Social service providers under COVID-19 duress: adaptation, burnout, and resilience

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Abstract

• Summary: This article examines the response of social services organizations and their workers to the COVID-19 pandemic in a northeastern U.S. state. Using an exploratory, cross-sectional survey design with a convenience sample (N = 1472), we ask: (1) how did agencies and social service workers manage service disruptions associated with COVID-19; (2) how did social service workers perceive shifts in clients’ needs; (3) how did social service workers experience the transition to remote interactions with clients; and (4) how did social service workers cope with COVID-related transitions and demands.

• Findings: Our findings tell a story of unprecedented crises alongside powerful attempts at adaptation, innovation, and resilience. Faced with extraordinary need among their clients, fears for their own health, and a breakdown of organizational and community functioning and guidance, social workers were able to learn and implement new technologies, adapt to increasing demands, manage new work-life boundaries, and find ways to address gaps in service while experiencing symptoms of burnout.

• Application: The impact of supervisory and administrative fragmentation and communication breakdowns in the face of crisis put social workers in an untenable position despite surprising abilities to adapt, innovate, and manage their professional lives while under duress. Assuring better supervisory/administrative infrastructure to support workers as they deliver services during crises will help in future crises.

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Keywords
Social work, COVID-19, social services, disaster/crisis, telehealth, burnout, adaptation

When the COVID-19 pandemic emerged early Spring of 2020, little research was available to understand how frontline social service workers might respond to the crisis. Early investigators suggested that frontline social workers were “building the bridge as we cross it” (Abrams & Dettlaff, 2020, p. 302–303) while others worked to assess the level of peritraumatic stress social workers felt (Miller & Grise-Owens, 2021) during the early stages of the pandemic. Questions remain about how social service organizations and their workers have fared during the ongoing pandemic at each stage, from the early abrupt adaptations to more recent developments after vaccination became available. We, too, wanted to understand how social workers and social service providers coped with the COVID-19 pandemic during its early days (including its exacerbation of social, economic, and racial inequalities). This extended set of crises in spring and summer of 2020 presented unparalleled circumstances where back-up services and personnel were scarce, especially as the pandemic spread across the United States.

In order to examine social work’s response, we drew on a large database of social workers maintained by a university-affiliated continuing education program in the state of New Jersey (NJ), one of the first states to experience high COVID-19 infection rates. We surveyed both direct practice clinicians and administrators about their experiences of service adaptation in the wake of the COVID-19 pandemic. We wanted to fill the gap and understand how they provided services and addressed client needs during the rapid changes in their typical work lives. Using survey methods with this convenience sample, we examined how their agencies adjusted and how they personally adapted; we asked about shifting client needs; we inquired about the professional guidance they received, while themselves coping with pandemic circumstances; and we explored how they felt about the transition to remote interactions with clients and colleagues. In sum, we used our data to examine how social service providers responded in the early days of what became recognized as truly unprecedented circumstances.

Background
In the Spring of 2020, the COVID-19 pandemic came to the United States, with surges in infection rates, hospitalizations, and deaths, especially in New York (NY) and NJ (O’Day & Veit, 2021). As is well-documented, the COVID-19 pandemic disproportionately affected low-income and Black, Indigenous, and People of Color (BIPOC) communities (Benfer & Wiley, 2020). COVID-19 related pressures created deterioration in the mental health indicators of all populations generally (Vindegard & Benros, 2020) and among health care workers on the front line of the pandemic particularly (Greenberg et al., 2020). Although health workers’ reactions were specifically monitored as they worked to meet the needs of hospitalized patients, social service providers garnered much less
attention during the pandemic, hence our interest in filling this gap and understanding the way they experienced and dealt with these challenges.

On March 9, 2020, NJ’s Governor Murphy declared a public health emergency and by March 21, 2020, he issued Executive Order 107 which closed everything but essential businesses (NJ.gov, 2021); the shut-down extended into the early summer. During this period, social service organizations and private psychotherapy practices were largely forced to close throughout the tri-state region of NJ, NY, and Pennsylvania. Even as NJ’s transmission rates waned during the summer of 2020 (O’Day & Veit, 2021), the pandemic’s profound impacts on organizations, social workers, clients, and the wider society reverberated. Yet, NJ’s context is important for other reasons. As a “Home Rule” state, multiple counties have autonomy and independent governance which has created historic fragmentation of services (Bruck, 2008), a situation that continues to this day (Weber & DeLoreto, 2020), causing the governor to have to overrule “Home Rule” in his executive orders in order to enforce public health precautions. With 565 counties in NJ (one less than the 566 that were functioning during the 2008 call for consolidation) and as one of the most diverse states in the nation, NJ is fragmented and experiences poor communication among towns, counties, and the state (Weber & DeLoreto, 2020).

In situating our broad question about how social service organizations and their workers adapted to pandemic stressors, we looked to several bodies of literature to help us frame our questions and understand our data. These included literature on organizational behavior, disaster preparedness and emergency response, adaptation to new technologies, and worker burnout.

Understanding the response of social workers to COVID-19 necessitates an examination of their organizational contexts. Brodkin (2021) recently built on Lipsky’s (1980) classic notion of street level bureaucracy that acknowledges the discretion and relative autonomy of social service workers. Lipsky originally theorized how public agencies and their workers attempted to navigate increasing service demands in the face of limited resources, slow-moving bureaucracies, and ambiguous public policies. A newer generation of scholars have expanded his model beyond the public sector to the non-profit and contracting sector, finding that terms of contracts and performance indicators also influence workers’ exercise of discretion (Brodkin, 2012). Most recently, Brodkin (2021) observes that Lipsky’s framework is grounded in routine practices whereas the pandemic circumstances allow us to examine how non-routine, crisis situations affect the work of frontline social service providers. Adding to Lipsky’s original framework, she proposed that frontline workers exercise their discretion in a crisis through: disrupted routines during which they develop new policies through practice as they work to modify distribution of resources in ways that fit the crisis; adaptation which allows for flexibility to address the disparity between demand for resources and actual available resources, while keeping routine practices similar to past practices; resistance which holds that new practices may occur given the right conditions and these may be in tension with routine practices; and workers may use innovation or redirection, transforming practices, not merely adapting old practices but developing truly new practices (innovation) or redefining the mission of the services (redirection). We wondered how NJ front-line social workers navigated their disrupted routines during the pandemic.
Literature on organizational responses to disaster emphasizes the critical role of networks in successful social service delivery. To be effective, networks require network structures, capacity and capabilities, trust between agencies, interoperable communication systems, pre-existing relationships, formal collaborative ties, boundary spanners, and an ability to learn in crises (Kapucu & Demiroz, 2017). Factors that hinder effective response include role ambiguity, lack of communications plans, and lack of facilitating factors (Kapucu & Demiroz, 2017). The lack of federal will to intervene early in the pandemic significantly limited guidance from emergency managers, such as the Federal Emergency Management Agency, and further impaired network functioning (Hertelendy & Waugh, 2020). Here, we recognized that the dynamics of the pandemic potentially undermined network efficacy and supervisory capacity and we questioned how these challenges affected social service workers’ experiences of COVID-19 disruptions.

One of the most significant adaptations in this period was the transition to remote social service delivery. The rapid shut down of office spaces and agencies in March 2020 yielded an expedited approval by the Centers for Medicare and Medicaid Services (CMS) (2021) for reimbursing services provided by telephone and videoconferencing. This changed the landscape of social and therapeutic services. Banks et al. (2020) surveyed active social workers around the globe during May 2020 and found that social workers adapted to increasing demand by working longer hours while innovating the practice of service delivery using telehealth, particularly in the United States and Europe. Notably, this was a challenge as social workers have not typically embraced remote technologies such as text therapy or videoconferencing for therapeutic purposes. Although telehealth options (e.g., Crisistextline.org, Betterhelp.com, Talkspace.com) proliferated over the last two decades, social workers’ acceptance of this technology lagged behind. Many were reluctant to embrace telehealth due to a belief in “the necessity of a face-to-face relationship,” as well as confidentiality and reimbursements concerns (McCarty & Clancy, 2002, p. 155). Nevertheless, the urgency of closed offices and client needs seemed to crack the reluctance of mental health clinicians and they moved onto virtual platforms (Békés & Aafjes-van Doorn, 2020), in large part enabled by CMS’s willingness to reimburse such services, and loosened state licensing requirements. Recent scholarship suggests this transition to remote work may have added to social workers’ distress during the early days of the pandemic in Kentucky (Miller & Grise-Owens, 2021), though the geographical breadth of this distress is less clear. Increased client mental health needs instigated a broader embrace of computer-assisted therapy even when clinicians were hesitant (Rosen et al., 2020). These transitions were a focus of our research.

The increased demands and challenges of social service provision during the COVID-19 pandemic are known, yet we know relatively little about how social work practitioners and administrators managed their professional and personal stressors. Burnout is a known outcome when the demands of work, structurally and emotionally, exceed the capacities of the worker to manage the circumstances (Lizano, 2015). Specific organizational circumstances also contribute to the experience of social worker dissatisfaction and subsequent burnout including increased demands for
productivity, lack of support, and difficulties with interdisciplinary collaboration (Kadushin & Kulys, 1995). Additionally, levels of supervision are known to affect social workers’ retention in their positions (Chiller & Crisp, 2012) and the availability of supportive supervision is viewed as part of ensuring social workers’ ability to continue caring for their clients when stressed (Newcomb, 2021). These aspects of social workers’ ability to do their work under the duress of the adaptations required by the pandemic, combined with the societal conversation on pandemic burnout and Zoom fatigue (Bailenson, 2021), meant that we aimed to broadly and holistically understand the experience of burnout among social service workers as they confronted the pandemic.

**Methods**

We used an exploratory, anonymous, cross-sectional survey design with a large convenience sample to address our research questions. We asked: (1) how agencies and social service workers managed service disruptions and safety risks associated with COVID-19; (2) how social service workers perceived and experienced shifts in clients’ needs; (3) how social service workers felt about the transition to remote interactions with clients and their perceptions of clients’ acceptance of telehealth; and (4) how social service workers coped with COVID-related transitions and demands.

**Sample**

Our study drew on a listserv of slightly over 35,000 individuals who participated in continuing education events associated with a school of social work in NJ over the last two decades. We sent an introductory letter, consent form, and survey instrument via email inviting these individuals to participate in a Qualtrics survey in September 2020, knowing that typical response rates to such online recruitment via large listservs tend to generate very low response rates (Poynton et al., 2019). We therefore expected a low traditional response rate, especially considering social workers’ demands on their time during the pandemic. Consequently, we designed our survey to elicit expansive qualitative data in order to ensure depth and richness of data even if we were unable to generate higher response rates. Eligibility criteria included respondents who were “employed in a public or private agency or in private practice (group or individual) as the COVID-19 pandemic began.” The Rutgers University Institutional Review Board approved the study. Of the 1642 individuals who started to respond to the survey, 1472 respondents completed the survey (all had been employed at the beginning of the pandemic), a nearly 90% completion rate. Eysenbach (2004) indicates this completion rate for internet surveys supports validity.

**Survey instrument**

Our survey included structured close-ended items with specified responses and open-ended items with text boxes. Items queried demographic and descriptive information about the respondents and their agency settings; COVID-19’s disruption/s on their
agencies’ services; and shifts in clients’ presenting needs. The survey also examined telehealth practices, including changes in private practice, workers’ perspectives on comparative quality of telehealth; and their personal challenges (and coping strategies) in balancing work and home life. Each quantitative item included a text box where respondents could expand on their answers.

**Analyses**

We conducted a variety of descriptive univariate analyses. We also used thematic analysis, a fundamental and flexible approach to qualitative data analysis applicable across varying qualitative data, allowing identification of emergent themes and patterns in the data (Braun & Clarke, 2006). Our thematic analysis involved four members of the research team reviewing all the qualitative data and generating and agreeing on a set of broad initial coding categories. The broad coding categories were then assigned to each team member, who refined and expanded the initial codes. The team members kept analytic memos and met regularly to review and reconcile the codes, explore their relationships, and eventually to reduce them into higher order and analytically richer, interpretive themes. Regular team meetings, memo-ing, peer debriefing, and reflexivity checks all enhanced the analytic rigor (Creswell, 2013).

**Results**

Our survey generated an overall sample of 1472. Respondents were asked to identify as either clinicians/direct practice ($N = 1137: 77\%$) or administrators ($N = 335: 23\%$). In addition to these mutually exclusive categories, respondents in both categories were asked if they engaged in private practice which generated a sub-sample of 448 people (thus this private practice sub-sample included those who identified as administrators ($N = 38$) and direct practice workers ($N = 410$)). Table 1 captures the sample’s diversity. The survey’s skip-logic meant some questions were answered by the full sample, clinicians/direct practice providers and administrators, or as private practitioners ($N = 448$). Hence, sample sizes vary depending on whether a section was directed to the full sample or just the private practitioners, whether respondents skipped portions of the survey, and whether they answered every item. It is important to reiterate that these data were collected at the end of the first summer of the pandemic (August to September 2020) before vaccination or coordinated political commitment to ending the pandemic was in evidence. Because the survey was answered anonymously, we provide no code numbers nor pseudonyms for the quote extracts presented in our results; within the Results tables and text, we include illustrative quotes that reflect the primary themes identified by our analysis.

**Impact on client needs**

We asked our full sample to identify major needs among their client populations as the pandemic took hold. Echoing national data, our respondents reported that the economic
fall-out of COVID-19 resulted in increased financial needs (~56%), job loss (54%), and housing (32%) and food (48%) insecurity for their clients. Respondents described how clients experienced increased caregiving burdens such as childcare (57%) and eldercare (27%) and had increased mental health (77%) and addictions (33%) concerns for family members and themselves. They identified other forms of client distress such as increasing rates of social isolation (76%) and decreases in access to informal support networks (53%). Mirroring our quantitative findings, our qualitative data are replete with references to higher acuity and growing psychological distress among clients in the wake of COVID-19. One respondent, an emergency room social worker, captured what many reported: “I have been seeing an alarming increase in suicidal ideation, anxiety that impacts daily functioning, an increase in alcohol and drug use, social isolation leading to decompensation in the elderly population, and a pervasive lack of services across all areas.”

**Workers’ experiences of disrupted organizational operations**

In addition to the pandemic’s toll on client communities, social service providers commented on experiences within their agency context. One respondent said:

I think 24/7/365 agencies have struggled the most because in the current climate, our services are needed now more than ever...I think crisis and other face-to-face mental health workers are struggling and being asked to do more work and hold more space while struggling with

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**Table 1. Demographic and professional characteristics (N = 1472).**

| Gender                  | N   | %   |
|-------------------------|-----|-----|
| Male                    | 138 | 9.4%|
| Female                  | 1325| 90.0%|
| Non-binary              | 4   | 0.3%|
| Missing                 | 5   | 0.3%|
| Race/Ethnicity          |     |     |
| Asian/Native Am./Other  | 77  | 5.2%|
| Black/African American  | 136 | 9.2%|
| Latino/a/x/Hispanic     | 123 | 8.4%|
| White                   | 1129| 76.7%|
| Missing                 | 7   | 0.5%|
| Age                     |     |     |
| 20–39                   | 450 | 30.6%|
| 40–59                   | 674 | 45.8%|
| 60+                     | 347 | 23.7%|
| Missing                 | 1   | 0.1%|
| Type of provider        |     |     |
| Clinician/Direct service| 1137| 77.0%|
| Administrator/Director  | 335 | 23.0%|
| Missing                 | 0   | 0.0%|
our own anxiety etc that COVID has sparked. Now more than ever I have recognized the lack of support that social workers have.

Many social service workers reported similar struggles, feeling unappreciated, unsupported, and expected to solve insolvable problems.

As documented in the larger literature (Shi et al., 2020), the pandemic resulted in major operational disruptions for agencies. Forty-eight percent of those who answered the question about service disruptions reported their agency closed for 1 to 23 weeks; approximately 10% of the respondents continued to provide their services face-to-face while about 30% transitioned to primarily remote delivery of services. Less than 1% reported that their agency had permanently closed.

Our qualitative data reveal the critical finding of the disruptive impact of the pandemic on remote administrative functioning, including impairments in cross-agency collaboration, local and state (safety net) functions, and staff support. Respondents missed informal communications with colleagues for support and consultation; many were frustrated by the lack of guidance both within their agencies’ supervisory and administrative staff and from governmental and professional bodies; others described a breakdown in governmental operations wherein social safety net agencies were not responding, seemingly inaccessible to clients or to the workers attempting to make referrals. Several named critical county and state-level vital services (housing, food insecurity, unemployment) that remained inaccessible during the first spring and summer of the pandemic. Importantly, supervisors and administrators recognized and appeared to appreciate staff frustrations but lacked clear guidance from and access to critical local, state, and community offices and services. This, in turn, affected their ability to provide much desired guidance to their staff. Nevertheless, administrators were generally quite proud of their staff and programs for their abilities to adapt and maintain their own service provision (Table 2).

Social workers recognized the social justice implications of the organizational failures. Communication breakdowns (with supervisory/administrative staff and county agencies) challenged providers to find new ways to deliver care and support, but guidance, decision-making, and funding for such improvements and innovations were not readily available. Without funding or guidance to generate new solutions or update technological equipment and services, workers had added frustration.

**Transition to telehealth/teletherapy**

Both administrators and practitioners in the private practice sub-sample focused on the transition to remote operations and client services as one of the largest pandemic-related challenges. Our respondents described the transition to telehealth for therapeutic contact and client services. Many described unforeseen benefits and adapted more quickly than anticipated. Close-ended items queried respondents engaged in private practice (N = 448), many of whom were also employed in agency settings, about their perspective on teletherapy within the context of their private practices. A majority (60%) endorsed
Table 2. Transition to remote services: organizational dynamics.

| Lack of intra-agency guidance, communication, and support | Administrators | Practitioners |
|----------------------------------------------------------|----------------|---------------|
| Agency was slow to respond to needs of staff. Slow in communication. Slow in making policies to govern the new environment. Staff were frustrated because of the lack of information. | | Agency has left clinicians to fend for themselves. No agency works to maintain communication, team collaboration, and self-care. |
| Break down of community and governmental services and responses | I think you should know that even though our services are open and seeing clients face to face, some of the community partners that we refer clients to are not. This can be a hinderance for continued care. Our larger county agency is still struggling and we are having trouble completing our work because of other agencies not being fully up to speed. | The access to social services & any state-affiliated entities has become abysmal. Clients continue to suffer when their concrete needs cannot be met when there is lack of staff available. Messages go unreturned, & clients & clinicians cannot move their agendas forward. |
| Administrative and funding challenges | I am overseeing an agency where a significant amount of staff are still furloughed but we are still providing services to the same number of clients who have a high level of need. My workload has increased exponentially to cover the responsibilities of furloughed individuals while ensuring my administrative duties | I’m doing the work of two people - it’s exhausting and unappreciated by employers. |
| Social justice implications of organizational breakdown | The impact on the developmental disability population and their support services is profound. The continued marginalization of the population by the inability of the federal government to have a cohesive response gravely concerns me via the lens of social justice and equity. | Systems were already faltering and poorly managed. Covid highlighted the enormity of the problems poor people endure daily. |
the item stating that teletherapy was “not as good as in person,” with 34% responding that it was “just as good as in person.”

In their qualitative comments, private practitioners provided extensive detail about what they perceived as the limits of telehealth, as well as the populations for whom they felt it was less than effective. The digital divide limited how telehealth was able to be used by clients, especially those who were already under-resourced. So-called “Zoom fatigue” affected clients and clinicians alike. Certain modalities (e.g., EMDR, play therapy, sand art) were difficult if not impossible in a virtual context and many found assessing for suicidality and substance use more challenging. Respondents noted how some client populations were not well served by telehealth: young children were too easily distracted; older adults were not technologically adept; and sometimes online interventions exacerbated mental health symptoms. Even so, many acknowledged benefits they had not expected. Some seemed almost religiously converted with one stating “I didn’t believe in this, but it is a blessing.” Some noted easier access for clients, fewer missed sessions, greater therapeutic engagement, and greater ease for clients because barriers of transportation, childcare, and some privacy worries (arrivals at agencies and offices) were now mitigated. Many seemed surprised, almost triumphant, about how well they managed the transition (Table 3).

**Burnout and coping**

Given the deep and complex professional challenges associated with COVID-19 and larger social and personal impact and stressors wrought by pandemic life, a majority of our respondents reported experiencing symptoms of burnout (61%). It should be noted that these percentages reflect the respondents who completed the section of the survey on burnout and coping, approximately 79% of those who had started the survey. Self-reported symptoms of compassion fatigue (42%) and reports of secondary traumatic stress (27%) combined with concerns about safety (33%; e.g., lack of personal protective equipment (PPE) and compliance with Centers for Disease Prevention and Control (CDC) guidelines) and difficulties connecting clients with needed services (46%) to yield a perfect storm of frustration and burnout. Table 4 captures both the overt expressions of burnout and the organizational contributors to burnout (e.g., breakdowns in local and state functions/guidance, cross-agency collaboration, and staff support). Both administrators and practitioners’ narratives emphasized high client demands, a sense of inability to meet those demands, challenges of maintaining boundaries, and increased levels of personal stressors and care needs. Although administrators reported awareness of burnout among their staff, clinicians felt isolated and often unsupported by agency supervisors (as noted here and in Tables 2 and 4), creating a toxic level of stress that generated burnout.

**Discussion**

Our investigation of social workers’ responses to COVID-19 tells a story of unprecedented crises alongside powerful attempts at adaptation, innovation, and resilience.
Faced with extraordinary need among their clients, fears for their own health and well-being, and a breakdown of organizational and community functioning and guidance, social workers were able to learn and implement new technologies, adapt to increasing demands, manage new boundaries given the blurring of work and home life, and find ways to address gaps in service, albeit with symptoms of burnout.

Our findings reveal an organizational and community context assailed by this unparalleled crisis. Echoing national data, our respondents described increasing material and psychological demands.

### Table 3. Challenges in transition to telehealth and telehealth adjustment.

| Challenges | Positive Administrators | Practitioners |
|------------|-------------------------|---------------|
| Telehealth- Expansion on answer of “Just as good or not”: ambivalent | HIGH BURNOUT PROVIDING TELEHEALTH services - difficulty providing sufficient mental health services to high risk …it was difficult to navigate the teams’ feeling of increased isolation and grief while at the same time treating high risk clients. I am proud that my team continued on and we built a successful telehealth service. | I have been surprised that teletherapy works as well as it does, but I cannot say it equals real in person contact. |
| Telehealth: Positive outcomes/Converted | A positive benefit, is that as a result of COVID-19 stay at home orders, the agency moved from SOLELY providing in person services to providing both phone and video sessions. Now that we are back in person, we continue to offer all three options:… our clients… now have the option to choose what best suits their needs and situations. | I have decided to not go back to in person sessions. Video works so well that I am converting my entire practice to only video, even after Covid passes. |
| Increased access/engagement | Client engagement/compliance actually increased with the use of virtual services. | My clients are appreciating greater casualness & no commute. |
| Challenges | | |
| Assessment and Intervention Limitations | Some of my population are struggling with addiction. Teletherapy makes it difficult to visually assess if someone may be under the influence. | |
| Digital divide | Many of our clients either do not have the technology to do online virtual therapy sessions or they don’t trust it. | |
| Zoom fatigue and technology problems/access for organizations | Telehealth is more exhausting mentally and physically for myself as a clinician which has left me no other option but decreasing the number of sessions per day and reducing number of open cases. | |

Faced with extraordinary need among their clients, fears for their own health and well-being, and a breakdown of organizational and community functioning and guidance, social workers were able to learn and implement new technologies, adapt to increasing demands, manage new boundaries given the blurring of work and home life, and find ways to address gaps in service, albeit with symptoms of burnout.
emotional needs among their clients coupled with significant social isolation and behavioral health impacts. These needs emerged in the context of deeply disrupted organizational operations characterized by a lack of internal and state-level communication and guidance, a breakdown of community and state safety-net services, the absence of normative collegial communication, and financial and administrative challenges as agencies closed for varied periods of time. It is unclear whether the fragmentation of services characteristic of “Home Rule” states like NJ exacerbated these disconnections and our respondents did not speak directly to this issue, but it seems clear that these breakdowns of supervisory and administrative guidance at multiple levels (agency, county, state) created circumstances that further taxed the direct practice workers’ abilities to cope.

Table 4. Burnout.

|                         | Administrators                                                                                                                                                                                                 | Practitioners                                                                                                                                                                                                 |
|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Feeling inadequate or   | Our mobile response program had significant layoffs (70% of the staff) and is now operating a 24/7 crisis response program with very few staff who are increasingly overwhelmed.                                    | I experienced burnout from the overwhelming request for therapy. …working twice as hard but half as good                                                                                                   |
| overwhelmed in face of  |                                                                                                                                                                                                             | Clients have been reaching out to me 24/7 via phone, email, text. It’s nonstop. Difficulty setting boundaries between home and work life; they all blur.                                                    |
| higher needs            |                                                                                                                                                                                                             |                                                                                                                                                                                                             |
| Boundaries blur         | It feels like there no “end” and “normal” work hours no longer apply- families and staff can and will contact at all hours of the day and night.                                                        |                                                                                                                                                                                                             |
|                         |                                                                                                                                                                                                             |                                                                                                                                                                                                             |
| Increased personal      | We’ve had an increase in stress and anxiety among our staff--adjusting to remote work/conducting teletherapy, childcare issues, grieving loss of loved ones to Covid-19, increased isolation. Staff [are] struggling with Covid as clients are. We have had to furlough, state has cut some funding. We are worried for our own families and worried for our clients. | I have had to cut back on my emergency availability due to my own family’s needs and my burnout. I have had to turn away a lot of people, including old clients… But my burnout is too high to add hours and their need is so great. |
| stressors while         |                                                                                                                                                                                                             |                                                                                                                                                                                                             |
| managing higher work    |                                                                                                                                                                                                             |                                                                                                                                                                                                             |
| demands                 |                                                                                                                                                                                                             |                                                                                                                                                                                                             |
| Work related emotional  | [M]y team experienced two suicides in less than 6 months. It was difficult to navigate the teams’ feeling of increased isolation and grief while at the same time treating high risk clients. | I have seen increased isolation and stress for both service providers and clients. Overall greater sense of vulnerability, rawness, and mortality struggles.                                          |
| stress                  |                                                                                                                                                                                                             |                                                                                                                                                                                                             |
Notably, a study of NY state mental health providers and administrators also reported communication breakdowns at supervisory, local, professional, and state levels as well (Murphy et al., 2021), despite NY having a stronger state-authority context.

Kapucu and Demiroz (2017) maintain that effective disaster response requires the existence of facilitating factors (e.g., the interactional capabilities of organizations—see literature reviewed above), while hindering factors (e.g., role ambiguity, lack of communications plans) impair such effectiveness. Our respondents reported hindering factors more than facilitating factors. Notably, recent literature that reports effective responses during the early days of the pandemic illustrates environments characterized by enough supervisory and administrative infrastructure and containing built-in redundancy, enabling them to maintain strong guidance and support structures for social service workers during the early days of the pandemic (Jones et al., 2021; Xenakis et al., 2021). This implies that an important factor in weathering and responding to crises is a robust supervisory and administrative infrastructure that is able to optimize communications within agencies and across organizations while providing clear guidance for direct practice workers.

Mirroring Banks et al.’s “snapshot” (2020, p. 570) of social workers’ responses to COVID across the globe, our respondents also observed that organizational and community-level shocks eroded social workers’ normative role as allocators of resources, leaving respondents frustrated, angry, and burnt out. Their focus on both the breakdown of the formal network guidance, and also the lack of access to collegial communications for problem-solving and support, explains some of their heightened stress, yet is a facet of the pandemic that is not receiving enough research attention. These structural communication deficits have implications for compassion satisfaction (the sense of fulfillment and pleasure derived from providing care—Bae et al., 2020) that will be addressed below in our discussion of burnout.

Respondents described a rocky transition to remote services and identified this as the largest pandemic-related challenge. Approximately 70% of participants reported providing primarily remote services with a majority (60%) believing that in-person services remained preferable to remote ones. “Zoom fatigue,” challenges translating particular interventions to the screen, the digital divide, and a failure to engage certain populations all marred telehealth’s potential in these helping professionals’ opinions. Yet others were self-described converts, citing higher participation rates, ease of use, and the intimacy of virtual sessions “within” client homes. It is possible that our sample (who were responding to an online survey via a continuing education listserv) are somewhat more technology-savvy and resourced in contrast to other research that has indicated that the lack of technological hardware and bandwidth was problematic for many mental health workers and their clients (Murphy et al., 2021).

Given the structural challenges across organizational and social service networks, it is unsurprising that we found deep evidence of burnout among our respondents. They reported increased demands for productivity and lack of support, known contributors to burnout (Kadushin & Kulys, 1995) along with the dimensions of burnout articulated in the classic literature such as emotional exhaustion and decreased feelings of personal accomplishment (Maslach & Jackson, 1981). Combining these work-related demands
with the personal toll of the pandemic, from family responsibilities to porous work-at-home arrangements to health concerns, all exacerbated feelings of burnout among our respondents. Social workers’ ability to feel compassion satisfaction that mitigates compassion fatigue and burnout seems to be founded in their emotional intelligence, work autonomy, and work-life balance (Bae et al., 2020). Our findings indicate that work-life balance was particularly impaired during the early months of the pandemic. With little administrative contact, workers may have felt so much “autonomy” that they felt a lack of guidance. Bae and colleagues (2020) suggest that transformational leadership that strives to stimulate and inspire workers to achieve their best professional selves is more likely to enhance compassion satisfaction and reduce burnout than other forms of leadership based on punishments and rewards; we add that ongoing contact, rather than hands-off trust, might also be beneficial. We contend that having access to ongoing clinical and supportive supervision is likely to enhance workers’ functioning under the duress of public health and other crises and should be addressed by organizations in their crisis management plans. Our findings join a larger body of street level organizational (SLO) research and validate the applicability of Brodkin’s (2012) model. These findings answer some of Brodkin’s (2021) more recent questions about what happens to SLOs and their workers under circumstances of crisis rather than routine functioning. Our data reflect substantial evidence of her hypothesis that workers practice adaptation in response to disrupted routines. These adaptations involved longer work hours, lower boundaries between home and work, and unrelenting worry about their clients’ and their own health. These are changes that maintain typical responsibilities while revising routines, thereby not meeting the threshold of revolutionary changes that innovations entail.

Brodkin (2021) suggests that in the face of overwhelming demand for adaptations under crisis conditions, workers would likely resist or innovate and redirect. A notable finding among our respondents was the level of willingness to engage in longer and more intense work as a response to client need rather than resistance to those demands. Slowing down was not evident in this early part of the pandemic. Providers’ resistance to pandemic-related shifts was more nuanced, such as noting agencies’ failures to comply with safety protocols, expressing distrust or dislike of telehealth, and occasionally considering leaving their jobs. Innovations characterized our respondents’ experiences somewhat, as they reported conversion to the unexpected benefits of remote service provision. Although these telehealth practices started as adaptations, those who were “converted” discussed plans to transform their practices in a post-pandemic world. This movement to consider transformative changes in the way practice is done constitute innovations.

Limitations of the study

Our study conclusions are limited to a sample gathered from a fairly urban tri-state area and coming from a group of workers invested in their professional identities as evidenced by their willingness to complete the survey. Nevertheless, we had wide representation of social service workers who provided nuanced details about their experiences as the pandemic unfolded from March through August 2020. The cross-sectional nature of our
survey does not allow us to capture how practice innovations resulting from the crisis transformed or persisted over time. We also cannot consider the longer-term trajectory and its implications for pandemic-related burnout among social service providers. Several of our analyses were limited because of overlap between direct practice workers and administrator categories among the private practitioners, and skip logic aspects of the survey that meant we could not always tease out specific responses from those different groups on each domain of interest. Moreover, given the anonymous survey design, we were not able to probe for additional information, clarification, and nuance as we would have in qualitative interviews. Nevertheless, for a cross-sectional survey with open-ended questions, we obtained relatively rich data.

Conclusions

In conclusion, what was striking about our respondents’ stories as they adjusted to social service provision at the end of the first summer of the pandemic was how they juggled family and home obligations while ramping up services to their clients and their organizations, all while feeling less supported by their agencies and state/federal organizations and isolated from their colleagues. Moving forward, research is needed to understand how these social service workers reconcile their resilience in the face of great client need, while experiencing burnout themselves. It can also consider how better levels of administrative and supervisory infrastructure could help support social workers in the face of crises. We need to understand how long adaptations and innovations can pair with resiliency before social workers are beyond their capacity and become burnt out in ways that may produce resistance. We must identify how to ensure that infrastructural supports like supportive supervision and better communication structures among social safety net organizations are maintained under crisis conditions to enable the workers to provide services. Research should examine the long-term implications of workers’ selflessness in providing social services under great duress. From a structural perspective, comparative research is needed to explore the role of devolution, service centralization, and service fragmentation in a crisis response context for social services. Finally, our study emphasizes the need for enhanced worker supports and effective crisis management planning among social service and governmental entities before the next pandemic or crisis arises.

Acknowledgements

We appreciate the time taken by the respondents to reflectively answer our survey to enable this research. We also are grateful for the “Grounded Research in Practice” project of the Rutgers University School of Social Work that provided the email listserv for the survey distribution.

Authors’ contributions

LC, EC, PF, and KH developed the survey with feedback by JM. KH disseminated the survey and generated the reports. LC, EC, PF, and JM reviewed all data and coded qualitative data for major themes. LC, EC, PF, and JM conducted varied literature reviews to enhance the analysis and develop the literature foundation for the manuscript. LC and JM conducted the in-depth analysis
of coded materials. JM wrote the first draft of the manuscript with major input and revision by LC. KH checked quantitative data. The final manuscript was edited by PF and reviewed by all authors.

**Ethics**

This study was approved as an expedited protocol (Pro2020002013) by the Rutgers University Arts & Sciences Institutional Review Board. The research was ethically reviewed by the university IRB, following the Belmont Report and the Declaration of Helsinki guidelines. All respondents indicated understanding of the informed consent prior to completion of the anonymous survey.

**Funding**

The authors received no financial support for the research, authorship, and/or publication of this article.

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**References**

Abrams, L. S., & Dettlaff, A. J. (2020). Voices from the frontlines: Social workers confront the COVID-19 pandemic. *Social Work, 65*(3), 302–305. https://doi.org/10.1093/sw/swaa030

Bae, J., Jennings, P. F., Hardeman, C. P., Kim, E., Lee, M., Littleton, T., & Saasa, S. (2020). Compassion satisfaction among social work practitioners: The role of work–life balance. *Journal of Social Service Research, 46*(3), 320–330. https://doi.org/10.1080/01488376.2019.1566195

Bailenson, J. N. (2021). Nonverbal overload: A theoretical argument for the causes of zoom fatigue. *Technology, Mind, and Behavior, 2*(1), 2–16. https://doi.org/10.1037/tmb0000030

Banks, S., Cai, T., de Jonge, E., Shears, J., Shum, M., Sobočan, A., Strom, K., Truell, R., Uriz, M. J., & Weinberg, M. (2020). Practising ethically during COVID-19: Social work challenges and responses. *International Social Work, 63*(5), 569–583. https://doi.org/10.1177/0020872820949614

Békés, V., & Aafjes-van Doorn, K. (2020). Psychotherapists’ attitudes toward online therapy during the COVID-19 pandemic. *Journal of Psychotherapy Integration, 30*(2), 238–247. https://doi.org/10.1037/int0000214

Benfer, E. A., & Wiley, L. F. (2020, March 19). Health justice strategies to combat COVID-19: Protecting vulnerable communities during a pandemic. *Health Affairs Blog ForeFront*. https://www.healthaffairs.org/do/10.1377/forefront.20200319.757883/full/

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brodkin, E. Z. (2012). Reflections on street-level bureaucracy: Past, present, and future. *Public Administration Review, 72*(6), 940–949. https://doi.org/10.1111/j.1540-6210.2012.02657.x

Brodkin, E. Z. (2021). Street-Level organizations at the front lines of crises. *Journal of Comparative Policy Analysis: Research and Practice, 23*(1), 16–29. https://doi.org/10.1080/13876988.2020.1848352
Bruck, A. (2008). Overruled by home rule: Why the New Jersey legislature’s latest attempt to end the waste, corruption, and inequality created by municipal fragmentation will fail. *Seton Hall Legislative Journal, 32*(2), 1112816. https://ssrn.com/abstract=1112816

Centers for Medicare and Medicaid Services (CMS). (2021). List of telehealth services. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Chiller, P., & Crisp, B. R. (2012). Professional supervision: A workforce retention strategy for social work? *Australian Social Work, 65*(2), 232–242. https://doi.org/10.1080/0312407X.2011.625036

Creswell, J. W. (2013). *Qualitative inquiry & research design: choosing among five approaches* (3rd ed.). Sage.

Eysenbach, G. (2004). Improving the quality of web surveys: The checklist for reporting results of internet E-surveys (CHERRIES). *Journal of Medical Internet Research, 6*(3), e34(1–7). https://doi.org/10.2196/jmir.6.3.e34

Greenberg, N., Docherty, M., Gnanapragasam, S., & Wessely, S. (2020). Managing mental health challenges faced by healthcare workers during the COVID-19 pandemic. *BMJ*, 368, m1211. https://doi.org/10.1136/bmj.m1211

Hertelendy, A. J., & Waugh, W. L. Jr (2020). Emergency management missing from the pandemic? *Journal of Emergency Management, 18*(7), 149–150. https://doi.org/10.5055/jem.0526

Jones, B. L., Phillips, F., Shanor, D., VanDiest, H., Chen, Q., Currin-McCulloch, J., Franklin, C., Sparks, D., Corral, C., & Ortega, J. (2021). Social work leadership in a medical school: A coordinated, compassionate COVID-19 response. *Social Work in Health Care, 60*(1), 49–61. https://doi.org/10.1080/00981389.2021.1885567

Kadushin, G., & Kulys, R. (1995). Job satisfaction among social work discharge planners. *Health & Social Work, 20*(3), 174–186. https://doi.org/10.1093/hsw/20.3.174

Kapucu, N., & Demiroz, F. (2017). Interorganizational networks in disaster management. In E. C. Jones, & A. J. Faas (Eds), *Social network analysis of disaster response, recovery, and adaptation* (pp. 43–60). Butterworth-Heinemann.

Lipsky, M. (1980). *Street-level bureaucracy: Dilemmas of the individual in public services*. Russell Sage Foundation.

Lizano, E. L. (2015). Examining the impact of job burnout on the health and well-being of human service workers: A systematic review and synthesis. *Human Service Organizations: Management, Leadership & Governance, 39*(3), 167–181. https://doi.org/10.1080/23303131.2015.1014122

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior, 2*(2), 99–113. https://doi.org/10.1002/job.4030020205

McCarty, D., & Clancy, C. (2002). Telehealth: Implications for social work practice. *Social Work, 47*(2), 153–161. https://doi.org/10.1093/sw/47.2.153

Miller, J. J., & Grise-Owens, E. (2022). The impact of COVID-19 on social workers: An assessment of peritraumatic distress. *Journal of Social Work, 22*. 3, 674–691. https://doi.org/10.1177/0308575921991950

Murphy, A. A., Karyczak, S., Dolce, J. N., Zechner, M., Bates, F., Gill, K. J., & Rothpletz-Puglia, P. (2021). Challenges experienced by behavioral health organizations in New York resulting from COVID-19: A qualitative analysis. *Community Mental Health Journal, 57*(1), 111–120. https://doi.org/10.1007/s10597-020-00731-3

Newcomb, M. (2022). Supportive social work supervision as an act of care: A conceptual model. *The British Journal of Social Work, 52*(2), 1070–1088. https://doi.org/10.1093/bjsw/bcab074

NJ.gov. (2021). Executive orders. https://nj.gov/infobank/eo/056murphy/

O’Day, C., & Veit, S. (2021). Track COVID-19 in New Jersey: Maps, graphics, regular updates (April 27, 2021). https://www.njspotlight.com/2020/03/tracking-cases-of-covid-19-county-by-county-in-new-jersey/
Poynton, T. A., DeFouw, E. R., & Morizio, L. J. (2019). A systematic review of online response rates in four counseling journals. *Journal of Counseling & Development, 97*(1), 33–42. https://doi.org/10.1002/jcad.12233

Rosen, C., Glassman, L., & Morland, L. (2020). Telepsychotherapy during a pandemic: A traumatic stress perspective. *Journal of Psychotherapy Integration, 30*(2), 174–187. https://doi.org/10.1037/int0000221

Shi, Y., Jang, H. S., Keyes, L., & Dicke, L. (2020). Nonprofit service continuity and responses in the pandemic: Disruptions, ambiguity, innovation, and challenges. *Public Administration Review, 80*(5), 874–879. https://doi.org/10.1111/puar.13254

Vindegaard, N., & Benros, M. E. (2020). COVID-19 pandemic and mental health consequences: systematic review of the current evidence. *Brain, Behavior, and Immunity, 89*, 531–542. https://doi.org/10.1016/j.bbi.2020.05.048

Weber, K., & DeLoreto, M. (2020, May 12). ‘Home rule’ conflicts likely as NJ reopens. *Law360*. https://www.law360.com/articles/1272540

Xenakis, N., Brosnan, M. M., Burgos, L., Childs, J., Deschamps, J., Dobrof, J., Farquhar, D. W., Genovesi, M. L., Goldgraben, K. R., Gordon, E., Hamilton, C., Koppel, S. R., Lipp, M. N., Potter, R., Rauch, A., Rodriguez, V., Schubert, E., Sollars, E. D., & Zilberfein, F. (2021). In the global epicenter: Social work leadership in a New York city hospital. *Social Work in Health Care, 60*(1), 62–77. https://doi.org/10.1080/00981389.2021.1885563