Article

The Impact of COVID-19 on Social Work Practice in Canada: A Comparison of Urban and Rural Contexts

by

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Abstract

Social workers involved in child maltreatment investigations faced considerable challenges during the COVID-19 pandemic. Interactions with children and families carried new restrictions and risks, which resulted in changes in practice. We conducted a two-phase, mixed-methods study which examined the impact of the COVID-19 pandemic on social workers who work with maltreated children from both urban and rural areas across Canada. More specifically, we examined changes in service delivery, as well as perceptions of safety, stress, worry, and how support differed between urban and rural social workers. Fifty social workers (62% urban, 38% rural) responded to the Phase 1 survey, disseminated in May 2020, with 34 (76% urban, 24% rural) responding to the Phase 2 survey in November 2020. Quantitative and qualitative data revealed that rural social workers reported more worry, stress and a greater need for mental health support, in addition to receiving less support than urban social workers during the first wave of COVID-19 cases. However, during the second wave of cases, urban social workers reported more stress, a greater need for mental health support, and receiving less support than rural social workers. Additional research is needed to further uncover the nature of the differences between rural and urban social workers, and to identify the prolonged effects of the COVID-19 pandemic on social workers.

Keywords: COVID-19, Canada, mixed-methods, urban and rural contexts, social work

Introduction

On March 11, 2020, the World Health Organization (2020) characterized the novel coronavirus (COVID-19) as a pandemic. The pandemic has since exposed health disparities, disproportionately affecting subsets of the global population (van Dorn et al., 2020), as societal inequalities have been suggested as mediators of vulnerability to the virus (Khazanchi et al., 2020; Yehia et al., 2020). Rural areas have been shown to be more susceptible to severe effects from COVID-19, partially as a result of poorer social determinants of health (Shah et al., 2020): older age, socioeconomic disadvantage and a lack of resources (i.e., health care and public health; (Kaufman et al., 2020). Likewise, healthcare workers and allied healthcare workers (e.g., social workers) continue to be at an elevated risk.

Recent research has revealed that frontline workers are at an increased risk of direct (e.g., increased infection rates; Nguyen et al., 2020) and indirect (e.g., stress from high-risk work environments and excessive workload; Magill et al., 2020) adverse effects of the pandemic (Cabarkapa et al., 2020; Shaukat et al., 2020; Teo et al., 2020). Despite these vulnerabilities, research on the effects of the pandemic on allied healthcare workers is scarce. This is concerning given that evidence suggests allied healthcare workers, such as social workers, were already at an increased risk of work-related stress, burnout, and secondary traumatic stress (McFadden, 2015; Wagaman et al., 2015).

Prior to the pandemic, the caseloads of social workers and the high demands of their work had been empirically documented (Barck-Holst et al., 2021; van Berkel & Knies, 2016). For example, they experience low levels of control in their workplaces, inadequate managerial support, blame-culture environments (Ravalier, 2019), and secondary trauma (Bride et al., 2007; Wagaman et al., 2015). This is particularly evident for those who work in the child protection sector, where COVID-19 and associated lockdowns have increased service demands and stress on workers, a corollary of the stress experienced by their service population (Williams et al., 2021). Furthermore, these stressors were likely compounded by the effects of the pandemic and associated preventative measures. Yet to date, little empirical evidence has documented the effects of the pandemic on social workers within this sector.

Social workers who regularly make home visits (e.g., the child welfare sector) may experience disruptions to their typical ability to monitor child wellness, which can increase stress about their ability to help children (de Jonge et al., 2020). Others may be required to adapt to new technologies that can come with challenges, hence limiting their ability to obtain specific information (e.g., condition of the home; Racine et al., 2020). Others may still be required to make home visits, placing them at risk of exposure to COVID-19. Unsurprisingly, professionals who work with at-risk children have been found to be at an increased risk of distress during the COVID-19 pandemic, (Miller, Nui et al., 2020). In addition to their clientele focus, other factors such as their geographic area of practice may exacerbate the potential for adverse effects as a result of COVID-19.

The pandemic may differentially impact social workers in rural and urban areas. In rural areas, there are additional health vulnerabilities (Centers for Disease Control and Prevention [CDC], 2017; DesMeules et al., 2006), which increase the risk for COVID-19 complications (Kaufman et al., 2020; Richardson et al., 2020). There are also fewer mental health resources available (Friesen, 2019; Mental Health Commission of Canada [MHCC], 2020) and a greater potential for healthcare systems to become overwhelmed (Miller, Becker et al., 2020; Paul et al., 2020). Conversely, urban social workers face an increased risk of contracting the virus as a consequence of higher total case counts, particularly at the outset of the pandemic (CDC, 2020; Richardson et al., 2020). They also experienced stricter public health measures, thereby suggesting additional changes to their practice early in the pandemic may have been more likely. Conversely, social workers in urban and rural settings may have been affected similarly by the pandemic, despite their different circumstances; that is, the level of stress may be similar in urban and rural areas, but the course different. To date, no research has examined the impact of COVID-19 on social workers, or their practice, as a function of their geographic area of practice.

The current study

We conducted two phases of a Canada-wide survey of social workers who work with maltreated children, or cases of suspected maltreatment (henceforth referred to as maltreatment). Phase 1 was disseminated from May to July 2020 and corresponded with the first wave (i.e., the initial influx of cases) of COVID-19, while Phase 2 was

disseminated from November 2020 to February 2021, which corresponded with the second wave (i.e., the second influx of cases). The survey explored how the pandemic has affected social workers and their practice, with particular attention paid to the different experiences of rural social workers (RSWs) and urban social workers (USWs). We identified RSWs and USWs using participants' self-reported geographic region of practice. We undertook this research with four primary aims. First, we examined whether social workers continued to perform their regular work duties (i.e., requesting medical exams, forensic interviews and child maltreatment investigations) and if so, what types of modifications (if any) were made to these work duties. The other three goals of this research were to examine social workers': (*i*) perceptions of their own safety at work and perceptions of their clients' safety; (*ii*) perceptions of stress and worry, and (*iii*) perceptions of support and need for support.

We developed three hypotheses. Due to the greater volume of cases in urban than rural areas, particularly early in the pandemic (CDC, 2020; Richardson et al., 2020), *(i)* we expected that USWs would report more frequent disruptions in their practice and more modifications to their practice than RSWs. However, given the increased risk for complications of COVID-19 (Kaufman et al., 2020; Richardson et al., 2020), reduced capacities of healthcare systems (Miller, Becker et al., 2020; Paul et al., 2020), and reduced mental health support in rural areas (Friesen, 2019; MHCC, 2020), *(ii)* we expected that RSWs would report more distress in the context of lower ratings of safety and support, as well as increased ratings for stress and worry. Lastly, given the prolonged duration of working under restrictions and associated stress (Magill et al., 2020), *(iii)* we expected to find increased needs for mental health support and concerns about burnout in Phase 2 among all social workers compared to Phase 1.

Method

Participants and Procedures

Eighty-four social workers who worked with maltreated children across Canada completed one or both of the surveys from Phase 1 (n = 50) and 2 (n = 34). Demographic information can be found in Table A1 in the supplemental materials. Detailed information about the population size of urban and rural areas for participants from each province can be found in Table A2 in the supplemental

materials. This study was approved by the McGill University, Brock University, and University of Regina research ethics boards.

Survey invitations were sent to organizations that work with maltreated children, and were distributed by the Department of Justice Canada and to all Child and Youth Advocacy Centres. Recipients were invited to share the surveys with colleagues who work with maltreated children. Participants received a $10.00 gift card for completing Phase 1 and a $20.00 gift card for Phase 2.

Measures

The surveys were part of a larger study examining the effects of COVID-19 on child maltreatment frontline workers (law enforcement, psychologists, etc.). Both surveys were administered via an online data collection platform (Qualtrics), and were available in English and French. Survey questions are available in the supplemental materials.

Phase 1

Participants answered questions about *how COVID-19 generally impacted their practice, COVID-19 health and safety measures*, *perceptions of safety and stress*, as well as support from, and *satisfaction with their employers' response to the pandemic*. Depending on their responses, some participants completed a series of follow-up questions specific to their work. Questions were both option-posing (e.g., yes/no, Likert scale or 'select all that apply') and open-ended.

Phase 2

Phase 2 was identical to Phase 1 with three exceptions. Participants completed fewer follow-up questions. Second, participants were asked about unique challenges they faced working in an urban or rural area and whether they thought collaboration between urban and rural areas would be beneficial (as the urban/rural comparison emerged as a point of interest during the exploration of Phase 1 data). Lastly, since Phase 2 was disseminated months into the pandemic, the emphasis was placed on how services had been modified.

Design and Analysis

This mixed methods study employed a convergent parallel design, specifically the data-validation variant. Quantitative and qualitative data were collected concurrently using closed-ended and open-ended questions. Quantitative data was given priority in this study, with the qualitative data helping to explain the nature of the quantitative results (Creswell et al., 2003).

Quantitative Analysis

In the section on changes in service delivery, the aim was to uncover the impact on social work practice. As such, responses for each area of practice were combined into two variables. The first variable was whether a service provision had continued despite the implementation of public health measures, while the second was whether or not a service provision had been modified as a result of health measures. Pearson chi-square tests were used to examine differences between responses from rural and urban areas. All other quantitative data are presented as proportions due to the small sample size, which was inadequate for inferential analysis.

Qualitative Analysis

Open-ended responses from Phases 1 and 2 were coded for themes. The first and second authors used an inductive approach to independently generate themes for each question extracted from the data (Thomas, 2006). For each question, responses that did not endorse common themes were coded as *other*. The researchers discussed disagreements in themes, and finalized a coding scheme. Responses were then coded independently by each researcher, with a Cohen's Kappa coefficient used to determine inter-rater reliability. For Phase 1, Kappa values ranged from 0.83 to 1.00, with an average of 0.93. For Phase 2, Kappa values ranged from 0.96 to 1.00, with an average of 0.96. Discrepancies were resolved via discussion.

Results

Quantitative and qualitative data are presented together by study aims. We first examined the impact of COVID-19 on social workers' practices. We next examined social workers' perceptions of safety, stress and worry about COVID-19, and their perceptions of support.

The Impact of COVID-19 on Social Work Practice

Phase 1

Participants were asked if they had continued to provide a service (i.e., request medical exams, psychotherapy, forensic interviews, maltreatment investigation interviews) after the implementation of COVID-19 precautionary measures. Overall, 90.4% of rural and 82.7% urban social work services were still offered after the implementation of precautionary measures. There was no significant difference between geographic areas $\chi^2(1) = .295$, $p > .05$.

Of the services still offered, the method of delivery had been modified for 65.8% of rural and 63.3% of urban social work services. There was no significant difference between geographic areas, $\chi^2(1) = .188$, $p > .05$. See Table 1 for the types of modifications reported for forensic interviews.

Table 1

Modifications to Forensic Interviews During Phase 1 and Phase 2

Interview Changes	Phase 1		Phase 2			
	Yes	Don't know	Increased	No change	Decreased	Not applicable
	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)
In person, without PPE						
Rural	0.0 (0)	14.3 (1)	0.0 (0)	0 (0)	66.7 (4)	33.3 (2)
Urban	0.0 (0)	0.0 (0)	0.0 (0)	36.4 (4)	45.5 (5)	18.2 (2)
In person, with PPE (i.e., masks)						
Rural	50.0 (3)	0.0 (0)	50.0 (3)	50.0 (3)	0.0 (0)	0.0 (0)
Urban	37.5 (3)	0.0 (0)	63.6 (7)	18.2 (2)	18.2 (2)	0.0 (0)
In person, physically distanced (2 metres)						
Rural	100.0 (6)	0.0 (0)	50.0 (3)	50.0 (3)	0.0 (0)	0.0 (0)
Urban	87.5 (7)	0.0 (0)	63.6 (7)	27.3 (3)	0.0 (0)	9.1 (1)
In person, outdoors						
Rural	-	-	83.3 (5)	0.0 (0)	16.7 (1)	0.0 (0)
Urban	-	-	0.0 (0)	45.5 (5)	18.2 (2)	36.4 (4)
Remote, via video						
Rural	25.0 (2)	0 (0)	33.3 (2)	16.7 (1)	0 (0)	50.0 (3)
Urban	62.5 (5)	0.0 (0)	9.1 (1)	18.2 (2)	18.2 (2)	54.5 (6)
Remote, via phone						
Rural	-	-	66.7 (4)	16.7 (1)	0.0 (0)	16.7 (1)
Urban	-	-	36.4 (4)	0.0 (0)	18.2 (2)	45.5 (5)

Note - Percentages are calculated as a function of all respondents to each question (not the full sample). Participants selected all modifications that applied to them.

Phase 2

Social workers who conducted forensic interviews were asked if specific modifications (i.e., increases or decreases) had been made to their interviewing practices since the onset of the second wave (see Table 1). Although more USWs

than RSWs reported using video during Phase 1, Phase 2 saw 33.3% (*n* = 2) more RSWs report video interviews. There was also a reported increase in PPE use and physical distancing during interviews, as well as outdoor and virtual interviews. More RSWs (100.0%; *n* = 4) also reported modifications to in-person interviews during the second wave than USWs (33.3%; *n* = 3; see Table 2).

Qualitative data provided further evidence of modifications in service (see Table 3). When asked which aspects of their employment had been most affected by public health measures, five primary themes emerged. RSWs most frequently commented on the diminished quality of interactions with clients (i.e., physical distancing measures, such as wearing PPE, detracting from rapport), as well as disruptions in service delivery and remote delivery (both 37.5% of responses; *n* = 3, respectively). Yet, USWs reported service delivery disruptions and remote delivery as the most common aspects of their employment affected by public health measures (39.13% of responses; *n* = 9).

Table 2

Quantitative Proportions

Question	Phase 1		Phase 2	
	Urban	Rural	Urban	Rural
	% (*n*)	% (*n*)	% (*n*)	% (*n*)
Have you made modifications to in-person forensic interviews?				
Yes	100.0 (8)	85.7 (6)	33.3 (3)	100.0 (4)
Not sure	0.0 (0)	14.3 (1)	-	-
Are you adhering to government/employer recommendations around COVID-19?				
Yes	82.4 (14)	85.7 (12)	65.2 (15)	100.0 (8)
Somewhat	17.6 (3)	14.3 (2)	34.8 (8)	0.0 (0)
No	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)

Question	Phase 1		Phase 2	
	Urban	Rural	Urban	Rural
	% (*n*)	% (*n*)	% (*n*)	% (*n*)
How safe do you feel in your job as a result of the pandemic?				
Extremely safe	16.7 (4)	28.6 (4)	0.0 (0)	0.0 (0)
Very safe	29.2 (7)	0.0 (0)	18.2 (4)	20.0 (1)
Moderately safe	25.0 (6)	42.9 (6)	50.0 (11)	80.0 (4)
Slightly safe	20.8 (5)	21.4 (3)	27.3 (6)	0.0 (0)
Not safe	8.3 (2)	7.1 (1)	4.5 (1)	0.0 (0)
How stressed do you feel in your workplace, relative to pre-COVID-19?				
Much higher	4.2 (1)	35.7 (5)	0.0 (0)	0.0 (0)
Moderately higher	41.7 (10)	14.3 (2)	22.7 (5)	0.0 (0)
Slightly higher	25.0 (6)	35.7 (5)	50.0 (11)	40.0 (2)
About the same	16.7 (4)	7.1 (1)	7.7 (2)	60.0 (3)
Slightly lower	4.2 (1)	0.0 (0)	7.7 (2)	0.0 (0)
Moderately lower	0.0 (0)	0.0 (0)	7.7 (2)	0.0 (0)
Much lower	8.3 (2)	7.1 (1)	0.0 (0)	0.0 (0)
How worried are you about COVID-19?				
Extremely worried	16.7 (4)	14.3 (2)	4.5 (1)	0.0 (0)
Moderately worried	45.8 (11)	57.1 (8)	72.7 (16)	80.0 (4)
Slightly worried	29.2 (7)	21.4 (3)	18.2 (4)	20.0 (1)
Not worried	8.3 (2)	7.1 (1)	4.5 (1)	0.0 (0)
How worried are you for when COVID-19 physical distancing measures are lifted?				
Extremely worried	20.8 (5)	42.9 (6)	-	-
Moderately worried	37.5 (9)	35.7 (5)	-	-
Slightly worried	29.2 (7)	14.3 (2)	-	-
Not worried	12.5 (3)	7.1 (1)	-	-

Question	Phase 1		Phase 2	
	Urban	Rural	Urban	Rural
	% (*n*)	% (*n*)	% (*n*)	% (*n*)
Has your employer made plans for when physical distancing measures are lifted?				
Yes	25.0 (6)	21.4 (3)	-	-
No	25.0 (6)	35.7 (5)	-	-
I don't know	50.0 (12)	42.9 (6)	-	-
Have you been provided with mental health support by your employer?				
Yes	76.5 (13)	64.3 (9)	39.1 (9)	62.5 (5)
No	23.5 (4)	28.6 (4)	60.9 (14)	25.0 (2)
Does not apply	0.0 (0)	7.1 (1)	0.0 (0)	12.5 (1)
Do you feel that you and/or your coworkers need additional mental health support as a result of your working during COVID-19?				
Yes	58.8 (10)	64.3 (9)	78.3 (18)	75.0 (6)
No	41.2 (7)	28.6 (4)	17.4 (4)	12.5 (1)
How satisfied do you feel with your employer's response to COVID-19?				
Extremely satisfied	25.0 (6)	35.7 (5)	9.1 (2)	25.0 (2)
Somewhat satisfied	45.8 (11)	35.7 (5)	40.9 (9)	25.0 (2)
Neither satisfied nor dissatisfied	4.2 (1)	7.1 (1)	31.8 (7)	0.0 (0)
Somewhat dissatisfied	25.0 (6)	14.3 (2)	13.6 (3)	12.5 (1)
Extremely dissatisfied	0.0 (0)	7.1 (1)	4.5 (1)	0.0 (0)
Do you think collaboration between rural and urban settings would be beneficial?				
Yes	-	-	59.1 (13)	60.0 (3)
No	-	-	40.9 (9)	40.0 (2)

Note - The responding sample for each question is noted with the percentage, as all questions were optional and may have not been relevant to all respondents.

Perceptions of Safety and Stress

Phase 1

Participants were asked about their adherence to public health recommendations, and how safe they felt working since the start of the pandemic. Similar levels of adherence and safety were reported between USWs and RSWs (see Table 2). Participants also provided open-ended responses on their perception of current risks in their job as a result of the pandemic (see Table 3). For both RSWs and USWs, the most frequently endorsed theme was an increased risk of COVID-19 exposure (80.0% [*n* = 8] and 52.4% [*n* = 12] of responses, respectively).

Participants then rated their level of COVID-19 related stress and worry. Notably, 35.7% (*n* = 5) of RSWs rated their stress levels as much higher in contrast to 4.2% (*n* = 2) of USWs. RSWs also reported greater levels of worry than USWs (see Table 2).

Reports of whether respondents felt that their employers had a plan for when physical distancing measures would be lifted were similar between RSWs and USWs (see Table 2). Participants were asked an open-ended question about what they thought would happen when physical distancing measures were lifted (see Table 3). The most frequent theme endorsed from both RSWs and USWs was that there would be an increase in COVID-19 cases when measures were lifted (84.6% [*n* = 11] and 63.6% [*n* = 14] of responses, respectively).

Phase 2

Social workers were asked about their adherence to public health recommendations and perceptions of safety while working during the second wave of the pandemic. Of note, all (*n* = 8) RSWs reported adhering to physical distancing guidelines compared to 65.2% (*n* = 15) of USWs. When asked how safe they felt in their workplace, all RSWs and 68.2% (*n* = 15) of USWs reported feeling very safe or somewhat safe.

As in Phase 1, participants were asked about their perception of current risks in their job as a result of COVID-19. Two primary themes emerged (see Table 3). The most frequently endorsed theme from both RSWs and USWs was an increased risk of

COVID-19 exposure (80% [*n* = 4] and 71.4% [*n* = 15] of responses, respectively). Interestingly, 19.1% (*n* = 4) of USWs, but no RSWs, reported concerns of burnout.

Stress levels and worry were also examined (see Table 2). Most (72.7%; *n* = 16) USWs indicated that their stress levels were slightly or much higher than pre-pandemic events, whereas 40% (*n* = 2) of RSWs indicated their stress levels were only slightly higher.

Satisfaction with Employers' Response to the Pandemic

Phase 1

When asked about the provision of mental health support from their employers, more USWs (76.5%; *n* = 13) reported receiving support than RSWs (64.3%; *n* = 9). When asked if they or their colleagues need mental health support as a result of working during the pandemic, slightly more RSWs reported a need for mental health support than USWs (see Table 2). As a measure of support, social workers were asked how satisfied they were with their employer's response to the pandemic, to which the majority of both USWs and RSWs reported feeling (extremely or somewhat) satisfied with their employer's response (see Table 2).

Open-ended responses were consistent with quantitative findings (see Table 3). Among RSWs, the most frequently endorsed issue was about concerns for staff health and safety (37.5% of responses; *n* = 3). However, the most common concern among USWs pertained to concerns about their young clients (66.6% of responses; *n* = 10). Participants were asked how agencies could support them as physical distancing measures were lifted. The most frequent suggestion among RSWs was to ensure the availability of psychological support (37.5% of responses; *n* = 3), while the most frequent suggestion from USWs was for flexibility in allowing work from home or in the office, depending on the workers' needs and preferences (21.1% of responses; *n* = 4).

Phase 2

Similar to Phase 1, participants were asked if they had been provided with mental health support from their employer. RSWs reported receiving more support during the

second wave of COVID-19 than USWs (see Table 2). When asked if they or their colleagues need mental health support, a greater proportion of USWs reported feeling that they, or their peers, needed additional mental health support. Further, more RSWs than USWs were extremely or somewhat satisfied with their employer's response to the pandemic (see Table 2).

Several themes emerged when examining participants' concerns about the impact of COVID-19 and their suggestions about how to best respond to the pandemic. RSWs equally endorsed a desire to receive additional support, allow flexibility in working from home, and that their employer's response was satisfactory (25% of responses [n = 1, respectively]; Table 3).

Table 3

Themes from Open-ended Responses

Survey Topic	Themes	Example Quotations
Aspects of employment most affected by public health measures	<u>Phase 2</u>	
	1) Diminished quality of client interactions	Wearing face masks makes it difficult to observe para-verbals and facial expressions during interviews and determine[e] safety.
	2) Reduced contact with clients and limited access to services for clients	Families' access to supportive services has diminished.
	3) Disruptions in service delivery and remote delivery	Visiting with children and parents has moved to as much virtual as possible.
	4) Safety concerns	Decreased feeling of safety due to lack of PPE and guidance in the workplace.
	5) Mental health difficulties associated with isolation and increases in stress	I have had to take on more of an emotional/therapeutic role with a lot of my clients as many people are struggling with stress, anxiety and other mental illnesses…There also exists additional stress as a result for concern for my own health and for that of my family.
Perception of current risks in job as a result of the pandemic	<u>Phase 1</u>	
	1) No perceived increased risk on the job	We are working from home and therefore there is no additional risks.
	2) Risk of exposure to COVID-19	Transference is my biggest concern, either giving COVID-19 to someone or giving it from someone.
	<u>Phase 2</u>	

Survey Topic	Themes	Example Quotations
	1) Increased risk of exposure to COVID-19	My job has always been risky, but now I fear contracting a virus in a client's home and getting my own family sick
	2) Burnout associated with increased workloads and mental health issues	Caseloads have gone up which increases stress…Many social workers are struggling with their mental health and how to manage stress with little to no support from upper management.
What participants thought would happen when physical distancing measures were lifted	<u>Phase 1</u>	
	1) Influx of cases in maltreated reports	A sharp increase in reported child abuse when schools resume…They will be seen regularly and will have more "safe people" they can talk with.
	2) Increase in COVID-19 cases (i.e., a second wave)	I expect a second wave and worry about how large it will be.
	3) Lack of adherence to health guidelines (if restrictions are reduced gradually)	A surge of unhealthy behaviours in shelters, lunch kitchens, and homes of my clients.
	4) Challenges in returning to work and maintaining workplace safety	Ability for centres like ours to obtain appropriate cleaning supplies has been difficult as they have been largely reserved for essential services and we are not considered such.
Concerns about COVID-19, and how to best respond to the pandemic	<u>Phase 1</u>	
	1) Concerns for staff health and safety, and ensuring staff safety	There is not enough space within the office to maintain social distancing.
	2) Provide sufficient staff support	Adjust caseload demands, spread work out more evenly, offer support for workers outside of self-seeking counseling support.
	3) Concerns related to child/youth clients (e.g., lack of support, safety, underreporting of maltreatment)	My concern is that some child maltreatment incidents are going unnoticed and not reported due to reduce[d] visibility.

Survey Topic	Themes	Example Quotations
	4) Concerns over PPE availability	PPE has not been easily accessible…It would be helpful to have a certain amount in my possession so as in-person meetings are happening I am already prepared.
	Phase 2	
	1) More training	More training and information would be useful.
	2) PPE concerns (i.e., lack of availability, proper use)	PPE training…Provide PPE for when I have to attend the courthouse.
	3) Provide adequate staff support	Increased mental health supports…Need to have more social workers, more staff, more human resources.
	4) Flexibility in working from home or offering remote delivery	Take a closer look at the viability of having staff work from home.
	5) Employer response has been satisfactory (i.e., no recommendations made)	I think we have done an excellent job and can't say I would make a bunch of recommendations as we are following health guidelines.
What agencies could do to help support social workers as health measures were lifted	Phase 1	
	1) Employer flexibility by allowing working from home (or in the office)	They could alternate our work days having some people work from home while others came into the office.
	2) Establish clear guidelines for the future (i.e., post-COVID-19)	Clear guidelines in how to support clients in the long term…We cannot continue to support clients in the way we have as I feel the solution was short-term or at least short-sighted. There have been little guidelines on how to protect ourselves and our clients in the office.
	3) Availability of physical support	Provide more masks in a timely manner – just received our first supply of 5 masks last week for a staff of 40.

Survey Topic	Themes	Example Quotations
	4) Availability of psychological supports	Better debriefing systems in place to support their employees. Having access to mental health webinars is not enough – especially when the webinars are during work hours and therefore unavailable to individuals carrying a caseload
	5) Importance of employers maintaining contact with employees about needs and concerns	Talk to us. Listen to us. Take our concerns about the work environment and workload seriously.
What employers could do to help support social workers during COVID-19	<u>Phase 2</u>	
	1) Availability of psychological supports	Anything to improve our mental health and the team environment we work in would help.
	2) Hire additional staff	Hire more employees due to the fact that we have to do so much more on our caseloads due to a lack of community resources.
	3) Increase training and other occupational supports	Provide training on virtual interviewing.
	4) Maintain a clear dialogue about employees' comfort levels, needs, and concerns; as well as employer policies and updates	Regular communication/open discussion to problem solve, brainstorm, and receive updates.

Note - Themes extracted from qualitative data from Phase 1 and 2. The *other* themes are excluded from the table.

Conversely, the most common concern among USWs pertained to the provision of adequate support from their employer (40% of responses; *n* = 8).

Participants were then asked what their employer could do to help support them as an employee working during COVID-19. The most frequent suggestion among RSWs (50% of responses; *n* = 2) did not match any of the extracted themes, but instead could be characterized by an omission of suggestions for employer support (i.e., no suggestions), which was congruent with the ratings of satisfaction with their agency's response to the pandemic (see Table 3). The most frequent suggestion from USWs (37.5% of responses; *n* = 6) related to increased training and support from their employer. For example, one participant suggested that 'providing training on virtual interviewing' would help support them, while another highlighted that 'increased training and support would be beneficial'.

Urban-Rural Comparison

Participants were asked about collaboration between rural and urban settings, whereby similar proportions of RSWs and USWs indicated that they thought a collaboration would be beneficial (see Table 2). Participants who indicated that collaboration would be beneficial provided an open-ended response on the nature of the collaboration. The primary themes endorsed related to reducing isolation, as well as promoting the sharing of resources, knowledge and support. Of the two responding RSWs, one described a need for resource sharing, whereas the other emphasized that the nature of collaboration would depend on the specific setting. Among USWs, 40% (*n* = 4) of respondents endorsed that collaboration would promote the sharing of resources, while another 40% (*n* = 4) of responses could not be thematically characterized. For instance, one respondent said, 'I'm not really sure what this could look like, but I always feel that any collaboration from other perspectives are helpful in this field', thereby indicating a willingness to explore collaboration between rural and urban workers.

Discussion

The overarching goal of this mixed-methods study was to identify differential impacts of the pandemic on social workers in urban and rural settings. We examined how COVID-19 generally impacted their practice, perceptions of safety and stress, and

satisfaction with employer responses to the pandemic. There were few differences between USWs and RSWs during the first wave of the pandemic, though RSWs tended to report slightly more stress and worry than USWs. During the second wave of the pandemic, USWs reported increases in stress, worry and a need for mental health support compared to the first wave. USWs also reported higher stress levels than RSWs in the second wave.

Most USWs and RSWs maintained service delivery during the first wave of the pandemic, and further, both made modifications which were similar between urban and rural settings. In Phase 2, social workers in rural and urban settings again reported similar modifications (i.e., remote delivery, physical distancing and PPE use) with the exception of RSWs shifting service delivery outdoors. This may be an advantage of working in a rural area, where reduced population and infrastructure density provides the opportunity for private outdoor interviews. Thus, contrary to our hypothesis, service delivery was similarly affected between urban and rural areas from Phase 1 and 2. This may have been a result of public health measures, which were implemented across entire provinces during the first wave of pandemic, regardless of an area's population density. However, during the second wave, public health measures tended to target urban more than rural areas. Given that many agencies involved in child maltreatment investigations are provincial rather than regional, the same policies may have been implemented, regardless of the population of their service region.

Although there were many similarities reported in service delivery, we observed differences in the perceptions of stress, worry, and safety between RSWs and USWs. In contrast to our hypothesis, there were similar perceptions among RSWs and USWs of safety in the workplace during Phase 1. For example, both USWs and RSWs primarily reported concerns related to COVID-19 exposure. One RSW succinctly summarized these concerns, saying ‘again, this role requires a lot of in-person contact. This in-person contact (often without the ability to complete screening questions, especially during child protection investigations), places us at an increased risk of exposure to COVID-19’. Nonetheless, during Phase 2 more RSWs tended to report feeling safe in the workplace compared to USWs.

During the second wave of the pandemic, COVID-19 cases rose substantially, particularly in more populated areas (CDC, 2021; Government of Canada, 2021), which may have resulted in diminished perceptions of safety among USWs. Additionally, USWs reported less adherence to public health guidelines than RSWs during Phase 2, suggesting that individual behaviour may have contributed to reduced perceptions of safety. One USW highlighted these concerns, reporting that:

> When going out to family homes, while we [ask] our screening questions, the validity and truthness of our clients' answers may be varied. A lot of our clients interact with many individuals and therefore they are not staying within their "bubble".

Similarly, RSWs reported higher levels of stress and worry than USWs during Phase 1. Conversely, USWs reported notable increases in stress and worry during Phase 2, and reported increased stress levels more frequently than RSWs. Both urban and rural participants reported concerns about exposure to the virus, hence illustrating a fear of infection and transmission as one source of stress and worry. Still, living in an urban environment with a higher population density may have placed additional stress on USWs, which was reported as a unique concern of urban participants. Saliently, many USWs reported population density as a concern due to higher total case counts and less opportunity for social distancing. For instance, one USW said, ‘High levels of population make it harder to social distance while shopping [and in] transit.’ Some participants also reported concerns about public health measures, such as returning to lockdown and remote delivery, which was more likely to occur in urban areas (Sharifi & Khavarian-Garmsir, 2020). It is also possible that USWs felt more stress and worry during the second wave, as the greater population density likely contributed to elevated caseloads and more individuals in need of service. One USW explained this concern, indicating their service population has ‘... higher needs due to higher incidences of poverty, mental health and substance use issues within population’, with another simply describing ‘busier caseloads’ as a concern. These potential sources of stress are consistent with findings from other studies regarding sources of stress on healthcare workers more generally during COVID-19 and other infectious disease outbreaks (Magill et al., 2020).

We expected RSWs would report reduced perceptions of support compared to USWs as a result of the relatively limited resources available in rural areas (Friesen, 2019; MHCC, 2020). USWs reported that employer mental health support was provided

more often than RSWs did during Phase 1. In contrast, during Phase 2, RSWs reported support provision more frequently than USWs. It seems that RSWs were provided with more support as the pandemic progressed, whereas USWs received more support at the outset of the pandemic. Respondents' satisfaction with employer support corresponded with the provision of psychological support, as satisfaction ratings were similar between USWs and RSWs during Phase 1. In contrast, Phase 2 rural participants' satisfaction with their employer's response increased, but urban participants' satisfaction decreased. These differences were highlighted in open-ended responses, as RSWs most frequently expressed a desire for allowing flexibility in working from home or the office, and the provision of additional support and training from their employer. USWs primarily expressed a desire for additional support and training from their employer. For example, an USW expressed a desire for employers to be 'having employees working from home or provide options to decrease exposure. Provide better mental health supports'. Importantly, however, during Phase 1 RSWs emphasized the importance of providing psychological support, while USWs emphasized flexibility in permitting working remotely or from the office, which may have resulted in rural employees receiving supplementary support. Moreover, the lack of an expressed demand for mental health support from USWs may have resulted in employers placing less emphasis on mental health support between the first and second wave of the pandemic.

Overall, RSWs appeared to struggle earlier in the pandemic, supporting our hypothesis that rural areas would report more distress in the context of reduced perceptions of safety and support, as well as increased stress and worry. Nevertheless, in the second wave of the pandemic, USWs reported increases in worry and stress, as well as reductions in perceived support and safety. This decline in well-being is important to highlight given the duration of the pandemic and the potential for burnout in a profession in which burnout has been noted as a serious concern (McFadden, 2015; Wagaman et al., 2015). Moreover, our results emphasize the importance of support for overall well-being, which has been found to be critical for social workers and reducing the likelihood of burnout (Kim & Stoner, 2008; Shier & Graham, 2011).

Burnout has long been a significant concern for social workers (Barck-Holst et al., 2021; Wagaman et al., 2015), although the concern seems magnified as a result of the pandemic. We expected to find increased concerns of burnout and need for mental health support in Phase 2, relative to Phase 1. Both patterns were observed. For example, one participant noted 'emotional burnout is the highest risk', and another reported 'burnout - increased workload with less support due to COVID restrictions'. Notably, burnout was reported only by USWs, which suggests it may be a more salient challenge faced by them. USWs reported facing unique challenges including higher caseloads, mental health difficulties as well as a perceived pressure to have services and resources readily available. Some participants highlighted this pressure, reporting, '... people are used to resources being available', and 'service pressures in [the] community because of the population'. In addition, one participant said that, 'This job is high stress on a good day, but add in all these additional stressors and it seems negligent not to assess where workers are at on an individual basis', which highlights the importance of addressing the added burden of the pandemic stressors. These challenges USWs faced have also frequently been associated with burnout without the added pressures of a pandemic (Barck-Holst et al., 2021).

RSWs faced their own unique challenges, primarily regarding limited access to resources, including technology, internet and even infrastructure. For example, one participant expressed concern about, 'not having a place to meet with youth given I work within a large region'. Although rural respondents did not explicitly highlight burnout as a concern, limited access to resources has been highlighted as a correlate of burnout (Lloyd et al., 2002). These results also support our hypothesis that RSWs would encounter challenges related to limited access to support, whereas USWs would express more concerns about contracting COVID-19.

Limitations and Future Directions

This is the first study to examine the impact of the COVID-19 pandemic on social workers and their practice across urban and rural settings within the same country. The mixed methods design allowed us to both uncover differences between social workers in urban and rural settings, and to elucidate the nature of the differences with qualitative data. However, several limitations exist. First, the small sample size was

detrimental to inferential statistical analysis, and may inadequately represent the rural experience. There are fewer RSWs than USWs, given the sizes of their service population, which likely contributed to the smaller sample size. However, the mixed methodology was implemented to offset sampling problems. It would have been ideal to compare responses from the same social workers at the two time points. In future research, more detailed qualitative research (e.g., focus groups) should be conducted to uncover more about the nature of the differences between RSWs and USWs. Finally, exploring the long-term effects of working through the pandemic on social workers is a critical next step.

Conclusion

This study examined the impact of the COVID-19 pandemic on urban and rural social workers who work with maltreated children. Both quantitative and qualitative data revealed few differences during the first wave of the pandemic, although RSWs tended to report being impacted more severely. Even so, findings shifted during the second wave of the pandemic, with USWs reporting more severe impacts than RSWs. Taken together, this study highlights the importance of all social workers receiving sufficient mental health support from their employer to help manage stress and minimize the risk of burnout. Moreover, results highlighted the importance of enhancing resources in rural areas to allow for RSWs to optimally engage in remote service delivery.

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