

Western Kentucky University

TopSCHOLAR®

---

Social Work Faculty Publications

Social Work

---

2020

## Perceptions of Workload and Job Impact as Predictors of Child Welfare Worker Health Status

Austin G. Griffiths

David Royse

Chris Flaherty

Crystal Collins-Camargo

Follow this and additional works at: [https://digitalcommons.wku.edu/socwk\\_fac\\_pub](https://digitalcommons.wku.edu/socwk_fac_pub)



Part of the [Community Health and Preventive Medicine Commons](#), and the [Social Welfare Commons](#)

---

This Article is brought to you for free and open access by TopSCHOLAR®. It has been accepted for inclusion in Social Work Faculty Publications by an authorized administrator of TopSCHOLAR®. For more information, please contact [topscholar@wku.edu](mailto:topscholar@wku.edu).

**Western Kentucky University**

---

**From the Selected Works of Austin Griffiths**

---

2020

# Perceptions of Workload and Job Impact as Predictors of Child Welfare Worker Health Status

Austin Griffiths, *Western Kentucky University*

David Royse, *University of Kentucky*

Chris Flaherty, *University of Kentucky*

Crystal Collins-Camargo, *University of Louisville*



Available at: <https://works.bepress.com/austin-griffiths/17/>

## WORKER HEALTH STATUS

### Perceptions of Workload and Job Impact as Predictors of Child Welfare Worker Health Status

Austin Griffiths<sup>a\*</sup>

David Royse<sup>b</sup>

Chris Flaherty<sup>c</sup>

Crystal Collins-Camargo<sup>d</sup>

This research was not supported by any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

<sup>a\*</sup> Corresponding author at: Western Kentucky University, Department of Social Work, 1906 College Heights Blvd. #11039, Bowling Green, KY 42101. *Email address:* [austin.griffiths@wku.edu](mailto:austin.griffiths@wku.edu)

<sup>b</sup> University of Kentucky, College of Social Work, 619 Patterson Office Tower, Lexington, KY 40506. *Email address:* [droyse@uky.edu](mailto:droyse@uky.edu)

<sup>c</sup> University of Kentucky, College of Social Work, 619 Patterson Office Tower, Lexington, KY 40506. *Email address:* [chris.flaherty@uky.edu](mailto:chris.flaherty@uky.edu)

<sup>d</sup> University of Louisville, Kent School of Social Work, Oppenheimer Hall, 2217 S. Third Street, Louisville, KY 40292. *Email address:* [crystal.collinscamargo@louisville.edu](mailto:crystal.collinscamargo@louisville.edu)

### Abstract

Turnover in the child welfare workforce remains a problem with detrimental consequences. While a robust body of literature has explored the influence of job factors on employee retention, and the presence of secondary traumatic stress and other related experiences in this population, little is known about the impact of such factors on the physical health of the practitioner. This manuscript is a first step in documenting the relationship between worker characteristics, perceptions of their job, and their self-reported health status. Utilizing the Child Welfare Employee Feedback Scale (CWEFS), a Binary Logistic Regression model identified Workload and Job Impact as significant predictors of poorer self-reported health status in a statewide sample of child welfare workers (n=511). Additionally, respondents working in urban areas and outside of their home county were approximately 1.5 times more likely to report a poorer health status. Findings suggest avenues for future research and agency administrator consideration.

*Keywords:* child welfare, turnover, retention, health, job impact, workload

### **Demands on the Child Welfare Workforce**

Child maltreatment is a major social problem in the United States. According to the U.S. Department of Health and Human Services (2018), 4.16 million referrals were made alleging the maltreatment of 7.5 million children in the federal fiscal year of 2017. Approximately 1,720 children died during that timeframe as the result of child maltreatment. The economic burden of child maltreatment, and associated social response is astronomical, with one estimate of an annual cost of \$2 trillion (Peterson et al., 2018).

Although arguably the responsibility of a variety of community agencies, confronting this social problem is the primary duty of the child welfare workforce. A competent and committed child welfare workforce is a fundamental necessity for assuring that protective and treatment services are provided to those in need (DePanfilis & Zlotnik, 2008; McFadden et al., 2015).

A considerable body of research has examined factors related to stress, burnout, and workforce turnover within child welfare agencies. Predicting workforce turnover has garnered particular attention, in that this phenomenon imposes great burdens upon child welfare agencies in terms of recruitment and training, as well as impeding service quality (Barth et al., 2008; Ellett et al., 2003; Ellett et al., 2007; Williams et al., 2011; Yankeelov et al., 2009; Zlotnik et al., 2005). Factors found to influence worker retention within child welfare agencies include: workers' sense of accomplishment, professional commitment to the profession, job satisfaction (Williams et al., 2011), reasonable workloads, adequate salary, opportunities for advancement (Ellett et al., 2003; Ellett et al., 2007; Zlotnik et al., 2005). Coworker and supervisor support (Kim & Kao, 2014; Williams et al., 2011; Zlotnik et al., 2005), and recognition for one's work (Barth et al., 2008; Ellett et al., 2007, Williams et al., 2011) also seem to be important variables. Additionally,

younger workers, professionals of color (Faller et al., 2010), and those working in urban settings (Barth et al., 2008) have each been found to experience less job satisfaction and greater intention to leave the workforce.

### **Stress and Health Consequences**

Prior research has established clear connections between stress and physical health (e.g. Stults-Kolemainen et al., 2014). Particularly, stress has been associated with coronary heart disease, acute myocardial infarctions, poor survival from cardiac events as well as changes in the immune and nervous systems (Stults-Kolehmainen et al., 2014). A review of the literature suggested that social workers may experience higher levels of stress than other comparable professionals (Lloyd et al., 2002). Research has documented that social workers in a wide range of settings report varying stress levels, influenced significantly by the workplace environment as well as their mental and physical health status (Senreich et al., 2020). Over twenty-five years ago, a study compared nurses and social workers in various types of settings, and found that child protective workers were at risk for poorer health than those working in schools, medical settings or with the elderly related to a variety of factors associated with the job (Marshall & Barnett, 1993). In child welfare specifically, however, workforce health has received less attention than the focus on turnover.

Frontline child welfare workers face extraordinary stress. These professionals are tasked with responding to situations characterized by exposure to traumatic content, risk to vulnerable clients, and ambiguity in decision-making protocols, all while negotiating daunting systemic barriers to providing optimal services. Researchers have identified several related psychological consequences experienced by child welfare workers. These include trauma, secondary traumatic stress, compassion fatigue, emotional exhaustion, and burnout as closely related, but distinct

conditions that workers experience in these positions (Boyas et al., 2012; Mor Barak et al., 2006; Nissly et al., 2005; Shier et al., 2012; Smith & Clark, 2011). In addition, studies have identified a connection to occupational hazards such as job strain, the degree of regulation and decision authority (Marshall & Barnett, 2003) and the work place environment, which may include crisis-driven workflow, high caseload, low levels of social support and supervision (Senreich et al., 2020).

There is a dearth of information regarding the effects of these factors on the health status of the child welfare workforce. However, research with other professionals, namely law enforcement officers and nurses, may be informative. Studies of work stress in law enforcement has shown that organizational factors (i.e. administration, workload and supervision) played a greater role in officers' perceptions of quality of life, than did operational factors (i.e. danger, complaints, frustration) (Hart et al., 1995). Gender was found to be a factor related to how specific psychiatric diagnoses were applied to officers who had experienced traumatic events. Male officers were more likely to receive a diagnosis of Posttraumatic Stress Disorder, whereas female officers were more likely to receive other diagnoses (Morash et al., 2006). Researchers also found that police officers who applied problem-focused coping strategies in response to experiencing stressful events were more likely to report improved perceptions of their work experiences (Hart et al., 1995).

Research on the health effects of job stress among police officers can be somewhat instructive, in terms of understanding such effect upon the child welfare workers. However, research within the nursing profession may be particularly relevant to child welfare. Nurses and child welfare workers experience similar experiences including high workload (LeSergent & Haney, 2005), secondary trauma (Beck, 2011; Dominguez-Gomez & Rutledge, 2009), and

compassion fatigue (Cocker & Joss, 2016; Hooper et al., 2010). Among nurses, high stress and job demands have been associated with health deterioration (Van der Heijden et al., 2008), headaches (Lin et al., 2007), weight gain, low levels of body satisfaction, and disordered eating (Zapka et al., 2009), and sleep disturbance (Daurat & Foret, 2004; Ferri et al., 2016).

Although research within the nursing profession provides potentially useful information that may help us to understand the effects of stress upon the wellbeing of child welfare workers, there are some notable differences between the professions that should be considered. Specifically, there may be differences in the public perception of these professions. Also, nurses have higher salaries. According to the Bureau of Labor Statistics (2018), the annual mean wage for “Registered Nurses” is \$75,510, compared to \$49,760 for “Child, Family, and School Social Workers.”

Considering the established connection between stress and numerous negative health outcomes, it is reasonable to expect that factors that lead to job dissatisfaction, stress, and intention to seek other employment will also contribute to workers’ perceptions of their emotional and physical health. Considerable research has been undertaken toward understanding worker turnover, as a drain on agency resources, and impediment to delivery of optimal services. Less attention has been paid to the health of the child welfare workforce. It would seem that maintaining a healthy workforce—one that is capable of maintaining psychological and physical health while responding to situations characterized as stressful and traumatic—may be as important as worker turnover. Worker health may need to be considered as an outcome worthy of study. Toward that end, an important initial step is to gain an understanding of child welfare workers’ perceptions of its health status and the health behaviors they employ to in an attempt to manage the daunting demands of this work.



### **Purpose of the Study**

The purpose of the study is to explore the self-reported health status of a statewide sample of frontline child welfare workers. This study will be the first of its kind, as there is currently no literature examining the health status of a statewide sample of child welfare workers and its relation to job stress and factors influencing the worker's experience. This study will add to the literature by answering the following research questions:

1. How does the frontline child welfare workforce perceive its own health?
2. Are there differences in the self-reported health status of the child welfare worker when considering demographic variables of interest (e.g. race/ethnicity, gender, working in one's home county, or working in an urban/rural location)?
3. Is the self-reported health status of the child welfare worker associated with age, tenure, intention to leave, or levels of job satisfaction as measured by the Child Welfare Employee Feedback Scale (CWEFS) and its subscales?
4. Which of the components of the CWEFS (Supervision, Job Impact, Peer Support, Accomplishment, Professional Development, Recognition, Workload, and Salary) and relevant demographic variables best predict child welfare workers identifying a poorer health status?

### **Methodology**

#### **Design and Data Collection**

This study utilized a descriptive research design to collect feedback from a statewide sample of child welfare workers in a southern state. An electronic survey was administered through Qualtrics and distributed by government email listserv to over 2100 professionals employed in various capacities (i.e. administrators, supervisors, front-line workers) in January of

2016. The purpose of the electronic survey was to provide employees with an opportunity to identify 1) strategies for improving employee retention, 2) issues regarding job satisfaction and dissatisfaction, and 3) suggestions for improving systematic processes. The instrument was therefore composed of both closed- and open-ended questions in these domains. The research protocol was approved by the Institutional Review Boards at the government agency and at the university level.

With respect to the distribution of the survey, employees received a preliminary notification email from the Commissioner who informed employees of the upcoming survey and encouraged participation. The research team's affiliation with local universities was explained to clarify that the study was not being conducted by agency staff. Approximately one week later, an agency administrator used their listserv to send an approved cover letter describing the voluntary and confidential nature of participation in the study and included a hyperlink to for direct service employees to access the electronic Qualtrics survey. Two weeks later, a one-time reminder email was sent to the workforce to finalize data collection.

### **Sample**

The sample of interest for this study is the frontline workers in the state's child welfare system—those with direct client contact and not in any supervisory role. A total of 511 respondents met criteria for inclusion in this study, out of the possible 1,351 front-line workers receiving the survey. While a response rate of 37.8% is low, it is higher than a similar study identifying perceived respect as a significant indicator for intention to leave their current job (Augsberger et al., 2012).

Table 1 provides detail regarding the study sample. The sample was primarily female (86.5%) and white (87.2%). Respondents averaged 37.62 (SD 9.86) years of age and reported

working for the agency 8.15 (SD 7.52) years. Related to location, about half of the respondents (51.2%) primarily worked in their home county and 64.7% reported working in a rural area. The majority of the respondents had never worked in child welfare before working at this agency (72.7%). Related to undergraduate education, 40.4% had an undergraduate degree in social work and 59.6% had an undergraduate degree in an “other” area. The majority of the sample did not have a graduate degree (68.5%); 22.5% had a Master of Social Work degree and 9% had a graduate degree in a different area (See Table 1).

### Measures

While the current study has yielded several articles focused on workforce perceptions of job satisfaction, factors influencing intention to stay, and qualitative explorations of the self-reported stress attributed to working in their positions (Griffiths, Desrosiers, et al., 2019; Griffiths, Harper, et al., 2019; Griffiths, Murphy, et al., 2019; Griffiths, Royse, Culver, et al., 2017; Griffiths, Royse, & Walker, 2018), this study focuses on a unique aspect of this data set where respondents provided self-reported quantitative information about their perceived health status not previously published. In addition to health-related data, the survey included 14 demographic questions, a single item focusing on the respondent's intention to leave child welfare employment, and scales measuring job satisfaction and dissatisfaction.

A single item self-reported ordinal health variable was created to capture the respondent's perception of their own current health status, drawn from the Centers for Disease Control and Prevention's Healthy Days Core Module (2019). In use since 1993, the Health-Related Quality of Life (CDC HRQOL-4) has been used in different surveys designed to measure behavioral risk, nutrition, and health outcomes. The authors chose a 4-point option to create a clearer positive-negative inference.

The Child Welfare Employee Feedback Scale (CWEFS) was utilized to examine respondent perceptions of job satisfaction and dissatisfaction across multiple domains. The CWEFS is a satisfaction-based instrument that was developed from key concepts found in peer-reviewed and published literature (Auerbach et al., 2010; Cahalane & Sites, 2008; Chen & Scannapieco, 2010; Ellett et al., 2003; Koeske et al., 1994; Shim, 2010), refined for the purposes of this study on workforce health. Specifically, a factor analysis separated the Workload subscale into two separate components (Workload, Job Impact). For the purposes of a health analysis, the research team believed this better explicated the contribution of each separate area with respect to understanding their influence on worker perception of health. Operational definitions of key variables of interest are as follows.

**Perceived health status.** Perceived health status was operationally defined by the respondent's ordinal selection (1- Excellent; 2- Good; 3- Fair; 4- Poor) to the following question: "How would you rate your current health status?"

**Intention to leave.** Intention to leave was operationally defined by the respondent's selection (1- Strongly Disagree, 2- Disagree, 3- Neutral, 4- Agree, 5- Strongly Agree) to the following question: "I plan on leaving this agency within the next 12 months."

**Satisfaction subscales.** The CWEFS indicates the respondent's level of satisfaction or dissatisfaction with specific items found to influence the child welfare workers' experience and intention to leave. Each of the items in the CWEFS were established by a five-point Likert response scale (1=Strongly Disagree, 2= Disagree, 3= Neutral, 4= Agree, 5= Strongly Agree). To facilitate a strengths-based approach in the assessment process, most of these items were positively framed (e.g. "I have a manageable paperwork load," "I am satisfied with the opportunities for promotion"). This study includes a refined version of the CWEFS that includes

a total of eight subscales (Supervision, Job Impact, Peer Support, Accomplishment, Professional Development, Recognition, Workload, and Salary), all of which were established through a Principal Components Analysis with acceptable coefficient alphas (.705 to .919). Table 2 identifies the item means, number of items in each subscale, sample questions, and coefficient alphas for each of the subscales. Mean scores representing respondent level of satisfaction were used in the current study. Higher scores indicated greater satisfaction.

### **Data Analysis Process**

SPSS Version 24 was utilized, as the data set was cleaned and listwise deletion was employed for all subsequent analyses (Baraldi & Enders, 2010). Univariate descriptive analyses were conducted to examine the perceived current health status of the frontline workforce. Independent samples t-tests were conducted to explore differences on behalf of the frontline workforce's self-reported health status and demographic variables of interest (e.g. race/ethnicity, gender, working in home county, or working in an urban/rural location). Bivariate correlations were conducted to assess for relationships between the self-reported health status of the child welfare worker and their age, tenure, intention to leave, and each of the subscales related to the CWEIFS. Finally, a multivariate binary logistic regression model was used to examine which of the components of the CWEIFS and relevant demographic variables best predicts the child welfare worker identifying a poor health status.

## **Results**

### **Research Question 1: Univariate Analysis**

A descriptive univariate analysis was used to examine how child welfare workers perceive their current health status. A total of 510 child welfare workers identified the perception

of their current health status through an ordinal variable, 51 (10.0%) identified their health status as “excellent,” 254 (49.8%) as “good,” 157 (30.8%) as “fair,” and 48 (9.4%) as “poor.”

### **Research Question 2: Bivariate t-Test Analyses**

Bivariate independent samples t-tests were conducted to examine mean differences in the respondent’s current health status and relevant categorical demographic variables (e.g. race/ethnicity, gender, working in home county, or working in an urban/rural location).

Given the limited diversity in the sample, the race/ethnicity variable was collapsed into two categories with one reflecting those who identified as “white” and the other reflecting “professionals of color.” Related to gender, the single respondent who selected “other” was removed from the analysis. The exploration of mean differences in current health status and relevant demographic variables resulted in striking similarities across the board, as none of the results were statistically significant (see Table 3).

### **Research Question 3: Bivariate Correlation Analyses**

Bivariate correlation analyses were conducted to examine the association between the 4-point ordinal variable reflecting the child welfare worker’s perception of their current health status, and their age, tenure, intention to leave, and their levels of satisfaction with each of the eight subscales of the CWEFS. Aside from age, significant associations were identified between the respondent's perception of their current health status and each additional variable.

Specifically, identifying a poorer health status was significantly associated with more years at the agency and the intention to leave. Related to the CWEFS, all eight subscales displayed inverse and significant relationships. Moderate significant relationships were identified between a poorer perception of health status and the level of satisfaction with Job Impact, Workload, and

Recognition. Weak, yet significant, relationships were identified with each of the five additional subscales (see Table 4).

#### **Research Question 4: Multivariate Binary Logistic Regression**

Binary Logistic Regression was used to analyze which components of the CWEFS (Supervision, Job Impact, Peer Support, Accomplishment, Professional Development, Recognition, Workload, and Salary) and relevant geographic factors would best predict the child welfare worker identifying a poorer perception of their health status.

For the outcome variable in this analysis, a dichotomous coding structure was used to change the ordinal health status variable into two groups that reflected good and not so good self-reported health. Respondents identifying their health status as “excellent” or “good” were placed in the reference category, and those reporting their health status as “fair” or “poor” were used as the outcome variable (1 = “fair/poor”; 0 = “excellent/good”). A total of 476 child welfare workers were included in the analysis; 284 (59.7%) had a positive perception of their health status and constituted the “excellent/good” group. Further, 192 (40.3%) respondents identified a poorer perception of their health status formed the “fair/poor” group. Predictor variables included the respondent’s mean score for each of the eight subscales in the CWEFS. Location was also considered, as the binary variables of location (1 = Primarily Urban) and working outside of their home county (1 = Yes) were recoded into dummy variables for use in the model.

Two subscales from the CWEFS were identified as statistically significant predictors of child welfare workers reporting a poorer health status. Job Impact (Wald = 17.016,  $p < .001$ ) was the most significant, followed by Workload (Wald = 4.268,  $p = .039$ ). The CWEFS was designed as a strengths-based instrument, and the significant inverse relationships in these two areas indicate their dissatisfaction with Workload and Job Impact are related to reporting poorer health.

After inclusion of the eight subscales and two binary geographic variables, the model produced a lower -2 Log Likelihood score of 530.096 and improved the correctly classified percentage to 73.3%. The Omnibus Chi Square score ( $\chi^2 = 111.886$ ,  $p < .001$ ) confirmed a significant improvement between Block 0 and Block 1. Further, the Hosmer and Lemeshow test revealed a goodness of fit ( $\chi^2 = 5.587$ ,  $p = .693$ ) and Nagelkerke's  $R^2$  identified that the model contributed 28.3% of the variance in the dependent variable (Nagelkerke, 1991). Regression coefficients for predictors of poorer health status can be seen in Table 5).

While the geographic variables were insignificant predictors in the model, results suggest that they may be an important consideration. Specifically, respondents primarily working in an urban area were 1.48 times more likely ( $OR = 1.477$ ,  $p = .087$ ) to report poorer health status and those working outside of their home county were 1.45 times more likely ( $OR = 1.451$ ,  $p = .08$ ) to be in the "fair/poor" group. Given the limited diversity in the sample (86.7% female; 86.7% white), gender and race/ethnicity did not provide a valuable contribution to the model.

## **Discussion**

### **Strengths and Limitations**

This study may represent the first to examine the relationship between worker characteristics and perceptions of their job, and their health status. The child welfare literature has largely focused on how job factors were associated with retention, such as job satisfaction, professional commitment to the profession, workload and supervision (e.g. Kim & Kao, 2014; Williams et al., 2011; Ellett et al., 2003; Ellett et al., 2007; Zlotnik et al., 2005). Another body of evidence has documented the experience of secondary traumatic stress and associated experiences in this population (e.g. Boyas et al., 2012; Mor Barak et al., 2006; Nissly et al., 2005; Shier et al., 2012; Smith & Clark, 2011). Outside child welfare, work-related stress and job



factors have been associated with adverse health impact on law enforcement officers (Hart et al., 1995), and nurses (e.g. Ferri et al., 2016; Zapka et al., 2009).

The documentation of the relationship between job factors and health status of child welfare workers, albeit based on self-report, is an important step forward and could be considered a wake up call to the field. Over 40% of the current study sample reported fair or poor health, with no statistically significant differences observed demographically. Similar to research on law enforcement and nurses, poorer health status was statistically associated with longer tenure at the agency, intention to leave, and all 8 subscales of the CWEFS. Job impact (which measures perceived impact of the job on the worker such as burnout), and workload significantly predicted perceptions of poorer health. Concerns regarding worker retention represent a concerning impact on the organization and by extension, on children and families served. This study goes a step further, documenting the potential cost of working in child welfare as it currently is experienced on the individual worker. The results of this exploratory study has implications not only for those choosing this field, but for health care costs as well.

Although the current study doesn't statistically test the mechanisms of inter-relationship between variables, the results hint at these dynamics which may influence worker turnover, but also absenteeism, and the physical capacity of workers to efficiently and effectively serve families. Further, those in urban areas, as well as those who were working outside their home county, were approximately 1.5 times more likely to report poorer health status. This suggests a possible amplification of the effects on health due to the additional time associated with commuting to do this work. Child welfare practice often requires staff to be on call and on the job well beyond normal working hours. There may be other factors associated with urban practice which further research exploration may help us understand.

As a first foray into examining the impact of factors associated with child welfare work on the health of the workforce, this study has notable limitations. Related to measurement, it is recognized that there are limitations to the amount of range and precision when deciding to use a 4-point response option for a dependent variable. Additionally, self-reported data always presents a risk of bias. While this study used a sampling frame of all public child welfare workers statewide, it must be acknowledged that these results are not generalizable across all child welfare systems. There may be factors associated with this particular agency and its structure, policy and procedures, or the overall health of the population of this particular state which influence the findings observed. The study was cross-sectional and represents a point in time measurement which could have been influenced by temporal factors. In addition, the response rate was relatively low, albeit higher than a study conducted with a similar population (i.e. Augsberger et al., 2012). It cannot be assumed that there is not a response bias reflected here. However, the response rate did approach 40% which is a substantial portion of the workforce.

There are also other factors not explored in the current study which may be related to the perceptions of health reported by workers in this sample. While we measured workload, job impact, supervision, peer support and related factors, there are other factors which may be at play. For example aspects of the crisis-driven, bureaucratic organizational culture often found in child welfare agencies may play a role. Pre-existing health concerns that may be exacerbated in the workplace may influence responses. Unhealthy habits or behaviors that child welfare workers have attributed to workplace stress, such as smoking, drinking alcohol, and poor eating are potentially relevant and may be related (Griffiths, Harper, et al., 2019; Griffiths, Royse, & Walker, 2018). Also, ability to engage in self care is another valuable factor worth consideration. While this study is a first step in examining the health status of the workforce, a significant amount

of additional research is necessary to further explicate the dynamics at play. The results of this study should be considered exploratory and interpreted with caution.

### **Recommendations**

The implications of this study for research and practice fall in two categories. First, this study is simply a first step in documenting a phenomenon that should be of concern to both child welfare workers and the organizations in which they work, however, it is important that the extent to which similar results can be replicated in other locations be examined. If the impact of adverse job factors on perception of health can be generalized to the broader child welfare population, research must then go beyond perceptions to indicators of actual health. If studies confirm the relationships suggested herein, the economic cost can then be calculated which may be necessary to move public policy to address the issues associated with these results.

While more research is clearly needed, there are implications for child welfare administrators. While the evidence that work-related factors have an adverse relationship with undesirable organizational, practice and even child outcomes has been demonstrated in the literature (e.g. Williams et al., 2011; Conrad et al., 2006; Glisson & Hemmelgarn, 1998), this study documents yet a new form of potential impact—the very health of the individual endeavoring to conduct this important work. The health care costs alone warrant attention to the health status of the child welfare workforce, if not the impact on the children and families served. This study is one of many pointing to the need for implementation of organizational strategies to reduce and remediate the stress on child welfare workers. Initiatives to promote positive selfcare and wellness, supportive supervision, health screening and workload reduction are obvious options worth consideration. Research into the relative impact of interventions to reverse this phenomenon will be important.

**Conclusion**

This study is certainly not the first to suggest an adverse impact of child welfare work on the workforce. Child welfare workers experience threats of violence as well as indirect trauma (Goddard & Hunt, 2011), compassion fatigue (Conrad & Kellar-Guenther, 2006), and emotional exhaustion (Cahalane & Sites 2008; Mena & Bailey, 2007). Notable pioneer in secondary traumatic stress, Charles Figley (2012), wrote: “Most CW workers care deeply about their clients and their families, and many may suffer from the inability to balance their own needs with those of their vulnerable clients” (p. 4). In fact, the current study suggests the work is actually making them sick. For a public system designed to address the needs of vulnerable children and families to not address this concern is indefensible and only serves to undermine its purpose.

## References

- Auerbach, C., McGowan, B. G., Ausberger, A., Strolin-Goltzman, J., & Schudrich, W. (2010). Differential factors influencing public and voluntary child welfare workers' intention to leave. *Children & Youth Services Review, 32*(10), 1396-1402.
- Augsberger, A., Schudrich, W., McGowan, B. G., & Auerbach, C. (2012). Respect in the workplace: A mixed methods study of retention and turnover in the voluntary child welfare sector. *Children and Youth Services Review, 34*(7), 1222-1229.
- Barth, R. P., Lloyd, E. C., Christ, S. L., Chapman, M. V., & Dickinson, N. S. (2008). Child welfare worker characteristics and job satisfaction: A national study. *Social Work, 53*(3), 199-209.
- Beck, C. T. (2011). Secondary traumatic stress in nurses: A systematic review. *Archives of Psychiatric Nursing, 25*(1), 1-10.
- Boyas, J., Wind, L. H., & Kang, S.-Y. (2012). Exploring the relationship between employment-based social capital, job stress, burnout, and intent to leave among child protection workers: An age-based path analysis model. *Children & Youth Services Review, 34*(1), 50-62.
- Cahalane, H., & Sites, E. W. (2008). The climate of child welfare employee retention. *Child Welfare, 87*(1), 91-114.
- Centers for Disease Control and Prevention. (2019). *Health-Related Quality of Life (HRQOL)*. Retrieved from: [https://www.cdc.gov/hrqol/hrqol14\\_measure.htm](https://www.cdc.gov/hrqol/hrqol14_measure.htm)
- Chen, S.-Y., & Scannapieco, M. (2010). The influence of job satisfaction on child welfare worker's desire to stay: An examination of the interaction effect of self-efficacy and supportive supervision. *Children & Youth Services Review, 32*(4), 482-486.

- Cocker, F., & Joss, N. (2016). Compassion Fatigue among healthcare, emergency and community service workers: A systematic review. *International Journal of Environmental Research and Public Health*, 13(6), 618.
- Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect*, 30, 1071-1080.
- Daurat, A., & Foret, J. (2004). Sleep strategies of 12-hour shift nurses with emphasis on night sleep episodes. *Scandinavian Journal of Work Environment & Health*, 30(4), 299-305.
- DePanfilis, D., & Zlotnik, J. L. (2008). Retention of front-line staff in child welfare: A systematic review of research. *Children and Youth Services Review*, 30(9), 995-1008.
- Dominguez-Gomez, E., & Rutledge, D. N. (2009). Prevalence of secondary traumatic stress among emergency nurses. *Journal of Emergency Nursing*, 35(3), 199-204.
- Ellett, A.J., Ellett, C.D. & Rugutt, J.K. (2003). *Executive summary: A study of personal and organizational factors contributing to employee retention and turnover in child welfare in Georgia*. Athens, GA: University of Georgia, School of Social Work.
- Ellett, A. J., Ellis, J. I., Westbrook, T. M., & Dews, D. (2007). A qualitative study of 369 child welfare professionals' perspectives about factors contributing to employee retention and turnover. *Children and Youth Services Review*, 29(2), 264-281.
- Faller, K. C., Grabarek, M., & Ortega, R. M. (2010). Commitment to child welfare work: What predicts leaving and staying? *Children and Youth Services Review*, 32(6), 840-846.
- Ferri, P., Guadi, M., Marcheselli, L., Balduzzi, S., Magnani, D., & Di Lorenzo, R. (2016). The

- impact of shift work on the psychological and physical health of nurses in a general hospital: A comparison between rotating night shifts and day shifts. *Risk Management and Healthcare Policy*, 9, 203-211.
- Figley, C. R. (2012, Spring). Helping that hurts: Child welfare secondary traumatic stress reactions. *CW 360: A Comprehensive Look at a Prevalent Child Welfare Issue*. Minneapolis, MN: Center for Advanced Studies in CW.
- Glisson, C., & Hemmelgarn, A. (1998). The Effects of Organizational Climate and Interorganizational Coordination on the Quality and Outcomes of Children's Service Systems. *Child Abuse and Neglect*, 22(5), 401-421.
- Goodard, C., & Hunt, S. (2011). The complexities of caring for child protection workers: The context of practice and supervision. *Journal of Social Work Practice*, 25, 413-431.
- Griffiths, A., Desrosiers, P., Gabbard, J., Royse, D., & Piescher, K. (2019). Retention of child welfare caseworkers: The wisdom of supervisors. *Child Welfare*, 97(3), 61-83.
- Griffiths, A., Harper, W., Desrosiers, P., Murphy, A., & Royse, D. (2019). "The stress is indescribable": self-reported health implications from child welfare supervisors. *The Clinical Supervisor*, 38(2), 183-201.
- Griffiths, A., Murphy, A., Desrosiers, P., Harper, W., & Royse, D. (2019). Factors influencing the turnover of frontline public child welfare supervisors. *Journal of Public Child Welfare*, 1-17.
- Griffiths, A., Royse, D., Culver, K., Piescher, K., & Zhang, Y. (2017). Who stays, who goes, who knows? A state-wide survey of child welfare workers. *Children and Youth Services Review*, 77, 110-117.

- Griffiths, A., Royse, D., & Walker, R. (2018). Stress among child protective service workers: Self-reported health consequences. *Children and Youth Services Review, 90*, 46-53.
- Hart, P. M., Wearing, A. J., & Headey, B. (1995). Police stress and well-being- Integrating personality, coping, and daily work experiences. *Journal of Occupational and Organizational Psychology, 68*, 133-156.
- Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., & Reimels, E. (2010). Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of Emergency Nursing, 36*(5), 420-427.
- Kim, H., & Kao, D. (2014). A meta-analysis of turnover intention predictors among US child welfare workers. *Children and Youth Services Review, 47*, 214-223.
- Koeske, G. F., Kirk, S. A., Koeske, R. D., & Rauktis, M. B. (1994). Measuring the Monday blues: Validation of a job satisfaction scale for the human services. *Social Work Research, 18*(1), 27-35.
- LeSergent, C. M., & Haney, C. J. (2005). Rural hospital nurse's stressors and coping strategies: A survey. *International Journal of Nursing Studies, 42*(3), 315-324.
- Lin, K. C., Huang, C. C. & Wu, C. C. (2007). Association between stress at work and primary headache among nursing staff in Taiwan. *Headache, 47* (4), 576-584.
- Lloyd, C., King, R., & Chenoweth, L. (2002). Social work, stress and burnout: A review. *Journal of Mental Health, 11*(3), 255-265.
- Marshall, N.L., & Barnett, R.C. (1993). Variations in job strain across nursing and social work specialties. *Journal of Community and Applied Social Psychology, 3*, 261-271.
- McFadden, P., Campbell, A., & Taylor, B. (2015). Resilience and burnout in child protection



- social work: Individual and organizational themes from a systematic literature review. *British Journal of Social Work*, 45(5), 1546-1563.
- Mena, K. C., & Bailey, J. D. (2007) The effects of the supervisory working alliance on worker outcomes. *Journal of Social Service Research*, 34, 55–65.
- Mor Barak, M. E., Levin, A., Nissly, J. A., & Lane, C. J. (2006). Why do they leave? Modeling child welfare workers' turnover intentions. *Children and Youth Services Review*, 28(5), 548-577.
- Morash, M., Kwak, D. H., & Haarr, R. (2006). Gender differences in the predictors of police stress. *Policing- An International Journal of Police Strategies & Management*, 29(3), 541-563.
- Nagelkerke, N. J. (1991). A note on a general definition of the coefficient of determination. *Biometrika*, 78(3), 691–692.
- Nissly, J. A., Barak, M. E. M., & Levin, A. (2005). Stress, social support, and workers' intentions to leave their jobs in public child welfare. *Administration in Social Work*, 29(1), 79.
- Peterson, C., Florence, C., Klevens, J. (2018). The economic burden of child maltreatment in the United States, 2015. *Child Abuse & Neglect*, 86, 178-183.
- Senreich, E., Straussner, S.L.A., & Steen, J. (2020). The work experiences of social workers: Factors impacting compassion satisfaction and workplace stress. *Journal of Social Service Research*, 46(1), 93-109.
- Shier, M. L., Graham, J. R., Fukuda, E., Brownlee, K., Kline, T. J. B., Walji, S., & Novik, N. (2012). Social workers and satisfaction with child welfare work: Aspects of work, profession, and personal life that contribute to turnover. *Child Welfare*, 91(5), 117-138.

- Shim, M. (2010). Factors influencing child welfare employee's turnover: Focusing on organizational culture and climate. *Children and Youth Services Review, 32*(6), 847-856.
- Smith, R. J., & Clark, S. J. (2011). Does job resource loss reduce burnout and job exit for professionally trained social workers in child welfare? *Children and Youth Services Review, 33*(10), 1950-1959.
- Stults-Kolehmainen, M. A., Tuit, K. & Sinha, R. (2014). Lower cumulative stress is associated with better health for physically active adults in the community. *Stress, 17* (2), 157-168.
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018). *Child maltreatment 2016*. Retrieved from Children's Bureau website:  
<https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment>.
- U. S. Department of Labor. (2018). *May 2018 National Occupational Employment and Wage Estimates, United States*. Retrieved from: <https://www.bls.gov/>
- Van der Heijden, B., Demerouti, E., & Bakker, A. B. (2008). Work-home interference among nurses: Reciprocal relationships with job demands and health. *Journal of Advanced Nursing, 62*(5), 572-584.
- Williams, S. E., Nichols, Q. I., Kirk, A., & Wilson, T. (2011). A recent look at the factors influencing workforce retention in public child welfare. *Children and Youth Services Review, 33*(1), 157-160.
- Yankeelov, P. A., Barbee, A. P., Sullivan, D., & Antle, B. F. (2009). Individual and organizational factors in job retention in Kentucky's child welfare agency. *Children and Youth Services Review, 31*(5), 547-554.

Zapka, J. M., Lemon, S. C., Magner, R. P., & Hale, J. (2009). Lifestyle behaviours and weight among hospital-based nurses. *Journal of Nursing Management, 17*(7), 853-860.

Zlotnik, J. L., DePanfilis, D., Daining, C., & Lane, M. (2005). *Factors influencing retention of child welfare staff: A systematic review of research*. Washington, DC: Institute for the Advancement of Social Work Research.

Table 1 *Sample Characteristics of Child Welfare Workforce (n = 511)*

<b>Worker Characteristics</b>	<b><i>f (Valid %)</i></b>	<b><i>Range</i></b>	<b><i>M (SD)</i></b>
Age		22-64	37.62 (9.86)
Years worked at agency		1-45	8.15 (7.52)
Gender			
Female	441 (86.5)		
Male	68 (13.3)		
Other	1 (0.2)		
How do you describe yourself?			
White	442 (87.2)		
Black or African American	41 (8.1)		
Hispanic or Latino	2 (0.4)		
Native American or American Indian	2 (0.4)		
Asian/Pacific Islander	3 (0.6)		
Biracial	8 (1.6)		
Other	9 (1.8)		
Do you primarily work in your home county?			
Yes	260 (51.2)		
No	248 (48.8)		
Which best describes the area in which you work?			
Basically Rural	326 (64.7)		
Basically Urban	178 (35.3)		
Is this your first job in child welfare?			
Yes	365 (72.7)		
No	137 (27.3)		
Undergraduate Degree			
Social Work	203 (40.4)		
Other	300 (59.6)		
Graduate Degree			
Social Work	112 (22.5)		
Other	45 (9.0)		
None	341 (68.5)		

Table 2 *Item Means and Cronbach's Alphas for Subscales*

<b>Subscale</b>	<b>Example Questions</b>	<b>Item Mean</b>	<b># Items</b>	<b>Possible Score</b>	<b>Alpha</b>
Salary	Our salaries are competitive with similar jobs; I am satisfied with the salary and benefits	1.87	2	2-10	.705
Workload	I have a manageable client caseload; I have a manageable paperwork load	2.12	5	5-25	.850
Job Impact	I am burned out from my job; I am emotionally exhausted from my job	2.44	3	3-15	.812
Recognition	I earn recognition from doing a good job; I am satisfied with the recognition of my work	2.57	3	3-15	.790
Professional Development	I am satisfied with the opportunities for promotion; I receive sufficient training to complete my job effectively	2.85	4	4-20	.721
Accomplishment	I feel like I am making a difference; I have a sense of accomplishment from doing my job	3.53	2	2-10	.787
Peer Support	I have sufficient support from my co-workers; The people I work with treat each other with respect	3.97	2	2-10	.806
Supervision	I have a competent supervisor; I have frequent contact with my supervisor	4.19	4	4-20	.919

Table 3 *Independent Samples T-Test with Perceived Health Status and Demographics*

<b>Categorical Variable</b>	<b>Dichotomous Response Option</b>		<b><i>t</i></b>	<b><i>p</i></b>
Gender	Male ( <i>n</i> = 68) 2.51 (.855)	Female ( <i>n</i> = 441) 2.38 (.783)	1.317	.189
Race/Ethnicity	White ( <i>n</i> = 442) 2.40 (.791)	Prof. of Color ( <i>n</i> = 64) 2.39 (.838)	-.071	.943
Home County	Yes ( <i>n</i> = 259) 2.35 (.794)	No ( <i>n</i> = 248) 2.44 (.793)	-1.363	.174
Location	Rural ( <i>n</i> = 325) 2.42 (.819)	Urban ( <i>n</i> = 178) 2.35 (.746)	1.031	.303

\*  $p < .05$ , \*\*  $p < .01$

Table 4 *Bivariate Correlations with Perceived Health Status*

<b>Variable</b>	<b><i>n</i></b>	<b><i>Correlation</i></b>	<b><i>p</i></b>
Age	478	-.02	.736
Years at Agency	495	.12	p < .01
Intent to Leave in Next 12 Months	509	.26	p < .001
Accomplishment Subscale	508	-.29	p < .001
Job Impact Subscale	507	-.44	p < .001
Peer Support Subscale	506	-.15	p < .001
Professional Dev. Subscale	507	-.28	p < .001
Recognition Subscale	507	-.31	p < .001
Salary Subscale	507	-.21	p < .001
Supervision Subscale	505	-.14	p < .001
Workload Subscale	503	-.38	p < .001

Table 5 *Regression Coefficients for Predictors of Perceived “Fair/Poor” Health Status (N = 476)*

<b>Predictor</b>	<b><i>B</i></b>	<b><i>Wald</i></b>	<b><i>Odds Ratio</i></b>	<b><i>p-value</i></b>
Accomplishment	-0.025	0.141	0.975	.708
Job Impact	-.212	17.016	0.809	<.001
Peer Support	-0.066	1.146	0.936	.284
Professional Development	-0.063	2.166	0.939	.141
Recognition	-0.025	0.229	0.976	.632
Salary	0.004	0.003	1.004	.959
Supervision	-0.026	0.649	0.974	.420
Workload	-0.076	4.268	0.809	.039
Outside of Home County	-0.372	3.055	1.451	.080
Urban Area	0.390	2.921	1.477	.087