2-15-2020

Barriers and Promoters of Retention of Direct Care Workers in Community Mental Health Agencies

Shinobu Watanabe-Galloway
University of Nebraska Medical Center, swatanabe@unmc.edu

Brent Khan
University of Nebraska Medical Center, brent.khan@unmc.edu

Mogens (Bill) Baerentzen
University of Nebraska Medical Center, mogens.baerentzen@unmc.edu

Zaeema Naveed
University of Nebraska Medical Center, Zaeema.naveed@unmc.edu

Barriers and Promoters of Retention of Direct Care Workers in Community Mental Health Agencies

Shinobu Watanabe-Galloway[a]*, Brent Khan[b], Bill Baerentzen[c] and Zaeema Naveed[d]

[a]Associate Professor, Department of Epidemiology, University of Nebraska Medical Center, College of Public Health, USA

[b]Associate Director, Behavioral Health Education Center of Nebraska, University of Nebraska Medical Center,USA. brent.khan@unmc.edu

[c]Behavioral Health Education Center of Nebraska, University of Nebraska Medical Center, USA. mogens.baerentzen@unmc.edu

[d]Department of Epidemiology, University of Nebraska Medical Center, College of Public Health. Zaeema.naveed@unmc.edu

*Corresponding Author: 984395 Nebraska Medical Center, Omaha, NE 68198-4395.

Phone: 402-559-5387

Fax: 402-552-3683

Email: swatanabe@unmc.edu

Table of Contents

Barriers and Promoters of Retention of Direct Care Workers in Community Mental Health Agencies

Abstract

Demand for behavioral health direct-care providers is increasing due to shortage of licensed behavioral health providers. However, high turnover has been reported among them with limited exploratory research. The present study aimed to identify a wide variety of barriers and promoters of retention and strategies to retain direct care workers. An online, self-administered survey designed to measure demographics, job satisfaction, perceived importance of various job aspects, intention to leave, perceived stress and sources of stress was administered among 179 direct care workers from four agencies. Multiple logistic regression exhibited higher odds of intending to leave for those who had higher general perceived stress (OR=1.3, CI=1.1-1.7) and those who experienced stress from supervisor (OR=5.0, CI=1.7-14.4) and organizational culture (OR=4.2, CI=1.1-18.4). Work-related stress is a prevalent issue among direct-care providers and may be associated with turnover. Policy formulation and implementation directed at strategies to reduce stress may be warranted to improve retention.

Key words: Direct care, behavioral health, health workforce, retention, turnover

BHECN | BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

Introduction

The US faces serious challenges in recruiting, training and retaining the behavioral health workforce (Health Resources and Services Administration/National Center for Health Workforce Analysis, Substance Abuse and Mental Health Services Administration/Office of Policy, Planning, and Innovation, 2015). The Health Resources and Services Administration (HRSA) estimated a current shortage of more than 10,000 FTEs for six different provider types including psychiatrists, psychologists and counselors (Health Resources and Services Administration/National Center for Health Workforce Analysis, Substance Abuse and Mental Health Services Administration/Office of Policy, Planning, and Innovation, 2015). Overall the behavioral health workforce has been aging, and many people are nearing the retirement age (Hyde, 2013). In addition, recruitment and retention of qualified behavioral health providers has been a huge challenge especially in rural communities and underserved urban settings, where there is a shrinking pool of behavioral health workforce (Hyde, 2013). Stigma associated with the behavioral health field, high workloads, and low salaries are among reasons for difficulty in attracting and retaining qualified individuals to the behavioral health occupations (Substance Abuse and Mental Health Services Administration,).

Direct care workers, typically entry-level positions, do not require formal training or licenses (Bukach, Ejaz, Dawson, & Gitter, 2017). Job titles commonly used to describe direct care workers include terms such as "associate", "assistant/assistive", "auxiliary", "aid", "support", "technician", and "unlicensed". The direct care workers perform a variety of tasks ranging from supporting hospital appointments to teaching relaxation skills. The roles include monitoring adherence to medications and signs of self-neglect; managing physical health such as taking blood pressure; performing therapeutic roles such as teaching anxiety management; building confidence and pet therapy; managing activities of daily living; and acting as a liaison with specialized care

(Wilberforce et al., 2017). Amid the shortage of licensed mental health professionals, direct care workers provide a variety of services to support the work done by licensed professionals (Bukach et al., 2017; Pace, 2009). There seems to be a global trend in the increase in the demand for direct care workers (Wilberforce et al., 2017). A recent report by the Health Resources and Services Administration (HRSA) projected that the demand for direct care workers in long-term care settings including psychiatric aids increases by 48% between 2015 and 2030 (U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, 2017). Because many behavioral health direct care professions are not licensed, it is difficult to accurately estimate the supply and demand for this workforce (Beck, Singer, Buche, Manderscheid, & Buerhaus, 2018). Nevertheless, behavioral health direct care providers play an important role in the care of people with mental illness and substance use disorders. Given the movement toward integrated primary care and continuing opioid epidemic, there are expected to be more demands for professionals who do day-to-day work to provide direct services to individuals with these conditions.

According to the Bureau of Labor, the annual turnover rate in 2017 was 43.0% for all industries combined and 33.2% for health care and social assistance sector (Bureau of Labor Statistics., 2018). State-wide and local studies indicate the turnover rate of 19% to 31% (Garner, Hunter, Modisette, Ihnes, & Godley, 2012; Rollins, Salyers, Tsai, & Lydick, 2010; Ryan, Murphy, & Krom, 2012) for overall behavioral health workers and 24% for behavioral health direct care worker specifically (Ejaz, Bukach, Dawson, Gitter, & Judge, 2015). In Douglas County, Nebraska, the annual turnover rate of unlicensed mental health providers is estimated to be 40-50% (Brent Khan, personal communication, September 6, 2018). Although ample research has been conducted to explore the phenomenon of turnover in the licensed behavioral health care providers, (Albizu-García, Ríos, Juarbe, & Alegría, 2004; Scanlan & Still, 2019) the literature is limited when it comes

to the direct care providers. In response to the need for better recruitment and retention strategies for unlicensed mental health providers, a task force was developed to conduct a survey study in the county. The present survey study aimed to identify barriers and promoters of retention and potential strategies to retain direct care workers.

Methods

Study participants were mental health providers, 19 years and older, employed by four behavioral health services organizations in Omaha, Nebraska, three of which are non-profit agencies and one is a local governmental entity. The government agency and one non-profit organization provide services to both adults and children. One non-profit agency provides services to only children and the remaining non-profit agency exclusively serves adults. All these organizations provide a variety of behavioral health and supportive services including counseling, psychiatric treatment, primary care services, employment and community support, and life skills development. An administrator at each of these agencies sent an online, self-administered survey link to all of their employees including direct care staff. Participation in the survey was voluntary. The employers allowed their employees to spend workhours to complete the survey. The survey was administered through RedCap.

To develop a survey instrument, the authors conducted a literature review, examined existing questionnaires, and obtained input from the human resource (HR) administrators of the four participating agencies. The final instrument included (Annex 1) five sections: 1) Demographics, 2) Job Satisfaction, 3) Reasons for Stay 4) Turnover Intention and 5) Stress. The demographics section covered the topics of gender, age, work experience, education, and the licensure status. The job satisfaction section included a single-item measure with seven response

options ranging from "completely satisfied" to "completely dissatisfied" and was adapted from an instrument validated by Dolbier et al (Dolbier, Webster, McCalister, Mallon, & Steinhardt, 2005).

For Reason to Stay Section, we sought input from HR administrators, as well as reviewed a job satisfaction survey conducted by Society for Human Resource management (SHM) (SHRM, 2017) and Module 3 (Job Facets: importance and contingencies) of the Michigan organizational assessment package (University of Michigan. Survey Research Center, 1975). We then selected the following factors that are potentially associated with intention to stay at work: wage, benefits, overtime, physical working conditions, career advancement, alternate job opportunities, client acuity, work-sponsored events, tuition reimbursement, performance bonus and relationship with supervisor and coworkers. The respondent was asked "How would the following items attract you to stay in the current organization?" Seven response options ranged from "not at all important" to "extremely important."

Turnover Intention Section included three items that were adapted from two published studies (Scanlan & Still, 2019; Shah, Fakhr, Ahmad, & Zaman, 2010). Intention to leave was determined by three statements: "I am actively looking for another job", "As soon as I find another job, I will quit" and "I often think about quitting my job" with three options each to choose from. The internal consistency (Cronbach's α) of this measure has been found to be 0.87 (Scanlan & Still, 2019; Shah et al., 2010). A variable "Intention to leave" was created from the three statements such that a "yes" to any one of the three items was taken as a "yes" for intention to leave.

Stress Section of the survey included two subsections. The first subsection measured perceived stress using three items adapted from Perceived Stress Scale 4 (PSS-4) (Cohen, Kamarck, & Mermelstein, 1983; Herrero & Meneses, 2006). One item was not used because it only relates to personal problems. The scores from three items were added to construct a single

BHECN | BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

numeric measure of stress. The second subsection asks the respondent to rate four specific sources of work-related stress—co-workers, supervisor, clients and organizational culture. Five response options ranged from "not at all stressful" to "very stressful".

A descriptive analysis was conducted to calculate frequencies and percentages of demographics and variables of employment status. Bivariate analysis was conducted with intention to leave as the outcome variable using chi-square test of independence for categorical variables and two-sample t-test for numeric variable. The categories within each variable were collapsed where deemed necessary due to small cell size. Finally, simple and multiple logistic regression analyses were conducted between intention to leave and covariates that were reported significant in the bivariate analysis. Crude and adjusted odds ratios were reported. A p-value of 0.05 was considered significant. The analysis was done using SAS software 9.4. The University of Nebraska Medical Center Institutional Review Board approved this study before its inception (IRB # 208-16-EX). Electronic informed consent was obtained for the anonymous survey and no identifiers were collected.

Results

A total of 179 unlicensed direct care providers responded from four agencies (response rate=21%). Table 1 summarizes the demographic characteristics of the participants. The age of the respondents ranged from 19 to 70 years with 39% of them between 19 and 29 years of age. Majority of the participants were females (84%). The highest level of education reported was doctoral or other terminal degrees (1%), and the lowest was high school or GED (18%) with the majority having a bachelor's degree (43%). About 30% of the participants had work experience of more than ten years in the behavioral health field while about 16% had spent less than a year at the time of survey administration. About one third (35%) worked at the current agency less than a

year and 24% worked one to two years at the current agency. The bulk of the surveyed had a full-time job status (76%). Only 17% were completely satisfied with their current job, and the rest had varying levels of satisfaction. About 33% of the participants expressed the intention to leave.

Findings from bivariate analyses between the demographics, job characteristics and perceived stress as covariates and the intention to leave as the outcome are shown in Table 2. There was a significant association with intention to leave with the "number of years worked in the behavioral health field" (p=0.0244). Less than 15% of individuals in the first two categories (worked less than one year, worked one to two years) indicated that they intended to leave the current position while about 40% of individuals who in the next two categories (worked three to five years, worked six to nine years) indicated their intention to leave. Stress caused by co-workers, supervisor, and organizational culture had a significant association with intention to leave while such assocaition was not observed for stress caused by clients.

Variables that were significant in bivariate analysis were retained in multiple regression analysis (Table 3). Individuals who worked three years and longer had higher adjusted odds of reporting their intention to leave compared to individuals who worked less than one year (worked 3-5 years: OR=5.8; worked 6-9 years: OR=3.6; worked 10 years or longer: OR=4.1). Also, individuals who experienced stress due to supervisor or organizational culture had higher adjusted odds of reporting their intention to leave (supervisor-related stress: OR=5.0; organizational culture-related stress: OR=4.2). Finally, individuals who reported any stress regardless the source (e.g., co-worker, client, supervisor, organizational culture) had a higher odds of reporting their intention to leave. Table with crude Odd ratios has been attached as appendix (Table 4).

Figure 1 demonstrates the various job aspects considered important to the participants regarding staying in an organization. Wage stood out with 91% participants labelling it as a vital

feature. Wage was followed by performance bonus (89%), career development opportunity (84%),

relationship with supervisors (83%) and physical working condition (82%) securing the top five

spots.

Figure 1. Percentage of respondents confirmed the importance of specific job aspect
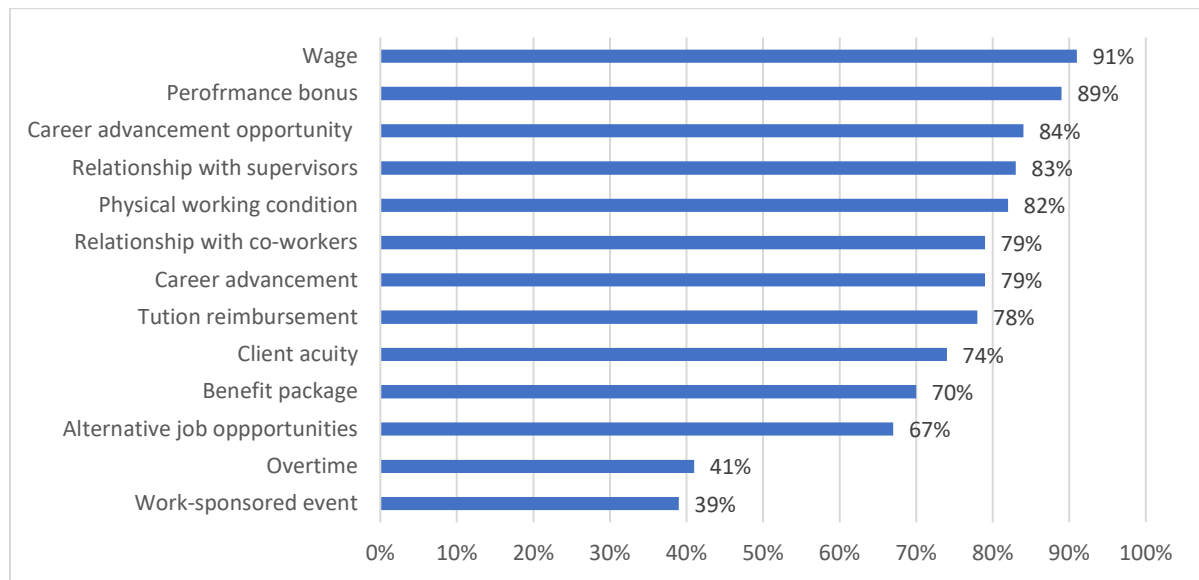
Discussion

Both licensed and direct care workforce are characterized by a high turnover rate, apart

from aging and retirement (Ejaz et al., 2015; Ryan et al., 2012). Quality and proficiency in services

delivered can be disrupted due to the existence of high staff turnover in a health care system. The

phenomenon is especially true when it comes to mental health service delivery, where a strong

therapeutic relationship between the provider and the patient is of utmost importance for trust

building and optimum care (Lemmon & Shuff, 2001). This study found a significant association

of intention to leave with stress. Specifically, the variables ascertaining the level of general stress

among the participants and those determining sources of stress i.e. supervisor and organizational

culture were all statistically significant in the multivariable analysis.

BHECN | BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

The findings of this study are comparable to the other studies conducted in the past using a mix of direct and licensed behavioral health providers as respondents. A study conducted by Scanlan et al. found stress or burnout to be positively associated with turnover (Scanlan & Still, 2013). Stress may be a consequence of staff shortage that is already documented for the mental health care providers thus leading to an increased workload. Furthermore, the stress from supervisors and organizational culture may result in poor teamwork and potential conflict. Literature has used a broader construct termed "burn out" to assess stress along with two other dimensions; depersonalization and reduced personal accomplishment (Paris & Hoge, 2010; Webster & Hackett, 1999). Burnout has been found to be fairly prevalent among the mental health workforce and has exhibited a significant association with intention to leave thus supporting the findings of this study (Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000; Kilfedder, Power, & Wells, 2001; Rupert & Morgan, 2005). Past studies have also found job satisfaction to be both directly and indirectly associated with turnover intentions through burnout (Blankertz & Robinson, 1997; Scanlan & Still, 2013).

Organizational culture is a broad term encompassing a wide range of underpinning dimensions such as leadership, mission, strategy, roles and responsibilities and human resource practices (Körner, Wirtz, Bengel, & Göritz, 2015). The importance of organizational culture lies in the fact that it influences organizational climate, provider attitudes, and employee behavior. Furthermore, negative organizational culture has been related to augmented emotional exhaustion in the employees (Aarons & Sawitzky, 2006b). For instance, organizational culture and policy influence organizational support, the departmental organization, remuneration, relations between management and staff and meeting of imposed deadlines and emotional demands of the clients which, in turn, have been reported to be relevant as being contributory stressors and as factors

impacting the provider's ability to manage job stresses (Coyle, Edwards, Hannigan, Fothergill, & Burnard, 2005).

A study conducted among social workers who provided mental health care in New York explored organizational culture and its relationship with role conflict, role ambiguity, opportunities for professional development, and social support (Acker, 2004). A significant negative association was found between social support and intention to leave while role conflict and role ambiguity had statistically significant positive correlations with the intention to leave (Acker, 2004). Another study of a sample comprised of licensed and direct care workers in California found an association between organizational culture and work attitude (Aarons & Sawitzky, 2006a). The study also found that work attitude was associated with staff turnover (Aarons & Sawitzky, 2006a). Organizational culture may produce some stressors resulting from policies related to working hours, salaries, human resource management, and human resource development. A targeted approach to bring a cultural change may impact many procedures within an organization and improve staff turnover.

When asked about the importance of various job aspects, wage emerged as the most important factor followed by performance bonus, career development opportunity, relation with supervisor and physical working condition in the descending order. These findings are supported by past studies. For example, a study in New York which surveyed mental health social workers found that social support from supervisors and coworkers, opportunities for professional development, salary amount and length of employment all had positive correlations with being satisfied with the job (Acker, 2004). Another study conducted in Ohio indicated that agencies with lower turnover offered higher maximum pay and were smaller in size (Bukach et al., 2017). Onyett

BHECN | BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

et al. found job satisfaction to be positively associated with job clarity and team identification (Onyett, Pillinger, & Muijen, 1997).

In conclusion, stress or burnout is a fairly prevalent issue among mental health care providers with a variety of factors associated with it. However, the literature on burnout in mental health providers, especially specific to direct care providers is quite weak. Furthermore, Majority of the studies conducted, including the current one, use a cross-sectional design that does not ascertain causality between stress and turnover. Longitudinal and interventional studies need to be conducted, identifying measures and strategies to reduce stress at work eventually leading to reduced turnover.

Policy Implications for behavioral health

The study found a strong association between stress at work and intentions to leave the current job. A few policy recommendations emanating from the findings of this study are as follows:

- Organizations need to adopt a system that offers a routine assessment of stress among the workers to have a better understanding of the prevalence and contributing factors. It is important to devise appropriate corrective measures such as elimination or mediation of major stresses depending on feasibility and enabling workers to practice stress survivor skills. Furthermore, the organizations should encourage supervisors to share and discuss assessment findings with the supervisees and be open to suggestions to rectify the issues that may include a change in organizational culture or the working environment.

- Interventions like supervisory support groups, peer support groups, and training/workshops should all be incorporated as essential tools to reduce stress associated with the aforementioned challenges of mental health work.

BHECN | BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

- Adoption of an "Open door policy" can encourage transparency and openness among employees working at different hierarchical positions.

- The results of this study indicate the importance of involving all mental health professionals in the decision-making and implementation of procedures. This is essential to avoid team conflicts that may be a big source of stress for the workers.

- Organizations should conduct a continuous evaluation of interventions through a pre and post assessment system. It is also important to consider phenomenon like "intention to quit" and "actual turnover" separately while conducting evaluations as the intention may not be an accurate measure of actual turnover.

Conflict of Interest:

Authors have no conflict of interest.

BHECN | BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

References:

1. Aarons, G. A., & Sawitzky, A. C. (2006a). Organizational climate partially mediates the
   effect of culture on work attitudes and staff turnover in mental health services.
   Administration and Policy in Mental Health and Mental Health Services Research, 33(3),
   289.

2. Aarons, G. A., & Sawitzky, A. C. (2006b). Organizational culture and climate and mental
   health provider attitudes toward evidence-based practice. Psychological Services, 3(1), 61.

3. Acker, G. M. (2004). The effect of organizational conditions (role conflict, role ambiguity,
   opportunities for professional development, and social support) on job satisfaction and
   intention to leave among social workers in mental health care. Community Mental Health
   Journal, 40(1), 65-73.

4. Albizu-García, C. E., Ríos, R., Juarbe, D., & Alegría, M. (2004). Provider turnover in public
   sector managed mental health care. The Journal of Behavioral Health Services & Research,
   31(3), 255-265.

5. Beck, A. J., Singer, P. M., Buche, J., Manderscheid, R. W., & Buerhaus, P. (2018).
   Improving data for behavioral health workforce planning: Development of a minimum data
   set. American Journal of Preventive Medicine, 54(6), S192-S198.

6. Blankertz, L. E., & Robinson, S. E. (1997). Turnover intentions of community mental health
   workers in psychosocial rehabilitation services. Community Mental Health Journal, 33(6),
   517-529.

7. Bukach, A. M., Ejaz, F. K., Dawson, N., & Gitter, R. J. (2017). Turnover among community
   mental health workers in Ohio. Administration and Policy in Mental Health and Mental
   Health Services Research, 44(1), 115-122.

8. Bureau of Labor Statistics. (2018). Economic news release: Table 16. annual total separations rates by industry and region, not seasonally adjusted. Retrieved from https://www.bls.gov/news.release/jolts.t16.htm

9. Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. Journal of Health and Social Behavior, 385-396.

10. Coyle, D., Edwards, D., Hannigan, B., Fothergill, A., & Burnard, P. (2005). A systematic review of stress among mental health social workers. International Social Work, 48(2), 201-211.

11. Dolbier, C. L., Webster, J. A., McCalister, K. T., Mallon, M. W., & Steinhardt, M. A. (2005). Reliability and validity of a single-item measure of job satisfaction. American Journal of Health Promotion, 19(3), 194-198.

12. Edwards, D., Burnard, P., Coyle, D., Fothergill, A., & Hannigan, B. (2000). Stress and burnout in community mental health nursing: A review of the literature. Journal of Psychiatric and Mental Health Nursing, 7(1), 7-14.

13. Ejaz, F. K., Bukach, A. M., Dawson, N., Gitter, R., & Judge, K. S. (2015). Examining direct service worker turnover in three long-term care industries in Ohio. Journal of Aging & Social Policy, 27(2), 139-155.

14. Garner, B. R., Hunter, B. D., Modisette, K. C., Ihnes, P. C., & Godley, S. H. (2012). Treatment staff turnover in organizations implementing evidence-based practices: Turnover rates and their association with client outcomes. Journal of Substance Abuse Treatment, 42(2), 134-142.

15. Herrero, J., & Meneses, J. (2006). Short web-based versions of the perceived stress (PSS) and center for epidemiological studies-depression (CESD) scales: A comparison to pencil and paper responses among internet users. Computers in Human Behavior, 22(5), 830-846.

BHECN

16. HRSA. (2015). National projections of supply and demand for selected behavioral health

practitioners: 2013-2025. Rockville, Maryland: Health Resources and Services

Administration/National Center for Health Workforce Analysis, Substance Abuse and Mental

Health Services Administration/Office of Policy, Planning, and Innovation. Retrieved from

https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-

analysis/research/projections/behavioral-health2013-2025.pdf

17. Hyde, P. (2013). Substance abuse and mental health services administration. report to

congress on the nation's substance abuse and mental health workforce issues. Retrieved from

https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf

18. Kilfedder, C. J., Power, K. G., & Wells, T. J. (2001). Burnout in psychiatric nursing. Journal

of Advanced Nursing, 34(3), 383-396.

19. Körner, M., Wirtz, M. A., Bengel, J., & Göritz, A. S. (2015). Relationship of organizational

culture, teamwork and job satisfaction in interprofessional teams. BMC Health Services

Research, 15(1), 243.

20. Lemmon, R., & Shuff, I. (2001). Effects of mental health centre staff turnover on HIV/AIDS

service delivery integration. AIDS Care, 13(5), 651-661.

21. Onyett, S., Pillinger, T., & Muijen, M. (1997). Job satisfaction and burnout among members

of community mental health teams. Journal of Mental Health, 6(1), 55-66.

22. Pace, B. (2009). Organisational views of the mental health support worker role and function.

Unpublished Paper. Waikato Institute of Technology, New Zealand,

23. Paris, M., & Hoge, M. A. (2010). Burnout in the mental health workforce: A review. The

Journal of Behavioral Health Services & Research, 37(4), 519-528.

24. Rollins, A. L., Salyers, M. P., Tsai, J., & Lydick, J. M. (2010). Staff turnover in statewide

implementation of ACT: Relationship with ACT fidelity and other team characteristics.

BHECN | BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

Administration and Policy in Mental Health and Mental Health Services Research, 37(5), 417-426.

25. Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. Professional Psychology: Research and Practice, 36(5), 544.

26. Ryan, O., Murphy, D., & Krom, L. (2012). Vital signs: Taking the pulse of the addiction treatment profession, a national report, version 1. Addiction Technology Transfer Center National Office in Residence at the University of Missouri–Kansas City. Retrived February 13, 2014.

27. SAMHSA. (2018). Recruitment & retention - building a recruitment and retention plan. Retrieved from http://toolkit.ahpnet.com/Building-a-Recruitment-and-Retention-Plan.aspx

28. Scanlan, J. N., & Still, M. (2013). Job satisfaction, burnout and turnover intention in occupational therapists working in mental health. Australian Occupational Therapy Journal, 60(5), 310-318.

29. Scanlan, J. N., & Still, M. (2019). Relationships between burnout, turnover intention, job satisfaction, job demands and job resources for mental health personnel in an Australian mental health service. BMC Health Services Research, 19(1), 62.

30. Shah, I. A., Fakhr, Z., Ahmad, M. S., & Zaman, K. (2010). Measuring push, pull and personal factors affecting turnover intention: A case of university teachers in Pakistan. Review of Economic and Business Studies, 3(1), 167-192.

31. SHRM. (2017). Employee job satisfaction and engagement: Doors to opportunity are open. Retrieved from https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/Documents/2017-Employee-Job-Satisfaction-and-Engagement-Executive-Summary.pdf

BHECN | BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

32. University of Michigan. Survey Research Center. (1975). Michigan organizational

assessment package: Progress report II. Michigan: Institute for Social Research.

33. USDHHS. (2017). Long-term services and supports: Direct care workers demand

projections, 2015-2030. Rockville, Maryland: U.S. Department of Health and Human

Services, Health Resources and Services Administration, National Center for Health

Workforce Analysis. Retrieved from

https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/hrsa-ltts-direct-care-worker-

report.pdf

34. Webster, L., & Hackett, R. K. (1999). Burnout and leadership in community mental health

systems. Administration and Policy in Mental Health and Mental Health Services Research,

26(6), 387-399.

35. Wilberforce, M., Abendstern, M., Tucker, S., Ahmed, S., Jasper, R., & Challis, D. (2017).

Support workers in community mental health teams for older people: Roles, boundaries,

supervision and training. Journal of Advanced Nursing, 73(7), 1657-1666.

BHECN | BEHAVIORAL HEALTH
EDUCATION CENTER
OF NEBRASKA

Community Mental Health Agencies

Table 1: Demographic characteristics, job information, and intention to leave the current job

VARIABLE	NUMBER	%
Gender		
Male	29	16%
Female	150	84%
Age (years)		
19-29	71	39%
30-39	34	19%
40-49	35	20%
50-59	30	17%
60-70	9	5%
Highest level of education		
High school or GED	32	18%
Associated degree or some college	49	28%
Bachelor's degree	78	43%
Master's degree	18	10%
Doctoral or other terminal degrees	2	1%
Number of years worked in BH field		
< 1	28	16%
1-2	31	17%
3-5	43	24%
6-9	23	13%
≥10	54	30%
Number of years worked in the current agency		
< 1	62	35%
1-2	43	24%
3-5	31	17%
6-9	19	11%
≥10	24	13%
Full-time job status		
Yes	136	76%
No	43	24%
Satisfaction with the current job		
Completely satisfied	31	17%
Mostly satisfied	74	41%
Somewhat satisfied	49	28%
Neither satisfied or dissatisfied	4	2%
Somewhat dissatisfied	16	9%
Mostly dissatisfied	5	3%
Completely dissatisfied	0	0%
Intention to leave		
Yes	59	33%
No	120	67%

Table 2: Bivariate analyses of demographics, job characteristics, and perceived stress associated with intention to leave

| | INTENTION TO LEAVE | | | | |
| | NO | | YES | | |
VARIABLE	Number	%	Number	%	P-value
Gender					
Male	19	65.5	10	34.5	0.4478
Female	108	72.5	41	27.5	
Age (years)					
19-29	55	77.5	16	22.5	0.3479
30-39	20	60.6	13	39.4	
40-49	24	68.6	11	31.4	
50+	28	71.8	11	28.2	
Highest level of education					
High school or GED	27	87.1	4	12.9	0.0729
Associated degree or some college	37	75.5	12	24.5	
Bachelor's degree	49	62.8	29	37.2	
Master's or higher	14	70.0	6	30.0	
Number of years worked in BH field					
< 1	24	85.7	4	14.3	**0.0244**
1-2	26	86.7	4	13.3	
3-5	25	58.1	18	41.9	
6-9	14	60.9	9	39.1	
≥10	38	70.4	16	29.6	
Number of years worked in the current agency					
< 1	49	79.0	13	21.0	0.2326
1-2	32	76.2	10	23.8	
3-5	20	64.5	11	35.5	
6-9	11	57.9	8	42.1	
≥10	15	62.5	9	37.5	
Full-time status					
Yes	94	69.6	41	30.4	0.3689
No	33	76.7	10	23.3	
Stress caused by co-workers					
Not stressful	44	83.0	9	17.0	**0.003**
Neutral	19	73.1	7	26.9	
Stressful	57	57.0	43	43.0	
Stress caused by supervisor					
Not stressful	67	87.0	10	13.0	
Neutral	21	72.4	8	27.6	**<0.001**
Stressful	32	43.8	41	56.2	
Stress caused by clients					
Not stressful	22	73.3	8	26.7	
Neutral	21	65.6	11	34.4	0.728
Stressful	77	65.8	40	34.2	
Stress caused by organizational culture					

Not stressful	42	93.3	3	6.7	
Neutral	26	76.5	8	23.5	**<0.001**
Stressful	51	51.5	48	48.5	

Table 3: Multiple logistic regression of intention to leave according to job information and stress

VARIABLE	REGRESSION COEFFICIENTS (B)	ADJUSTED ODDS RATIO (95%CI)	P-VALUE
Number of years worked in BH field			
< 1		Referent	
1-2	0.002	1.0 (0.2-5.4)	0.0145
3-5	1.76	5.8 (1.3-25.3)	
6-9	1.28	3.6 (0.7-17.8)	
≥10	1.41	4.1 (0.9-17.5)	
Stress caused by co-workers			
Not stressful		Referent	0.9224
Neutral	-0.59	0.5 (0.1-2.7)	
Stressful	-0.19	0.8 (0.2-2.6)	
Stress caused by supervisor			
Not stressful		Referent	0.2135
Neutral	0.32	1.3 (0.3-5.6)	
Stressful	1.62	5.0 (1.7-14.4)	
Stress caused by organizational culture			
Not stressful		Referent	0.5499
Neutral	0.28	1.3 (0.2-7.1)	
Stressful	1.44	4.2 (1.1-18.4)	
Perceived stress	0.30	1.3 (1.1-1.7)	0.0027

BHECN | BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

Table 4: Simple logistic regression of intention to leave according to job information, and stress

VARIABLE	REGRESSION COEFFICIENT (B)	CRUDE ODDS RATIO (95%CI)	P-VALUE
Number of years worked in GH field			
< 1		Referent	
1-2	0.14	1.2 (0.2-4.8)	0.07
3-5	1.83	6.2 (1.8-21.1)	0.002
6-9	1.34	3.8 (1.0-14.0)	0.24
≥10	1.18	3.2 (0.9-10.7)	0.33
Rate the level of stress caused by co-workers			
Not at all stressful		Reference	
Neutral	0.58	1.8 (0.5-5.5)	0.89
Stressful	1.30	3.6 (1.6-8.3)	0.004
Rate the level of stress caused by supervisor			
Not at all stressful		Reference	
Neutral	0.93	2.5 (0.8-7.3)	0.76
Stressful	2.14	8.5 (3.8-19.2)	<0.0001
Rate the level of stress caused by organizational culture			
Not at all stressful		Reference	
Neutral	1.46	4.3 (1.04-17.7)	0.73
Stressful	2.57	13.1 (3.8-45.3)	<.0001
Perceived stress	0.31	1.4 (1.1-1.6)	0.0005