, even offering virtual visits at a lower or at no cost. Despite these trends, current evidence suggests that the general population seems reluctant to access health providers in this manner (Barnett, Ray, Souza & Mehrotra, 2018) and despite issues of disparity in access to specialty care providers, most telemedicine users are located in urban, rather than rural, areas.

Our results suggest a similar trend among social workers seeking or providing clinical supervision. While our exploratory study found no statistical variance in e-supervision use or attitudes by age group, supervisors experienced with e-supervision suggested that the technology is more comfortable for and fits the learning style of younger supervisees. This idea is supported by evidence that younger people are using telemedicine at higher rates (Barnett, Ray, Souza & Mehrotra, 2018). Perhaps e-supervision will naturally increase over time as the population unfamiliar and/or uncomfortable using e-communication in all its forms decreases. Our results indicating that those with e-supervision experience have more positive attitudes toward it would appear to suggest that this might be the case. On the other hand, the supervisors that were interviewed also suggested that as experience increases, especially experience with videoconferencing, the contrast between e-supervision and in-person contacts decrease, even for those of us who did not grow up with the world wide web or social media.

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However, our results also indicated that while experience with e-supervision is related to attitudes towards its use, it is unrelated to perceived quality of supervision. Therefore, the profession's negative perceptions of e-supervision leading to policies that restrict or exclude its use for the purpose of clinical licensure, may be based on false assumptions rather than reason or evidence. There is also some suggestion that concerns about e-supervision, at least those suggested in this research, apply primarily to methods other than videoconferencing. While this distinction was more obvious in data from the qualitative interviews, numerous survey respondents also stressed the difference between videoconferencing and telephone contact in their unstructured comments.

This study's results don't appear contrary to the information currently available about tele-medicine in general. Research suggests that despite rapid growth, consumer's use of telemedicine remains relatively uncommon (Barnett, Ray, Souza & Mehrotra, 2018). While perhaps rarely used, according to a systematic review of research for the Agency for Healthcare Research and Quality, there "is sufficient evidence to support the effectiveness of telehealth for specific uses…" (Totten, Woman, Eden, McDonagh, Griffin, Grusing, & Hersh, 2016, p. vii), including counseling and psychotherapy. The fact that telemental health use has grown more steadily than primary care and has grown more in areas with fewer providers of psychiatry services (Barnett, Ray, Souza & Mehrotra, 2018) would seem to support those results.

Despite the empirical evidence suggesting that telehealth is particularly useful for mental health services and for granting access to underserved areas, social workers and regulating boards, for the most part, continue to resist its adoption for the purposes of clinical supervision. However, as these perceptions about the deficits in electronic delivery options seem to decrease as exposure increases and online degree programs are increasingly common, it seems likely that the profession will be more accepting in the near future. Therefore, the current dissonance between the acceptance toward online delivery methods for graduate education and resistance to e-supervision may be temporary.

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Appendix

E-Supervision for Clinical Social Work

1

Thank you for your interest in participating in this study called *Perceptions about Use and Effectiveness of E-Supervision for Clinical Social Work License Candidates*. With this survey, you should have received additional information about the study and your rights as a research participant. If you have questions or need another copy of that information, please contact Laura Lowe at laura.lowe@ttu.edu or Cara Speer at 806-742-2400. If you would prefer to complete a web-based version of this survey, please use the camera on your mobile device to scan the QR code on the right or navigate to https://goo.gl/MjySw7.

The first group of questions are about your attitudes toward clinical e-supervision. For the purposes of this study, we are defining e-supervision as meetings that occur by telephone or by video (such as Facetime, Google hangout, or Skype). There are no right or wrong answers to these questions; please respond even if you have not participated in any e-supervision.

In comparison to face-to-face supervision, where on each scale between adjective pairs would you place e-supervision? [please indicate either adjective or value between]

pleasant	2	3	4	5	6	intimidating
ethical	2	3	4	5	6	inappropriate
awkward	2	3	4	5	6	convenient
boring	2	3	4	5	6	interesting
costly	2	3	4	5	6	affordable
casual	2	3	4	5	6	formal
effective	2	3	4	5	6	ineffective
simple	2	3	4	5	6	complicated
optional	2	3	4	5	6	necessary
personal	2	3	4	5	6	detached
disliked	2	3	4	5	6	preferred

2

Please indicate your level of agreement with each of the following statements.

E-supervision requires users to own and use complicated software.

strongly agree   agree   neutral   disagree   strongly disagree

It is easier to schedule e-supervision meetings than face-to-face meetings.

strongly agree   agree   neutral   disagree   strongly disagree

Clinical supervision should not be delivered via electronic methods.

strongly agree   agree   neutral   disagree   strongly disagree

E-supervision provides more options to fulfill requirements for licensing/credentialing.

strongly agree   agree   neutral   disagree   strongly disagree

It is more difficult to maintain confidentiality using e-supervision methods.

strongly agree   agree   neutral   disagree   strongly disagree

It is easy to share materials, such as an article or Eco-map, in an e-supervision meeting.

strongly agree   agree   neutral   disagree   strongly disagree

E-supervision meetings are frequently interrupted by bad audio/video connections.

strongly agree   agree   neutral   disagree   strongly disagree

Regulating boards should limit the number of clinical hours attained through e-supervision.

strongly agree   agree   neutral   disagree   strongly disagree

Relationships with supervisors are best developed through face-to-face meetings.

strongly agree   agree   neutral   disagree   strongly disagree

Special training should be required for clinical supervisors who use e-supervision.

strongly agree   agree   neutral   disagree   strongly disagree

The next few questions are about your experience with licensing and clinical supervision.

3

As best you can recall, when did you **first** attain your **clinical** social work license or credential?

month: _____   year: _____

Have you ever acted as a clinical supervisor to another professional working toward a social work license/credential?

no _____ (please proceed)   yes_____ **(PLEASE SKIP TO PAGE 5)**

Estimate how many total hours of clinical supervision you obtained for the purpose of licensing.

total hours: _____

Thinking about those total hours, please estimate what proportion or percentage were delivered via.... [should sum to 100%]

face-to-face meetings	_____
telephone conferences	_____
video conferences	_____
email	_____
another way	_____ (specify: _____)
TOTAL	<u>100%</u>

The following questions are about your personal experience during clinical supervision.

In general, do you believe that your clinical supervisor...

	yes	no	unsure
was aware of his/her own personal and professional strengths and limits?			
was aware of his/her own professional knowledge and competencies?			
appropriately maintained documentation regarding your clinical supervision for licensing or credentialing?			
was up to date about professional practice best practices, laws, and regulations?			

4

Thinking about your relationship together, did your clinical supervisor...

	yes	no	unsure
develop an environment that facilitated your communication?			
effectively manage conflict/disagreement between the two of you?			
develop an environment that reflected a working alliance between you?			
establish and maintain appropriate boundaries between you?			
monitor and address the impact of your relational dynamics?			
address thoughts, feelings, and behavior between you?			
ask you for feedback and respond appropriately when provided?			
effectively manage power and authority between you?			

Thinking about your meetings together, did your clinical supervisor…

	yes	no	unsure
use reflection, analysis, and contextual attributes of the case situation to help you integrate experiences into your ongoing practice?			
facilitate the acquisition of advanced social work knowledge in assessment, case planning, intervention, and evaluation?			
follow up on case planning, such as reflecting on what happened and revising plans?			
address issues of personal safety and risk?			
assess your strengths as well as areas needing improvement?			
provide constructive feedback that both validated your effective performance and offered you support in areas needing improvement?			
evaluate and provide you with recommendations on your performance?			
guide or direct you toward ethical practice within the regulations and laws regarding social work?			

5

As best you can recall, when did you **first** begin providing **clinical** supervision for other professionals working toward clinical social work licensing/credentialing?

_____month   _____year

Estimate for how many social workers you provided clinical supervision for the purpose of social work licensing/credentialing **during the past 3 years**?

_____

Thinking about those hours of supervision you provided, estimate what proportion or percentage were delivered via.... [should sum to 100%]

face-to-face meetings	_____
telephone conferences	_____
video conferences	_____
email	_____
another way	_____ (specify: _____)
total	<u>100%</u>

Thinking about yourself <u>as a clinical supervisor</u>, please indicate your level of agreement with each statement.

I am aware of my own personal and professional strengths and limits.

strongly agree	agree	neutral	disagree	strongly disagree

I am aware of my own professional knowledge and competencies.

strongly agree	agree	neutral	disagree	strongly disagree

I appropriately maintain documentation regarding clinical supervision for licensing or credentialing.

strongly agree	agree	neutral	disagree	strongly disagree

I am up to date on professional practice best practices, laws, and regulations.

strongly agree	agree	neutral	disagree	strongly disagree

6

Thinking in general about your meetings with clinical supervisees, please indicate how often you do each activity.

I use reflection, analysis, and contextual attributes of case situations to help supervisees integrate experiences into their ongoing practice.

always   usually   sometimes   rarely   never

I facilitate supervisees' acquisition of advanced social work knowledge in assessment, case planning, intervention, and evaluation.

always   usually   sometimes   rarely   never

I follow up on case planning, such as reflecting on what happened and revising plans.

always   usually   sometimes   rarely   never

I address issues of personal safety and risk with supervisees.

always   usually   sometimes   rarely   never

I assess my supervisees' strengths as well as areas needing improvement.

always   usually   sometimes   rarely   never

I provide constructive feedback that both validates supervisees' effective performance and offers support in areas needing improvement.

always   usually   sometimes   rarely   never

I evaluate and provide supervisees with recommendations on her or his performance.

always   usually   sometimes   rarely   never

I guide or direct supervisees toward ethical practice that is within regulations and laws regarding professional social work.

always   usually   sometimes   rarely   never