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Literature Scan: Staff Wellbeing in Crisis Support

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About the Help through Crisis programme

Help through Crisis is a £33 million National Lottery funded programme set up by the National Lottery Community Fund, the largest funder of community activity in the UK. It supports 69 partnerships across England which help people who are experiencing or at risk of hardship crisis to overcome the difficulties they are facing to plan for their futures. The partnerships receiving National Lottery funding through the Help through Crisis programme bring together small voluntary groups and established charities to work together locally. Working together, they offer people advice, advocacy and support which matches their personal circumstances. The aim is to look at the issues people face, and the underlying causes, from their basic needs, to their physical and mental health, to skills and employment. People are supported to draw on their personal experiences to build on their skills and strengths so they are ready to seize the opportunities and challenges ahead.

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Abstract

The purpose of this literature scan is to identify the impact crisis support work has on staff wellbeing, including their mental health, as described in the research literature. Specifically, this scan has focused on identifying evidence of recent trends in staff wellbeing in the sector, the impact of staff wellbeing on the people using services, and examples of good practice in tackling staff burnout.

Several themes emerge from the literature that are of relevance to Help through Crisis (HtC). Firstly, in the context of crisis support, workers are at a higher risk of developing burnout (which involves emotional exhaustion, detachment and low job satisfaction) as well as vicarious trauma. Secondly, reduced staff wellbeing compromises the provision of quality care and effective support for people using services. This can delay recovery periods or fail to resolve people's crises, which in turn can lead to reoccurrence of crisis.

The literature scan briefly explores effective strategies for preventing and dealing with vicarious trauma and staff burnout. It has found the best strategies and approaches are those that are directed at both an individual and organisational level. A focus on providing coping skills for individuals coupled with changes to organisational structures are seen as critical in addressing challenges to staff wellbeing in the literature. Examples include providing adequate resources for workload, quality supervision, increased autonomy, shared power and appropriate support from management and co-workers.

This literature scan is intended to be used internally within the Learning, Support and Evaluation team, with the aim to support the development of policy commentaries and wider resources for HtC. Whilst its primary use is for internal use for the Learning, Support and Evaluation team, this literature scan is also intended to provide learning that can be shared with HtC partnerships.

Literature Scan: Staff Wellbeing in Crisis Support

Scope

The purpose of this literature scan is to gain a better understanding of the impact that crisis support work has on staff wellbeing, including their mental health. The literature scan outlines the key research findings relating to crisis intervention work and staff mental and physical wellbeing. As part of this, we have highlighted examples of good practice in tackling the challenges surrounding burnout for those working in hardship crisis.

The following research questions are addressed:

1) What are the recent trends around staff wellbeing for those working in hardship crisis support?
2) In what ways do staff support issues affect the support received by people using the service?
3) What examples of good practice exist that tackle challenges around staff wellbeing and burnout for those working in hardship crisis support?

Definitions

For the purposes of this review, we are using the terms 'hardship crisis work', 'front-line work' and 'crisis intervention work' interchangeably. Crisis intervention workers are those who meet and assist individuals in crisis situations and aim to reduce the chance of recurring crisis. The wider literature suggests the events which trigger crisis are varied and include suicide, homicide, intimate partner violence, sexual assault and abuse, bereavement and grief, substance abuse, natural disaster, war, terrorism, school shooting as well as migration and refugee crisis (Jackson-Cherry et al., 2010). In the context of the HtC programme, wider triggers may also include mental health problems, homelessness or housing upheavals. As such, a crisis intervention worker could include a wide variety of roles from blue light emergency personnel such as firefighters, paramedics, police officers, to Accident and Emergency (A&E) nurses, trauma counsellors, domestic violence workers, social workers and immigration support workers.

Recent trends in staff wellbeing: burnout and vicarious trauma

In recent years there has been a growing recognition of the importance of employee wellbeing, including the drivers of wellbeing in the workplace, and the links between wellbeing and workplace performance. This follows significant research exploring these issues, such as the Foresight Mental Capital and Wellbeing Project (2008). This project emphasises the importance of promoting wellbeing in the workplace as part of a wider drive towards societal prosperity and wellbeing. Wellbeing encompasses mental and physical health, as well as wider social wellbeing. This section focuses on aspects of mental wellbeing, in particular burnout and vicarious trauma as key factors in employee wellbeing.

There is evidence showing there is rising concern about mental health problems at work. For example, one study by the Mental Health Foundation (2017) shows that around 15% of people experience mental health problems at work in the UK. It is also estimated that 300,000 people with long-term mental health problems will lose their jobs each year (Farmer and Stevenson, 2017). The impact of mental health problems carries a high cost for society as a whole. Evidence shows that 70 million days are lost from work each year due to mental ill-health, making it the leading cause of sickness absence in the UK (Mental Health Foundation, 2017).

Although many people at work are experiencing mental health problems, there are two key themes that characterise the causes of mental health problems for those working in crisis intervention:

1. The excessive workload which may lead to higher levels of burnout and compassion fatigue
2. The challenging, often traumatic and distressing contexts they work in leading to trauma.[1] Trauma is broadly defined as events or circumstances that are experienced as harmful or life-threatening, with enduring impacts on physical, emotional, mental and/or social wellbeing (SAMHSA, 2014).

This literature review focuses on burnout and vicarious trauma, which involves stress, exhaustion and psychological symptoms that mimic post-traumatic stress disorder (PTSD)-like symptoms (Baird and Kracen, 2006), and the impact both have on staff wellbeing. PTSD is an anxiety disorder caused by very stressful, distressing and/or frightening events (NHS, 2018).

[1] The literature suggests that crisis staff workers such as social workers often support vulnerable and marginalised groups at points of crisis and deal with distressing situations such as lifelong trauma, loss, abuse, creating emotionally charged contexts (Hussein 2018).

Burnout

"Burnout" is defined as a state of being worn out due to excessive demands placed on a professional's personal resources and consists of emotional exhaustion, depersonalisation, and lowered work productivity (Maslach, 1982). It is usually understood as resulting from ongoing stress in the workplace that, over time, results in poor mental health and impairs functioning on the job and in the individual's personal life (Stalker and Harvey, 2002). Evidence shows poor mental health has a negative impact on a person's functioning, which affects their ability to do their job:

> "Functioning at work is about whether the things that employees do in their day-to-day work create positive interactions with their surroundings and helps them to meet their basic psychological needs. It includes whether they feel they can express themselves, use their strengths, and have a sense of control over their work." (Jeffrey et al., 2014, p.33).

The evidence shows that people who achieve good standards of wellbeing at work are less likely to suffer from stress which often leads to more serious mental health problems. Employees are:

> "Likely to be more creative, more loyal, more productive and provide better customer satisfaction than those with poor levels of wellbeing at work." (ibid, p.14).

The New Economics Foundation (NEF) Dynamic Model of Wellbeing in relation to work highlights the different features of wellbeing and the relationships between them (Thompson and Marks, 2008). As Figure 1 demonstrates, there is a link between the external conditions an individual operates within, as well as their personal resources that in turn influence how well they are able to function. Wellbeing is viewed as a complex and dynamic process of internal and external factors which come together to influence how we live our lives.

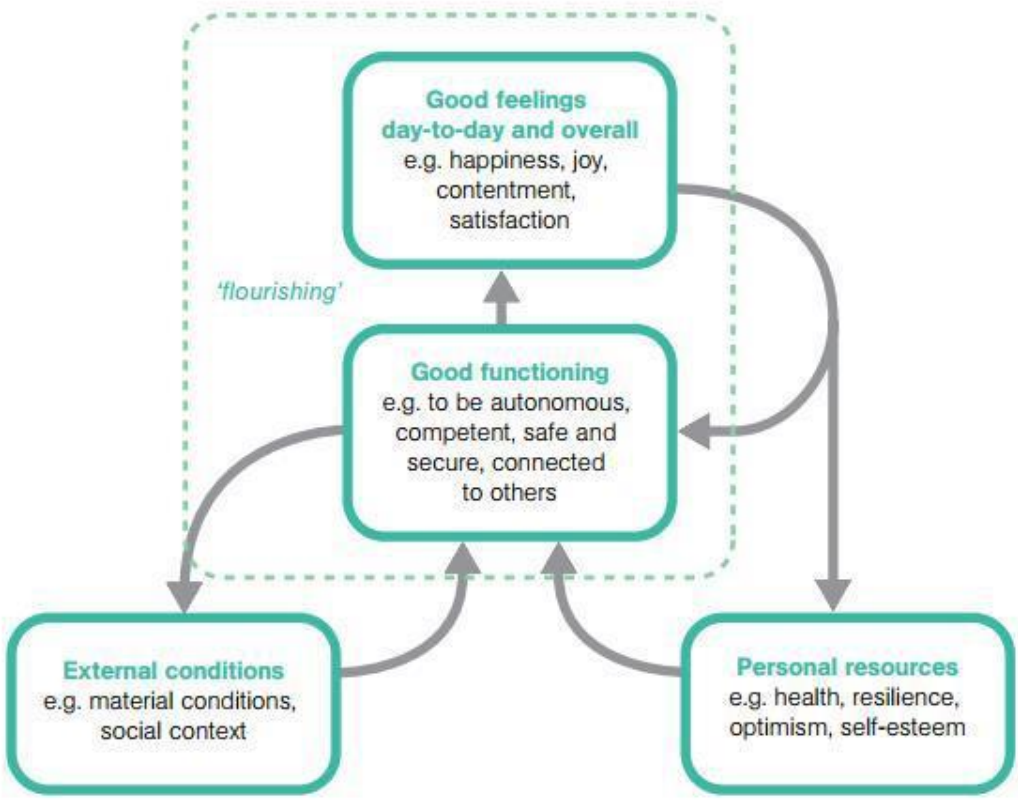

Figure 1: The Dynamic Model of Wellbeing (Jeffrey et al., 2014)

Figure 1 separates the different features of wellbeing, and their relationships to one another. The external conditions experienced by an individual and the personal resources they can draw upon both influence how well a person functions in the world around them. This in turn influences the feelings that an individual experiences and their overall evaluations of life. The feedback loops between these elements work together to create a dynamic system. A person's overall experience of life feeds back into their personal resources, with people who feel competent and connected to others in their workplace or where they live more able to take an active role in influencing their external conditions.

Studies have shown that the causes of job-related burnout can be grouped into three categories – a) personal characteristics, b) job and role characteristics, and c) organisational characteristics.

a) **Personal characteristics:** while there is no conclusive evidence to suggest a link between certain personality attributes and higher levels of burnout, some studies have shown people with less experience in the workplace tend to have a higher expectation of themselves leading to higher burnout. Personal coping mechanisms can also have an impact on one's level of burnout. For example, "active coping strategies", such as talking to a friend, partners or family members are

associated with less depersonalisation[2] and increased personal accomplishment (Leiter and Harvie, 1996 as cited in Stalker and Harvey, 2002). Passive coping strategies such as using alcohol were positively correlated with emotional exhaustion and associated with high depersonalisation and lower personal accomplishment for staff (ibid).

b) **Job-role characteristics** can be further grouped into three categories:

i. Worker-client relationship: some studies have shown that the characteristics of an employee-client relationship are a critical antecedent to burnout (Cordes and Dougherty, 1993; Stalker and Harvey, 2002). Burnout is highly likely in this context when staff are working with people in a distressing and emotionally charged context, "especially with individuals who are suffering, angry, or difficult to help" (Stalker and Harvey, 2002, p.10). This can mean that people working in these environments are more prone to higher instances of burnout (ibid).

ii. Work overload: an increasing number of studies have shown how the level of staff caseloads is associated with a higher level of burnout across a variety of occupations (Cordes and Dougherty, 1993; Lee and Ashforth, 1996; Stalker and Harvey, 2002). For example, studies have shown strong links for mental health workers, between:

"The perception of having too many cases and burnout, between hours of patient contact per week and burnout, and between high levels of time pressure and burnout" (Stalker and Harvey, 2002, p.12).

iii. Role conflict and role ambiguity: role conflict or ambiguity are also associated with higher burnout. This is when there are incompatible or unclear expectations between an employer and employee in a particular role (Cordes and Dougherty, 1993; Stalker and Harvey, 2002).

c) **Organisational characteristics:** studies have shown significant associations between high levels of burnout with low autonomy of workers and high levels of control by management (Epstein and Silvern, 1990, Savicki, 1993, Leiter and Harvie, 1996 as cited in Stalker and Harvey, 2002). For example, one study (O'Driscoll and Schubert, as cited in Stalker and Harvey, 2002) found that social workers reported more emotional exhaustion when there was a perceived lack of support from their organisation. The study found social workers reported more personal accomplishment when they

[2] Depersonalisation in the workplace involves staff shutting themselves off to beneficiaries, or becoming more callous towards them, due to excessive stress (West et al., 2009).

perceived that the "decision process was democratic and that the staff members were involved in decisions influencing their work" (O'Driscoll and Schubert, as cited in Stalker and Harvey, 2002, p.13).

Impact of burnout on staff

Burnout has been associated with a large number of negative conditions affecting different types of employees, their organisations, and the clients they serve. There are several studies on the impact of burnout on health and overall wellbeing, primarily focusing on healthcare professionals such as nurses. These studies show employees who experience burnout often experience impaired emotional and physical health and a diminished sense of wellbeing (Stalker and Harvey, 2002).

Some studies have shown correlations between burnout and aspects of physical and mental health. For example, one study focusing on a sample of service workers in a Swedish city[3] found burnout was associated with increased depression, anxiety, sleep problems, impaired memory, neck and back pain, and alcohol consumption (Peterson et al., 2008). Another study of social workers in New York found that high levels of burnout, particularly emotional exhaustion and depersonalisation, were related to greater reports of flu-like symptoms and symptoms of gastroenteritis (Acker, 2010). Another investigated the relationship between job-related burnout and depressive disorders in 3,276 workers in Finland. (Ahola et al., 2005 as cited in Morse et al., 2012). The study found individuals with mild burnout were 3.3 times more at risk of having major depressive disorder, and those with severe burnout were 15 times more likely to have major depressive disorder (ibid).

Burnout in crisis support staff

Further evidence suggests that staff who work with vulnerable people may be at an increased risk of higher levels of burnout. For example, social workers provide emotional and practical support to vulnerable service users who are likely to suffer from emotional trauma and mental health conditions. The higher level of stress among social workers may be linked to the nature of social work in delivering support in highly emotional contexts (Mänttäri-van der Kuip, 2014 as cited in Hussein, 2018). It is important to note that higher burnout amongst those working with vulnerable people is not necessarily due to the nature of their role alone but coupled with other factors such as the provision of inadequate resources (Stalker and Harvey, 2002). It has been suggested that the causes of burnout and stress among social workers include inadequate staffing, excessive workload, poor leadership, lack of support, lack of opportunity for skills development and negative public image (Bove and Pervan, 2013).

Similarly, crisis intervention workers or front-line workers such as nurses, paramedics, police officers, firefighters and domestic violence workers may also work long hours, be exposed to traumatic events

[3] The sample included nurses, physicians, social workers, occupational therapists, physiotherapists, dentists, dental hygienists, administrators, teachers, and technicians.

and suffer from work related stress. Thus, the primary drivers of burnout for crisis intervention workers can involve structural problems within the workplace.

Vicarious trauma or secondary traumatic stress

There is a growing wealth of evidence showing the psychological effects of traumatic events extend beyond those directly affected (Bride, 2007; Beckerman and Wozniak, 2018). Research shows that people who work with those who have suffered trauma may experience PTSD-like symptoms after frequent exposure to specific trauma through their work and clients (Bride, 2007). This topic will be explored in greater depth in a separate literature scan but is briefly discussed here as important context for staff wellbeing in the crisis support sector.

The observation that caregivers of people who have experienced trauma may themselves become indirect trauma victims is termed vicarious traumatisation, or secondary traumatic stress (Bride and Figley, 2009). Secondary traumatic stress has been defined as:

> "The natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p.7 as cited in Slattery and Goodman, 2009, p.1359).

Some view this as an "occupational hazard of providing direct services to traumatized populations" (Bride, 2007, p.63). Literature on the impact of trauma work among psychotherapists (Pearlman and Mac Ian, 1995; Bober and Regehr, 2006), domestic violence and sexual assault counsellors (Baird and Jenkins, 2003; Wasco and Campbell, 2002 as cited in Slattery and Goodman 2009), social workers (Bride, 2007), emergency medical personnel (Galloucis, Silverman and Francek, 2000 as cited in Slattery and Goodman, 2009), and firefighters (Al-Nasar and Everly, 1999 as cited in Slattery and Goodman, 2009) has shown the potential for burnout and vicarious trauma or secondary traumatic stress when working with groups who have experienced trauma.

This exertion of empathy can gradually or quickly turn to stress, exhaustion, and PTSD-like symptoms. A common PTSD symptom is re-experiencing, in which a person involuntarily and vividly relives the traumatic event through flashbacks, nightmares, repetitive and distressing images or sensations, or physical sensations (i.e., sweating, trembling, feeling sick or in pain); other symptoms include avoidance and emotional numbing, hyperarousal and extreme irritability and self-harming or other destructive behaviour (NHS, 2018). Staff working with people experiencing crisis often hear distressing and challenging stories from their clients. The negative impacts of working with trauma survivors can include a broad range of emotional and behavioural consequences, including intrusive thoughts and disturbing imagery along with negative emotions such as anger, sadness and anxiety corresponding to their clients' traumatic material. McCann and Pearlman's (1990) elaboration of the concept of vicarious traumatisation

in relation to therapists, explained how the therapist may begin to incorporate into their schema painful images, thoughts and feelings associated with exposure to service-users' traumatic memories.

Figley (1995) categorised the effects of working with trauma survivors into three classifications:

a) Indicators of psychological distress or dysfunction which may include distressing emotions, numbing or avoidance of working with traumatic material from the client, sleep disturbances or nightmares, physiological arousal;
b) Cognitive shifts which may include changes in dependence and trust, a heightened sense of vulnerability; and
c) Relational disturbances which may include increased stress or difficulties related to trust and intimacy.

Slattery and Goodman (2009) found the factors that usually contribute to vicarious trauma can be grouped into two categories – a) individual contributors such as an individual's degree of exposure to traumatic experience and b) workplace contributors such as the quality of workplace social support (co-worker cohesion), clinical supervision (quality) and access to power (shared power) within the organisation.

The impact of staff wellbeing on performance and people who use services

Significant workload and stress can also create the conditions for serious mistakes to happen, and have a detrimental effect on beneficiaries.

High levels of burnout signify that workers possess insufficient resources to deal with the demands of their job, leading to impaired job performance at work. Employee burnout has been correlated with a number of negative organisational measures, including reduced commitment to the organisation and repeated absenteeism and turnover (Stalker and Harvey, 2002).

Furthermore, studies have found people who are burnt out often attend work when they are unfit and unwell (Boorman, 2009). Evidence shows that 'presenteeism', which involves staff attending work when they are unfit to do so, is a widespread problem among front-line workers, in particular nurses. In one study, 82% of nurses reported they had gone to work despite being unwell (Royal College of Nursing, 2013). Another report found that 'presenteeism' is greater in those who work long hours and experience managerial pressure to return to work (Boorman, 2009). This emphasises the importance of organisations involved in supporting vulnerable people in high risk situations of promoting steps to ensure good levels

of mental health of staff in recognition that poor mental health affects job performance, and has an adverse impact on beneficiaries' experience and the outcome of the service provided.

Studies have also shown 'presenteeism' can lead to errors being made, that put clients and beneficiaries at risk (West et al., 2006; Gärtner et al., 2010; Garrow, 2016; Farmer and Stevenson, 2017; Mental Health Foundation, 2017). For example in one US study, burnt out junior doctors were significantly more likely to self-report suboptimal patient care (agreeing with the statements "*I did not fully discuss treatment options or answer a patient's questions*" or "*I made . . . errors that were not due to a lack of knowledge or inexperience*") compared with non–burnt out junior doctors (Shanafelt et al., 2002, p.358).

Similarly, studies have shown vicarious trauma, just like burnout, is responsible for a decrease in concern for clients, which often leads to a decline in the quality of client care (Trippany et al., 2004). There is evidence that professionals who are affected by vicarious trauma are at a higher risk of making poor professional judgments than those who are not affected (Bride et al., 2007; Munroe et al., 1995; Pearlman and Mac Ian, 1995; Stamm, 1997 as cited in Bercier and Maynard, 2015).

As a consequence of experiencing vicarious trauma, crisis intervention workers may develop negative coping mechanisms such as victim blaming, detachments in order to dissociate themselves from others and the situation and non-empathic distancing to deal with clients' traumatic experiences (Bercier and Maynard, 2015). This, in turn, may lead to clients feeling emotionally isolated and detached from those workers who are trying to help them (ibid.). Client's treatment by those working to meet their needs may have an impact upon their recovery. When people are affected by trauma, they are vulnerable and require kindness and compassion from those they come into contact with. This is because their treatment may have an impact on their recovery. Evidence from clinical studies shows that anxiety and fear can delay healing in patients (Cole-King and Harding, 2001; Weinman et al., 2008), while good communication with patients contributes positively to wellbeing and hastens recovery (Suchman, 1993; Shuldham, 1999).

Good practice approaches and prevention

Interventions designed to tackle burnout have been conceptualised within three broad categories:

1. Interventions targeting strategies at individual workers
2. Interventions that are designed to change the work environment
3. Interventions that combine both individual and environmental changes (Morse et al., 2012)

Interventions focused on the individual

Most burnout programmes have focused on changing the individual to improve burnout, typically, with the goal of reducing work stress by improving the person's coping skills. Evaluations of individual-level interventions suggest that coping skills programmes are often effective for reducing burnout, especially emotional exhaustion. Some of these programmes also have led to positive physiological results (e.g. lower blood pressure) for employees (Awa et al., 2010 as cited in Morse et al., 2012). For example, providing training in mental health awareness in workplaces is helpful in reducing stigma and also changing people's attitudes about mental health and wellbeing, thus increasing staff confidence in seeking help. An evaluation of the impact of three mental health interventions on attitudes and knowledge towards mental health in fire service managers found that participants showed increased knowledge in relation to how to recognise signs of stress and their attitudes shifted towards "becoming more tolerant, hopeful, compassionate and less judgmental" (Moffitt et al., 2014, p. 110). In addition to this, studies have shown that practices in meditation and mindfulness to reduce stress can improve mood and communication skills (Morse et al., 2012).

However, interventions targeted at individuals have been found to be an unsustainable way of addressing burnout. Some studies have shown that the significant improvements in burnout that accrued from individual-focused interventions often disappeared six to twelve months after the completion of the intervention. Changes are not sustainable unless booster sessions are included in the programme (Awa et al., 2010 as cited in Morse et al., 2012).

Interventions focused on organisations

There is widespread evidence showing organisational factors are a strong predictor of individual burnout. Research shows a number of organisational-environmental factors are related to burnout, including an excessive workload, role conflict, a lack of autonomy among other things (Morse et al., 2012).

Evidence suggests that a number of possible changes in organisational practices may help decrease or prevent burnout, including:

- Increasing social support for employees, especially by teaching communication and social skills to supervisors (Burke and Richardsen, 1993, Halbesleben and Buckley, 2004 as cited in Morse et al., 2012)
- Increasing individual employee autonomy and involvement in decision-making (Burke and Richardsen, 1993 as cited in Morse et al., 2012)
- Reducing role ambiguity and conflicts for employees (Stalker and Harvey, 2002)
- Providing regular supervision, including peer supervision (Morse et al., 2012)
- Decreasing workloads and promoting self-care as a value within the organisational culture (Feingold, 2008 as cited in Morse et al., 2012)

To elaborate on the third bullet point regarding reducing role ambiguity, an organisation can develop "a very clear, explicit, well developed, and uniform ideology on which work in the setting [is] based" (Cherniss, 1993, p. 147 as cited in Stalker and Harvey, 2002) that has been accepted by everyone in the organisation. This, together with regular meetings with supervisors and colleagues to discuss and debrief about work, can reduce role ambiguity. Evidence also shows that one of the defining factors for higher burnout is when workers believe they cannot influence organisational sources of stress (Stalker and Harvey, 2002). Conversely, those who believed that they could affect change in their organisation, and were successful in their efforts to do so, reduced the likelihood of burnout and stress (ibid).

Interventions that focus on the individual and the organisation

A small number of studies have examined interventions that targeted change strategies at both the individual and the organisational level.

A study described interventions targeted at individual workers that were cognitive-behaviourally oriented, which involved modifying staff's thinking and behaviour, and included activities such as assertiveness training (van Dierendonck et al., 1998). Workers were encouraged to look at their situation in a different way and see opportunities for personal growth. This was alongside training about burnout, including the risk factors to burnout and how it applied to their work. In addition, a parallel intervention was introduced for supervisors who were provided with training to improve their communication and social skills (ibid). Results showed that absence, and deprived feelings diminished compared with the study's control groups. The most profound effects were among participants who could draw on social resources, such as support from supervisors and colleagues (ibid).

Meanwhile, studies show that interventions targeted at the organisational level, such as leadership style, perceived support from management, provision of structure and clear expectations about roles, and involvement of staff in decision-making seem to be associated with a reduced incidence of burnout (Stalker and Harvey, 2002). For example, an intervention targeted at the organisational level and found that social workers reported more emotional exhaustion when there was a perceived lack of support from the administration, a belief that the organisational influence process was top down, and workers had little autonomy to influence decision-making (ibid.). In contrast, social workers reported more personal accomplishment when they perceived that the decision-making process was democratic and that staff members were involved in decisions influencing their work (ibid).

Evidence shows both prevention and intervention strategies at the organisational level, in the areas of organisational culture, workload, work environment, education, group support, supervision, and resources for self-care, can be effective (Bell et al., 2003). Furthermore, findings indicate that interventions at the individual level, such as co-worker support and quality clinical supervision, are critical to staff wellbeing and that:

> "An environment in which there is shared power—that is, respect for diversity, mutuality, and consensual decision making—provides better protection for advocates than more traditional, hierarchical organisational models." (Slattery and Goodman, 2009, p.1358)

The same study found shared power was the only workplace variable to significantly predict vicarious trauma above and beyond individual factors (ibid).

Reflections

This literature scan sought to address the following three research questions:

1) What are the recent trends around staff wellbeing for those working in hardship crisis support?
2) In what ways do staff support issues affect the support received by people using the service?
3) What examples of good practice exist that tackle challenges around staff wellbeing and burnout for those working in hardship crisis support?

The literature highlights the relationship between crisis intervention and staff wellbeing, including staff performance and the quality of care provided. It also briefly reviews existing interventions designed to improve staff wellbeing.

The impact of working in hardship crisis support has far-reaching impacts on staff health and overall wellbeing, with a potentially negative impact on both mental and physical health. The literature emphasises the distinctive nature of the crisis intervention role, which involves working in distressing contexts, with people in crisis situations and witnessing or listening to potentially challenging and emotional stories. Consequently, staff may suffer from poor mental and physical health, emotional exhaustion, detachment and low job satisfaction, and are at risk of developing PTSD-like symptoms as a result of vicarious trauma or secondary traumatic stress.

Coupled with inadequate resources and organisational structures, the negative impacts of hardship crisis support work on staff health and overall wellbeing may affect the provision of high-quality, effective care and support for the people using services. The literature describes the impact this may have at an organisational level including absenteeism, staff turnover as well as presenteeism, which may put the people using services at risk. It notes that a person's healing process from trauma is highly dependent not only on the type of treatment they access, but also how they are obtaining this treatment. This can be affected when staff are detached and burnt-out when providing care and support.

Finally, the literature has briefly highlighted a number of interventions designed to tackle challenges around staff wellbeing, burnout and vicarious trauma for those working in hardship crisis support at both individual and organisational levels. Organisational and environmental factors are strong predictors of individual burnout and vicarious trauma, and as such, interventions should aim to change structures

within an organisation to address this. A focus on providing adequate resources for workload, quality supervision, increased autonomy, shared power and appropriate support from management and co-workers were seen as critical in addressing challenges to staff health and wellbeing.

Prioritising staff wellbeing in crisis support is essential, given that crisis support staff are at a higher risk of developing burnout (which involves emotional exhaustion, detachment and low job satisfaction) and vicarious trauma, and that reduced staff wellbeing compromises the provision of quality care for people using services. Lower quality and less effective care for people using services can delay people's recovery or fail to resolve their crises, therefore potentially leading to crisis reoccurrence or intractability.

As such, there are important implications for services delivering HtC. HtC service providers must be aware of how the trauma of those in crisis situations may well become part of the experiences of those working in crisis support, therefore negatively impact their health, wellbeing and service delivery. Two tangible actions that HtC service providers could take to improve staff wellbeing include:

- Training staff on issues around burnout, including the risk factors to burnout, how it applies to their work, and coping mechanisms, as an intervention targeting individuals.
- Ensuring that the organisational culture promotes self-care as a value and provides self-care resources for staff, management and people using services.

Dual-pronged interventions that target both the individual and organisational levels are most likely to promote staff wellbeing. The findings from this literature scan provide a basis to further investigate the relevance and role of a trauma informed approach in frontline crisis support, and how this could benefit both providers and users of HtC services.

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If you have any comments or questions about any of the issues discussed in this literature scan, please get in touch with the Learning, Support and Evaluation team using the email address below, or via the Slack platform.

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