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Relationship between Provider Stigma and Predictors of Staff Turnover among Addiction Treatment Providers

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Abstract

To further our knowledge about feasible targets for improving quality of addiction treatment services, the current study provides preliminary assessment of the relationship between provider stigma and indicators of staff turnover. As predicted, results suggest that higher provider stigma was significantly related to lower ratings of job satisfaction and workplace climate. However, provider stigma was not significantly related to burnout. Our preliminary findings, if replicated, suggest the importance of considering provider stigma as a risk factor for future staff turnover and job dissatisfaction. Promising provider stigma interventions do exist and offer viable opportunity for improving quality of addiction treatment.

Keywords

Addiction treatment facilities; provider stigma; staff turnover; burnout; job satisfaction; workplace climate

Introduction

The importance of providing high-quality treatment for substance use disorders (SUDs) cannot be overstated given that an estimated 22.5 million people are in need of it (Substance Abuse and Mental Health Services Administration, 2014). Unfortunately, there are concerns about the quality of available services (McLellan, Carise, & Kleber, 2003; Miller, Sheppard, Colenda, & Magen, 2001) and high rates of staff turnover (Eby, Burk, & Maher, 2010; Garner, Hunter, Modisette, Ihnes, & Godley, 2012; Knudsen, Ducharme, & Roman, 2006, 2009). Because staff turnover has a detrimental impact on quality of care for SUDs (Ducharme, Knudsen, & Roman, 2008; Knight, Broome, Simpson, & Flynn, 2008), it is important to identify potential intervention targets for improving retention rates among treatment providers.

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Provider burnout (Ducharme et al., 2007; Knudsen et al., 2009; Knudsen, Roman, & Abraham, 2013), low job satisfaction (Eby & Rothrauff-Loschober, 2012; Knight, Broome, Edwards, & Flynn, 2011), and negative opinion about workplace climate (Knudsen et al., 2013; McNulty, Oser, Johnson, Knudsen, & Roman, 2007; Rothrauff, Abraham, Bride, & Roman, 2011) may be a risk factor for attrition. Unfortunately, the underlying component behind these constructs (i.e., dissatisfying work environment) does not easily render itself for an intervention. Given its potential for attenuation (Hayes et al., 2004) and likely relevance to staff turnover, this study focused on provider stigma.

Based on studies conducted predominantly in medical settings, health care providers endorse negative views toward patients with SUDs (see Howard & Chung, 2000; Kelleher, 2007; von Boeckel, Brouwers, Van Weeghel, & Garretsen, 2013 for reviews). Provider stigma is associated with lower quality of care (Kelleher, 2007; von Boeckel et al., 2013), increased burnout (Hayes et al., 2004; Vilardaga et al., 2011), higher turnover intentions (von Hippel, Brener, & von Hippel, 2008), and lower ratings of job satisfaction (Ford, Bammer, & Becker, 2008, 2009) and workplace climate (Vilardaga et al., 2011).

Arguably, provider stigma, burnout, job satisfaction, and workplace climate play an integral role in quality of care through their influence on staff turnover. Still, with the notable exception of Hayes et al. (2004), the majority of prior studies were conducted either within medical settings or high-resource addiction treatment centers thereby limiting their generalizability (Knudsen, Knudsen, Ducharme, & Roman, 2007; von Boeckel, Brouwers, van Weeghel, & Garretsen, 2014). Therefore, it is important to study these factors within community addiction treatment facilities, which is the focus of this study.

Method

Participants and procedures

We conducted secondary data analysis from two waves of a web-based survey (i.e., Fall 2014 and Winter 2015) of treatment providers ($N = 38$) in publicly funded addiction treatment facilities in Los Angeles county. Participants were 62% female, 50% Caucasian, and majority (i.e., 64%) worked in the residential treatment facilities. Study was approved by the research organization's Institutional Review Board, and all participants provided informed consent.

Measures

Job satisfaction and workplace climate were assessed by the Satisfaction and Mission scale, respectively, from the Texas Christian University *Survey of Organizational Functioning* (TCU SOF; 2005). For job satisfaction, participants responded to six items reflecting the extent to which they like their colleagues, value what they do, and feel appreciated for their work. Workplace climate was measured by five questions reflecting the extent to which participants endorse main goals and objectives of their workplace. Higher scores (1 = *disagree strongly* to 5 = *agree strongly*) indicate more job satisfaction or better workplace climate.

Burnout was assessed through the Exhaustion Scale of the Maslach Burnout Inventory–Human Services Survey (MBI-HSS; Maslach & Jackson, 1996). Responding to nine questions participants reported the frequency of emotional and physical job fatigue (0 = *never* to 6 = *every day*), with higher scores indicating more burnout.

Provider stigma was evaluated by an adapted version of the Perceived Discrimination and Devaluation Scale (PDDS; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). The PDDS asks about participants' perceptions of how other people would feel toward individuals with mental illness and has been adapted to other populations, including individuals with SUDs (i.e., Schomerus, Matschinger, Lucht, Angermeyer, 2014). Participants were asked to rate each of the 12 items in Table 1 (1 = *strongly disagree* to 6 = *strongly agree*), with higher scores corresponding to greater endorsement of provider stigma.

Analytic strategy

Separate stepwise linear regression models were used to test the hypothesis that provider stigma predicted each of the three outcomes (i.e., job satisfaction, burnout, and workplace climate) after controlling for a prior assessment of these variables. Thus, we were able to ascertain whether provider stigma accounted for additional variance in each of the three outcomes.

Results

As presented in Table 1, provider burnout was modest ($M = 13.56$, $SD = 11.43$), participants' job satisfaction ($M = 40.48$, $SD = 6.08$) and workplace climate ($M = 36.74$, $SD = 7.07$) ratings were favorable, and they expressed neutral attitudes toward individuals with a history of SUDs ($M = 42.06$, $SD = 19.02$).

Job satisfaction entered in Step 1 accounted for 29% of the variance, $F(1, 36) = 16.74$, $p < .001$ (see Table 2). Next, provider stigma was added, leading to significantly improved model fit $F(2, 35) = 12.23$, $p < .001$ and 38% of outcome variance explained. Higher provider stigma was significantly related to lower job satisfaction.

Workplace climate entered in Step 1 accounted for 40% of the variance, $F(1, 36) = 26.52$, $p < .001$. Addition of provider stigma led to significant improvement in model fit $F(2, 35) = 16.51$, $p < .001$ and 46% of variance explained. Higher provider stigma was significantly related to lower ratings of workplace climate.

Burnout entered in Step 1 accounted for 60% of the variance, $F(1, 36) = 57.02$, $p < .001$. Provider stigma did not improve model fit, $F(2, 35) = 27.73$, $p < .00$, suggesting lack of a significant relationship between provider stigma and burnout.

Discussion

The current pilot study is one of the first to focus on the relationships between provider stigma and variables related to staff turnover within community SUDs treatment facilities. Participants' responses to provider stigma questions are consistent with past research

documenting stigmatizing views toward individuals with SUDs among health care providers in medical settings (Kelleher, 2007; von Boeckel et al., 2013).

In line with prior work (Ford et al., 2008, 2009), our preliminary data suggests that addiction treatment providers endorsing more prejudicial views were significantly less satisfied with their job, even after controlling for earlier job satisfaction. Although these results need to be replicated, there is an accumulating body of evidence that negative views toward patients with SUDs might be related to job satisfaction.

Treatment providers, who more strongly endorsed prejudicial views toward individuals with a history of SUDs, expressed significantly worse opinions about workplace climate. Although preliminary, our results are consistent with those reported by Vilardaga et al. (2011) suggesting a significant relationship between provider stigma and lower endorsement of workplace climate among providers in high-resource SUDs treatment facilities. Further, job satisfaction and workplace climate both represent participants' views of structural factors within the workplace. Our results suggest a consistent relationship between structural factors and provider stigma.

We did not find support for the relationship between provider stigma and professional burnout. These results are contrary to our prediction and prior studies, which were mostly based in settings different from the addiction community clinics represented here (Hayes et al., 2004; Vilardaga et al., 2011; von Hippel et al., 2008). Still, this study is limited due to small sample size. Hence, our discrepant findings ought to be interpreted with considerable restraint.

Negative opinion about workplace climate has been related to lower job satisfaction (Albery et al., 2003; Ford et al., 2008, 2009) as well as higher burnout and work-related stress among addiction treatment providers (Farmer, Clancy, Oyefeso, & Rassool, 2002; Shoptaw, Stein, & Rawson, 2000; Vilardaga et al., 2011). Consequently, there is a need to address such systemic problems within SUDs treatment settings. In light of our preliminary support for the relationship between provider stigma and job satisfaction and workplace climate, it's possible that provider stigma interventions might be related to improvements in providers' views about their work (Hayes et al., 2004). This, in turn, might be related to lower staff turnover rates (Knudsen et al., 2013) thereby leading to improvements in clinical care and patient outcomes (Ducharme et al., 2007; Knight et al., 2011).

These results should be interpreted in light of several limitations. First, given that our sample was recruited in California, the generalizability of our data is limited. Second, due to a small sample size and cross-sectional design, more research is warranted with larger samples and longitudinal design to clarify the nature of the relationship between provider stigma and variables related to staff turnover. Third, our provider stigma instrument consisted of questions about participants' perceptions of the extent to which individuals coping with SUDs are viewed negatively by others. Although these constructs are related, and perceived stigma measures have been used in prior studies (Fortney et al., 2004; Keyes et al., 2010; Li et al., 2013), reports of more direct inquiries into providers' attitudes are warranted to gain a better understanding of this complex and understudied phenomenon. Fourth, we were unable

to assess the extent to which social desirability impacted participants' responses. Because implicit stigma measures are thought to address social desirability concerns (van Boeckel et al., 2014; von Hippel et al., 2008), our results ought to be replicated by with multimethod assessment procedures.

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Table 1

Percent of participants endorsing agreement with the provider stigma items.

Provider Stigma Item	Agreement[a]
1. Most people would willingly accept someone with history of substance use problems as a close friend.[b]	71.7%
2. Most people believe that someone with history of substance use problems is just as intelligent as the average person.[b]	64.2%
3. Most people believe that someone with history of substance use problems is just as trustworthy as the average citizen.[b]	55.8%
4. Most people would accept someone with history of substance use problems as a teacher of young children in a public school.[b]	38.5%
5. Most people feel that entering a treatment facility of substance use problems is a sign of personal failure.	52.8%
6. Most people would not hire someone with a history of substance use problems to take care of their children, even if he or she had been clean for some time.	60.4%
7. Most people think less of someone with a history of substance use problems.	56.6%
8. Most employers will hire someone with a history of substance use problems if he or she is qualified for the job.[b]	64.2%
9. Most employers will pass over the application of someone with a history of substance use problems in favor or another applicant.	60.4%
10. Most people in my community would treat someone with a history of substance use problems just as they would treat anyone.[b]	59.5%
11. Most young women would be reluctant to date a man with a history of substance use problems.	64.2%
12. Once they know a person has a history of substance use problems, most people will take his or her opinions less seriously.	52.8%

[a]Percent of participants, who at least “somewhat agreed” with each statement.

[b]Agreement with these items represents lower stigma. Thus, they were reverse-coded.

Table 2

Summary of sequential regression analysis of provider stigma as a predictor of job satisfaction, workplace climate, and professional burnout, $N = 38$.

Step	β	*SE* β	Adjusted R^2	ΔR^2
		Job Satisfaction Wave 2		
1. Job satisfaction Wave 1	.58***	.13	.29***	.29**
2. Provider stigma	−.31*	.16	.38*	.09*
		Workplace Climate Wave 2		
1. Workplace climate Wave 1	.67***	.12	.40***	.40
2. Provider stigma	−.25*	.26	.46*	.06*
		Professional Burnout Wave 2		
1. Professional burnout Wave 1	.78***	.12	.60***	.60
2. Provider stigma	.01	.16	.59	.01

* $p < .05$.

*** $p < .001$.