

DEVELOPMENTAL DISABILITIES TASK FORCE
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PERSONNEL TURNOVER IN COMMUNITY GROUP HOMES FOR MENTALLY
RETARDED PEOPLE IN THE TWIN CITIES METROPOLITAN AREA

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PREFACE

In January 1981, the Developmental Disabilities Task Force of the Metropolitan Health Planning Board/Metropolitan Council began to examine the extent and causes of staff turnover in community residential facilities for mentally retarded people in the Twin Cities Metropolitan Area. The study concentrated on employees who provided direct service to clients.

This report gives study findings, which are based on a regional survey of residential providers. The conclusions contain some heartening news and a warning. The good news: Staff turnover in Area community facilities is much lower than in other areas of the country. Furthermore, all measures of turnover—turnover rates and actual number of staff terminations, full-time turnover and part-time turnover—have been declining for the last two years.

The warning: The last several years have been turbulent times of economic uncertainty and widespread unemployment. Many providers attribute low turnover to the unfavorable job market. If the decline in turnover is due to these factors, the problem may return as the economy recovers unless administrators take corrective action. The report cites numerous strategies that administrators said reduced turnover among direct-care staff. Not all these strategies require increases in compensation. Many administrators thought that giving staff more responsibility and more say in management decisions were the best ways to keep good staff.

Acknowledgement is due many people. Administrators and program directors responded promptly to the surveys even when their responses required laborious calculations or compiling old data. The Developmental Disabilities Task Force reviewed and commented on several drafts of the study. Dr. K. Charlie Lakin of the Center for Residential and Community Services at the University of Minnesota provided valuable background information on the problem of turnover and shared results of his national study.

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BACKGROUND

Since the 1950's a dramatic shift has occurred in the way human services are provided to people with developmental disabilities. Normalization—the idea that disabled people are entitled to lives as normal as possible—took hold in Denmark in 1959 and soon became the dominant philosophy in service delivery throughout much of the world.

As understanding and acceptance of "normalization" spread, it became obvious that institutionalization practices had to be reversed. Pressure for deinstitutionalization escalated in the 1970s. In Minnesota, the number of community residential facilities for mentally retarded people increased from 105 in 1974 to over 300 today¹. Nationally, the number of mentally retarded people in public institutions declined by roughly 70,000 between 1967 and 1982.² Many of those who formerly resided in large public institutions moved to one of the nearly 4,500 community residential facilities developed as normalization took hold throughout the United States. These facilities are new and they are small. Over half have been established since 1973, and nearly three-fourths are serving 10 or fewer persons³.

Although deinstitutionalization reversed many earlier practices, one problem that did carry over from the institutional era was staff turnover. As early as 1912, administrators of public facilities were decrying the rapid rotation in direct-care staff⁴. Recently, several studies have examined direct-care staff turnover rates both in public facilities and in community residential facilities. Table 1, which summarizes these studies, shows that facility turnover rates fluctuate considerably. Some facilities report no turnover, while similar ones may report rates of 200 percent or more. Researchers have found average turnover rates of 26 percent to 71 percent.

Several authors have highlighted the critical importance of direct-care staff in operating a successful facility and have expressed concern at these high turnover rates. In Lakin and Bruininks' 1981 study⁵, nearly two-thirds of administrators questioned said that staff turnover was a problem in their facility. In a 1976 study⁶ of community facilities, only "inadequate funds" was rated as a more serious problem in running programs. Finally, of the 2,100 administrators responding to a 1980 survey, 84 percent cited a major problem in the area of recruitment, retention or training.

Lakin cites several reasons why stability of direct-care staff is important. First, turnover increases the cost of recruiting and training staff, and may generate higher administrative expenses.

Second, while the evidence is not conclusive, studies suggest that turnover adversely affects the quality and continuity of services. An early study⁸ concluded that in some facilities for mentally retarded persons, residents may deal with 20 new direct-care staff in a six-month period. In studies of hospital patients, high staff continuity has been linked with earlier discharge of patients, while turnover was related to poorer standards of nursing care. Another author suggested a relationship between the number of suicides among mental patients and the necessity that they deal with a steady stream of new staff. Moreover, researchers have found that it isn't the least-able staff who leave. Price concluded that high performers were more likely to leave⁹. while a 1980 study found that only 30 percent of terminated staff were "below average"¹⁰.

Finally Lakins, discussing normalization, points out that "nothing...violates this principle more than rapid rotation of those persons to whom mentally retarded persons in residential facilities must turn for those primary relationships, which most members of society find in families."¹¹

Table 1
TURNOVER RATES AS REPORTED
IN EARLIER STUDIES

<u>Study</u> ¹²	<u>Site</u>	<u>System-Wide Rate</u>	<u>Facility Avg. Rate</u>	<u>Facility Range</u>
Bensberg and Barnett (1966)	37 public facilities	—	30%	2-102%
Scheerenberger (1978)	public facilities	—	26%	3-126%
Ganju (1979)	public facilities in Texas	—	1978: 64% 1979: 71%	38-88% 45-112%
Landesman-Dwyer, et al (1976)	community facilities in Washington	—	42%, had 100% or more	—
George (1980)	community facilities in Tennessee	small 100% large 65%		0-200%
Lakin and Bruininks (1981)	71 public, 151 community facilities	29.5% 55.4%	32.8% 54.2%	2-157% 0-400%

TWIN CITIES TURNOVER STUDY

In 1981, the Developmental Disabilities Task Force of the Metropolitan Council/Metropolitan Health Planning Board began an examination of turnover rates among direct-care staff in community residential facilities in the Twin Cities Metropolitan Area. For several years, task force members had been concerned about reports of high turnover in such facilities. Although the extent of the problem in Minnesota had not been documented, the experience of professionals and reports of parents and advocates led the task force to suspect that the Twin Cities mirrored the situation nationally. Furthermore, turnover and ways to combat it were frequently addressed by those intending to develop new community residential facilities in the Region.

STUDY DETAILS

The task force effort was intended to discover:

1. Turnover rates by facility and for the system as a whole;
2. Facility characteristics related to turnover, such as size and clientele;
3. Administrators' opinions about the causes of turnover in their facilities; and
4. The cost of replacing a terminated employee.

A questionnaire was mailed to a random sample of approximately one-third of the community residential facilities* in the Metropolitan Area. Facility administrators responded to four questions:

1. For full-time and part-time direct care staff: the number of direct care staff positions in the budget and the number of controllable terminations** in 1982;
2. Their most successful strategy(ies) for retaining direct-care staff;
3. The average cost of replacing a staff member (a worksheet was attached to aid in this calculation); and
4. The importance of each of 10 factors as a cause of controllable staff turnover. Because recent economic changes were alleged to have distorted staff turnover and its causes, administrators were asked to rank importance of each factor as a cause of staff turnover in the last few years, and in the last six months.

A follow-up questionnaire was also distributed to collect turnover rates for the previous two years and to determine if administrators felt that turnover had, in general, changed in the last few years.

* The study was restricted to community residential facilities licensed under DPW Rule 34 and certified as an Intermediate Care Facility for the Mentally Retarded (ICF-MR), or licensed under DPW Rule 80.

** Controllable terminations were those not caused by death, illness, pregnancy, retirement or layoff.

For each facility in the sample group, additional data was secured from the Developmental Disabilities State Program Office, Department of Energy, Planning and Development, regarding the characteristics of the facility's clients and its various personnel and compensation policies. The facilities ranged in size from 6 to 101 persons. Three quarters of the facilities had 15 or fewer residents, while nearly 20 percent had 48 or more residents. Two-thirds of the homes sampled served mild or moderately retarded people; the remainder serving those with severe or profound retardation. One-third of the facilities reported that more than a quarter of their residents had multiple handicaps, although only two reported that all residents were multiply handicapped. Similarly, a quarter of the respondents said that more than half of their residents had severe behavior problems.

STUDY RESULTS

SYSTEM-WIDE TURNOVER RATES

Over three-quarters (26) of the 34 facilities responded to the initial survey or to the follow-up questionnaire. There was no pattern among facilities that didn't respond, such as size of facility or characteristics of residents. Tables 2 and 3 summarize the statistics on turnover rates.

Table 2
SYSTEM-WIDE TURNOVER OF DIRECT-CARE STAFF
IN COMMUNITY RESIDENTIAL FACILITIES
1980-1982

	1982	1981	1980
Full-Time Positions	19%	24%	34%
Part-Time Positions	29	52	64
All Positions	23	37	49

Table 3
AVERAGE FACILITY TURNOVER RATES FOR DIRECT-CARE STAFF
1980-1982

	1982 N=26			1981 N=25			1980 N=17		
	Range	Mean	Median	Range	Mean	Median	Range	Mean	Median
Full Time	0-100%	19.8%	0%	0-100%	24.1%	20.0%	0-100%	32.5%	19.75%
Part Time	0-100	35.5	31	0-125%	45.0	38.8	0-125	60.1	55.00
All Staff	0-83	27.2	23	0-121%	38.0	35.0	0-121	52.3	50.00

The respondents listed 237 full-time direct-care positions and 194 part-time positions in 1982. The turnover rate (controllable) was 19 percent among full-

time employees and 29 percent among part-time employees. Both rates are considerably lower than rates reported in the literature (see Table 1). There has also been a steady reduction in system-wide staff turnover during the last two years. Overall staff turnover, for example, declined from 49 percent in 1980 to less than half that rate in 1982.

FACILITY TURNOVER RATES

Since the focus of the study was not system-wide rates, but average turnover in a facility, the facility statistics were also calculated. As Table 2 shows, the range of controllable turnover rates among-facilities was very wide. In 1982, facilities had turnover rates of from 0 to 100 percent for full-time or part-time employees and from 0 to 83 percent for direct-care employees. The means (averages) were 19.8 percent for full-time employees, 35.5 percent for part-time employees and 27.2 percent for all direct-care staff. While the range of facility turnover rates is comparable to that found in earlier studies, the average facility turnover rate is substantially lower. In some cases, turnover rates in earlier studies are more than twice as large as the rates found here. Yet even these low average rates overestimate turnover. The median (middle) facility turnover rate for full time employees was zero percent; over one-half of the facilities responding reported no full-time turnover in 1982.

The difference between the averages and medians has two causes. First, a few facilities had high turnover. Fully 60 percent of all full-time turnover occurred in two large (48 or more residents) facilities. Second, a few facilities recorded high turnover rates when one or two people departed from a very small staff. This combination of factors increases the average for all facilities even though most facilities had no full-time turnover.

Comparing 1982 rates with earlier years provides an interesting contrast. Although the range of facility turnover rates has not changed, the average facility rate has declined substantially since 1980. Full-time turnover rates have decreased from 32.5 percent in 1980 to 19.8 percent today. The changes in part-time and overall rates are even more dramatic. In both cases the 1980 rate is twice as high as the corresponding 1982 rate. Of the 26 administrators responding to the survey, roughly 70 percent said their facilities had experienced lower turnover in 1982 than in previous years. In the few instances where turnover was said to have increased, the increase was attributed to unique circumstances such as a change in ownership/management. Over 60 percent of administrators who said that turnover in their facility had decreased attributed the decrease to the economy, as Table 4 shows.

Table 4
ADMINISTRATORS' RESPONSES: WHY WAS YOUR FACILITY'S
TURNOVER LOWER IN 1982 THAN IN PREVIOUS YEARS?
(N=18)

Economy/No Jobs	61.0%
Program Maturity	22.0
Improved Hiring Practices	11.0
Increased Benefits/Pay	11.0
Good Working Relationship	11.0
Better Work Schedules	5.5
Better In-Service Training	5.5

TURNOVER AND CHARACTERISTICS OF THE FACILITY

The focus of several earlier studies has been individual clients and organizational characteristics related to turnover. Lakins reviewed the relationship between the factors and staff turnover; his summary table is reproduced here in the Appendix.

Because the current study focused on administrator reports and perceptions, conclusions about the types of individuals who leave or stay in direct-care jobs cannot be drawn. However, several facility characteristics and administrative practices were examined for possible associations with staff turnover. Also, a later section looks at administrator ratings of 10 possible causes of turnover.

The relationship between turnover and the following facility characteristics was examined: functioning level of clients, proportion of clients with multiple handicaps, proportion of clients with behavior problems, and size of facility. In addition, a relationship was sought between turnover and certain administrative or personnel practices, such as personnel policies, performance appraisals, job descriptions, and a staff development plan. These data were obtained from an earlier training needs survey of the same facilities.

Part-time, full-time and total staff turnover were examined. The analysis measured turnover in two ways: 1) annual turnover rates, and 2) the actual number of staff who left direct-care jobs during the year. Because so many facilities experienced no turnover, a statistical analysis of characteristics related to turnover is hard to interpret. Table 5 summarizes the factors examined and their relationship to staff turnover.

Table 5

FACTORS THAT MAY INFLUENCE DIRECT-CARE STAFF TURNOVER

<u>Characteristic</u>	<u>Relationship to Rate</u>	<u>Turnover Measures Actual Number</u>
Client Characteristics		
Functioning Level	No	No
Multiple Handicaps	No	No
Behavior Problems	Yes(-)	No
Facility Size	No	Yes(+)
Personnel Practices		
Personnel Policy	No	No
Performance Appraisals	No	No
Job Descriptions	No	No
Staff Development Plan	No	No

Neither facility size nor administrative practices* were related to the turnover rate of a facility. Indeed, only one characteristic was significantly related. As the proportion of clients with severe behavior problems went up, the rate of staff turnover went down. There was nothing in the data to explain this paradox.

RETENTION STRATEGIES

Respondents cited 11 strategies they thought had been successful in retaining direct-care staff. Table 6 lists these in order.

Table 6
ADMINISTRATORS' RESPONSES: SUCCESSFUL STRATEGIES
FOR RETAINING DIRECT-CARE STAFF
(N=24)

<u>Strategy**</u>	<u>Respondents Citing</u>
Involving staff in decisions	43.0%
Adequate/improved fringe benefits	25.0
Giving autonomy/responsibility	19.0
Competitive salaries	19.0
Providing adequate support	12.5
Training opportunities	12.5

**In addition, the following five strategies were each cited by one administrator: open communication, management by objectives system, variety in duties, opportunity for advancement and the economy.

Clearly, administrators thought that participatory management and compensation issues were the most important determinants of job satisfaction.

COST OF REPLACING DIRECT-CARE EMPLOYEES

Although the reported cost of replacing an employee ranged from \$20 to \$1,000, the average and the median were much closer, \$327 and \$255, respectively. Included in these costs were separation costs, overtime to cover the vacant position, advertising the vacancy, interviewing applicants and orienting and training new employees.

Several factors were responsible for the disparity in reported replacement costs. First, facilities with multiple vacancies were able to economize by advertising several vacancies and training several new employees simultaneously. Second, because not all facilities returned the worksheet, it is not clear that administrators consistently estimated all costs related to replacing a new employee. These replacement costs are lower than the \$500 average reported in a 1980 study of community residential facilities in Tennessee.

*The statistical analysis was limited because all the facilities in the sample tended to follow the same administrative practices. For example, all had personnel policies and job descriptions, but only two had a staff development plan.

In addition to dollar costs of turnover, several administrators commented on the "intangible" toll staff separation exacts on resident programs and continuity of care.

ADMINISTRATORS' RATINGS OF FACTORS CAUSING TURNOVER

Administrators were asked to rate the importance of 10 factors as causes of controllable direct-care staff turnover in their facilities. Each factor was rated on a scale of 1 (very important) to 5 (not at all important). Because changes in the economic climate were alleged to have altered the causes and extent of recent staff turnover, administrators were asked to rate the ten factors as a cause of turnover in both "the last few years" and "in the last six months."

Table 7 lists the mean (average) and median ratings of each factor. Although very few facilities had experienced recent turnover, all still rated causes of turnover in the last six months. Presumably, these administrators were citing factors they thought caused turnover in community facilities in general.

Table 7
ADMINISTRATORS' RATINGS OF 10 FACTORS AS CAUSES
OF CONTROLLABLE DIRECT-CARE STAFF TURNOVER

	(N=24) (1 very important cause; 5-very unimportant cause)			
	Last Mean	Few Years Median	Last Six Mean	Months Median
New Career/Return to School	1.7	2	1.9	2
Lack of Career Advancement	2.3	2	2.8*	3
Salary	2.6	3	3.1*	3
Fringes	2.6	2	3.1*	3
Hours	2.6	3	3.1	3
New Job in DD	3.3	3	3.6*	4
Client Problems	3.5	3	3.3	3
Location	3.6	3	3.4	3
Supervisor Problems	3.7	4	3.4	3
Co-Worker Problems	3.7	4	3.4	3

* These differences in mean were significant at $p=.10$ or beyond.

The most important causes of direct care staff turnover in the last few years have been: career changes/return to school and lack of career advancement. Salary, fringes and hours all tied for third place. In the last six months, staff turnover was attributed to the same factors in roughly the same order.

Although the rank order of the factors is roughly the same in both time periods, most factors are deemed less important causes in the more recent time period. The exceptions are "location" and three "interpersonal" factors (problems with clients, supervisors or co-workers). Comparison of the medians draws a similar picture. Two interpersonal factors are the only factors whose importance as a cause increases when the two sets of medians are compared.

CONCLUSIONS

At this time in the Metropolitan Area, staff retention is not a serious problem in community residential facilities. The system-wide turnover rate is a fraction of the rates reported in studies conducted throughout the nation. Regarding facility turnover rates, although the range of rates is comparable to other studies, the average facility rate is much lower than rates reported in other studies. Indeed, over one-half of facilities reported no full-time turnover in 1982.

When 1982 is compared with earlier years, it is clear that all measures of turnover—both system-wide and facility rates—have declined. The current economic situation is an obvious culprit and, in fact, 61 percent of respondents who noted decreases in recent facility turnover mentioned the economy as a factor. The analysis of reasons that staff leave their jobs seems consistent with an economic explanation. A dearth of alternatives means that staff must be "pushed" from their jobs by an intolerable situation.

Interpersonal factors—problems with clients, supervisors or co-workers—were the only factors with higher ratings when causes of turnover in the last six months were compared with causes in the last few years.

In short, current economic conditions have allowed administrators to "buy time" in terms of making direct-care jobs more attractive. If, in fact, the economy is suppressing a normally higher turnover rate, then the problem will resurface with economic recovery. There are effective actions available to administrators even in a field plagued by low pay. On the bright side, four of the six retention strategies cited by administrators did not require increases in compensation. Clearly, administrators think that job enrichment is as important as compensation in making direct-care jobs attractive to qualified people.

As the economy improves, three additional types of research should be undertaken. First, administrators should be surveyed to determine turnover rates in a more favorable job market. Second, additional facility characteristics should be investigated. For example, does the type of staffing—houseparent vs. shift staff—affect the turnover rate. And third, staff surveys must be done to verify administrators' observations about the causes of turnover and to determine "profiles" of the types of people who are likely to accept and remain in direct care positions.

FOOTNOTES

1. Data supplied by Mental Retardation Division, Minnesota Department of Public Welfare, St. Paul, Minn.
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 16. M. J. George and A. A. Baumeister. Employee Withdrawal and Job Satisfaction in Community Residential Facilities for Mentally Retarded Persons. American Journal of Mental Deficiency. 85(6). 1981. 639-647.
 17. K. C. Lakin and R. H. Bruininks. op. cit.
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APPENDIX

Relationships Between Selected Factors and Employee Job Instability

Factor	Relationship	
	Yes	no
Age	X(-)*	
Length of Service	X(-)	
Sex		X
Family Influence	X(+)	
Amount of Education	X(+)	
Pay	X(-)	
Upward Mobility	X(-)	
Integration	X(-)	
Communication	X(-)	
Autonomy	X(-)	
Routinization	X(+)	
Use of Employee Ability	X(-)	
Realism of Expectations	X(-)	
Facility Size	X(+)	
Interest Level of Work	X(-)	
Independence of Clients	X(-)	
Perception of Status	X(-)	
Satisfaction with Supervisor or Work Unit	X (-)	
Company Opportunity	X (+)	

* An inverse relationship (-) means that as the predictor (e.g. age) goes up, the amount of employee turnover goes down. In a positive relationship (+) , as the value of the predictor increases, the amount of turnover also increases.

Source: K. C. Lakin and R. H. Bruininks. Occupational stability of direct care staff of residential facilities for mentally retarded people (1981).