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Child welfare workers and peritraumatic distress: The impact of COVID-19

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ABSTRACT

Whilst there is broad consensus that COVID-19 has had a pernicious impact on child welfare services, in general, and child welfare workers, specifically, this notion has not been thoroughly examined in the literature. This exploratory study examined COVID-19 related peritraumatic distress among child welfare workers (N = 1996) in one southeastern state in the United States (U.S.). Findings suggest that the study sample was experiencing distress levels above normal ranges; 46.4% of participants were experiencing mild or severe distress. Sexual orientation, self-reported physical and mental health, relationship status, supervision status, and financial stability impacted distress levels experienced by child welfare workers. Overall, data suggest that COVID-19 is impacting child welfare workers and there is a need to conceptualize, implement, and evaluate initiatives aimed at assuaging distress among child welfare workers.

1. Introduction

Coronavirus (COVID-19) pandemic has fundamentally altered child welfare practice. Distancing guidelines, evolving regulatory edicts, and substantial significant restrictions in legal operations (e.g., court processes) have significantly impacted workers’ abilities to perform seminal child welfare duties. Indeed, as Jerry Milner, Associate Commissioner at the Children’s Bureau, aptly concluded in a letter to child welfare leaders: “The COVID-19 pandemic has created unprecedented challenges for our health and human services systems in serving our most vulnerable families, children, and youth” (2020, para 1).

Indubitably, these circumstances have taken a toll on child welfare workers. Whilst a plethora of local, state, and federal entities have proffered strategies to assist workers in assuaging the impact of COVID-19, personal and professional challenges associated with the pandemic persist. This paper examines the impacts of these challenges.

This exploratory study examined peritraumatic distress among child welfare workers (N = 1996) in one southeastern state in the United States (U.S.). To collect primary data, researchers deployed the COVID-19 Peritraumatic Distress Index (CPDI; Qiu et al., 2020). CPDI is a self-report instrument designed to measure COVID-19 specific distress. This is the first known empirical study to explicitly examine this topic among child welfare workers. After a brief review of pertinent background literature, this paper will explicate results, discuss findings, and proffer salient practice, policy, and research implications.

2. Background

A well-functioning child welfare system is essential to wellbeing. Per the Child Welfare Information Gateway (2013), child welfare workers carry out an array of tasks aimed at child and family safety, permanency, and wellbeing. Barth (1999) explained that the impact of the work performed by child welfare workers reverberates for generations and extends beyond an individual child or family, but to society as a whole. In short, the importance of the work that child welfare workers perform cannot be overstated.

2.1. Challenges of child welfare work

In general, there is a host of problematic occupational concerns related to child welfare practice. Griffiths and Royse (2017) suggested that child welfare workers experience higher rates of compassion fatigue and occupational stress, when compared to other social service providers. Miller et al made similar assertions (2018). Kim et al. (2011) and Blome and Steib (2014) reported that child welfare workers experience high caseloads and lower perceptions of personal accomplishment, when juxtaposed with workers in other contexts. Lizano et al. (2014) explained that the work-related strain experienced by child welfare workers negatively impacted overall worker wellbeing. Others have discussed a host of inimical physical and psychological conditions experienced by child welfare workers (e.g., Salloum et al., 2015; Griffiths et al., 2017; Schelbe et al., 2017). Indeed, even in the best of times, child welfare practice can be challenging.
2.2. Child welfare work during COVID-19

To be clear, empirical research examining the impact of COVID-19 among the child welfare workforce is in the nascent stages. However, research conducted in other areas illustrate the impact of COVID-19 on an array of practitioners. For instance, in a cross-sectional study of physicians, advanced practice providers, residents/fellows, and nurses, Shechter et al. (2020) found that nearly 60% of participants reported acute stress and nearly half of the sample exhibited symptoms for depressive disorder related to COVID-19. Lai et al. (2020) and Xiao et al. (2020) reached similar conclusions. In a broader review of six articles published about the impact of COVID on healthcare workers, Spoorthy et al. (2020) concluded that factors such as gender, age, and lack of social support, among others, were linked to stress, anxiety, and depressive symptoms among study participants. In assessing literature about the impacts of COVID-19 on the public, Torales et al. (2020) found that the pandemic has contributed to a host of problematic circumstances. In addition to those noted by Spoorthy et al. (2020), Torales et al. (2020) discussed denial, anger, and fear that has been brought about by the pandemic. These authors went on to discuss the impact that these issues may have on prevention and decision-making related to the pandemic.

Empirical studies notwithstanding, several outlets have made assertions about the impact of COVID-19 on the child welfare system, more broadly, and workers, more specifically. For example, the National Conference on State Legislatures (2020) asserted that court restrictions have dramatically slowed child welfare processes and impacted workers’ abilities to navigate seminal functions associated with performing their duties. Kelly (2020) maintained that these restrictions have presented difficulties in managing child welfare cases. Merritt and Simmel (2020) explained that many workers experienced abrupt transitions to virtual and/or remote work and service environments.

In some instances, child welfare workers, particularly child protective service workers, have continued to initiate and conduct home visits, etc. Akin to those in traditional healthcare settings (e.g., hospitals), these workers have been concerned about the availability of adequate personal protective equipment (PPE) and exposure to COVID-19 (see Fadel, 2020).

Given the sweeping impact of the pandemic, it is probable that COVID-19 has exacerbated the challenges for engaging in child welfare work. These negative impacts can be felt not only by the child welfare workers, but the children and families they seek to serve. Whilst the impact of the pandemic has been explored among other practitioner groups (such as healthcare professionals, etc.), works that examine this impact among child welfare workers is nominal, at best. A thorough review of relevant databases revealed no such studies. This paper seeks to contribute to addressing that limitation in the current literature.

2.3. Study purpose and research questions

The overarching purpose of this exploratory study was to examine COVID-19 peritraumatic distress among child welfare workers. This is the first work known to the authors to examine the impact of COVID-19 on distress among this population. In so doing, this study offers insight into how to alleviate distress among child welfare workers during COVID-19.

Specifically, this study was guided by three (3) research questions:

Research Question 1: What are COVID-19 related peritraumatic distress levels among child welfare workers?
Research Question 2: Are there group differences in COVID-19 related peritraumatic distress by participant demographic/professional characteristics?
Research Question 3: What demographic/professional characteristics predict COVID-19 related peritraumatic distress?

2.4. Methodology

2.4.1. Sampling protocol

This study employed a cross-sectional design. Primary data were collected via an electronic survey administered via an online survey management program (e.g., Survey Monkey). Researchers sought, and were granted, institutional review board (IRB) approval and a waiver of documentation of informed consent. All data were collected during Summer 2020.

To recruit participants for this study, researchers circulated the approved study invitation to statewide child welfare groups and professional membership associations. In turn, participants were asked to forward the invitation to other potential participants. This approach does not permit for the calculation of a response rate. Those who participated in the survey were offered a chance to enter a $500 incentive drawing. Researchers did utilize features that disabled IP and email address tracking. The incentive link was not connected to the primary survey link. All participants self-identified as a public or private child welfare worker at the time of the survey.

2.4.2. Instrument

Primary data pertaining to distress were collected using the COVID-19 Peritraumatic Distress Index (CPDI; Qiu et al., 2020). CPDI is a 24-item scale designed to examine COVID-19 specific peritraumatic distress. For clarity, peritraumatic distress refers to the physiological and/or emotional distress experienced by an individual during a traumatic event. Bunnell et al. (2018) explained that peritraumatic distress is related to the development of posttraumatic stress disorder (PTSD).

CPDI entails parameters associated with stress, as outlined in the International Classification of Diseases (11th Rev.). Each item is anchored at 0 indicating never and 4 indicating most of the time. Example items include: “Compared to usual, I feel more nervous and anxious” and “I feel insecure and bought a lot of masks, medications, sanitiser, gloves and/or other home supplies.” In terms of scoring, the CPDI scores range from 0 to 100, with higher scores indicating more distress. Cut scores are as follows: 0–28 (normal distress); 29–52 (mild distress); and, 53–100 (severe distress). The Cronbach’s alpha of CPDI for this study was 0.91 (p < 0.001).

In addition to the CPDI, researchers collected demographic and professional data necessary to adequately describe the sample. Variables of interest included: Gender; Age; Years of Practice Experience; Hours Worked Per Week; Sexual Orientation; Race; Relationship Status; Education Level; and Professional Membership Group Status, among others.

Participants were asked to self-report their Physical Health Status and Mental Health Status, respectively. Response options for both of these variables included Excellent, Very Good, Good, Fair, or Poor. Participants were also asked about their Current Financial Situation. Response categories included: I cannot make ends meet; I have just enough money to make ends meet; I have enough money, with a little left over; or, I always have money left over. Remote Work Status was operationalized by asking participants if they had worked primarily remotely since March 11, 2020, the date COVID-19 was declared a pandemic. Participant responses to the instrument are summarized in Table 1.

2.4.3. Data analysis

All data were analyzed via SPSS 26. Once data were cleaned, researchers initiated descriptive, bivariate and multivariate inferential analyses. Descriptive analysis showed frequency and mean distribution of main variables. Bivariate examination included correlation analyses, robust one-way analyses of variances (Brown-Forsythe tests) or independent sample t-tests. Multivariate inferential analysis included hierarchical multiple ordinary least squares regression.
Table 1
Demographic characteristics of child welfare workers (N = 1996).

| Variable                          | N   | %   |
|-----------------------------------|-----|-----|
| Gender                            |     |     |
| Male                              | 188 | 9.4 |
| Female                            | 1804| 90.4|
| Other                             | 4   | 0.2 |
| Sex Orientation                   |     |     |
| Heterosexual or Straight          | 1760| 88.7|
| Gay or Lesbian                    | 84  | 4.2 |
| Bisexual                          | 120 | 6.0 |
| Others                            | 20  | 1.0 |
| Race/Ethnic Background            |     |     |
| White non-Hispanic                | 1787| 90.1|
| Black non-Hispanic                | 155 | 7.8 |
| Hispanic                          | 24  | 1.2 |
| Asian                             | 16  | 0.8 |
| American Native                   | 2   | 0.1 |
| Current Relationship Status       |     |     |
| Married                           | 1320| 66.1|
| Partnered                         | 164 | 8.2 |
| Widowed                           | 36  | 1.8 |
| Divorced                          | 188 | 9.4 |
| Separated                         | 36  | 1.8 |
| Never married                     | 252 | 12.6|
| Highest Academic Degree           |     |     |
| Bachelor’s                        | 48  | 2.4 |
| Master’s                          | 1916| 96.0|
| Doctorate                         | 24  | 1.2 |
| Professional Degree               | 8   | 0.4 |
| Members of Professional Organization(s)? | |     |
| Yes                               | 528 | 26.7|
| No                                | 1452| 73.3|
| Physical Health Status            |     |     |
| Excellent                         | 236 | 11.9|
| Very Good                         | 676 | 34.1|
| Good                              | 800 | 40.3|
| Fair/Poor                         | 272 | 13.7|
| Current financial situation       |     |     |
| I cannot make ends meet.          | 96  | 4.8 |
| I have just enough money to make ends meet. | 500 | 25.2|
| I have enough money, with a little left over. | 952 | 48.0|
| I always have money left over.    | 436 | 22.0|
| Mental Health Status              |     |     |
| Excellent                         | 136 | 6.9 |
| Very Good                         | 704 | 35.5|
| Good                              | 884 | 44.6|
| Fair/Poor                         | 260 | 13.1|
| Work Remotely after COVID         |     |     |
| Yes                               | 1680| 84.2|
| No                                | 316 | 15.8|
| Supervision Status                |     |     |
| Yes                               | 464 | 23.4|
| No                                | 1520| 76.6|

3. Results

3.1. Participants

A total of 1996 (N = 1996) child welfare workers participated in this study. Of the participants, 800 of them were employed by a private child welfare agency; 1196 of them were employed by a public child welfare agency. Typical survey respondents were aged 41.44 (SD = 11.51) years and had been practicing in child welfare for 13.42 (SD = 12.7) years. Additional demographic information is included in this study.

3.2. CPDI scores and correlations

The mean CPDI score for participants was 29.06 (SD = 13.87); with a range of 86. At an individual level, 53.6% of the sample had CPDI scores within the normal range; 40.5% in the mild range; and 5.9% in the severe range.

Correlation analyses between the total distress scores and various continuous demographic variables yielded one significant relationship. Specifically, Age (r = −0.151, p < .001) was significantly correlated with CPDI scores, whereby older participants tended to have lower CPDI scores.

3.3. Group differences

Due to the exploratory nature of the study, ANOVAs were initiated to assess group differences in CPDI scores. Analyses detected significant differences in mean total scores for the following variables: sexual orientation, physical health, mental health, supervision status, current financial status, and current relationship status. Table 2 contains a summary of results for these analyses.

For sexual orientation, participants were put into two categories for the purpose of analysis: “heterosexual or straight” vs. “not heterosexual or straight” (e.g., gay or lesbian and bisexual). Analysis revealed significant effects [F(1, 1934) = 1.355, p < .001, Cohen’s d = 0.024]. Participants who identified as “heterosexual or straight” (M = 28.29, SD = 13.66) had significantly lower CPDI scores than did those who identified as “not heterosexual or straight” (M = 35.05, SD = 14.11).

For the purpose of analyses, current marital status was categorized as “married” or “not married.” Significant cross-group differences in CPDI scores were detected by participants’ current marital status [F(1, 1934) = 2.048, p < .001, Cohen’s d = 0.005], with those who were “married” (M = 28.32, SD = 13.56) reporting significantly lower distress scores than “not married” (M = 30.47, SD = 14.36).

Analyses found significant differences by supervision status [F(1, 1934) = 0.062, p < .05, Cohen’s d = 0.003]. Participants who identified as “child welfare worker supervisors” (M = 27.71, SD = 13.81) appeared significantly lower than that of those who reported “no supervisory responsibilities” (M = 29.46, SD = 13.87).

Both physical and mental health status yielded significant differences. For physical health status, participants reporting “fair” and “poor” statuses were combined into one level to reduce sample imbalance across the levels. A significant difference was detected, F(3, 1932) = 15.131, p < .001, η² = 0.023. Post-hoc analysis (Turkey HSD test) revealed that the mean total distress scores for those who reported “excellent physical health” (M = 25.30, SD = 12.65) were significantly lower than the mean scores of those who reported “very good” (M = 27.45,
SD = 14.07), “good” (M = 31.13, SD = 13.92), or “fair or poor physical health conditions (M = 30.06, SD = 13.18), respectively.

Similarly, when comparing mean CPDI scores by mental health status, participants who reported “fair” and “poor” were combined into one level to reduce sample imbalance across the levels. Analyses revealed significant differences, F(3, 1929) = 145.88, p < .001, η² = 0.172. Post-hoc analysis (Turkey HSD test) revealed that the total mental distress scores for those who reported “excellent mental health” (M = 17.41, SD = 8.48) were significantly lower than the mean scores of those who claimed “very good” (M = 24.88, SD = 12.28), “good” (M = 30.76, SD = 12.81), and “fair or poor” mental health conditions (M = 40.27, SD = 14.55), respectively.

Lastly, differences were detected by financial status. To reduce the sample imbalance across the four levels, those who reported “I cannot make ends meet,” and “I have just enough money to make ends meet,” were combined into one level. A one-way robust ANOVA (Brown-Forsythe test) was used to compare mean total distress scores between the different financial status and was found to be statistically significant, F(2, 1929) = 65.17, p < .001, η² = 0.062. A Games-Howell test revealed a significantly lower mean total distress score for those who indicated “I always have money left over” (M = 23.30, SD = 11.56) than those who noted “I cannot make ends meet” and “I have just enough money to make ends meet” (M = 29.34, SD = 13.07), or “I have enough money, with a little left over” (M = 32.98, SD = 15.20), respectively.

3.4 Multivariate analysis

To explore the effects key predictor variables may have on CPDI scores, a multiple regression analysis was conducted on total distress scores. Age, years of child welfare practice, physical health status, mental health status, gender, sexual orientation, marital status, supervision status, and financial situation were included as predictors of total distress scores. This model was statistically significant for total COVID distress, F(16, 1747) = 34.835, p < .001, R² = 0.242, adjusted R² = 0.235.

Results revealed that seven variables significantly predicted total distress: married (p < .01), financial status (p < .001), physical health (p < .001), mental health (p < .001), age (p < .05), and sexual orientation (p < .001). The older and married social workers tended to have lower distress scores by 1.843 and 0.999 points, respectively. Identifying as “heterosexual or straight” seemingly predicted lower total distress scores by 4.787 points. Compared to those who reported “excellent physical health”, child welfare workers who reported “very good,” “good,” or “fair/poor” physical health were inclined to score higher on the total COVID distress scale by 3.197, 2.737, and 6.499 points, respectively. Likewise, those who reported “excellent mental health”, when compared to those who reported “very good,” “good,” or “fair/poor” mental health, scored 5.934, 11.472, and 21.25 points higher, respectively. For those who reported “I cannot make ends meet,” “I have just enough to make ends meet,” or “I have enough with a little left over” impacted distress scores by 6.305 and 4.537 points respectively, after controlling for all other variables. Table 3 for the results of the regression analysis.

4. Discussion

This study is likely the first to examine COVID-19 related distress among child welfare workers. Overall, data indicates that child welfare workers in this sample were above normal ranges and fall into the mild distress category. Nearly half of all participants scored in a range indicating mild or severe peritraumatic distress stress related to COVID-19.

In many ways, these findings may not be surprising. In a national examination of the general public, Paivson et al. (2020) concluded that over half of their sample reported having higher stress levels as a result of COVID-19. As well, these findings are somewhat consistent with the afore-referenced literature related to other professional groups, such as healthcare professionals (e.g., Shechter et al., 2020). In addition to professional challenges, child welfare practitioners may be coping with personal challenges, such as homeschooling, caregiving, economic uncertainty, and the like, that may impact their professional roles. These conditions, plus an uncertain prospect for improved conditions in the immediate future, can certainly cause distress among those experiencing them.

COVID-19 related distress among child welfare workers can be disconcerting for an array of reasons. For example, this distress may lead to professional burnout, which in turn, may contribute to retention issues (Lizano et al., 2014). As well, it is possible, that COVID-19 distress may impact practice decisions. Miller, Donohue-Dish, et al. (2018) and Griffiths et al. (2017) suggested that wellness factors, or lack thereof, can negatively impact child welfare workers’ abilities to adroitly manage caseloads. That in mind, the level of distress among participants in the current study, specifically, and in the larger child welfare workforce, more broadly, certainly warrants more critical examination and response.

That said, the fact that the sample is not experiencing more distress is noteworthy. To be clear, any level of distress among child welfare workers is concerning. However, 53.6% of participants in this study did fall within a “normal” range of distress. While there are no published examinations of peritraumatic distress related to COVID-19 among child welfare workers, a recent study of secondary traumatic stress among child welfare workers in three states, Rienks (2020) concluded that nearly 60% of the sample experienced moderate, high, or severe stress. Given the attention that the impact of the pandemic has had on child welfare, one might have surmised higher levels of distress among the participants in the current study.

There are a number of additional factors that may be impacting distress, or lack thereof, among child welfare workers. For example, several outlets have discussed the fact that calls to child protective services have slowed during the pandemic (e.g., Welch & Haskins, 2020).
Moreover, much of the work has shifted to virtual/remote tasks. Interestingly, these dynamics may have offered some temporary reprieve associated with high caseloads, volumes, etc. that may cause stress among child welfare workers.

Among participants in this sample, age did appear to significantly impact distress. Age was correlated with distress such that older participants experienced less distress and being older significantly predicted decreases in distress. This is consistent with other research, in general, about age and stress. For instance, Jorm et al. (2005) examined generalized psychological distress, by age. These researchers concluded that distress tended to decrease as one got older. It is also possible that older participants may be better able to cope with distress as a result of more financial stability, etc. have better coping skills as it relates to distress (e.g., Scheman et al., 2001). Still yet, age may be related to other factors, such as parenting young child(ren), etc. that may be especially relevant during the pandemic. All told, these findings affirm cursory notions that different age groups may be experiencing COVID-19 differently.

Analyses revealed that several demographic variables impacted COVID-19 distress. Individuals who were married experienced less distress than did those who were not; marital status was a significant predictor of less distress. Several authors have discussed the importance of connectedness and romantic/social relationships to overall well-being. For instance, Fincham and Beach (2010) concluded that marriage is associated with better mental wellbeing and Miller, Lianekhammy, et al. (2018) found that individuals who are married tend to engage in more frequent self-care practices, when compared to those who are not married. As well, many states, including the one in which this study occurred, implemented strict distancing and isolation mandates. Being married may provide additional support, in a time when others are isolated from their social networks. This support can be integral to addressing COVID-19 related distress.

Interestingly, supervisors experienced less distress than did nonsupervisors. This is somewhat counter to previous assertions that child welfare supervisors may experience more stress than other child welfare professionals (e.g., Dill, 2007). It is possible that being a supervisor is a proxy for other variables, such as financial status, as supervisors may typically earn more salary. Additionally, supervisors may be better informed about agency dynamics and responses associated with the pandemic. Or still yet, supervisors’ experience may permit them to better navigate or cope with distress specifically associated with COVID-19, such as not having to initiate home visits, conduct face-to-face interviews, etc. All of these factors may contribute to less distress for child welfare supervisors.

Perhaps not surprisingly, physical and mental health appear to impact COVID-19 distress. In short, analyses indicate that participants with better physical or mental health, respectively, experience less COVID-19 related distress. This finding is consistent with a line of research inquiry linking physical/mental health to overall wellbeing (e.g., Perales et al., 2014).

There are a number of factors associated with physical/mental health that may impact current findings. For example, many physical and mental wellbeing routines may be disrupted during COVID-19. Due to community health guidelines, most gyms and health facilities were closed at periods during the pandemic and counseling/therapy sessions may have been limited or have transitioned to virtual/tele delivery options. Veritably, accessibility to resources, and facilities, can impact COVID-19 related distress.

Financial status also seems to be linked to lower distress associated with COVID-19. In summary, those reporting more financial stability appear to experience lower distress. Intuitively, these findings may be expected. Finances are often a life stressor. Previous research pertaining to child welfare workers has linked financial status to self-care and wellness practices (Miller et al., 2019). COVID-19 has likely exacerbated that stressor.

In terms of sexual orientation, identifying as heterosexual or straight appeared to significantly decrease distress. Given previous literature about LGBTQ* professionals, these findings may not be surprising. Evidence suggests LGBTQ* individuals face an array of challenges that exacerbate stressors. LGBTQ* practitioners must also face issues associated with role encapsulation, tokenism, homophobia, heterosexism, heterocentrism, hostile workplaces, inadequate access to formal and professional mentorship opportunities, professional isolation, and loneliness, (Dentato et al., 2016; Lasala et al., 2008), among others.

4.1. Study strengths and limitations

This study has several strengths. Notably, this is the first known study to explicitly examine COVID-19 distress among child welfare workers. The CDC (2020) has discussed the importance of understanding COVID-19 associated stressors as a way to better address those stressors. In addition, though exploratory, the study has a more than adequate sample size of child welfare workers and examines the concept of peritraumatic distress related to the pandemic. Data from the current study may provide valuable information for child welfare employers to more adeptly support workers during COVID-19 and other disasters.

This work must also be considered within the context of several limitations. For example, all participants self-selected into the study and self-identified as a public child welfare worker. The sample was overwhelmingly female and white, which may not be reflective of larger child welfare worker populations. A more diverse sample may have yielded different responses, which might have impacted the results. Given the nature of this study, and the population, a social desirability bias may be impacting data associated with the current study. The instrument utilized for this study is relatively new. Though this is to be expected given the quickly emerging science associated with COVID-19, this instrument should be further assessed for use among broader populations, to include child welfare workers. Additionally, this study did not examine a number of job-specific factors, such as caseload, etc. Given these limitations, assertions based on this study must be made carefully and critically.

4.2. Implications

Given that confirmed cases of COVID-19 are on the rise in the U.S., it is imperative to conceptualize approaches to supporting child welfare workers in dealing with challenges, and associated consequences, of COVID-19. Nearly half of the participants in this study were experiencing distress associated with the pandemic. As such, studies that examine the impact of the pandemic on child welfare should identify pragmatic strategies for assuaging distress. The following paragraphs briefly outline salient implications derived from the above-referenced findings.

To be clear, to deal with COVID-19 related distress among child welfare workers, responses from both the individual and organizations (e.g., employer) may be necessary. For individual child welfare workers, attention should be focused on developing self-care practices conducive to assuaging distress. Several entities (e.g., Centers for Disease Control, 2020; National Child Traumatic Stress Network, 2020) have discussed the importance of self-care during the pandemic. This importance has also been discussed in previous research works associated with child welfare workers (e.g., Miller, Donohue-Diob, et al., 2018). Typical steps in this regard include establishing robust self-care plans, delineating implementation strategies for said plans, and evaluating progress (Grise-Owens et al., 2016).

From an organizational standpoint, consideration should be given to conceptualizing and implementing broader initiatives aimed at supporting child welfare workers in dealing with the distress associated with COVID-19. A host of authors have discussed the importance of workplace culture, to include offering support, for child welfare workers (e.g., Ellett et al., 2007; Madden et al., 2014). There are several
ways in which organizations can actualize such initiatives. For example, organizations may look to foster interactions among child welfare workers that extend beyond traditional work spaces. This may take the form of virtual accountability, check-in, and support groups. Findings from the current study suggest that certain employee groups (e.g., LGBTQ+) experience higher levels of distress as such, targeted or specialized groups may be impactful in helping to address distress. Such initiatives should be conceptualized in a participatory fashion – that is – with the input of child welfare workers.

Certainly, membership organizations can be helpful in achieving supportive aims for child welfare workers. Groups such as the Child Welfare League of America (see https://www.cwla.org/coronavirus/) and Prevent Child Abuse America (see https://preventchildabuse.org/coronavirus-resources/) have provided web pages, documents, and guidelines to assist workers in dealing with the pandemic. Other entities, such as the Children’s Bureau (see https://www.acf.hhs.gov/cb/resource/covid-19-resources) have proffered resource pages.

From a macro perspective, it is imperative that regulatory entities continue to promulgate policies directed at providing relief during COVID-19. For instance, remote work arrangements may be an ideal approach to assuaging stress among child welfare workers, even absent a pandemic. Other edicts related to PPE requirements, virtual visits, etc. should be assessed and weighed as a necessary response to ensure the safety of workers.

Research implications abound. Most importantly, researchers should continue to examine the impact of COVID-19 on a variety of stakeholders, including child welfare workers, service recipients, and foster parents, to name a few. What’s more, researchers should assess practices and policies, such as remote work arrangements, etc., for efficacy and efficiency. Other areas include the impact of age and how COVID-19 may impact underrepresented groups, such as LGBTQ+ and practitioners of color, other job-related factors, such as caseload, and how these variables may moderate/distress to, name a few.

5. Conclusion

The critical mission of child welfare workers is laudable and essential. If the wellbeing of children and families served by these workers is to be actualized, the needs of the practitioners must be assessed and addressed. This is particularly true during a pandemic, that by any measure, has had a profound impact on the child welfare system.

Though this exploratory study fills a unique gap in the current child welfare research literature, it is in no way a definitive work to understand the true impact of COVID-19 on child welfare services, and those who perform those services, workers, employers, researchers, and policy makers must continue to examine the short, medium, and long-term impacts of COVID-19. This study can serve as a starting point for that work.

CRediT authorship contribution statement

J. Jay Miller: Conceptualization, Methodology, Chunhui Niu: Data curation. Shannon Moody: Writing - review & editing.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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