Israeli Health Care Social Workers’ Personal and Professional Concerns during the COVID-19 Pandemic Crisis: The Work–Family Role Conflict

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Abstract

This exploratory study focuses on the personal and professional concerns of Israeli social workers in hospitals and community health settings during the coronavirus (COVID-19) pandemic. Other studies omitted health care social workers’ needs and concerns. Participants included 126 social workers (120 females, 5 males and 1 other gender identity) in hospitals and community health settings who completed an online survey during the height of the first wave of COVID-19 in Israel. Measures included questions on exposure to COVID-19, sense of safety at work, perceived support, and personal and professional concerns. Two open-ended questions about the social workers’ concerns and the perceived concerns of their patients were included. The results showed that 17 per cent reported one of their inter-disciplinary team testing positive for COVID-19. Only one-third of the social workers felt safe from COVID-19 infection in their workplace. Mothers of dependent children were more concerned about income loss and about balancing work and family requirements than mothers of older children. ‘Home–work conflict’ was also a main theme in the qualitative data. In conclusion, the work–home role conflict took an especially heavy toll during the COVID-19 pandemic on social workers who were mothers to dependent children.

Keywords: COVID-19, organisational support, personal and professional concerns, social workers in health care, work–family conflict
Introduction

The coronavirus (COVID-19) pandemic infected almost 116 million people by the first week of March 2021 and killed more than 2.5 million people worldwide. In Israel, almost 800,000 cases and 6,000 deaths were confirmed (Hopkins, 2020). In this outbreak, health care workers laboured on the front line. As the pandemic unfolded, it became clear they were at greater risk of becoming infected by the virus (Pan et al., 2020; Wilkason et al., 2020). They were also at high risk for depression, loneliness, and a low level of social support (Fang et al., 2021), and experienced insomnia, heightened anxiety, and other stress-related symptoms during the COVID-19 outbreak (Pappa et al., 2020; Zhang et al., 2020).

Whilst there is relatively extensive literature on the mental health state of health care workers in general, only two publications described the role of the social workers in China during the COVID-19 pandemic (Yu et al., 2021), and another conducted in Spain found social workers there overwhelmed by the COVID-19 situation (Muñoz-Moreno et al., 2020). Nonetheless, we did not find any study addressing the mental health state or personal and professional concerns of social workers in health care during the COVID-19 crisis. Accordingly, this preliminary study aims (i) to describe the condition of social workers in health care settings in Israel in terms of their personal and professional concerns, sense of safety at work, and perceived personal and professional support during the first wave of the COVID-19 pandemic; and (ii) to address one potentially vulnerable group: social workers who are mothers to young children; and compare their concerns, sense of safety and support to those of female social workers with older, non-dependent children.

Israeli health care social workers’ personal and professional concerns during the COVID-19 pandemic

In Israel, health care social workers were part of the front line teams. The COVID-19 pandemic was managed by the Israeli government, which determined the guidelines for lockdowns (e.g. what working places were to be closed and what percentage of workers were allowed to be present), and set the criteria for getting COVID-19 tests (that were free of charge). Non-essential workers had to take a paid leave of absence from work. It took a struggle of the Social Workers Union, as well
as some employers, for the government to acknowledge social workers as essential workers.

Health care social workers in Israel were able to continue assisting clients, but they had to modify their usual approach to patient interactions. In situations where it was possible or even necessary to avoid face-to-face contact with patients or their families (e.g. when interacting with quarantined family members of patients who could not come to the hospital), they switched to online or phone call interactions. This alteration caused changes in their daily routines and demanded adaptations of their skills and their customary practices and psycho-social intervention approaches (Levin-Dagan and Strenfeld-Hever, 2020).

The introduction of distance meetings with clients had the potential to create difficulties in providing client services. Distal patient–social worker interaction was already identified as a barrier to practice in a qualitative study conducted amongst social workers in Canadian health settings during the SARS pandemic. In that study, social workers indicated that mandatory wearing of masks distanced them from patients and their families, made it harder to identify patients' nonverbal facial gestures and emotions, and constituted a major communication barrier (Gearing et al., 2007). The role of social workers in health care includes direct practice—mainly counselling and crisis interventions, and discharge planning services (Judd and Sheffield, 2010). These functions are usually performed in close proximity to the patient’s bed, with face-to-face interactions with patients and their families. Such face-to-face interaction with clients is considered a fundamental aspect of social work practice, a way to gain trust and encourage better commitment to treatment (Broadhurst and Mason, 2014). In addition, in Israel the face-to-face interaction with patients customarily also involves physical touch, such as holding the patient’s hand or providing a pat on the back or a hug. Whilst controversial (Kelly et al., 2017), physical touch is acknowledged in health care literature in general (Kelly et al., 2014) and in social work in particular (Green, 2017) to have therapeutic value for the patient. This kind of interaction with clients was forbidden during the COVID-19 social distancing guidelines. The resultant changes in the social workers’ daily routines were predicted to be a major part of social workers’ professional concerns and were therefore addressed in this study.

As for personal concerns, during the period of time this study was conducted, many social workers were asked to take leaves of absence, which threatened their income security. Others were sent to quarantine due to actual or suspected COVID-19 infection. These absences, documented in studies conducted in other countries on health care teams in general, created a wider overload on health care teams who had to work with fewer staff members (Huang et al., 2020; Wilkason et al., 2020) and were also associated with greater stress amongst those who stayed in
quarantine (Brooks et al., 2020). All these work changes occurred in an otherwise stressful time in the social workers’ personal lives as, like all other Israelis, they had to adhere to the ‘stay at home’ governmental demands (except when going to their workplace), and in many cases had to take care of dependent children whilst the schools were closed, and were additionally worried about older family members and friends. These types of challenges during COVID-19 pandemic are known to be especially prominent in professions dominated by women (Alon et al., 2020), which includes social work. It was therefore important in our study to explore the workers’ professional concerns about their patients and their social work practice during the pandemic, as well as uncover their personal fears and concerns during this stressful period.

Sense of safety

One factor found to be strongly associated with a decrease in stress symptoms amongst general health workers was a sense of safety (Cai et al., 2020). Recent research has pointed to the importance of reassuring safety in the health care setting during the COVID-19 crisis (Gold, 2020), reinforcing earlier findings. For example, a study conducted amongst nurses during the 2003 SARS outbreak in Canada revealed that fear of being infected by the virus and a low sense of safety at work were associated with nurses’ higher levels of distress (Maunder et al., 2004). Fear of being infected and fear about insufficient protective measures were also associated with greater insomnia amongst health care workers in China during COVID-19 (Zhang et al., 2020). Similarly, an international mixed-methods study amongst front line maternal and neonatal health care providers in eighty-one countries during the COVID-19 pandemic found that health workers’ fears for their own and their family’s safety were a major concern associated with increased stress levels (Semaan et al., 2020). None of these studies, however, addressed social workers in health care. We therefore examined sense of safety at the workplace during the COVID-19 outbreak.

Social support

Social support in general is a well-known protective factor against physical and mental health problems (Holt-Lunstad et al., 2010). Amongst health care workers, support from supervisors and co-workers is a significant predictor of the workers’ organisational commitment in regular times (Yang et al., 2019). Support from supervisors in health care settings has been shown to be especially vital during epidemic and pandemic times (Wilkason et al., 2020). Accordingly, instrumental and
emotional support from superiors, as well as from family members, was associated with better mental health amongst health care teams during COVID-19 (Cai et al., 2020; Kisely et al., 2020), whilst a study conducted amongst clinicians and faculty at a USA university found that poor support by supervisors during the COVID-19 pandemic was associated with greater anxiety, depression and work exhaustion (Evanoff et al., 2020). In another study, this time amongst health care workers in Japan during COVID-19, about ten per cent of the workers reported that mental health support might be useful to them (Sahashi et al., 2020). These studies, however, did not target social workers. We therefore examined the extent of perceived support, both at the workplace and from family and friends during the COVID-19 outbreak.

Social workers with dependent children: Are they a vulnerable group?

Several vulnerable groups amongst health care workers in the context of COVID-19 have been identified, amongst them: workers parenting dependent children (Koh et al., 2005; Lung et al., 2009; Kisely et al., 2020). The vulnerability of workers with dependent children can be elucidated by role strain theory (Goode, 1960; Ko and Hwang, 2020), which asserts that individuals often face a conflicting array of role obligations. If someone conforms fully with one role, that person may experience difficulty in fulfilling other roles due to conflict amongst the different roles in time, place, energy or other resources (Goode, 1960). Work responsibilities may clash with family roles due to the limited resources we all face. When job demands increase, role strain may result, bringing negative psychological and behavioural consequences, including parenting distress (Ford et al., 2007; Ko and Hwang, 2020), depression (Frone, 2000) and work-related negative outcomes such as absenteeism and sick leave (Svedberg et al., 2018).

Mothers may experience greater work–family conflict than fathers (Borelli et al., 2017). During epidemics, female health care workers with dependent children (age zero to eighteen) have found themselves torn between their work and family commitments, their professional duties and their concern for the safety and needs of their close ones (Koh et al., 2005; López-Atanes et al., 2020). Nonetheless, several studies, such as a recent one conducted amongst health care workers in Iran during COVID-19, did not find associations between being a parent to dependent children and burnout (Jalili et al., 2020). However, parenting in this study was not stratified by gender. Another recent study found a reverse association: being a parent (of undifferentiated gender) of children at home was associated with less anxiety and depression amongst health care providers and other university faculty (Evanoff et al., 2020).
In an effort to clarify the extent of worker vulnerability, this study further compared the personal and professional concerns of female social workers in health care who had dependent children to those who did not.

Summary

Whilst there is relatively sufficient amount of evidence to suggest that health care workers are more distressed in times of epidemic in general and COVID-19 pandemic in particular (e.g. Kisely et al., 2020), very little is known about social workers in health care. This exploratory study focused on the personal and professional concerns of Israeli social workers in hospitals and community health settings during the COVID-19 pandemic. We also addressed their extent of exposure to COVID-19, sense of safety and perceived support in the workplace, as well as the support from their social networks. We compared the responses of female social workers with dependent children to those without dependent children. Given the exploratory nature of this study, we stated research questions and not hypotheses:

i. What are the personal and professional concerns of social workers in health care settings in Israel during COVID-19?

ii. What are the level of exposure to COVID-19, sense of safety, and level of support at the workplace and from family and friends, amongst this group?

iii. Will mothers of dependent children demonstrate different levels or types of personal and professional concerns than mothers of non-dependent children?

Methods

Participants, design and procedure

A total of 126 social workers (120 females; 5 males; 1 other gender identity) in hospitals (86.1 per cent) and community health settings (13.9 per cent) participated in an online survey (using Qualtrics for constructing the questionnaire) employing a mixed-methods (quantitative and qualitative) research design. Participants came from twelve health care settings: ten acute hospitals and two community health organisations. Their average age was 46.48 (standard deviation; SD = 11.04). Almost 56 per cent (55.6 per cent; n = 69) had dependent children (at least one child aged less than 18 years old), 43.7 per cent (n = 55) had children older than eighteen and two (1.6 per cent) did not have children. All participants’ mother tongue was Hebrew. Four of the participants were directors of the social work unit at health settings, whereas all the rest provided direct intervention. We did not assess the length of their work history or their ethnicity.
The study was approved by the Hebrew University’s ethics committee. All participants gave written consent by checking a box ‘I agree’ at the first screen of the online questionnaire. The link to the questionnaire was distributed to social work department heads in each in each hospital and community health setting via WhatsApp or email. The department head then distributed it to her workers, requesting completion of the anonymous questionnaire on a voluntary basis. The questionnaire was distributed between 1 April and 19 May 2020, in the midst of the first wave of COVID-19 in Israel. During this time, many workers worked from home, were requested to take a leave of absence or worked overtime in the hospitals using online equipment. During this period, several lockdowns were announced, most businesses were closed and strict restrictions on movement outside the home were mandated. Towards the end of the survey, things went back to a new normal, including reopening of the schools, albeit with strong measures of social distancing and mandatory masks. Given this context, we tried to minimise any pressure on the social workers by providing a very short questionnaire, sending very few reminders and limiting distribution to the head of the social work department, who distributed the link only when she felt her supervisees could allocate a few minutes to completing the questionnaire.

**Measures**

Items detailing the study’s measures and their distribution are presented in Table 1

*Exposure to COVID-19*

Four questions were asked (e.g. ‘Since the beginning of the COVID-19 pandemic, have you been in quarantine due to infection or suspected infection?’).

*Sense of safety at work*

Two questions were asked (e.g. ‘To what extent are you afraid of being infected with/testing positive for COVID-19?’) (see Table 1).

*Personal and professional concern*

Five closed-end questions and two open-ended questions were asked. The closed questions were asked with the opening of ‘To what extent does each of the following hold true for you since the outbreak of..."
Table 1 Research questionnaire items and their distribution (N = 125)

| Per cent | Per cent | Per cent |
|----------|----------|----------|
| No       | Yes—I was suspected of being infected | Yes—I tested positive |
| Exposure to COVID-19 | 95.2 | 4.8 | 0 |
| Since the beginning of the COVID-19 pandemic, were you in isolation due to infection or suspected infection | Per cent | Per cent | Per cent | Per cent |
| No       | Yes | If yes, how many? | If yes, how many |
| 1–5      | 68.2 | 1–5 | 31.8 |
| 6–10     | 31.8 | 6–10 | 68.2 |
| Were any of your patients infected by COVID-19? | 79.8 | 20.2 | 68.2 | 31.8 |
| Has anyone from your interdisciplinary team been infected by COVID-19? | 83.2 | 16.8 | 83.3 | 16.7 |
| Has anyone from your family or close friends tested positive for COVID-19? | 92.0 | 5.6 | 2.4 |

Sense of Safety at work

(continued)
Table 1. (Continued)

|                                             | Per cent | Per cent | Per cent |
|---------------------------------------------|----------|----------|----------|
|                                             | Not at all | To a small extent | To a moderate extent | To a high extent | To a very high extent |
| Concern about the possibility of testing positive for COVID | 5.6 | 33.1 | 46.0 | 11.3 | 4.0 |
| Feeling safe from getting COVID at the workplace | 3.2 | 18.4 | 46.4 | 31.2 | 0.8 |
| Personal and professional concerns | Very untrue of me | Somewhat untrue | Somewhat true | True | Very true |
| Having trouble doing the job because of the restrictions imposed by the COVID-19 outbreak | 15.2 | 33.6 | 28.8 | 15.2 | 7.2 |
| Having trouble working remotely (online) | 29.0 | 36.3 | 19.4 | 9.7 | 5.6 |
| Having trouble balancing work and family requirements/commitments | 42.6 | 23.8 | 18.0 | 8.2 | 7.4 |
| Concerned about income loss | 44.7 | 22.8 | 10.6 | 8.1 | 13.8 |
| Having a hard time doing the work due to overload | 54.8 | 24.2 | 11.3 | 6.5 | 3.2 |

Almost no support

|                                             | 1 | Per cent | 2 | Per cent | 3 | Per cent | 4 | Per cent | 5 | Per cent | 6 | Per cent | 7 | Per cent | 8 | Per cent | 9 | Per cent | 10 | Per cent |
|---------------------------------------------|---|----------|---|----------|---|----------|---|----------|---|----------|---|----------|---|----------|---|----------|---|----------|
| Support at the workplace | 5.6 | 4.0 | 3.2 | 6.4 | 10.4 | 12.8 | 12.0 | 10.4 | 23.2 | 12.0 |
| Support from family and friends | 1.6 | 1.6 | 1.6 | 1.6 | 9.6 | 8.8 | 15.2 | 25.6 | 17.6 | 16.8 |
COVID-19?’ (e.g. ‘Having trouble doing your job because of the restrictions imposed in light of COVID-19?’) Items are presented in Table 1. Responses were provided on a five-point Likert type scale ranging from 1 ‘not at all’ to 5 ‘very much true’.

Two open-ended questions were asked: ‘What are your concerns at work during this time of the COVID-19 pandemic?’ and ‘What are your patients’ concerns during this time of the COVID-19 pandemic?’

Perceived support

Two questions were asked about support in their workplace and support from their surroundings (see Table 1).

Data analysis

Quantitative data were analysed using SPSS version 25 (IBM Corp, 2017). Descriptive statistics (frequencies, means and SD) for all study variables were followed by bivariate analysis $t$ test groups and pairs. Given that previous studies (Kisely et al., 2020) found age to be associated with health care stress and that having dependent children may be associated with mother’s age, we compared mothers of dependent and not dependent children using analysis of covariance (ANCOVA) whilst controlling for age. For the latter analysis, we excluded the five male social workers.

Open-ended questions

We analysed the concerns offered by any participant using a constant comparative method. Data were analysed by reading the open-ended responses and noting common codes that emerged, then returning to the data to ensure the codes fit the responses. Two authors separately coded the responses; we then discussed and resolved discrepancies. When the codes differed, we discussed our perceptions of the codes and data until we were in agreement about the code assignment (Charmaz, 2006). In order to calculate the percentages of responses for each category, we counted the number of participants who indicated the central concern of each category. In Tables 3 and 4, we provide example responses from different participants for each category label.

Results

Exposure to COVID-19

Six social workers (4.8 per cent) had been in quarantine due to suspicion of being infected by the virus. 20.2 per cent ($n=25$) of the social workers had provided care to COVID-19 patients. 16.8 per cent ($n=21$)
reported that one of their inter-disciplinary team had tested positive for COVID-19. A further eight per cent \((n = 10)\) reported that at least one of their friends or family members had been infected by the virus.

**Safety concerns**

Totally, 15.3 per cent \((n = 15)\) of the social workers were ‘to a high extent’ or ‘very high extent’ concerned about the possibility of being infected. Only one-third (thirty-two per cent) of the social workers felt safe from being infected at their workplace ‘to a high extent’ or ‘very high extent’. The greater the feeling of safety, the lower their concern about being infected, and vice versa \((r = -0.24, p < 0.01)\).

**Professional and personal concerns**

Of the five concerns asked in the closed end questions, the greatest concern was ‘having trouble doing the job because of the restrictions imposed by COVID-19 outbreak’; 51.2 per cent reported that this
statement was ‘somewhat true’ to ‘very true’ for them. There followed in order of concern: having trouble working remotely, with 34.7 per cent of participants reporting that this statement was ‘somewhat true’ to ‘very true’ for them; having trouble balancing work and family requirements/commitments (33.6 per cent); and concern about income loss, with 32.5 per cent reporting this statement was ‘somewhat true’ to ‘very true’ for them. Of least concern was overload at work; only twenty-one per cent reported this statement as ‘somewhat true’ to ‘very true’ for them. The findings are presented in Table 1.

Perceived support at work and from friends and family

Table 1 presents the distribution of the responses to this question. The mean (on a scale from 1 = almost no support to 10 = a lot of support)
The mean for perceived support from friends and family was significantly higher; mean = 7.54 (SD = 2.01) as a paired sample t-test showed (t(124) = 3.44, p < 0.01).

Differences between social workers who are mothers to dependent children (zero to eighteen) and those who are not (eighteen and above)

Table 2 presents means and SD of the two groups’ sense of safety, personal and professional concerns and perceived support, after controlling for age. ANCOVA (where age serves as covariance) revealed differences between the two groups in three areas. Mothers of dependent children were more concerned about income loss (F(1, 109) = 5.97, p = 0.016), and much more concerned about balancing their work and family requirements (F(1, 108) = 32.53, p < 0.001) than mothers of older children. Mothers of dependent children also reported lower levels of support from family and friends (F(1, 111) = 5.90, p = 0.017).

Open-ended questions

The first item asked each respondent to indicate what he/she was concerned about in his/her place of work during the COVID-19 outbreak. The total number of responses was ninety-five; some social workers offered multiple responses, and thirty-one social workers did not respond. Respondents listed a variety of thoughts or experiences that contributed to their concerns; some were personal concerns (e.g. concern about
contracting the virus, concern about financial difficulties), whilst others were professional concerns (e.g. concerns about changes in the psychosocial treatment setting with patients, work overload). Based on their answers, we identified six categories of responses. In addition, there were other individual answers that could not be assigned to categories, such as uncertainty, lack of protective gear, social isolation, lack of appreciation from managers and a feeling that there was nothing to be concerned about. Table 3 presents the results of the six main categories. As can be seen, the main concern of the participants was contracting the virus and transmitting the virus to family members and patients. The second concern was concentrated in changes in the setting with patients. Only four per cent expressed concern about lack of appreciation and support from their managers, and another four per cent supervisors were concerned about lack of clear workplace guidelines regarding how to take care of their employees.

The second item asked each respondent to indicate what his/her patients were concerned about during the COVID-19 outbreak. The total number of responses was 105; again, there were social workers who provided more than one response, and twenty-one offered none. We identified the five categories presented in Table 4. As can be seen, the largest category included concerns of contracting the virus, whilst the smallest category included more general health concerns.

Discussion

This study addressed the personal and professional concerns of social workers in hospitals and community health settings in Israel during the first wave of the COVID-19 pandemic. Overall, respondents were not as concerned about many of the issues raised as might have been expected. Given that this study was conducted at the beginning of COVID-19 in Israel, social workers probably did not feel highly overwhelmed at this point, and they also might have lacked awareness of it being only the beginning of a long pandemic.

Nevertheless, results of this study showed that social workers reported a relatively low level of perceived safety at their workplace; only one-third (thirty-two per cent) of the social workers felt safe from being infected in the workplace to ‘a high’ or ‘very high extent’. The low level of perceived safety can be partially explained by the rapid changes and inconsistent messages that were received from the Israeli Ministry of Health, the hospital immediate supervisors and the hospital administration regarding practice mitigation guidelines. This interpretation is in accord with findings from other countries, such as Australia, about the confusion health care workers (not necessarily social workers)
experienced with regard to mitigation guidelines during the first wave of COVID-19 (Digby et al., 2021). In addition, a significant proportion of the phone or online interventions performed by the social workers were carried out in the hospital itself, and they therefore remained at risk for contracting the virus within the hospital.

The qualitative data suggested they were also afraid of transmitting the virus to family members or patients. Given that previous studies found health care workers to be at greater risk for becoming infected when providing care to persons with infectious diseases in general (Koh et al., 2005) and with COVID-19 in particular (Wilkason et al., 2020), these findings are not surprising and reflect the context of their working environment. A low level of perceived safety at the workplace is associated with increased burnout and absenteeism amongst health care providers (Evanoff et al., 2020; Jalili et al., 2020) and should therefore raise concern.

Social workers were highly concerned by the restrictions imposed by the pandemic. More than 50 per cent of the participants in our study indicated this aspect was ‘somewhat true’ to ‘very true’ for them. The restrictions affected both social workers who worked in COVID-19 patient wards and those who continued their work with patients in regular wards. The support of family members during hospitalisation, which receive strong emphasis in Israel (Auslander, 2011), could not take place as usual. Many patients were hospitalised with fewer visits or no visits at all by their family care-givers. The necessity of changing the format in which social work interventions were conducted from face-to-face to online or other remote forms was perceived by many social workers as a barrier and was also perceived as challenging for the patients. This concern was indicated by more than one-third of the social workers in this study despite accumulative evidence suggesting no differences between online and face-to-face interventions in clients’ outcomes and satisfaction (Murphy et al., 2009). Our findings showed that many social workers in health care are committed to the perception that distance interventions are not a first choice; distance format is a source of great concern for them. The fact that this change in work format was rapid, without preparation or previous experience with this style of work, may serve as an explanation for the high level of concern shown by the social workers.

Mothers of dependent children were found in this study to be more concerned about income loss and about balancing work and family commitments than were mothers of non-dependent children. These findings are in accord with a recent report indicating that COVID-19 social distancing measures that included closing schools and day cares exacerbated gender inequality, making working mothers one of the major victims of the COVID-19 pandemic, and may have negative
consequences in the long run until the global economy recovers. These negative consequences are especially prominent in professions dominated by women (Alon et al., 2020), including social work.

Whilst studies suggest that organisational support, including supervisor and peer support, is a protective factor against excessive work–family conflict (Byron, 2005; Michel et al., 2011), our findings showed that social workers who are mothers of dependent children did not receive greater organisational support than mothers of non-dependent children. In times of pandemic, social workers are torn between investing their energy in efforts to continue their high standard of professionalism, and prioritising their commitment to their family needs and health (Gearing et al., 2007). Our findings showed that this dilemma is stronger amongst social workers who are mothers of dependent children.

Our qualitative results suggested that mothers of dependent children showed greater personal concerns: fear of being infected and concern about family–work conflict, whilst mothers of non-dependent children showed greater professional concerns, mainly the move to distal interaction with patients and their families. These discrepancies might reflect age differences (e.g. younger social workers may feel more at ease with online interventions). Another explanation is that social workers who are mothers to older children worked more extensively with patients during COVID-19 pandemic, than mothers to younger children. The latter had often stayed at home with their children and therefore had less experience with the new model of remote interaction. These interpretations should be tested further.

Insufficient support was found to be a connecting thread throughout our findings. Social workers perceived a lower level of support at their workplace than from their social network. Mothers of dependent children perceived a lower level of support from their social network than mothers of older children. The patients were also perceived as lacking social support. Thus, it seems that support is a scarce resource throughout hospital populations in times of pandemic.

Previous studies amongst health care workers (but not social workers) emphasised the importance of supervisory and peer support, both in regular times and during a pandemic (Kaufman et al., 2020). For example, a study conducted in a large Italian hospital during the COVID-19 pandemic found that human resource management support and accessible counselling services were important in reducing job stress and burnout amongst the health workers (Ramaci et al., 2020). The distress of health care workers in Wuhan, China, led to the provision of a vast network of online peer support groups and individual support sessions, although participation in those support options was voluntary (Cheng et al., 2020). To the best of our knowledge, such a support infrastructure has not yet been offered in Israeli health care settings; the absence might explain...
the relatively low level of support at work perceived by the social workers in this study.

**Limitations**

This study was, to our best knowledge, the first to examine health care social workers’ concerns during the COVID-19 pandemic. Nonetheless, as an exploratory study, it relied on a convenience sample and thus may not represent all Israeli health care social workers’ concerns during the pandemic. In addition, it assessed only a few background variables in order to assure a brief survey. Thirdly, due to the small sample size, it did not compare mothers to small children (e.g. zero to six) to mothers to older, yet dependent children (age seven to eighteen). Fourth, it did not measure anxiety or depression; therefore, it could not reveal the associations between sense of safety, fear of being infected, personal and professional concerns, and social workers’ psychological distress. Further, it focused only on the negative aspects of the pandemic—social workers’ concerns—so we cannot indicate what type of positive changes may have occurred in the practice of health care social workers during COVID-19 that might or should be continued later on. These topics, as well as achieving a deeper understanding of the antecedents and consequences of work–home conflict during epidemics, should be addressed in future studies.

**Practice implication**

Part of the low sense of safety at work perceived by the social workers may reflect the fact that the guidelines kept changing and that directors of the social work departments were not part of the decision-making teams concerning those guidelines. We therefore recommend including directors of social work departments in hospitals and community health settings in the hospital staff decision-making team when setting guidelines during epidemics. In addition, it is important to create infrastructure for online support and the continuation of consistent online clinical supervision and team meetings during epidemics. Finally, special attention should be provided to vulnerable groups: social workers with personal or family medical preconditions, as well as mothers of small children.

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