

# Main Findings for the Occupation of Social Work

Results from the UK and Northern Ireland  
Health & Social Care Workforce Study

Dr Paula McFadden  
Dr Justin MacLochlainn  
Prof. Jill Manthorpe  
Dr Heike Schroder  
Dr Denise Currie  
Ms Susan McGrory  
Prof. Jermaine Ravalier  
Ms Patrica Nicholl  
Dr Rachel Naylor  
Dr John Mallett

# Social Workers well-being, quality of working life and coping while working during and post-pandemic: Main findings from the UK and Northern Ireland Surveys

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## REPORT

Dr Paula McFadden<sup>1</sup>

Dr Justin MacLochlainn<sup>1</sup>

Professor Jill Manthorpe<sup>5</sup>

Dr Heike Schroder<sup>3</sup>

Dr Denise Currie<sup>3</sup>

Ms Susan McGrory<sup>1</sup>

Professor Jermaine Ravalier<sup>4</sup>

Ms Patricia Nicholl<sup>3</sup>

Dr Rachel Naylor<sup>1</sup>

Dr John Mallett<sup>1</sup>

<sup>1</sup>Ulster University; <sup>2</sup>Southern Health and Social Care Trust, <sup>3</sup>Queen's University Belfast; <sup>4</sup>Bath Spa University; <sup>5</sup>King's College London

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### 1. Summary of Main Findings

The 6th Phase of this UK-wide multi-disciplinary study explored the impact of providing health and social care in the post-pandemic era from November 2022 until January 2023. The present analysis

involving the social worker occupation builds upon the findings from five earlier Phases, beginning during May 2020 following the first wave of the COVID-19 pandemic in the UK. Within these six phases of data-collection, we received 4,340 survey responses from social workers.

The study provides a unique opportunity to gain in-depth understanding of how the pre- and post-pandemic times have impacted on social workers' working life, as well as effects on their own health and well-being. Our social work report presents survey findings collected over the six-months from the end of 2022 and up to early 2023, as well as presenting findings from combined phases. During this Phase (Phase 6), life was returning to pre-pandemic norms for most people in society, there were few remaining public restrictions. Social care services were therefore adapting themselves to a post-pandemic time. Other impacts of the pandemic have placed increasing pressures on care services, such as sickness absences, staff vacancies, and retention problems, with mental health problems now affecting workforce stability.

Multiple workplace factors are described as a 'vicious cycle'. For example, increased job-related pressures, exacerbated by staffing shortages and vacancies add to job stress and this affects staff's mental health and well-being. Some respondents indicate lasting or new depression and anxiety because of working through the pandemic. While the survey found many staff had made use of employer's support services, not everyone sees them as accessible or helpful. Investment is still needed here; the report's authors recommend.

This report evidences the impact of working during the three years since the onset of COVID-19, on social workers wellbeing, burnout, coping and work-related quality of life. The inter-relationship between burnout and wellbeing and working conditions, confirms that when quality of working life decreases, burnout increases, wellbeing decreases, intention to leave employers and the occupation increases, and negative way of coping also increases. This is evidence which needs to be taken seriously by employers and commissioners, as the workforce is currently in a critical state. All professions in the main study, have been negatively affected by their work environments on an unprecedented scale, however, social workers and social care workers have been most impacted in our analysis of Phase 6.

### **Summary of Key Findings from Phase 6:**

#### **Impact of COVID-19 on service pressures at end of 2022/start of 2023.**

- A tiny minority (2.2%) reported that their service had not been impacted (services stepped down/changed due to COVID-19)
- Nearly two-thirds of all respondents (61.2%) reported feeling overwhelmed by increased and continued pressures.

### ***Intention to Leave Employer***

- Nearly half of the social workers UK-wide (48.9%) had considered changing their employer, with the highest proportion of these being from England (53.8%), closely followed by Northern Ireland (52%), Scotland (45.6%) and Wales (35%).

### ***Intention to Leave Occupation***

- Over a third of social workers UK-wide (36.2%) also had considered changing their occupation with the highest proportion of these being from England (44.2%), followed closely by Northern Ireland (36.2%), Scotland (32.4%), and Wales (26.7%).
- Throughout the six Phases of study, social workers indicated that manager support (39.5%), a pay increase (37.8%) well-being support (32.1%), and safer working conditions (28.1%), would change their minds about wanting to leave their employer or current occupation.

### **Employer Support**

- Most respondents reported not taking up employer support (71.6% UK-wide). Respondents from Wales had the highest percentage uptake of employer support (34.7% within Wales). For those respondents who accessed employer support, the most common forms were manager support (46.3%), peer support (42.7%), and well-being support (38.6%). When respondents were asked why they had not taken up employer support, 29.8% felt the support was not needed as they had support from elsewhere, 23.8% indicated that the support was not needed at all, 19.4% stated that support was not accessible or at an inconvenient time, and 27.0% stated other reasons.

### ***Intention to leave: Lower Quality of Work Life, Higher Burnout, and lower Wellbeing.***

- Both well-being and quality of working life decreased from Phase 1 of the study to Phase 6.

- Respondents who felt overwhelmed by increased pressures scored significantly lower in wellbeing and quality of working life scores than those who only felt some impact of COVID-19 and those who were not impacted by COVID-19 pressures.
- Respondents who reported considering changing their occupation scored significantly lower in well-being and quality of working life scores than those who did not consider changing their occupation.
- Respondent who reported that their service did not operate a safe staff-to-service user ratio scored significantly lower in well-being and quality of working life scores compared to those who did believe their service operated a safe staff-to-service user ratio.
- Northern Ireland had the highest proportion of respondents with “lower quality of working life” (53.5%) and Wales had the highest proportion with “higher quality of working life” (39%).
- In this sixth Phase of the study burnout scores had been the highest of all the Phases. We found that UK-wide, in Phase 6, 19.7% of respondents had low personal burnout, 43.6% had moderate personal burnout, 36.6% had high/severe levels of personal burnout. Phase 6 also revealed an overall increase in the level of work-related burnout: 25.4% had low burnout, 40.7% had moderate burnout, with 33.8% of social workers reporting high/severe work-related burnout. In relation to client-related burnout, we found that although this remains low the measure is showing a negative trend. In Phase 6, 71.3% reported low burnout, 23.3% reported moderate burnout, and a further 5.4% reported high/severe levels of client-related burnout.
- Respondents who felt that their service was overwhelmed by increased pressures experienced significantly more personal, work-related, and client-related burnout than those not impacted and those impacted but not significantly.
- Respondents who took employer support reported significantly higher scores of both personal and work-related burnout than those who did not take up employer support.
- Respondents who considered changing their occupation scored significantly higher scores on personal, work-related, and client-related burnout than those who did not consider changing occupation.
- Respondents who believed their service did not operate a safe staff-to-service user ratio scored significantly higher on personal, work-related, and client-related burnout than those who believed their service operated a safe staff-to-service user ratio.

- We found strong negative correlations between personal burnout and well-being scores and quality of working life. Work-related burnout had a similar strong negative correlation with wellbeing and quality of life. Whereas client-related burnout had a moderate negative correlation with wellbeing and quality of life. This indicates that as burnout in any area increased, respondents' well-being and quality of working life decreased.

The survey findings suggest robust and reliable support systems/services are needed among all social worker employers to stabilise the workforce, increase retention, and promote wellbeing at work. Positive examples of supportive interventions have included working within capacity, safe staffing levels and manageable workloads, supportive working culture, co-worker support, camaraderie, team support, manager support, and support for managers. The reliance on managers to provide such support requires adequate and sustained support for managers themselves. This was confirmed by our focus group participants (Read our full 6<sup>th</sup> Phase Report here: <https://www.hscworkforcestudy.co.uk/reports-publications>) who confirmed that the main support people benefit from is each other. Therefore, building teams and support for teams are critically important.

## 2. Aim

The study aimed to measure wellbeing and coping, burnout, work related quality of life of social workers over approximately 3 years following the onset of the COVID-19 pandemic.

This study's findings were extracted from the previous six Phases of our wider research (see Figure 1.) on health and social care worker well-being and coping during COVID-19. Phase 1 (data collected between May – July 2020), Phase 2 (data collected between November 2020- February 2021), Phase 3 (data collected between May – July 2021), Phase 4 (data collected between Nov 2021-February 2022) and Phase 5 (data collected between May – July 2022). Each phase used surveys and focus groups, to further explore the impact of providing health and social care during the COVID-19 (SARS-CoV-2) pandemic in Northern Ireland and the UK. This study focused specifically on the experiences of Social Workers and comprises of quantitative findings only.

*Figure 1. Research Phases of Wider Study*





## 2.1. Objectives

1. To gather demographic and work-related information from a cross-sectional convenience sample of Social Workers in the UK and Northern Ireland.
2. To examine the perspectives of Social Workers on the challenges they are facing while providing health and social care during the COVID-19 pandemic, including their perspectives on employers' supports and potential ways to improve these.
3. To assess well-being, quality of working life and levels of burnout in this workforce.
4. To find out what coping strategies are used to deal with work-related stressors and the effects of these strategies on respondents' well-being, quality of working life and levels of burnout.
5. To elicit detail about perceived levels of safe staffing and the effects of this on respondents' work life and their health and well-being post-pandemic.

## 3. Methodology

### 3.1. Primary Research Instrument Survey

Data for this current report were collected using the online survey questionnaires from six phases of our Health and Social Care Workforce Study. The survey was predominantly quantitative. The main parts of the survey covered the areas below:

- **Demographic and work-related information:** age, sex, country of work, occupational group, ethnicity, disability status, relationship status, job tenure, hours of work, working overtime, working at home, considering changing one's occupation and/or employer, the effects of the pandemic on one's place of work, the impact of COVID-19 and employer support or use of any employer support.
- **Open-ended questions:** two questions related to 1) the impact of COVID-19 on respondents' place of work and 2) whether respondents believed their service operated a safe staff-to-service user ratio.
- **Mental well-being:** Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS; NHS Health Scotland, 2008).
- **Quality of working life:** Work-Related Quality of Life scale (WRQOL; Easton & van Laar, 2018).
- **Burnout:** Copenhagen Burnout Inventory (Kristensen, Borritz, Villadsen, & Christensen, 2005).
- **Coping with COVID-19-related occupational demands:** 20 items from Brief COPE (Coping Orientation to Problems Experienced, Carver, 1997).

- **Coping with work-related stressors:** 15 items from Clark, Michel, Early and Baltes (2014).

### 3.1.1. Mental Well-being

Mental well-being was assessed using the Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS; NHS Health Scotland, 2008). The scale contains seven items asking respondents to indicate how often in the previous two weeks they had feelings or thoughts described in each of the items (e.g., I've been feeling useful). The seven items are rated using a five-point Likert scale ranging from 1 = 'None of the time' to 5 = 'All of the time'. The item scores are summed to provide an overall well-being score, which can range from 7 to 35. Higher scores indicate better mental well-being. We used cut-off points shown in Table 2.1. to categorise respondents into those who were *probable* or *possible* cases of depression or anxiety (Warwick Medical School, 2021):

Table 2.1. Categories created by SWEMWBS Score

Case of anxiety/depression	SWEMWBS score
Probable (Likely)	7-17
Possible	18-20

### 3.1.2. Quality of Working Life

Quality of working life was assessed using the Work-Related Quality of Life scale (WRQOL; Easton & van Laar, 2018), which consists of 24 items. These assess six different domains of working life: Job career satisfaction (six items), Stress at work (two items), General well-being (six items), Home-work interface (three items), Control at work (three items), and Working conditions (three items). The last item measures overall well-being and does not contribute to the domain score. Respondents used a five-point Likert scale ranging from 1 = 'Strongly disagree' to 5 = 'Strongly agree' to indicate their disagreement with the work-related statements (e.g., I have a clear set of goals and aims to enable me to do my job). The overall quality of working life score is calculated by summing the 23 items. Total scores can range from 23 to 115 and higher scores indicate better quality of working life. Domain scores are calculated by summing the scores for the items belonging to each domain. The Stress at Work items are reverse scored for consistency with the other domain scores, so higher stress at work is presented by lower scores for this domain only. The overall and domain scores can be categorised into Lower, Average, and Higher quality of working life using the cut-off points shown in Table 2.2, which were developed from health service norms (Easton & van Laar, 2018).

Table 2.2: Categories created by WRQOL Score

Level of quality of working life	WRQOL domain						Overall WRQOL score
	Job career satisfaction	Stress at work	General well-being	Home-work interface	Control at work	Working conditions	
Lower	6-19	2-4	6-20	3-9	3-8	3-9	23-71
Average	20-22	5	21-23	10-11	9-10	10-11	72-82
Higher	23-30	6-10	24-30	12-15	11-15	12-15	83-115

### 3.1.3. Burnout

Burnout was assessed using the Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005), which is a 19-item measure of three different areas of burnout: personal (six items), work-related (seven items) and client-related (six items). The items (e.g., Does your work frustrate you?) are rated on a five-point Likert scale (wording differs across items) scored from 0 to 100. For each area of burnout, a mean score (ranging from 0 to 100) is calculated. Higher scores indicate greater burnout. The three areas of burnout are defined by Kristensen et al. (2005) as follows:

- Personal burnout: *“state of prolonged physical and psychological exhaustion”*
- Work-related burnout: *“state of prolonged physical and psychological exhaustion, which is perceived as related to the person’s work”*.
- Client-related burnout: *“state of prolonged physical and psychological exhaustion, which is perceived as related to the person’s work with clients”*.

In the current report, we categorised the burnout scores in each burnout area into Low, Moderate, High, and Severe burnout using the cut-off scores (see Table 2.3) frequently cited in the literature (e.g., Creed, Sidebotham, Gamble, Pallant, & Fenwick, 2017).

Table 2.3: Cut-off points for CBI Burnout scores

Level of burnout	Burnout cut-off scores
Low	0-49
Moderate	50-74
High	75-99
Severe	100

#### 3.1.4. Coping with COVID-19 Related Occupational Demands

Coping with COVID-19 related occupational demands was assessed using 20 items selected from the 28-item BRIEF Cope scale (Carver, 1997). These items assess ten coping strategies, including Active coping, Planning, Positive reframing, Acceptance, Emotional support, Instrumental support, Venting, Substance use, Behavioural disengagement, and Self-blame. Each coping strategy is assessed with two items, which are summed to give a total score. Respondents were asked to indicate how often they have been using the strategies described in the items using a four-point Likert scale ranging from 1 = 'I haven't been doing this at all' to 4 = 'I've been doing this a lot'. Scores for each coping strategy can range from 2 to 8 and higher scores indicate that respondents use the specific coping strategy more often.

#### 3.1.5. Coping with Work-Related Stressors

Coping with work-related stressors was assessed using 15 items from the 81-item scale assessing work and family stressor coping strategies, developed by Clark et al. (2014). The 15 items assessed five specific coping strategies (three items per strategy), including Family-work segmentation (not handling family related things while working), Work-family segmentation (not handling work while at home), Working to improve skills/efficiency, Recreation and relaxation, and Exercise. Respondents were asked to use a six-point Likert scale ranging from 1 = 'Never have done this' to 6 = 'Almost always do this' to indicate how often they have been doing what is described by the items to cope with work stressors. The scores for each item are averaged and can range from 1 to 6. Higher scores indicate that respondents use the specific coping strategy more often.

### 3.2. Study Respondents: Sampling, Access, and Recruitment

Respondents were Social Workers in the UK and Northern Ireland who were working in social care during the six Phases of the original study (May 2020- January 2023). A wide variety of recruitment channels and methods were utilised to reach as many potential respondents as possible. Outreach took place through the Northern Ireland Social Care Council, Social Care Wales, the five Northern Ireland Health and Social Care Trusts, Community Care magazine, the Health and Care Professions Council, and the British Association of Social Workers. These regulatory bodies, unions, associations, and lead professionals used a variety of methods to disseminate the study information, including

newsletters, direct emails, or social media platforms. A dedicated website was also used to raise awareness about the study among the health and social care staff.

The final sample was a convenience sample of those who chose to participate in the study following receipt of communication through the above-mentioned bodies, associations, and individuals. Respondents completed the survey online which was hosted on Qualtrics™ by accessing a dedicated weblink or using a QR code. The survey was completed anonymously to encourage honest responses and was available in both the English and Welsh language.

### 3.3. Data Analysis

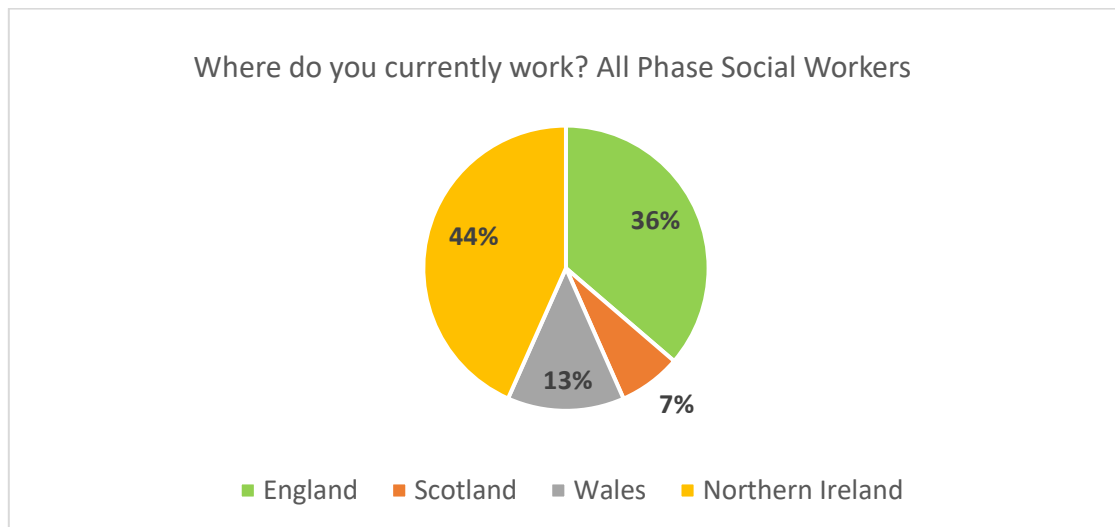
Quantitative survey data were analysed using SPSS 28. The analysis presented in this report draws primarily on descriptive statistics, specifically frequencies, percentages, and mean values of the measured constructs, as well as some correlations. Sub-group demographics were compared using analyses of variance (ANOVA), and independent samples t-tests. Multiple regression analyses were used to examine the association between coping strategies and mental well-being, quality of working life and burnout, and to compare findings with those from Phases 1-6 of the study. Analyses were conducted with raw data. The analyses were conducted with all available data. Some participants had missing data and therefore the sample total for the different analyses differs throughout this report.

### 3.4. Sample Profile of all Phase Data

A total of 4340 Social Workers responded to the six Phases of surveys. Most of the responses came from Northern Ireland (n = 1881, 43.3%), followed by England (n = 1575, 36.3%), Wales (n = 576, 13.3%), and then Scotland (n = 308, 7.1%). (See Figure 2.).

Most respondents were female (85.3% UK-wide) with a similar gender distribution across countries. Those aged 50-59 years age comprised the largest age category (29.9% UK-Wide). Scotland had the highest proportion of respondents in the 50-59 age group (33.2% within Scotland). Most respondents were of White ethnic origin (94.1% UK-wide). England had the highest proportion of respondents who identified as belonging to an ethnicity other than White (13.4% within England). Some respondents had a disability (n=527, 13.2%). England had the highest proportion of respondents with a disability (15.5% within England). Most respondents UK-wide were married (53.5%) or single (20.9%).

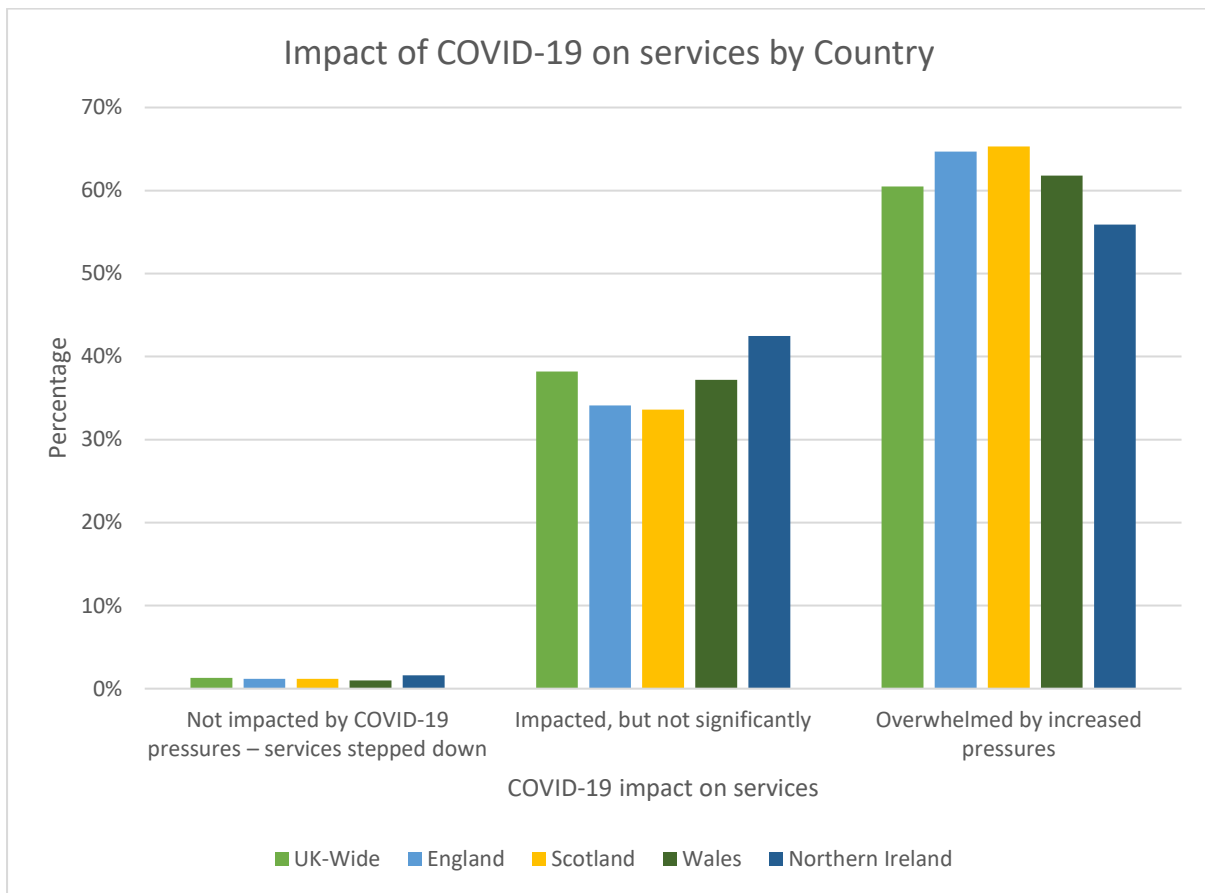
Figure 2. Country of Respondents



UK-wide, nearly two-thirds of all the respondents worked in the community (62.5% UK-wide), while 11.2% (UK-wide) worked in a hospital. Most worked in the statutory HSC Trust (45.6% UK-wide), closely followed by the statutory Local Authority (38.5%). Just under one-third of study respondents UK-wide were line managers in their jobs (31.5%). Most respondents were employed on a permanent basis (90.4% UK-wide) with the majority employed full-time (85.6% UK-wide), typically working 37.5 hours per week (73.6% UK-wide). Scotland had the highest proportion of respondents employed on a part-time basis (19.7% within Scotland). A total of 32.7% of respondents UK-wide typically did not work overtime but since the start of the pandemic, slightly less, 26.2% UK-wide, did not do any overtime. Overall, respondents reported working significantly more hours of overtime since the start of the pandemic compared to before it. Around a third of the respondents (34.7% UK-wide) had taken no sick days, 19.5% had taken less than 10 sick days. UK-wide, 40.1% of respondents said that at least some of their sickness absence was related to COVID-19. When sick, over half of respondents (51.0% UK-wide) reported being paid by their employer.

A large proportion of respondents UK-wide had either 11-20 years of work experience (28.8%) or 21-30 years (22.6%). Wales had the highest proportion of those with 11-20 years of experience (33.9% within Wales). The main area of practice for most respondents was working with children (41.7% UK-wide) followed by adults (15.7%). UK-wide, only 1.3% reported that their service had not been impacted (services stepped down due to COVID-19) with 60.5% reporting feeling overwhelmed by increased pressures (See Figure 2.1.).

Figure 2. 1. Impact of COVID-19 on Services by Country (All Phases)



Respondents were asked whether they worked from home before the pandemic, over one-half of respondents did not work from home at all (53.8% UK-wide). During the COVID-19 pandemic era from March 2020-January 2023, 12.2% of respondents reported they were able to work from home all the time, while 64.3% could work from home some of the time.

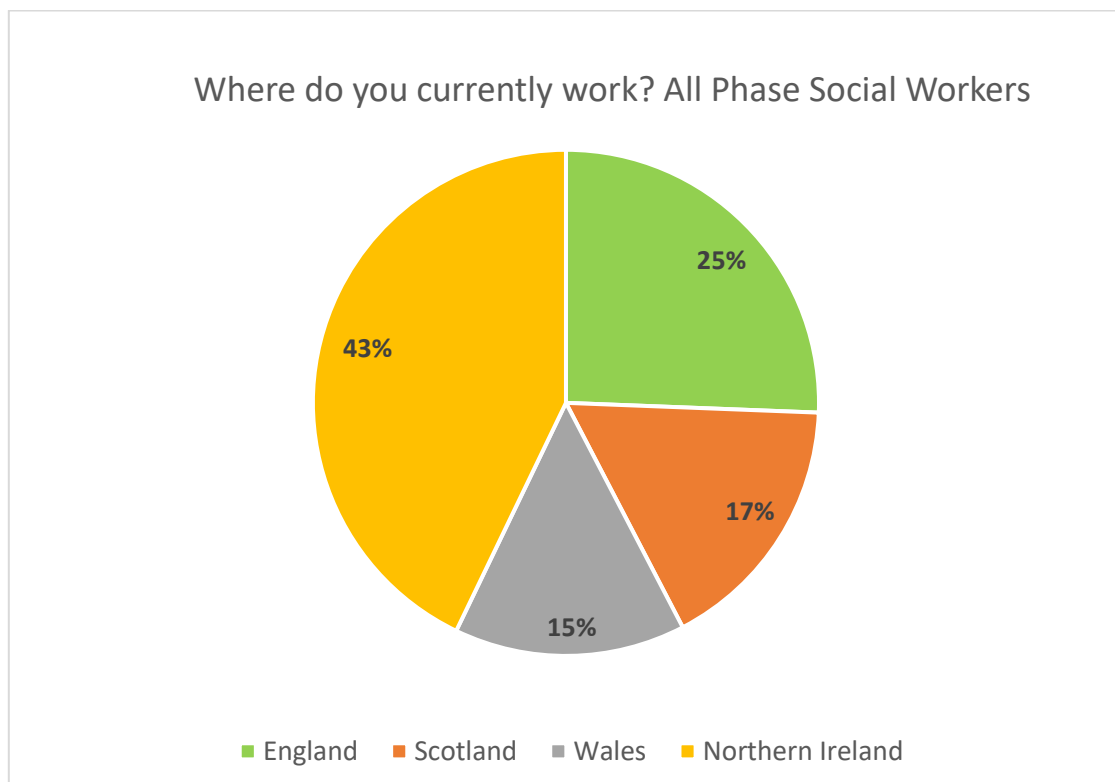
Respondents were also asked whether they had considered changing their employer or occupation since the start of the pandemic. Over one-half of the respondents UK-wide (52.0%) had considered changing their employer, with the highest proportion of these being from England (58.3% within England) and closely followed by Northern Ireland (53.3% within Northern Ireland). Nearly one-half of respondents UK-wide (45.5%) also had considered changing their occupation with the highest proportion of these being from England (51.6% within England) and closely followed by Scotland (46.6%). Respondents indicated that manager support (39.5%), a pay increase (37.8%) and well-being support (32.1%), and safer working conditions (28.1%), would change their minds about wanting to leave their employer or current occupation. Most respondents were still in the same job on the same contractual working hours (77.2% UK-wide) as they had been since the pandemic arrived.

Most respondents reported not taking up employer support (71.6% UK-wide). Respondents from Wales had the highest percentage uptake of employer support (34.7% within Wales). For those respondents who accessed employer support, the most common forms were manager support (46.3%), peer support (42.7%), and well-being support (38.6%). When respondents were asked why they had not taken up employer support, 29.8% felt the support was not needed as they had support from elsewhere, 23.8% indicated that the support was not needed at all, 19.4% stated that support was not accessible or at an inconvenient time, and 27.0% stated other reasons.

### 3.4.1. Sample Profile of Phase 6 Data

A total of 406 Social Workers responded to the survey. Most of the responses came from Northern Ireland (n = 174, 42.9%), followed by England (n = 104, 25.6%), Scotland (n = 68, 16.7%). Wales (n = 60, 14.8%), (See Figure 3.). Most respondents were female (83.3% UK-wide) with a similar gender distribution across countries. Those aged 40-49 years age comprised the largest age category (32.0% UK-Wide). Wales had the highest proportion of respondents in the 40-49 age group (35.0% within Wales).

Figure 3. Country of Respondents Phase 6





The majority of respondents were of White ethnic origin (96.3% UK-wide). England had the highest proportion of respondents who identified as belonging to an ethnicity other than White (12.5% within England). Some respondents had a disability (n=70, 17.2%). England had the highest proportion of respondents with a disability (21.2% within England). Most respondents UK-wide were married (57.1%) or single (17.0%). A tiny minority (2.2%) reported that their service had not been impacted (services stepped down/changed due to COVID-19) With nearly two-thirds of all respondents (62.1%) reporting feeling overwhelmed by increased and continued pressures.

#### **Intention to leave employer and intention to leave occupation.**

Nearly half of the social workers UK-wide (48.9%) had considered changing their employer, with the highest proportion of these being from England (53.8%), closely followed by Northern Ireland (52%), Scotland (45.6%) and Wales (35%). With over a third of social workers UK-wide (36.2%) had considered changing their occupation with the highest proportion of these being from England (44.2%), followed closely by Northern Ireland (36.2%), Scotland (32.4%), and Wales (26.7%).

#### 3.4.2. Safe staffing in Phase 6

In Phase 6 respondents were asked '*Do you believe your service operates a safe staff-to-service user ratio*'? Nearly two-thirds of social workers UK-wide (64.7%) believed that their service did not operate a safe staff-to-service user ratio. England had the highest percentage of respondents indicating an unsafe staff-to-service user ratio (69.7%), closely followed by Northern Ireland (66.5%). Nearly two-thirds of respondents who were line managers (62.5%) reported an unsafe staff-to-service user ratio, and close to three-quarters of respondents in the 30-39 age group (72.9%) reported similar beliefs. Interestingly, those respondents who took no sick days reported the highest percentage of believing their service operated a safe staff-to-service user ratio.

## 4. Findings

The following sections provide a summary of the quantitative findings from Phase 6, with particular attention given what has changed from the five previous Phases.

#### 4.1. Mental Well-being

Mental well-being was assessed using the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS; NHS Health Scotland, 2008). The overall UK-wide mean well-being score in our sixth Phase sample was 20.34, which is more than three points below the population mean of 23.61 (NHS Health Survey for England, 2011; See Figure 4.).

This score is also lower than the mean score of 21.37 reported in Phase 1 (See Figure 5.) and the mean score of 20.36 reported in Phase 2 and the mean score of 20.76 reported in Phase 5 of the study. However, in this sixth phase of the study the well-being score was slightly higher from the reported mean score of 20.32 in Phase 3 and the same as the mean score in Phase 4 (20.34) of the study (Table 3.1.1). The overall mean score including all six Phases of study was 20.67. Both England and Northern Ireland had lower well-being scores in Phase 6 in comparison to Phase 5 of the study.

*Figure 4. Mean Overall Well-being Score by Country Phase 6*

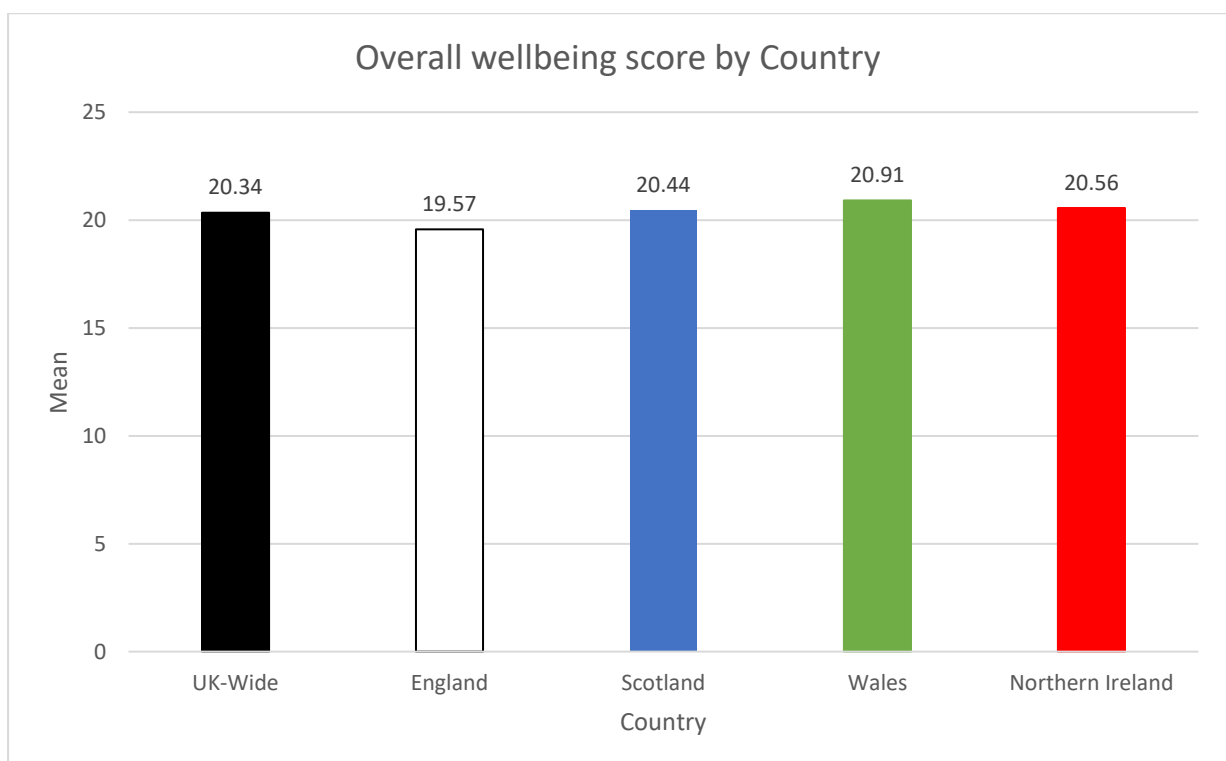


Figure 5. Well-being by Study Phase and Country

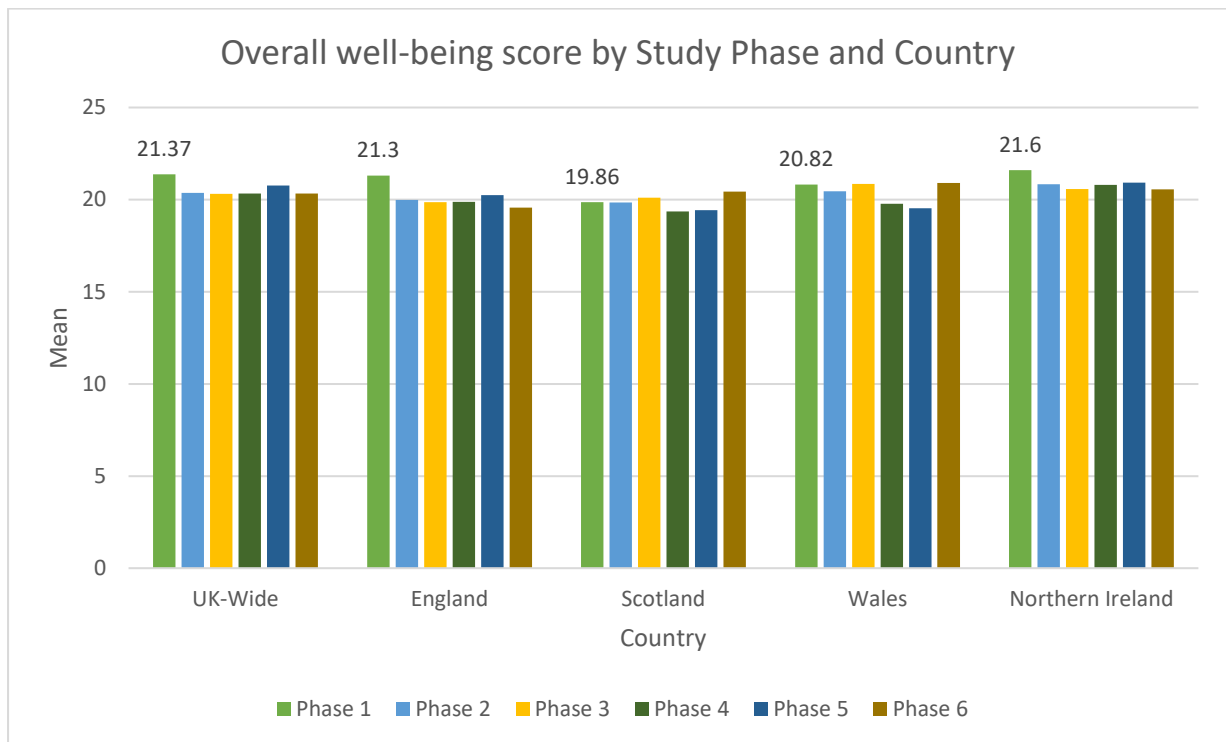


Table 3.1.1: Mean Overall Well-being Score by Study Phase and Country

Study phase	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	21.37	21.30	19.86	20.82	21.60
Phase 2	20.36	19.99	19.85	20.46	20.83
Phase 3	20.32	19.87	20.10	20.86	20.58
Phase 4	20.34	19.88	19.36	19.78	20.80
Phase 5	20.76	20.25	19.43	19.53	20.93
Phase 6	20.34	19.57	20.44	20.91	20.56

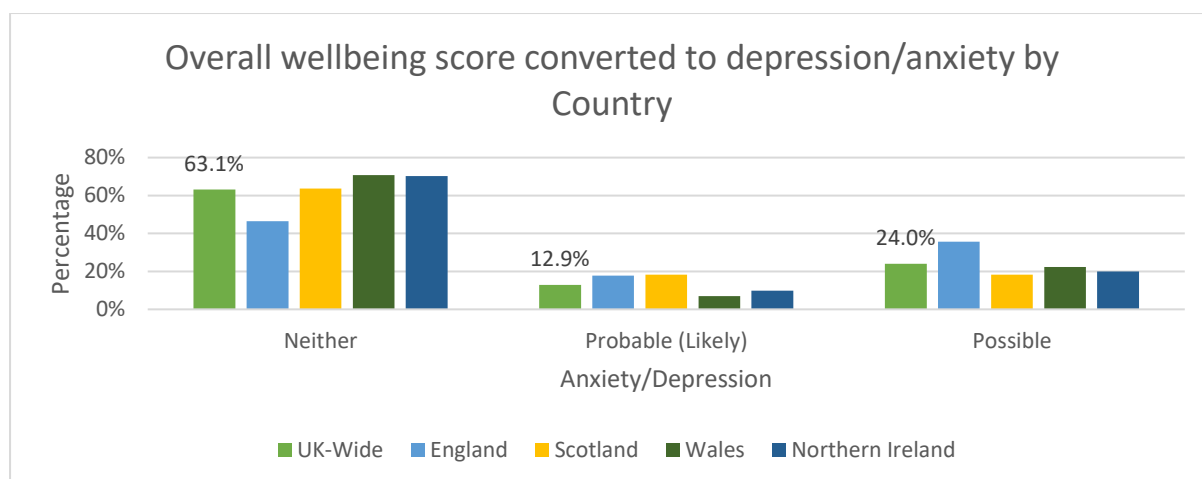
### Depression and Anxiety (Phase 6)

When the well-being scores were converted to indicate probable or possible cases of depression/anxiety (See Figure 6.), it was found that in the sixth Phase, UK-wide, 12.9% were

probable (likely) cases of anxiety or depression and a further 24.0% were possible cases of anxiety or depression (See Table 3.1.2. & Table 3.1.3.).

To explain the meaning of scores on the Short Warwick Edinburgh Mental Wellbeing Scale, and to put these results in context, it is helpful to illustrate what the scores mean. Possible scores in the scale are 7 to 35. Higher scores indicate better mental wellbeing. Cut-off scores categorise respondents into those who were probable or possible cases of depression and / or anxiety. Scores from 7 to 17 are 'probable' case of depression and / or anxiety. Scores of 18-20 are 'possible' cases of depression and / or anxiety. The literature on normative levels of wellbeing in public health surveys indicates a score of 23.6 as accepted population mean wellbeing score (NHS Health Survey for England, 2011). Taken together through all Phases of the study UK wide, the estimated proportion of mean scores for social workers, has remained between 20-21 which shows that wellbeing has not improved, even as the population begins to move beyond the pandemic era.

Figure 6. Overall Well-being Score Converted to Depression/Anxiety by Country (Phase 6)



\*See Table 2.1 for cut-off scores.

Table 3.1.2.: Overall Well-being Score Converted to Depression/Anxiety by Country (Phase 6)

Case of anxiety/depression	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Neither	63.1%	46.5%	63.6%	70.7%	70.2%
Probable (Likely)	12.9%	17.8%	18.2%	6.9%	9.9%
Possible	24.0	35.6%	18.2%	22.4%	19.9%
<b>Total</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>

Table 3.1.3.: Well-being scores translated to likelihood of anxiety/depression scores UK-wide.

Study phase	UK-Wide	
	Probable (Likely)	Possible
Phase 1	7.8%	16.7%
Phase 2	12.2%	24.8%
Phase 3	14.1%	21.0%
Phase 4	14.2%	23.9%
Phase 5	13.8%	15.6%
Phase 6	12.9%	24.0%

\*See Table 2.1 for cut off scores

### Demographic variables and Mental Wellbeing (Phase 6)

We also looked at the associations of other variables with mental well-being and found the following:

- Respondents who felt overwhelmed by increased pressures scored significantly lower in wellbeing scores than those who only felt some impact of COVID-19 and those who were not impacted by COVID-19 pressures (see Figure 7. & Table 3.1.4. for all phase comparisons).
- Respondents who reported considering changing their occupation scored significantly lower in well-being scores than those who did not consider changing their occupation.
- Respondent who reported that their service did not operate a safe staff-to-service user ratio scored significantly lower in well-being scores compared to those who did believe their service operated a safe staff-to-service user ratio.

Figure 7. Mean Overall Well-being Score by the Impact of the Pandemic on Services (Phase 6)

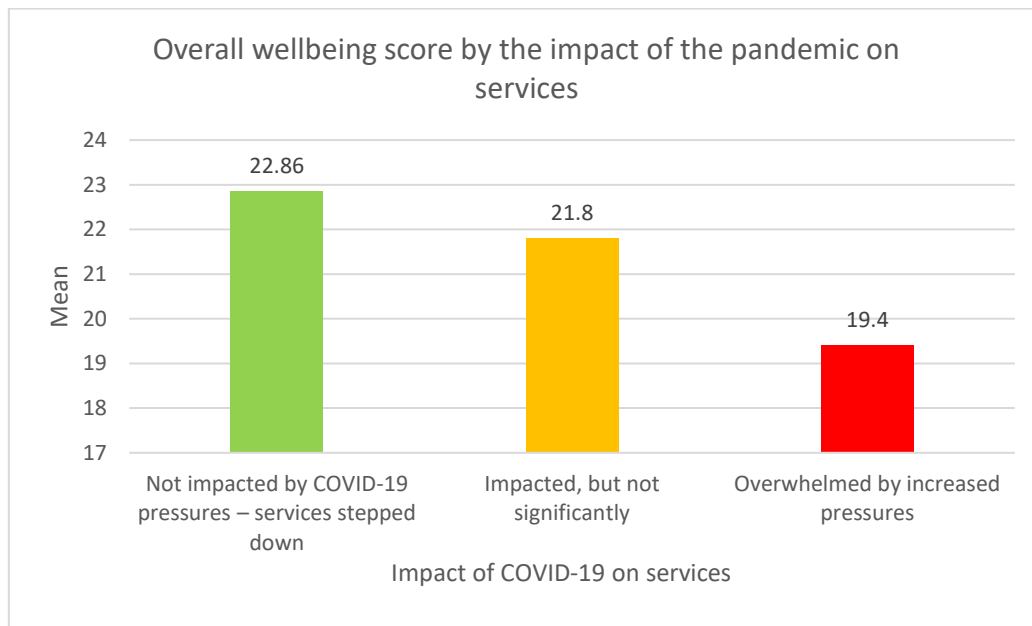


Table 3.1.4.: Overall well-being scores by those overwhelmed working in the pandemic.

Study phase	Respondents overwhelmed	
	Mean well-being score	Percentage of respondents
Phase 2	19.80	56.9%
Phase 3	19.65	63.7%
Phase 4	19.55	64.1%
Phase 5	20.21	60.2%
Phase 6	19.40	61.2%

### Multiple Regression Model Predicting Well-being Scores (Phase 6)

Research question: Do coping mechanisms predict Well-being scores when controlling for demographic and country of work variables?

Method: A multiple linear regression model was constructed with the Well-being scores (SWEMWBS) as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

**Results:** The model explained 49.2% of the variance (adjusted  $R^2 = .436$ ,  $F(36, 325) = 8.75$ ,  $p < .001$ ).

The following coping strategies predicted overall well-being score (SWEMWBS):

1. **Carver's Acceptance:** respondents with higher Acceptance scores had higher Well-being scores ( $\beta = .354$ ,  $p < .001$ ).
2. **Carver's Use of emotional support;** respondents with higher Use of emotional support scores had higher Well-being scores ( $\beta = .274$ ,  $p = .011$ ).
3. **Carver's Behavioural disengagement:** respondents with higher Behavioural disengagement scores had lower Well-being scores ( $\beta = -.265$ ,  $p = .022$ ).
4. **Carver's Self-blame:** respondents with higher Self-blame scores had lower Well-being scores ( $\beta = -.570$ ,  $p < .001$ ).
5. **Clark et al.'s Family-work segmentation;** respondents with higher Family-work segmentation scores had lower Well-being scores ( $\beta = -.507$ ,  $p = .004$ ).
6. **Work-family segmentation:** respondents with higher Work-family segmentation scores had higher Well-being scores ( $\beta = .334$ ,  $p = .018$ ).

## 4.2. Quality of Working Life

Quality of working life was assessed using the Work-Related Quality of Life (WRQOL) Scale (Easton and Van Laar, 2018). Higher scores represent higher quality of working life. The overall WRQOL score in Phase 6 across the UK was 71.11 (See Figure 8. – 11. & Table 3.2.1.) which was the lowest score of all the phases (i.e., Phase 1 – 78.91; Phase 2 – 75.92; Phase 3 – 71.46; Phase 5 – 74.49) except Phase 4 where the WRQOL score was slightly lower than Phase 6 scores -70.82 (See Table 3.2.2). Analysis of individual countries showed that England scored the lowest in all domains of the WRQOL apart from

working conditions where Scotland reported the lowest score. **Stress at work was reversed scored** indicating English respondents were reporting higher levels of stress (See Table 3.2.1. & Figure 9.).

Figure 8. Mean Overall Quality of Working Life Score by Country (Phase 6)

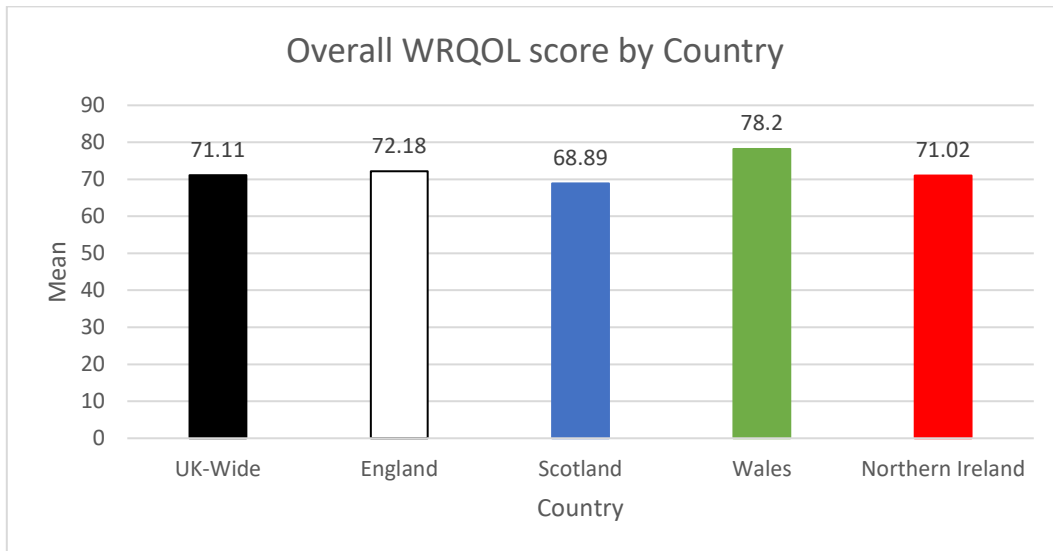


Table 3.2.1.: Mean Quality of Working Life Scores by Country (Phase 6)

WRQOL domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Job career satisfaction	20.38	19.90	20.28	22.56	19.96
Stress at work	4.01	3.74	3.82	4.51	4.06
General well-being	18.23	16.90	18.39	19.66	18.47
Home-work interface	9.95	9.62	10.34	10.88	9.66
Control at work	9.28	9.04	9.06	10.20	9.18
Working conditions	9.27	8.96	8.76	10.58	9.20
<b>Overall WRQOL score</b>	<b>71.11</b>	<b>72.18</b>	<b>68.89</b>	<b>78.20</b>	<b>71.02</b>



Figure 9. Mean Quality of Working Life Scores by Country (Phase 6)

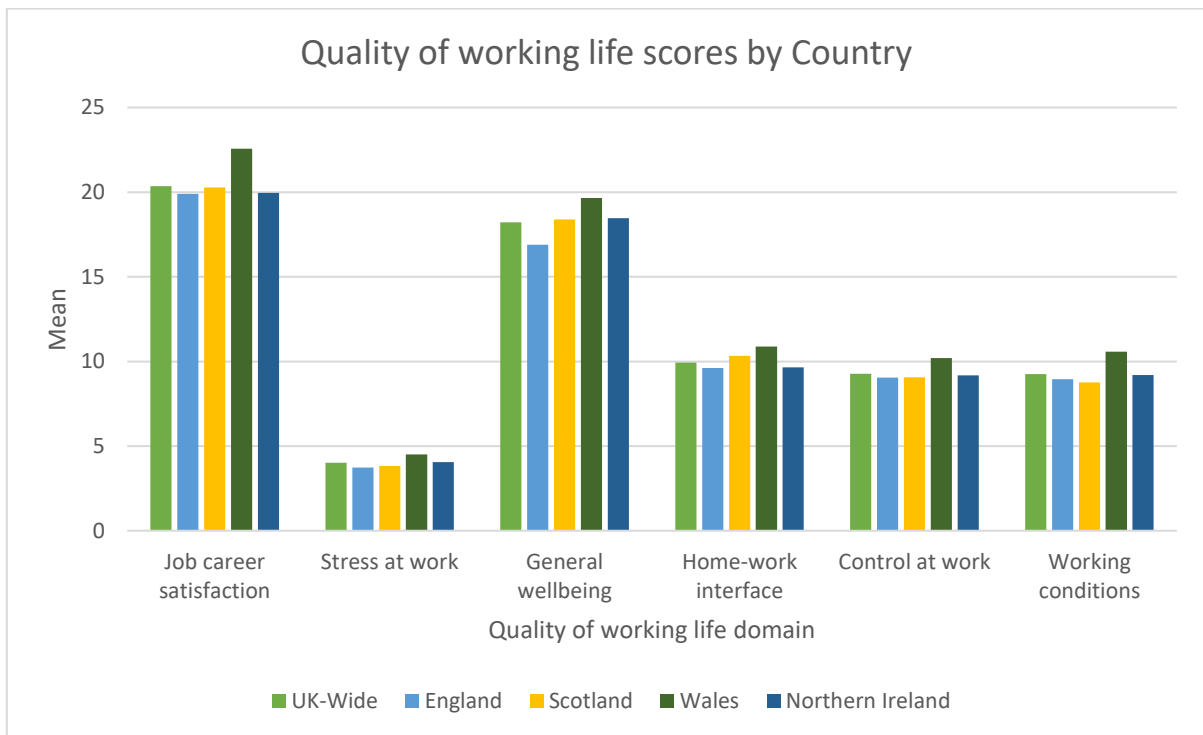


Figure 10. UK-wide Mean Quality of Working Life Scores by Study phase (All Phase).

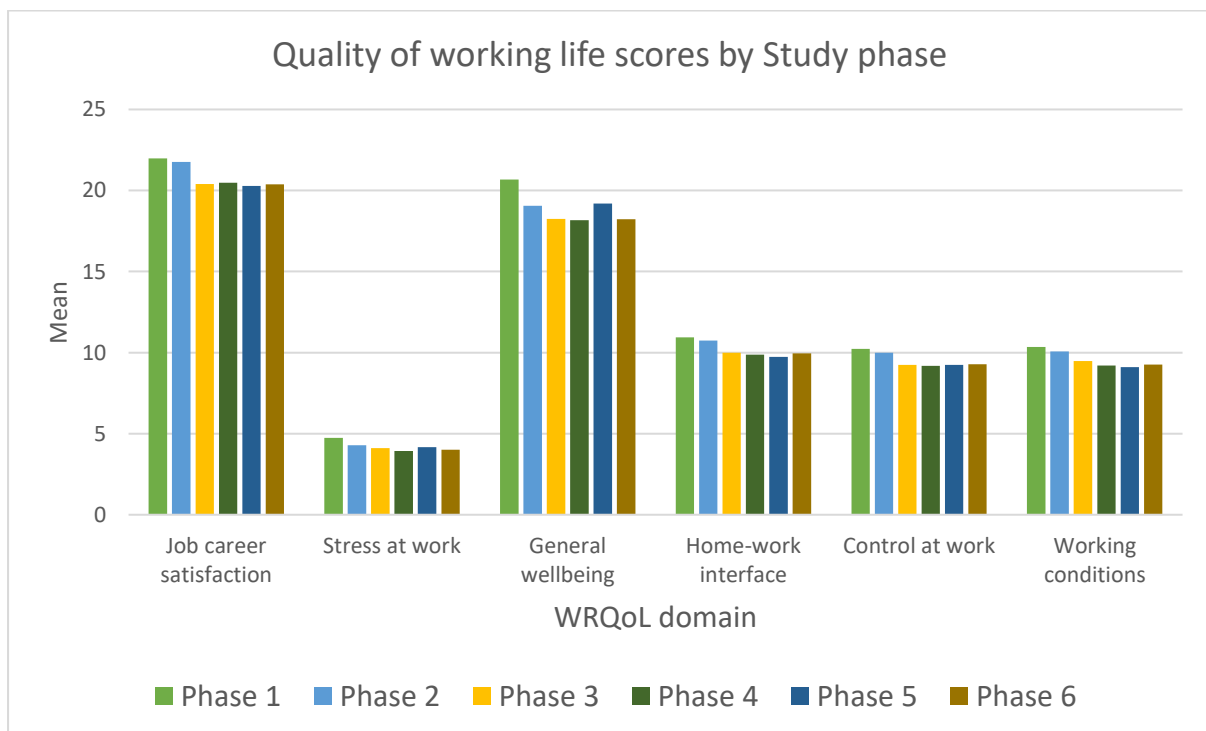
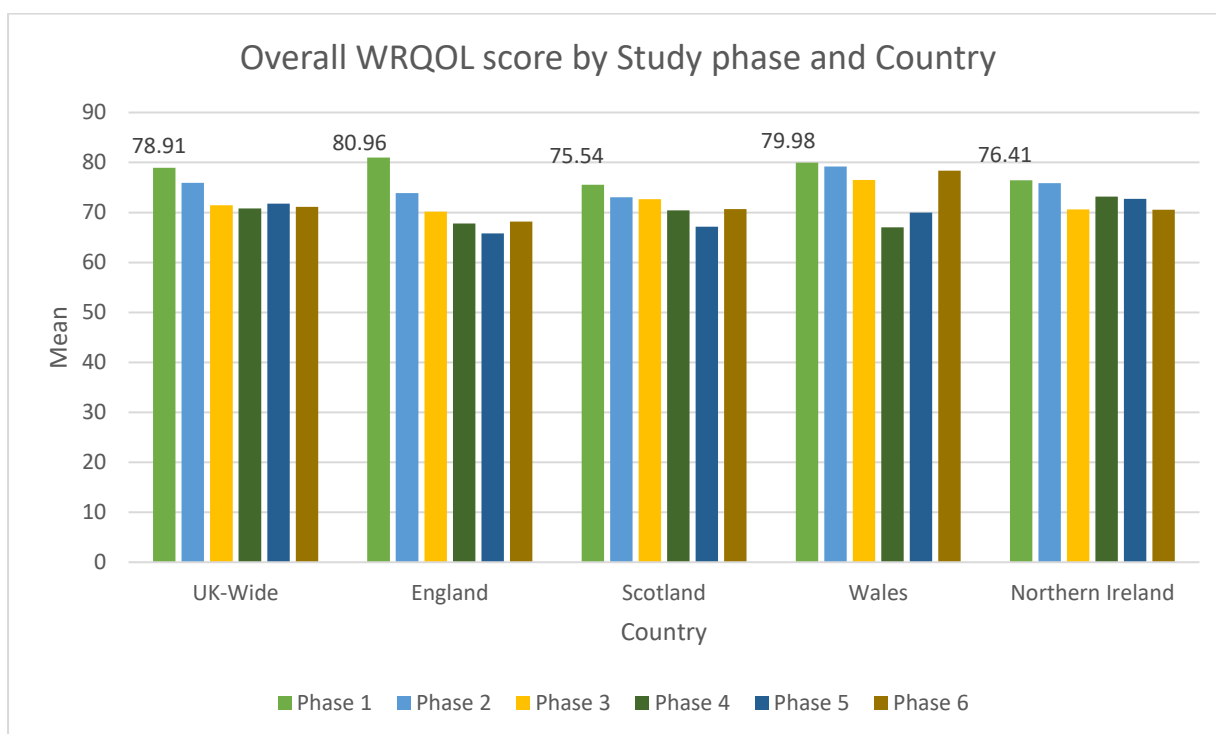


Figure 11. Mean Overall Quality of Working Life Score by Study Phase and Country (All Phase)



As shown in Table 3.2.2., in Phase 6, the decrease in mean WRQOL scores was observed UK-wide and shown Northern Ireland.

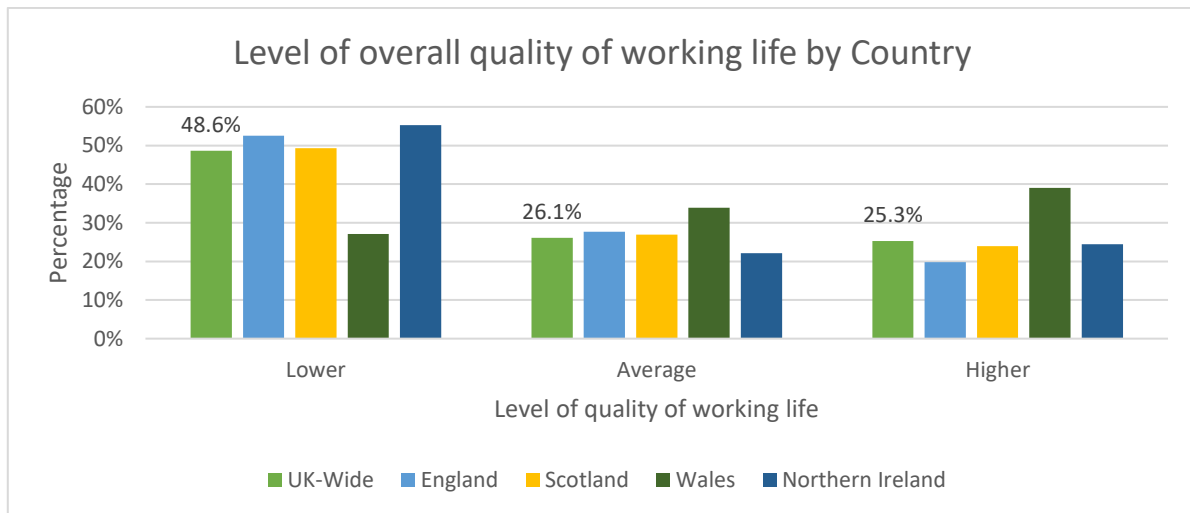
Table 3.2.2.: Mean Quality of Working Life Score by Study Phase and Country

Study phase	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	78.91	80.96	75.54	79.98	76.41
Phase 2	75.92	73.90	73.07	79.21	75.85
Phase 3	71.46	70.15	72.66	76.49	70.62
Phase 4	70.82	67.82	70.42	67.00	73.18
Phase 5	71.75	65.82	67.17	70.00	72.75
Phase 6	71.11	68.17	70.66	78.39	70.52

## Work-related Quality of Life Categories

When the WRQOL scores were converted to Lower, Average, or Higher quality of working life, we found that UK-wide, 48.6% of respondents had lower quality of working life, 26.1% had average quality of working life and 25.3% had higher quality of working life in Phase 6 (See Figure 12. & Table 3.2.3.).

Figure 12. Level of Overall Quality of Working Life by Country (Phase 6)



Note: See Table 2.2 for WRQL cut off points for lower, average, and higher scores.

In Phase 5, 49.6% of respondents had lower quality of working life, 23.0% had average quality of working life and 27.5% had higher quality of working life. In Phase 4, 52.1% of respondents had lower quality of working life, 24.6% had average quality of working life and 23.3% had higher quality of working life. In Phase 3 in which 50.2% of respondents had lower quality of working life, 24.1% had average quality of working life and 25.7% had higher quality of working life. While in Phase 2, 36% of respondents had lower quality of working life, 29.4% had average quality of working life and 34.6% had higher quality of working life and 28.8%, 26.3%, and 45% for higher, average, and lower quality of working life respectively in Phase 1 of the study. Results from this study (Phase 6) indicate a nearly half of all social workers had a lower level of WRQOL quality life.

Table. 3.2.3.: Level of Overall Quality of Working Life by Country (Phase 6)

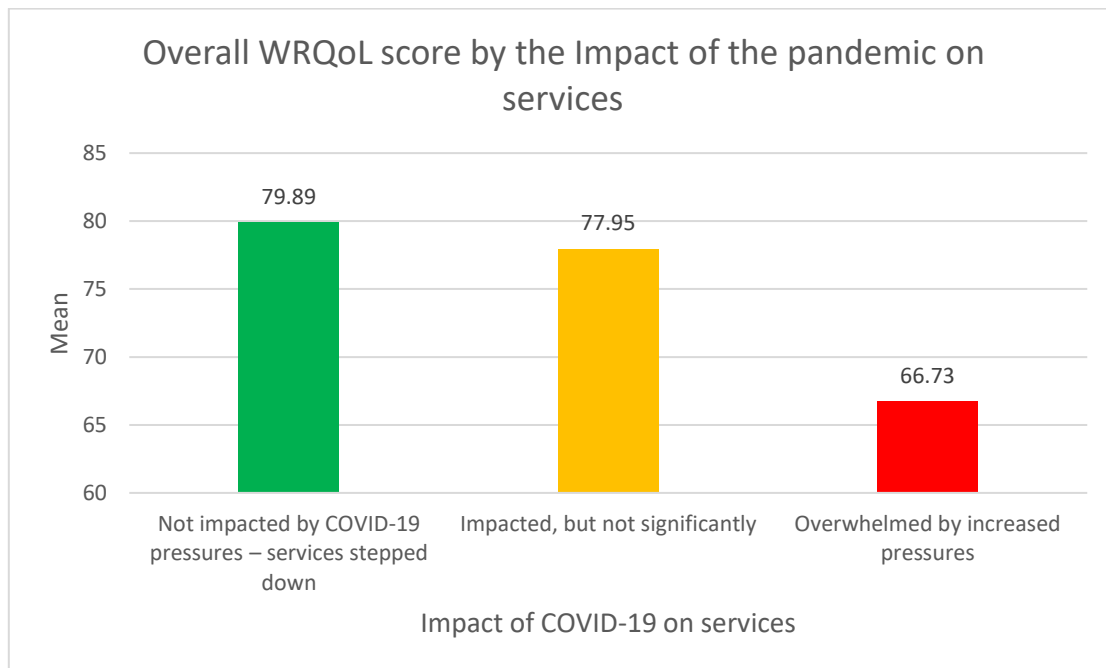
Level of WRQOL	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Lower	48.6%	52.5%	49.3%	27.1%	55.3%
Average	26.1%	27.7%	26.9%	33.9%	22.1%
Higher	25.3%	19.8%	23.9%	39.0%	24.4%
<b>Total</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>

### Demographic variables and Quality of Working Life (Phase 6)

Analyses of the associations of other variables with the overall quality of working life revealed the following:

- The overall WRQOL score was significantly higher in Wales compared to England, Scotland, and Northern Ireland. When respondents were categorised into those with lower, average, and higher quality of working life, Northern Ireland had the highest proportion of respondents with “lower quality of working life” (53.5%) and Wales had the highest proportion with “higher quality of working life” (39%).
- Females had significantly higher quality of working life than males.
- Respondents in the 30-39 age group scored significantly lower than those in the 60+ age groups.
- Respondents without a disability scored significantly higher than those with a disability.
- Respondents working with adults scored significantly higher scores than those working with older people. Likewise, those working with older people scored significantly lower than those working in mental health and those who selected ‘other’ as their main area of practice.
- Respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact and those who felt no impact of COVID-19 (see Figure 13.).

Figure 13. Mean Overall WRQOL Score by the Impact of the Pandemic on Services (Phase 6)



### Multiple Regression Model Predicting Quality of Working Life Scores (Phase 6)

Research question: Do coping mechanisms predict Work-Related Quality of Life (WRQOL) scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the Work-related quality of life scores (WRQOL) as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)

- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

Results: The model explained 46.8% of the variance (adjusted  $R^2 = .41.0$ ,  $F(36, 325) = 7.96$ ,  $p < .001$ ).

The following coping strategies predicted overall work-related quality of life score (WRQOL):

1. **Carver's Planning:** respondents with higher Planning scores had lower WRQOL scores ( $\beta = -1.939$ ,  $p = .006$ ).
2. **Carver's Use of emotional support:** respondents with higher Use of emotional support scores had higher WRQOL scores ( $\beta = 1.508$ ,  $p = .004$ ).
3. **Carver's Behavioural disengagement:** respondents with higher Behavioural disengagement scores had lower WRQOL scores ( $\beta = -2.026$ ,  $p < .001$ ).
4. **Carver's Self-blame:** respondents with higher Self-blame scores had lower WRQOL scores ( $\beta = -.980$ ,  $p = .025$ ).
5. **Clark et al.'s Family-work segmentation:** respondents with higher Family-work segmentation scores had lower WRQOL scores ( $\beta = -2.582$ ,  $p = .003$ ).
6. **Clark et al.'s Work-family segmentation:** respondents with higher Work-family segmentation scores had higher WRQOL scores ( $\beta = 2.095$ ,  $p = .002$ ).

Other variables predicting the overall WRQOL score:

7. **Sex:** respondents who were male ( $\beta = -3.783$ ,  $p = .045$ ) had lower WRQOL scores than those who were female.
8. **Country of work:** respondents working in Wales ( $\beta = 7.351$ ,  $p = .001$ ) had higher WRQOL scores than those working in England.
9. **Number of sick days in previous 12 months:** those who reported being off sick for less than 10 days ( $\beta = -3.854$ ,  $p = .015$ ), 11-20 days ( $\beta = -6.063$ ,  $p = .010$ ), 41-60 days ( $\beta = -8.067$ ,  $p = .029$ ), and more than 60 days ( $\beta = -5.981$ ,  $p = .033$ ) had lower WRQOL scores than those who did not take sick days.

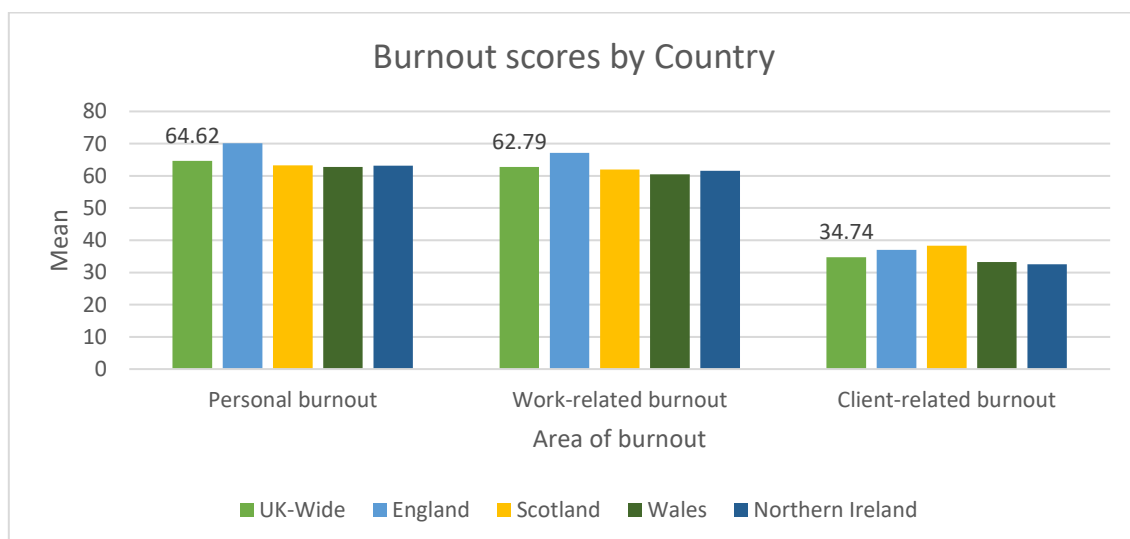
### 4.3. Burnout

Burnout was measured from Phase 2 onwards. In Phase 6 the personal burnout score UK-wide was 64.62, which is higher than the personal burnout scores in Phase 5 (61.41), Phase 4 (63.43), Phase 3 (63.24), and Phase 2 (60.76). The work-related burnout score across the UK was 62.79 which was higher than Phase 5 (61.19), Phase 4 (61.82), Phase 3 (61.80), and Phase 2 (58.38). The client-related burnout score across the UK was 34.74 which was higher than Phase 5 (30.51), Phase 4 (30.60), Phase 3 (30.98) and Phase 2 (30.19) respectively (See Table 3.3.1. & Figure 14.).

Table 3.3.1.: Mean Burnout Scores by Country (Phase 6)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout	64.62	70.12	63.21	62.72	63.13
Work-related burnout	62.79	67.14	61.99	60.46	61.52
Client-related burnout	34.74	37.06	38.35	33.21	32.58

Figure 14. Mean Burnout Scores by Country (Phase 6)



## Burnout categories

Overall, there was an increase in personal burnout in Phase 6. We found that UK-wide in Phase 6, 19.7% of respondents had low personal burnout, 43.6% had moderate burnout, 36.6% had high/severe levels of personal burnout (See Figure 15.).

This compares to Phase 5 personal burnout, when 26.6% of respondents had low burnout, 43% moderate, 30.5% high/severe levels. Moreover, in Phase 4 personal burnout scores UK-wide were 24.6% of respondents had low, 39.5% moderate, 36% experienced high/severe personal burnout. Additionally, in Phase 3, 20.9% of respondents had low burnout, 46.2% moderate burnout, with 32.9% reported high/severe personal burnout. In Phase 2, 24.7% reported low personal burnout, 48.3% reported moderate burnout, 27.1% reported high/severe burnout. (Table 3.3.2.).

Figure 15. Level of burnout UK-wide (Phase 6)

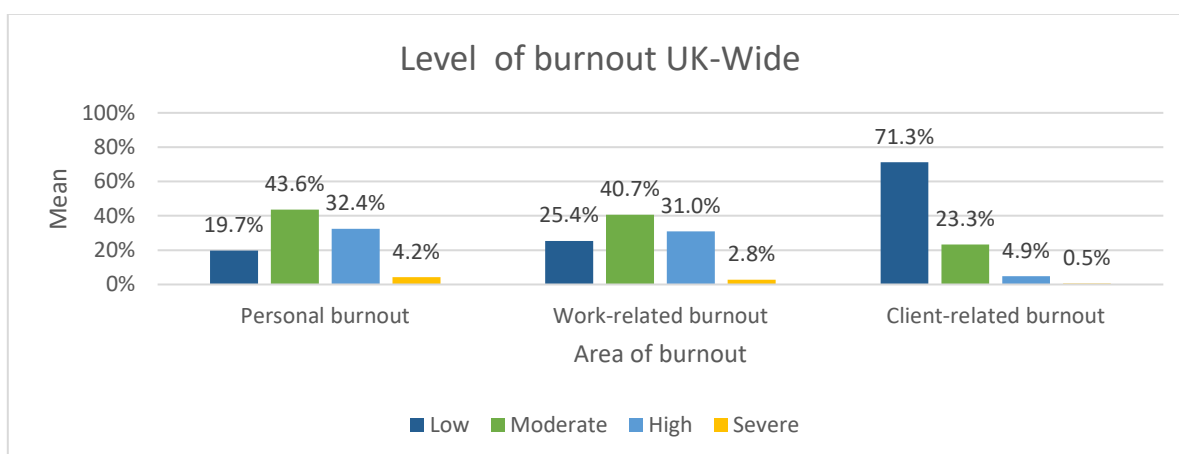


Table 3.3.2.: Level of Burnout by Country (Phase 6)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
<b>Personal burnout:</b>					
Low	19.7%	14.6%	16.4%	22.0%	23.3%
Moderate	43.6%	42.7%	49.3%	45.8%	41.3%
High	32.4%	35.9%	31.3%	28.8%	32.0%
Severe	4.2%	6.8%	3.0%	3.4%	3.5%
<b>Total</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>



<b>Work-related burnout:</b>					
Low	25.4%	22.5%	25.4%	29.3%	25.9%
Moderate	40.7%	34.3%	38.1%	39.7%	45.9%
High	31.0%	40.2%	34.9%	29.3%	24.7%
Severe	2.8%	2.9%	1.6%	1.7%	3.5%
<b>Total</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>
<b>Client-related burnout:</b>					
Low	71.3%	67.0%	64.4%	75.0%	75.0%
Moderate	23.3%	25.5%	30.5%	19.6%	20.6%
High	4.9%	5.3%	5.1%	5.4%	4.4%
Severe	0.5%	2.1%	0.0%	0 (0.0%)	0%
<b>Total</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>	<b>(100%)</b>

\*See table 2.3 for cut-off scores

Phase 6 also reveals an overall increase in the level of work-related burnout: 25.4% had low burnout, 40.7% had moderate burnout, with 33.8% reporting high/severe work-related burnout. In Phase 5, 29.8% had low burnout, 37% had moderate burnout and a further 33.1% experienced high to severe levels of work-related burnout. In Phase 4, 25.2% of respondents had low burnout, 43.5% moderate, 31.4% reported high/severe burnout. In Phase 3, 26% of respondents had low burnout, 42.1% moderate, and a further 32% experienced high/severe levels. In relation to work-related burnout in Phase 2, 29.1% experienced low burnout, 47.5% experienced moderate burnout and a further 23.4% experienced high or severe burnout (See Table 3.3.2.).

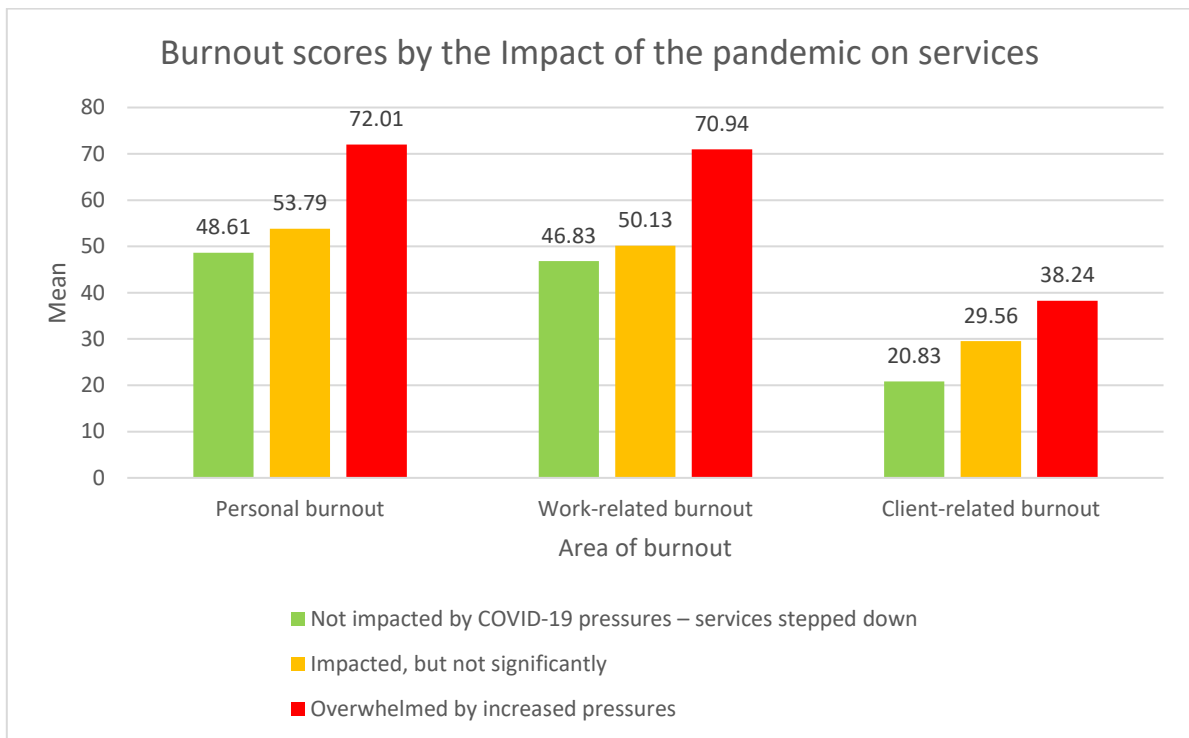
Finally, in relation to client-related burnout, this remains low but showing a negative trend. In Phase 6, 71.3% reported low burnout, 23.3% reported moderate burnout, and a further 5.4% reported high/severe levels of client-related burnout. In Phase 5, 77.8% reported low burnout, 19.0% reported moderate burnout and a further 3.2% reported high or severe burnout (See Table 3.3.2). In Phase 4, 76.4% reported low burnout, 19.4% reported moderate burnout and a further 4.3% reported high or severe burnout. In Phase 3, 79.2% had reported low burnout, 16.8% reported moderate burnout and 4% reported high or severe burnout. For client-related burnout in Phase 2, 80.9% had reported low burnout, 17.1% reported moderate burnout and 2% reported high or severe burnout.

### **Demographic variables and Burnout Phase 6**

The analyses of the associations of other variables with burnout scores revealed the following:

- Males experienced significantly higher levels of client- related burnout than females.
- The 60+ age group scored significantly lower in personal burnout than the 16-29, 30-39, and 40-49 age groups.
- The 60+ age group scored significantly lower in work-related burnout than the 16-29, 30-39, and 40-49 age groups.
- Respondents without a disability experienced significantly less personal and work-related burnout than those who reported a disability.
- Respondents working with older people scored significantly higher in work-related burnout than those who selected 'other' as their main area of practice.
- Respondents who were line managers scored significantly lower in client-related burnout than those who were not line managers.
- Respondents who felt that their service was overwhelmed by increased pressures experienced significantly more personal, work-related, and client-related burnout than those not impacted and those impacted but not significantly (see Figure 15.).
- Respondents who took employer support reported significantly higher scores of both personal and work-related burnout than those who did not take up employer support.
- Respondents who considered changing their occupation scored significantly higher scores on personal, work-related, and client-related burnout than those who did not consider changing occupation.
- Respondents who believed their service did not operate a safe staff-to-service user ratio scored significantly higher on personal, work-related, and client-related burnout than those who believed their service operated a safe staff-to-service user ratio.

Figure 16. Mean Burnout Scores by the Impact of the Pandemic on Services (Phase 6)



### Correlations among Burnout, Quality of Working Life, and Wellbeing

As shown in Table 3.3.3., we found strong negative correlations between personal burnout and well-being scores and quality of working life. Work-related burnout had a similar strong negative correlation with wellbeing and quality of life. Whereas client-related burnout had a moderate negative correlation with wellbeing and quality of life. This indicates that as burnout in any area increased, respondents’ well-being and quality of working life decreased.

Table 3.3.3. Correlations between Burnout, Well-being (SWEMWBS) and WRQOL Scores

Burnout area	Well-being	Quality of working life
Personal	-.655**	-.579**
Work-related	-.684**	-.711**
Client-related	-.442**	-.451**

\*\* = Correlations are statistically significant at  $p < .001$  (2-tailed)

## Multiple Regression Model Predicting Personal Burnout Scores (Phase 6)

Research question: Do coping mechanisms predict Personal Burnout Scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the personal burnout scores as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

Results: The model explained 48.6% of the variance (adjusted  $R^2 = .429$ ,  $F(36, 326) = 8.56$ ,  $p < .001$ ).

The following coping strategies predicted personal burnout scores:

1. **Carver's Acceptance**: respondents with higher Acceptance scores had lower personal burnout scores ( $\beta = -1.649$ ,  $p = .005$ ).
2. **Carver's Behavioural disengagement**: respondents with higher Behavioural disengagement scores had higher Personal burnout scores ( $\beta = 1.604$ ,  $p = .020$ ).
3. **Carver's Self-blame**: respondents with higher Self-blame scores had higher Personal burnout scores ( $\beta = 2.697$ ,  $p < .001$ ).
4. **Clark et al.'s Work-family segmentation**: respondents with higher Work-family segmentation scores had lower Personal burnout scores ( $\beta = -2.107$ ,  $p < .001$ ).

5. **Clark et al.'s Exercise:** respondents with higher Exercise scores had lower Personal burnout scores ( $\beta = -1.520, p < .015$ ).

Other variables predicting personal burnout scores:

6. **Number of sick days in previous 12 months;** respondents who took less than 10 sick days ( $\beta = 4.730, p = .015$ ), those who took 11-20 sick days ( $\beta = 9.486, p = .001$ ), and those who took more than 60 sick days ( $\beta = 7.164, p = .038$ ), all had higher personal burnout scores than those who took no sick days.
7. **Effects of the pandemic on services;** respondents who felt their services had felt overwhelmed by increased pressures ( $\beta = 15.458, p = .005$ ) had higher personal burnout scores than those who felt no impact.

### **Multiple Regression Model Predicting Work-Related Burnout Scores (Phase 6)**

Research question: Do coping mechanisms predict Work-Related Burnout Scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the Work-related burnout scores as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)

- Clark coping domains (continuous variables)

Results: The model explained 51.0% of the variance (adjusted  $R^2 = .456$ ,  $F(36, 326) = 9.43$ ,  $p < .001$ ).

The following coping strategies predicted personal burnout scores:

1. **Carver's Acceptance:** respondents with higher acceptance scores had lower Work-related burnout scores ( $\beta = -1.259$ ,  $p = .041$ ).
2. **Carver's Behavioural disengagement:** respondents with higher Behavioural disengagement scores had higher Work-related burnout scores ( $\beta = 2.447$ ,  $p < .001$ ).
3. **Carver's Self-blame:** respondents with higher Self-blame scores had higher Work-related burnout scores ( $\beta = 2.441$ ,  $p < .001$ ).
4. **Clark et al.'s Family-work segmentation:** respondents with higher Family-work segmentation scores had higher Work-related burnout scores ( $\beta = 2.781$ ,  $p < .011$ ).
5. **Clark et al.'s Work-family segmentation:** respondents with higher Work-family segmentation scores had lower Work-related burnout scores ( $\beta = -3.383$ ,  $p < .001$ ).

Other variables predicting the work-related burnout score:

6. **Number of sick days in previous 12 months;** respondents who took less than 10 days ( $\beta = 4.492$ ,  $p = .026$ ), those who took 11-20 sick days ( $\beta = 10.377$ ,  $p < .001$ ), and those who had more than 60 days sick leave ( $\beta = 10.519$ ,  $p = .004$ ) had higher work-related burnout scores than those who took no sick days.
7. **Effects of the pandemic on services;** respondents who felt overwhelmed by increased pressures ( $\beta = 12.503$ ,  $p = .030$ ) had higher work-related burnout scores than those who felt no impact.

### **Multiple Regression Model Predicting Client-Related Burnout Scores (Phase 6)**

Research question: Do coping mechanisms predict Client-Related Burnout Scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the Client-related burnout scores as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

Results: The model explained 31.2% of the variance (adjusted  $R^2 = .235$ ,  $F(36, 322) = 4.05$ ,  $p < .001$ ).

The following coping strategies predicted client-related burnout scores:

1. **Carver's Substance use:** respondents with higher substance use scores had higher Client-related burnout scores ( $\beta = 1.628$ ,  $p = .037$ ).
2. **Carver's Self-blame:** respondents with higher Self-blame scores had higher Client-related burnout scores ( $\beta = 1.613$ ,  $p = .019$ ).
3. **Clark et al.'s Work-family segmentation:** respondents with lower Work-family segmentation scores had higher Client-related burnout scores ( $\beta = -2.583$ ,  $p < .017$ ).
4. **Clark et al.'s Working to improve skills/efficiency:** respondents with higher Working to improve skills/efficiency scores had lower Client-related burnout scores ( $\beta = -2.817$ ,  $p = .020$ ).

Other variables predicting the client-related burnout score:

5. **Disability:** respondents who had a disability ( $\beta = 6.379$ ,  $p = .024$ ) had higher work-related burnout scores than those who did not have a disability.

6. **Line manager status:** respondents who were line managers had lower client-related burnout scores than those who were not line managers ( $\beta = -4.763, p = .038$ ).

#### 4.4. Coping

##### **Demographic variables and coping Phase 6**

The analyses of the associations of other variables with coping scores revealed the following:

- Northern Ireland scored significantly higher in the use of instrumental support than those in England. Additionally, Northern Ireland scored significantly higher on family-work segmentation than those in Wales. Whereas England scored significantly higher than all other countries on work-family segmentation.
- Females scored significantly higher in working to improve skills/efficiency than males. Whereas males scored significantly higher levels of substance use than females
- Respondents who belonged to the 60+ age group scored significantly lower scores in self-blame than those of the 16-29, 30-39, and the 40-49 age groups. Moreover, those in the 60+ age group scored significantly higher scores in recreation and relaxation than those in the 40-49 age group.
- Respondents working with older people scored significantly lower scores in working to improve skills/efficiency than those who selected 'other' as their main area of practice.
- Respondents overwhelmed by increased pressures scored significantly higher in instrumental support, venting, and behavioural disengagement than those who were impacted but not significantly. Likewise, those overwhelmed, scored significantly higher in self-blame than those impacted but not significantly and those who were not impacted. Moreover, respondents overwhelmed scored significantly lower in work-family segmentation and recreation and relaxation than those who were impacted but not significantly.
- Those respondents who have taken up employer support scored significantly higher in active coping, planning, positive reframing, use of emotional support, use of instrumental support, venting, and self-blame than those who did not take up employer support.
- Those respondents who have taken up employer support scored significantly lower in substance use than those who did not take up employer support.



- Respondents who considered changing their occupation scored significantly higher in active coping, planning, instrumental support, venting, behavioural disengagement, and self-blame than those who did not consider changing occupation. Moreover, respondents who considered changing their occupation scored significantly lower in work-family segmentation and working to improve skills/efficiency than those who did not consider changing occupation.
- Respondents who believed their service did not operate a safe staff-to-service user ratio scored significantly higher on the use of instrumental support, venting, behavioural disengagement, and self-blame than those who believed their service operated a safe staff-to-service user ratio.

Figure 17. Mean Carver Coping Scores by Country (Phase 6)

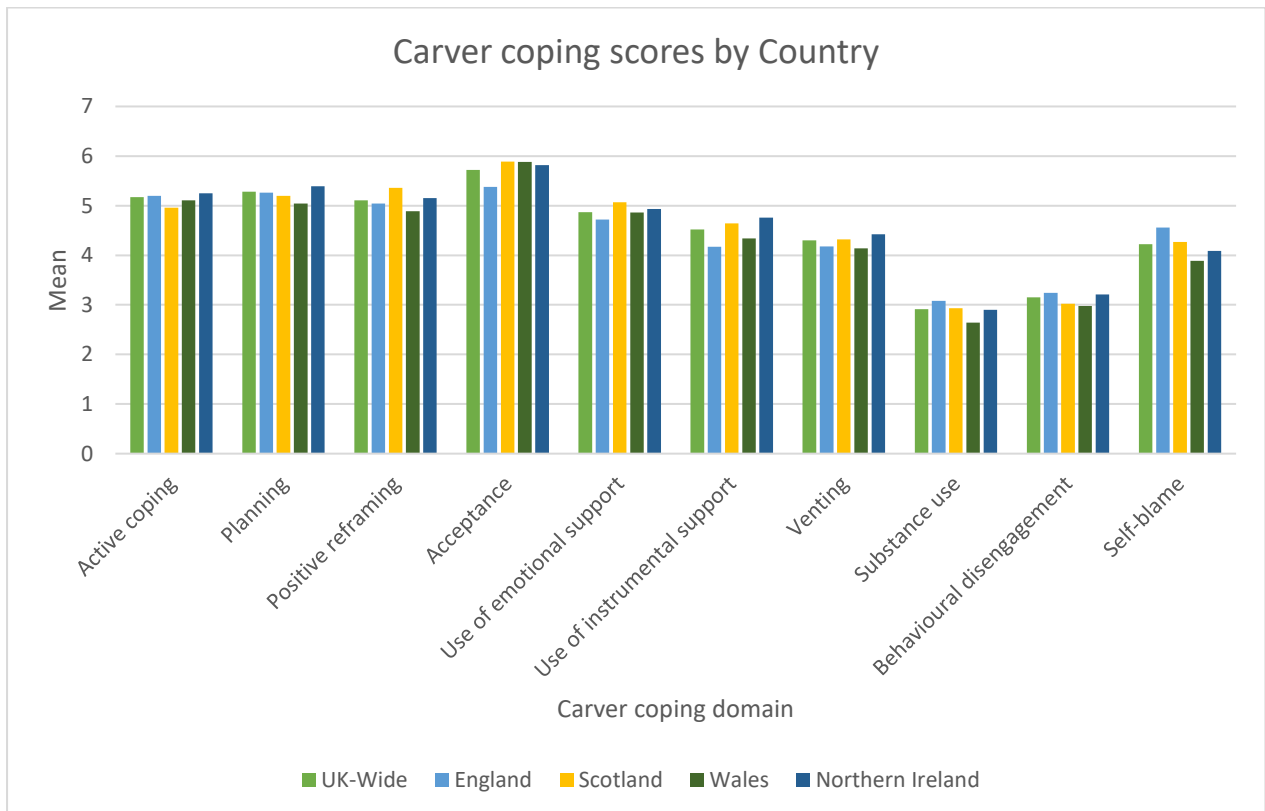


Table 3.4.1. Mean Coping Scores by Country (Phase 6)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Active coping	5.17	5.20	4.96	5.11	5.25
Planning	5.28	5.26	5.20	5.04	5.39
Positive reframing	5.11	5.04	5.36	4.89	5.15
Acceptance	5.72	5.38	5.89	5.88	5.82
Use of emotional support	4.87	4.72	5.07	4.86	4.93
Use of instrumental support	4.52	4.17	4.64	4.34	4.76
Venting	4.30	4.18	4.32	4.14	4.42
Substance use	2.91	3.08	2.93	2.64	2.90
Behavioural disengagement	3.15	3.24	3.02	2.98	3.21
Self-blame	4.22	4.56	4.27	3.89	4.09
Family-work segmentation	5.03	4.94	5.15	4.79	5.14
Work-family segmentation	4.52	4.21	4.76	4.66	4.60
Working to improve skills/efficiency	4.16	4.12	4.31	4.25	4.13
Recreation and relaxation	3.64	3.53	3.76	3.72	3.66
Exercise	3.43	3.11	3.66	3.45	3.55

## 5. Comparison Between the Six Phases.

This section presents descriptive comparisons of data from Phase 1 (May – July 2020) and Phase 2 (November 2020 – February 2021) Phase 3 (May – July 2021), Phase 4 (November 2021-February 2022), Phase 5 (May – July 2022) with Phase 6 (Nov 2022 – January 2023) of the study.

*Note: regression coefficients used in this report are unstandardised.*

### 5.1. Well-being Scores by Study Phase and Country

The overall mean well-being scores decreased from Phase 1 of the study to Phase 6, both UK-wide and within both England and Northern Ireland. Between Phase 2 to Phase 6 of the study, the overall mean well-being scores slightly decreased both UK-wide and within England and Northern Ireland,

whereas both Scotland and Wales showed a slight increase. However, between Phases 3 and 6, the overall mean well-being scores slightly increased UK-wide whereas both England and Northern Ireland showed a slight decrease. Between Phase 4 and Phase 6, the overall mean well-being scores remained the same whereas both England and Northern Ireland showed a slight decrease. Between Phase 5 and Phase 6, the overall mean well-being decreased UK-wide whereas both England and Northern Ireland showed a slight decrease in well-being scores (See Figure 18. & Table 4.1.1.).

Figure 18. Mean Overall Well-being Score by Study Phase and Country (All Phases)

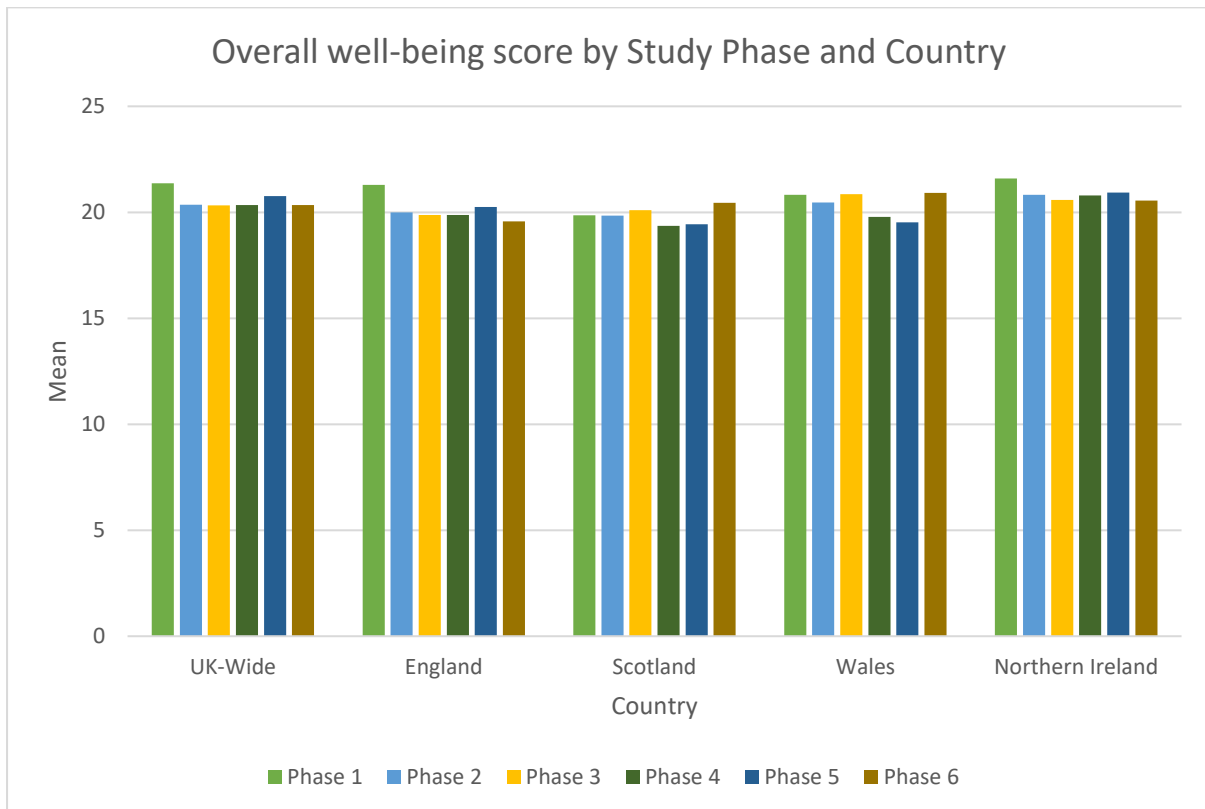


Table 4.1.1.: Mean Overall Well-being Score by Study Phase and Country

Study phase	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	21.37	21.30	19.86	20.82	21.60
Phase 2	20.36	19.99	19.85	20.46	20.83
Phase 3	20.32	19.87	20.10	20.86	20.58
Phase 4	20.34	19.88	19.36	19.78	20.80
Phase 5	20.76	20.25	19.43	19.53	20.93
Phase 6	20.34	19.57	20.44	20.91	20.56

*UK-wide analysis:* Using regression analysis, the decrease in the overall mean well-being scores between Phase 1 and Phase 6 of the study was found to be **statistically significant**, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = -.976, p < .001$ ). There was a slight decrease in the overall mean well-being scores between Phase 2 and Phase 6 of the study which was found to be not statistically significant when controlling for demographic variables ( $\beta = .054, p = .787$ ). The difference in the overall mean wellbeing scores between Phase 3 and Phase 6 of the study was not statistically significant when controlling for demographics ( $\beta = -.010, p = .963$ ). Similarly, the slight decrease in the overall mean wellbeing scores between Phase 4 and Phase 6 was not statistically significant when adjusting for the same covariates ( $\beta = -.050, p = .851$ ). Finally, the decrease in the overall mean wellbeing scores between Phase 5 and Phase 6 of the study was **statistically significant** when adjusting for the same covariates ( $\beta = -.293, p = .032$ ).

## 5.2. Quality of Working Life Scores by Study Phase and Country

The overall WRQOL score decreased from Phase 1 of the study to Phase 6, both UK-wide and across the individual countries. Between Phase 2 and 6, there was also a decrease UK-wide, and across the individual countries. Comparing Phase 3 and Phase 6 there was a decrease UK-wide, but respondents

in Wales had overall WRQOL scores which increased. Between Phase 4 and Phase 6, there was a slight increase UK-wide, but respondents in Northern Ireland had overall WRQOL scores which decreased. Between Phase 5 and Phase 6, there was a slight decrease UK-wide, but respondents in England, Scotland, and Wales had overall WRQOL scores which increased (See Figure 19. & Table 4.2.1.).

Figure 19. Mean Overall Quality of Working Life Score by Study Phase and Country

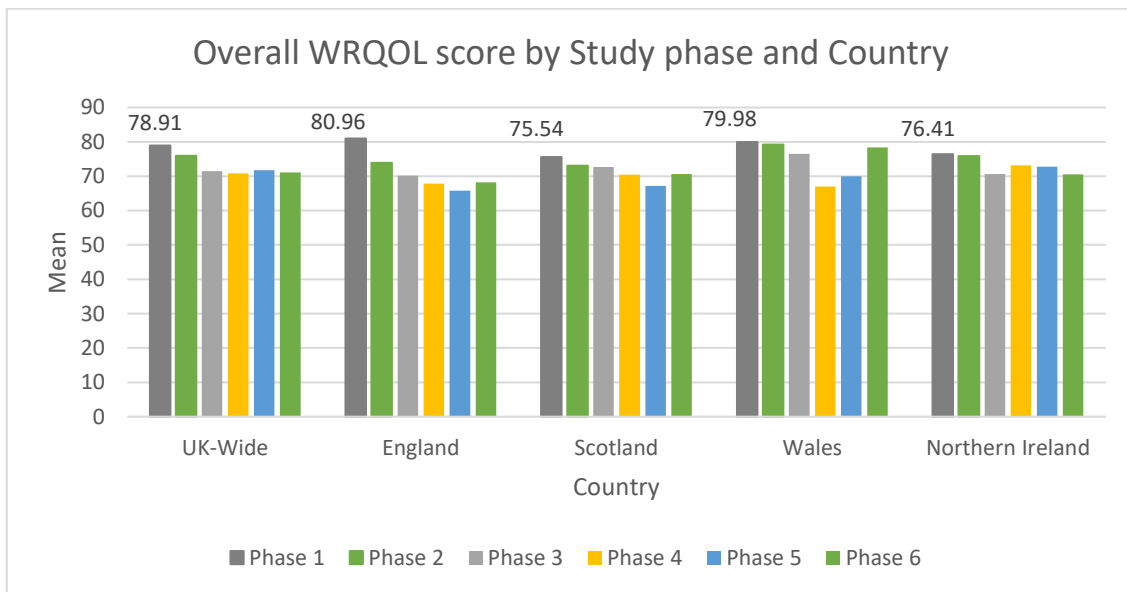


Table 4.2.1.: Mean Quality of Working Life Score by Study Phase and Country (All Phases)

Study phase	Country				
WRQOL domain	UK-Wide	England	Scotland	Wales	Northern Ireland
<b>Phase 1</b>					
Job career satisfaction	21.98	22.47	21.65	22.25	21.36
Stress at work	4.73	4.79	4.42	4.89	4.67
General well-being	20.65	20.82	18.69	20.47	20.62
Home-work interface	10.94	11.38	10.77	11.53	10.33
Control at work	10.24	10.65	10.31	10.53	9.67
Working conditions	10.34	10.84	9.69	10.32	9.76
<b>Overall WRQOL score</b>	<b>78.91</b>	<b>80.96</b>	<b>75.54</b>	<b>79.98</b>	<b>76.41</b>

<b>Phase 2</b>					
Job career satisfaction	21.77	21.50	20.42	22.67	21.44
Stress at work	4.29	4.03	4.32	4.59	4.34
General well-being	19.06	18.33	19.39	19.40	19.61
Home-work interface	10.76	10.62	10.10	11.34	10.45
Control at work	9.99	9.68	9.47	10.49	9.99
Working conditions	10.07	9.94	9.36	10.71	10.01
<b>Overall WRQOL score</b>	<b>75.92</b>	<b>73.90</b>	<b>73.07</b>	<b>79.21</b>	<b>75.85</b>
<b>Phase 3</b>					
Job career satisfaction	20.39	20.27	20.72	21.73	20.02
Stress at work	4.11	4.11	4.32	4.35	3.96
General well-being	18.22	17.48	18.44	19.38	18.44
Home-work interface	9.98	9.96	10.33	10.54	9.74
Control at work	9.25	9.03	9.31	10.05	9.16
Working conditions	9.47	9.31	9.53	10.45	9.30
<b>Overall WRQOL score</b>	<b>71.46</b>	<b>70.15</b>	<b>72.66</b>	<b>76.49</b>	<b>70.62</b>
<b>Phase 4</b>					
Job career satisfaction	20.44	20.04	19.53	20.60	20.88
Stress at work	3.95	3.68	4.42	4.50	4.02
General well-being	18.21	17.21	17.32	16.10	19.05
Home-work interface	9.88	9.58	10.95	8.60	10.01
Control at work	9.19	8.60	8.84	8.10	9.70
Working conditions	9.19	8.71	9.37	9.10	9.52
<b>Overall WRQOL score</b>	<b>70.82</b>	<b>67.82</b>	<b>70.42</b>	<b>67.00</b>	<b>73.18</b>

<b>Phase 5</b>					
Job career satisfaction	20.28	18.71	20.50	20.00	20.48
Stress at work	4.17	4.03	3.83	4.25	4.20
General well-being	19.20	17.35	16.17	18.67	19.58
Home-work interface	9.70	9.65	9.25	9.17	9.92
Control at work	9.24	8.18	9.08	9.42	9.38
Working conditions	9.12	8.91	8.33	8.50	9.19
<b>Overall WRQOL score</b>	<b>71.75</b>	<b>65.82</b>	<b>67.17</b>	<b>70.00</b>	<b>72.75</b>
<b>Phase 6</b>					
Job career satisfaction	20.36	19.90	20.28	22.56	19.96
Stress at work	4.01	3.74	3.82	4.51	4.06
General well-being	18.22	16.90	18.39	19.66	18.47
Home-work interface	9.94	9.62	10.34	10.88	9.66
Control at work	9.28	9.04	9.06	10.20	9.18
Working conditions	9.26	8.96	8.76	10.58	9.20
<b>Overall WRQOL score</b>	<b>71.11</b>	<b>68.17</b>	<b>70.66</b>	<b>78.39</b>	<b>70.52</b>

*UK-wide analysis:* Using regression analysis, the decrease in the overall WRQOL scores between Phase 1 and Phase 6 of the study was found to be **statistically significant**, when controlling for the effects of respondents' country of work, sex, age, ethnicity and disability status ( $\beta = -7.316, p < .001$ ). The results for WRQOL domain scores (controlling for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -1.531, p < .001$ ).

- Stress at work: **Significant decrease** in scores (this item is reversed scored thus indicating an increase in stress over the two measured time-points) from Phase 1 to Phase 6 ( $\beta = -.716, p < .001$ ).
- Working conditions: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -.899, p < .001$ ).
- Control at work: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -.892, p < .001$ ).
- General well-being: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -2.331, p < .001$ ).
- Home-work interface: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -1.015, p < .001$ ).

Using regression analysis, the change in the overall WRQOL scores between Phase 2 and Phase 6 of the study was **statistically significant**, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = -4.205, p < .001$ ). The results for WRQOL domain scores (controlling for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: **Significant decrease** in scores from Phase 2 to Phase 6 ( $\beta = -1.062, p < .001$ ).
- Stress at work: **Significant decrease** in scores from Phase 2 to Phase 6 ( $\beta = -.291, p = .008$ ).
- Working conditions: **Significant decrease** in scores from Phase 2 to Phase 6 ( $\beta = -.629, p < .001$ ).
- Control at work: **Significant decrease** in scores from Phase 2 to Phase 6 ( $\beta = -.671, p < .001$ ).
- General wellbeing: **Significant decrease** in scores from Phase 2 to Phase 6 ( $\beta = -.884, p = .002$ ).
- Home-work interface: **Significant decrease** in scores from Phase 2 to Phase 6 ( $\beta = -.682, p < .001$ ).

Using regression analysis, the change in the overall WRQOL scores between Phase 3 and Phase 6 of the study was not statistically significant, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = -.492, p = .619$ ). The results for



WRQOL domain scores (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: No significant change in scores from Phase 3 to Phase 6 ( $\beta = -.060, p = .841$ ).
- Stress at work: No significant change in scores from Phase 3 to Phase 6 ( $\beta = -.095, p = .397$ ).
- Working conditions: No significant change in scores from Phase 3 to Phase 6 ( $\beta = -.222, p = .202$ ).
- Control at work: No significant change in scores from Phase 3 to Phase 6 ( $\beta = .021, p = .910$ ).
- General well-being: No significant change in scores from Phase 3 to Phase 6 ( $\beta = -.061, p = .843$ ).
- Home-work interface: No significant change in scores from Phase 3 to Phase 6 ( $\beta = -.055, p = .764$ ).

Using regression analysis, the change in the overall WRQOL scores between Phase 4 and Phase 6 of the study was not statistically significant, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = -.491, p = .692$ ). The results for WRQOL domain scores (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: No significant change in scores from Phase 4 to Phase 6 ( $\beta = -.293, p = .428$ ).
- Stress at work: No significant change in scores from Phase 4 to Phase 6 ( $\beta = .000, p = .998$ ).
- Working conditions: No significant change in scores from Phase 4 to Phase 6 ( $\beta = -.039, p = .864$ ).
- Control at work: No significant change in scores from Phase 4 to Phase 6 ( $\beta = .020, p = .930$ ).
- General well-being: No significant change in scores from Phase 4 to Phase 6 ( $\beta = -.103, p = .788$ ).
- Home-work interface: No significant change in scores from Phase 4 to Phase 6 ( $\beta = -.134, p = .548$ ).

Using regression analysis, the change in the overall WRQOL scores between Phase 5 and Phase 6 of the study was not statistically significant, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = -1.121, p = .075$ ). The results for WRQOL domain scores (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: No significant change in scores from Phase 5 to Phase 6 ( $\beta = .104, p = .574$ ).
- Stress at work: **Significant decrease** in scores from Phase 5 to Phase 6 (lower scores mean higher stress) ( $\beta = -.270, p < .001$ ).
- Working conditions: No significant change in scores from Phase 5 to Phase 6 ( $\beta = -.189, p = .082$ ).
- Control at work: No significant change in scores from Phase 5 to Phase 6 ( $\beta = .016, p = .893$ ).
- General well-being: **Significant decrease** in scores from Phase 5 to Phase 6 ( $\beta = -.579, p = .002$ ).
- Home-work interface: No significant change in scores from Phase 5 to Phase 6 ( $\beta = .108, p = .349$ ).

### 5.3. Burnout Scores by Study Phase and Country

The overall personal burnout, work-related burnout and client-related burnout scores increased from Phase 2 of the study to Phase 6 UK-wide and in each individual country (See Figure 20. – 22.).

Between Phase 3 and Phase 6, overall personal burnout, work-related burnout, and client-related burnout scores increased UK-wide, and in the individual countries of England, Scotland, and Wales, whereas a decrease was observed in all three burnout measures in Northern Ireland.

Between Phase 4 and Phase 6, UK-wide personal, work-related, and client-related burnout increased. In England and Northern Ireland, all three measures of burnout increased whereas Scotland and Wales both showed decreases in personal, and work-related burnout scores. Wales also showed decreases in client-related burnout between phase 4 and phase 6.

Between Phase 5 and Phase 6, UK-wide all three measure of burnout increased. In England and Wales, both personal- and work-related burnout increased whereas client-related slightly decreased. Northern Ireland showed increases in all of the three measures burnout scores. Wales showed

increases in personal, and work-related burnout, and a decrease in client-related burnout between phase 5 and phase 6.

Figure 20. Personal Burnout Score by Study phase and Country (All Phases)

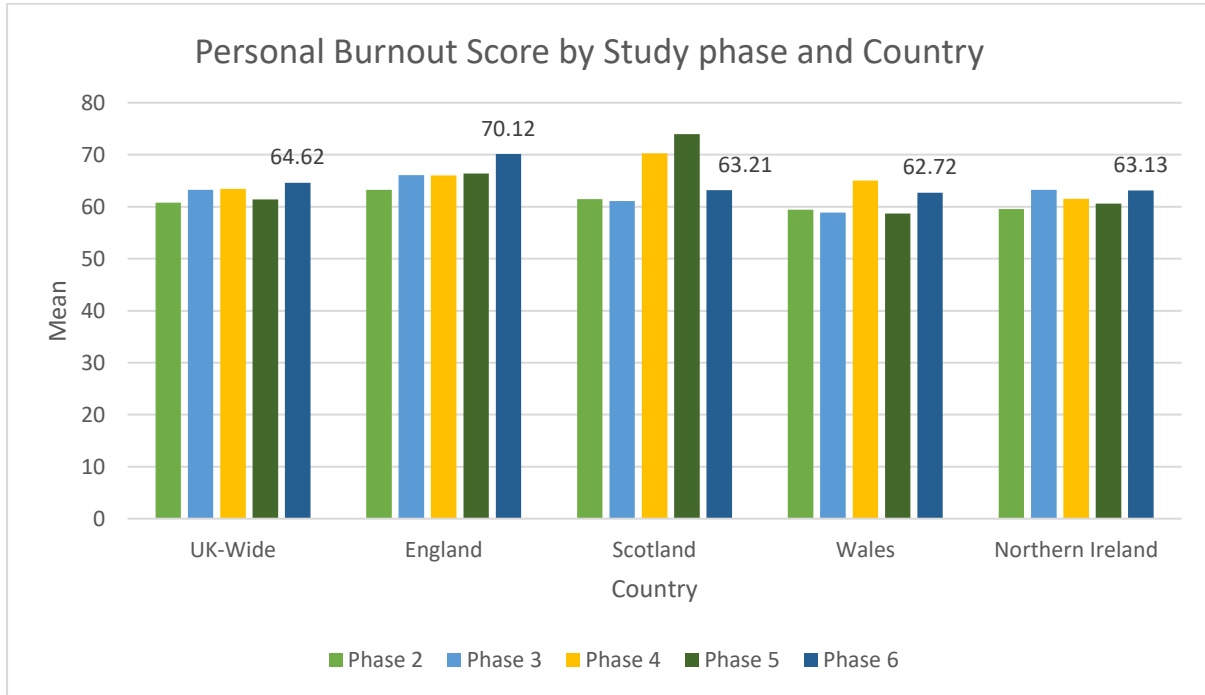


Figure 21. Work-related Burnout Score by Study phase and Country (All Phases)

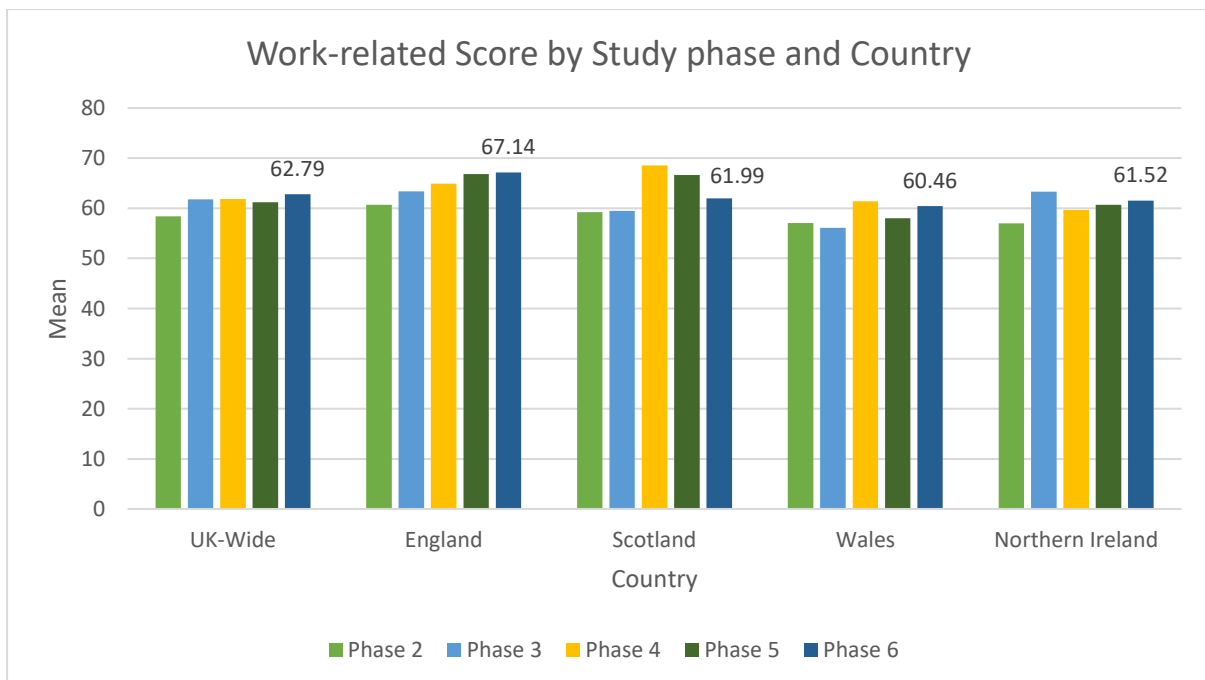
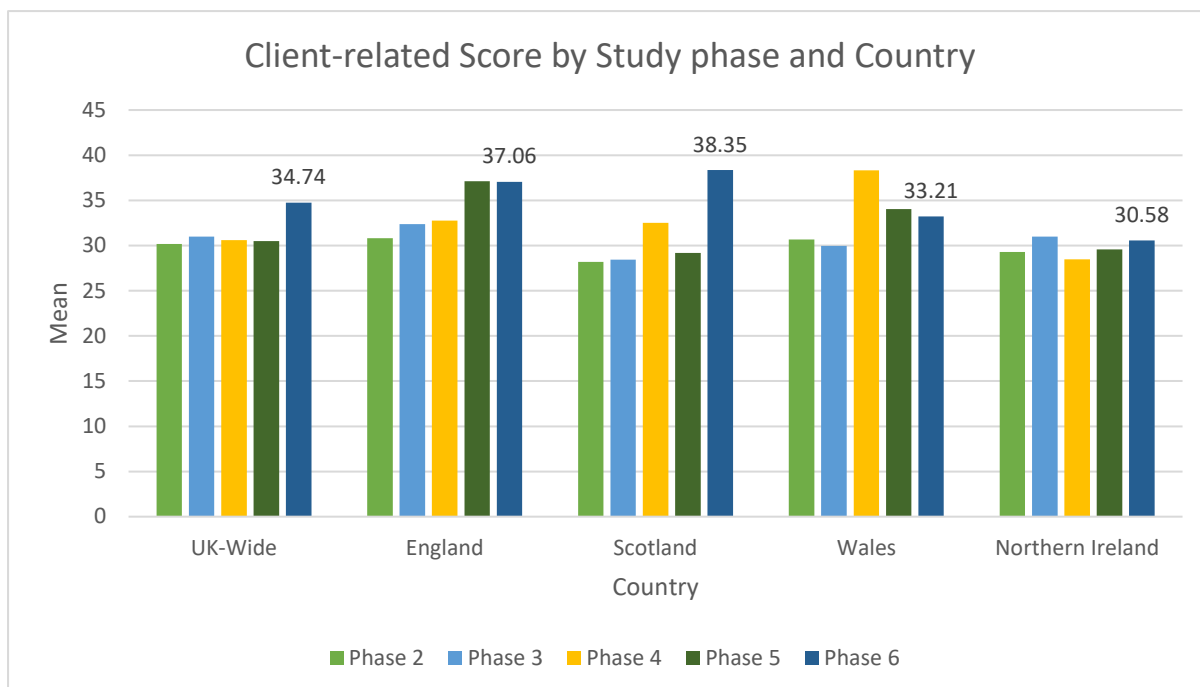


Figure 22. Client-related Burnout Score by Study phase and Country (All Phases)



Note: Low or no client burnout are scores from 0 to 49; moderate burnout is 50-74; high burnout is 75 to 99. Severe burnout is 100. Mean scores of clients related burnout, therefore remained in the low or no burnout range across all phases. However, it does show an increase in Phase 6 UK wide, England, Scotland, and Northern Ireland, with a decrease in Wales. Mean scores of personal and work-related burnout, remain in the moderate category though all Phases across countries.

Multiple regression analysis revealed that there was a **significant increase** in personal burnout from Phase 2 to Phase 6, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 4.303, p < .001$ ). There was also a **significant increase** in work-related burnout ( $\beta = 4.192, p < .001$ ) and a **significant increase** in client-related burnout ( $\beta = 5.153, p < .001$ ) from Phase 2 to Phase 6, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Multiple regression analysis revealed that there was no significant difference in personal burnout from Phase 3 to Phase 6, after accounting for respondents' country of work, occupational group, sex, age, ethnicity, and disability status ( $\beta = 1.656, p = .184$ ). There was also no significant difference in work-related burnout ( $\beta = .972, p = .456$ ). However, there was a **significant increase** in client-related burnout ( $\beta = 3.461, p = .015$ ) from Phase 3 to Phase 6 after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Multiple regression analysis revealed that there was no significant difference in personal burnout from Phase 4 to Phase 6, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 1.386, p = .376$ ). There was also no significant difference in work-related burnout ( $\beta = 1.172, p = .474$ ) or client-related burnout ( $\beta = 3.475, p = .055$ ) from Phase 4 to Phase 6 even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Multiple regression analysis revealed that there was a **significant increase** in personal burnout from Phase 5 to Phase 6, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 1.583, p = .043$ ). There was also a **significant increase** in work-related burnout ( $\beta = 2.372, p = .005$ ) and also in client-related burnout ( $\beta = 2.406, p = .007$ ) from Phase 5 to Phase 6 even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

#### 5.4. Carver Coping Scores by Study Phase and Country

UK-wide there was a significant decrease in the use of all positive coping strategies except for Instrumental Support where no significant difference was found. Additionally, an increase in the use of negative coping strategies such as Venting, Behavioural disengagement, and Self-blame from Phase 1 of the study to Phase 6 (See Figure 23. & Table 4.4.1.)

*UK-wide analysis:* Using regression analysis, the differences between Phase 1 and Phase 6 of the study on the different Carver coping strategies (accounting for the effects of country of work, sex, age, ethnicity and disability status) were as follows:

- Active coping: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -.841, p < .001$ ).
- Planning: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -.548, p < .001$ ).
- Positive reframing: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -.895, p < .001$ ).
- Acceptance: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -.783, p < .001$ ).
- Use of emotional support: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -.390, p < .001$ ).
- Use of instrumental support: No significant difference in scores from Phase 1 to Phase 6 ( $\beta = -.110, p = .313$ ).
- Venting: **Significant increase** in scores from Phase 1 to Phase 6 ( $\beta = .656, p < .001$ ).
- Substance use: No significant change in scores from Phase 1 to Phase 6 ( $\beta = .081, p = .380$ ).

- Behavioural disengagement: **Significant increase** in scores from Phase 1 to Phase 6 ( $\beta = .573$ ,  $p < .001$ ).
- Self-blame: **Significant increase** in scores from Phase 1 to Phase 6 ( $\beta = .914$ ,  $p < .001$ ).

UK-wide there was a significant decrease in the use of Active Coping, Positive Reframing, Acceptance, and Emotional Support coping strategies and a significant increase in the use of negative coping strategies such as Behavioural Disengagement, and Self-blame from Phase 2 of the study to Phase 6.

*UK-wide analysis:* Using regression analysis, the differences between Phase 2 and Phase 6 of the study on the different Carver coping strategies (accounting for the effects of country of work, sex, age, ethnicity and disability status) were as follows:

- Active coping: **Significant decrease** in scores from Phase 2 to Phase 6 ( $\beta = -.269$ ,  $p = .011$ ).
- Planning: No significant difference in scores from Phase 2 to Phase 6 ( $\beta = -.194$ ,  $p = .091$ ).
- Positive reframing: **Significant decrease** in scores from Phase 2 to Phase 6 ( $\beta = -.590$ ,  $p < .001$ ).
- Acceptance: **Significant decrease** in scores from Phase 2 to Phase 6 ( $\beta = -.488$ ,  $p < .001$ ).
- Use of emotional support: **Significant decrease** in scores from Phase 2 to Phase 6 ( $\beta = -.278$ ,  $p = .009$ ).
- Use of instrumental support: No significant difference in scores from Phase 2 to Phase 6 ( $\beta = -.166$ ,  $p = .119$ ).
- Venting: No significant change in scores from Phase 2 to Phase 6 ( $\beta = -.021$ ,  $p = .838$ ).
- Substance use: No significant change in scores from Phase 2 to Phase 6 ( $\beta = -.074$ ,  $p = .448$ ).
- Behavioural disengagement: **Significant increase** in scores from Phase 2 to Phase 6 ( $\beta = .303$ ,  $p < .001$ ).
- Self-blame: **Significant increase** in scores from Phase 2 to Phase 6 ( $\beta = .299$ ,  $p = .009$ ).

UK-wide there was a significant decrease in the use of most positive coping strategies and no significant change in the use of negative coping strategies from Phase 3 of the study to Phase 6.

*UK-wide analysis:* Using regression analysis, the differences between Phase 3 and Phase 6 of the study on the different Carver coping strategies (accounting for the effects of country of work, sex, age, ethnicity and disability status) were as follows:

- Active coping: **Significant decrease** in scores between Phase 3 and Phase 6 ( $\beta = -.242$ ,  $p = .030$ ).
- Planning: No significant difference in scores between Phase 3 and Phase 6 ( $\beta = -.214$ ,  $p = .065$ ).

- Positive reframing: **Significant decrease** in scores from Phase 3 to Phase 6 ( $\beta = -.404, p < .001$ ).
- Acceptance: **Significant decrease** in scores between Phase 3 and Phase 6 ( $\beta = -.258, p < .001$ ).
- Use of emotional support: **Significant decrease** in scores from Phase 3 to Phase 6 ( $\beta = -.217, p = .048$ ).
- Use of instrumental support: No significant change in scores between Phase 3 and Phase 6 ( $\beta = -.044, p = .683$ ).
- Venting: No significant change in scores between Phase 3 and Phase 6 ( $\beta = -.117, p = .291$ ).
- Substance use: No significant change in scores between Phase 3 and Phase 6 ( $\beta = -.160, p = .132$ ).
- Behavioural disengagement: No significant change in scores between Phase 3 and Phase 6 ( $\beta = .145, p = .135$ ).
- Self-blame: No significant change in scores between Phase 3 and Phase 6 ( $\beta = -.041, p = .742$ ).

UK-wide there was no significant change in the use of coping strategies from Phase 4 of the study to Phase 6.

*UK-wide analysis:* Using regression analysis, the differences between Phase 4 and Phase 6 of the study on the different Carver coping strategies (accounting for the effects of country of work, sex, age, ethnicity and disability status) were as follows:

- Active coping: No significant change in scores between Phase 4 and Phase 6 ( $\beta = -.051, p = .714$ ).
- Planning: No significant change in scores between Phase 4 and Phase 6 ( $\beta = -.062, p = .674$ ).
- Positive reframing: No significant change in scores between Phase 4 and Phase 6 ( $\beta = -.107, p = .424$ ).
- Acceptance: No significant change in scores between Phase 4 and Phase 6 ( $\beta = -.157, p = .210$ ).
- Use of emotional support: No significant change in scores between Phase 4 and Phase 6 ( $\beta = .016, p = .905$ ).
- Use of instrumental support: No significant change in scores between Phase 4 and Phase 6 ( $\beta = .035, p = .796$ ).
- Venting: No significant change in scores between Phase 4 and Phase 6 ( $\beta = -.043, p = .748$ ).
- Substance use: No significant change in scores between Phase 4 and Phase 6 ( $\beta = .133, p = .278$ ).
- Behavioural disengagement: No significant change in scores between Phase 4 and Phase 6 ( $\beta = .076, p = .535$ ).

- Self-blame: No significant change in scores between Phase 4 and Phase 6 ( $\beta = .087$ ,  $p = .573$ ).

UK-wide there was a significant decrease in the use of some positive coping strategies and no significant change in the use of negative coping strategies from Phase 5 of the study to Phase 6.

*UK-wide analysis:* Using regression analysis, the differences between Phase 5 and Phase 6 of the study on the different Carver coping strategies (accounting for the effects of country of work, sex, age, ethnicity and disability status) were as follows:

- Active coping: No significant change in scores between Phase 5 and Phase 6 ( $\beta = -.107$ ,  $p = .123$ ).
- Planning: No significant change in scores between Phase 5 and Phase 6 ( $\beta = -.096$ ,  $p = .191$ ).
- Positive reframing: **Significant decrease** in scores between Phase 5 and Phase 6 ( $\beta = -.199$ ,  $p = .004$ ).
- Acceptance: **Significant decrease** in scores between Phase 5 and Phase 6 ( $\beta = -.255$ ,  $p < .001$ ).
- Use of emotional support: No significant change in scores between Phase 5 and Phase 6 ( $\beta = -.026$ ,  $p = .718$ ).
- Use of instrumental support: No significant change in scores between Phase 5 and Phase 6 ( $\beta = -.029$ ,  $p = .681$ ).
- Venting: No significant change in scores between Phase 5 and Phase 6 ( $\beta = .068$ ,  $p = .319$ ).
- Substance use: No significant change in scores between Phase 5 and Phase 6 ( $\beta = -.017$ ,  $p = .775$ ).
- Behavioural disengagement: No significant change in scores between Phase 5 and Phase 6 ( $\beta = .069$ ,  $p = .240$ ).
- Self-blame: No significant change in scores between Phase 5 and Phase 6 ( $\beta = -.027$ ,  $p = .719$ ).



Figure 23. Mean Carver Coping Scores by Study Phase UK-wide (All Phases)

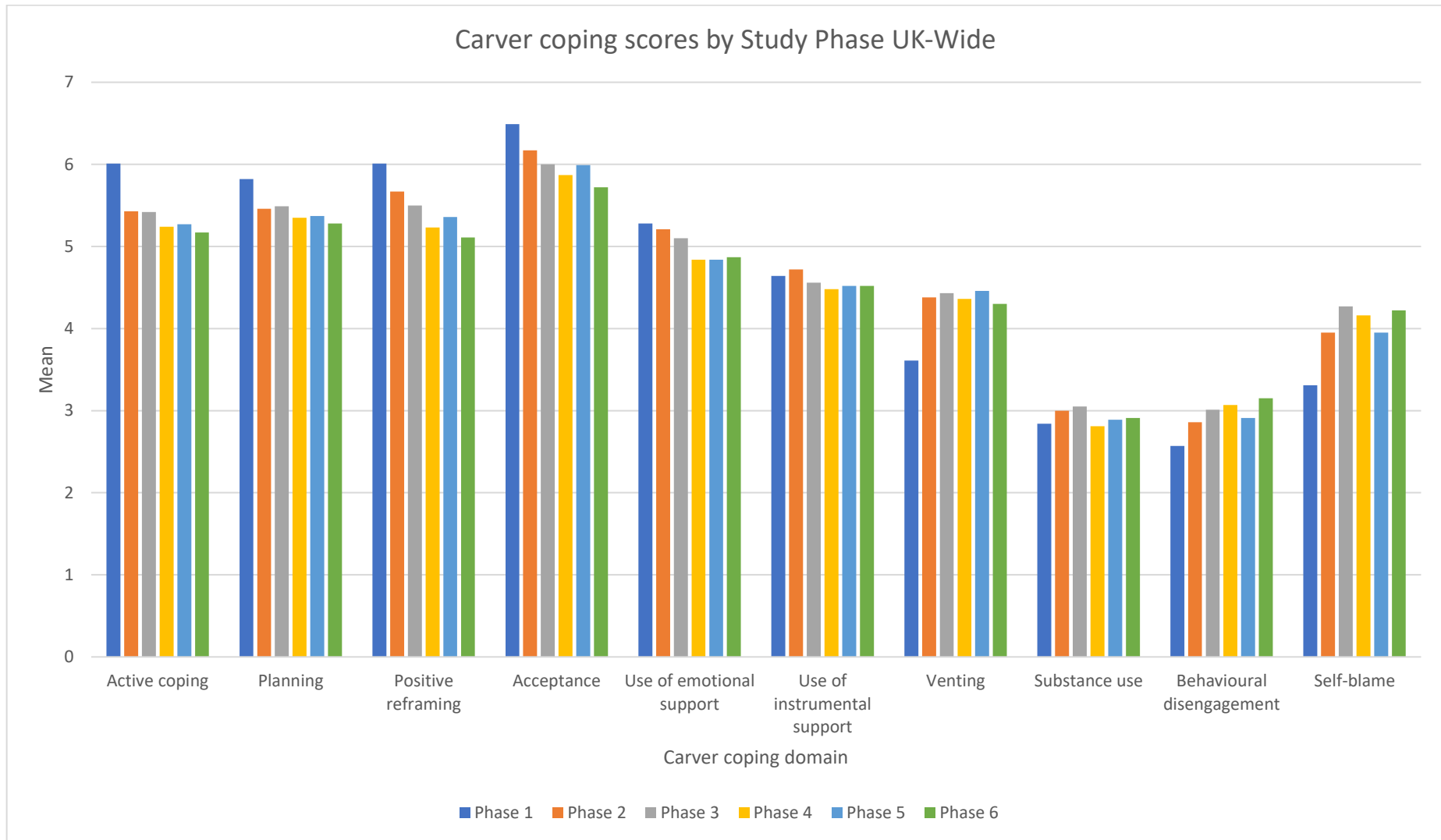


Table 4.3.1.: Mean Carver Coping Scores by Study Phase and Country (All Phases)

Study phase	Country				
Coping domain	UK-Wide	England	Scotland	Wales	Northern Ireland
<b>Phase 1</b>					
Active coping	6.01	5.89	5.42	5.92	6.22
Planning	5.82	5.74	5.50	5.76	5.94
Positive reframing	6.01	5.92	5.46	5.96	6.18
Acceptance	6.49	6.48	6.00	6.24	6.62
Use of emotional support	5.28	5.32	4.85	4.41	5.30
Use of instrumental support	4.64	4.64	4.19	4.63	4.70
Venting	3.61	3.52	3.85	3.94	3.67
Substance use	2.84	2.83	2.92	3.02	2.79
Behavioural disengagement	2.57	2.61	2.38	2.69	2.54
Self-blame	3.31	3.33	3.65	3.37	3.29
<b>Phase 2</b>					
Active coping	5.43	5.33	5.35	5.44	5.56
Planning	5.46	5.45	5.30	5.40	5.56
Positive reframing	5.67	5.59	5.40	5.65	5.89
Acceptance	6.17	6.21	6.16	6.10	6.23
Use of emotional support	5.21	5.28	5.05	5.25	5.09
Use of instrumental support	4.72	4.80	4.49	4.67	4.70
Venting	4.38	4.46	4.14	4.32	4.41
Substance use	3.00	3.10	3.09	2.97	2.86
Behavioural disengagement	2.86	2.98	2.75	2.89	2.70
Self-blame	3.95	4.10	4.07	3.87	3.85
<b>Phase 3</b>					
Active coping	5.42	5.34	5.69	5.68	5.34
Planning	5.49	5.44	5.67	5.73	5.43
Positive reframing	5.50	5.38	5.73	5.54	5.53
Acceptance	6.00	5.87	6.29	6.08	6.00
Use of emotional support	5.10	5.07	5.16	5.04	5.09
Use of instrumental support	4.56	4.53	4.45	4.56	4.61
Venting	4.43	4.53	4.33	4.04	4.49
Substance use	3.05	3.05	3.15	3.05	3.03
Behavioural disengagement	3.01	3.17	3.12	2.66	2.96
Self-blame	4.27	4.58	4.52	3.81	4.08
<b>Phase 4</b>					
Active coping	5.24	5.05	5.27	5.00	5.39
Planning	5.35	5.36	5.53	5.30	5.34
Positive reframing	5.23	5.15	5.40	4.20	5.37
Acceptance	5.87	5.75	5.40	5.20	6.01
Use of emotional support	4.84	4.70	4.73	4.50	4.93
Use of instrumental support	4.48	4.36	4.53	4.00	4.57
Venting	4.36	4.42	4.67	4.10	4.29
Substance use	2.81	2.67	3.40	2.70	2.82
Behavioural disengagement	3.07	3.16	3.60	3.40	2.93
Self-blame	4.16	4.34	4.40	4.40	3.98

Phase 5					
Active coping	5.27	5.38	5.42	5.08	5.26
Planning	5.37	5.22	4.83	5.25	5.43
Positive reframing	5.36	4.94	5.25	5.17	5.43
Acceptance	5.99	5.94	5.17	5.83	6.05
Use of emotional support	4.84	4.75	5.00	5.33	4.81
Use of instrumental support	4.52	4.31	4.25	5.17	4.53
Venting	4.46	4.19	4.25	4.67	4.49
Substance use	2.89	2.88	3.67	2.83	2.85
Behavioural disengagement	2.91	3.16	3.00	3.17	2.87
Self-blame	3.95	4.31	4.83	4.17	3.85
Phase 6					
Active coping	5.17	5.20	4.96	5.11	5.25
Planning	5.28	5.26	5.20	5.04	5.39
Positive reframing	5.11	5.04	5.36	4.89	5.15
Acceptance	5.72	5.38	5.89	5.88	5.82
Use of emotional support	4.87	4.72	5.07	4.86	4.93
Use of instrumental support	4.52	4.17	4.64	4.34	4.76
Venting	4.30	4.18	4.32	4.14	4.42
Substance use	2.91	3.08	2.93	2.64	2.90
Behavioural disengagement	3.15	3.24	3.02	2.98	3.21
Self-blame	4.22	4.56	4.27	3.89	4.09

### 5.5. Clark Coping Scores by Study Phase and Country

There was a decrease in four out of the five Clark et al.'s coping strategies from Phase 1 of the study to Phase 6 UK-wide (See Figure 24. & Table 4.5.1.).

*UK-wide analysis:* Using regression analysis, the differences between Phase 1 and Phase 6 of the study on the different Clark coping strategies (accounting for the effects of country of work, sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: No significant difference in scores from Phase 1 to Phase 6 ( $\beta = .039, p < .487$ ).
- Work-family segmentation: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -.251, p < .001$ ).
- Working to improve skills/efficiency: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -.271, p < .001$ ).
- Recreation and relaxation: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -.382, p < .001$ ).
- Exercise: **Significant decrease** in scores from Phase 1 to Phase 6 ( $\beta = -.602, p < .001$ ).

There was a significant decrease in the use of Exercise from Phase 2 of the study to Phase 6 UK-wide.

*UK-wide analysis:* Using regression analysis, the differences between Phase 2 and Phase 6 of the study on the different Clark coping strategies (accounting for the effects of country of work sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: No significant change in scores from Phase 2 to Phase 6 ( $\beta = -.012$ ,  $p = .823$ ).
- Work-family segmentation: No significant change in scores from Phase 2 to Phase 6 ( $\beta = -.079$ ,  $p = .250$ ).
- Working to improve skills/efficiency: No significant change in scores from Phase 2 to Phase 6 ( $\beta = -.102$ ,  $p = .123$ ).
- Recreation and relaxation: No significant change in scores from Phase 2 to Phase 6 ( $\beta = -.126$ ,  $p = .102$ ).
- Exercise: **Significant decrease** in scores from Phase 2 to Phase 6 ( $\beta = -.329$ ,  $p < .001$ ).

There was a significant decrease in the use of Exercise from Phase 3 of the study to Phase 6 UK-wide.

*UK-wide analysis:* Using regression analysis, the differences between Phase 3 and Phase 6 of the study on the different Clark coping strategies (accounting for the effects of country of work, sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: No significant change in scores between Phase 3 and Phase 6 ( $\beta = -.030$ ,  $p = .603$ ).
- Work-family segmentation: No significant change in scores between Phase 3 and Phase 6 ( $\beta = -.081$ ,  $p = .259$ ).
- Working to improve skills/efficiency: No significant change in scores between Phase 3 and Phase 6 ( $\beta = -.107$ ,  $p = .118$ ).
- Recreation and relaxation: No significant change in scores between Phase 3 and Phase 6 ( $\beta = -.115$ ,  $p = .149$ ).
- Exercise: **Significant decrease** in scores between Phase 3 and Phase 6 ( $\beta = -.379$ ,  $p < .001$ ).

There were no significant differences found in Clark et al.'s coping strategies from Phase 4 of the study to Phase 6 UK-wide.

*UK-wide analysis:* Using regression analysis, the differences between Phase 4 and Phase 6 of the study on the different Clark coping strategies (accounting for the effects of country of work, sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: No significant change in scores between Phase 4 and Phase 6 ( $\beta = .141, p = .071$ ).
- Work-family segmentation: No significant change in scores between Phase 4 and Phase 6 ( $\beta = -.062, p = .501$ ).
- Working to improve skills/efficiency: No significant change in scores between Phase 4 and Phase 6 ( $\beta = -.049, p = .567$ ).
- Recreation and relaxation: No significant change in scores between Phase 4 and Phase 6 ( $\beta = -.058, p = .562$ ).
- Exercise: No significant change in scores between Phase 4 and Phase 6 ( $\beta = -.191, p = .116$ ).

There was a significant decrease in the use of Exercise from Phase 5 of the study to Phase 6 UK-wide.

*UK-wide analysis:* Using regression analysis, the differences between Phase 5 and Phase 6 of the study on the different Clark coping strategies (accounting for the effects of country of work, sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: No significant change in scores between Phase 5 and Phase 6 ( $\beta = -.028, p = .435$ ).
- Work-family segmentation: No significant change in scores between Phase 5 and Phase 6 ( $\beta = -.057, p = .214$ ).
- Working to improve skills/efficiency: No significant change in scores between Phase 5 and Phase 6 ( $\beta = -.041, p = .376$ ).
- Recreation and relaxation: No significant change in scores between Phase 5 and Phase 6 ( $\beta = .038, p = .458$ ).
- Exercise: **Significant decrease** in scores between Phase 5 and Phase 6 ( $\beta = -.153, p = .009$ ).

Figure 24. Mean Clark Coping Scores by Study Phase UK-wide (All Phases)

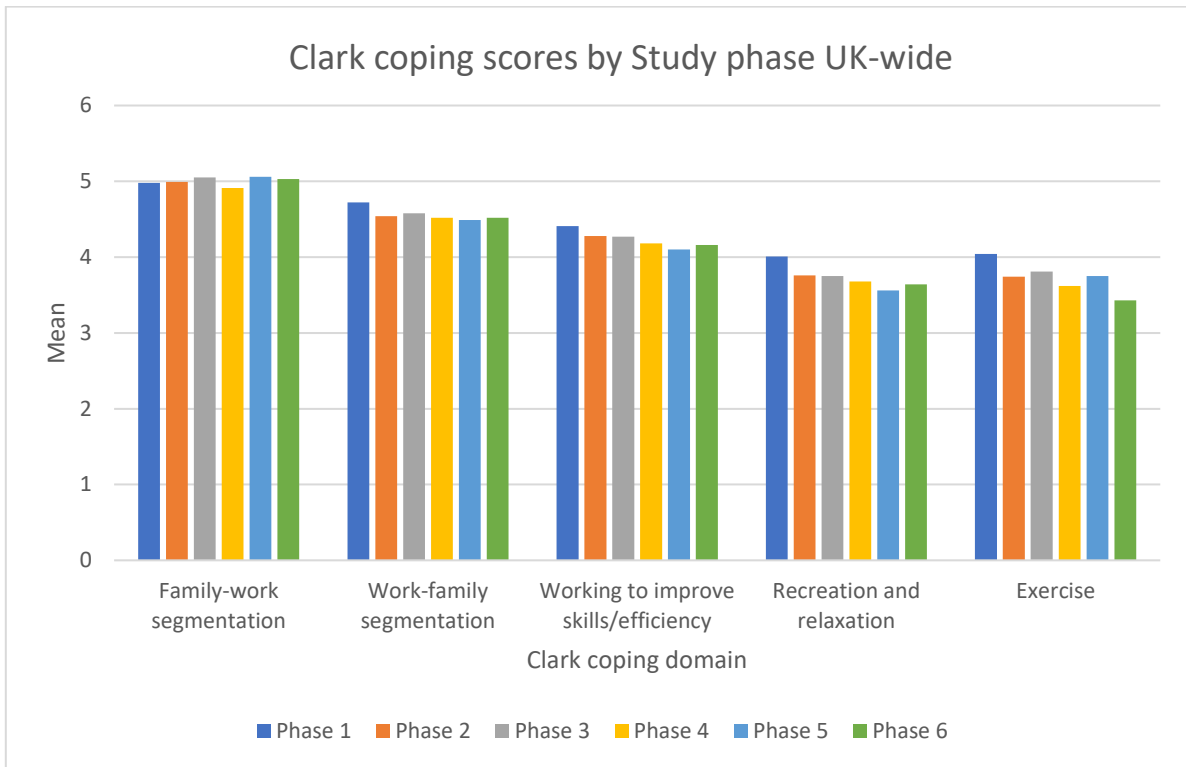


Table 4.4.1.: Mean Clark Coping Scores by Study Phase and Country (All Phases)

Study phase	Country				
Coping domain	UK-Wide	England	Scotland	Wales	Northern Ireland
<b>Phase 1</b>					
Family-work segmentation	4.98	4.96	4.94	4.79	5.01
Work-family segmentation	4.72	4.75	4.78	4.73	4.66
Working to improve skills/efficiency	4.41	4.37	4.36	4.24	4.47
Recreation and relaxation	4.01	4.05	3.89	4.18	3.95
Exercise	4.04	4.00	3.79	4.04	4.10
<b>Phase 2</b>					
Family-work segmentation	4.99	4.98	5.22	4.87	5.08
Work-family segmentation	4.54	4.49	4.56	4.58	4.57
Working to improve skills/efficiency	4.28	4.28	4.11	4.33	4.28
Recreation and relaxation	3.76	3.75	3.28	3.78	3.86
Exercise	3.74	3.66	3.86	3.77	3.81
<b>Phase 3</b>					
Family-work segmentation	5.05	4.91	5.14	5.09	5.11
Work-family segmentation	4.58	4.43	4.69	4.86	4.59
Working to improve skills/efficiency	4.27	4.24	4.20	4.54	4.27
Recreation and relaxation	3.75	3.68	3.77	3.90	3.75
Exercise	3.81	3.81	3.73	3.62	3.90
<b>Phase 4</b>					
Family-work segmentation	4.91	4.88	5.02	4.67	4.93
Work-family segmentation	4.52	4.51	4.58	4.43	4.53
Working to improve skills/efficiency	4.18	4.22	4.13	4.20	4.15
Recreation and relaxation	3.68	3.67	3.40	3.60	3.69
Exercise	3.62	3.38	3.24	3.70	3.80
<b>Phase 5</b>					
Family-work segmentation	5.06	4.97	5.14	4.69	5.08
Work-family segmentation	4.49	4.23	4.53	4.39	4.52
Working to improve skills/efficiency	4.10	4.13	4.03	3.92	4.11
Recreation and relaxation	3.56	3.66	3.56	3.44	3.55
Exercise	3.75	3.60	3.17	3.97	3.77
<b>Phase 6</b>					
Family-work segmentation	5.03	4.94	5.15	4.79	5.14
Work-family segmentation	4.52	4.21	4.76	4.66	4.60
Working to improve skills/efficiency	4.16	4.12	4.31	4.25	4.13
Recreation and relaxation	3.64	3.53	3.76	3.72	3.66
Exercise	3.43	3.11	3.66	3.45	3.55

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