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# COVID-19 Impact on Children’s Social Work Practice and Social Worker Well-being: A Mixed Methods Study from Northern Ireland and Great Britain during 2020–2022

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## Abstract

Social workers were heavily impacted by the COVID-19 pandemic. In this study, we examined the well-being, burnout and work conditions of UK children’s social workers at five time points of the COVID-19 pandemic. This was a cross-sectional mixed methods study analysing data from 1,621 social workers who worked in children’s services in the UK in 2020–2022. Data were collected using anonymous online surveys which included both quantitative and qualitative questions. The mental well-being of

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participants decreased as the pandemic progressed and work-related burnout increased. In the later stages of the pandemic, children's social workers in Northern Ireland fared better than their Great Britain counterparts in relation to their well-being and levels of burnout. Thematic analysis of qualitative data revealed four major themes: Changes in service demand and referrals, Adapted ways of working, Staff shortages and Emotional impact. The findings highlight the challenges that the children's social workers encountered during the COVID-19 pandemic and have implications for policy, practice and research.

**Keywords:** burnout, children's social workers, COVID-19, well-being, working conditions

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## Introduction

Social workers in the UK were heavily impacted by the COVID-19 pandemic and, although they often worked creatively, social distancing guidelines substantially limited their activities (Ferguson, 2017).

Prior to the pandemic, the social work profession was one of the most stressful occupations in the UK (Ravalier, 2019). Poor retention of social workers in children's services seems to be a global problem contributing to workforce inexperience (Healy et al., 2007), which affects services to children and families. A large-scale UK study identified work-related stress as the single most important factor contributing to social workers' decision to leave their profession (Coffey et al., 2004). High levels of stress among social workers have long been documented (Coyle et al., 2005) as has the relationship between chronic exposure to work-related stressors and burnout (Lee and Ashforth, 1996; Kim and Stoner, 2008). Burnout can negatively affect service users and lead to negative outcomes (Jun et al., 2021). Moreover, stress and burnout contribute to poor well-being and health outcomes for social workers (Salvagioni et al., 2017; Griffiths et al., 2023), which can exacerbate retention problems.

A recent overview of systematic reviews of studies revealed the negative effects of COVID-19 on the health and well-being of front line healthcare workers, including high levels of stress, burnout, depression, anxiety, sleep disorders and post-traumatic stress disorder (PTSD; Chirico et al., 2021). Social workers were also reported to experience high levels of stress and burnout during this period, with high levels of emotional and mental health problems, such as grief, secondary trauma PTSD (Dima et al., 2021; Holmes et al., 2021; Wu et al., 2022). They also practiced less self-care, compared to pre-pandemic times (Miller and Reddin Cassar, 2021), which risks stress and burnout.

Stress, burnout and poor well-being in social workers during COVID-19 can be conceptualised in terms of the Job Demands-Resources (JD-R)

model (Bakker and Demerouti, 2007). The JD-R model suggests that every occupation has certain job demands and certain resources. Job demands are physical, psychological, social or organisational factors that are associated with physiological or psychological costs, such as high work pressure or negative emotional demands, and they may lead to stress. Job resources are those factors that help one achieve work goals, reduce job demands or contribute to learning and personal growth. Examples include supportive colleagues or job autonomy. If job demands consistently outweigh job resources, the worker is likely to experience burnout, which then decreases well-being and increases health problems and turnover intentions (Schaufeli and Bakker, 2004; Schaufeli *et al.*, 2009; McFadden *et al.*, 2018). The job demands on social workers increased substantially during the pandemic and have led to numerous negative outcomes in the workforce and to services (Dima *et al.*, 2021; Holmes *et al.*, 2021; Wu *et al.*, 2022).

## Study aims

There are limited data and explorations of the health and well-being of UK children's social workers during the pandemic. This study therefore aimed to examine the impact of COVID-19 on the well-being of children's social workers in the UK at five time points of the pandemic. It also examined burnout and the working conditions of these social workers, as working conditions and health and well-being are closely related (Murtin *et al.*, 2022). We hypothesised that well-being decreased and burnout increased as the pandemic progressed. We also compared levels of well-being and burnout between Great Britain (GB; England, Wales, Scotland) and Northern Ireland (NI), since a pre-COVID-19 study (McFadden *et al.*, 2020) revealed differences between the nations. Based on this study, we hypothesised that well-being would be better and burnout would be lower in NI compared to GB. Working conditions were examined through qualitative data which helped contextualise the quantitative findings and provided insights into how concerns relating to protecting children at risk of harm during the pandemic, impacted working conditions and the well-being of social workers.

## Materials and methods

### Study design

A mixed methods survey design was employed as it enables a deeper and more meaningful exploration of experiences. Qualitative data were used to contextualise the quantitative findings. Data came from a largescale study 'Health and social care workers' quality of working life and coping while

working during the COVID-19 pandemic', which explored the experiences of UK nurses, midwives, allied health professionals, social care workers and social workers (England, Scotland, Wales, NI) during the first years of the COVID-19 pandemic. The wider study was cross-sectional and based on survey data collected at five time points; May–July 2020 (Phase 1), November 2020–February 2021 (Phase 2), May–July 2021 (Phase 3), November 2021–February 2022 (Phase 4) and May–July 2022 (Phase 5). Data were collected online using the Qualtrics survey platform. Due to the anonymous nature of the survey, data could not be linked across the phases.

## Participants

Participants were recruited through communications sent by professional associations, employers, regulators and unions, and through social media advertisements (Twitter and Facebook). Eligibility criteria included participants self-reporting their occupation. This study analysed a subset of the full sample's responses; specifically, social workers from children's services. Overall, 1,621 children's social workers participated (Phase 1: 499, Phase 2: 530, Phase 3: 296, Phase 4: 120, Phase 5: 176).

## Ethical considerations

Participation in the study was voluntary. All potential participants received a participant information sheet, containing relevant information including confidentiality, personal risks (e.g. if someone needed support, we provided a list of resources) and benefits (e.g. participating in knowledge creation about the collective experiences of the profession during the pandemic). Participants provided informed consent prior to accessing the survey. The study received ethical approval from the Research Ethics Filter Committee in the School of Nursing at Ulster University (Ref No. 2020/5/3.1) and from the Health Research Authority (Ref No. 20/0073).

## Measures

### *Demographic and work-related variables*

We asked participants about their demographic and work-related information to help readers contextualise findings in terms of the composition of the sample demographics. Variables included gender, age, ethnicity, country of work (England, Scotland, Wales, NI), disability status, full-time or part-time employment and number of years of work experience. Diversity and inclusion variables were included so analysis could address demographic differences.

### *Mental well-being*

Mental well-being was assessed using the seven-item Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS; [Stewart-Brown et al., 2009](#)). Using a five-point Likert scale, ranging from 1 to 5, participants reported their feelings and thoughts over the previous two weeks. Item scores were summed and converted to metric scores to enable comparison with other samples. Scores ranged from 7 to 35; with higher scores indicating better well-being. We selected the scale as having good psychometric properties ([Ng Fat et al., 2017](#)) and for its brevity and use in other studies for comparisons.

### *Burnout*

The Copenhagen Burnout Inventory (CBI; [Kristensen et al., 2005](#)) was used to assess personal burnout, work-related burnout and client-related burnout. Personal burnout (six items) is defined as a 'state of prolonged physical and psychological exhaustion'. Work-related burnout (seven items) is defined as a 'state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work'. Client-related burnout (six items) is defined as a 'state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work with clients' ([Kristensen et al., 2005](#)). Participants use a five-point Likert scale to answer the questions. A total score is calculated for each subscale as the average of the items on the subscale. This can range from 0 to 100, with higher scores indicating greater burnout. The psychometric properties of the inventory are good ([Montgomery et al., 2021](#)). We selected the CBI because it measures three aspects of burnout, all relevant to social workers experiencing existential changes to life and work during the pandemic ([Dekel and Baum, 2010](#)).

### *COVID-19-related working conditions*

Working conditions were assessed with one quantitative question, used in Phases 2–5: 'Which of the following work-related groups do you consider yourself to belong to?'. Response options included 'Not impacted by COVID-19 pressures—services stepped down', 'Impacted, but not significantly' and 'Overwhelmed by increased pressures'. Participants in each phase were also asked an open-ended question: 'What was the impact of COVID-19 on your specific place of work, so far, in relation to patient/service user numbers and service demand?'. The reference period for Phases 2–5 was since the end of the previous study phase.

## Data analysis

To examine mental well-being and burnout across the study phases and between GB and NI, scores were compared using independent samples *t*-tests and Mann–Whitney *U*-tests (when data were not normally distributed). All significance tests were one-tailed and pairwise deletion was employed for the analyses. Effective sample sizes are reported in the respective effect sizes *r* were calculated for each comparison.

Qualitative data were analysed thematically (Braun and Clarke, 2006). This involved initial familiarisation with the narratives and subsequent coding for meaning. The low-level codes were then aggregated into higher-level themes.

## Results

### Sample description

Demographic and work-related information for the combined study sample and individually across the five phases are shown in Table 1. Briefly, most participants were female, aged between thirty and fifty-nine, of White ethnic background and a large proportion worked in NI.

### Mental well-being

Table 2 reports SWEMWBS scores for each study phase and by country (GB versus NI). In the full sample, the highest score was observed in phase 1. Comparison across study phases revealed that Phase 1 scores in the full sample were significantly higher than Phase 2 ( $t=4.83$ ,  $df=893$ ,  $p<0.001$ ,  $r=0.16$ ), Phase 3 ( $t=3.99$ ,  $df=691$ ,  $p<0.001$ ,  $r=0.15$ ), Phase 4 ( $t=3.15$ ,  $df=534$ ,  $p<0.001$ ,  $r=0.14$ ) and Phase 5 scores ( $U=30428.00$ ,  $p=0.034$ ,  $r=-0.08$ ).

There were no significant differences in mental well-being between GB and NI in Phase 1 ( $U=21529.50$ ,  $p=0.203$ ,  $r=-0.04$ ) and Phase 3 ( $U=8497.50$ ,  $p=0.312$ ,  $r=-0.03$ ). In Phase 2 ( $U=19550.50$ ,  $p=0.032$ ,  $r=-0.09$ ), Phase 4 ( $U=804.50$ ,  $p<0.001$ ,  $r=-0.36$ ) and Phase 5 ( $t=-2.76$ ,  $df=156$ ,  $p=0.004$ ,  $r=0.22$ ), well-being scores were significantly higher in NI compared to GB.

### Burnout

Table 3 shows the burnout scores across the study phases and separately for GB and NI. Burnout was not measured in Phase 1, but the measure

Table 1. Descriptive characteristics of the sample.

| Variable                        | Combined sample | Phase 1    | Phase 2    | Phase 3    | Phase 4    | Phase 5    |
|---------------------------------|-----------------|------------|------------|------------|------------|------------|
| <b>Gender</b>                   |                 |            |            |            |            |            |
| Female                          | 1,403 (86.6)    | 443 (89.0) | 457 (86.2) | 252 (85.1) | 103 (85.8) | 148 (84.1) |
| Male                            | 212 (13.1)      | 54 (10.8)  | 71 (13.4)  | 42 (14.2)  | 17 (14.2)  | 28 (15.9)  |
| Other                           | 5 (0.3)         | 1 (0.2)    | 2 (0.4)    | 2 (0.7)    | –          | –          |
| <b>Age, years</b>               |                 |            |            |            |            |            |
| 16–29                           | 170 (10.5)      | 55 (11.0)  | 64 (12.1)  | 22 (7.4)   | 10 (8.3)   | 19 (10.8)  |
| 30–39                           | 418 (25.8)      | 126 (25.3) | 148 (27.9) | 69 (23.3)  | 28 (23.3)  | 47 (26.7)  |
| 40–49                           | 484 (29.9)      | 152 (30.5) | 159 (30.0) | 82 (27.7)  | 40 (33.3)  | 51 (29.0)  |
| 50–59                           | 445 (27.5)      | 136 (27.3) | 135 (25.5) | 100 (33.8) | 30 (25.0)  | 44 (25.0)  |
| 60+                             | 104 (6.4)       | 30 (6.0)   | 24 (4.5)   | 23 (7.8)   | 12 (10.0)  | 15 (8.5)   |
| <b>Ethnic background</b>        |                 |            |            |            |            |            |
| White                           | 1,528 (94.4)    | 471 (94.4) | 489 (92.4) | 278 (94.6) | 116 (96.7) | 174 (98.9) |
| Black                           | 43 (2.7)        | 18 (3.6)   | 16 (3.0)   | 7 (2.4)    | 2 (1.7)    | –          |
| Asian                           | 15 (0.9)        | 2 (0.4)    | 9 (1.7)    | 4 (1.4)    | –          | –          |
| Mixed Race                      | 32 (2.0)        | 8 (1.6)    | 15 (2.8)   | 5 (1.7)    | 2 (1.7)    | 2 (1.1)    |
| <b>Country of work</b>          |                 |            |            |            |            |            |
| England                         | 550 (33.9)      | 223 (44.7) | 170 (32.1) | 102 (34.5) | 39 (32.5)  | 16 (9.1)   |
| Scotland                        | 77 (4.8)        | 16 (3.2)   | 23 (4.3)   | 26 (8.8)   | 7 (5.8)    | 5 (2.8)    |
| Wales                           | 252 (15.5)      | 25 (5.0)   | 187 (35.3) | 30 (10.1)  | 2 (1.7)    | 8 (4.5)    |
| Northern Ireland                | 742 (45.8)      | 235 (47.1) | 150 (28.3) | 138 (46.6) | 72 (60.0)  | 147 (83.5) |
| <b>Disability</b>               |                 |            |            |            |            |            |
| Yes                             | 170 (11.4)      | 40 (8.7)   | 47 (9.7)   | 43 (15.8)  | 15 (13.2)  | 25 (15.3)  |
| No                              | 1,296 (86.7)    | 409 (89.3) | 430 (88.3) | 224 (82.1) | 98 (86.0)  | 135 (82.8) |
| Unsure                          | 29 (1.9)        | 9 (2.0)    | 10 (2.1)   | 6 (2.2)    | 1 (0.9)    | 3 (1.8)    |
| <b>Employment</b>               |                 |            |            |            |            |            |
| Full-time                       | 1,425 (88.2)    | 428 (86.3) | 469 (88.8) | 261 (88.5) | 106 (88.3) | 161 (91.5) |
| Part-time                       | 190 (11.8)      | 68 (13.7)  | 59 (11.2)  | 34 (11.5)  | 14 (11.7)  | 15 (8.5)   |
| <b>Years of work experience</b> |                 |            |            |            |            |            |
| Less than 2                     | 118 (7.3)       | 42 (8.4)   | 45 (8.5)   | 16 (5.4)   | 12 (10.0)  | 3 (1.7)    |
| 2–5                             | 231 (14.3)      | 64 (12.8)  | 77 (14.5)  | 54 (18.2)  | 14 (11.7)  | 22 (12.5)  |
| 6–10                            | 267 (16.5)      | 83 (16.6)  | 92 (17.4)  | 43 (14.5)  | 13 (10.8)  | 36 (20.5)  |
| 11–20                           | 496 (30.6)      | 151 (30.3) | 180 (34.0) | 73 (24.7)  | 41 (34.2)  | 51 (29.0)  |
| 21–30                           | 352 (21.7)      | 105 (21.0) | 99 (18.7)  | 72 (24.3)  | 29 (24.2)  | 47 (26.7)  |
| More than 30                    | 156 (9.6)       | 54 (10.8)  | 37 (7.0)   | 37 (12.5)  | 11 (9.2)   | 17 (9.7)   |

Note. Presented are valid percentages to account for missing data.

was added in Phase 2, as data from the wider study showed that it was important for this cohort of social workers. In the full sample, personal burnout scores were significantly lower in Phase 2, compared to Phase 3 ( $t = -2.15$ ,  $df = 738$ ,  $p = 0.016$ ,  $r = 0.08$ ), but the Phase 2 scores were not significantly different from Phase 4 ( $t = -1.50$ ,  $df = 143.77$ ,  $p = 0.068$ ,  $r = 0.12$ ) or Phase 5 scores ( $t = -1.08$ ,  $df = 243.28$ ,  $p = 0.142$ ,  $r = 0.07$ ). Work-related burnout scores were significantly lower in Phase 2 of the study compared to Phase 3 ( $t = -2.53$ ,  $df = 731$ ,  $p = 0.006$ ,  $r = 0.09$ ), they were marginally lower in Phase 2 compared to Phase 4 ( $U = 22447.00$ ,  $p = 0.05$ ,  $r = -0.07$ ), and significantly lower in Phase 2 compared to Phase 5 ( $t = -1.78$ ,  $df = 234.64$ ,  $p = 0.038$ ,  $r = 0.12$ ). Client-related burnout scores in Phase 2 were not significantly different from scores in Phase 3 ( $t = 0.66$ ,  $df = 685$ ,  $p = 0.255$ ,  $r = 0.03$ ), Phase 4 ( $t = 1.39$ ,  $df = 538$ ,



**Table 2.** Mental well-being scores by study phase and country.

| Study phase | Full sample |  | GB  |  | NI  |  |
|-------------|-------------|--|-----|--|-----|--|
|             | N           | M (SD)/Median<br>(Interquartile range) | n   | M (SD)/Median<br>(Interquartile range) | n   | M (SD)/Median<br>(Interquartile range) |
| 1           | 427         | 21.44 (3.33)/20.73 (4.86)              | 234 | 21.28 (3.28)/20.73 (3.96)              | 193 | 21.64 (3.39)/21.54 (4.86)              |
| 2           | 468         | 20.38 (3.27)/19.98 (3.27)              | 338 | 20.24 (3.25)/19.98 (4.37)              | 130 | 20.74 (3.30)/19.98 (3.76)              |
| 3           | 266         | 20.37 (3.60)/19.98 (4.37)              | 142 | 20.34 (3.57)/19.98 (4.37)              | 124 | 20.41 (3.66)/19.98 (4.22)              |
| 4           | 109         | 20.28 (3.80)/19.25 (5.23)              | 42  | 19.02 (3.01)/18.29 (2.74)              | 67  | 21.08 (4.04)/20.73 (5.52)              |
| 5           | 158         | 20.64 (3.58)/20.73 (4.62)              | 28  | 18.98 (3.69)/18.59 (4.46)              | 130 | 21.00 (3.47)/20.73 (3.96)              |

**Table 3.** Burnout scores by study phase and country.

| Study phase                 | Full sample |  | GB       |  | NI       |  |
|-----------------------------|-------------|--|----------|--|----------|--|
|                             | <i>N</i>    | M (SD)/Median<br>(Interquartile range) | <i>n</i> | M (SD)/Median<br>(Interquartile range) | <i>n</i> | M (SD)/Median<br>(Interquartile range) |
| <b>Personal burnout</b>     |             |  |          |  |          |  |
| 2                           | 472         | 60.64 (19.09)/62.50 (20.83)            | 341      | 61.18 (19.28)/62.50 (25.00)            | 131      | 59.22 (18.56)/62.50 (20.83)            |
| 3                           | 268         | 63.85 (20.45)/66.67 (28.13)            | 144      | 64.53 (20.25)/66.67 (29.17)            | 124      | 63.07 (20.72)/66.67 (25.00)            |
| 4                           | 109         | 64.22 (23.14)/66.67 (31.25)            | 42       | 71.03 (21.19)/75.00 (25.00)            | 67       | 59.95 (23.45)/62.50 (37.50)            |
| 5                           | 159         | 62.74 (21.97)/62.50 (25.00)            | 28       | 71.58 (18.74)/75.00 (23.96)            | 131      | 60.85 (22.21)/62.50 (25.00)            |
| <b>Work-related burnout</b> |             |  |          |  |          |  |
| 2                           | 467         | 58.74 (19.60)/60.71 (25.00)            | 337      | 59.43 (19.93)/60.71 (21.43)            | 130      | 56.92 (18.68)/57.14 (22.32)            |
| 3                           | 266         | 62.59 (20.32)/64.29 (28.57)            | 142      | 62.93 (19.77)/64.29 (28.57)            | 124      | 62.21 (32.14)/64.29 (32.14)            |
| 4                           | 107         | 62.58 (20.67)/60.71 (20.67)            | 42       | 68.45 (18.00)/67.86 (23.21)            | 65       | 58.79 (21.51)/57.14 (28.57)            |
| 5                           | 158         | 62.45 (23.59)/64.29 (36.61)            | 28       | 72.45 (19.85)/75.00 (25.00)            | 130      | 60.30 (23.84)/64.29 (35.71)            |
| <b>Client burnout</b>       |             |  |          |  |          |  |
| 2                           | 436         | 32.09 (20.80)/29.17 (29.17)            | 318      | 32.82 (20.57)/29.17 (25.00)            | 118      | 30.12 (21.37)/25.00 (34.38)            |
| 3                           | 251         | 30.97 (22.69)/29.17 (33.33)            | 135      | 31.93 (22.43)/29.17 (29.17)            | 116      | 29.85 (23.05)/27.08 (33.33)            |
| 4                           | 104         | 28.93 (21.46)/29.17 (37.50)            | 42       | 33.13 (21.87)/37.50 (37.50)            | 62       | 26.08 (20.87)/25.00 (34.38)            |
| 5                           | 149         | 32.90 (20.68)/33.33 (29.17)            | 27       | 41.20 (23.04)/41.67 (20.83)            | 122      | 31.06 (19.76)/33.33 (30.21)            |

$p = 0.083$ ,  $r = 0.06$ ) or Phase 5 ( $t = -0.41$ ,  $df = 583$ ,  $p = 0.341$ ,  $r = 0.02$ ) of the study. Client-related burnout scores were consistently lower than personal burnout or work-related burnout scores in all phases.

Comparing GB with NI on personal burnout, there were no significant differences between them in Phase 2 ( $U = 20,723.00$ ,  $p = 0.112$ ,  $r = -0.06$ ) or Phase 3 ( $U = 8,581.00$ ,  $p = 0.292$ ,  $r = -0.03$ ), but in Phase 4 ( $U = 973.00$ ,  $p = 0.004$ ,  $r = -0.26$ ) and Phase 5 ( $U = 1,268.00$ ,  $p = 0.005$ ,  $r = -0.20$ ), personal burnout was significantly higher in GB. This was similar in relation to work-related burnout; there were no significant differences between the countries in Phase 2 ( $U = 20029.50$ ,  $p = 0.076$ ,  $r = -0.07$ ) or Phase 3 ( $U = 8,662.00$ ,  $p = 0.410$ ,  $r = -0.01$ ), but in Phase 4 ( $U = 967.50$ ,  $p = 0.006$ ,  $r = -0.25$ ) and Phase 5 ( $U = 1,272.00$ ,  $p = 0.006$ ,  $r = -0.20$ ), work-related burnout was significantly higher in GB. Finally, in relation to client-related burnout, there were no significant differences between GB and NI in Phase 2 ( $U = 17,379.50$ ,  $p = 0.118$ ,  $r = -0.07$ ) or Phase 3 ( $U = 7,397.50$ ,  $p = 0.225$ ,  $r = -0.05$ ), but in Phase 4 ( $U = 1,021.00$ ,  $p = 0.031$ ,  $r = -0.18$ ) and Phase 5 ( $U = 1,183.00$ ,  $p = 0.022$ ,  $r = -0.19$ ), client-related burnout was significantly higher in GB.

## COVID-19-related working conditions

Only 1.4% of participants ( $n = 15$ ) said their work had not been impacted by COVID-19 pressures and their services were stood down, while 38.6% ( $n = 413$ ) said that their work had been impacted, but not significantly. Most, 59.8% ( $n = 640$ ), had felt overwhelmed by increased pressures. From the analysis of qualitative data, many social workers reported being negatively affected by rapidly changing practices and expressed concerns about the safeguarding of children. For example, school closures led to increases in referral rates and intensification of child protection-related concerns requiring statutory interventions. The following four major themes emerged from the data: Changes in service demand and referrals, Adapted ways of working, Staff shortages and Emotional impact.

### *Changes in service demand and referrals*

In Phase 1, which corresponded to the early stages of the COVID-19 pandemic in the UK, most participants reported an increase in service demand and/or referrals, or an initial decrease, followed by a substantial increase:

Service demand is higher because more children are spending more time in their homes where majority of potential abuse takes place. (Female, twenty to twenty-nine years, NI, community based, Phase 1)

I chair child protection case conferences and the number of children who have suffered significant harm due to the lockdown restrictions has increased significantly especially in the area of those witnessing domestic violence from their father towards their mother'. (Female, fifty to fifty-nine years, England, community based, Phase 1)

Service demand initially declined but we have now seen a massive increase which is stretching the service and court system. (Female, twenty to twenty-nine years, England, community based, Phase 1)

In Phase 1, a substantial proportion of participants reported no change or even a reduction in service demand and referrals, primarily due to school closures since a large proportion of referrals would normally come from there. This reduction gave rise to concern among many social workers as it meant that children were not being seen regularly by other professionals who would make referrals if needed:

Initially service demand for new referrals decreased as we found that very few referrals were coming in. This was impacted by no schools, no health visits (school nurse, HV) and limited police engagement. (Female, thirty to thirty-nine years, Wales, community based, Phase 1)

Whenever the schools reopen we have a significant increase of referrals as children disclose matters which have been missed. (Female, thirty to thirty-nine years, Wales, community based, Phase 2)

As the pandemic progressed and schools and other services reopened, participants often reported increased service demand and referrals:

Dramatic increase in demand and huge increase in vacancies and sickness amongst staff. Referrals of serious harm including domestic homicide and child death hugely increased. (Female, sixty to sixty-five years, England, community based, Phase 4)

Despite some participants reporting reduced service demand or referrals at the start of the pandemic, a consistent theme amongst the narratives across the study was more complexity of new referrals and increased support needs from existing cases. The increased complexity was particularly in terms of mental health needs, domestic abuse and substance misuse:

Significant increase in complexity of the work, likely due to the effects of COVID-19 impacting on mental health and domestic abuse, social isolation, and reduced services/community support. This means each family require more visits, support, and more are escalated to legal interventions. (Female, thirty to thirty-nine years, England, community based, Phase 2)

During lockdowns, when schools and respite services were closed, families' support needs increased substantially, since children were at home. Several participants reported that foster placements were collapsing and numbers on child protection registers increasing.

One reason offered for the increased case complexity, which also contributed to increased service demands, was that other community services that would normally support families, remained closed, or were not providing direct face-to-face services. This left many families unsupported for a long time and, consequently, social workers had to step in:

There hasn't been a significant increase in referrals but existing casework has become a lot more complex and other agencies are offering less so we are picking up the slack. (Female, thirty to thirty-nine years, England, community based, Phase 2)

### *Adapted ways of working*

Participants described how their practice changed during the pandemic, as they were no longer able to conduct routine face-to-face visits with children and families. Several reported that cases were being risk assessed and only emergency visits undertaken. Doorstep visits, rather than in-home visits, were mentioned. Working from home, or remote working, became the new normal as attending the office was discouraged. For many participants virtual visits posed significant challenges:

...new ways of working (remote/telephone) brought anxieties about being able to connect with and support families meaningfully. (Female, fifty to fifty-nine years, NI, family centre based, Phase 2)

Families have been less willing to engage remotely and it's difficult to assess risk and need when unable to visit the family home or see families in person. (Female, forty to forty-nine years, Wales, children's locality team, Phase 2)

It's been difficult to work remotely. Meaningful work with children and young people is more challenging. (Female, thirty to thirty-nine years, England, community based, Phase 1)

Several believed the quality of their work was negatively affected by remote working:

Support offered to foster carers and looked after children has reduced in quality due to lack of home visits. (Male, sixty to sixty-five years, Wales, community based, Phase 2)

### *Staff shortages*

Staff shortages were a major theme, primarily in the study's later phases. Participants frequently mentioned staff sickness and isolation due to COVID-19 but also staff leaving and not being replaced. This increased pressures on those remaining, resulting in higher workloads and case-loads that often felt unmanageable:

...we have 30% vacancies in our front-line teams and no one applying for advertised posts (Female, forty to forty-nine years, Wales, community based, Phase 5)

Caseload numbers were excessive and it never felt that I was 'on top' of things or met the needs of my service users in a way that I should. (Female, fifty to fifty-nine years, NI, community based, Phase 3)

Several participants reported team vacancies and difficulties with staff retention and recruiting:

So many staff have left due to the pressure that we are covering the caseload of two teams but with half of our team staffed. The demand is overwhelming. (Female, thirty to thirty-nine years, NI, community based, Phase 5)

Some participants felt low staff numbers were unsafe:

Staff shortages leading to unsafe staffing levels and staffing ratios outside of care plans. (Female, forty to forty-nine years, NI, residential childcare, Phase 4)

...at one point there was one social worker (with) over 70 children. (Female, forty to forty-nine years, NI, social work manager, Phase 5)

### *Emotional impact*

Increased work pressures from greater service demand, more complex cases, reduced availability of community resources, staff shortages and higher caseloads, appear to have left the social workers in our sample mentally depleted. Participants mentioned stress, isolation from colleagues, and how the demanding nature of their work affected mental health and morale. Staff exhaustion and burnout were also mentioned:

...staff feeling burnt out and leaving for other posts which increases pressure, higher caseloads which adds to stress and worry when you don't get to see your families within statutory timescales. (Female, thirty to thirty-nine years, NI, community based, Phase 2)

2 years of relentless work, including several months where other services did not complete interventions and therefore staff are burnt out. (Female, thirty to thirty-nine years, England, local authority child protection, Phase 5)

Some participants felt work-life balance was disrupted as a result of working from home and the blurring of boundaries between work and home:

Families have become more dependent on social workers making the job more demanding. In addition to this, the working from home has made things more difficult as there is blurred boundaries and it is often hard to

switch off as the work laptop and phone is more accessible. (Female, twenty to twenty-nine years, NI, community based, Phase 5)

Feelings of isolation when working from home. No work life balance. Bringing people's complex child protection issues into your home environment. (Female, forty to forty-nine years, Wales, Phase 2)

## Discussion

This study aimed to examine the impact of COVID-19 on the well-being, burnout and working conditions of children's social workers in the UK across five phases of the pandemic using a cross-sectional survey design. We evidenced a reduction in well-being and increase in burnout across five data collection points over a two-year period of the pandemic and placed the findings in the context of concern about social worker attrition escalating further since COVID-19 (Foley and Foster, 2022). This enabled comparisons between study phases and across different countries and provided 'real time' examination of the granular detail on children's social worker well-being as the pandemic progressed between 2020 and 2022. It is critical that evidence such as this is addressed by those in positions of influence. If workforce well-being and retention interventions are not sustained, social work risks continuous churn and instability, which ultimately impacts service users and the wider society.

Our hypothesis was partially supported, as we found that the mental well-being of children's social workers decreased from Phases 1 to 5 of the study and work-related burnout increased from Phases 2 to 5. However, we found little or no changes in personal burnout and client-related burnout. Our second hypothesis was partially supported, as we found that in Phase 2 and subsequently, mental well-being was better among NI social workers compared to those in GB. Consistent with this finding, personal, work-related and client-related burnouts were significantly higher in GB participants compared to NI in Phases 4 and 5. Themes from qualitative data corroborate quantitative findings, showing increased work pressures from increased demand and referrals, greater case complexity, changed working practices, staff shortages and high emotional impact of the whole situation, which together provide explanations for lower well-being and higher burnout in the sample.

We acknowledge that our findings need to be considered in light of a lack of diversity in the sample. Most participants (95%) identified as White. According to a systematic review of ethnic diversity in social work, the front line children and family workforce in England was more ethnically diverse than the wider population (Fitzhenry *et al.*, 2022). Additionally, our sample was mostly female. This reflects other

Westernised studies of the social work profession, which is predominantly female, albeit with managers being disproportionately male (Hicks, 2015). Furthermore, it is acknowledged how the COVID-19 pandemic negatively impacted on working women (more than their male counterparts), with childcare and other caring responsibilities falling primarily on females, particularly those working from home (Andersen *et al.*, 2022). These diversity factors are important contextual information relating to our findings, as although the pandemic impacted everyone, it did not impact everyone equally (Suleman *et al.*, 2021). This is an important area for further research.

Whilst diversity and inclusion are critically important, our findings are in line with other studies in this area (Dima *et al.*, 2021; Holmes *et al.*, 2021; Wu *et al.*, 2022), evidencing that social workers' health and well-being were negatively impacted during the pandemic. Work-related burnout increased as the pandemic progressed and this is not surprising, considering the qualitative reports of almost consistently increased service demand and referrals, combined with staff shortages. Interestingly, client-related burnout scores remained well below the personal and work-related burnout scores throughout the pandemic. This reflects a study of Romanian social workers (Dima *et al.*, 2021) and implies that the primary stressors in our sample were not client-related, but rather work- or organisation-related. These could be unmanageable workloads, instability or lack of clarity regarding guidelines and working procedures (Dima *et al.*, 2021). Participants' narratives support these quantitative findings; many social workers felt emotionally exhausted and burnt out due to increased work pressures. Some mentioned mental health problems and isolation, and the blurring of home-work boundaries, as reported in other social work studies during COVID-19 (Kingstone *et al.*, 2022).

The finding of NI social workers faring better than their GB counterparts in terms of well-being and burnout in the later phases of the study is interesting. It is hard to tell why this is so since NI has a higher proportion of children living in deprivation than GB and there is a strong positive relationship between neighbourhood deprivation and the proportion of Looked After Children and children on the child protection register (Bywaters *et al.*, 2020). Deprivation may be associated with service demand (Hood *et al.*, 2020) and yet, of the four UK nations, NI, which has the highest rates of deprivation, has the lowest rates of intervention (Bywaters *et al.*, 2020). It is possible that larger families and closer family ties in NI serve as a protective factor, but further comparative research is needed to explain the findings.

The narratives of social workers connect their reduced levels of well-being with pandemic-induced higher risks in child protection work due to rapid changes at home and school closures to prevent contagion, which had a particularly negative impact on vulnerable children.



Comments relate to referral reductions during that time, followed by an increase once schools reopened. Schools are essential for child safeguarding, with school staff often being the first to report concerns about a child (Baginsky *et al.*, 2022). During the first 3 months of the pandemic, English schools that remained open to vulnerable children and children of critical workers experienced low attendance, with less than 20% of children 'in need' attending (Department for Education, 2020). An observational study from England, reported a 37% decrease in child protection medical examinations during the first pandemic lockdown (March–June 2020), compared to the same period the previous year (Garstang *et al.*, 2020), concluding that school closures risked harm to children due to the abuse remaining hidden. A systematic review of twenty-four studies similarly reported fewer official child maltreatment referrals but found an increase in child maltreatment, evidenced by analyses of online testimonials, rates of physical injuries and calls to help-lines (Marmor *et al.*, 2023).

Social workers had to adapt their working practices during lockdown. The shift posed challenges for them, as they found it harder to make meaningful connections with children and families; as reported elsewhere (Kingstone *et al.*, 2022). Prior to the pandemic, child protection social workers routinely saw children in their family homes, and physical and emotional closeness were commonly used to build relationships with children and families (Ferguson, 2016; Winter *et al.*, 2017). Ferguson (2017) conceptualised 'the unheld child' to explain how effective relational Social Work requires seeing and listening to the child, which can be done virtually, but also using physical closeness, play, observation and sometimes touch, in order to understand the child's world. During COVID-19, physical contact was severely restricted and appears to have had a significant negative impact upon families.

Another major theme in the narratives was staffing problems, including staff sickness, staff leaving and difficulties filling vacancies. There were widespread difficulties recruiting children's social workers during COVID-19 (Local Government Association, 2021). As suggested by Harrikari *et al.* (2021), 'the pandemic period brought a wide range of challenges to social work and revealed its weaknesses' (p. 1652). One such weakness is long-standing staff shortages, amplified by the pandemic. Participants reported increased pressures due to colleagues on sick leave, isolating with COVID-19 or quitting their jobs.

Taken together, our findings are in line with the JD-R model (Bakker and Demerouti, 2007); as the pandemic progressed, service demands, caseloads and complexity of cases increased, as did staff shortages. Almost all had to adapt to new ways of working, combined with high demands, thus leading to lower mental well-being, stress and burnout. This study therefore shows how COVID-19 had a negative impact on UK children's social workers, as reflected in their deteriorating mental

well-being and increasing rates of burnout, which in turn may have impacted service users and safeguarding practices.

### Strengths and limitations

The main strength of this study is the large sample size from whom data were provided at five time points throughout the pandemic. This enabled the examination of trends in burnout and well-being over time. One limitation is the cross-sectional nature of the study, as the same social workers could have participated at different time points. However, due to its anonymous nature, we cannot identify who responded once or several times. We relied on a convenience sample and it is possible that the recruitment methods did not reach some potential participants, noting in particular low numbers of participants with disabilities and from ethnic minorities. Another limitation is that the four nations of the UK were not proportionally represented in the sample which could reflect slightly different recruitment approaches in the four nations. As such, the findings should not be considered representative of all UK children's social workers. Finally, the study did not measure COVID-19 incidence rates in the sample, and it is possible that this might have had affected the results relating to pressures on the workforce.

### Implications and future directions

Despite the limitations, this study has important implications. The well-being of social workers in our sample was low (Ng Fat *et al.*, 2017) and burnout was high. This may have negative consequences for children and families and it may lead to increased sickness absence (Jun *et al.*, 2021), retention problems and turnover. Staffing problems require policy-makers' attention, as they may have social and economic implications for employers and society. The finding of NI social workers having better well-being and lower burnout scores in the later stages of the pandemic, compared to GB social workers, could be explored in more detail in other research. The difference could be partially explained by cultural factors, but it is also possible that certain employer interventions were responsible for the difference.

### Conclusion

This study provides evidence of reduced well-being and increased burnout in children's social workers, and the possible impact of these on service users. This evidence should be acknowledged by employers and

regulators, commissioners, unions and professional bodies, who could proactively intervene to ensure this trajectory does not continue. We have provided evidence from five different time points during the pandemic, that the well-being of children's social workers in the UK was low and work-related burnout increased as the pandemic progressed. Children's social workers in our sample experienced increased work pressures due to higher service demand and referrals, increased case complexity, staff shortages and many acknowledged the negative emotional impact of their working conditions. These findings have important implications for policymakers, as the pandemic has highlighted problems that need fresh and effective attention.

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