BEST PRACTICES FOR IMPROVING ACCESSIBILITY IN VIRTUAL CARE

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Abstract

Social work services prior to the COVID-19 pandemic generally preferred in-person service delivery. When the lockdowns during the COVID-19 pandemic began, social workers needed to modify their practice and pivot to a virtual delivery format to ensure safety as well as continuity of service for the individuals and communities they support. Current literature on virtual care in social work lacks clear identification of best practices for virtual care service delivery. Additionally, 1 in 5 Canadians have a disability. Given the prevalence of disability, social workers must consider how accessibility is impacted by service delivery methods. This research aims to address the gap in the literature by centering the narratives of 7 social workers who have disabilities, who both access and provide virtual care services. This research is guided by Critical Disability Theory (CDT) and the *Nothing About Us Without Us* movement to explore the social construction of disability within virtual care service delivery, from the perspective of those with disabilities. A focus group was conducted to elicit the experiences of these social workers. Using narrative and reflexive thematic analysis, five themes were identified: 1) digital literacy, 2) privacy, 3) factors enhancing accessibility, 4) factors challenging accessibility, and 5) practice standards in the digital domain. Reflecting on the themes identified in the data analysis, in conjunction with the literature review, a set of guiding best practices are proposed to support accessible virtual care service delivery in social work. Implications for policy and practice are discussed, as well as limitations of this research and potential directions for future research in virtual care and accessibility.

Definitions

Within this thesis, the following terms are defined as:

Digital social work: Digital social work is any component of social work practice that necessitates the use of technology. This could include examples such as documentation and researching community resources.

Virtual care: Virtual care and virtual social work practice are defined within this thesis as social work that is conducting over technology and virtual platforms that is *relational* in nature. Examples include conducting a session over videoconferencing software, telephone, or via text/short message service (SMS).

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Introduction

Approximately one in five individuals, or twenty percent of the Canadian population, experiences a disability in their lifetime (Canadian Survey on Disability Reports, 2017). Given the prevalence of disability, service delivery in social work practice must be designed to meet the needs of this population. The landscape of social work services prior to the COVID-19 pandemic focused on service delivery in an in-person format (Goldkind et al., 2018). This method creates barriers to service for many people experiencing disabilities (Ng et al., 2022). The COVID-19 pandemic lockdown conditions resulted in an increase of virtual care services available in social work, as a means of ensuring continuation of service during this difficult time of lockdowns (Peláez & Kirwan, 2023).

The National Association of Social Work (NASW) *Standards for Technology in Social Work Practice* (2017) highlights that social work services must be accessible to marginalized populations. Social work's goal of empowering individuals and ensuring equitable care has historically dismissed the potential of virtual care and the role that virtual care can play in addressing the barriers individuals with disabilities face in accessing social services (Zhu & Andersen, 2021). Peláez & Kirwan in *The Routledge International Handbook of Digital Social Work* (2023) identify one of the gaps in the current literature on digital social work, is determining best practices for virtual social work. This thesis endeavours to start a conversation around best practices in virtual social work, specifically as it relates to eliminating ableism in social work service delivery for individuals living with disability.

My experience in social work is focused on diverse, marginalized populations; this experience informs my research. Through my own experience accessing virtual care as someone with a disability, as well as my experience with many individuals who have disabilities, I have found that this research into virtual care is needed. This research is both timely and relevant, since many social work service providers have switched to online formats for service delivery recently (Peláez & Kirwan, 2023). I do not believe virtual care is currently optimized, nor do I believe that best practices for virtual care have been identified, based on my experience with the populations I have served since the beginning of the COVID-19 pandemic. For myself, my family and friends, as well as the individuals I have supported through my work, there is often a clear divide between those who find virtual care beneficial and those who do not.

Additionally, through a review of the relevant literature, it has become apparent that many studies focus on *levels of efficacy* of virtual care; however, these studies do not outline whether the social worker (or other helping professional) has received specific training in virtual service delivery, or how they may have adapted their approach to an online format. Some research has noted that social workers have a gap in knowledge regarding digital literacy and virtual service delivery and suggest that social work programs incorporate these skills into their curriculum (Byrne, 2023; Reamer, 2023; Zhu & Andersen, 2021).

This led me to believe that one possibility for not including specific curricula around virtual care delivery could be due to a lack of knowledge of how best to serve clients virtually. I also believe that those who receive services virtually and identify as having a disability would have valuable insight into what might work best for their needs. Individuals are experts in their own lives, and therefore I employ a Critical Disability Theory (CDT) approach to this research. CDT asserts that disability is not attributed to a perceived "impairment" within the individual, but rather as socially constructed through the built environment resulting in social exclusion (Davis, 2016; Hosking, 2008). CDT advocates for the inclusion and full participation of individuals in society by altering the social conditions which create disability (Davis, 2016;

Hosking, 2008). In addition to CDT, I approached this research guided by the Disability Rights Movement (DRM) and their slogan “Nothing about us without us” (Charlton, 1998). Honouring the specialized knowledge and centring the lived experiences of social workers with disabilities was a goal of this research. Improving virtual social work care has the potential to challenge the ableist structures inherent in current service delivery methods in social work practice, hopefully resulting in more equitable service delivery.

This thesis was designed to address the following high-level research question: “*What are the best practices for improving care and accessibility for individuals with disabilities in virtual social work practice*?” Based on the focus group discussion and the data, the final overarching research question this research addresses is: “*What are the best practices for improving accessibility for individuals with disabilities in social work practice?”* The “best practices” I am seeking to address include practices that make virtual care in social work more accessible for clients.

To answer this question, I conducted qualitative research using a focus group informed by critical disability theory. This approach promotes the goals of CDT by honouring the narratives of social workers living with disabilities (Garland-Thomson, 2018; Kitchin, 2000; Kroll et al., 2007), and their lived experiences of both accessing and providing virtual care services, to better understand how virtual care can be improved upon. This research did not focus on how participants can be trained to support access to care, which would be more aligned with the medical model of disability. Instead, this research considered the social construction of disability in virtual care services and sought to determine how virtual care can be designed to better support accessibility for all individuals. This is aligned with a critical social model of disability (Garland-Thomson, 2018).

As is common in research I had to modify my original plan for a minimum of two focus groups. As you will learn throughout this thesis, my sampling and recruitment strategy of horizontal networked sampling (Geddes et al., 2018) did not result in a large enough pool of participants to accommodate multiple groups. As a cis-gendered, heterosexual, white woman, who lives with disability, I recognize that my personal social location impacts this research, specifically in the data analysis method I chose to employ as well as the success of my recruitment.

As a result, a single focus group was facilitated with seven participants. The focus group was conducted over Zoom Cloud software, which supported the use of a chat feature as well as English closed captions, which enhanced accessibility for participants. The focus group was 2 hours in length, and transcription through Zoom was used to support data analysis. The data was uploaded to Dedoose data analysis software to support coding and analysis.

I utilized narrative (Fraser, 2004) and reflexive thematic analysis (Clarke & Braun, 2017) through a CDT lens to analyze the transcript produced in the focus group. I identified the following five major themes in my analysis: 1) Digital Literacy, 2) Privacy, 3) Factors That Enhanced Accessibility, 4) Factors That Challenged Accessibility, and 5) Practice Standards in the Digital Domain. From these major themes, there were additional sub-themes. Based on the themes identified by the participants, filtered through my personal experience in the data analysis, I present a list of seven best practices that social workers can use to guide their practice in virtual care.

Research Question:

My overarching research question for this thesis is "*What are the best practices for improving accessibility for individuals with disabilities in social work practice?*"

Thesis Chapters

There are a total of six chapters including this introduction. In the following chapter, (Chapter 2), I present my critical review of the current literature on virtual social work practice and virtual care. Chapter 3 details the theoretical framework, anchored in post structural Critical Disability Theory and the *Nothing About Us Without Us* movement. Chapter 4 outlines my methodology and methods for this research, a qualitative study guided by critical theory that utilizing focus group and is rooted in reflexive thematic analysis. Chapter 5 presents my reflexive thematic data analysis results, and finally, Chapter 6 provides my Discussion of this research, limitations, and the implications of this research on social work practice.

Appendices

This thesis also includes eight appendixes which contain the materials created to support the research process including the ethics approval certificate and the materials used to support the focus group process. The appendixes are organized, and at the end of the thesis as follows:

Appendix A: Ethics Approval
Appendix B: Email Recruitment Script
Appendix C: Letter of Information & Informed Consent
Appendix D: Recruitment Poster
Appendix E: Screening Questionnaire
Appendix F: Counselling Supports
Appendix G: Focus Group Guide

Appendix H: Oath of Confidentiality

Literature Review

This chapter provides an overview of the current landscape of literature related to virtual care in social work. Digital social work will be defined here as any component related to social work that necessitates the use of technology. This could include using technology for client information systems, e-mails, text messaging, and social media use. Virtual care in this thesis will specifically refer to: “Virtual care refers to patient-physician interactions related to diagnosis, evaluation, and management conducted remotely using some combination of text, audio, and video either synchronously or asynchronously.” (Herzer & Pronovost, 2021, p.429). Therefore, virtual care is a relational model, including telephone interactions and videoconferencing; in contrast digital social work encompasses all aspects of technology involved in social work services, such as electronic client information services and text messaging.

Digital social work existed prior to the COVID-19 pandemic; however, it was the conditions created by the lockdowns associated with COVID-19 that led to social workers using technology more frequently, and in new ways, to ensure continuation of services in unprecedented times (Peláez & Kirwan, 2023). This increase in digital service delivery led to new research in the field of digital social work. Importantly, the development of best practices and methodologies specific to digital social work practice is currently lacking in the literature (Peláez & Kirwan, 2023). Many scholars have demonstrated the efficacy of virtual care; however, very few have explicitly stated the ways that service delivery was tailored to the unique conditions of digital social work. My research aims to close the gap in this knowledge and initiates a dialogue on the ways social workers navigate the digital space to improve accessibility for those with disabilities, in order to shift the ableist standard of in-office care to create truly equitable care models for all service users.

Digitization of Social Work

Social work as a field has historically emphasized the importance of face-to-face, in-person support (Goldkind et al., 2018). However, in recent decades, social work has also begun to incorporate Information and Communication Technologies, or ICTs, into practice (Goldkind et al., 2018). ICTs include computers, cellular phones, and internet, among others (Goldkind et al., 2018). According to Goldkind et al. (2018):

> Every area of our discipline has been prompted to evolve by technology: technology is used to deliver social work education, it is reformulating the rules of research, it offers new approaches for individual and group work, and it continues to manufacture new tools for activism and community-based practice. (p.1)

This technological evolution and the resulting digitization of social work as a field of practice was "accelerated" by the conditions created by the COVID-19 pandemic of 2020 (Peláez & Kirwan, 2023). Due to the pandemic, digital social work was employed more frequently, as lockdowns prevented services from being provide in-person (Peláez & Kirwan, 2023). As the digitization of social work (and society as a whole) progressed, the issue of access to technology created a "digital divide" between those who could fully participate in society through digital means and those who could not (Peláez et al., 2023). According to Peláez et al. (2023), "… to fully participate in society requires use of technology." Social services were moved to digital delivery, socialization was now occurring across social networking platforms, and as a result, social workers have now been faced with additional areas of social inclusion and exclusion, based on access to technology (Peláez et al., 2023). The digitization of social work has thus created new opportunities and challenges for those working in the field.

Digital Literacy

While virtual social work has shown promising results, the reality is that virtual care continues to have untapped potential, due to varying levels of digital literacy. Julien (2018) states that:

> Digital literacy, from a pragmatic point of view, is the set of skills, knowledge and attitudes required to access digital information effectively, efficiently, and ethically. It includes knowing how to evaluate digital information, and how to use it in decision-making.
>
> (p. 2243).

Furthermore, Julien (2018) asserts that definitions of digital literacy vary depending on culture. For example, what is "digitally literate" for a culture that focuses on complex computer systems in Western society might look very different from a culture that values agriculture (Julien, 2018). Juien (2018) notes some definitions of digital literacy include the ability to access and use technology, as well as creating and interpreting digital information.

Within the context of social work practice, most social workers have not received digital literacy training as part of their social work education and professional development training (Earle & Freddolino, 2022). Yet, social workers use digital applications and data extensively throughout their practice, whether this be in documentation, completion of referrals, or conducting virtual visits through video conferencing software. Most client information and health information is currently maintained in digital databases. In 2016, the National Association of Social Workers (NASW) partnered with three additional associations in social work practice:

the Association of Social Work Boards (ASWB), the Council on Social Work Education (CSWE), and the Clinical Social Work Association (CSWA), to develop a task force which addresses standards of practice use of technology. Together, this task force published the *Standards for Technology in Social Work Practice* (2017). These standards highlight the need for social workers to demonstrate competency in the use of digital technology and information systems, including the understanding of ethical use of technology in practice. Furthermore, this document (NASW, 2017) states: “The standards and their interpretations are intended to set a minimum core of excellence for professional practice when social workers use technology and to provide a framework to address possible benefits, challenges, and risks that arise when using technology.” (p. 8).

Based on the practice standards established by these social work authorities, any social worker engaging with digital information in their work should be able to demonstrate competency around technology. However, a lack of digital literacy training in the social work field, and at all levels of clinicians in North America, puts social workers at a disadvantage when providing optimal care involves the use of digital technology. The lack of attention and resources related to digital literacy for social workers places individual social workers and clients (more generally) at serious risk (Byrne, 2023; Reamer, 2023; Papaganou et al., 2015).

Worldwide, social work programs have neglected to provide the necessary training to social workers to ensure they are comfortable and competent in digital service delivery (Byrne, 2023; Zhu & Andersen, 2021). While internationally, there are now competency measures for social workers engaging with technology, social work schools continue to fail at setting students and new graduates up for success by failing to incorporate digital literacy training into its curricula (Byrne, 2023; Zhu & Andersen, 2021). Not only do social workers require digital literacy training (Byrne, 2023; Zhu & Andersen, 2021), but to provide services in a way that is meaningful for clients, service users must also be digitally literate to ensure they comfortable with the information technologies used to deliver virtual care. Detlor et al., 2022 found that digital literacy training yields positive learning outcomes, such as increased confidence and comfortability with information technologies.

The available literature while limited, highlights a lack of digital literacy training particularly as it pertains to marginalized populations, including older adults (Detlor et al., 2022), and individuals with intellectual disabilities (Krysta et al., 2021). This lack of digital literacy training means many groups continue to lack digital skills/capacity, resulting in the phenomenon of the "digital divide," (van Dijk & Hacker, 2018).

The digital divide Is generally described as a form of exclusion around the use of digital technologies. Van Dijk & Hacker (2018) define it as: "The digital divide, spanning from unequal physical access and different digital skills to usage of digital media, is a major problem for increasing participation for all citizens. Those without access and skills have no stake in online participation." (p.52) The digital divide results in a sizeable gap in digital literacy related to a variety of factors, many of which relate specifically to the context of a particular social group or population. For example, when considering the digital divide in the context of older adults populations it is important to consider an aging population may not have had access to technology in the past; groups of people who do not have access to technology currently may experience this lacking due to any number of factors, including social, economic, and lack of infrastructure to support internet networking (Byrne, 2023; Julien, 2018; UNESCO, 2022).

To address the gaps in digital literacy for social workers, schools of social work worldwide have an obligation to their students, and clients, to educate those entering the field to ensure competency in practice (Byrne, 2023; Reamer, 2023). To reduce chances of harm in practice, potentially caused by privacy breaches or security breaches, social workers must be trained in digital judgment (Reamer, 2023; Zhu & Andersen, 2021). To provide client-centred care, delivered via telehealth platforms, social workers must be trained in digital literacy to ensure they can assist service users in accessing technology, as well as delivering services in an effective way as mediated by the particular technologies available to workers and clients.

The literature points to a correlation between perceived benefits of digital literacy and wellbeing (Detlor et al., 2022). An increase in comfortability and confidence in the use of technology for virtual care is demonstrated to lead to more satisfied service users and providers (Olsen et al., 2012; Stewart et al., 2017; Thomas et al., 2022). In studies where the participants were provided with digital literacy education prior to engaging with the relevant technology, participant views of virtual care were generally positive (Olsen, Fiechtl, & Rule, 2012; Richards et al. 2018; Spooner et al., 2019). This was true for both service providers, and service users involved in these studies.

While educating social workers and service providers on digital literacy is one piece of the puzzle, another piece is providing digital literacy training to service users. Digital literacy and improving access to technology can have profound effects on an individual, and (naturally then) society's, well-being (Detlor et al., 2022; Julien, 2018). Thus, digital literacy is a tool of empowerment for individuals who wish to take their wellness into their own hands.

Digital technology opens the potential for greater social service reach. Where someone may have been limited to the services available to their geographic area in the past, now services can be delivered to remote locations by the best practitioners and specialists available via virtual care, and service users can embrace these opportunities (Ramsey & Montgomery, 2014). One can also use online library access to research their own well-being, and peer-reviewed journals relevant to their experience. If members of society are provided with the opportunities to obtain training in digital literacy, societies will have the potential to experience greater well-being and healthier communities because of access to digital content and resources. A key indicator of a digitally literate society would be decreasing the gap of the digital divide, meaning more individuals and marginalized populations would have to receive digital literacy training to ensure competency to access the same opportunities as others who possess greater skills in technology.

Another issue of access relates to affordability. The cost of technology can be an access barrier for services, and the literature highlights that low socio-economic areas do not have access to reliable internet networks (Biswas et al., 2014). A study by Biswas et al. (2014) found that 70% of individuals living in social housing in the UK did not have internet access. Additionally, these authors highlight the digital divide in the USA was observed to be associated with the “prohibitive” costs of internet access (Biswas et al., 2014). In Canada, Indigenous communities have historically been excluded from internet networking access, and a new Government of Canada initiative launched in 2024 aims to address this disparity (Government of Ontario, 2024). The above findings highlight the ways that the digital divide further excludes individuals and communities from full participation in society. The digital divide’s potential to perpetuate social exclusion is thus is a social justice issue that social workers should be working to eradicate.

Clinical Practice in a Digital Context

A review of the literature demonstrates that virtual care has clinically significant outcomes, comparable to traditional in-office, or face-to-face service delivery (Barak et al., 2014; Ramsey & Montgomery, 2014). Barak et al. (2014) conducted a meta-analysis of psychotherapy delivered via virtual platforms. The authors analyzed how effective treatment was, based off multiple measures of effectiveness, including: self-reports, expert ratings, behavioural reports, and physical reports. Barak et al.'s (2014) analysis demonstrated internet-based psychotherapeutic interventions have similar treatment outcomes to in-person psychotherapy, as measured by effect size (ES). Effect size is the measurement used in quantitative research that describes the relationship between outcomes in a study, and it can identify how meaningful a relationship may be based on if the ES is small or large (Sullivan & Feinn, 2012). Barak et al. (2014) found that cognitive-behavioural therapy (CBT) was the most effective therapeutic intervention to be delivered virtually. Barak et al. (2014) also found that there was no significant difference between services delivered synchronously, or where the practitioner and client join in real time together to conduct the service, versus asynchronous service delivery. In asynchronous delivery, the client could access the support and content outside of the times the practitioner would be present. However, for asynchronous delivery, the authors did find that interactive sites were more effective than static sites (Barak et al., 2014).

A review conducted by Ramsey & Montgomery (2014) found that virtual care interventions yielded statistically significant results, demonstrating clinical benefits for participants. Two of the main benefits afforded by virtual care found in this review include improved accessibility to services, as well as delivery of services to clients who would not have otherwise received care, either due to geographical location or decreasing wait times to access services due to less time spent on travel for agencies. The authors note that,

> "…the wide range of benefits reported across studies exemplify the potentially dynamic role that technology can play as the primary mode of delivery or as a feature supporting a larger intervention. Traditional "low-tech" interventions that suffer from limited client reach, poor client–therapist communication, or limited therapist time or training may benefit from incorporating technology-based approaches into treatment delivery." (p.896)

This review focused on mental health-specific interventions, the authors found studies from diverse populations that support the consideration of virtual care for mental health in a variety of settings, including CBT for anxiety, self-help groups, as well as hospice care (Ramsey & Montgomery, 2014).

Byrne & Kirwan (2019) studied the potential for relationship-building in practice with the use of technology. These authors suggest social workers felt technology helped them relate to their clients; by using the client's preferred digital platform, rapport was improved. In particular, youth social workers (perhaps due to youths' digital literacy and their familiarity and comfortability with technology) felt this way of connecting with their clients fostered deeper connections than they previously developed with clients (Byrne & Kirwan, 2019). This study also highlights the benefit of technology in fostering greater connections between workers and their teams or supervisors, by improving access and speed of connection to other professionals in busy environments (Byrne & Kirwan, 2019).

Another study conducted by Earle & Freddolino (2022) looked at the ways that Masters of Social Work students viewed the effects of virtual care on therapeutic alliance. Participants in this study held positive views about the potential of technology to foster a good therapeutic alliance that would ultimately positively impact client outcomes. However, several social work students were still apprehensive about the benefits of virtual care on therapeutic alliance. The authors found that a lack of comfort with, and confidence in, virtual care practices negatively impact participants' perceptions of technology-mediated therapeutic alliance development.

Similarly, Richards et al. (2018) looked at the therapeutic alliance in psychotherapy through asynchronous services offered as adjunct to in-office psychotherapy. This study used the goACT platform for clients to connect with their psychotherapists in–between in-person appointments. goACT is a software package (mobile and web-based) that clients and their psychotherapist can use for digital connection, as wells as supports therapeutic "home work" activities such as journaling, as well as Short Messaging Service (SMS), and assessments. All clients and psychotherapists were provided with training for the goACT application prior to use in this study. This study found that goACT, when used in collaboration with face-to-face visits with a psychotherapist, had a positive effect on the therapeutic alliance.

The authors propose this was achieved by creating an additional space where the psychotherapist can demonstrate care, outside of billable office visits. Richards et al. (2018) suggest this signals to the client that they are more important than just the time they are billed for. While this was considered an advantage in this study, others may consider accessing a social worker outside of the time they are compensated for as detrimental, particularly for the social worker's well-being. The authors note that the psychotherapists surveyed in this study may have had more positive views towards the incorporation of technology into their practice, because in this instance the technology was not the primary modality of care delivery, but rather an adjunct addition to a traditional care model. In this case, rather than replacing in-person psychotherapy, goACt enhanced it. This study found that allowing the client to be more present and exercise more control over the therapeutic process through goACT, fostered greater motivation in the client and higher levels of accountability to share the therapeutic work. In this example, empowering the client to exercise more power and control over their goals can be positive for the therapeutic alliance.

Eliminating Barriers to Service

While virtual social work services can offer significant benefits, if clients are continuously bumping up against barriers to accessing services, then many potential clients may become deterred from accessing these services in the first place. A recognized barrier to services for clients is extensive travel time for appointments, particularly if the client resides in a rural location. Wait times for services in rural areas are oftentimes longer than those of urban centres (Olsen, Fiechtl, & Rule, 2012). Olsen et al. (2012) studied the strain placed on the community services system by high levels of service demand for early intervention programs for children with disabilities, in combination with too few service providers in rural areas. The authors argue that travel between clients drastically impacts wait list times and therefore time to access treatment (Olsen et al., 2012). Olsen et al. (2012) found that by offering virtual services, time to access service was decreased, due to a reduction in time spent travelling by practitioners. The authors conclude that incorporating virtual care delivery into early intervention programs could increase efficiency, thus leading to improved treatment outcomes (Olsen et al., 2012). Therefore, virtual care is uniquely able to address the barrier of travel time and distance for services in remote communities.

Improving Accessibility for Those with Disabilities

The National Association of Social Workers' *Standards for Technology in Social Work Practice* (2016) clearly outlines that social workers should be using technology to "… meet the needs of diverse populations, such as people with differing physical abilities." Given that these standards were published in 2016, the social work field should have worked on creating access to virtual care prior to now. Unfortunately, prior to the COVID-19 pandemic in 2020, most services were delivered in-person and the shift to a virtual format seems to only have occurred to reduce transmission rates and protect the well-being of clients and workers from the virus (Krysta et al., 2021; Thomas et al., 2022; Wang et al., 2022). A general apprehension towards virtual care in social work prior to the COVID-19 pandemic possibly resulted in the suboptimal delivery of social services over telehealth platforms during the pandemic, due to a lack of familiarity and training in virtual care (Byrne, 2023; Sobota, 2021). However, individuals with disabilities benefitted from this modified delivery format, because they could receive services in a way that was accessible for them (Ng et al., 2022). Clients with disabilities were no longer required to make accommodations to attend in-person appointments (Ng et al., 2022). Additionally, those who were at higher risk of transmitting COVID-19 were able to safely access services from their home (Ng et al., 2022). The social model of disability asserts that disability is socially constructed, and created by the environments in which bodies are placed, rather than being a characteristic of the body itself (La Rose et al., 2022). If a client's needs are met by facilitating a client's need to receive services in the environment in which they are most comfortable, and recognizing that this environment must also be safe for this individual, then services should be tailored to meet the unique needs of service users, rather than service users being expected to conform to ableist-informed forms of care, such as face-to-face office visits. When care is offered in a way that is most accessible to clients, then social work is creating equitable access to service delivery, and therefore living up to the social work value of the pursuit of social justice. Providing virtual social work services has the potential to support more equitable care for marginalized populations; however, to do so, these authors draw attention to the necessity of access to internet networks and hardware devices to support this work (Ng et al., 2022).

Modality-Specific Considerations

Virtual care has the potential to be modified to suit various practice styles, including that of cognitive-behavioural therapy (CBT) and more creative or arts-based social work modalities. Stewart et al. (2017) conducted a study on trauma-focused cognitive-behavioural therapy (TF-CBT) in youths living in underserved communities who experienced at least one barrier in accessing trauma-focused services. TF-CBT, and CBT in general, frequently uses worksheets with clients in practice. At first glance, telehealth may not seem like a natural fit for this type of intervention. However, this study made use of the "share screen" function that is often embedded into videoconferencing software, thus allowing for the client to see the worker's screen, and likewise allows the worker to view the client's screen, when shared (Stewart et al., 2017). This way, work was shared with each other, and worksheets were completed collaboratively using this technology. This study experienced a remarkable 0% dropout rate, and 100% of the participants reported they were satisfied with the virtual format of service delivery. While a 0% dropout rate is likely rare, this study highlights the benefit of virtual care using TF-CBT.

Spooner et al. (2019) suggest that technology can be used to support therapeutic programs (2019); the authors explored programs delivering arts-based therapy to veterans in the United States using videoconferencing technology. Difficulties accessing veteran's rehabilitation centres for essential support, primarily due to travel between home and the centre, prompted this research (Spooner et al., 2019). Spooner et al. (2019) presents three case studies of remote arts-based therapies used to improve well-being in veterans. The first case study focused on the use of telehealth to support recovery from acquired brain injury. In this approach the participant created a narrative using found objects in the client's home with the goal of making greater sense of a period of life this client could no longer recall. The authors suggested that had this client been required to travel to receive services, this type of story building might not have been possible due to the removal of the client from their home environment. Therefore, videoconferencing therapy in this instance supported this Veteran's needs.

The second case study presented by Spooner et al. (2019) used videoconferencing to deliver creative dance-based therapies to a veteran experiencing mobility issues. This client would be supported with therapeutic movement-based practice by his therapist through videoconferencing, and often with his spouse, who was also his primary caregiver, at home and present with him to support his movements. Following this dance-based intervention, this client improved his mobility.

The third case study which also focused on care to a vet recovering from an acquired brain injury included participation in music therapy, as a means of supporting his passion for music held prior to the brain injury (Spooner et al., 2019). Music therapy was delivered via videoconferencing technology. This individual experienced an improvement in his coping skills and a reduction in his reported pain, which the researchers attributed to the treatment this individual received in the program. The above studies highlight the potential of virtual care to facilitate the delivery of therapies previously limited to in-person delivery.

Building Community

Virtual care and technology hold the potential to offer an online, accessible space for community building. A study conducted in Beijing, China during the COVID-19 pandemic demonstrates the capacity for community-building in online space. Wang et al. (2022) created an online community for individuals as a means of combatting feelings of isolation during the COVID-19 pandemic lockdowns. This study utilized an online chat service, called WeChat, to deliver a program called 'Garden on the Balcony' (GoB). In this program, individuals of all ages were invited to participate in gardening in their place of residence and share their progress and results via WeChat. Participants in the GoB program were later invited to participate in a focus group, sharing their experiences with GoB and WeChat. Data analysis of the focus groups found the program resulted in increased resiliency in study participants, and a feeling of community. The researchers found resiliency was fostered by enhancing family bonds, creating meaningful activities during uncertain times, and focusing on promoting strengths in the study's participants.

Another study by O'Neill (2018) examined the creation of communities in online chat spaces on the popular website Reddit. This study looked at the activities of victim-survivors of sexual violence who used Reddit. The author found that participating in this online forum created an open and safe space where survivors of sexual assault could come together and share their stories without the fear of shame and victim-blaming that often occurs when survivors of sexual assault share their stories. O'Neill noted that victims access these online communities to share their stories, as well as obtain advice/ find a supportive community. Unfortunately, society often incorrectly blames sexual assault survivors, and so participating in this online community affords a certain level of anonymity to survivors that can help them feel safe to disclose their story to others. The researchers note this level of anonymity is not afforded to survivors in in-person care models.

Similarly, the previously mentioned study with U.S. veterans, conducted by Spooner et al. (2019), also found that virtual care provided an online community for military veterans to come together and receive support. The provision of virtual care in this study facilitated the delivery of services which can promote community re-integration for veterans. The above examples support the use of virtual care and technology in the creation of online community spaces.

Professional Boundaries

Transitions of service delivery to virtual spaces has created a need for considerations in how technology has altered the ways in which social workers practice. Boundaries are a key component of professional practice in social work; however, with the advent of social media and virtual care, additional considerations around boundaries are needed. The NASW highlight that social workers must practice ethically, and the NASW have created a section called "Section 2.09: Maintaining Professional Boundaries" within their *Standards for Technology in Social*

Work Practice (2017). This section addresses the potential for social workers or clients to access information about each other online or across social media sites. Additionally, the *Standards for Technology in Social Work Practice* highlights that workers and clients could share common contacts through social media. The NASW outlines numerous examples of potential scenarios where boundaries in practice may get crossed, and how to avoid these. Generally, social workers should clearly outline social media policies with clients in advance of the start of services.

Richards et al. (2018) noted that psychotherapists had to draw up new contracts which included these considerations; reviewing these policies with clients regarding boundaries in their work was an important way of educating about the relevant policies. This study focused on boundaries around the times the worker online and accessible to clients. Social workers, and employees in many sectors, have expressed concerns around always feeling “on” and the need to work at non-traditional times due to technology (Aroles, Mitev, & Vaujany, 2019). Aroles et al. (2019) highlights that at-home working has blurred the lines between work and home. According to the authors, “work always wins” and employees are finding it more difficult to disconnect from work when at home. Conversely, Richards et al. (2019) found no additional work was created for the social workers who incorporated virtual care into their practice. This difference in findings could be due to the social workers in Richards et al. (2019) proactively maintaining professional boundaries with contracting. Further research should be conducted in this area to determine what the possible long-term impact of the dissolution of physical workspaces will have on workers.

The elimination of physical boundaries in virtual care, while seemingly beneficial, also brings with it new questions around service delivery and licensure. As the NASW’s *Standards* *for Technology in Social Work Practice* (2017) highlights, social workers must practice within the geographic space where they are licensed. For instance, clinicians licensed in one jurisdiction should be physically in that same jurisdiction to provide services. This also includes considering the location the client is receiving services in, and if different from the clinician's, the clinician must determine what is required to practice ethically in both areas. The onus is placed on the social worker to determine if they are practicing in accordance with the jurisdiction within which they are licensed, as well as the location their client is situated in. This raises questions around liability, and these are potentially new considerations that social workers did not have to grapple with in the past.

Privacy and Confidentiality

Privacy and confidentiality are also important topics to explore in relation to virtual care, because the virtual space creates new opportunities for surveillance and breaches of confidentiality to take place (Byrne & Kirwan, 2019; Reamer, 2023). Reamer (2023) highlights that digital social work offers less control over confidentiality, as a client could be recording the session, someone could be off the screen observing, or texts and e-mails can be posted publicly. Similarly, Byrne & Kirwan (2019) caution that access to the internet introduces the potential for social workers to search clients or vice-versa. Social workers surveyed in this study shared their experiences of clients creating social media posts about their work, and even instances where social workers were recorded, and their work was posted online without their knowledge.

Expanding this theme, La Rose (2019) analyzed a video of a child protection worker being recorded, and ultimately posted on the popular video streaming platform, YouTube.

According to La Rose, the utilization of sousveillance, or the recording of an interaction using a smartphone to demonstrate the ways in which power relations play out in these relationships, could have been used as a form of "meaning making" by the family. Sousveillance is significant, as it presents a novel situation in social work service that was not a concern decades ago. Sousveillance has the potential of holding workers accountable, as it offers visual proof of an interaction (La Rose, 2019). However, videos could also contain parts of information that takes interactions out of context, and thus could be harmful (La Rose, 2019). The act of being recorded could also impact the ways one practices, as recordings could provoke anxiety in some workers (La Rose, 2019). Social work education and agencies need to provide social workers with the education required in handling situations of sousveillance, as it is a phenomenon that could happen frequently and without the worker's knowledge.

Informed Consent

A key value of social work service is informed consent. In the world of technology, the available literature questions whether the Terms of Service Agreements (ToS) of online services are ethical (Goldkind & Wolf, 2020). The authors asked participants to review the Terms of Service Agreement for a third-party direct-to-consumer telemental health service. This study found that the ToS were not aligned with the principles of human rights-informed care practices. The ToS agreement relieved the service provider of any liability related to care offered on the platform, even eliminating liability associated with vetting the service providers on the platform (Goldkind & Wolf, 2020). Thus, service providers are left with an increased responsibility to ensure they are practicing ethically, and service users are responsible for ensuring the service provider is licensed and legally allowed to practice. Without education on examining ToS critically, it is questionable whether all social workers are aware of their role in understanding the ToS to ensure they are practicing ethically (Goldkind & Wolf, 2020).

Additional questions around informed consent relate to the need of service users to agree to the ToS agreement prior to receiving services (Goldkind & Wolf, 2020). The authors argue that a client who is in a state of crisis may not be able to fully comprehend the document, and thus their consent is not informed (Goldkind & Wolf, 2020). The authors also highlight that these agreements are often written with a lot of legal jargon, thus rendering it incomprehensible for most service users (Goldkind & Wolf, 2020). The authors assert that in the future, ToS should be written in plain language, and be translated into multiple languages to ensure ethical delivery of services (Goldkind & Wolf, 2020). Additionally, according to the authors, social workers are required to fully understand the consent and data collection of the technology they are using. This would entail understanding how data is stored, used, and retrieved (Goldkind & Wolf, 2020). Unfortunately, as already discussed, most social workers have not received digital literacy training, and thus are highly unlikely to be knowledgeable in this area.

The Future of Virtual Care

The literature clearly demonstrates both benefits and pitfalls of virtual care. Digital social work has a place within service delivery, and can create more equitable access to services, if done properly. To ensure the longevity of virtual care, a number of suggestions have been made by Thomas et al. (2022). These authors propose five requirements to ensure continuation of telehealth services beyond the COVID-19 pandemic. The five requirements include: the development of a digitally literate workforce, the empowerment of clients, reformed funding, improving the digital environment, and the full integration of telehealth services into routine care models. Digital literacy in social work practice should also include the development of skills to facilitate virtual practice (Thomas et al., 2022).

Spooner et al. (2019) note that skill development is a requirement in the seamless delivery of telehealth services. According to Spooner et al. (2019), visual cues are limited to what is presented on the screen in what could be considered a curated image. As a result, verbal communication skills must be developed to ensure seamless communication between clients and workers. The development of skills in workers and clients alike need to be combined with technical support to support, in the case that technical issues arise (Thomas et al., 2022). The second requirement is the empowerment of service users. In this case, the authors argue that clients should be feeling empowered to advocate for access to telehealth services for themselves. Reforming funding requires reconsideration from benefits providers, as well as the government, to ensure virtual care services are accessible and affordable. The authors commend benefits providers for covering telehealth services during the pandemic, and highly encourage the continuation of coverage for virtual care after pandemic restrictions are lifted. Improving the digital environment would include improving wireless connectivity and service quality (Thomas et al., 2022). Unfortunately, connectivity issues do occur in virtual care, and when they happen, negatively impact service quality (Thomas et al., 2022). The integration of virtual care into care delivery is essential to ensure individuals can access care in the format that works best for them (Thomas et al., 2022). Addressing these areas of virtual care can ensure the continued delivery of virtual services into the future.

The literature also highlights how considerations around the future of virtual care must include the ways that virtual care can increase opportunities in social work, but also lead to oppression and marginalization due to lack of access to technology (Byrne, 2023; Peláez & Kirwan, 2023; Singer, 2023). A Government of Ontario News release from March 13, 2024 highlights the ways the Canadian Government is investing in infrastructure changes aimed at improving internet access for rural and Indigenous communities (Government of Ontario, 2024). This news release acknowledges that Canada is lagging in access to high-speed internet, compared to other countries worldwide (Government of Ontario, 2024). Internet connection accessibility is one key piece of ensuring virtual care is accessible; however, another crucial piece to this puzzle is how to get access to the devices required to use these networks. A failure to address these issues will only lead to further marginalization of individuals who cannot access virtual services. To improve health equity, ensuring access to the technology required for virtual care is essential.

Virtual care has great potential to create equitable access to social work services. The above literature review highlights the ways in which virtual care can eliminate some common barriers experienced by service users, including the ableist standard of requiring in-person visits. With approximately 20% of the Canadian population experiencing a disability in their lifetime (Government of Canada, 2017), eliminating health inequities in service delivery is essential to satisfy the requirement of social work services being accessible to marginalized populations (NASW, 2017). The importance of digital literacy cannot be stressed enough, and schools of social work as well as social service organizations need to prioritize addressing the gap in digital literacy of social workers to ensure the delivery of ethically-sound services. Virtual care creates fantastic opportunities for society, and social work should embrace the potential of virtual care in supporting social justice goals.

Key considerations for future research in digital social work, highlighted by Peláez & Kirwan in *The Routledge International Handbook of Digital Social Work* (2023), is determining best practices for digital social work, as well as developing new methodologies of social work specific to the digital space '…based on co-design and participation of all actors involved." (p.516) My research aims to begin the discussion around what constitutes best practice for virtual social work, specifically as it relates to services provided for individuals with disabilities. It is my hope that by co-developing best practices based on the lived experiences of service users and service providers who have a disability, virtual social work services can better support the needs of those with or without disabilities, by creating a more equitable service experience for all.

Theoretical Framework

Why Critical Disability Theory

This thesis is grounded in critical disability theory (CDT). My arrival at the decision to employ CDT to guide my research happened deductively, when I originally applied for my MSW. I was studying for my BSW during the COVID-19 pandemic. On May 25, 2020, the horrific killing of George Floyd, which spurred the Black Lives Matter (BLM) movement, happened. The political landscape at the time was situated under the presidency of Donald Trump in the United States of America. These events, combined with witnessing the devastating impact of the social determinants of health on COVID-19 outcomes for oppressed communities, ignited a fire in me to call attention to injustice. Seeing loved ones and myself struggle with health issues during this time, I was thankful (as were they) for the accessibility of virtual visits with care providers. The ability to access care virtually was essential to peoples' well-being during this time.

While virtual care increased accessibility in some ways, I felt it could be improved upon. During the start of the COVID-19 pandemic, my class pivoted to an online, synchronous format. While this increased accessibility and allowed students to continue their learning, it was also a chaotic time as many individuals were learning new online platforms and etiquette for online class participation. Historically, social workers were deterred from providing services virtually (Ramsey & Montgomery, 2014). Social work as a field was slower at adopting technology for practice, compared to other services, due to concerns raised regarding confidentiality, the negative impacts on client trust, and perceived negative impacts on service delivery as it relates to the client-social worker relationship in practice (Ramsey & Montgomery, 2014).

During the pandemic, services needed to continue, and service providers needed to earn an income. Virtual spaces allowed for services to continue; however, I noticed a divide between those who felt that virtual services were beneficial and those who did not. I found these services invaluable, and effective in my context. This prompted me to consider the fact that service providers have the ability to tailor services in a way that meets client needs, in the context of virtual services; this adaptability maybe what makes the difference. Many of the folks I spoke with were accessing services due to a disability (e.g. physical health issue, mental health issue, and neurodivergent issues).

Based on these experiences, I am exploring the ways that social work services can be tailored to support the needs of clients with disabilities, rather than clients needing to adapt to the new technology. This goal of improving outcome for those who experience oppression based on perceived ability, or ableism, informed my approach to this research. Individuals with disabilities might not be consulted or included when developing new technology or service delivery models, and this prompted my need to include individuals with lived/living experience of disability who could share their unique experience to further the discussion around accessibility in virtual care, and collaboratively develop a set of best practices for social workers in the future. It is the amplification of the voices of those with lived experience of disability within this research project that spurred the use of emancipatory theoretical frameworks, which aligns well with CDT. Thus, critical disability theory informed all aspects of my research.

Critical Disability Theory (CDT)

Critical disability theory (CDT) is interdisciplinary and includes multiple frameworks (Meekosha & Shuttleworth, 2009; Thomas, 2004). CDT came about in the 1970's and was born out of critical social theory, popularised by the Frankfurt School in the 1930's, as a response to the Medical Model of Disability (Meekosha & Shuttleworth, 2009; Davis, 2016). The critical social theory of today takes into consideration today's social issues, which includes race, gender, and disability, among other social movements (Meekosha & Shuttleworth, 2009). Critical social theory (CST) challenges traditional theory, in that rather than merely explaining society, CST's aim is to critique mainstream theory with a goal of social change, and ultimately, emancipation (Brown & Strega, 2015; Meekosha & Shuttleworth, 2009).

The Disability Rights Movement began in the 1980's and was born out of the Civil Rights Movement as a response to the Medical Model of Disability (Garland-Thomson, 2018). The Medical Model focused on essentialism and pathologization, responding to a deviation from what was considered "normal" with a fix or cure in order to "improve" the individual's quality of life (Garland-Thomson, 2018). The Medical Model centred notions of disability, and any negative consequence of the disability, within the individual (Garland-Thomson, 2018). In contrast, The Disability Rights Movement aimed to challenge this framework of disability by linking it to other social movements at the time. Much like the Civil Rights Movement's argument that Racism is a social and political construction that leads to discrimination of people based on skin colour, leading to oppression, the Disability Rights Movement highlighted the ways that individuals with impairments are limited, not necessarily due to a physical limitation, but rather due to the ways society perceives one with a limitation that differs from what is deemed “normal” in society. This binary of “normal” versus “abnormal” results in oppression that individuals with disabilities experience as ableism (Garland-Thomson, 2018).

The activism speared by the Disability Rights Movement led to the development of the Social Model of Disability, which proposes that disability is not inherently caused by an impairment, but rather by the complex ways that society, both attitudinally and structurally, creates a social environment that oppresses individuals who do not meet what society deems “normal” (Davis, 2016; Hosking, 2008). While the Medical Model focuses on “fixing” any impairment that deviates from the social norm, the Social Model focuses on inclusion and valuing of individuals as they are (Hosking, 2008). Thus, equality and full participation in society, through modifying the social environment and not “fixing” the individual, is the goal of the Social Model of Disability.

In the beginning, CDT focused primarily on physical impairments; however, in time, CDT came to include multiple aspects of the individual, including mental health and neurodiversity (McWade, Milton, & Beresford, 2015). McWade, Milton, & Beresford (2015) highlight that while the Neurodiversity Movement and the Mad Studies Movement do have their nuanced differences, what these movements share in similarity with CDT, in that these groups experience oppression and discrimination based on their “impairments” and are often grouped together legislatively under the umbrella of “disabilities.”

For example, McMaster University’s Student Accessibility Services website groups physical, mental health, and neurodiversity-related diagnoses together on their website as disabilities (McMaster University, 2024). Additionally, the Ontario’s Accessibility for Ontarians with Disabilities Act (AODA), 2008, also groups physical and mental health impairments together under the wider-term “disability.” These similarities in experiences of oppression, as well as the grouping together of these unique lived experience under one singular category within the legislation as “disabilities” that suggests the relevance of CDT to my research. I am therefore similarly choosing to include those under the collective umbrella of physical impairment, neurodiversity, and mental health as living with disability. Given the goal of advocacy and empowerment for those with disabilities, as well as a lack of differentiation between these categories in University-based policy and in legislation, a differentiation was not made in this research among specific categories of disabilities; rather, for the point of this research anyone who self-identified with a “disability” was welcome to participate.

While scholars in CDT differ in some respects from one-another, such as differing in their definition of disability, or to what extent a social model contributes to one’s experience of disability; CDT as a field of inquiry has at its centre a goal of social justice, of emancipation, and of hope that is embedded in critical social theories (Davis, 2016; Hosking, 2008; Meekosha & Shuttleworth, 2009; Thomas, 2004; Tremain, 2023). Within this research, I take a Social Model approach to disability. This perspective recognizes that pain and physical impairments may have significant impacts on an individual. In the context of virtual care services in social work, the way service providers structure their services has a potential impact on the service recipient. In my research, I am not interested in the ways an individual must adapt to the technology, but rather the ways the technology and service delivery can be tailored to the needs of the individual, and thus aligned with a Social Model of Disability.

Nothing About Us Without Us & The Disability Rights Movement (DRM)

James Charlton's *Nothing About Us Without Us: Disability Oppression and Empowerment* (1998) is a text which contains the Disability Rights Movement's slogan "Nothing about us without us", and it is the DRM's goal of centring the voices and lived experiences of those with disabilities which guided my approach to this research. In this text, Charlton takes a social model of disability and applies it to the empowerment and inclusion of individuals with disability, focusing on amplifying the voices of those who have historically experienced oppression based on a difference from society's definition of "normal" (whether that difference be physical, mental, neurological, or cognitive in nature). Charlton shares how he first heard the expression "Nothing about us without us" in South Africa in 1993, and that in the context of the Disability Rights Movement (DRM), he states:

> for the first time in recorded human history politically active people with disabilities are beginning to proclaim that they know what is best for themselves and their community. This is a militant, revelational claim aptly capsulized in the statement "Nothing About Us Without Us."" (Charlton, 1998, p.4).

Charlton also discusses the "Dialectics of disability oppression and empowerment" (Charlton, 1998, p.4). Charlton is critical of the ways disability was addressed historically, noting that power differences in those with a disability, compared to those without one, has resulted in powerlessness in the community, and a dependency of the disability community on others, as well as poverty, institutionalisation, and degradation. Charlton draws awareness to the resistance of disability oppression present in the DRM. The author notes that there is heterogeneity in each person's lived experience of disability; however, there are also significant similarities in that globally, those who have disabilities experience oppression and also resist this oppression, both as individuals and in the collective (Charlton, 1998). Similarly, Ed Roberts, founder of the World

Institute on Disability, has stated: “If we have learned one thing from the civil rights movement in the U.S., it’s that when others speak for you, you lose…” (Driedger, 1989:28, as quoted in Charlton, 1998, p.3). Nothing About Us Without Us seeks to place the power back into the hands of disabled individuals, and the disability community, and amplify the voices to those who have historically been silenced, recognizing their role as the expert in their own lives.

Similarly to CDT, the neurodiversity movement also utilises the slogan “nothing about us without us” as a form of resistance to ableism (Catala, 2023). The ontological position of CDT and nothing about us without us, is that the personal experience of those living with disabilities is valid, and arguably of more value than that of an outsider’s assumption of what one’s experience of disability and ableism might look like (Catala, 2023). Nothing about us without us is an important framework from which I drew for my research, as I sought to engage with individuals who are members of the disability community, to ensure that their voices and experience was heard in the development of best practices for the delivery of virtual care. As a person who lives with disability, I want to create an empowering space for voices to be heard, and to create space for people to come together and shape the services of the future in ways that are best suited to their own needs.

Methodology and Research Process

Methodology

My thesis research focused on the lived experiences of individuals with disabilities with virtual care service delivery. This topic is closely associated with critical disability theory (CDT), which is more compatible with qualitative rather than quantitative research methods. The overarching research question undertaken through this thesis research is "What are the best practices for improving care and accessibility for individuals with disabilities in virtual social work practice?" To answer my research question, I sought to explore the lived experiences of people with disabilities. I was not interested in a singular "truth," as one might be with more positivist approaches to research (Mason, 2018). Instead, I endeavoured to learn about the varied experiences of individuals with disabilities have as they receive and provide virtual care services. I was interested in hearing the stories that were shared, and understanding more deeply how their experiences are related to the processes and outcomes of virtual care, and ways of understanding that aligns more closely with qualitative inquiry (Mason, 2018).

CDT and the critical theories that inform these perspectives also highlight the varied experiences of individuals, rather than focusing on a singular "right" experience (Garland-Thomson, 2018). It is CDT's rejection of what is "right" and CDT's orientation towards the lived experiences and knowledge of those living with disability (Garland-Thomson, 2018) that inspired my research framework (Figure 1). In contrast, a more positivist, empirical approach would align with the medical model thinking that CDT challenges; the medical model seeks to "fix" or "cure" people and to align everyone's experiences with a "norm" based on social standards (Garland-Thomson, 2018).

Figure 1

Research Framework

- CDT's critique of disability being within the individual.
- CDT asserts disability is socially constructed.
- CDT's emphasis on power and social justice and the ways that this has contributed to ableism, inform this research.

- The Disability Rights Movement (DRM) emphasizes centreing the lived expereince of those with disabilities.
- Individuals with disabilities should be consulted in the policies and practices that impact them.
- Iinfluenced who would participate and my data collection methods and analysis.

- Focus groups centre lived experience.
- Creating the conditions for a dual process that encourages reflection and empathy of participants.
- This shared experience allows for richer dialogue and building of shared understanding of virtual care.

- Narrative analysis centres the lived experiences of the participants, in a way that considers socio-political implications.
- Reflexive thematic analysis considers the researcher's lived expereince and subjectivity in the identification of themes within data.

Focus Groups

For my research, I chose to use a focus group method as a way to mobilize participant knowledge. Focus groups align well with a critical disability theoretical framework, as both CDT and focus groups centre the voices of individuals living with disabilities (Kitchin, 2000; Kroll et al., 2007). Focus groups are interviews where multiple participants are involved. The focus group has a specific focused topic, for instance, shared experiences in the case of social science research (Kamberelis & Dimitriadis, 2020; Liamputtong, 2011; Kitchin, 2000), or in the case of my research the experience of social workers living with disability receiving and providing virtual care services.

Generally speaking, focus groups are used for three primary functions: 1) for political activation; 2) to engage in participant inquiry, and to support pedagogical activities (Huffman, 2024; Kamberelis & Dimitriadis, 2020). The inquiry function of a focus group is most closely tied to the research that I require. In addition to social science research focus groups may be used in market research (Kamberelis & Dimitriadis, 2020; Kroll et al., 2007). The pedagogical function of focus groups is tied to teaching and learning where the group may serve a socio-educational function (Kamberelis & Dimitriadis, 2020). Finally, the political function of a focus group is linked to social justice; scholars highlight focus groups as playing a role in social movements like feminism, where the use of the "collective testimony" of women whose direct experience was discussed in the focus groups, with a goal of emancipation (Kamberelis & Dimitriadis, 2020).

The political function inherent in focus groups was of particular interest to me, and use of these groups are important in social justice research (Huffman, 2024; Kamberelis & Dimitriadis, 2020). As Kamberelis & Dimitriadis (2020) explain, the facilitation of social justice within focus groups comes about through "… the ways these groups allow participants to coalesce around key issues, coproducing knowledge and strategies for transcending their social, economic, and political circumstances." (p.490) This social justice function of focus groups aligns with CDT's goals of social justice and emancipation (Davis, 2016; Hosking, 2008; Meekosha & Shuttleworth, 2009; Thomas, 2004; Tremain, 2023).

Focus groups consider the knowledge of the group as truth (Mason, 2018; Huffman, 2024). The epistemological view of focus group research is about understanding the lived experience of participants as experts in their own experience (Mason, 2018); this is in line with my own beliefs, that frame participants' embodied experience in virtual care as a person with disability as a unique kind of knowledge. The personal observations and considerations of their own and others' care within the virtual context, contribute to the body of knowledge within digital social work scholarship. The shared space of a focus group creates a space where these experiences can be shared and reflected upon.

Focus groups also bring out group dynamics, allowing for spaces of collaboration, whereas the dyadic nature of individual interviews would not facilitate such an experience (Kamberelis & Dimitriadis, 2020). My decision to use focus groups was also motivated by this collaborative space created in focus groups, with the aim of supporting group members to share and reflect on their own experiences in a setting that could foster a feeling of community. Additionally, the collaborative aspect had the potential to encourage new ideas around one's own experience, thus enhancing the data.

Focus groups can also create a more "natural interaction" than other methodologies might (Kamberelis & Dimitriadis, 2020). This "natural interaction" has two possible functions. The first is that in creating a natural interaction, participants might be more inclined to share their narratives more comfortably based on a less-clinical format of "data collection". The second function was the facilitation of the focus group within a virtual space, thus creating a similar environment to that of virtual care so that the focus groups would take place in-situ. By recreating the situational context of virtual care, parallel process might occur due to the shared situational factors (McCue & Lane, 1995). Parallel process is:

> Parallel process is an unconscious repetition of a conflict within two similar interpersonal settings. Specifically, it is an interpersonal repetition which occurs in both therapeutic and supervisory relationships. Such repetitions are most likely to occur when shared situational factors exist. (p.13)

Facilitation of the focus group through Zoom videoconferencing created the potential for the parallel process occur, as participants used introspection and self-disclosure when sharing the experiences of clients as well as their personal experiences with virtual care. This recreation of the client's experience has the potential to enhance empathy for and understanding of the opportunities and challenges faced by clients in virtual care.

Additionally, focus groups can level power dynamics typically observed in dyadic research methods, such as interviews, allowing the group to lead the research (Kamberelis & Dimitriadis, 2020). It was my intention to create a space where participants felt free to share their personal experience, however they chose to describe it. If new research questions were to arise during the focus group, I would encourage the participants to elaborate on this area, given participants highlighted the topic. This research was designed to highlight the experience of those with disabilities who access virtual care. It is the synergistic nature of the focus group to create a safe space for participants to come together and share their experiences, along with lessening my power as a researcher, that prompted my use of focus groups as my method.

Some drawbacks to focus groups include the unpredictability of a focus group (Parker & Tritter, 2006); scheduling difficulties of participiants (Huffman, 2024); group dynamics (Parker & Tritter, 2006); and ethical considerations, like confidentiality (Parker & Tritter, 2006). Bringing a group of individuals together can result in unpredictable conversations and situations (Parker & Tritter, 2006). To manage these unpredictable conversations, I provided participants with a list of counselling services and crisis lines, in case anything problematic was raised during the focus group. Additionally, participants were assured they could choose to leave the focus group at any time, and were encouraged to check in and inform me that everything was ok, as I would follow-up if they dropped off the group unexpectedly for safety reasons. Participants were also encouraged to remain in the group and could choose to stop participating, either by no longer engaging in conversation or keeping their cameras off, if they chose to stop participating at any point. Participants were informed in advance that their honorarium would not be impacted by withdrawing.

Scheduling is a noted difficulty in focus groups, due to accommodating many schedules (Huffman, 2004). Scheduling was difficult, as many participants were students and/or working and so for most participants, evening participation worked best. There were two potential participants identified through screening calls who wished to participate, but due to scheduling differences, could not be accommodated. Providing virtual groups over Zoom Cloud was beneficial, as participants did not need to schedule in travel, especially for participants who lived in cities other than Hamilton.

Negative group dynamics, such as silence during the group and participants who dominate the conversation, can emerge during focus groups (Parker & Tritter, 2006). I had prepared a list of questions in advance for a semi-structured interview, to provide some prompts in the event that conversation had stalled. The focus group I facilitated had no period of silence, and was quite lively with all participants contributing multiple times, and participants also contributed both verbally and through the embedded chat feature. Four participants contributed often, and another 2 had less frequent contributions in the focus group discussion. The participants would often engage in conversation around how one's experience either represented their own experience in some way, or at times, there were participants whose experience differed from what the group was sharing. All experiences were respected, and no single person dominated the discussion.

Confidentiality is another difficulty in focus groups research noted in the literature (Parker & Tritter, 2006). Researchers will outline how they are safeguarding confidentiality in their research; however, researchers cannot *guarantee* confidentiality in focus groups, resulting in an ethical dilemma (Parker & Tritter, 2006). I outlined my framework for ensuring confidentiality in my ethics application. Additionally, confidentiality was reviewed during screening, outlined in the LOI, and reiterated prior to the start of the focus group, including reviewing the Oath of Confidentiality. I obtained each participant's verbal agreement to the Oath of Confidentiality at the beginning of the focus group. Participants were also informed that while I took all measures possible to ensure confidentiality, there was still a possibility of their involvement in this research being shared by another participant, therefore highlighting the risk inherent in participation of this focus group.

Virtual Focus Groups

The focus group was facilitated virtually through the Zoom Cloud platform. The choice to facilitate the groups online was intentional. The ability of focus groups to facilitate group discussion and dynamics in situ (Kamberelis & Dimitriadis, 2020) made a virtual focus group the most appropriate setting for the research. Additionally, the built-in features of the Zoom Cloud platform, namely the chat function and closed captions, enhanced accessibility for individuals who would find these features helpful, and even necessary for their participation. Past research on virtual focus groups has highlighted that results from virtual versus in-person focus groups yielded similar results in terms of “depth” of discussion, and therefore facilitating a virtual focus group would likely produce a similar quality of data as in-person data collection would (Menary et al., 2023; Kite & Phongsavan, 2017).

Recruitment

My recruitment strategy centred on networked sampling, as my goal was to recruit as many participants who would have first-hand experience with accessing virtual care with disability. Networked sampling looks to a researcher’s personal network to support recruitment, the theory being that an individual’s network can access an additional pool form which to draw a sample that is likely to be more appropriate for the research than a convenience sample would (Geddes et al., 2017; Huffman, 2024). Huffman (2024) highlights how networked sampling can utilize individuals who identify as allies and support connections with additional participants with lived experience. Therefore, network sampling aligns well with critical disability theory in that it can support with accessing a pool of individuals with lived/living experience. Given that I was not involved in the disability community, drawing on my network proved useful in recruitment to support sourcing potential participants who havedisabilities and lived experience in accessing virtual care.

Recruitment began after first obtaining ethics approval from the McMaster Research Ethics Board (MREB #6971, Appendix A). Initially, recruitment was undertaken through the McMaster School of Social Work List Serve, whereby an email (Appendix B) was sent to current students and alumni with a flyer regarding the study and the Letter of Information (LOI, Appendix C) , describing the research process and purpose. Interested persons were instructed to e-mail myself, the Principal Investigator, expressing interest. Once I received an e-mail expressing interest, we coordinated a time to connect via telephone and reviewed the LOI, informed consent, and complete a telephone screener to determine eligibility. 1 participant was recruited through this process. My goal was to have 4-6 participants in the focus group, so it was at this time I had to consider other recruitment strategies.

My original recruitment strategy had failed. I pivoted to using horizontal networking (Geddes, Parker, & Scott, 2018) as my recruitment strategy. Geddes et al. (2018) highlight that when researchers have less “strong” ties to a pool of potential participants, snowball sampling is unlikely to produce large enough sample. In my case, not being involved in the disability community meant I did not have many strong ties to potential participants. However, as a student in the McMaster School of Social Work, both for my BSW and MSW degrees, I had developed a network that I could access for support with recruitment. Accessing this network between my contacts, with the hopes that these contacts would reach out to their networks, is referred to “horizontal networking” by the authors (Geddes et al., 2018). This allows a researcher to access “weak” ties, with the hopes of expanding their sample pool (Geddes et al., 2018). I ultimately landed on distributing social media posters (Appendix D) on my personal Instagram and LinkedIn accounts using this horizontal networked outreach, and e-mails to personal contact (Geddes et al., 2018). To facilitate this approach, an amendment to my original ethics application was required. A new ethics clearance was received prior to my second round of recruitment.

The social media posters developed for this phase of outreach contained brief descriptions of the research, eligibility criteria, a QR Code to access the full Letter of Information, and MREB ethics clearance information. Interested individuals were instructed to reach out via e-mail. When I received an inquiry about the research, I followed the same process as originally outlined, including reviewing the Letter of Information, informed consent, and screening for eligibility over the telephone. I recruited another 6 participants through this method.

Eligibility criteria for participation in this study included identifying as someone who has a disability, over the age of 18, residing in Canada, and either providing or receiving virtual care services from a helping professional or paraprofessional within the past 5 years (possible examples of virtual care used as examples in the flyers, letter of information, and posters included: receiving or conducting counselling or therapy, either individually or in a group format, through a videoconferencing platform and/or attending or providing a doctor's appointment or nursing appointment through videoconferencing). Not identifying as having a disability was an exclusion criterion, as the focus of this research is on highlighting the lived experiences of individuals with disabilities. An individual without a disability would not possess this knowledge. Additionally, participants were required to have availability in April or May of 2024 to participate in a 2-hour focus group virtually. Screening for eligibility was conducted via telephone, where I asked each participant the questions outlined in the screening questionnaire (Appendix E). Once participants were deemed eligible through the screening process and had verbally confirmed their understanding of the LOI and provided their informed consent, participant consent and contact information was stored in a secure document that was password-protected on my personal laptop.

Consent was reviewed at multiple points in the recruitment process, as well as during the focus group. Participants were informed of their right to consent to participate, as well as their right to withdraw their consent at any point without any repercussions. Participants were also informed if they chose to withdraw their consent, or chose to stop participating at any point during the focus group, they would still receive their honorarium. One limit to the consent that was highlighted was that if they contributed information to the discussion prior to withdrawing their consent, due to the interactive nature of a focus group, it may have been difficult to remove certain data afterwards. Consent was recorded on an Oral Consent Log and stored on my password-protected personal laptop.

Participants were informed the focus groups would take place over Zoom videoconferencing, and that the focus group session would be transcribed within the Zoom platform. A link to the Zoom privacy policy was included in the LOI for participants to review prior to participation. Prior to the date of the focus group, the Zoom link was e-mailed to participants. The evening prior to the focus group, I sent the link again, and attached the list of counselling support resources for participants (Appendix F), while also including a phone number to reach me at should there be any technical issues.

The Research Process

Participant knowledge was mobilized through the virtual focus group discussed earlier in this chapter. The virtiual group were undertaking using the Zoom videoconferencing platform. The focus group was recorded on Zoom Cloud, and transcription enabled. English closed captioning was also enabled, to support the accessibility needs of participants. Participants were aware of recording and transcription and consented prior to participation. Videorecording of the focus group was deleted from my encrypted laptop following fidelity check of the transcription. Participants utilized a pseudonym and were permitted to keep their cameras off if they preferred to aid with anonymity and confidentiality. The focus group was 2 hours in length.

I began the focus group by reviewing the introduction to the research, group norms, and confidentiality, as outlined in the Focus Group Guide (Appendix G). I then obtained verbal agreement to the Oath of Confidentiality (Appendix H). Following these steps, I began asking the questions, as outlined in the Focus Group Guide (Appendix G), and facilitating discussion while encouraging additional considerations as participants raised new topics. The questions were also posted in the chat function of Zoom, to enhance accessibility. The questions posed to the group were intended to develop a deeper understanding of the personal experience of service providers and users of virtual care, and how these experiences could lead to best practices, which aligns with CDT and *Nothing About Us Without Us.*

At the end of the focus group, participants noted that they appreciated having a space to discuss this topic, that they felt the research is “important” and that they appreciated the “representation” this research provided, as the research focused on the personal narratives of individuals living with disabilities. Participants were e-mailed a $25 Mastercard e-gift card as honoraria following the focus group. The videorecording, transcript, and consent log were stored on my encrypted laptop and encrypted hard drive until transcription was checked for accuracy. Following review of the transcript, and removing any identifying information form the transcript, the videorecording was deleted from my devices.

Coding and Analyzing the Participant Narratives

The reviewed transcription was then uploaded to software for computer-assisted thematic analysis. Qualitative Data Analysis Software (QDAS) is a software package that facilitates data analysis on a digital platform (Humble, 2020). For my research, I decided to use QDAS to conduct my data analysis, as it provides the following advantages: QDAS expediates data analysis process and retrieval of data, improves data organization, and eliminates paper-based data analysis (Humble, 2020). The software I chose to use was Dedoose, which is a mixed-methods QDAS; however, I chose to use it strictly for qualitative analysis.

I used Clarke & Braun's (2017) framework for reflexive thematic analysis, which builds on these authors' original 2006 paper on thematic analysis. These authors highlight the ways that a researcher's lived experience acts as a filter for analysis; analysis is not read literally. Using this methodology means that themes do not "emerge," but rather they are purposefully identified by the researcher (Clarke & Braun, 2017). My lived experience, the interview guide I created for the focus group, and the discussion amongst participants guided my analysis. As I reviewed the data, I identified major themes, along with corresponding sub-themes, and coded these within the Dedoose program.

In my analysis of this data, I recognize I am an agent in this knowledge production (Braun & Clarke, 2019) and what is presented is my interpretation of the focus group themes, filtered through my own experience and ontology; another researcher bringing a different lived experience to the research process might well code and analyze these same stories in different ways. The coding of the data was not linear; I frequently oscillated between identifying themes, identifying sub-themes, and then reviewing these themes and sub-themes again. At times, themes were provided new titles to better align with what I identified the theme as emphasizing. Thematic analysis, as outlined by Geddes et al. (2017) normalizes this non-linear approach to data analysis.

During my data analysis, I selected exemplar quotes from the focus group discussion that I felt best highlighted what the group was sharing. The exemplar quotes are not exhaustive, and represent only a few excerpts of the focus group discussion transcript. In an effort to maintain confidentiality, I have avoided publishing identifying aspects of quotes by substituting the identifying detail, such as school name or city name, with an explanation of the identifying information enclosed within square brackets.

The analysis chapter of this thesis is organized with the major themes appearing in order of my perception of perceived impact on virtual care service sin social work, rooted in my reflexive analysis of the participants' narratives. What follows is a review of my findings from this analysis.

Analysis

In this chapter I present my analysis of the focus group discussion completed as part of my MSW thesis research focused on best practices in virtual care. The focus group was conducted with social workers with disabilities who have direct experience with receiving and providing virtual care services. I was interested in the personal narratives of the participants in relation to their experience as service users and as social workers who have accessed and provided virtual care for individuals with disabilities.

To support this qualitative study, I analyzed the transcript of the virtual focus group facilitated using the Zoom Video Meetings Platform. To make meaning of this focus group discussion, I used narrative analysis (Fraser, 2004) and reflective thematic coding, both approaches being consistent with the critical post-structural orientation I am embracing for this study (Clarke & Braun, 2017). Narrative analysis centres the stories of 'ordinary people' and recognizes the storyteller as the expert, honouring their knowledge (Fraser, 2004). Narrative analysis aligned with my goal of centring lived experiences of social workers with disabilities. Reflexive thematic coding considers a researcher's own subjectivity as an important aspect of the analysis (Braun & Clarke, 2019). This is important, because my own experience is reflected in the way I analyzed this data. Therefore, the following analysis highlights key themes and presents exemplar quotes that did not merely "emerge" from the data set, but rather are purposefully identified by myself, the researcher, drawing upon the narratives of the participants, my own lived experience, the interview guide informed by the key literature in this area, and explicated in the discussions of the focus group participants.

The remainder of this chapter will briefly review the recruitment, data collection, and data analysis processes as well as presenting the analysis of the focus group discussions. My analysis of this rich qualitative data identified five major themes, which are as follows: 1) Digital Literacy, 2) Privacy, 3) Factors That Enhance Accessibility, 4) Factors That Challenge Accessibility, and 5) Practice Standards in the Digital Domain. These findings illustrate the complexities of accessing virtual care services in social work, including both benefits and drawbacks of social work in a virtual space. These themes are used to organize the presentation of my analysis.

Recruitment

Recruitment occurred over two phases, due to an unsuccessful initial recruitment strategy. Initially, recruitment was undertaken through the McMaster School of Social Work List Serve; however, only a single participant was recruited through this method. A second round of recruitment occurred through my personal Instagram and LinkedIn accounts, using a horizontal-networked outreach approach (Geddes et al., 2017). This resulted in an additional 6 participants being successfully recruited for a total of 7 potential participants.

Due to time limitations resulting from the delay resulting from the need to seek an amendment to my ethics approval I elected to complete only one focus group. In my original research plan I intended on facilitating two focus groups; one with virtual care service users who are neither professional social worker nor paraprofessional helper living with disabilities, and another with professional or paraprofessional helper who have provided virtual care services and who have a disability. However, all the participants recruited fell into this second category of service providers with disabilities. As a result, I decided to schedule a single focus group with all 7 participants, as attrition of research participants is common in voluntary studies, and I expected some participants to drop out before the group was held (Ahern & Le Brocque, 2005). In the end, there was no participant attrition, and the single focus group went ahead with 7 participants who attended that evening.

Participants

A demographic form was sent out to participants following the focus group via Google Forms. Of the 7 participants, 5 replied to the survey; of the 5 respondents, 4 identified as female, and 1 identified as male. Three of the respondents were between the ages of 30-39, one was between 40-49 years of age, and another one was between 50-59 years old. All had participated in virtual care services, and all the participants have provided social work services; one participant is no longer practicing social work.

Method

The focus group was facilitated for 2 hours using Zoom videoconferencing. Zoom utilities were used to support the success of the group which included the use of live captions, embedded transcription, and chat features to enhance accessibility for participants. The resulting transcription was reviewed for accuracy and uploaded to a Qualitative Data Analysis Software (QDAS), called Dedoose, for analysis. QDAS are found to expediate aspects of the data analysis process, such as the organization of data; the process of coding as well as eliminating the need for paper-based manual analysis (Humble, 2020). These benefits of QDAS were appealing to me when considering how to code my data.

Dedoose is a mixed-methods QDAS, allowing for both qualitative and quantitative analysis (Humble, 2020). Based on the methodology employed in my research, my analysis focused on qualitative approaches. Therefore, the information I focused on in the data analysis was participant experience, guided by the questions I posed in the interview guide, and shared through participants' verbal narratives presented during the focus group discussions.

In analyzing these stories of experiences, I used narrative and reflexive thematic coding. This form of data analysis is not focused on determining the "truth" through a literal reading of the data, but rather focuses on meaning-making and stories shared as "read" through the researcher's own subjectivity (Braun & Clarke, 2019). The methodology is consistent with the critical post structural approach I employing as part of my attention to a critical disability perspective (Clarke & Braun, 2017). When reviewing the transcript, patterns that I identified in the data were coded as themes, with smaller sub-themes also identified (Braun & Clarke, 2006). Additionally, the lines of the personal narratives were considered on their own, as well as in comparison to other participants and the ways the conversation unfolded in the focus group (Fraser, 2004). Below you will find selected quotations from the transcript that are interpreted by me as representative of the themes discussed. These exemplar quotes are not exhaustive, but rather are what I felt are present as good examples of the themes revealed in this group discussion.

Summary of Findings

The following section will explore the major themes and their sub-themes identified through the data analysis process. These themes include: 1) Digital Literacy, as it relates to clients and service providers, 2) Privacy, with sub-themes identified here including *private spaces* and *limitations to privacy and confidentiality;* 3) Factors that enhanced accessibility, including *self-advocacy, closed captioning, outreach services, reducing temporal and spatial* *barriers,* and *sensory advantages*; 4) Factors that challenged accessibility, including *lack of access to technology, social worker registration,* and *screen time impacting health*; and 5) Practice standards in the digital domain, including the sub-themes of *therapeutic modalities, hybrid group format, assessments, crisis intervention,* and *boundaries*.

Digital Literacy

One theme that emerged during the focus group analysis was *digital literacy*. Knowing how to use technology is essential for social work practicing in virtual care settings. Some social workers and clients have knowledge of these platforms and technologies available, whereas others do not. Participants highlight this in the ways they have adjusted their practice or thought about adjusting practice, to improve accessibility for clients, including preparing instructions in advance and supporting with setting up technology prior to session. One participant shared:

> I think one of the things that's obviously going to be helpful to enhance virtual care is to have instructions ready to go. Because not everyone, as we talked about, has digital literacy, we can't assume that folks know how to use the platforms. And there's so many different platforms out there that practitioners use. And it can be very, very overwhelming to try and juggle this. I can speak both as a service provider and a service user.

It is important to understand that there are variations in functionality of virtual care platforms and adjusting to a new platform might not always be smooth for clients or social workers. This participant identified the need for instructions made available to clients and the need for support for clients' digital literacy needs by providing instructions before the session takes place. Additionally, this same participant shared that:

> ... when we first started at the agency I was working at, we worked with a lot of older adults who did not have the skills or resources to access technology. So, for many virtual appointments, we would bring them into the office. Set up an iPad, you know, everyone was masked. Get them all set up and then we would be in the other room. So if they did need any troubleshooting for tech, it was there. I think something along those lines is very,

> very, very helpful for folks who may not have access to A) Private spaces or B) might not have the ability to use the technology.

The process implemented above demonstrates how a social worker and the agency they worked at supported individuals with regards to digital literacy in a novel situation. Improving access to the technology used for services ensured continuity of services during the COVID-19 pandemic. Here, the agency worked collaboratively with service users by identifying there was a need for digital literacy support and taking care to ensure service users were comfortable and supported with the setup process.

Another experience highlighted in the focus group was that service providers should be reflective on their practice and potential bias related to digital literacy and the digital divide. One participant shared that some older adults, who possibly did not have exposure or education relating to technology and thus may require a little more support for accessing services, were sometimes left to figure the technology out on their own. This participant shared:

> Being willing to meet people where they're at and like rather than being judgmental about that, just appreciating that you might not understand their experience or the reality of why they might see things like that. I think it would be huge because like I have heard of social workers kind of… a little bit belittling. Just kind of writing off, especially older folks, as not being with the times… and like you being discouraging or making fun of them for that isn't going to help it either.

A key social work value identified by the Canadian Association of Social Workers (2024) is to provide a safe, non-judgmental space for folks to receive support in a way that meets their needs. Not being a supportive presence for clients could negatively impact the trust and the confidence of the client in the social worker’s ability, potentially harming the therapeutic alliance and working relationship. Additionally, not meeting client needs in accessing virtual care creates exclusion from social work services, therefore further impacting one’s health due to the digital divide. Both of the above examples highlight the fact that service providers can make services more accessible to individuals who might require particular support with the technology used; part of this support includes being non-judgmental and providing practical assistance in response to digital literacy needs.

Social workers in the focus group discussed the need to include specific education in virtual care and digital social work for service providers. One participant reflected on their own experience with virtual care, both before and after the COVID-19 pandemic, and how they observe virtual service education continuing to be an opportunity in academia:

> And at first at the time, I was actually very much against it. I was like, nope, I don't want to do virtual. This doesn’t make sense to me. I was very resistant to it. But then, you know, we had a pandemic and it was like, okay, well, this is how I'm going to make a living, right? So I had to learn. And so for me it was really about I had to learn from other people, and just talk to a lot of younger people in the field who were using more virtual services and just gain from their experiences, and be very open to their feedback and information. But school did not prepare me for that at all just because it wasn’t a thing. And even though it has been a thing. I mean, I'm a TA in the social work department at a university. And I would not say that we talk about this very much. I talk about it as a TA because I'm working with students on a foundation of course. But that's me. That's not embedded in the curriculum. That's just me because I'm experiencing it. So I want to let them know. But aside from when we were doing online classes with students, that was not something we talked about.

Thus, while this social worker notes that virtual care education was not formally added into the curriculum, they also recognized the need and supported social work students with some education around virtual social work. Another participant added:

> Yeah, and I think like even on top of that, so we do need to really reinforce like and start teaching… virtual counseling as a foundation. And as part of that, text message counseling as well and chat-based counseling. Because I'm having more and more clients who want to text with me on my work cell phone and I have to kind of put the brakes and look I don't have training in text message counseling. It's a very specific model. So, I have to insist that you can text me for, you know, appointment scheduling, etc. But if you need more of that therapeutic connection, please give me a call. So, I think that's something we have to start instilling more within education is like, you know, how to competently, safely and effectively do text-based counseling and service provision as well.

The above excerpts identify a need to include education for providing virtual care services, such as videoconferencing for social work services, as well as education on digital social work more broadly, such as using technology to schedule appointments. Additionally, the above participant identified a need for instruction on text-based service delivery.

One participant also reflected on the continuity of virtual care, despite the lockdown measures no longer being in effect:

> So there's so many services that are doing at least a hybrid model now, education, social services, as much as possible. Because it's cheaper. And because people want to stay home. And we're not talking about it. So I think we need to talk about it. And I think it does need to become part of our curriculum. It can't just be something that, you know, we've thrown out now because the pandemic is over. This is not going anywhere. You know and there is a place for it so we have to talk about the ways we can make it work.

Participants continue to provide services in virtual format, as well as access services virtually, signaling the likelihood that virtual care is in fact "not going anywhere." Given the potential longevity of virtual care, education around this practice needs to be incorporated into programs in human services.

Additionally, one participant added that if educating social workers on virtual care, there is also a need to provide education about thinking critically and the rationale for providing services virtually:

> Not that we shouldn't do it, but that like I would want it to be accompanied with like a very critical lens towards why we would do it and… through this conversation we see that like there are very, very valid and excellent reasons for learning how to provide great virtual care for people, and then also there are times where we're not actually providing virtual care because it's good for the person receiving care. It's because it's good for the organization, because they can cut down on costs. It's good for the government who can say, oh, actually can provide that, right? ...the education around providing this care is not really there in programs. But some way to do differentiate, like criticize why we're doing it and when it's when it's being done for the person.

This participant's concerns about *who* ultimately benefits from virtual care points to the need for social workers to engage in critical things about practice and whether practicing virtually will benefit the clients they serve. This could be facilitated in social work programs, through additions to the curriculum. Furthermore, experienced clinical supervisors could engage in this critical thinking and support social workers who have already completed their degree but would benefit from reflecting on their virtual practice.

Another participant highlighted some of the specific ways social workers need to engage in critical thinking about the technology being used in digital social work practice, particularly as it relates to surveillance. He shared:

> I teach a critical analysis of social work class at a university in the MSW program, and we do have a whole section on social work and surveillance, and is technology being used to surveillance and monitor marginalized populations. Is technology being used as a tool to I would say surveil and monitor social work itself and are using these tools potentially going to strip away the creativity of using social work and make it more evidence-based instead of evidence-informed. So, I'm very critical of the role of technology within care.

The concerns noted above about surveillance and monitoring of service users, as well as the use of technology to organize digital social work should be a concern for all individuals using technology in their practice. Technology can structure the work, collect data on all parties involved, and thus present newer challenges in social work practice that might not have been present a decade ago. Therefore, while technology has the potential of being a positive aspect in practice, service providers must also think critically about how technology might impact them or their clients. To engage with critical thinking around digital social work, service providers must receive digital literacy training.

Privacy

Privacy considerations were mentioned throughout multiple sections of the focus group. Social workers have the responsibility to respect clients' rights to privacy and confidentiality (CASW, 2024), with certain exceptions. Privacy considerations in virtual social work mentioned by the focus group include ensuring a client is in a private space, as well as explaining the ways that client information can potentially be breached in digital social work. Throughout the transcript, privacy appeared 8 times in the discussion, and sub-themes of *private spaces* and *new limitations to privacy and confidentiality* were identified. Ensuring privacy in digital social work is clearly important for this group, and the excerpts selected below emphasize the importance of privacy in virtual care based on the subthemes which fall under this larger category.

Private Spaces

Focus Group participants identified several concerns categorized as privacy-related issues. These included finding private spaces from which to practice or attend virtual care sessions. The lack of a private location for participation was described as an obstacle in virtual care.

Participants currently engaged as practitioners identified *lack of privacy* as a new challenge presenting during the COVID-19 pandemic. Privacy and confidentiality in the digital social work context became more of a consideration that had to be explicitly outlined when obtaining consent from a client. This was evident in one participant's statement:

> So a lot of clients just not having access to a safe space. Some getting creative and doing sessions from like your car. But these are things that I had to really start to consider and actually wrote into my treatment contract and started addressing during my initial consultation with people just to ensure that they did have a safe space and what that might look like.

The need for social workers to explicitly add this point to their existing contracts indicates a new consideration within virtual social work practice.

This lack of private locations where clients might participate in virtual care is reflected in the following narrative which shares a participant's experiences in relation to their work with youth:

> ...the privacy thing was an issue especially because they'd be in like... home with their parents and if they wanted to say certain things that their parents might not agree with or might not... they felt that their parents might not love. That was hard for them.

These social workers noticed that clients might not feel safe enough to share what they're experiencing if they felt those around them, potentially their parent(s), would not agree with what was said. This can impact the social worker's ability to support a client with what is truly impacting a client's ability to function and thrive, given that clients may be reserved and hesitant to share their concerns.

Another participant reflected the issue of a lack of private spaces as a challenge for many clients as reflected in the following statement:

> "… in the pandemic and one of the big issues that I found at first was privacy. So, a lot of clients just not having access to a safe space. Some getting creative and doing sessions from like your car."

Focus group participants also reported the ways in which they noticed new options for safe and private spaces being carved out for virtual activities, including one participant's observation of: "There were spots on campus at the university that were made available for folks to access connection and private rooms." This quote demonstrates institutions, such as university campuses, recognizing this as a need and creating a solution to meet that need, highlighting this was identified as an essential component to accessing care during a time of change.

Limitations of Privacy & Confidentiality

Participants also identified that conversations around limits to confidentiality and privacy in virtual care and digital social work are different than those of in-person services. One participant highlighted this stating:

> What I really appreciate about their approaches..., anyone I've seen through virtual care is they're very transparent about the limitations of privacy and confidentiality.

Informed consent in social work involves providing clients with specific information about the unique limitations, with regards to privacy and confidentiality, of digital social work. This quote highlights that social workers were engaging in critical thinking about their practice even in the changing landscape of the popularization of virtual care. The social workers' recognition of this potential limitation to confidentiality for this participant seems to have positively impacted the participant's trust in their clinician.

Factors That Enhanced Accessibility

Factors affecting accessibility centred around participants' experience of self-advocacy skills to ensure they accessed *appropriate* services. Additionally, access to needed technology to support virtual care, both in terms of hardware such as devices (e.g. Cell phones, computers, and tablets) and software offering closed captioning. Participants identified outreach services as helpful in continuing services virtually for communities who might not have access to hardware and internet networks. Flexibility in scheduling was noted as a benefit for clients and service providers with disabilities. Additionally, the ability to continue to receive care when ill, and allowing one to provide or receive care in a space that meets their sensory needs were noted as factors supporting accessibility in virtual care.

Self-Advocacy Skills

All participants in the focus group personally experienced accessing virtual social work services. The experience of receiving services personally, as well as participating in the focus group, gave participants parallel processing (McCue & Lane, 1996) experience of both giving and receiving virtual care- even though the contexts may differ. This parallel processing has the potential to enhance empathy and thus the experiences of clients (McCue & Lane, 1996). Through the service recipient lens, one theme presented was the benefit of self-advocacy skills for service users. Participants highlighted that virtual social service delivery introduced new challenges for clients to access appropriate care on a digital platform. One participant shared that:

> Through all of these barriers like and all of these services that I was accessing that are supports or various support services for folks with disabilities, whether that's like job counseling, student accessibility services, or like actual just like straight-up mental health services… the same issues that kept coming up were the self-advocacy thing. So, I think it's like... much more difficult to advocate for yourself within the virtual context, A. because it's so new. And we like basically just like lack there's like representational poverty around the entire thing right... like only halfway through the hermeneutic loop.

This “new” aspect of virtual care introduced new barriers to accessing services, and more importantly, the process of ensuring *appropriate* services were accessed. Navigating the social service system can be daunting, not knowing where to start, or what type of service might benefit oneself, can be a barrier to searching for services.

Another participant noted that:

> ... I don't know how I would have navigated the system, because it's there is a disconnect when there is a virtual service and the practitioner doesn't really know of the services available in your area. I've had to do a lot of system navigation myself. Thankfully because I'm in the field, I'm a little bit better inept to do that than most clients. But a lot of networking calls, [my location] is a dead area for a lot of networking calls. [My location] is a dead area for a lot of stuff. So, it really was left up to me as the client to go on this journey to find something appropriate for myself.

Therefore, when considering system navigation and locating the most appropriate services, individuals had to be able to identify their own needs and assess the potential clinician’s competency to provide virtual services remotely. As the participant notes, their own skills of service navigation from being in the field were critical for them to locate the services they required. These reflections on self-advocacy and system navigation in virtual care identify new skills that might be required of service users, and new considerations for service providers. To facilitate system navigation, community agencies should consider these narratives regarding the difficulties social workers have faced when designing marketing materials and determining how to best connect with the communities they serve.

Closed Captioning

On of the participants shared how her experience with closed captioning software enabled her to provide virtual services to clients, as well as receive services personally. She stated:

> As someone who's been a service user and also a service provider, having automatic closed captioning available for services have been hugely helpful and necessary, particularly during the pandemic. I don't think I would have been able to receive or provide any kind of care, because I wouldn't be able to communicate with people with masks. And that really increased accessibility for me where it is a little bit and has been a little bit of a drawback is. Some platforms that provide care virtually are limited in terms of being able to use this caption. So, for something like Teams or Zoom, closed captioning is embedded alongside privacy and security standards. So, it's easily accessible but for other third party platforms…Through hospitals if you use like [digital information system] virtual calls they don't have close caption embedded, well at least at the time when I use them they didn't. I don't think that's changed. But, [digital information system]doesn't have them embedded. I've used some other third party sites, but [digital information system]is the biggest one that comes to mind. And I have used third party automatic transcription apps. This was at the height of the pandemic. But that also does not necessarily meet privacy and security standards for information. And patients who like don't know where their information is going to and how it's informing those kinds of services. And it's not safe, like for their privacy. So that's also a barrier.

This quote highlights the ways that this social work identified a need for both herself, as well as those she was supporting virtually. This social worker recognized the system available to her through work was not meeting the needs at the time. Recognizing there was alternative technology that existed to support this need, this social worker opted to use what was available elsewhere to ensure her own needs and the needs of service users were met. While this participant was able to find a way to continue providing and receiving services when the technology available by their employer or service provider did not meet her needs, she also recognized that this technology can impact privacy if you need to source it from a third party.

Outreach Services

Barriers to accessing virtual care highlighted by the group include the concepts of a lack of technology to support access to virtual care, such as hardware/devices (e.g. tablets, cell phones), and not having access to appropriate internet service (eg. highspeed internet). In response to these challenges, one participant shared that he and his agency worked to improve accessibility during the pandemic to ensure people could continue to receive care through outreach services:

> "You have to meet people where they are at. I started an outreach team at my agency during COVID for that reason and made a huge difference."

Outreach for virtual services was therefore an offering that was creatively put in place to support the identified need of access to technology, especially during the pandemic.

Reducing Temporal and Spatial Barriers

A benefit of virtual care that participants identified which afforded greater accessibility for individuals with disabilities was flexibility with the time and location of appointments. As one participant, who resides in a rural area shared, the time it would take to travel to-and-from appointments would make receiving this care inaccessible. Another participant shared her experience with neurodiversity and that:

> I have with my neurodivergence, I have trouble with, like I'm very time blind. So, it was a benefit in that I didn't have to worry about like doing traffic math and I got to go pee 3 times before I leave math.

For this participant, planning ahead for appointments and factoring in other challenges related to travelling to an in-person appointment, such as traffic, made attending in-person appointments more challenging.

Another participant shared about their experience when not feeling well:

> I just wanted to mention some positives that I had through my virtual care experience. I really appreciate the flexibility in terms of like when and where I needed it. It was there... I like the grace of virtual appointments in the sense of like if I'm not feeling too well, I

> can keep my camera off. If like I'm sick and coughing like I can reschedule, and they understand and I just appreciate that low barrier approach.

For this participant, not feeling well enough to attend in-person appointments didn’t always mean they had to miss their appointment; if a virtual option was available, they could continue to receive support without cancelling.

Another participant shared similar views around rescheduling and accommodations when clients need that:

> With my certain clients who I know can get very sick on the fly like very spontaneously. I'm not very strict with my late policy, you know, so if they contact me and they say, you know what, I woke up today and I'm throwing up and I feel awful. I don't charge them a late fee. I'm very flexible with them around that, which I've heard is very hard to find. And I do find that my clients don't abuse that privilege. I don't think I've ever had a client abuse that privilege. They only use it when they really, really have to. You know, but that flexibility has been really, really important to people. Because, you know, and I, I need it too, right? So, I really want to honor that with clients and recognize that, you know, people don't abuse those things because they want to abuse them. If you genuinely need that accommodation, you should be able to utilize it.

These excerpts from the focus group highlight the ways that virtual care can increase accessibility for clients who could struggle with making it to appointments on time due to the executive functioning effects of neurodiversity on time management, or who are experiencing physical health symptoms that might prevent them from accessing in-person visits, such as an acute episode of a chronic illness, which could be more frequent depending on a person’s diagnosis.

While virtual care was considered to have benefits regarding flexibility of scheduling, one participant shared how this new flexibility meant that clients were now accessing care from their cars and driving while attending their appointments; a choice that potentially causes risk to the participant and the community as well as reducing the effectiveness of the intervention. The addition of new discussions around being in a safe space, and the "treatment contract" or what responsibilities a social worker and a client each have in the therapeutic process, is highlighted on the following participant quote:

> So when we talked about privacy, there were things that were coming up like a client being in their car driving somewhere while we were supposed to have session. And just being aware of those little things like, we're talking about some heavy subjects and I don't really want you driving a car right now. So, you know. I wouldn't normally go over that in a consult. I wouldn't normally go over that in a treatment contract, but I started to observe these things and put them in my treatment contract. And lay foundations during my consults like. I expect that you're going to be in a safe room, you know, stable somewhere, not driving, not in the process of doing something that could put you or other people at risk. Because that's a concern that we wouldn't otherwise have if we were meeting someone in the office.

This issue presented itself frequently for this participant, and so the social worker felt the need to address these new safety concerns in their contracts and consults. This participant highlights this as a novel situation that was not otherwise considered when someone attends in-person appointments.

Sensory Advantages

Participants also shared the benefits of virtual care as it relates to the sensory needs of care providers and care recipients. Sensory needs are needs based on an individuals' bodily engagement with sensory information in their environment, such as smells, touch, and sound (Brewin, 2022). Two participants described the benefits virtual care provided to support their sensory needs and those of their clients. One participant shared:

> Running my own practice and doing it virtually has made a world of difference for me because there are lots of triggers that got brought into my work with clients or working with them in person. I mean, I enjoy working with people in person, but I mean, I have a

> neurological disorder. It's affected by things like perfumes and scents and various things that would just come in and when I worked in nonprofit it was like okay just deal with it but the client's in my office and now, I'm getting vertigo, and I can't really function very well, and I'm getting my aura... so as someone with a disability that's chronic and always active having a virtual practice has really helped me to navigate my symptoms. And so it helps my clients who have disabilities, but it also helps me work better with them.

This benefit to sensory needs was echoed with another participant adding the following statement:

> I just wanted to affirm the environment control thing so huge. I have like mountains of sensory issues. And just being able to control my environment helps me be that much more focused and intentional... Yeah, as a person, a neurodivergent person, it's just been outstanding.

The above statements demonstrate that the physical environments of some workplaces are potentially not the healthiest environment for those with disabilities, even exacerbating their symptoms. The ability to control one's physical space can be immensely beneficial for those with disabilities, both as a service user and service provider. In this way, virtual care can support the sensory needs of both social workers and their clients.

Factors That Challenged Accessibility

Participants shared various factors they felt challenged accessibility in virtual care, including: *lack of access to technology*, including hardware (devices) and internet networks, limitations imposed on *social workers and college registration* due to regulations impacting practice based on geographic location, and *screen time negatively impacting their health.* The barriers to accessing virtual care that are identified in the below analysis need to be considered, and ideally removed, when accessing, designing, and providing virtual care service.

Lack of Access to Technology

Participants reported that a lack of access to devices and appropriate internet networks negatively impacted accessing virtual care. One participant shared from their personal experience of receiving virtual care that a lack of access to stable and reliable internet was one of the problems faced; they stated:

> … main issue is with internet connectivity, so phone calls were used more often than not.”

> Additionally, this participant noted difficulty with the stability of their connection during the focus group, further highlighting the impact of internet networks on social work practice beyond virtual care contexts.

Another participant added the following statement regarding technology barriers:

> ... who I actually work with mostly right now is like people who don't have a phone consistently. And also don't have access to wi-fi consistently, and don't have access to their own basic needs consistently. Right. So, it's quite difficult for that kind of care to be an option offered.

This lack of access to hardware devices and consistent, reliable wi-fi was identified as a barrier to accessing virtual care, and needs to be acknowledged by service providers prior to offering virtual services.

Social Worker Registration

Another challenge for workers in virtual care identified in the analysis was around registration with social work regulatory bodies, and whether where the social worker or client was located impacted one’s ability to provide or receive services. One social worker shared:

> I think that's the one thing for me like my stance is that you know people understand that I'm licensed in Ontario so if you're in another jurisdiction I don't have that oversight,

> and/or ability, so I make it very clear that you have to you have to reside in Ontario and have informed consent that you're receiving, this is from an Ontario practitioner.

Another participant reflected on her experience with determining where she can legally provide services, sharing the following:

> Yeah, just on that, that was something that I had to do a lot of research on because I was getting people from a lot of different provinces and so I learned that I'm licensed in Ontario through the college of social workers. But I also learned the ins-and-outs of my insurance, which covers me across the country. And the provinces where counseling is not a regulated profession, we can take people from. It's like a really gray area. I found that other practitioners haven't known about that as well and we've kind of, you know, figured it out. Outside of like Quebec, Nova Scotia, and I think Alberta. Those are the 3 where we can't [practice].

Unfortunately, not knowing the standards of where you are legally allowed to provide services could put a social worker at risk of losing their registration. As is shared in the above statements, one provider opted to provide services in Ontario only, while another provider chose to expand to other provinces and territories. However, when practicing outside of Ontario, the social worker shared it's “a really gray area.” Lack of clarity around regulations places social workers at professional risk, which could impact a social worker’s willingness to provide virtual services to people in other geographic locations.

Screen Time Impacting Health

A participant shared how in contrast to the participant’s experiences shared above, where the virtual delivery of social work improved participants’ well-being from a sensory perspective, the digitization of social work and virtual spaces negatively impacted their own well-being:

> … I get migraines when I look at a screen for too long. So, on the one hand having to be a practitioner that is able to offer support online is really good, and then like I myself have a neurologist who's like you should be limiting your screen time so it's kind of difficult there.

Recognizing there are varied experiences between participants and whether technology supported or negatively impacted their health, social workers need to be aware of their own well-being and what their own needs might be to be able to practice in a way that will be supportive to both their needs and the needs of their client(s). Digital social services often require a lot of work utilizing screens (whether that be for research, system navigation, client records management, videoconferencing, and more), and what was shared in this focus group is that the extensive screen time could be detrimental to those who have certain disabilities.

Practice Standards in the Digital Domain

The theme of practice standards in the digital domain explores participants' experiences with the digitization of social work, and how digitization has impacted their practice. Factors highlighted by focus group participants that impact success within therapeutic interventions in virtual care include the following sub-themes: *therapeutic modalities, hybrid group formats, assessments, crisis intervention,* and *boundaries.*

Therapeutic Modalities

Focus group participants shared how different modalities were either compatible or incompatible with the services they received or provided in their virtual social work practice. Participant narratives highlighted that certain modalities did not translate well to a virtual format, specifically somatic-based interventions and interventions with individuals who experience symptoms related to social anxiety. One participant's experience with virtual care from a client perspective shared that:

> … the biggest barrier was some of the modalities that were very beneficial to me weren't as accessible. So, things like EMDR [Eye Movement Desensitization and Reprocessing] and some other somatic modalities that have been absolutely crucial to me. We had to make accommodations in that regard. So, of course for like EMDR, you have a reduced field of vision and there's the issue of like camera distortion, like what's lost in translation. So, when you're when you're trying to rewire your brain it's, I really wonder, how much of a detriment, like I can't say it was all bad. I had a lot of success, but the success came through resilience and adaptation. So we kind of had to like find our own way through that.

Another participant shared how as a service provider, their experience with providing virtual care for individuals with social anxiety, who would likely benefit from leaving their home, was a "drawback." This participant shared:

> Yeah, just to kind of tie into it, just from the practitioner standpoint, I think that's been the biggest. The drawback of virtual care is that I notice a lot of my folks who struggled with social anxiety, agoraphobia, getting out of the house and that those were some really big goals for them. Oh, we had a lot of setbacks and it's taken quite some time to kind of get back into that routine.

Also related to specific modalities, one participant shared how virtual care is ineffective in her work with unhoused individuals who are focusing on having their basic needs met:

> So I was just gonna say that the other thing that I should probably mentioned about in terms of my work with people. So like right now I work with people who are unhoused and who use substances, and I think if we're talking about virtual care with different people who might, yeah, have difficulty accessing that kind of care, like the folks that I work with. It does not work to offer to have mental health support, or you know any other kind of support, being offered virtually. And in fact, we only see any kind of like quote unquote "success" with supporting people when we bring practitioners to the place where people are.

What is essential from these experiences is considering how specific modalities, and virtual care in general, may not be most appropriate for certain needs, specifically those that might perpetuate avoidant behaviours, such as the social anxiety symptoms mentioned above, somatic work, and with individuals who benefit from more practical support in-person. Similarly to social work pre-digitization, service providers need to consider the ways that certain modalities support or hinder the work with clients.

One participant shared how she modified her virtual practice to support the needs of clients who would benefit from modalities encouraging them to leave their home, stating:

> Yeah, I think as a practitioner and someone who struggles with some of these challenges, it forced me to be creative and as social workers, those of us in the room are social workers. We tend to be creative, right? So, you know, a big thing for me was troubleshooting with my clients and maybe doing a walk and talk. Right? So, okay, we identify this is the problem. I do relational work. It's a problem for me too. So I'm going to get my phone. And we're going to go for a walk, right? You on your phone, me on my phone. Let's just get outside. Let's just see how that feels. Let's sit in that feeling. Let's do that piece and those were some of the things that I found really, really helpful for my clients that were struggling and also for myself.

Here, the social worker was describing the creative way she encouraged clients to leave their home in times where the potential safety of the home would be counterproductive in the intervention, such as with individuals with agoraphobia or social anxiety. This social worker was able to identify a need and modify her practice in the virtual context to create an intervention that was supported by the available technology and virtual care.

Hybrid Group Format

Another form of service delivery via videoconferencing, called a hybrid group, which is where some service users are in-person and others participate online, was reported to have been a challenge to facilitate. One participant shared:

> I would say one of the biggest challenges that did not meet the needs was, kind of just when we were in that weird bit of in-between phase when we are doing hybrid groups that were a mix of virtual and in-person. The problem was that the folks who are coming into

> the groups virtually felt quite disconnected from everyone in the room in person, and as a group facilitator, it was really hard for me to… keep eye contact with folks in the room and then also try and look at the screen. And then trying to talk like, Hey, I notice this person on virtual is distracted, doing something else, and trying to bring them back into the group and stay present with the [in-person] group. So, that is one of the big things that we found did not work well.

The delivery of hybrid groups presented a new challenge for this participant, and the format of the group seems to have required quite a lot of attention in different areas simultaneously. This division of attention presented a new challenge that in-person groups might not have previously.

Assessments

Another benefit of virtual care noted by a participant is that videoconferencing allows the service provider to virtually enter a client's space. This participant shared how they could assess clients differently from how they had assessed previously in-office. The example that was shared is:

> One of the things that I found made maybe a little bit more effective in virtual care is for folks who would only come to see me in the office, where I was able to get an idea of the environment a little bit more. So, one of the things so clients would say, you know, I'm not doing so well. And it's, well, can you help me understand what's going on, then they'll be like, well, you know, look at my room and they actually take their camera and show me what their room would look like. "See, like, I'm not staying on top of things." And then you will say, "Wow, you are right. You're really struggling right now. Let's figure out a plan to get back on track." and things like that are really helpful. With food insecurity, they would actually open up their fridge and say, "Look, I don't have any food right now." So then from a case management standpoint, I would get them resources. You know, get them linked up for food bank, etc.

This quote highlights that while a social worker in some agencies/roles might have been able to see the client in their environment prior to virtual care, with the advent of videoconferencing, social workers who would not typically enter the client's environment now had an additional means to assess their client at home or in the community, supporting the worker's ability to address a client's needs appropriately.

Social workers also shared ways the virtual environment negatively impacted their ability to assess clients. Assessment is key in practice to providing appropriate, timely, and safe support. One participant stated:

> If we were in person, I'd be able to pick up that the clothes might be a little bit "off" or they might be more disheveled or those things you can hide or keep together online. So it's really difficult for me to sometimes get a full assessment of where someone's at with their mental health. And in fairness too, when I've been sitting with my therapist, I've had some days where I know I'm holding it together a lot better than I might look in-person and so he's not necessarily getting the full story either.

Virtual care has some added benefits for completing assessments in context where in office visits were previously the norm. For example, virtual care allows for a "virtual visits" allowing the social worker to virtually enter a client's space, as was previously discussed. However, virtual care does place limits on some senses. For example, olfactory senses are not engaged, and visually, what is shared is what the client wishes to share, as demonstrated in this participant's experience. As this participant points out, she is able to recognize that as a service user, there are ways to conceal how a client is "really" doing, as she has done in the past.

Crisis Intervention

Crisis intervention in a virtual context was a new situation for some practitioners, and was introduced without proper training for some. While crisis services have been offered through phone lines historically, such as lines provided by the Canadian Distress Line Network that started in 2002 (Government of Canada, 2024), participants found virtual crisis intervention challenging and difficult to navigate at times when they have not received proper training. The concerns around crisis intervention in virtual care were apparent when the primary form of service was not a crisis service. One participant shared their challenges with crisis situations in virtual care:

> Yeah, I think speaking to that as a service provider. I have really struggled with crisis situations from a virtual standpoint. Just because if someone is in crisis it's real it could be really, really difficult when you don't have that human connection in person. I find it so much easier to, you know, engage in some mindfulness, figure out the context of the crisis. Creating a safety plan and making sure that you're going to be okay once you leave my door. I've had situations when someone is in crisis virtually and then we have a bad internet connection. I can't get back to connecting with this person. Then my anxiety levels start to go up and because I'm bound by duty to report harm to self or others. I have had to make the really unfortunate decision sometimes to do a wellness check, which probably isn't needed, but I'm bound to do it. And I have found that, again, some of those trespasses and those breaches that have confidentiality. When I'm doing crisis intervention in person, having that face space so I can do a really thorough assessment, build safety and make sure that the person's okay.

The above quote illustrates this participant's discomfort around responding to a crisis through virtual services, where in this role, this participant would not normally support crisis intervention virtually. For this participant, he found he could better support individuals in crisis when he was face-to-face with a client, and in-person. The additional complexities introduced by duty to report and technical issues resulted in an ethical dilemma for this participant.

Another participant shared their experience with crisis services as a client in virtual care:

> One thing specifically for mental health services. I think that's super important to keep in mind is especially with, bound geographical boundaries not really being an issue in virtual care. We really need to be aware of the crisis lines available in the geographical area that your client is living in. I've had a couple of therapists, which I've steered clear of because when I asked the question of like, okay, so what do I do in a crisis? Their answer is really… not of a great help.

Crises can bring up a lot of emotion for service providers and clients. The participants' reflection that at times, they felt their anxiety rise in the context of crises during virtual care where connection was lost, is understandable. Without direction on how to support a client through a crisis virtually, or what to do if connection is lost, was a novel situation that this participant needed to navigate. The experience of the one participant as a client who was seeking supports, and in screening potential providers, noted the lack of knowledge of crisis supports in other regions by her potential service providers, and she was able to identify this as a knowledge gap of the provider. These experiences highlight the need for service providers to work on building their own skills or receive additional training in supporting clients in crisis appropriately if providing virtual care.

The above analysis demonstrates that as social workers, we need to engage in critical thinking around the ways we approach services, to determine what may and may not be appropriate virtually.

Boundaries

Another practice consideration presented by the participants is how to address boundaries in a virtual care context. Prior to the pandemic, most social workers worked outside of their own home created a divide between work life and personal life. However, with the lockdown conditions of the pandemic, many social workers shifted to providing services from their own space. One participant shared:

> I think from a self-care standpoint, I found doing virtual care primarily a detriment to my own self-care because I was practicing, you know, within my own environment and all of a sudden work and home became quite a mesh in each other.

Another participant added:

> And one of the things that's really helpful for me is recognizing work is work. And home is home and that did not happen during you know the lock downs and everything and it just became really, really, really messy. So I personally I prefer doing my appointments at the

> office, whether it be virtual or in-person, because then I can have my two different environments where social work guy is and then where not social work is and that has definitely helped me.

These social workers felt that practicing social work from their personal space negatively impacted their well-being. This should be considered before social workers provide services from their home, as two participants in this focus group noted that providing services from their personal home was not ideal.

The above analysis demonstrates some of the complexities and nuances of virtual care in social work practice. The major themes of digital literacy, privacy, factors that enhanced accessibility, factors that challenged accessibility, and practice standards in the digital domain each contain sub-themes that provide details of social workers with disabilities' personal experience in receiving and providing virtual care services. What follows is a discussion of this research and its implications for the future of virtual social work practice.

Discussion

This thesis explores the personal lived experiences of social workers with disabilities who provide and receive virtual care services, in an effort to answer the research question: *What are the best practices for improving accessibility for individuals with disabilities in virtual social work practice?* The initial plan for this project was a study that included at least two focus groups was unfortunately impacted due to sampling and recruitment. As a result, a single focus group was conducted.

The focus group discussion uncovered the following themes: digital literacy, privacy, factors that enhanced accessibility, factors that challenged accessibility, and practice standards in the digital domain. These overarching themes identified through reflexive thematic analysis of the participant narratives highlight areas of virtual care identified by social workers with disabilities that should be considered for further research.

The following chapter presents my consideration of the themes identified through the process of data coding and provides analysis of the meaning made from these themes informed by my own knowledge as social worker as well as considering the meaning made based on the current literature. From the identified themes, a list of proposed best practices for virtual care are outlined for practicing social workers to consider when delivering virtual care services. Limitation and reflections of this research are also explored, followed by implications of this research on the social work field and future possibilities.

Digital Literacy

Digital literacy was a significant theme in the focus group. A focus on digital literacy was anticipated due to the dominance of this topic in previous literature (Byrne, 2023; Earle & Freddolino, 2022; Reamer, 2023; Zhu & Andersen, 2021). Participants highlighted the ways they supported clients with virtual care sessions, for example, inviting them into the office to set up the technology, or having a set of instructions for clients to follow to access the appointment. The importance of support is also reflected in the scholarship of Thomas et al. (2022), where the authors note that support with setting up technology is essential to ensure the client is comfortable with the technology used for the appointment.

The notion of the digital divide was also discussed by the focus group members. Those members of the group who engaged in practice noted in particular, this ‘gap in knowledge’ was evident with older adults seeking virtual care. This theme is clearly reflected in previous literature which clearly indicates that the digital divide can be reframed as an opportunity for improvement, not just within social work context, but in society more generally (Detlor et al., 2022; Krysta et al., 2021; Byrne, 2023; Julien 2018; UNESCO, 2022). Given the potential benefits that digital literacy could have in society, in particular the opportunities noted in the focus group, such as improving accessibility to virtual care, more digital literacy training should be offered and made available to social workers and clients. The digital divide will not be solved immediately, therefore social workers need to be provided with ways to support clients who would benefit from virtual care, to ensure they are comfortable with using the technology prior to attending virtual appointments (Thomas et al., 2022).

Participants noted their education was insufficient in the area of digital literacy and virtual care practice. The *Standards for Technology in Social Work Practice* (NASW, 2017) outlines that digital literacy is a required skill for social workers to practice competently in the field when using technology; however, participants in the focus group noted they have not received formal digital literacy training either within their social work education or within the context of their employment. While some social workers took initiative to learn from other social workers when they felt they needed support with these skills, few formal resources were made available in the field. Social work regulatory bodies need to modify curricula and ensure that schools of social work include education in the areas of virtual care and digital literacy to support this identified gap in social worker knowledge.

Some participants discussed the approach they use to support digital literacy in their work with newer social workers. One participant who is currently working as a Teaching Assistant noted that they intentionally ensure virtual care is covered as a topic in the classroom where they teach. These learnings from the participants highlight concerns around a lack of training in virtual social work highlighted in previous literature continue to this day (Byrne, 2023; Sage & Singer, 2023; Reamer, 2023). Given the prevalence of daily digital social work tasks in contemporary practice, schools of social work, employers, and clinicians should work collaboratively to ensure that digital literacy and virtual care skills are taught and continually upgraded as technology changes. A focus on continuous development in digital literacy skills for social workers will ensure current and future social workers will possess the relevant skills to support service users through technology changes.

Privacy

An emerging challenge for social workers providing virtual social work was the issue of privacy. One of the central issues related to privacy that presented within the focus group discussion was the need for private spaces to facilitate sessions/service meetings between social workers and clients. Some participants highlighted the issue of clients attending their appointments from their vehicle; this was described as a new phenomenon not previously faced by the participating social workers. This phenomena of in-car attendance by service users/clients was understood to potentially pose a safety risk to clients, a factor which had to be considered by social workers engaging in virtual care. Some participants noted that concerns about in-car attendance needed to be added to their service contracts to ensure safety of clients. Participants highlighted the need to facilitate discussions around distracted driving and safety with clients who elected to undertake social work interactions while driving.

The sub-theme of *private spaces* was not a theme identified in the literature review, however its prominence in the group discussion suggest the need to offer an important consideration for practicing social workers in the future. In contrast, concerns around privacy and confidentiality in the literature tend to focus on other new situations social workers could encounter in their work, such as recordings of their sessions being posted virtually on social medial sites (La Rose, 2019). Additionally, the potential of clients locating their social workers online is another privacy issue that has resulted from digitalization in the field (Byrne & Kirwan, 2019).

Participants also shared the consideration of “private spaces” should be explored with new clients, especially with children and youth. In situations where someone may not be allowed to speak openly, such as in a house where family members could overhear, may require other approaches to safeguarding privacy or to alerting people to the fact that privacy may be lacking during a particular intervention. If virtual services are preferred by clients, there may be an opportunity for social workers to support the client with locating a private space they can access, such as at a library or other public location, as identified by participants, that can facilitate an accessible but private online appointment.

Factors That Enhanced Accessibility

Participants in the focus group shared, as persons with disabilities, suggestions about the ways that accessibility was enhanced by virtual care. These suggestions included self-advocacy skills to ensure client needs are met in virtual spaces; offering closed captioning to support those who require captions to be able to fully participate in virtual care sessions; outreach services to provide services where clients might not have access to wi-fi or devices; reducing temporal and spatial barriers to support those who might not be able to physically get to an appointment on time, which included the ability to continue to receive care when ill and the ability to access services outside of their geographic area; and allowing one to receive or provide virtual care in a space that meets their sensory needs.

Self-advocacy was another sub-theme that emerged during the focus group. When I conducted the literature review, self-advocacy was identified in the relevant scholarship as an element to be investigated within virtual care and digital social work, specifically as it relates to advocating for services users to have the option to receive services virtually (Thomas et al., 2022). However, the social workers in the focus group clearly outlined the ways that they and their clients had to take control of their own care, and advocate for their needs to be met.

For instance, one participant discussed the importance of knowing what kinds of questions to ask potential therapists during consultations to ensure she was receiving the most appropriate care. However, this participant also identified that many clients would not have this level of experience, and thus might be at a disadvantage when it comes to navigating virtual supports. With this knowledge, social workers should consider exploring virtual care-specific questions when meeting with clients, such as the client's location and crisis services available.

The literature also demonstrates the capacity of virtual care to support accessibility, specifically in terms of scheduling and providing much-needed services in remote locations, as well as providing access to specialists virtually in spaces and places where there is limited access to these service providers (Olsen, Fiechtl, & Rule, 2012; Boon et al., 2022). As one participant shared, she recognizes her services can benefit many individuals with specific needs nation-wide. This participant supports specific diagnoses, and individuals may not be able to source these supports locally, depending on their location. Therefore, increasing reach for specialized services is one way that virtual care can support accessibility needs.

What was not identified in my literature review was the benefit of one's own space to support sensory needs, or the use of closed captioning/transcription in virtual care. The potential of virtual care to support sensory needs by facilitating sessions in a space that is beneficial to an individual's sensory need differences can ensure that more individuals can access the care they require to support their well-being. The use of closed-captioning is immensely beneficial for individuals who require the use of closed-captioning to fully participate in virtual care. Further research in specifying the ways technology could support different needs is required, especially for clients who might lack awareness of the ways they may benefit from different technologies, possibly because they have not yet received a diagnosis. If an individual is unaware of their own needs, or what technology is available to support accessibility, this could create a barrier to accessing virtual care.

Factors That Challenged Accessibility

Significant barriers to accessibility in virtual care were identified by this focus group. One significant barrier, echoed in the literature, was the issue of access to the technology required for virtual care (Byrne, 2023; Julien, 2018; Peláez et al.; 2023; Singer, 2023; Thomas et al., 2022; UNESCO, 2022). Offering virtual care services can be beneficial; however, as participants shared, it was apparent that some individuals do not have access to technology, including both hardware (devices such as computers and cell phones) and/or software (such as videoconferencing software or closed captioning software), or reliable internet service. Participants shared that clients who struggle to meet their basic needs often do not have the financial resources to access virtual care, or network access. Reflecting the significance of this issue, the Government of Ontario also published a news release in March of 2024 outlining the steps the government is taking to improve infrastructure for internet networking access in the province. Based on the feedback within this focus group significant steps must be taken to ensure that technology access for virtual care is equitable across the province in urban and rural locations.

Another obstacle identified by focus group participants related to virtual care was the issue of access to supplemental materials that might be required by clients within a virtual care context. This included factors like, ensuring clients had appropriate materials available to support their full participation, such as worksheets that might not be as accessible to clients in a digital format; familiarity and capacity to use technology-based resources and support, such as accessibility utilities like closed captioning and increased font sizes. For example, one social worker's need to facilitate the use of a closed-captioning service when captioning capacity was not embedded in the platform the service agency required workers to use. Another example included modifying practice techniques to support service users' desired outcomes, such as improving social anxiety-related symptoms; in this case one social worker shared her thought of providing a "walk and talk" service to clients who needed to leave their home as a component of intervention.

Similarly, examples of adapting to hybrid practices to meet clients' needs in unique circumstances were also found in the literature. Examples of adaptations related to providing services when physical limitations would impact access to care include the concept of the *Garden on the Balcony* study, reflected in the work of Wang et al. (2022), that used a web-based chat service called WeChat to create a virtual community to support group members coping with isolation during the COVID-19 pandemic lockdowns in China. Another example presented in the research literature explored U.S. veterans' accesses to appropriate digital supports when travel to a facility would be too cumbersome/costly (Spooner et al., 2019). This study demonstrated ways and means to provide arts-based therapy remotely to support veteran recovery.

Social work practice has encountered barriers to accessibility during the transition to digitization of social work and the provision of virtual care services. The structural and systemic issues impacting accessibility to virtual care, demonstrated in the lack of internet networking in Ontario, as well as limited access to technology devices (hardware) and software, need to be addressed in policy changes. Social workers can support accessibility in the ways they ensure clients have the materials required for intervention, advocating for equitable care in virtual service delivery, as well as developing new ways to deliver care to those who cannot access in-person support.

Practice Standards in the Digital Domain

The participants identified the ways that digitization and virtual delivery of social work services impacted their practice. The practice standards highlighted by the focus group, parallel those found in the literature and include modality-specific practice in virtual care, assessments in the digital context, crisis intervention, and boundaries.

The participants indicated, based on their experience in both accessing and delivering virtual care, certain modalities did not translate well to a virtual format. Social workers identified Dialectical

Behavioural Therapy (DBT), Eye Movement Desensitization and Reprocessing Therapy (EMDR), and somatic therapies, as challenging approaches to master in a digital context. One participant reported that having a "reduced field of vision" with EMDR impacted their ability to derive benefits from this modality. The literature demonstrates that online EMDR has been shown to be beneficial (Yurtsever et al., 2022); however, a myriad of variables between service delivery could have occurred to produce the difference between this participant's experience and the available scholarship.

Additionally, participants identified the need for exercising caution when supporting individuals with symptoms of social anxiety and agoraphobia, as participants found anxious symptoms and the avoidant behaviours associated with these experiences were exacerbated by virtual care, resulting in the worsening of symptoms. Attention to which modalities translate well to virtual format is also echoed in the literature, with research supporting the use of cognitive-behavioural therapy (CBT), support groups, and hospice care (Azy et al., 2007; Ramsey & Montgomery, 2014). More research will need to be conducted in specific modalities, as well as eclectic social work, to determine which counselling modalities might support individuals best in virtual contexts.

Another practice standard highlighted in the analysis included crisis situations. When delivering social work services in crisis situations, participants shared that they struggled when faced with an ethical dilemma of protecting a client's privacy and confidentiality, versus calling for a safety check when service connection is lost. Additionally, participants shared that service providers need to be aware of crisis services available to that person, specific to the client's region. The literature review did not highlight crisis situations in virtual care; however, crisis was noted in relation to assessing a client's ability to provide informed consent to Terms of Service agreements when in a state of crisis (Goldkind & Wolf, 2020). Further research should be conducted on the ways that virtual care service providers can competently address safety needs in times of crisis.

Licensing as a virtual care social worker also presented challenges for participants in the focus group. One participant shared their practice of explicitly outlining in their service contracts that clients will be receiving services in Ontario only. This is important because of the OCSWSSW requirement that clients receive services in the province by whom the social worker is licensed (Ontario College of Social Workers and Social Service Workers, 2024). Ensuring that service users are receiving ethical care is an important concern, even in virtual care contexts. Another participant shared that they felt their services were required to specific populations, and so the decision to practice in other provinces and territories required research on their part, noting it was a "gray area" to navigate. Indeed, the OCSWSSW (2024) directs practicing social workers to contact the regulatory body of the area the client is in for further guidance, rather than clearly outlining cross-jurisdictional practice guidelines. Given that physical boundaries do not exist in virtual care, clearer guidance is required from regulatory bodies regarding licensing to ensure social workers can practice ethically.

Boundaries specific to virtual care were another theme discussed in the focus group. Initially, the discussion focused on social worker self-care in relation to working space versus home space. The literature review highlighted professional boundaries related to access to practitioners outside of scheduled working hours (Aroles, Mitev, & Vaujany, 2019), looking up clients/providers on social media (Richards et al., 2018), and separating the therapeutic and work from home space to support self-care (Aroles, Mitev, & Vaujany, 2019). While the group did not raise concerns regarding being accessible outside of working hours, or clients researching them online, separating work from home was very important for the participants. With some employers reducing physical space in offices due to the ability to work from home, to support employee wellness, employers should consider maintaining optional office space to support the separation of work hours form personal life. More research on how working from home as a social worker or helping professional impacts one's wellbeing could be beneficial.

Finally, virtual social work centred around the various components of a biopsychosocial assessment was discussed by participants. Participants highlighted, the ability to host videoconferencing sessions afforded social workers a glimpse into a person's living space, perhaps offering insights and key details around how a client is currently functioning. In contexts where in office visits rather than in-person home visits are the norm, video conferencing provided greater insight into clients' personal space. However, participants also noted videoconferencing also has the potential to limit information, as clients can as easily positions themselves such that the camera view offers only what they would want the service provider to see. Service users also can blur backgrounds, or select a virtual background from a list of background options, which could also impact assessment. At times, this could mask safety concerns, specifically around issues of hygiene. The issue of what might be occurring off-screen, such as another individual listening in or the interaction being recorded was also discussed. Within the literature, La Rose (2019) found that sousveillance is a newer phenomenon that social workers did not have to be concerned about in the past; however, with advancing technology, and critique of power structures related to the role of social workers (such as in child protection services), sousveillance creates a method of observing and managing the work by those who typically hold less power in these situations. Social workers should weigh the risks and benefits of offering virtual care services, and whether an assessment would need to be conducted in-person to appropriately support clients.

Best Practices

Based on the findings and discussion above, I felt that a summary list of "best practices" would be a beneficial tool to support future virtual social work services. The focus group was a small group and thus not representative of the population as a whole. However, the themes highlighted by the focus group parallelled many of the themes identified in the literature review. This thesis identified a lack of direction and education in virtual care guidelines as an opportunity in social work practice. The following best practices for social workers have been identified by myself, based on my reflective thematic analysis and literature review, to support individuals with disabilities in accessing virtual care:

1. Assess digital literacy levels of clients and be reflective of your own digital literacy skills, prior to the first appointment, and provide support as needed. This could look like demonstrating setting up technology or providing instructions beforehand.
2. Facilitate securing private spaces for virtual care, if a need is identified (such as a private room in a library or other public space).
3. Be knowledgeable of and ensure clients are aware of privacy and confidentiality differences in virtual care, and include these topics in service contracts, as well as in consultations.
4. Create a safety plan with clients outlining what to do in a crisis. This includes reviewing what might happen if connectivity is lost, so that clients and social workers can make informed decisions whether virtual care is appropriate.
5. Critically assess whether the client will benefit from virtual care and be aware of the limitations to virtual care based on specific modalities. Check in with the client regularly and adjust as needed.
6. Consider whether yourself or your client might benefit from accessibility support, such as closed captioning. Implement support as necessary.
7. Be critical about the level of support you can competently provide in remote virtual care work. Be knowledgeable of relevant resources in that area.

The best practices suggested above reflect the key themes identified during the focus group conducted for my thesis research. Based on the themes emerging from the focus group and literature review, significant structural and policy changes would be required to optimize virtual care in the future. Structural changes that support access to technology and wireless networks (in terms of both infrastructure and cost (Government of Ontario, 2024), are barriers to widespread virtual care offerings. Additionally, regulating bodies for social work provides vague guidance when it comes to digital social work and virtual care. Clearer expectations for social workers practicing virtually are required to support ethical service delivery. Finally, schools of social work must start to include digital literacy and virtual care as key aspects of social work educational curriculum.

Limitations & Reflections

This research, while important, also comes with its limitations. To begin, this research is limited in scope and offers only soft generalizability due to the small sample size and is thus not representative of the population. The focus group participants were social workers who identified as having a disability, and as such the sample was not diverse. Participants shared diversity in areas of disability, with participants sharing lived/living experience such as neurodiversity, mental health, and physical health. Additionally, the majority (80%) of the sample identified as female – which is reflective of the gendered nature of social work practice with 86% of all social work identifying as women (La Rose, 2019). There were only 7 participants in the focus group, which is a comfortable size for a focus group but a small sample size for the overall study. Ideally, at least two focus groups would have been conducted with 4-7 participants in each. Challenges in recruitment and the limitation of a master's thesis timeline contributed to this small sample size. Future research should be conducted with a larger sample size to include diverse perspectives related to virtual care and accessibility.

Another factor that might have impacted recruitment is the inclusion criteria of having received virtual care personally. Those who consider themselves digitally literate and felt comfortable with technology may have been more inclined to participate due to this inclusion criteria. Facilitating the research through videoconferencing could have acted as a barrier to some individuals wanting to participate. This limitation was noted while reviewing the data. In the future, alternative options for participation, such as over telephone, or in-person, might better support various levels of digital literacy and encourage more participation.

The restriction of time also impacted what was discovered in the focus group. I would have ideally had more time with the group, though this is difficult to anticipate in advance. Because the focus group was intended to be held for 2 hours, I was hesitant to request participants to stay for any additional time. I was also hesitant to reach out to participants after the focus group, as the expectation of time was clearly laid out prior to consenting to participation. However, if I had additional time near the end of the focus group, I would have used this time to review the key themes discussed, clarify any questions, and collaboratively develop the list of best practices for virtual care.

Another factor that might impact the findings presented would be my own ontological and epistemological positioning. Because the group did not collectively develop the best practices proposed in this thesis, but rather the best practices were identified based on my use of reflexive thematic coding and interpretation of the data, ultimately the findings are mediated by my own worldview and subjectivity. Furthermore, this analysis is filtered by my theoretical framework rooted in post structural critical theory. This is another area where community-based research (CBR) would be beneficial in future research, to ensure the lived experiences of those who have disabilities and access virtual care can develop the research questions most salient to their experience and reflect on the best practices for their own care.

As I reflect on this research process, I am able to identify ways I would adjust my approach in future research endeavours. To begin, this was my first time recruiting for research with participants. In the future, I would develop a more robust recruitment strategy, especially if my research is with a specific group of individuals, such as individuals with disabilities. I would allow more time for recruitment and start building connections with the community prior to engaging in research. Completing community-based research from start-to-finish would also be a priority with additional time, as I do feel strongly that the community should design the research that impacts them. Additionally, I would ensure I conduct a member check after the thesis is written to verify that participant stories and perspectives are accurately portrayed prior to publication. These are my main takeaways from this process that I would adjust in future research projects.

Implications

This thesis serves to reflect the personal experiences of those with disabilities, who provide professionally and receive virtual care personally. Their contributions play a role to fill knowledge gaps in virtual care processes to hopefully support social workers with providing excellent virtual care in the future. As was outlined above, virtual care in social work can be both a positive and negative experience, depending on who is providing or receiving the service and its context. The best practices outlined consider what might be in the control of the social worker and client; however, further research into virtual care practices and improvements in structural support for those who need virtual care, and policies to assist with outlining standards of care in virtual work are also needed. Given the best practices listed, and the discussions that took place in the focus group, a key message for social workers should be to educate yourself on virtual care, assess and re-assess whether virtual care is meeting your client’s needs (as well as your own), and continuously reflect on your practice in collaboration with the client.

Future Possibilities

It is my hope that this thesis will serve as a catalyst to a larger discussion around accessibility, virtual care, and how social work can dismantle ableist service delivery formats to facilitate more equitable service delivery in the future. The viewpoints presented in this thesis highlight the narratives of a diverse group of community members who are experts in their own experience. I hope that policy makers, institutions, and individual social workers work diligently towards social justice, as it relates to virtual care, using this thesis as a starting point to inform themselves and society of the necessity of accessibility in virtual social work.

Presented with time constraints in the MSW program, and a lack of personal participation in the disability community, Community Based Research (CBR) was not feasible for this thesis. In the future, I would like to apply CBR principles to research, including members of the community for every step of the research process (Kwan & Walsh, 2018). The choice to amplify the voices of those who have disabilities in this research was intentional and aligned well with the tenets of Critical Disability Theory (Hosking, 2008; Meekosha & Shuttleworth, 2009). This was my way of including the viewpoints and lived experiences of those who potentially experience oppression, in the form of ableism, to ensure their voices are heard, and affect change in the future of virtual care services.

The above findings highlight that while virtual social work can improve accessibility, disability is heterogeneous, and therefore what works for one person may not work for another. This research is timely and relevant, and future research on virtual social work should be conducted with the disability community to ensure that services are equitable and meet the needs of service users.

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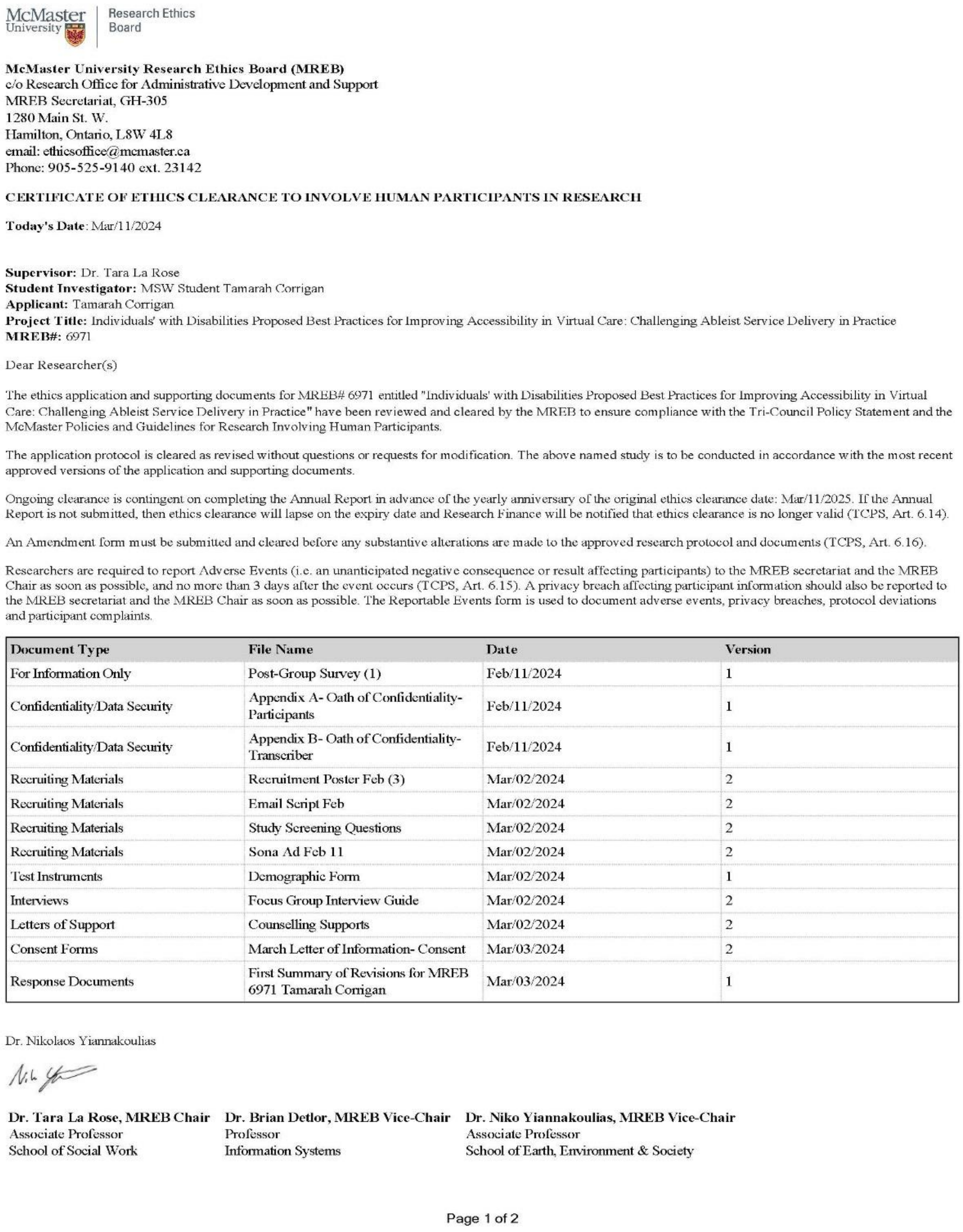
Appendices

Appendix A : Ethics Approval



McMaster University | Research Ethics Board

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CERTIFICATE OF ETHICS CLEARANCE TO INVOLVE HUMAN PARTICIPANTS IN RESEARCH

Today's Date: Mar/11/2024

Supervisor: Dr. Tara La Rose
Student Investigator: MSW Student Tamarah Corrigan
Applicant: Tamarah Corrigan
Project Title: Individuals' with Disabilities Proposed Best Practices for Improving Accessibility in Virtual Care: Challenging Ableist Service Delivery in Practice
MREB#: 6971

Dear Researcher(s)

The ethics application and supporting documents for MREB# 6971 entitled "Individuals' with Disabilities Proposed Best Practices for Improving Accessibility in Virtual Care: Challenging Ableist Service Delivery in Practice" have been reviewed and cleared by the MREB to ensure compliance with the Tri-Council Policy Statement and the McMaster Policies and Guidelines for Research Involving Human Participants.

The application protocol is cleared as revised without questions or requests for modification. The above named study is to be conducted in accordance with the most recent approved versions of the application and supporting documents.

Ongoing clearance is contingent on completing the Annual Report in advance of the yearly anniversary of the original ethics clearance date: Mar/11/2025. If the Annual Report is not submitted, then ethics clearance will lapse on the expiry date and Research Finance will be notified that ethics clearance is no longer valid (TCPS, Art. 6.14).

An Amendment form must be submitted and cleared before any substantive alterations are made to the approved research protocol and documents (TCPS, Art. 6.16).

Researchers are required to report Adverse Events (i.e. an unanticipated negative consequence or result affecting participants) to the MREB secretariat and the MREB Chair as soon as possible, and no more than 3 days after the event occurs (TCPS, Art. 6.15). A privacy breach affecting participant information should also be reported to the MREB secretariat and the MREB Chair as soon as possible. The Reportable Events form is used to document adverse events, privacy breaches, protocol deviations and participant complaints.

Document Type	File Name	Date	Version
For Information Only	Post-Group Survey (1)	Feb/11/2024	1
Confidentiality/Data Security	Appendix A- Oath of Confidentiality-Participants	Feb/11/2024	1
Confidentiality/Data Security	Appendix B- Oath of Confidentiality-Transcriber	Feb/11/2024	1
Recruiting Materials	Recruitment Poster Feb (3)	Mar/02/2024	2
Recruiting Materials	Email Script Feb	Mar/02/2024	2
Recruiting Materials	Study Screening Questions	Mar/02/2024	2
Recruiting Materials	Sona Ad Feb 11	Mar/02/2024	2
Test Instruments	Demographic Form	Mar/02/2024	1
Interviews	Focus Group Interview Guide	Mar/02/2024	2
Letters of Support	Counselling Supports	Mar/02/2024	2
Consent Forms	March Letter of Information- Consent	Mar/03/2024	2
Response Documents	First Summary of Revisions for MREB 6971 Tamarah Corrigan	Mar/03/2024	1

Dr. Nikolaos Yiannakoulias

Dr. Tara La Rose, MREB Chair	Dr. Brian Detlor, MREB Vice-Chair	Dr. Niko Yiannakoulias, MREB Vice-Chair
Associate Professor	Professor	Associate Professor
School of Social Work	Information Systems	School of Earth, Environment & Society

Page 1 of 2

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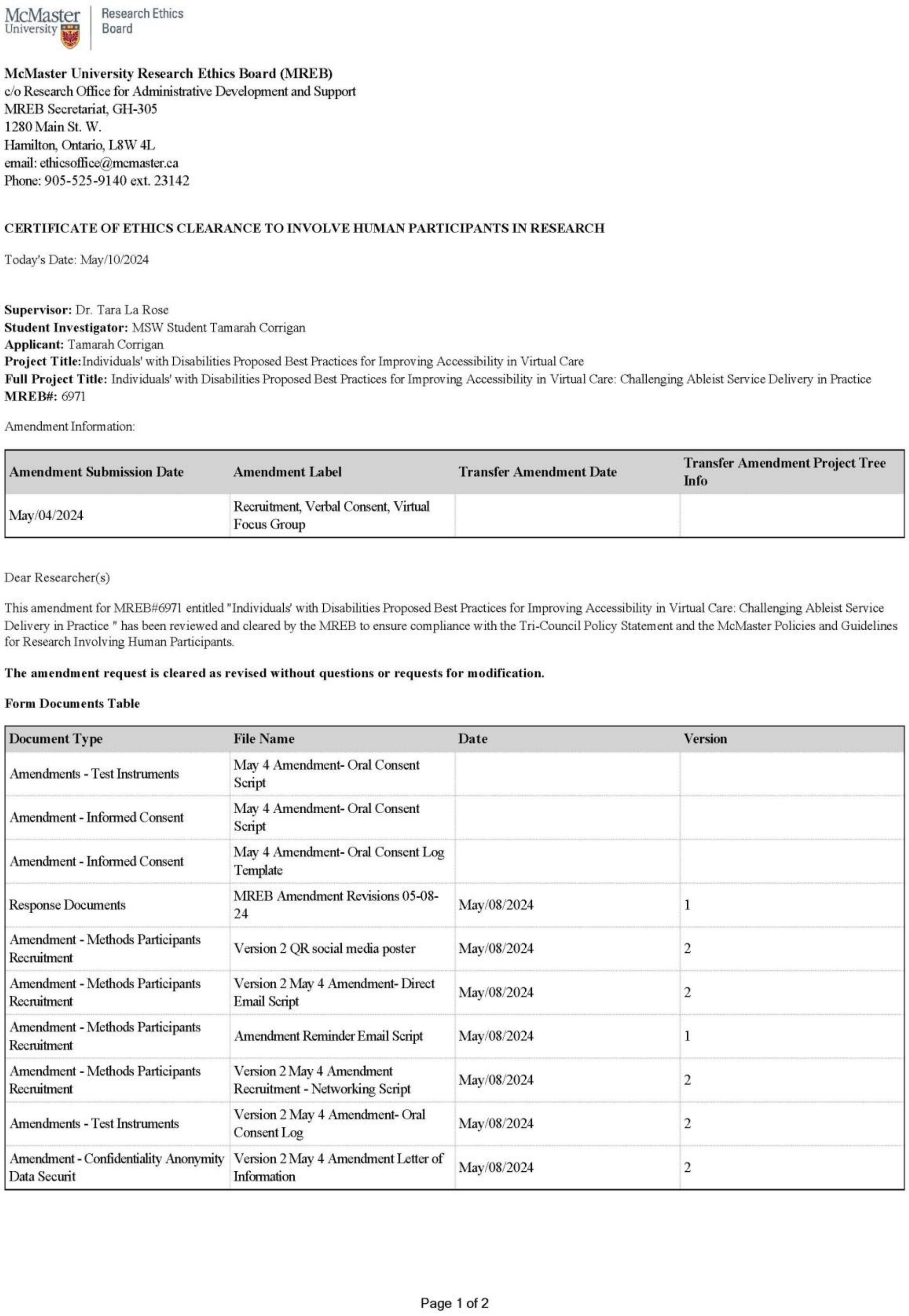

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CERTIFICATE OF ETHICS CLEARANCE TO INVOLVE HUMAN PARTICIPANTS IN RESEARCH

Today's Date: May/10/2024

Supervisor: Dr. Tara La Rose
Student Investigator: MSW Student Tamarah Corrigan
Applicant: Tamarah Corrigan
Project Title: Individuals' with Disabilities Proposed Best Practices for Improving Accessibility in Virtual Care
Full Project Title: Individuals' with Disabilities Proposed Best Practices for Improving Accessibility in Virtual Care: Challenging Ableist Service Delivery in Practice
MREB#: 6971

Amendment Information:

Amendment Submission Date	Amendment Label	Transfer Amendment Date	Transfer Amendment Project Tree Info
May/04/2024	Recruitment, Verbal Consent, Virtual Focus Group		

Dear Researcher(s)

This amendment for MREB#6971 entitled "Individuals' with Disabilities Proposed Best Practices for Improving Accessibility in Virtual Care: Challenging Ableist Service Delivery in Practice " has been reviewed and cleared by the MREB to ensure compliance with the Tri-Council Policy Statement and the McMaster Policies and Guidelines for Research Involving Human Participants.

The amendment request is cleared as revised without questions or requests for modification.

Form Documents Table

Document Type	File Name	Date	Version
Amendments - Test Instruments	May 4 Amendment- Oral Consent Script		
Amendment - Informed Consent	May 4 Amendment- Oral Consent Script		
Amendment - Informed Consent	May 4 Amendment- Oral Consent Log Template		
Response Documents	MREB Amendment Revisions 05-08-24	May/08/2024	1
Amendment - Methods Participants Recruitment	Version 2 QR social media poster	May/08/2024	2
Amendment - Methods Participants Recruitment	Version 2 May 4 Amendment- Direct Email Script	May/08/2024	2
Amendment - Methods Participants Recruitment	Amendment Reminder Email Script	May/08/2024	1
Amendment - Methods Participants Recruitment	Version 2 May 4 Amendment Recruitment - Networking Script	May/08/2024	2
Amendments - Test Instruments	Version 2 May 4 Amendment- Oral Consent Log	May/08/2024	2
Amendment - Confidentiality Anonymity Data Securit	Version 2 May 4 Amendment Letter of Information	May/08/2024	2

Dr. Nikolaos Yiannakoulias

Dr. Tara La Rose, MREB Chair	**Dr. Brian Detlor, MREB Vice-Chair**	**Dr. Niko Yiannakoulias, MREB Vice-Chair**
Associate Professor	Professor	Associate Professor
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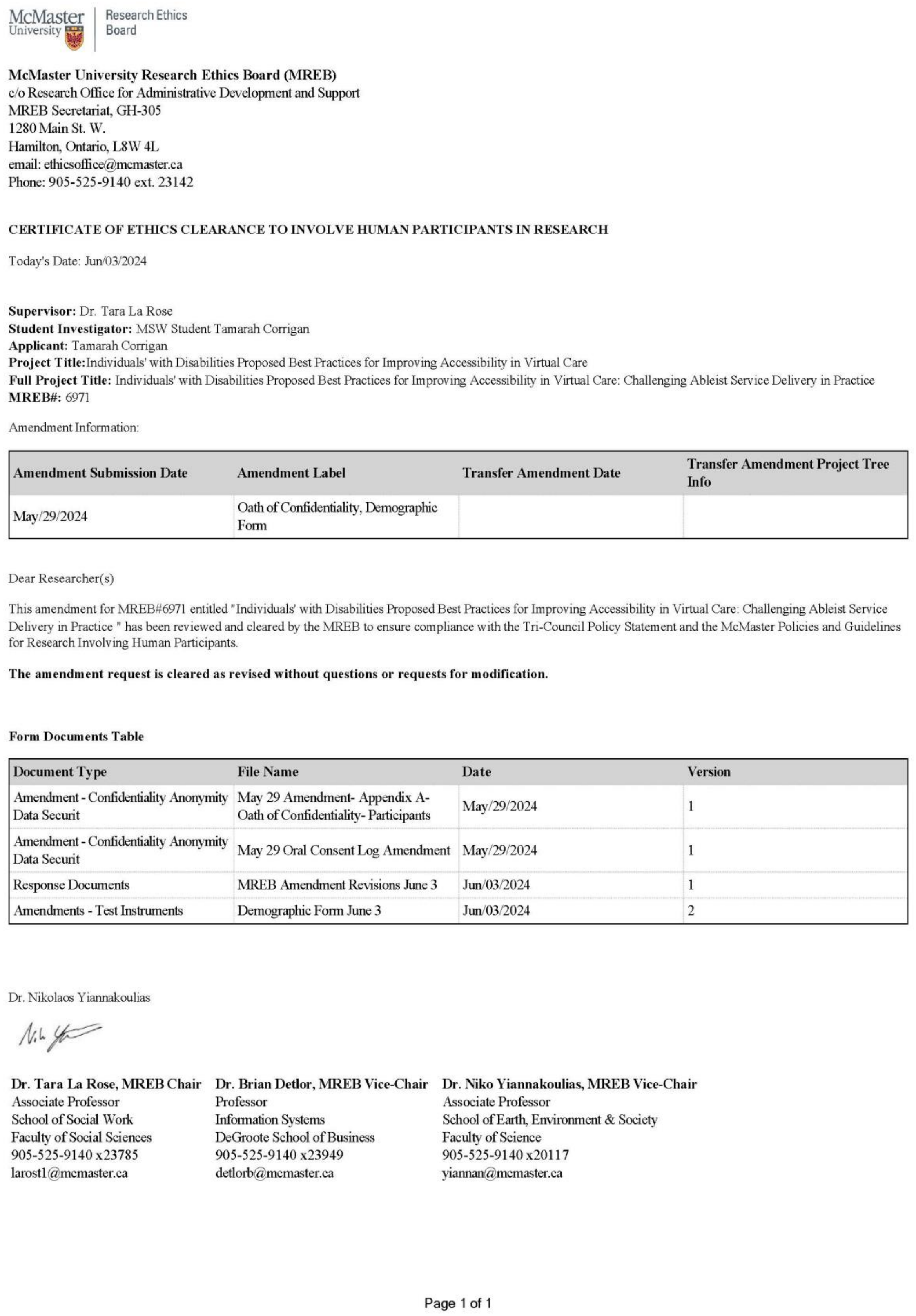
laroset@mcmaster.ca	detlorb@mcmaster.ca	yiannan@mcmaster.ca

Page 2 of 2



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CERTIFICATE OF ETHICS CLEARANCE TO INVOLVE HUMAN PARTICIPANTS IN RESEARCH

Today's Date: Jun/03/2024

Supervisor: Dr. Tara La Rose
Student Investigator: MSW Student Tamarah Corrigan
Applicant: Tamarah Corrigan
Project Title: Individuals' with Disabilities Proposed Best Practices for Improving Accessibility in Virtual Care
Full Project Title: Individuals' with Disabilities Proposed Best Practices for Improving Accessibility in Virtual Care: Challenging Ableist Service Delivery in Practice
MREB#: 6971

Amendment Information:

Amendment Submission Date	Amendment Label	Transfer Amendment Date	Transfer Amendment Project Tree Info
May/29/2024	Oath of Confidentiality, Demographic Form		

Dear Researcher(s)

This amendment for MREB#6971 entitled "Individuals' with Disabilities Proposed Best Practices for Improving Accessibility in Virtual Care: Challenging Ableist Service Delivery in Practice " has been reviewed and cleared by the MREB to ensure compliance with the Tri-Council Policy Statement and the McMaster Policies and Guidelines for Research Involving Human Participants.

The amendment request is cleared as revised without questions or requests for modification.

Form Documents Table

Document Type	File Name	Date	Version
Amendment - Confidentiality Anonymity Data Securit	May 29 Amendment- Appendix A- Oath of Confidentiality- Participants	May/29/2024	1
Amendment - Confidentiality Anonymity Data Securit	May 29 Oral Consent Log Amendment	May/29/2024	1
Response Documents	MREB Amendment Revisions June 3	Jun/03/2024	1
Amendments - Test Instruments	Demographic Form June 3	Jun/03/2024	2

Dr. Nikolaos Yiannakoulias

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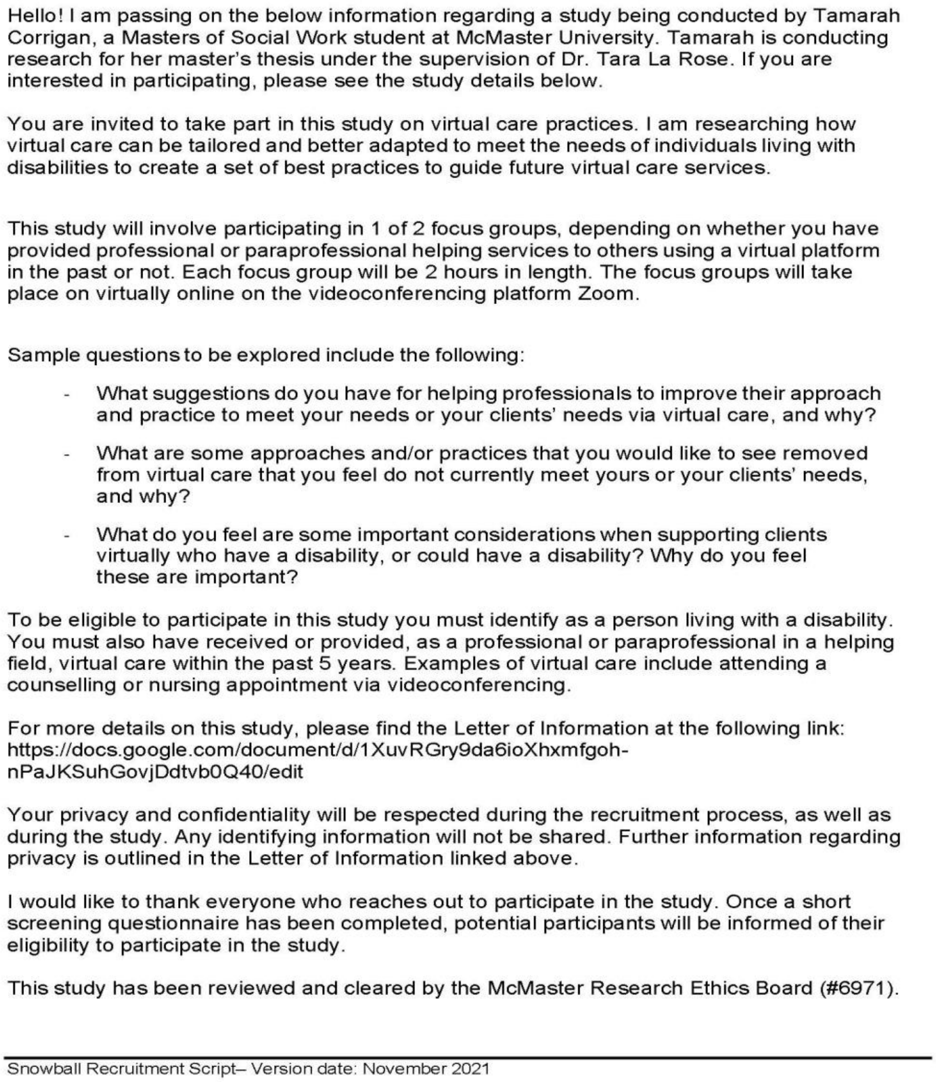
Page 1 of 1

Appendix B : Email Recruitment Script



Hello! I am passing on the below information regarding a study being conducted by Tamarah Corrigan, a Masters of Social Work student at McMaster University. Tamarah is conducting research for her master's thesis under the supervision of Dr. Tara La Rose. If you are interested in participating, please see the study details below.

You are invited to take part in this study on virtual care practices. I am researching how virtual care can be tailored and better adapted to meet the needs of individuals living with disabilities to create a set of best practices to guide future virtual care services.

This study will involve participating in 1 of 2 focus groups, depending on whether you have provided professional or paraprofessional helping services to others using a virtual platform in the past or not. Each focus group will be 2 hours in length. The focus groups will take place on virtually online on the videoconferencing platform Zoom.

Sample questions to be explored include the following:

- What suggestions do you have for helping professionals to improve their approach and practice to meet your needs or your clients' needs via virtual care, and why?
- What are some approaches and/or practices that you would like to see removed from virtual care that you feel do not currently meet yours or your clients' needs, and why?
- What do you feel are some important considerations when supporting clients virtually who have a disability, or could have a disability? Why do you feel these are important?

To be eligible to participate in this study you must identify as a person living with a disability. You must also have received or provided, as a professional or paraprofessional in a helping field, virtual care within the past 5 years. Examples of virtual care include attending a counselling or nursing appointment via videoconferencing.

For more details on this study, please find the Letter of Information at the following link: https://docs.google.com/document/d/1XuvRGry9da6ioXhxmfgoh-nPaJKSuhGovjDdtvb0Q40/edit

Your privacy and confidentiality will be respected during the recruitment process, as well as during the study. Any identifying information will not be shared. Further information regarding privacy is outlined in the Letter of Information linked above.

I would like to thank everyone who reaches out to participate in the study. Once a short screening questionnaire has been completed, potential participants will be informed of their eligibility to participate in the study.

This study has been reviewed and cleared by the McMaster Research Ethics Board (#6971).

Snowball Recruitment Script– Version date: November 2021

Sincerely,

Tamarah Corrigan

Study Title: Individuals with Disabilities Proposed Best Practices for Improving Accessibility in Virtual Care
Networking Recruitment Script

PARTICIPANTS NEEDED FOR RESEARCH IN VIRTUAL CARE

Dear [Insert Name Here],

Hello, my name is Tamarah Corrigan and I am a Masters of Social Work student and principal investigator conducting research at McMaster University. I identify as someone living with a disability and I am hoping to gather information from individuals who identify as living with a disability with the hopes of improving accessibility in virtual care services in the future. I am conducting this research under the supervision of Dr. Tara La Rose. Would you be willing to pass along my name and contact information, and the following short description of my study, to your network? There is no obligation for you to pass along this information, and there will be no consequences if you do not provide this information.

I am inviting volunteers to participate in a focus group that will take approximately 2 hours for which they will receive a $25 Mastercard e-gift card. The study will take place online via the Zoom videoconferencing platform. English closed captioning will be available for the focus group.

To be eligible to participate in this study they must identify as a person living with a disability. They must also have received or provided, as a professional or paraprofessional in a helping field, virtual care within the past 5 years. Examples of virtual care include attending a counselling or nursing appointment via videoconferencing.

Your participation in this study is voluntary. There will be no consequences to you for not choosing to participate. Should you choose to participate, and later wish to withdraw from the study after providing consent, you will be able to do so without consequence.

For the full details of the study, please read the attached letter of information.

I appreciate you taking the time to review this study's information. I hope you have a fantastic rest of your day.

Sincerely,

Tamarah Corrigan
corrigat@mcmaster.ca

This study has been reviewed and received ethics clearance from the McMaster Research Ethics Board, project # 6971.

Second portion of script for the liaison to share:

Appendix C : Letter of Information & Informed Consent

LETTER OF INFORMATION / CONSENT

Individuals' with Disabilities Proposed Best Practices for Improving Accessibility in Virtual Care: Challenging Ableist Service Delivery in Practice

Student Investigator:	**Faculty Supervisor:**
Tamarah Corrigan	Tara LaRose
	Associate Professor
Department of Social Work	Department of Social Work
McMaster University	McMaster University
Hamilton, Ontario, Canada	Hamilton, Ontario, Canada
(905) 525-9140 ext. 23793	**(905) 525-9140 ext. 23793**
E-mail: (McMaster Address)	E-mail: (McMaster Address)
corrigat@mcmaster.ca	**larost1@mcmaster.ca**

Purpose of the Study:

You are invited to take part in this study on virtual care practices. I am researching how virtual care can be tailored and better adapted to meet the needs of individuals living with disabilities to create a set of best practices to guide future virtual care services.

I am doing this research for a thesis under the supervision of Dr. Tara LaRose.

This is a line of research that I hope to continue in the future and will use your data for this project as well as for future related studies.

Procedures involved in the Research:

This study will involve participating in 1 of 2 focus groups, depending on whether you have provided professional or paraprofessional helping services to others using a virtual platform in the past or not. Each focus group will be 2 hours in length. The focus groups will take place on virtually online on the videoconferencing platform Zoom.

You will be asked to participate in a focus group that includes 2-5 other individuals participating in the research in a group format. These focus groups will be video recorded, and I will be taking brief notes of major themes as they arise during the focus groups, with your permission. You do not need to have your camera on when recording is in progress. The focus groups will be transcribed on the Zoom platform. English closed captioning will be used during the focus groups for accessibility.

Sample questions to be explored include the following:

- What suggestions do you have for helping professionals to improve their approach and practice to meet your needs or your clients' needs via virtual care, and why?
- What are some approaches and/or practices that you would like to see removed from virtual care that you feel do not currently meet yours or your clients' needs, and why?
- What do you feel are some important considerations when supporting clients virtually who have a disability, or could have a disability? Why do you feel these are important?

Do you feel your education provided you with the skills and knowledge to provide services via a virtual platform? Why or why not?

I will also ask you for some demographic/background information, including your age and gender identity. This information will be gathered in a survey provided at the end of the focus group. The purpose of this survey is to determine who the study's findings can likely be applied to (generalizability), as well as identifying potential future research areas of need.

Potential Harms, Risks or Discomforts:

You should be aware that there are potential risks when taking part in this study such as potential psychological risks, including being vulnerable in a group format, and other participants making a comment or passing judgment on the participant. To manage or minimize this risk, I will review group guidelines prior to the focus group starting that will include respecting others and allowing one to finish speaking prior to providing your own input. Additionally, I will request that participants use "I" statements when discussing their feelings and/or experiences. Should tensions arise in the group, I will be sure to de-escalate any instances of conflict or tension between participants to ensure well-being.

Another potential risk would include hearing others describe their experience in virtual care, and a participant becoming uncomfortable and/or triggered by the information. During the focus groups, I will be requesting that every participant refrain from sharing details of specific events that could be considered sensitive and/or offensive to other participants. Should a participant become uncomfortable or experience a negative emotion as a result of information shared or discussed, I will request that participants feel free to excuse themselves from the Zoom meeting, or turn their camera off, to take the space they need. I will also request that all participants provide a "thumbs up" signal to me, if they do leave the Zoom meeting, to signal to me they are alright. In the absence of this signal, I will excuse myself from the Zoom meeting and follow-up with the participant to ensure their well- being.

Potential social risks involved in my study would include other participants sharing information following the focus group that could include identifying information of the participants. To lessen this risk, I will ensure to review privacy and confidentiality prior to beginning each focus group, which will outline that information shared in the focus group is to remain private and confidential outside of the group, with the exception that de-identified information shared in group will be included in the final thesis document. Another risk includes confidential information being accessed through the Zoom application. To mitigate this risk, Zoom has a privacy policy to protect user data. You can access Zoom’s privacy policy here:

https://explore.zoom.us/en/privacy/?_ics=1714840845676&irclickid=~37Z1QX26ac54535Y128c5WX4YQYZSV2 40PVRSIJEDCxqoe~82SPG&_ga=2.196900523.609783930.1714840808-212204215.1714840808. There is

also a potential risk of of confidential information being accessed on my external hard drive or laptop or phone's recording app, which will be mitigated by securing these devices with a password.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable during the focus group. I describe below the steps I am taking to protect your privacy.

Potential Benefits

The research will not benefit you directly. I hope to learn more about the ways that virtual care can be tailored to become a more accessible format of service delivery in the future. I hope that what is learned as a result of this study will help us to better understand the specific needs of individuals with disabilities. This could help create a set of best practices for virtual care in the future, to support everyone who accesses care in a virtual format.

Incentive/Payment or Reimbursement

You will be provided with a $25 Mastercard electronic gift card for your participation in this study. The e-gift card will be sent to you via email within 72 hours following the study, due to card processing times.

Confidentiality

Participation in this study will include interacting with others in a group format. You will be required to verbally agree to an Oath of Confidentiality and agree to not share anything that was said outside of the Zoom meeting and the focus group. This Oath of Confidentiality will include agreeing to keep all information collected during this study confidential and that you will not reveal by speaking, communicating or transmitting this information in written, photographic, sound, electronic (disks, tapes, transcripts, email) or in any other way to anyone outside the research team. Additionally, you will agree to inform the researchers as soon as you discover that you know any participant either as a family member, friend, or acquaintance or in any other way; so that the researcher can take the appropriate steps to manage or minimize any conflicts of interest that might occur because of any dual roles you may have. I will undertake to safeguard the confidentiality of the discussion. I will ask the other members of the focus group to keep what you say confidential, but I cannot guarantee that they will do so. Please keep this in mind in deciding what to share with the group. You will use a pseudonym to help differentiate who is speaking when recording the interviews, to make it easier to remove their personal contributions to the discussions if they wish to do so. Unfortunately, due to the group nature of a focus group, it will not be possible for me to withdraw your personal contributions from the data.

I will be recording the Zoom interviews electronically, using the Zoom video recoding feature, as well as transcription feature. Data will be stored on my password-protected laptop, as well as an external hard drive, which is also password-protected.

Following completion of transcription and verifying the transcription matches the data collected, the video recordings will be deleted. No identifying information will be retained, and names will be redacted. The transcripts will remain with me on my password-protected laptop to maintain confidentiality.

What if I change my mind about being in the study?

Your participation in this study is voluntary.

If you want to stop being in the focus group you can stay and simply stop talking or you can leave, but it will not be possible for you to pull out your data from the flow of the conversation because of the interconnected nature of this type of group discussion where a person’s comments can stimulate the sharing of comments made by others in the group.

Information about the Study Results:

I expect to have this study completed by approximately September, 2024. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study: If you have questions or need more information about the study itself, please contact me at:

Tamarah Corrigan
corrigat@mcmaster.ca

This study has been reviewed by the McMaster Research Ethics Board and received ethics clearance under project **6971**. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Office

Telephone: (905) 525-9140 ext. 23142

E-mail: mreb@mcmaster.ca

CONSENT

- I have read the information presented in the information letter about a study being conducted by Tamarah Corrigan, of McMaster University.

- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I have been given a copy of this form.
- I agree to participate in the study.

Consent Questions:

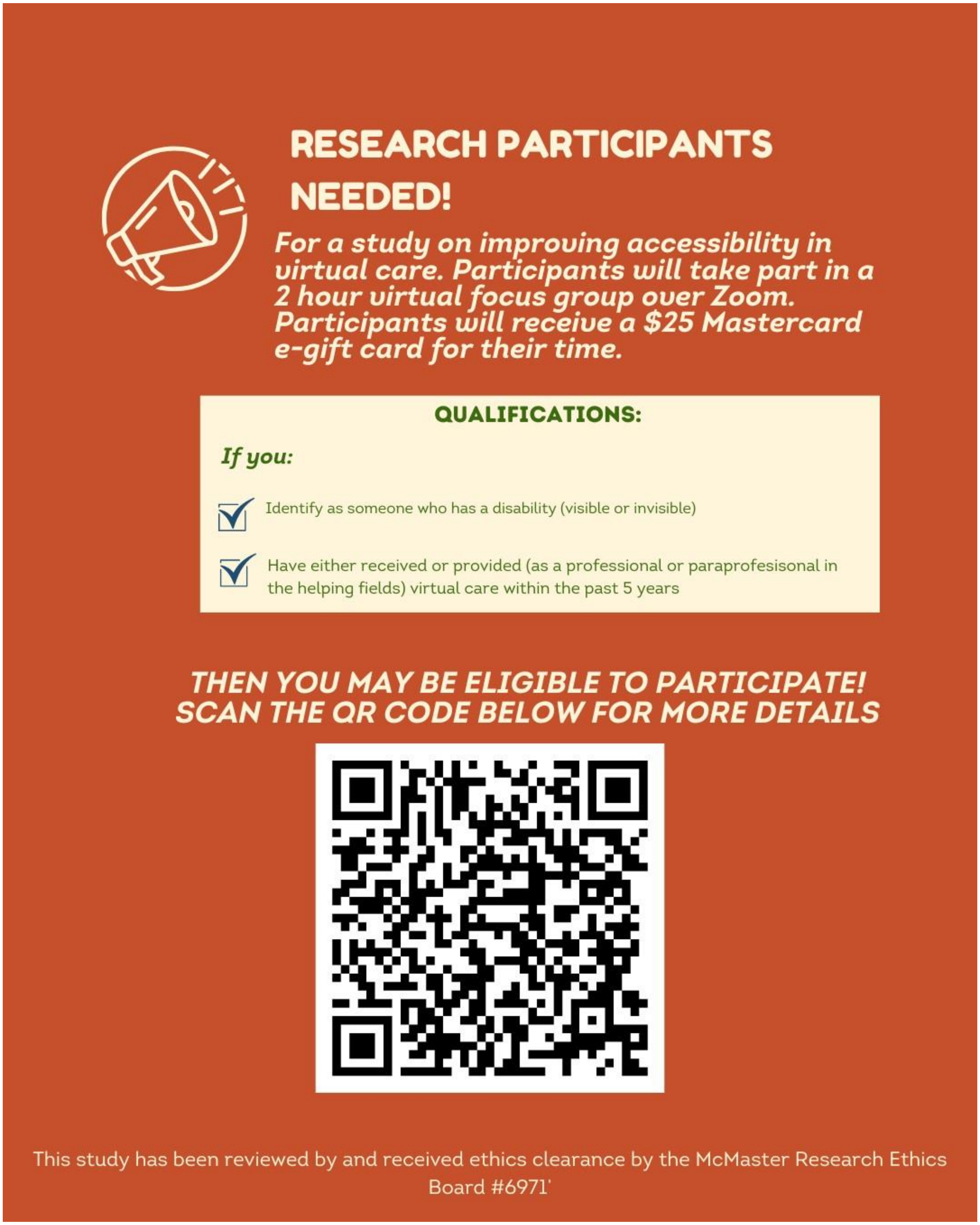
You will be asked to consent to the following questions before the focus group discussion:

1. Would you like a copy of the study results? If yes, where should we send them by email?

Do you agree to video recording? You may choose to have your camera turned off during the focus group.

2. Do you agree to be contacted for a follow up interview or study? How do you prefer to be contacted?

Appendix D: Recruitment Poster



RESEARCH PARTICIPANTS NEEDED!

For a study on improving accessibility in virtual care. Participants will take part in a 2 hour virtual focus group over Zoom. Participants will receive a $25 Mastercard e-gift card for their time.

QUALIFICATIONS:

If you:

- ☑ Identify as someone who has a disability (visible or invisible)
- ☑ Have either received or provided (as a professional or paraprofesisonal in the helping fields) virtual care within the past 5 years

THEN YOU MAY BE ELIGIBLE TO PARTICIPATE!
SCAN THE QR CODE BELOW FOR MORE DETAILS

This study has been reviewed by and received ethics clearance by the McMaster Research Ethics Board #6971'

Appendix E: Screening Questionnaire

Study Screening Questions

I will ask the potential participant the following questions:

1. Do you identify as someone who has a disability? Yes/No

2. Have you received virtual services from a helping professional or paraprofessional in the past 5 years? *Possible Examples of Virtual Care include:*

- *Receiving or conducting counselling or therapy (individually or in a group format) through a videoconferencing platform.*
- *Attending or providing a doctor's appointment or nursing appointment through videoconferencing.*

Yes/No

3. Are you a professional or paraprofessional in the helping fields or a student in the helping professions who has provided virtual services in your field in the past 5 years? Yes/No

4. Are you available to participate in a focus group on McMaster campus in late April or early May?

Appendix F: Focus Group Guide

Focus Group Guide

Virtual Care with Individuals with Disabilities

Researcher(s): Tamarah Corrigan

[THE COMPLETION OF THE INTRODUCTORY SECTION OF THE FOCUS GROUP SHOULD TAKE APPROXIMATELY 10-15 MINUTES]

I) INTRODUCTION AND INSTRUCTIONS:
Hello, my name is Tamarah Corrigan. Thank you for agreeing to participate in this focus group meeting. Just to remind everyone, I'm looking at opinions about your experience as an individual with a disability and your ideas about improving virtual care service delivery.

What is a focus group? A focus group is an interactive group discussion where we can gain several perspectives about a topic and members of the group can think about and comment on what others have said in the group.

In a minute, we will all introduce ourselves using a pseudonym, which may be different from your first name. But first, I would like to walk you through the consent form that is in front of you.

[FOR FACILITATOR: REVIEW INFORMED CONSENT FORM AND ANSWER ANY QUESTIONS ABOUT IT. COLLECT SIGNED CONSENT FORMS AND ENSURE THAT PARTICIPANTS HAVE A COPY OF THE LETTER OF INFORMATION TO TAKE WITH THEM (IF APPROPRIATE FOR THE TOPIC AND GROUP).

Confidentiality: **[*READ ALOUD] -*** Before we begin our discussion, I want to spend a few moments talking about confidentiality and to go over some basic ground rules for our focus group discussion today:

- Everyone's views are welcomed and important.
- The information which we will collect today will be attributable *(connected or associated)* to you <u>as</u> <u>a group</u>.
- We will not identify quotes or ideas with *any one person* of this group. Because of the nature of small communities or groups, it is possible that people could link participants in this room to quotes in the report. This is why we need to talk about confidentiality.
- We *are* assuming that when we learn about one another's views, they remain confidential. In a small community (group) like this, people are identifiable to some degree by their views and opinions.
- Having said this, and having made these requests, you know that we cannot guarantee that the request will be honoured by everyone in the room.
- We are asking you to make only those comments that you would be comfortable making in a public setting; and to hold back making comments that you would not say publicly.
- If you want to stop being in the focus group you can leave or stay and simply stop talking, but it will not be possible for you to pull out your data from the flow of the conversation because of the interconnected nature of the group discussion where one person's comments can stimulate the sharing of comments made by others in the group.
- Anything heard in the room should stay in the room.

- All voices are to be heard, so I will step in if too many people are speaking at once or to make sure that everyone has a chance to speak.
- I may also step in if I feel the conversation is straying off topic.
- You can expect this discussion group to last about 2 hours.

Use of Tape Recorder

- As you will recall, this focus/discussion group will be recorded to increase accuracy and to reduce the chance of misinterpreting what anyone says.
- All tapes and transcripts will be kept under lock and key by the researcher.
- Names will be removed from transcripts. Participants will have coded numbers attached to their name which only I will know.
- Only I and my thesis supervisor, Tara LaRose, will have access to transcripts (with your personal names removed) of this focus group.
- I'll also ask that when using abbreviations or acronyms, you say the full name at least once to aid transcription.
- We may also use a "flip chart" to write down key points during the focus group and take notes.

[AT THIS POINT, GROUP MEMBERS CAN QUICKLY INTRODUCE THEMSELVES –remind them that it is '<u>first names only</u>'.]

II. INTERVIEW

FOCUS GROUP DISCUSSION BEGINS WITH THE FACILITATOR ASKING THE FIRST QUESTION. (YOU CAN PROVIDE PARTICIPANTS WITH THE QUESTIONS ON A SHEET OF PAPER, FLIP CHART OR SCREEN IF YOU WISH).
OPEN UP DISCUSSION FOR GENERAL RESPONSES OF PARTICIPANTS TO EACH QUESTION.

Interview questions: Focus group interviews will be conducted in a semi-structured format, using mostly open-ended questions.

Focus Group #1 (individuals who are neither professional nor paraprofessionals) Questions:

1. What techniques and/or processes do you feel made virtual care more or less accessible for you, and why?
2. What techniques and/or processes do you feel made virtual care more or less effective for you, and why?
3. What suggestions do you have for helping professionals to improve their approach and practice to meet your needs via virtual care?
4. What are some approaches and/or practices that you would like to see removed from virtual care that you feel do not currently meet your needs?
5. Do you have any additional suggestions or feedback for helping professionals who deliver virtual services to individuals who have a disability?
6. Given that you are the providers of this knowledge, how would you prefer this information to be shared with the public following this study? (knowledge mobilization)

Focus Group #2 (individuals are either professional or paraprofessionals) Questions:

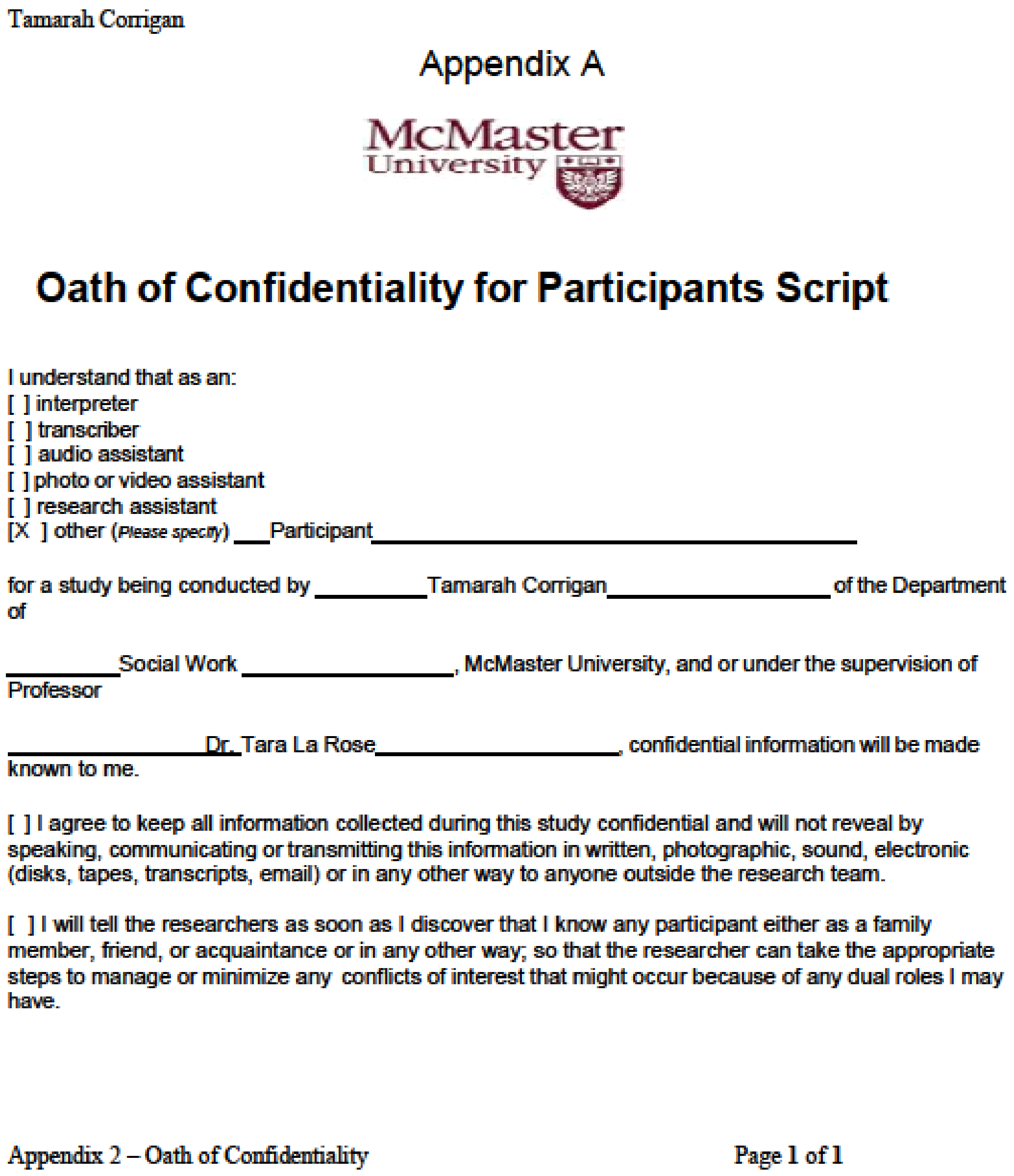
7. What techniques and/or processes do you feel made virtual care more or less accessible for you or your clients, and why?
8. What techniques and/or processes do you feel made virtual care more or less effective for you and your clients, and why?
9. What suggestions do you have for helping professionals to improve their approach and practice to meet your needs or your clients' needs via virtual care, and why?
10. What are some approaches and/or practices that you would like to see removed from virtual care that you feel do not currently meet yours or your clients' needs, and why?
11. What do you feel are some important considerations when supporting clients virtually who have a disability, or could have a disability? Why do you feel these are important? 12. Do you feel your education provided you with the skills and knowledge to provide services via a virtual platform? Why or why not?
13. Do you have any additional suggestions or feedback for helping professionals who deliver virtual services to individuals who have a disability?
14. Given that you are the providers of this knowledge, how would you prefer this information to be shared with the public following this study? (knowledge mobilization)

- Is there anything we forgot or is there something important that we should know about your experience with virtual care?

III. WRAP-UP:

- ***[IF IT IS APPROPRIATE], INTRODUCE THE FOLLOWING ANONYMOUS "POST-WORKGROUP INFORMATION SHEET" NOW.***
- ***REMIND PARTICIPANTS THAT "WHAT IS SAID IN THE ROOM SHOULD STAY IN THE ROOM".***
- ***THANK THE PARTICIPANTS.***

Appendix G: Oath of Confidentiality



Tamarah Corrigan

Appendix A

Oath of Confidentiality for Participants Script

I understand that as an:
[ ] interpreter
[ ] transcriber
[ ] audio assistant
[ ] photo or video assistant
[ ] research assistant
[X] other (*Please specify*) ___Participant______________________________

for a study being conducted by _________Tamarah Corrigan_________________ of the Department of

_________Social Work _________________, McMaster University, and or under the supervision of Professor

________________Dr. Tara La Rose____________________, confidential information will be made known to me.

[ ] I agree to keep all information collected during this study confidential and will not reveal by speaking, communicating or transmitting this information in written, photographic, sound, electronic (disks, tapes, transcripts, email) or in any other way to anyone outside the research team.

[ ] I will tell the researchers as soon as I discover that I know any participant either as a family member, friend, or acquaintance or in any other way; so that the researcher can take the appropriate steps to manage or minimize any conflicts of interest that might occur because of any dual roles I may have.