Can Infusing Servant Leadership into Supervision Mitigate Against Employee Burnout?

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Abstract

Purpose: The present conceptual paper sets out to answer the question, can a model of servant leadership be infused within supervision in order to mitigate employee burnout and negative stressful experiences in the health and social care sector?

Design/Approach: A brief targeted review of the literature was undertaken to assess the extent of burnout in the health and social care sectors. The supervision literature was also explored for possible gaps in effectiveness. The outcomes associated with servant leadership were distilled, focusing on employee wellbeing and how these are linked to burnout.

Findings: The literature suggests that burnout and related concepts such as secondary trauma and compassion fatigue impact these professions disproportionately. At the same time, servant leadership is suggested to mitigate some of these factors. The author presents a conceptual model of servant leadership supervision consisting of an ideographic model of servant leadership, Servant Leadership Scale-28 (SLS-28), using the most recent meta-analysis defining this construct, and previously validated measures in the extant literature to inform its design. A Servant Leadership Supervision Scale (SLSS) is also presented aligning its use to several of the core characteristics of servant leadership practice.

Research Implications/Limitations: This conceptual model may help reduce burnout of health and social care sector employees. It is the first articulated servant leadership supervision model specifically put forward to reduce burnout in this population. Limitations are considered in light of the conceptual paper having no primary data.

Practical Implications: A model of servant leadership supervision that can be infused into health and social care supervision.

Introduction

As many as 70% of individuals have experienced at least one traumatic event and 30.5% of individuals have been exposed to four or more such incidence (Benjet et al., 2016). Thus, we can extrapolate that a significant percent of people in the general workforce have emotional support needs. However, the health and social care sectors are characterised by additional high levels of employee burnout globally, with as many as 43% of the

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healthcare work force experiencing these phenomena (Medscape, 2020; Schaufeli, 2018). Infusing Servant Leadership into the supervisory process may be one way to mitigate against some of the negative impacts associated with burnout. Thus, the present paper offers a trans-theoretical model of supervision based on servant leadership, that can be infused into the supervisory approach of those working within clinical and psychosocial roles in health and social care settings. As such, it is considered a professional supervisory approach linked to professional practice across systems of care. Health and social care professions represent a broad and diverse group of practitioners working with those presenting with medical and psychosocial issues. Thus, while professional training is domain specific, there is little consistency in the type of supervision provided within or between each profession. In some instances, a supervisory qualification is required, however, in many cases seniority and practice-based experiences are enough. One method to help prepare supervisors for supervisory roles could be servant leadership, which has been demonstrated as an evidence-based leadership approach (Eva et al., 2020; Lee et al., 2019). However, until very recently there has been inconsistency in its definition, and no supervisory framework currently exists. Thus, the purpose of the present paper is twofold:

➢ Firstly, to articulate a conceptual model of servant leadership based on the latest definitions of this approach and some of the core characteristics within the literature.
➢ Secondly, to offer up a supervisory model of servant leadership that infuses the core characteristics of this approach into its practice in order to potentially mitigate against employee burnout.

Supervision in Health and Social Care

While the roles and tasks of health and social care employees can vary significantly, supervisory processes can be considered more generic in nature. Although numerous definitions exist of supervision in the health and social care literature, with differential priorities, most will share similar themes and functions. Namely, supervision is a learning and development environment, provided by a more senior person of the same or similar profession. Supervision is reflective and developmental, relationship-based, and focuses on the accusation of skills, knowledge, and competencies in order to provide ethically-sound client work, the achievement of organisational goals, and that the supervisees' wellbeing and needs are being considered (Hawkins & Shohet, 2012; Morrison, 2005; Watkins, 2020). Consistent with the above summary of supervision, Proctor (2001), outlined one of the most popular models of supervision, the three functions of supervision: normative (managerial), formative (educational), and restorative (supportive).

Watkins (2020) considers supervision the key signature pedagogies of psychiatry and other related mental health professions. In a Scottish study, Allbutt et al. (2017) argued that there are inconsistencies across the broader health and social care sectors when related to supervision and supervisory practices. Specifically, they suggest that a "lack of professional, organisational or local commitment to implement robust supervisory structures and processes was seen as a major barrier to supervision" (p.1).

In an American context, Evans et al. (2016) make the case that due to a general lack of requirements for counselling supervisors to have specific training in supervisory practices, leadership models should be considered and integrated into supervisory competencies. The benefits of infusing leadership models into counselling supervision are numerous because this is "a cost-effective solution to addressing the lack of formalized training to supervisors in the field" (p.5). Considering that much of the clinical supervision provided

to therapists would be reflective of that within the health and social care sector in general, it would seem conceptually sound to extend this call to these professions also. Thus, the present paper seeks to do just that.

Defining Servant Leadership

Servant leadership is a leadership approach articulated by Robert Greenleaf...a paradoxical approach, serving to lead. Greenleaf (1970) posits that:

> *The Servant-Leader is servant first. ...It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead. ...The best test, and difficult to administer is this: Do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, and more likely themselves to become servants? And, what is the effect on the least privileged in society? Will they benefit, or at least not further be harmed?* (p.7).

Although there has been a proliferation of servant leadership theories in the literature, they all converge and share similar ideas, behaviours, and characteristics. Servant leadership has service as a first priority, focuses on listening to employees, self-awareness in the leader, and considers how to think about others, situations, and organisations. It is this moral (Lemoine, et al., 2019) and ethical (Hartnell et al., 2020) position, that is focused on others, and characterised by trust, fairness, and high-quality relationships (Lee et al., 2019), that is at the heart of servant leadership. Two meta-analyses demonstrate servant leadership as an evidence-based leadership approach, with predictive validity above and beyond transformational leadership (Hoch et al., 2019) and authentic and ethical leadership, (Lemoine et al., 2019).

At the same time, the Greenleaf definition is a fairly abstract description of what this approach entails. Yet, it is also one of the best available definitions. Perhaps for this reason, researchers set about distilling the pertinent characteristics of servant leadership. Thus, there has been a proliferation of theoretical models added to the literature (e.g., Barbuto & Wheeler, 2006; Keith, 2008; Liden et al., 2008; Page & Wong, 2000; Reed et al., 2011; Spears, 1995; Sendjaya et al., 2008; van Dierendonck & Nuijten, 2011).

The defining philosophy of servant leadership concerns itself with putting the needs of employees before that of the leader and organisational objectives, and developing employees to and grow personally and professionally (Liden et al., 2008; Spears, 1995). It is this primary focus of servant leadership that differentiates it from other leadership approaches (van Dierendonck & Nuijten, 2001; Sendjaya et al., 2008). Servant leadership is a social model of leadership founded on strong ethical and moral principles. Servant leaders deconstruct traditional power structures and hierarchical systems in an organisation by inverting the traditional pyramid structure. This changes the direction of organisational energy, which is now flowing upwards in the direction of employees and clients (Blanchard, 2001). By focusing on serving as a first priority, servant leaders ignite a cycle that leads to employees reciprocating this behaviour to the leader, colleagues and stakeholders, leading to employee wellbeing, and organisational effectiveness.

This leadership philosophy is certainly congruent with the work of those in the health and social care sectors. Indeed, it may operationalise many organisations' missions and values. That is, these organisations are designed to work with important social issues such as health, poverty alleviation, and psychosocial problems. Therefore, the personal values of the leader should embody these issues. As Buckingham et al. (2014, p.10) note:

> *Being clear what your values are, adhering to them, being passionate about them, being transparent about them, and having alignment between personal and*

organisational/sectoral values. Values based leadership, it was suggested, requires emotional investment. This was seen as particularly important for third sector leadership.

Harvey (2001, p.38) suggests that for servant leaders: "chasing profits is peripheral; the real point of business is to serve as one of the institutions through which society develops and exercises the capacity for constructive action." Moreover, servant leaders have as their primary concern, the growth of employees, the consumer stakeholders, and then the organisation and the bottom line. Hartnell et al. (2020) suggest that servant leaders do have task achievement as an ethical and moral obligation to all stakeholders. But it is the care and involvement of employees that takes precedence, many organisational outcomes are indirectly impacted by this type of leadership approach (Eva et al., 2020; Lee et al., 2019; Parris & Peachy, 2012). Several of these outcomes are directly related to employee wellbeing, and thus, when used in supervision, they can possibly mitigate against issues of burnout and stress in the workplace.

Burnout in Health and Social Care

Burn out, compassion fatigue, and secondary traumatic stress are significant issues for health and social care employees (Benfante et al., 2020; Benjet et al., 2016; Medscape, 2020; Schaufeli, 2018). While often used as interchangeable terms each construct is defined differently with different and overlapping characteristics. For the purpose of clarity, the following definitions and descriptions are provided. Secondary trauma or vicarious trauma as it is also called, involves negative changes in the practitioners view of self, others, and the world as a result of prolonged empathic engagement with individuals' trauma-related thoughts, memories, and emotions. Indeed, it can also manifest as intrusive thoughts as well as behavioural and emotional manifestations in practitioners (McCann & Perlman, 1990). Secondary trauma can be differentiated from compassion fatigue and burnout because it is a construct specific to those working with trauma survivors. As such, it may be more prevalent in counsellors, psychologists, social workers and psychiatrists in the health and social care sectors.

Compassion fatigue is defined as empathic strain and exhaustion resulting from caring for people in some type of distress. While the abovementioned practitioners suffer from compassion fatigue, other helping practitioners such as nurses, doctors, and first responders also do. Symptoms can manifest much like Post Traumatic Stress Disorder. However, unlike secondary trauma exposure, compassion fatigue is not thought to impact cognitive distortions in the same way. In their systematic review, Cocker and Joss (2016), suggest that compassion fatigue can be described as the convergence of secondary traumatic stress and cumulative burnout.

Burnout is defined as a persistent state of exhaustion, cynicism, and inefficacy as a result of work-related stress (Maslach et al., 2001). The central tenant of burnout is emotional exhaustion due to high work demands and often presents as frequent absenteeism, chronic irresponsibility, in addition to underperformance on clinical and administrative functions. Williamson et al. (2020, p.1) suggest that "*burnout is more usually related to the demands of work (including caregiving and studying) and its contextual components, such as long hours, insufficient support or control, and heavy workload, than the specific nature of work involved.*" As such, burnout is a general construct to which all members of the health and social care sectors are susceptible. While each construct is defined differently, there is much overlap in the symptoms and impact each construct will have on an employee's wellbeing, and work life. At the same time, the type of supports that supervision can put in place will be similar, and having a Servant Leadership supervisory

approach is one way organisations can support employees experiencing these stressful events.

It is somewhat ironic that those who look after our health are those who are most at risk of psychological distress. Maslach and Jackson (1996), inform us that burnout is characterized by a sense of diminished personal accomplishment. Moreover, lack of decision-making ability, poor training, high caseloads, and low support are antecedents to burnout (Morse et al., 2012). Servant leadership, and servant leadership supervision with its developmental focus, high support, and promotion of autonomy, may be one way to mitigate against some of these issues. As Greenleaf (1970, p.5) articulates;

> *A servant-leader focuses primarily on the growth and well-being of people and the communities to which they belong. While traditional leadership generally involves the accumulation and exercise of power by one at the 'top of the pyramid,' servant leadership is different. The servant-leader shares power, puts the needs of others first, and helps people develop and perform as highly as possible*.

During research with 600 social workers, Acker (2010) found a positive association with burnout and physical health morbidities. Burnout has also been associated with addiction issues in health and social care professionals (Pedersen, et al., 2016). Landrum et al. (2010) concluded that employee feelings of burnout significantly predicted lack of service user involvement and participation in their treatment. Holmqvist and Jeanneau (2006) demonstrated that burnout is also significantly associated with negative and rejecting feelings by nurses towards service users. This is concerning when prevalence rates from international literature suggest that burnout is estimated at 40% in nurses (Brand et al., 2010).

Robinson-Keilig (2014) found that secondary traumatic stress has been associated with withdrawal from work in stressful situations and the avoidance of interactions with service users. At the same time, Bride et al. (2009) found 36% of participants in their study avoided traumatized clients to different extents. This represents a serious issue across professional practice with implications for health outcomes for clients, and ethical issues for practitioners.

Compassion fatigue has been linked to avoidance behaviours, including increased sick leave (Toppinen-Tanner et al., 2005) and absence and turnover (Morse et al., 2012). Also, secondary trauma is associated with lower levels of commitment (Asag-Gau & Van Dierdendock, 2011; Bride & Kintzle, 2011), burnout is correlated with dissatisfaction in the workplace (Scanlan & Still, 2013). Research analysing turnover in 42 mental health facilities in American cities, (Bukack et al., 2017) found that agencies lost as much as 26% of their employees annually to turnover. A British work-related stress and wellbeing report (*Health and Safety Executive*, 2020) may help us understand possible implications of these statistics by informing us that rates of stress, anxiety, and depression within health and social care professions is 2,350 per 100,000, amounting to 104,000 cases during 2019-2020.

The research suggests that work-related burnout, compassion fatigue, and secondary trauma are key predictors of morbidity in employees, negative outcomes for service users, and impact upon organisational outcomes differentially. Thus, exploring methods to mitigate against these issues is extremely important. Effective leadership and supervision may be two methods that can be utilised to limit such issues, and servant leadership with its focus on others may specifically assist with limiting some of the antecedents of burn out as cited previously, (Morse et al., 2012). The general servant leadership outcome

literature points to several ways in which this approach can help improve wellbeing in employees.

Servant Leadership Outcomes

The following discusses some of the outcomes associated with servant leadership. Especially, this leadership approach is correlated with more trusting and open supervision relationships (Chatbury et al., 2011; Senjaya & Pekerti, 2010; Zhao et al., 2016). Sokoll (2014) demonstrated that employees exhibited a strong commitment to their supervisor when the supervisor had a servant leader's approach. Other outcomes include reduced employee turnover (Babakus et al., 2011; Zhao et al., 2016; Kashyap & Rangnekar, 2016); increased employee job satisfaction (Mayer et al., 2008; Schneider & George, 2011; Chan & Mak, 2014); psychological safety (Chughtai, 2016; Schaubroeck et al., 2011; Yan & Xaio, 2016); and employee wellbeing (Jaramillo et al., 2009; Lee et al., 2019: Rieke et al., 2008). As an added incentive, servant leadership is viewed as being very important for effective leadership across cultures, with a large study (Mittal & Dorfman, 2012) consisting of 12,681 cases spread across 59 societies illustrating its endorsement. Given the ever-increasing multicultural demographics in health and social care sectors, servant leadership and servant leadership supervision may act as a "universal leadership language."

Servant Leadership and Burnout

Employees who perceive characteristics of servant leadership in their supervisors are significantly less likely to experience feelings of burnout (Babakus et al., 2011; Rude, 2003, 2004; Upadyaya et al., 2016). Upadyaya et al. (2016) demonstrated that servant leadership predicted a lack of burnout, improved work engagement, and better life satisfaction. Bobbio and Manganelli (2015) also demonstrated the mediating impact of servant leadership on burnout in nurses. While there is still a paucity of direct studies exploring burnout specifically, the general outcomes studies cited previously cover many of the domains also considered to impact and be impacted by burnout.

The Present Model

There has been a proliferation of servant leadership models within the literature, although welcome additions to the extant literature. Mahon (2020) argues that no value has been added to the average practitioners understanding and practice of servant leadership. Therefore, the present conceptual framework is put forward to fill this gap using the latest understanding and definition of servant leadership from meta-analysis (Eva et al., 2020; Lee et al., 2019). Thus, the starting point for the present model is based on Eva's (et al., p.114) servant leadership definition:

> *(1) other-oriented approach to leadership (2) manifested through one-on-one prioritizing of follower individual needs and interests, (3) and outward reorienting of their concern for self towards concern for others within the organization and the larger community.*

Additionally, Lee's (et al., 2019) meta-analysis suggests that the following three ideas need to be practiced in order for servant leadership to be transmitted to followers; trust, fairness, and high-quality relationships. Taken together, both research findings inform the current model in conjunction with seven core characteristics distilled from the literature.

In essence, these characteristics are utilised to operationalise the definition and three ideas outlined by both meta-analyses. While other characteristics can be, and are used, the present model is the first to take into consideration this latest research definition and

ideas and incorporate it into a model that would seem to be consistent with the core values and practices in health and social care work. Anderson and Sun (2015, p.6) that "studies that have developed measures for servant leadership have elicited 43 overlapping dimensions." Sendjaya (2003) identified 100 characteristics in the extant literature. Parris and Peachy (2012) suggest that previous definitions of this leadership approach has been vague, and thus, servant leadership has been kept open to a wider population of people. It is the author's position that once the key definition as set out by Eva et al. (2020) and the three ideas of trust, fairness, and high-quality relationships (Lee et al., 2019) are operationalised, the characteristics used do not have to be prescriptive. In this way, previous models are not dismantled, thereby keeping servant leadership open to a wide audience.

For these reasons, the author puts forward the Servant Leadership Scale-28 (SLS-28) which incorporates the definition, ideas, and use characteristics that would be most familiar to those in the health and social care sector. Using previously psychometrically-validated items from several measures in the literature (Barbuto & Wheeler, 2006; Dierendonck, 2011; Ehrhart, 2004; Liden, 2008), and a conceptual paper, the author has constructed the SLS-28.

While not considered a psychometrically-reliably sound instrument, it does serve an ideographic purpose for developing and tracking these characteristics in Servant Leaders. The characteristics are: listening, professional development, empowerment, accountability, serving others, emotional healing, and self-awareness. The author contends that these seven characteristics operationalise the definition and key ideas as set out in meta-analyses (Eva et al., 2020; Lee et al., 2019). The following outlines these characteristics as a general servant leadership model (*Figure 1*) and discusses how they can be incorporated into health and social care supervisory processes supported by the use of the Servant Leadership Supervisor Scale SLSS (*Figure 2*).

Figure 1

Servant Leadership Scale-28 (SLS-28)

Characteristic	Scale Items	Questions
Listening	Adapted Thomas Hajduk, Ph.D. (2009) listening scale	1, 8, 15, 22
Empowering	Liden (2008) measure	2, 9, 16, 23
Professional Development	Adapted from Ehrhart (2004) and Liden (2008) measures	3, 10, 17, 24
Serving Others	Barbuto & Wheeler (2006) and Liden (2008) measures	4, 11, 18, 25
Accountability	van Dierendonck (2011)	5, 12, 19, 26
Self-Awareness	Self-developed	7, 14, 21, 28
Emotional Healing	Liden (2008); Barbuto (2006)	6, 13, 20, 27

Listening
Servant leadership has as a characteristic: listening to employees (Keith, 2008; Spears, 1995). Greenleaf articulated listening in his early writing on servant leadership; this was then distilled into Spears' (1995) model.

According to Keith (2008, p.1);

> *By listening, servant-leaders are able to identify the needs of their colleagues and customers. That puts them in a good position to meet those needs. When they do, their*

organizations are successful — their colleagues are able to perform at a high level, and they have happy customers, clients, patients, members, students, or citizens.

Listening does not only help leaders to gather important information about the development of others and the organisation, it also mediates another important organisational concept, Psychological Safety (Yan & Xaio, 2016; Chughtai, 2016). It is the author's position that when employees feel accepted and safe, they feel comfortable to engage in interpersonal risk-taking, such as becoming more involved in organisational discussions with leaders as they pertain to important work and role objectives, and bringing more creative and innovative ideas in for consideration. Psychological safety is also essential for employees to feel safe and secure in their interpersonal relationships. The servant leader will seek out and use as many opportunities as they can find to listen to employees, they embody a deep respect for employees and demonstrate this by listening respectively to opinions, ideas, feelings, and worries, all key issues for those experiencing burnout. Many health and social care professionals are trained in active listening skills, therefore, bringing these into the supervisory process should not pose much difficulty to supervisors. Listening in captured on the SLSS in the relationship item:

Figure 2

Servant Leadership Supervisor Scale (SLLS)

Item	Corresponding SLS-28 Item
Approach to Supervision	Professional development, self-awareness
Relationship	Listening, empowering
Meeting my Needs	Serve others, emotional healing, professional development
Organisation Meeting my Needs	Accountability, serve others, professional development

Servant Leadership Supervisor Scale (SLLS)

The SLSS is a four-item measure assessing the supervisory relationship from a servant leadership approach. It is completed at the end of every supervision session by the supervisee and seeks to assess the supervisees' satisfaction on a scale of 1 to 10 on four key areas that are aligned to their developmental needs, with a total score of 40. The resulting information is then discussed by both parties, resulting in a culture of feedback that can be used in real time to meet the needs of the supervisee. The scale loosely captures the items on the SLS-28. The SLSS has been adopted from the Leeds Alliance in Supervision Scale (Wainwright, 2010) and the author added an organizational item in order to more accurately reflect a servant leadership organization and supervisory process from the perspective of supervisees. Of course, this does mean the psychometric reliability is impacted, however, we see this scale as an ideographic measure to be used to generate discussion between supervisor and supervisee based on a servant leadership philosophy, and is thus, subjective. Critically, the SLSS builds on the work of the SLS-28 by offering a supervisory approach that uses characteristics from the servant leadership model, and provides supervisees with a mechanism to assess how their supervisor and organisation are meeting their needs, including needs related to burnout, compassion fatigue, and secondary traumatic stress. If a supervisor is providing supervision consistent with a servant leadership philosophy, then some of the antecedents of burnout such as low support, poor training, and feelings of a lack of personal accomplishment, and emotional stress can be prevented, identified, or minimised. Importantly, the SLSS is not a reactionary tool, but can work as a preventative measure by its routine use to develop supervisees on an ongoing basis.

Empowerment

Servant leadership also has a core value of empowerment; indeed, it has been discussed in terms of it being a distinctive focus (Liden et al., 2008; Parris & Peachey, 2012; van Dierendonck, 2008). Miller et al. (2001, p.1881) suggest that work environments that are designed to empower allow for employee access to "information, support, and resources necessary to accomplish work, as well as those that provide opportunities for growth and development of knowledge and skills." Buchen (1998) explains that empowerment happens when leaders embrace the idea of *primus inter pares*, first among equals; employees become collaborators and fully involved in organisational life. As articulated previously, a lack of involvement in decision-making seems to be one of the antecedents of burnout among employees. Hence, an empowering approach to supervision may help mitigate against this. Again, this characteristic would seem to be consistent with many of the professions, especially those more aligned to the social work and therapy type professions, although not exclusively so.

Serving Others

Servant leaders invert the traditional organizational pyramid, and place other key stakeholders such as employees at the top (Keith, 2008). Blanchard (2001) and Cortez et al. (2017) inform us that servant leaders, after setting the mission and vision, remove all barriers and serve their employees through prioritising their needs. The author sees this as the energy within a servant leadership organisation as moving upwards from the bottom, instead of downwards from the top. This one, what seems a simple act but actually a difficult task, ignites a new energy within an organization where the focus is on employees and services users instead of on the whims and wishes of the leader. Vince and Pedler (2018) suggest that it is of paramount importance to consider how power relationships can impact on leadership outcomes. For the author, the responsible use of power can be considered a core tenant of servant leadership.

Thus, in the SLS-28, serving others is assessed, which in turn is aligned to the definition set out by Eva et al. (2020), that is, the outward reorientation of self-interest and the prioritising of others interests and needs. Serving others can be considered to be consistent with all health and social care professions. Using both the SLS-28 with its serving others item, and the SLSS measure in supervision can assist with tracking the progress of servant leader supervisors in meeting supervisees' needs in general, and those related to burnout, compassion fatigue, and secondary trauma specifically.

Professional Development

Servant leaders show interest in and encourage employees in their career plans, and further delegate important work responsibilities to employees (Liden et al., 2008). This is one method used by servant leaders to develop organisational capacity and servant leadership capacity in employees. Servant leaders use coaching to develop those in the organisation. Servant leadership requires leaders to build strong relationships and communication in order to evaluate and gain insight into the abilities, needs, desires, and goals, of their employees (Chinomona & Pooe, 2013). As Greenleaf (1970, p.3) suggests, "the work exists for the person as much as the person exists for the work." Kent (2008, p.2) unpacks this quote further and provides the following analysis:

> *Work should provide people with opportunities to learn and grow and fulfil their potential. When your colleagues grow, the capacity of your organization grows. Developing colleagues includes a commitment to extensive on-the-job training, as well as formal education, new assignments, and internal promotions.*

While organizational policies and systems are put in place to promote good governances and organisational effectiveness, the relationship between individual supervisor-supervisee can follow different paths. The servant supervisor takes time to get to know each of the supervises and as such, the boundary between professional and personal lives is more fluid and dynamic (Eva et al., 2020).

This individuation of the supervisory relationship shows appreciation, care, and is linked to many of the key servant leadership characteristics and ideas, including Eva et al.'s (2020) definition of servant leadership. Maslach and Jackson (1996) suggest that burnout is characterized by feelings that one is lacking in personal accomplishment. Therefore, helping supervisees develop, not just in task-related matters, but their personal accomplishments may help mitigate against feelings of burnout through continuous development. Thus, servant leadership supervision should go beyond organizational task-related role, and incorporate employees' general professional interests where possible. We propose that this will further generate a sense of fairness, thus transmitting servant leadership. The SLSS can be utilized by employees to track their satisfaction with the extent to which supervisors and the organization are meeting these needs.

Accountability

Employing accountability as a leadership behavior is one method of developing congruence between organizational and employees' goal attainment. Others include setting clear expectations, having confidence in others, and holding others accountable for controllable behaviour and outcomes. Accountability is outlined in the literature as being responsible for, ensuring transparent practices, holding others accountable, monitoring performance, and setting clear expectations congruent with an individual's current capability. It is also used to hold the leadership and organization ethically accountable for its mission, finances, and impact on society. Of course, supervisors must also be able to take feedback on their practices as part of accountability structures.

While the SLS-28 has an accountability item, the Servant Leadership Supervision Scale (SLSS) is another method that employees can use in supervision to provide feedback on how the supervisor and organization are meeting their developmental needs. Afterall, the core tenant of servant leadership is service to others; employees should therefore be able to speak to how supervisors and the organizations embody this approach. Like the previous characteristic, this will demonstrate fairness, but also trust.

Moreover, as lack of involvement in decision making, and poor training and development opportunities have been identified as antecedents of burnout, it is proposed that including these issues in a developmental supervisory relationship may limit the potential impact of burnout on employees. The Servant Leadership Supervision Scale SLSS has been designed by the author for supervisees to provide feedback to their supervisors on important developmental and emotional needs congruent with a servant leadership approach.

Self-awareness

Self-awareness strengthens the servant leader's ability to work with others. Awareness also helps the leader in understanding issues involving ethics and values and their application. Keith (2008) suggests that self-awareness is a key practice of servant leaders and that servant leaders should be aware of their strengths, limitations, and the impact of their words and behaviour on others. Self-awareness comes from reflective practices. Supervisors should role model this self-awareness characteristic both by engaging in supervision with their own supervisors, but also in challenging supervisees to see beyond

their current skills, abilities, and limitations. The self-awareness characteristic is aligned to the approach to supervision in the SLSS — that is, the structure and focus of the session.

Many of the health and social care professions are geared towards building awareness in their services users, thus, it is a congruent practice that should assimilate into the supervisory relationship. Servant leaders utilize many methods of building awareness, including measures of personality and general reflective opportunities. They should be open to both using these methods and any other that can help built awareness in their employees, especially as it relates to managing burnout and related stressful events. At the same time, servant leaders should be accountable for the supervision they offer to supervisees and taking feedback from supervises is one way they can build their self-awareness of the supervisory process. Thus, the SLSS can be used to help build this self-awareness as it relates to their servant leader supervision practices.

Emotional Healing
A disposition towards emotional healing is suggested as a unique characteristic of servant leadership. Many people experience emotional difficulties and have suffered from emotional difficulties; of course, these are then brought into the workplace. Barbuto and Wheeler (2006, p.107) define emotional healing as the "leaders' ability to facilitate sufferers' spiritual recovery from hardship and trauma." Dacher (1999) and Sturnick (1998) suggested that emotional healing is a skill needed and lacking by many leaders. Many supervisors may view emotional healing as a soft skill and not part of their supervisory role, however, it may be one of the most important characteristics in the context of employee burnout and other stressful work-related experiences.

Consequently, those operating within a servant leadership approach in general, and specifically a servant leadership supervisory role, must attend to the emotional needs of supervisees as they relate to this issue. A worrying trend is occurring specifically within health and social care, due to COVID-19. Benfante et al. (2020) suggest that as many as 35% of healthcare workers have experienced trauma. It may be especially important at the present time for those in both leadership and supervisory roles to consider how they can support the emotional healing that is needed by employees due to the added morbidity burden of COVID-19.

Discussion
The present conceptual paper seeks to address the question of how can servant leadership be infused into the supervisory process within health and social care settings in order to possibly mitigate against burnout in the workplace. A model of servant leadership aligned to the most recent definition of this leadership approach has been presented (SLS-28), using characteristics of previous psychometrically-validated scales. A servant leadership supervision scale (SLSS) has also been presented as a supervisory tool congruent with the servant leadership approach which can be used to support supervises developmentally, and prevent burnout experiences.

This paper contributes to the research literature in several ways. Firstly, it extends servant leadership theory and practice by assimilating findings from meta-analysis into the design of a characteristic model. Secondly, this paper answers the call by Evans et al. (2016) to infuse a leadership approach into clinical supervision competencies in order to address some of the inconsistencies in practitioner supervisory training. While the initial request was for clinical supervision within counselling, we see no reason why this should not be extended to the wider health and social care sectors considering their similar supervisory aims. It will also go some way to addressing Allbutt et al. (2017) concerns regarding the

inconsistencies in supervisory practices and lack of implementation across health and social care services by offering a standardised approach with measures to help implementation.

Limitations to this conceptual paper are considered from the perspective that both the SLS-28 and the SLSS have been designed by the author without primary research attesting to their reliability and validity. While the construction of both measures was informed by previous reliable measures within the literature, this represents limitations in their use. For these reasons, the scales should only be utilised as ideographic measures within the supervisory relationship. At the same time, another limitation is the lack of primary data to suggest that these individual scales and approaches will reduce burnout within employees of supervisors using them. Thus, future research may wish to empirically examine both these measures using primary data as they relate to servant leadership in general, and the role of the supervisor using the SLSS for reducing burnout in employees.

Conclusion

The prevalence of burnout within the health and social care sectors is a worrying issue for practitioners, supervisors and policy makers as it impacts on morbidity, wellbeing, work life, and organisational effectiveness. The literature demonstrates the need for methods to reduce the impact burnout has on employees, but also the impact this has on service user care, as well as organisational outcomes. A model of Servant Leadership based on meta-analysis findings and using characteristics that are congruent with the work of health and social care professionals have been put forward and discussed as a means to achieve this. The author conceptually addressed how burnout can be reduced within this sector by infusing a model of servant leadership into the supervisory process.

Servant leadership and servant leadership supervision can be utilised within the health and social care sectors in order to provide employees with a supportive supervisory experience thus reducing and preventing the impact burnout can have on employee wellbeing. By attending to supervisees' emotional and developmental needs, a servant leadership approach to supervision may act as a protective factor to some of the antecedents of burnout, compassion fatigue, and secondary traumatic stress. Thus, the author calls on those in the health and social care sectors to consider integrating this conceptual model into existing structures, procedures, and policy in order to have a more psychologically satisfied workforce and effective organisation.

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