A Case Study of Social Work Leadership in the Pandemic Intervention in Wuhan

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Abstract

Social workers in Wuhan, China were among the first to respond to the public health crisis caused by Coronavirus disease (COVID-19) in early 2020. Social workers in Wuhan developed and implemented an effective interventional model integrating online and offline volunteers of multiple professions—the ‘4 + 1’ model—to support affected individuals in the process of battling the pandemic. Transformational social work leadership played a vital role in the widely adopted model in China, characterised by idealised influence—attributed (or charisma); idealised influence—behavioural; inspirational motivation; intellectual stimulation and individual consideration. Contextual performance is also discussed, followed by a discussion on why social work can play a leadership role in inter-disciplinary intervention in the pandemic crisis. The article concludes with the areas social workers can improve on for the betterment of leadership.

Keywords: disaster response, leadership, social work, volunteerism

Accepted: July 2021

Introduction

A pandemic is a unique form of disaster categorised as a public health emergency (Rosoff, 2008). Social workers’ intervention in a public health emergency was first documented in the great influenza pandemic that caused millions of deaths in 1918 (Kerson, 1979) and extended into SARS, H5N1 (the bird flu) and HINI (the swine flu) in the twenty-
first century. Social workers deliver sources and services to affected populations (Galambos, 2005), provide psychological first-aid (Yanay and Benjamin, 2005; Javadian, 2007; Levenson, 2017), design and implement different programmes (Dodds and Nuehring, 1996) and link agency organisations (Pyles, 2007).

Although there is abundant literature on social work’s involvement in disaster management, practice and research, reports about social work’s involvement in public health emergency response are relatively few (e.g. Rosoff, 2008; Blake, 2015), and the literature of social work leadership in disaster management is even more limited. Chinese social workers started to engage in crisis intervention after the Wenchuan earthquake in 2008 (Chen et al., 2020). Social work as a profession, however, has yet to be acknowledged by the mainstream society in China (Garrett, 2020), nor have the emergency management departments at different levels of Chinese governments incorporated social work into the current crisis response system (Chen et al., 2020; Wang, 2020). This article will report social workers’ endeavours of developing and delivering a COVID-19 service model in Wuhan, China, in 2020, together with multidisciplinary professionals and community volunteers. Most importantly, this article will focus on social work leadership in the process of supporting and serving affected communities in the pandemic.

Social work leadership in the literature

Social work practice needs both management and leadership. Management entails implementation of routines and coordination of everyday tasks, while leadership is about setting directions, goals, standards and the vision of an organisation (Mary, 2005; Sullivan, 2016). Brilliant (2001) states, ‘managers may solve problems and keep organizations functioning, . . . leaders are creative, take risks, and promote innovation and organizational growth’ (p. 236). Being more inclusive and altruistic than leaders in business and governmental agencies, social work leaders usually ground their leadership in social service visions, promoting values of the profession, such as empowerment and equity, and motivating employees and facilitating social changes and justice (Bass, 1998; Rank and Hutchison, 2000). Furthermore, client-centredness is always the core value of social work practice, where ‘successful leaders venerated people known as clients and worked tirelessly to help the organization maintain a nearly obsessive focus on improving the lives of recipients of service’ (Sullivan, 2016, p. 557). Though social work management and leadership may overlap in the practice of accomplishing tangible goals of helping people and management focuses on present routine and stability, leadership is about sustainability and connecting the present with the future (Northouse, 2001; Mary, 2005).
Tafvelin (2013) stated that leadership is an influencing process, exerting intentional influence over other people to guide, structure and facilitate activities and relationships in a group or organisation. It is oriented towards social vision and change, not simply, or only, organisational goals (Foster, 1989). Three leadership types in social work, ‘laissez-faire leadership’, ‘transactional leadership’ and ‘transformational leadership’, have been studied (Bass, 1990; Mary, 2005). Laissez-faire leadership is described as ‘hands-off’ due to the absence of actual leadership, while transactional leadership combines reward and punishment, emphasising on contingent reward and the leader’s expectations on team members. The leader and follower have an exchange relationship—financially (productivity), psychologically (praise) or politically (loyalty or promises for votes). In transformational leadership, the leader encourages team members to broaden interest and increase awareness and acceptance of the purposes and mission of the group. Not only does the leader motivate members to work towards the greater good, but he/she also inspires members to create their visions of goals (Bass, 1998; Mary, 2005).

Transformational leadership is regarded as an effective leadership model in the social work field, emphasising the relationship between leaders and followers in the leadership process, aiming to maximise all members’ potential (Mary, 2005; Fisher, 2009). It emphasises that leaders have several responsibilities, including raising members’ awareness and understanding of moral values and inspiring vision, encouraging members to transcend their own personal goals and interests for the collective good (Bass, 1985). The leader also needs passion, a sense of optimism, political acumen, the ability to look into the future in shaping priorities, tenacity and a penchant for adventure (Mary, 2005). A transformational social work leader focuses on broadening and inspiring the visions for team members, while respecting their self-determination. Bass (1985) first identified four principles of transformational leadership (the four Is) and Bass and Avolio (1990) further differentiated idealised influence as attributed or behavioural. The five characteristics of transformational leadership are as follows:

- Idealised influence—attributed (or charisma). The leader has high moral standards and is a role model to followers.
- Idealised influence—behavioural. The leader has a vision for the organisation and the ability to draw people together around it.
- Inspirational motivation. The leader motivates team members to have high expectations and motivate them toward action.
- Intellectual stimulation. The leader challenge and enable team members to be creative and innovative in problem solving.
- Individual consideration. The leader nurtures a supportive environment for self-actualisation of team members with goal setting, opportunity and leadership style best fit for individual members (Mary, 2005; Rowold, 2005; Fisher, 2009).
Several studies (e.g. Gellis, 2001; Mary, 2005) have found that social work leaders ‘were generally transformational in nature’ (Fisher, 2009, p. 363), because this style is congruent with professional values of social work, including participatory action, empowerment, self-determination and self-realisation (Packard, 2003). Mary’s (2005) findings explicitly indicate that ‘transformational characteristics correlate strongly with leadership success’ (p. 112), including effectiveness, extra effort and satisfaction with the leader.

In the following sections, we will describe the ‘4+1’ crisis response model led by social workers during the COVID-19 pandemic in Wuhan in spring, 2020, followed by a discussion on the transformational social work leadership that was formed and performed through the intervention model.

The case: the ‘4 + 1’ crisis response model

In order to provide proper treatment to the significant number of COVID-19-infected individuals with mild symptoms, reduce the spread of the virus and the severe shortage of hospital spaces, the Chinese government created twelve mobile cabin hospitals (MCHs) in existing large buildings (e.g. stadiums) in Wuhan in February 2020 (Xinhua News, 2020). The MCHs struggled with a tremendous shortage of manpower and resources due to the sudden strike of the pandemic in a city populated by over eight million people (https://www.statista.com/statistics/466957/china-population-of-wuhan/), and the fact that the nation was celebrating the Chinese New Year holiday. On the one hand, health care practitioners struggled with insufficient medical supplies (e.g. suits, masks and medicine) and administrative challenges (e.g. communicative barriers between local health care professionals and those from other parts of China who spoke different dialects). On the other hand, MCH patients were facing unmet needs for basic daily living (e.g. accessible and usable toilets) due to the temporary nature of the setup of the MCHs, and delayed examinations or treatments caused by the sheer number of patients in care. Mental health issues also became pronounced among MCH residents in the recovery stage, such as demonstrated anxiety related to the doubt of full recovery, worries about emerging discrimination against recovered patients in the community, grief for deceased loved ones and concerns about family members back home.

The Good Companions Response Team (GCRT), established by social work educators, students and frontline practitioners, was one of the earliest and longest lasting volunteer groups to answer to the multi-aspect challenges. From beginning to provide services on 26 January 2020 to the lockdown lifted on 8 April 2020, the GCRT had had 488 volunteers including 128 social workers, 115 psychotherapists, 63
healthcare professionals, and 66 administrative assistants; the volunteers served 4,695 individuals from 36 online service groups covering local communities, quarantine sites, and MCHs in Wuhan as well as Chinese communities overseas for a total of 45,890 hours’ (Yu et al., 2021, p. 133).

The GCRT developed and applied a model that was later called the ‘4 + 1’ model (Figure 1). Providing remote support to individuals in crises, the group recruited social workers, health care providers, psychologists and administrative assistants online, then connected with patient volunteers in the MCHs using smart phones and the China-based social media App WeChat. All volunteers, the GCRT members were divided into three or four groups to work in shifts every day. Each group usually worked for three to four hours, depending on the daily workload. Through patient volunteers, the team was able to intervene for MCH residents’ physical, mental and social well-being.

Targeted groups were infected patients in MCHs and in the community. They were referred to GCRT and provided with GCRT members’ WeChat contact information by practitioners, fellow patients or concerned individuals. Once connected with CGRT via WeChat, they would be organised into WeChat groups of 30–200 people. Patients were able to ask questions about medical treatment and their health conditions, and could express anxiety, worries, desperation or anger, and their concerns about basic daily life needs such as access to clean toilets and water, and socialisation to enhance peer support and morale to battle
the disease. The nature of the services needed by the targeted group was diverse and emergent, ranging from information provision, counselling, online diagnosis, coordination with health care workers (e.g. efficient distribution of meals and medications), to supplying tangible materials that could be as small as blindfolds for sleeping. The four types of ‘professionals’ (i.e. social workers, doctors, psychologists and administrators) usually provided information and coordinated for resource mobility in WeChat groups, while one resident volunteer would carry out the activities that needed to be conducted in person in the field.

Being group coordinators, social workers were responsible for arranging and assigning caseloads to group members, communicating with doctors and psychotherapists about patients’ issues and related challenges, and providing emotional and morale support to group members. Social workers would also organise group meetings to review the outcomes of a day’s work and set up the work plan for the next day at 9 p.m. every evening.

More than 200 professionals were involved in the frontline work at all times during the intervention period. GCRT adopted a two-dimensional management structure for the frontline practitioners, vertical and horizontal. Along the vertical line, four different professions responded to the demands of services and information within their occupational specialties, under their own monitoring and conducted training and recruitment of new members within their profession. Along the horizontal line, different levels of leaders of professional groups coordinated and collaborated to mobilise resources and manpower to provide prompt response to the ever-changing and diverse demands and wants of service recipients. There were three levels of team leads: a director, the coordinators of multidisciplinary teams and the managers of specific professional teams. The director carried out most the leadership role while the coordinators performed some leadership duties as well. The managers acted mostly as facilitators and implementers. The whole management system was built up as a net, facilitating the communication and collaborative work among different lines of services.

Another 100+ individuals were involved in second-line work including general information distribution (e.g. publishing articles on websites and short videos on Tik Tok about new understanding of the virus and new development of prevention and intervention strategies); resource information collection (e.g. where and how to purchase daily living supplies, where to find community doctors and blood supply); referral (difficult cases that required extensive support would be transferred to specialists in certain professions); and online training and education (e.g. grief management sessions for service providers and recipients). The second-line team members provided critical analysis, support and training from theoretical perspectives of each profession in online team meetings once a
week, which was found extremely helpful by the frontline members. Yu et al. (2021) have elaborated in greater detail the activities and management of the ‘4 + 1’ crisis response model.

Discussion: transformational social work leadership in the ‘4 + 1’ model

Social workers were the backbone of the GCRT team and its intervention in the pandemic crisis in Wuhan in spring of 2020. They initiated and established the teams, successfully serving over 4,000 affected individuals in MCHs and communities. Many social work practitioners and students provided professional services and support to clients, such as counselling and resource mobilisation. More importantly, social workers acting as directors and coordinators not only organised and monitored daily intervention activities, but also drew hundreds of volunteers with diverse background towards one direction—unconditionally helping those in need. When reviewing and reflecting on their crisis response endeavours, the GCRT social work leaders realised that their leadership could best be described as transformational in nature, which aligned well with social work values such as empowerment, self-determination, positive regard and respect, by which they conducted practice.

Idealised influence—attributed (or charisma)

With prompt and accurate assessment of the changes and needs caused by the emergent pandemic situation, the social work leaders (the director and coordinators) were able to recruit a variety of volunteers, including those with professional expertise, to meet the needs of the targeted populations by demonstrating their vision and passion of serving those in crisis, by delivering the message: ‘We are in this together.’ Volunteers from diverse backgrounds were motivated and encouraged by such enthusiasm, as well as their leaders’ effective organisation and resource mobilisation. The social work leaders arranged team members to take up certain positions or responsibilities based on their capacity, personality and specialty. While the leaders were the backbone of the team, they did not run the team in a top-down manner, but enabled everyone to play a significant role in the decision-making process. Any member’s suggestion, if deemed effective and feasible by the team, could change the direction of the intervention. Rooted in social work values of helping others in need, the leaders’ motivations of founding the GCRT team were selfless, which helped shape the shared goal of the team and members who focussed on providing prompt, dependable and sustained services to COVID-19-affected individuals and families over material gain or fame. One team member shared a comment from a fellow social worker...
in a different province: ‘We wanted to have an intervention team like yours, but no one can lead like your director in our province.’

Aiming to provide services to community residents in quarantine since the beginning of the Wuhan lockdown on 23 January, the GCRT Director developed an online social work manual which was published immediately on the ‘Social Work in Wuhan’ webpage operated by the Wuhan government. The manual soon became the guide for social work intervention during the pandemic in China. Based on this initial model, the GCRT team started to provide services to community residents, and eventually developed the aforementioned ‘4 + 1’ model. Social work values and training equipped the leadership with a holistic perspective to evaluate targeted groups’ needs, encompassing physical and mental health at multiple levels. An inter-disciplinary team with social work leadership had a vision of integrating community strengths, professional expertise, available resources, creativity and a strong commitment to action to effectively respond to the pandemic crisis.

**Idealised influence—behaviour**

A transformational social work leader acknowledges the motivation of team members for collaborating to achieve for the common good. The GCRT team started as a much smaller team with dozens of social work educators and students and served in only a couple of communities. When the Wuhan government called for society help to facilitate operating MCHs due to a severe shortage of human resources, GCRT answered the call and was able to recruit a large number of qualified volunteers swiftly. The leaders ‘believe the success of the team is related to Chinese people’s emotion of “family-country” (jia guo qing huai, 家国情怀) and to patriotism’ (Yu et al., 2021, p. 136), as traditionally Chinese people ‘connect individual families with the rise and fall of the country, and when the country is in crisis, citizens are responsible to help each other to let the country get ahead of the crisis’ (Yu et al., 2021, p. 136). Social work leaders acknowledged the strong motivation in individuals and reinforced the vision of helping each other and the country throughout the process of crisis intervention. Some volunteers continued to contribute to GCRT after MCHs were discontinued. The fundamental goal of helping others was the prominent condition for the actualisation of social work leadership in an inter-disciplinary team.

**Inspirational motivation**

The social worker leaders motivate team members to have high expectations and take action in achieving their goals. In order to assure the
quality of services provided by volunteers, training and supervising system were established in the early stages. Volunteers of the three professions (i.e. social work, psychology and medicine) were trained before they started taking shifts and attended supervisory meetings hosted by experts in the field to discuss the challenging or special cases they had encountered. Social work and psychological experts were members of Social Workers without Borders and the medical experts were experienced doctors. The supervising mechanism was critical in helping team members overcome compassion fatigue and any sense of helplessness during a very difficult time. Team members reported they had obtained valuable growth in their own professions, as well as a sense of belonging and solidarity in meetings, experience-sharing sessions and gatherings.

Intellectual stimulation

The social work leaders challenged team members to be creative and innovative in problem-solving in the service delivery process and in meetings. Usually the leader would initiate discussion topics and encourage frontline workers and other team members to contribute their thoughts, ideas and suggestions. Members of different professions would have the opportunity to advocate for clients from a specific professional perspective, in order to improve services for clients’ well-being. After discussions, action plans would be generated, and the details of how to implement the plan would be discussed among team members, group managers and coordinators. The leadership team would monitor the implementation and providing support when needed.

Individual consideration

The social work leaders intended to build a supportive environment for self-actualisation of team members at the same time they were initiating the GCRT team. As four different types of professionals were involved in the crisis response activities from early stages, respecting professionalism of each profession and operating with a ‘parallel management’ style were the keys for social workers to motivate team members for action toward a common goal. In such ‘parallel management’, the operation of administration and interventional practices were separate, though related. While social work leaders (the director and coordinators) were in charge of assuring the team was moving toward the agreed-upon goals and overseeing daily operation with the assistance of administrative members, the experts in different professions provided specific technical supervision and guidance to team members performing services of a particular profession. The social work leaders fully respected the quality
standards of practice in each profession, and supported and facilitated training sessions run by experienced team members to enhance interventional skills and knowledge of all members. With a focus on everyone’s strengths and expertise, all members were collaborators, where the leader took the leading role in goal-setting, resource mobilising and facilitation of programme implementation.

The social work leaders also acknowledged team members formally and informally for their contributions to their mutual goals and to helping those in need to get through the pandemic crisis. The regular training and supervision sessions helped team members enhance professional skills, acquire feedback and suggestions for improvement and receive recognition for their contributions and achievements. These team-building activities greatly enhanced team members’ sense of belonging, achievement and honour and, in turn, sustained a high level of morale.

In addition, transformational social work leaders focussed on broadening and inspiring the vision for team members, respecting their self-determination. The team was likely aiming for ‘contextual performance’ as opposed to typical task performance under a transactional leadership approach (May, 2005). Defined as the performance and outcomes driven by a positive and dynamic work context, context performance is usually achieved through team-building, networking and moral enhancement activities (Jawahar and Carr, 2007). Borman and Motowidlo (1997) used a five-category taxonomy to summarise contextual performance:

1. persisting with enthusiasm and extra effort as necessary to complete own task activities successfully;
2. volunteering to carry out task activities that are not formally part of one’s own job;
3. helping and cooperating with others;
4. following organisational rules and procedures; and
5. endorsing, supporting and defending organisational objectives (p. 102).

Compared to traditional transactional performance, contextual performance indicates greater group energy and creativity. The GCRT’s teamwork demonstrated numerous characteristics of contextual performance, such as helping other members and carrying out tasks that were not formally part of their work, demonstrating enthusiasm in the volunteer intervention work, showing a willingness to work extra hours on a daily basis and, through all of these tactics, developing a strong group identity and sense of belonging.

Emphasising a collaborative operational mechanism, a transformational social work leadership applies less top-down instructions or formal authority than conventional leadership. The leaders focused on developing and nurturing the relationships between the leadership and team members, among team members (existing and newly recruited) and
between team members and service users. The leader remained a high sensitivity to other professions’ boundaries, respected team members’ strengths and expertise and valued their professional integrity. Social work interpersonal communication techniques were vital tools in leadership implementation, such as organising, facilitating and supporting the intervention actions in MCHs.

Conclusion and limitations

In our experience, social workers best fit the requirements for the leadership in inter-disciplinary crisis intervention. Health care professionals, such as doctors and psychologists, usually maintain an understanding of definite roles of professionals and patients/clients in the doctor–patient relationship where doctors and psychologists are viewed as the experts and patients/clients the individuals ‘in trouble’. Health care professionals also emphasise clear occupational boundaries and frame their practice within their designated professions. Social workers fully respect the regulations and standards established in different professions; however, social work moves beyond what each profession can do and focusses on what all professions can do together. Social work leaders have the vision of inter-disciplinary collaboration because the pursuit of the holistic well-being of individuals and the society as a whole is a fundamental value of social work. Social workers are pragmatic, which enables them to mobilise all resources in different professions and create opportunities to generate best services and facilitate efficient delivery.

The GCRT social work leaders expanded the collaboration to involve the targeted population. Delabelling service users as ‘patient’, the team viewed all willing individuals as abled helpers. The patients/residents with mild symptoms in MCHs had strong motivation to help fellow residents; therefore, they were recruited to be the critical ‘1’ in the ‘4+1’ model to carry out intervention activities in the field where online helpers could not go. The volunteer residents assisted in field activities, such as meal distribution, coordinating for check-ups and discharge plans, which greatly enhanced their sense of control and empowerment. Contributing to the collaborative endeavour to battle the pandemic helped participants achieve self-actualisation.

Social workers are sensitive to the varied needs of people. While health care professionals might wait for individuals to come to them for help, social workers would engaged with targeted groups, observed service recipients and sometimes identified their needs even before service recipients themselves realised them. In the WeChat groups, patients rarely consulted the psychologists even though they were undergoing tremendous stress and experiencing mental health issues. The social workers often took the initiative to befriend the patient, demonstrating
empathy and offering support and company. Eventually, when trust was built and the patient discussed his/her issues, the social worker was able to connect the patient with a psychologist. The doctors and psychologists indicated that they had benefitted from social workers’ work style and communication skills. Social workers becoming the leaders of the interdisciplinary team in the pandemic intervention seemed a natural outcome.

The ‘4+1’ crisis response model led by social workers demonstrated several strengths. First, the GCRT team acted swiftly upon recognising social needs as the direct result of the sudden strike of the pandemic. The design of the intervention approach integrated the online and offline personnel and resources from the very beginning, forming the foundation of the ‘4+1’ model that has been later duplicated by other social service groups and agencies. Built on the existing Internet and cell phone supply system, the online component (services provided by four professions) not only assured the individuals’ safety under the threat of infectious viruses, but also did not generate any additional costs for equipment and supplies to overcome the lockdown and quarantine restrictions. Secondly, the online component also made connecting people from different geographical areas and social circles much faster and easier than traditional communication approaches. For example, the GCRT team was able to recruit volunteers within a few days who were agency managers, university professors and registered psychologists from within China and around the world. Thirdly, service users, regardless of their locations, were able to access the service gateway without delay or wait time. Whether having questions or issues, they could make posts in the GCRT WeChat groups; anyone in the group (usually dozens to hundreds of people in a group) could see the post and respond to it. GCRT members on duty (four shifts between 9 a.m. and 9 p.m. every day) could respond with professional support and conduct intake for further intervention as soon as they received immediate notifications on their phones; even when GCRT members were unavailable immediately occasionally such as in the middle of the night, other experienced service users could reply with supportive and comforting messages, share experiences or explain the unavailability of GCRT members. Around-the-clock accessibility of services offered great comfort to those seeking urgent help which they might not have acquired through traditional crisis intervention approaches. Service seekers might not always look for or be able to receive immediate assistance, but knowing that a group of responsible helpers were always there was therapeutic and comforting because the individual believed ‘I’m not alone in this.’

Several aspects of the ‘4+1’ model could be improved. First, due to the sudden and urgent nature of the pandemic crisis, the GCRT members responded to the crisis in such a swift manner that none had been well prepared to set up an action plan or organisational structure. There
were no models or frameworks in the literature or practice reports that the leadership team could refer to. Reflecting on the haphazard experience of trying to help in the midst of shock, uncertainty, anxiety and physical social isolation, we considered it vital to share our experience with fellow practitioners in order for all to better prepare for future crises (at the time this article was written, the third wave of COVID-19 was still affecting most countries). Moreover, the success of the ‘4+1’ model was mainly demonstrated in MCHs, a relatively closed environment. It requires further discussion and experience-sharing to explore effective means and models to deliver services to affected individuals and families in the community.

Secondly, although the online component was critical for services to be delivered, insufficient local human resources could significantly hinder the quality and quantity of the services. At times the online professionals suggested an excellent intervention idea without knowing if it was feasible to actualise locally. It is essential to involve as many local community members who could be present in person to carry out certain interventions in crisis response activities; however, recruitment of members in the field will likely remain a challenge in a pandemic crisis for non-profit, volunteer-based social service organisations.

Thirdly, social work leaders need to further familiarise themselves with the development of new interventional models and approaches in various crises, the foremost of which are pandemic and/or public health crises. As many crises require inter-disciplinary intervention, we as social workers should better prepare ourselves to lead in crisis intervention by integrating social work values such as empowerment, strengths perspectives, equity and solidarity, with strong leadership skills such as inspiring, motivating and supporting team and individual growth.

In contemporary health social work, social workers frequently play a marginalised or subordinate role such as assessing patients’ and families’ resources, social networks, emotions, etc. Through analysing the leadership model that the GCRT team applied in the intervention in two MCHs in Wuhan during the pandemic in early 2020, it is evident that not only are social workers capable of providing direct services, but they can also be effective leaders for inter-disciplinary teams through team management, personnel organisation and intervention design and implementation.

**Acknowledgements**

We thank all the volunteers for their selfless efforts to support the individuals and families in crises through the platforms of the GCRT.

**References**

Bass, B. M. (1998) *Transformational Leadership: Industrial, Military, and Educational Impact*, Mahwah, NJ, Lawrence Erlbaum.
Bass, B. M. (1990) ‘From transactional to transformational learning: Learning to share the vision’, *Organizational Dynamics*, **18**(3), pp. 19–31.

Bass, B. M. (1985) ‘Leadership: Good, better, best’, *Organizational Dynamics*, **13**(3), pp. 26–40.

Bass, B. M. & Avolio, B. J. (1990) *Multifactor Leadership Questionnaire*. Palo Alto, CA: Consulting Psychologist Press.

Blake, P. (2015) ‘Pandemic planning: What are my obligations? Considerations for members of the Ontario College of Social Workers and Social Service Workers’, available online at: https://www.ocswssw.org/wp-content/uploads/2015/01/Pandemic-Plan-Obligations-Article.pdf (accessed January 9, 2021).

Borman, W. C. and Motowidlo, S. J. (1997) ‘Task performance and contextual performance: The meaning for personnel selection research’, *Human Performance*, **10**(2), pp. 99–109.

Brilliant, E. (2001) ‘Social work leadership: A missing ingredient’, *Social Work*, **31**(5), pp. 325–31.

Chen, T., Wang, L. and Wang, B. (2020) ‘The disaster relief and social work after the Wenchuan earthquake in Mainland China’, *China Journal of Social Work*, **13**(1), pp. 70–84.

Dodds, S. and Nuehring, E. (1996) ‘A primer for social work research on disaster’, *Journal of Social Service Research*, **22**(1–2), pp. 27–56.

Fisher, E. (2009) ‘Motivation and leadership in social work management: A review of theories and related studies’, *Administration in Social Work*, **33**(4), pp. 347–67.

Foster, W. (1989) ‘Toward a critical practice of leadership’, *Critical Perspectives on Educational Leadership*, **3**, 39–62.

Galambos, C. M. (2005) ‘Natural disasters: Health and mental health considerations’, *Health & Social Work*, **30**(2), pp. 83–86.

Garrett, P. M. (2020) ‘Looking east: (Re-)creating a social work ‘industry’ in the People’s Republic of China’, *Critical Social Policy*, **40**(3), pp. 410–29.

Gellis, Z. (2001) ‘Social work perceptions of transformational and transactional leadership in health care’, *Social Work Research*, **25**(1), pp. 17–25.

Javadian, R. (2007) ‘Social work responses to earthquake disasters: A social work intervention in Bam, Iran’, *International Social Work*, **50**(3), pp. 334–46.

Jawahar, I. M. and Carr, D. (2007) ‘Conscientiousness and contextual performance: The compensatory effects of perceived organizational support and leader-member exchange’, *Journal of Managerial Psychology*, **22**(4), pp. 330–49.

Kerson, T. S. (1979) ‘Sixty years ago: Hospital social work in 1918’, *Social Work in Health Care*, **4**(3), pp. 331–43.

Levenson, J. (2017) ‘Trauma-informed social work practice’, *Social Work*, **62**(2), pp. 105–13.

Mary, N. (2005) ‘Transformational leadership in human service organization’, *Administration in Social Work*, **29**(2), pp. 105–18.

Northouse, P. (2001) *Leadership: Theory and Practice*, Thousand Oaks, CA, Sage.

Packard, T. (2003) ‘The supervisor as transformational leader’, in Austin, M. J. and Hopkins, M. J. (eds), *Supervision as Collaboration in the Human Services: Building a Learning Culture*, Thousand Oaks, CA, Sage.

Pyles, L. (2007) ‘Community organizing for post-disaster social development: Locating social work’, *International Social Work*, **50**(3), pp. 321–33.

Rank, M. G., & Hutchison, W. S. (2000) ‘An analysis of leadership within the social work profession’. *Journal of Social Work Education*, **36**, 487–502.
Rosoff, P. M. (2008) ‘The ethics of care: Social workers in an influenza pandemic’, *Social Work in Health Care*, 47(1), pp. 49–59.

Rowold, J. (2005) ‘Multifactor leadership questionnaire psychometric properties of the German translation’. Mind Garden, Inc., available online at: https://www.mindgarden.com/documents/MLQGermanPsychometric.pdf (accessed May 17, 2021).

Sullivan, W. P. (2016) ‘Leadership in social work: Where are we?’, *Journal of Social Work Education*, 52 (Supp1), pp. S51–61.

Tafvelin, S. (2013) ‘The transformational leadership process: Antecedents, mechanisms, and outcomes in the social services’ (Doctoral dissertation, Umeå Universitet), available online at: https://www.diva-portal.org/smash/get/diva2:640843/FULLTEXT01.pdf (accessed January 9, 2021).

Wang, S. (2020) Conjugation of professional function in social work’s involvement in public crisis governance: Based on the prevention & control governance amid COVID-19 pandemic in China’, *Social Work and Management*, 20(6), pp. 5–11.

News X. (2020) ‘Twelve mobile cabin hospitals are built in Wuhan, over 20,000 beds available’, available online at: http://www.xinhuanet.com/2020-02/19/c_1125596243.htm (accessed January 9, 2021).

Yanay, U. and Benjamin, S. (2005) ‘The role of social workers in disasters: The Jerusalem experience’, *International Social Work*, 48(3), pp. 263–76.

Yu, Z., Tan, W. and Niu, L. (2021) ‘The experiences of the Good Companions Response Team during the COVID-19 pandemic in Wuhan, China: A multiprofessional team led by social workers’, *Asia Pacific Journal of Social Work and Development*, 31(1–2), pp. 132–38.