INFLUENCE OF RETENTION STATISTICS
ON SUBSTANCE ABUSE PRACTICE

THE INFLUENCE OF RETENTION STATISTICS
ON A SHORT-TERM RESIDENTIAL SUBSTANCE ABUSE
TREATMENT FACILITY

BY

IAN ROBERTSON

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TITLE: The Influence of Retention Statistics on a Short-term Residential
Substance Abuse Treatment Facility

AUTHOR: Ian Robertson
Bachelor of Social Work (Niagara University)

SUPERVISOR: Dr. Roy Cain

Abstract

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By: Ian Robertson
Master of Social Work Program
McMaster University
Hamilton, Ontario

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Residential addiction agencies are confronted by government with the expectation of collecting retention data. Retention as a statistic is being used to measure treatment effectiveness. The use of retention statistics to measure treatment effectiveness creates tension for managers and staff. This research will explore the use of retention statistics within the organization and the tension it creates for manager and frontline staff. The collection of retention data has shaped policies and practices that are "number-centered" versus "client-centered." Previous literature on retention statistics and personal interviews were methods utilized to gather data.

Acknowledgements

TABLE OF CONTENTS

Introduction

The production of administrative data has become as important to residential substance abuse treatment facilities as the services they provide. In today's performance-driven economy-focused climate, agencies must produce factual data that reflect the effectiveness of their services. Edmund De Jesus (2001) suggests that factual data justifies programs. Statistical data can form the basis on which those within it judge the performance of an organization (p. 19). Client "retention" data – the number of clients who remain in residence for a prescribed period of treatment - is one method used to measure treatment effectiveness and client improvement for the purpose of seeking funding. Carroll (1996) also states that in substance treatment, retention is more or less the outcome and better retention tends to be associated with better outcomes in terms of reductions in substance use (p.6).

The tracking of retention has been used to measure the effectiveness of organizations and agencies based on past findings of client outcome. However, focusing on retention as an outcome can create many new difficulties for service providers. For example, the need to demonstrate high retention rates may influence who is admitted for treatment. According to Roberts, Ogborne, Leigh, & Adam (1999), "in aiming to improve outcomes, [addiction] services may employ high requirements which will likely increase success rates [retention], but deny services to those in most need of help. Inevitably, by maximizing outreach to those who need treatment the most, agencies may be working with poor

candidates for success regarding outcome measurements" (p.64). When retention becomes the measured outcome, clients with enhanced psychosocial functioning are more likely to be admitted for treatment based on their ability to complete treatment. Thus, the focusing on retention as a measured outcome can influences who receives treatment.

When treatment effectiveness and client improvement are determined by length of stay, treatment services begin to adopt new methods and interventions to retain their clients. The retaining of clients or "keepology" (Fyock, 2000, p.175) as a treatment approach creates new conflicts for substance abuse addiction workers. These conflicts are evident in program delivery and case management. The pressure to focus simultaneously on numbers and on client can be frustrating and overwhelming. These frustrations are evident when residential counsellors have to make decisions about clients who tell them they are ready to leave treatment early or about other clients who have been admitted to the program and are not treatment-appropriate or treatment-ready. This project will examine how tracking retention statistics in a short-term substance abuse residential treatment facility influences organizational decision-making regarding client service.

Research Objectives

The objective of this research is to understand how administrative data collection, and specifically how tracking client "retention" influences addiction treatment services. To reach this objective, I will interview a number of service providers and administrators at a treatment agency about their data collection practices and policies. I will examine how they define retention, how they collect information relating to retention, and how this information is used by the agency and its funders. By conducting this research, I hope to gain insight into the ways administrative data collection shapes organizational practices and treatment services in a residential substance abuse setting.

Literature Review

So what's in a Number?

Numbers help us make sense of our lives and they influence many of the decisions we make. One author suggests that "the need to measure is a ritual that begins at birth. A screaming newborn is placed on a table and measured. A youngster stands proudly, anxiously, against the wall at home where writing is allowed, by the magic marker growth chart. Measurements might be monthly, weekly, or, for those especially ambitious and vertically challenged kids, daily. The ultimate joy is to see a new hash mark above the previous one, however minimal the advancement. Ah, the power of measurement!" (De Jesus, 2001, p.19). We have come to learn that much of who we are is determined by numbers: our age, height, weight, salary, house or apartment number, and bank account, are among them. Numbers play an important role in how we are defined within our society. They measure us to others and, to a large extent we are judged by them.

The need to construct meaning from numbers goes beyond the individual to the broadest macro institutions of our society. In the western world since the eighteenth century, governments have increased the resources and effort put into enumerating their countries' assets and people, eventually resulting in a large data base to aid in governance (O'Neill, 2003, p. 250). Junius Wood (1986) states that governments produce statistics in greater abundance than all the private agencies combined (p.47). Numbers provide a means to control

individuals and groups. Numbers are a major instrument for constructing objectivity and standardization (Horstman, 2000, p.40). Within this context, agencies and organizations have learned the value of producing numbers.

Factual data must be determined by someone using specific criteria. Does this person have an investment in the numbers that became defined as "factual?" What criterion was used to accept one set of numbers and then discount another? How were the numbers formed, produced, shaped and ultimately created? Joel Best (2001) provides an interesting perspective on these many questions. He suggests that all statistics are produced by and are by-products of decisions by various officials (p.24). The officials make choices that shape whatever statistics finally emerge from their individual organization or agency and then the organization provides a context for those choices. Best (2001) states that social statistics have two purposes. The first is public, and the other is hidden (p.13). The public purpose is to give an accurate description of society. The hidden uses of statistics are evident when used to support particular views about social problems. People who take on advocacy roles use statistics to support their viewpoint, thereby creating a means to bring others around to their way of thinking. In so doing an advocate can lead others to support a position, a cause, and an interest. People's actions determine how statistics are created. Choices and decisions are made while "official statistics" are being constructed. People decide how numbers are counted, calculated, and interpreted. Best (2001)

summarizes that statistics are socially constructed by people in his book "*Damned Lies and Statistics*".

> *"Statistics do not exist independently; people have to create them. Reality is complicated, and every statistic is someone's summary, a simplification of that complexity. Every statistic must be created, and the process of creation always involves choices that affect the resulting number and therefore affect what we understand after the figures summarize and simplify the problem. People who create statistics must choose definitions – they must define what it is they want to count – and they must choose their method – the ways they will go about their counting. Those choices shape every good statistic, and every bad one. Bad statistics simplify reality in ways that distort our understanding while good statistics minimize that distortion. No statistic is perfect, but some are less imperfect than others. Good or bad, every statistic reflects its creators' choices"*
> *(Best, 2001, p.160)*

Others have questioned the construction, interpretation, and use of statistics. In 1946, Junius Wood suggested that a group of statistics might have a thousand angles (p.47). Thousands of ideologies can draw thousands of conclusions, and yet only one conclusion will be selected and subsequently "defined" as correct. Wood suggested that statistics can be shaded and hand-picked to get the desired result (p.48). Further, he suggested that the evil of statistics is hidden when the result is credited to a statistician and labelled as statistics instead of political propaganda (p.48). Wood questioned the validity of numbers, how they were produced, organized, and selected to be defined as statistics. Wood's (1946) work supports the argument that statistics are produced within an agenda (p.47).

Others have recognized that statistics are not necessarily politically neutral, and that the motives of the those producing the statistics are open to question. Lesley Saunders (2000) studied a national statistical data base that was established throughout the educational system in the United States to measure the performance of students in the nation's public schools (p.241). The goal of studying this statistical database was to measure student progress, as well as the prevailing educational standards. The statistical data for this study were generated by government agencies. These data were termed "value added data" (Saunders, 2000, p.242). Defining the research as "value added data" implied that this project would focus on assessing the quality, standard or value of the educational system. Although this project was presented as being beneficial to improving education, Saunders asked: did all parties outside of those who conducted the research understand it in the same context? How would the national tracking of this performance data be interpreted at a local level by teachers? In fact, teachers reported that performance data evoked anxiety and some teachers viewed it as an overt threat (Saunders 2000, p. 254).

Saunders (2000) identified the government as the major stakeholder and the pupils and teachers as the sample being measured (p.241). The stakeholders viewed themselves as being impartial in generating performance data, but such perception is rarely interpreted as being neutral by those who are being assessed. Statistical data that are not transparent or understood might not be accepted as legitimate (Saunders, 2000, p. 254). Chan and Lenth (2002) are of

the opinion that "we shouldn't trust statistics proferred by a person who has an agenda; but Best emphasizes that all social research is driven by people who have an agenda, and that neither the underlying social issues nor the statistical data would even exist if it were not for someone setting an agenda to identify, characterize, promote, and investigate it" (p. 156).

In summarizing the value of statistics, Chan and Russell suggest that "statistics are often quoted and accepted without much thought, and yet when asked, people don't trust statistics or statisticians. In spite of these difficulties, society really needs good statistics to function" (Chan & Russell, p.156).

Do Any "Good" Statistics Exist?

> Bad statistics simplify reality in ways that distort our understanding while good statistics minimize that distortion. No statistic is perfect, but some are less imperfect than others. (Best, 2001, p.161)

According to Best (2001), "good statistics should be based on more than just guessing. Good statistics should have evidence of clear, reasonable definitions. These statistics should be based on clear, reasonable measures and these statistics should be generated from good samples" (p.59). Another factor that adds validity to statistics, and improves their quality is when the observations that constituted the evidence for the produced outcome statistics are constructed systematically and comprehensively (Rubin and Babbie 2001, p. 28). In order to do this, good researchers and statisticians recognize their personal biases and

will find ways to gather observations that are not influenced by their biases. To accomplish this, the researcher must ensure that the sample for observation is large enough and diverse. Clear definitions, awareness of potential personal biases from the producers of the statistics, caution against over-generalization, and replication of the study, all assist in producing good statistics. All procedures should be specific to make evident the basis for the conclusions reached and in order to measure whether statistical data is accurate, it needs to be replicated to ensure that the prior findings were objective, accurate, and generalizable. By replicating the study, researchers are able to investigate if the same conclusions are produced (Rubin and Babbie, 2001, p. 28). Good statistics, although not perfect, do exist and can be produced.

Within the field of addictions, statistics such as client retention have become an important component of treatment centres' reporting to government agencies. This raises a number of questions: why is the tracking of retention considered to be so valuable; what is the purpose of collecting client retention data; what impact does the tracking of retention have on how the addiction field functions; who is the advocate who collects the statistics; and how are statistical data interpreted once they are produced? The following sections will review the construction of tracking "retention" as a statistic. In examining the literature, the process of reporting, the anticipated benefits, and the different methodological challenges will be identified while tracking retention. The construction of retention

benefits will be examined from two perspectives, those of the corporate world and the world of addictions.

The Invisible "Eye" of Statistics

Statistics have hidden power. Smart (2002) describes the hidden power of statistics from a Foucauldian perspective. He states that "in the sixteenth and seventeenth centuries the art of government was conceived in terms of the model of the family, that is government of the state was likened to a form of surveillance, of control which is as watchful as that of the head of a family over its household and his goods" (Smart, 2002, p.129). Governmental statistics became a science that identified specific problems within its population. Statistics became the major component of the new technology of government. Parton describes Foucault's notion of governmentality as an "ensemble formed by the institutions, procedures, analysis and reflection, the calculations and tactics, that allow the exercise of this specific albeit complex power. The regulation of the population has proven to be the unending concern of governmentality" (Chambon, Irving & Epstein, 1999, p.104). Statistics are a means of surveillance and a method of control by those for whom the numbers were created.

RETENTION and its Corporate Evolution

The tracking of retention over time has been used to measure the effectiveness of organizations and agencies. Outside of addiction agencies and other related organizations, retention is used to measure outcome. In the private sector statistics are used to measure employee retention rates within an organization. High rates of employee retention within a corporation suggest a happy, and satisfied staff, and an effective employer. Companies having high employee retention rates have greater profitability. Happier and more productive the staff can positively influence customer satisfaction. Bosses who allow flexible work schedules present a major job benefit for employees, influencing employee retention rates (Izzo et. al., 2002, p. 54). Low employee retention in the private sector often comes with an expensive price tag. The process and cost of advertising, recruiting, retraining, and orientating new staff is an extra financial strain and there is decreased productivity until the new employee stands on his or her own feet in the company (Kaye & Jordan-Evans, 2000, p.29). When retention rates are low in a corporation, the outcome is often attributed to the manager, who then becomes characterized as lacking management skills (Izzo & Withers, 2002, p.57). According to Kaye (2001), president of a training firm for Career Systems International, employees do not leave companies, but instead they leave their bosses (p.58).

Within the corporate world, retention plans are being designed to minimize employee turnover rates. Strategies to enhance retention are being studied in

order to reverse the current trend. One author writes that the secret to improving retention in the corporate environment is to "keep the people who keep you in business." This can be done by:

1. being a company that people want to work for

2. selecting the right person in the first place

3. coaching to maintain commitment (Fyock, 2000, p. 173)

The corporate influence on tracking employee "retention" rates parallels the tracking of client "retention" in the field of residential substance abuse treatment. Within residential substance abuse treatment, tracking client retention has become a vital part of an agency's outcomes reported to political bodies such as the Ministry of Health and Long Term Care. Many of the themes that the corporate sector uses to describe "good" or "poor" retention have been adopted by substance abuse agencies. The most common theme is that the clients retained in treatment longer have better outcomes. One study states that "alcohol and drug treatment completers (those who stay for the full program of treatment) have better outcomes than dropouts. Length of time spent in a treatment episode is moderately related to outcome for alcoholics and strongly related to outcomes for drug abusers" (Oene, Schipper, De Jong, & Schrijver, 2001, p.253).

In following the corporate definition of retention, it could be suggested that addiction clients, (like corporate customers), with high rate of retention, leave substance abuse treatment facilities happier than they were, and satisfied with the service. Corporations which retain staff are considered to be effectively run.

Treatment facilities that retain clients are considered to have effectively-run programs with quality counsellors, who support the needs of their clients to remain invested in treatment, (like staff that remain happily invested in their corporations.) When clients remain in treatment, bed utilization is high, which helps the agency's finances, since most are funded by length of stay and bed utilization rates. High retention statistics have other benefits for agencies as well. The following section will briefly review some of these benefits.

RETENTION Benefits for Addiction Treatment

Some studies have suggested that the correlation between the length of time spent in treatment and clinical outcomes is strong enough to deserve ongoing investigation. These studies tend to deem outcomes as favourable when the client surpasses the critical threshold: that is three-months or longer in treatment (Gossop, Marsden, Stewart & Rolfe, 1999, p.90). Three other researchers identified the length of time spent in treatment as an important predictor of improvement, post-treatment outcomes, and conclude that clients who stayed in residential rehabilitation programmes for periods of three months or more had greatly improved outcomes compared to those who left earlier (Gossop et al., 1999, p.90).

However, even clients who decide to leave treatment earlier report some decrease in their substance misuse. One study of 408 clients from 23 residential treatment programs correlated the length of time in treatment and substance use

outcomes. The finding reported that "more than one-third of the clients who stayed in substance abuse treatment for less than the critical threshold (under a 3 month period) were abstinent from heroin at one year, and 61% were abstinent from stimulants. Even the simple procedure of admitting patients to a treatment program may lead to some improvement in drug misuse problems" (Gossop, et. al., 1999, p.95). Apparently, therefore any amount of retention in treatment demonstrates some benefits to the individual.

Retaining clients is beneficial to other clients who are receiving the same treatment. Individuals who depart from treatment early have a negative impact on those who remain in treatment by disrupting group solidarity. The act of early departure from treatment can create a "wave effect" that encourages others to terminate early (Harris, 1998, p2). Early departures negatively affect the stability of the remaining clients and of the program overall.

The final area where tracking retention appears beneficial is in the management of the agency as a whole. Tracking retention provides information to structure the culture, client services, and other organizational areas of the agency. Carroll (1996) describes the benefits of tracking retention from an agency perspective. She states that "the tracking of retention can be conceived as an important treatment outcome that reflects a good fit between patient, therapist, treatment, and setting" (p.19). From this perspective, agencies benefit from establishing practice and procedures that improve the quality of treatment.

These changes will influence outcomes by improving retention rates (Carroll, 1996, p.19).

Factors that Influence Treatment "RETENTION" Outcomes

Because of agencies' use of retention statistics as the benchmark for measuring success, research has focused on exploring what factors influence the numbers that evolve. This next section will identify interventions that can enhance or lower agency retention.

RETENTION as a "Good Fit"

Many residential treatment programs offer a single modality approach to treatment. Carroll (1996) suggests that "with a one size fits all model, variation in retention and outcome have traditionally been ascribed to patient factors and characteristics (p.5). Thus patients who are a "good fit" for a given approach are more likely to remain in treatment, and those who are less well suited are more likely to drop-out." She also states that there is no universal client characteristic associated with retention, and likewise, there is no universal client characteristic associated with drop-outs from one treatment setting to another setting using vastly different treatment approaches (Carroll, 1996, p.5). Within the "good fit" construct of retention, retention itself may have more to do with what investigators and treatment providers do than who the clients are (Carroll, 1996, p.13).

RETENTION and Readiness to Change

Motivation towards recovery may influence both the length of stay and retention outcome in treatment. One well-developed theory of motivation involves the "readiness for change" theory from the transtheoretical model. In this model there are five stages of change of which treatment-seeking behaviour marks the "action" phase of readiness for change (Prochaska & DiClimente, 1994, p. 44). Those identified in the "action" phase of internal change demonstrate higher engagement and active investment in the change process itself, thereby, enhancing the individual's engagement in the treatment process. Residential treatment programs generally provide programming geared to those in the "action" stage of change. Many who come for treatment are externally driven from sources mandating that they be in treatment. Mandated clients, otherwise know as precontemplators, often become labelled "noncompliers" and tend to stay in treatment significantly less time than compliers, the average difference in the length of stay amounting to one week   (Oene et. al., 2001, p.259). Prochaska, DiClimente and Norcross (1994) have stated that "professionals who equate change with action design terrific action-oriented change programs, and are bitterly disappointed when sign-up rates are minuscule, or when a large number of participants drop out of the program after a brief stay. Successful programs designed to help precontemplators are vastly different from those designed for people in the action stage. Programs must be geared to the different stages they are in, not just to action" (p.44).

Those who have moved farther along in the stages of the "readiness to change" model will have a higher degree of engagement in the treatment process. They have a higher internal motivation to change, (thus influencing the retention outcomes) as compared to those who have not moved past the early stages of the model.

RETENTION and Matching Needs

In general, residential treatment settings are predominantly geared to providing programming that treats the addiction as the primary focus and places issues outside of the addiction as the secondary focus. One group of researchers describes this by noting that although "drug treatment programs have increasingly recognized clients' multiple needs and have increased service diversity to meet those needs, comprehensive programs providing services to meet all client needs are rare" (Hser, Polinsky, Maglione & Anglin, 1999. p.300). According to a study on "matching needs" within addiction treatment programs in Los Angeles County, researchers identified that clients in drug treatment programs typically face multiple problems in addition to substance use dependency. These additional problems may include medical needs, psychological distress, legal involvement, employment problems, family relationship problems, and housing difficulties. The researcher of this study measured predictors of treatment retention and found that the two measures of needs-and-service-matching were both significantly correlated with treatment

retention. The study concluded that enhancing treatment services to address client needs provided an important means of increasing client retention and improving treatment outcomes (Hser et. al., 1999). Harris (1998) reported the following areas that influenced attrition: minority status, income level, drug dependence, type of substance, occupational stability, extent of social isolation, psychiatric diagnoses, gender, empathy felt by client, impulsivity, expectations regarding therapy, psychological mindfulness, level of academic functioning, previous treatment attempts, and level of motivation (p.2). Within the context of the "matching" process of receiving care, she suggested that on the hierarchy of client needs, addiction itself may not always be the priority, but instead could include other problems outside of the substance use that the client presents or arrives to treatment with. The proper identification of the client's global need directly influences client retention rates.

RETENTION through Client/Counsellor Matching

Researchers have investigated the relationship between the influence of a client's perception of their counsellor and their length of stay (Kasarabada, Hser, Boles & Huang, 2002, p.327). A group of researchers studied the phenomenon of retention in short-term residential substance abuse treatment facilities. They reported that "the patient's perception of the quality of the therapeutic relationship is amongst the most important factors in the prediction of treatment retention. By measuring the client's perception of the therapist using a cooperation scale, a

positive association with length of stay in treatment was identified, indicating that patients who perceive a stronger working relationship with their therapist, tend to stay in treatment for a longer period of time" (Oene et. al., 2001, p. 259).The findings from this research suggest a positive correlation between a client's perception of their counsellor and length of stay for both outpatient and residential groups. (Kasarabada et. al., 2002, p. 332).

Research has suggested that clients use age, gender, and ethnicity to construct judgement for the "ideal" drug treatment counsellor. This research also indicated that different client groups (female, male, indigenous, Caucasian, or black) expressed preferences for different types of counsellors characterized by different combinations of traits (Rohrer, Thomas, & Yasenchak, 1992, p. 731). This research suggests that treatment agencies need to have a diversity of counsellors in order to provide a better opportunity for counsellor/client matching which influences length of stay.

When looking at the matching process and the long-term impact it has on substance use, Kasarabada, Hser, Boles and Huang (2002) suggest that "...favourable counselling relationships and effects are most potent during the course of treatment and have facilitated longer stays in treatment, but they wane in importance over time after treatment in their impact on patients' alcohol and drug use" (p.332).

This literature would suggest that client/counsellor matching determines the investment level of the client and affects whether they decide to remain in

treatment or leave early. Early termination of treatment according to this theoretical paradigm is not representative of the client exclusively. When interpreting retention outcomes, other variables such as client/counsellor matching, matching of needs, stages of change and a "good-fit" need to be considered before any conclusions are made. The following section will review retention and substance abuse outcomes.

RETENTION and Substance Use Outcomes

Researchers have investigated whether treatment duration has a direct impact on decreasing substance use (Zhang, Friedmann, & Gerstein, 2003, p. 673). This study was comprised of 4005 clients in 62 treatment programs. Of the 4005 clients, 443 clients were from seven methadone clinics, 1703 clients were from 31 out-patient non-methadone programs, 1183 clients were from 19 long-term non-methadone programs, and 676 clients were from 5 short-term residential programs (p. 674). The findings from this study suggest a positive relationship between treatment duration and drug use outcomes in 3 of the 4 modalities. The three modalities with positive relationships were methadone maintenance, out-patient non-methadone and long-term residential programs. The short-term (30 days or under) residential program modality did not have a positive outcome (p.680). This study raises new questions as to whether retention as a measured outcome is relevant or helpful in short-term residential settings.

RETENTION and Reporting Methods

The educational system places great emphasis on tracking "hard" outcomes such as retention and graduation rates. Stephen Potter (2004) did a national (U.S.) retention study in the educational system on the difficulties of reporting stay-versus-go outcomes (p.53). He found that "when an institution reports a low retention rate, the implication is that many students are dropping out. Yet many of these so-called dropouts (or more accurately, stopouts) are actually transfer students. Distinguishing between the two is quite important, as an institution can legitimately argue that its retention rates should be revised to include these transfer-out students" (Porter, 2004, p.54). Porter (2004) states that any retention initiative must be tailored to two types of students: students who decide to continue their education at another institution and students who decide to drop out of higher education altogether (p.54). The latter have very particular needs and may require different intervention to prevent their leaving. This research provides insight to the interpretation of raw retention data and its inability to allow for a more complex view of retention/attrition behaviour. The author of this study suggests the benefits of using more qualitative means of measurement such as exit and withdrawal surveys to better understand retention outcomes and their meaning (Porter, 2004, p.68). Addiction systems generally have not used qualitative methods such as exit interviews or follow-up contact to gain understanding for individuals who leave treatment early.

Methodology

The primary focus of this project is to examine the importance of tracking retention in a short-term substance abuse residential treatment facility and the extent to which retention influences organizational decision-making regarding client service. Specifically, this research, using a grounded theory approach, will explore how retention statistics are defined, and by whom, and how such data are used inside and outside of the organization. Data have been gathered from individually-focused interviews with both administrative staff and frontline addiction workers from a residential substance abuse facility.

Sampling Procedures

An information letter and consent form detailing the purpose of the research was sent to the administrative and frontline staff of a residential substance abuse facility inviting volunteers to participate in sharing their knowledge, experience, and understanding relating to area being researched (appendix B). Questions addressed the influence of retention statistics on substance abuse treatment and the structural organization of the agency. A list of questions was used by the interviewer as a guide (appendices C & D). These questions provided a framework for the participants to construct and reflect on their own experiences relating to the influence of tracking retention data and its organizational meaning for them working within a residential substance abuse treatment facility.

Interviews

In an effort to develop a broad understanding of the influence of retention from a meso perspective within the agency, three administrative staff members volunteered to share their experiences relating to this area of research. These focused interviews provided the researcher an opportunity to acquire information relating to this research from an administrative and agency governance perspective. In order to gain insight to the influence of numbers from a micro perspective, this study included the voluntary participation of two frontline addiction workers. Interviews with this cohort group would provide insight to how data, and its application impacts frontline staff. An interview guide form was used during all interviews. Interviews were conducted during a one and a half hour timeframe. All focused interviews were held offsite of the residential short-term substance abuse treatment facility. Each interview was taped after the participants completed the Consent to Participate form.

Administrative Individual Interviews

The aim of the administrative interview was to gain understanding about how retention statistics are collected and reported to government funders and further to understand how retention operates within the agency. In order to investigate this, three administrative individuals, the agency director (Master degree in Family and Systems Therapy), past clinical coordinator (Master's degree in Social Work), and a statistician (Master's degree in Mathematics), were

selected and voluntarily agreed to be interviewed. These individuals were selected because of their responsibilities relating to the construction, organizing, and reporting of retention data. The agency director is a female of middle age who has been at the agency since its inception. The clinical coordinator, a male of middle age, has retired within the last year, after working in the agency since its inception. Previously, he had a specific interest in tracking client retention using quantitative methods and evaluating the measured outcomes using the statistical data analysis program *Statistical Package for Social Sciences* (SPSS). He also has knowledge and experience in establishing the current policies and procedures for the agency based on his findings from quantitative data outcomes. The contracted statistician is a female of middle age with knowledge and experience in collecting agency data, who reports findings to the agency's director and to the provincial agency that tracks all addiction outcomes.

Frontline Staff Individual Interviews

In an effort to develop a greater understanding of statistical data and its impact on frontline staff, individual interviews were conducted with two addiction counsellors. A letter of invitation was distributed to all staff within the agency. Those who were interested in participating expressed this by approaching the researcher. One female and one male agreed to participate. The female counsellor is middle aged. She has a college diploma as a Social Service Worker and eight years of employment at the agency. The male participant is also

middle aged with ten years of employment at the agency. Academically, this participant has a Bachelor's Degree in Religious Studies and he is currently in his second year of studies for a Bachelor of Social Work degree. The interviews focused on understanding how frontline worker collect client data and the impact these data have on them in the decisions they make in relation to client service.

Ethical Considerations

For this project, the researcher fulfilled multiple roles. The preliminary role consisted of gathering empirical information such as journals, articles and books relating to this project. Other task included applying to the McMaster University Research Ethics Review Board, and arranging and conducting focused interviews. In all interactions with participants, it was the role of the researcher to ensure that participants understood the risks and benefits of taking part in the study. Participants were informed that their names, and their agency's name and location, would not be disclosed within the project. Participants were also informed that confidentiality may not be an absolute based on what they report. They were informed that they might be identified by what they said and therefore, they were reminded that they did not have to answer questions if they felt any discomfort. It was explained to all individuals participating in the study that they would have access to a summary sheet outlining the findings of the study. The objective of the study was explained to each participant and participants were encouraged to ask questions at any time. All participants were informed of their

rights: to refuse to be audio taped and to withdraw from the study at any time, if they chose.

All participants were provided with the names and contact numbers of McMaster University's Research Ethics Review Board supervisor along with the School of Social Work supervising faculty member. Prior to the study, all participants were informed of the purpose and application of all data for the study.

Limitations

There are several areas where researcher biases evident in this study:

- The researcher is an employee of the organization and having prior knowledge and experience regarding the context of issues within the study. There is a possibility of researcher bias in what gets selectively noticed and observed.

- As this study was conducted within one substance abuse treatment facility, these finding cannot be generalized for all addiction facilities.

- Only five people participated in this study. With the study group being so small, these findings may not be generalized.

- A single interview approach was used for this research. Questions can be raised regarding the degree of trustworthiness between the researcher and the participants.

- Although one participant requested a follow-up interview to expand on previous information shared, this was the exception. Post interview member-checks were not used in this study.

Results

My review of the literature suggests that retention statistics play an important role in addiction treatment programs because they provide some measure of the programs' effectiveness: treatment is often deemed to have been successful if the client stays for the entire course of treatment. Researchers such as Simpson & Sells (1982) suggest that retention numbers are important in reflecting the effectiveness of treatment programming. As many people accept the idea that "retention reflects effectiveness" these statistics often play an important role in addiction treatment agencies, and they are seen by researchers, managers, and front line staff as meaningful.

My study reveals that retention statistics are viewed as meaningful by my respondents, but not in the way suggested in the literature. Respondents in this study suggest that retentions statistics can play other important roles in treatment agencies, and that their perceived importance varies according to the role of the respondent. There was a general agreement among my respondents that the retention numbers are important, but that their importance has little to do with treatment effectiveness. In this section, I will examine how the managers and front line workers in the agency understand the importance of retention statistics, and how the numbers shape their day-to-day work. I will also show how the meaning of the statistics leads respondents to exercise great care in the numbers they produce. Agency managers use numbers differently than front line staff. I will first discuss what the numbers mean for managers, and what they try to do about them.

Retention statistics play a number of roles for managers: they fulfil a basic funding requirement, they can assist in certain kinds of decision making, they represent a mechanism for government monitoring and control of the agency, they allow for the surveillance of front line staff, and they can provide for positive recognition of the agency.

What Do Numbers Mean for Managers?

Managers understand that statistics have a central role both within the agency and outside of it. Having the right statistics supports the agency in receiving renewed funding. Statistics are used for making decisions and evaluating the frontline workers.   Managers recognize that the provincial profile of the agency can be elevated by collecting specific data. The following section will discuss these findings.

Funding

Managers in the agency are conscious that they are required to collect retention statistics as a basic condition of their funding from the province. They all recognize that the province will withhold funds if the agency does not provide periodic reports on their retention statistics. Having statistics for funding bodies demonstrates efficiency and suggests a well run program; it also shows that a treatment program works. One participant interested in collecting data describes the use of statistics and its arrangement for funding in stating,

> the operational plan is what they base our renewed funding on. So
> the basic requirements are to provide program stats like numbers of

clients served etc.,but also included in that are numbers of completers and length of stay for residential treatment and the numbers of visits and duration for outpatient clients.

While the production of retention statistics is important, the managers also recognized that the accuracy of the number is not actually very important. Indeed, there is not a standard definition of what constitutes successful completion of the program, which gives managers considerable latitude in what they report as a treatment success. Respondents were aware that data they forwarded to their funding bodies was not closely monitored. The agency statistician did not remember anyone ever questioning the numbers they provided. So they could submit statistics that showed the agency in a positive light, even though they recognized that the numbers had little or nothing to do with treatment success. One participant described what they would do if there was a discrepancy in the numbers that they might report to the ministry:

> Oh, we report the better one, of course, and why wouldn't you because nobody is paying attention. Nobody at the ministry level knew either. They never questioned it either and they never knew either.

In one situation, the retention data reported in an operational plan that went to their funders misrepresented the actual situation. One participant reported, "It [retention] was about 60-70%, but we were reporting in our operating plan 90%." Since there was no standard definition, and no one in the government seemed to verify the statistics, it made good sense to managers to submit statistics that made the agency's programs look effective. The timely production of statistics,

particularly those that suggested that the agency's programs work, helped to ensure the ongoing funding of the organization.

Decision-making

Managers were sometimes able to use their retention statistics to assist in decision making, despite their recognition that the numbers were problematic. Numbers that supported a particular decision could be highlighted to justify it. Numbers that did not support other decisions could be easily discounted or ignored. However, at least one manager valued organizational statistics, and thought that their retention numbers were not completely meaningless. He thought that the numbers were sometimes helpful to him in making certain kinds of decisions. This manager stated,

> I couldn't think of people not keeping numbers and I am not married to numbers. Understand   I am not a numbers guy. I just think it is wrong to ignore it. I wanted to have numbers that are supportive of the decision-making process here. Not that they would rule or run the decision-making process based on what the numbers tell you. Numbers, you know the old saying "figures lie and liars figure" you know. However to say that numbers are meaningless is also wrong.

He thought that while numbers can support organizational decision-making, caution is still required on how they are interpreted. Numbers are a support in decision-making, but they cannot be the sole consideration. Mangers described the benefit of considering numbers in conjunction with other factors in making decisions. One participant metaphorically described this notion:

> There are so many radical variables, extraneous variables you know and it is an indicator. You have to be goddam careful that you

don't ride the horse [being the numbers] believing that somehow the horse knows where it's going. You know what I mean. Maybe the horse wants to go in a different direction than you want to go, but it is a horse, nonetheless, you see. I think it is an indicator of something and it certainly is an indicator that you can use to say; well you know.

Some respondents also described statistics as a helpful tool to monitor agency biases and myths. They noted that a number of myths existed in the agency regarding client service. Numbers, however problematic, can help challenge unsubstantiated beliefs. One participant described how numbers provided a different lens -- a "supposedly objective" lens -- to view organizational myths and biases.

Having a numbers perspective kept me out of a lot of prejudicial corners. There are a lot of prejudicial ideas around this business, right. A lot are just plain friggen myths or well, a little prejudice and a lot of it was just plain wrong. So, looking at it objectively, supposedly objectively, provided an interesting perspective and it kept me out of my own biases and things like that.

At the very least, the existence of numbers that conflicted with his (or others') perceptions would help them stop and think about their assumptions and views. In this way, even if the numbers were clearly problematic, they could still be useful.

Surveillance through Numbers

Statistics provide a mechanism for the funders to monitor the agency. Much like Foucault's notion of the panopticon (1977, p. 207), retention statistics allow the province invisibly to observe the operation of the agency. Data collected by

the agency are entered into a provincial web-based program. DATAS is an organization funded by the Substance Abuse Bureau of the Ministry of Health and Long Term Care to manage the database and forward reports directly to the ministry bureaucrats. These reports are periodically generated and submitted to the ministry without the direct knowledge of agency managers. Agency managers know that reports will be forwarded, but no one knows when the Ministry of Health is going to extract individual organizational numbers from the data base. Therefore, the Ministry of Health can now invisibly observe any provincially funded addiction agency at any time through the numbers they produce, without their being aware that they are being watched and evaluated. One manager described this.

> So with the increased use of databases there's "good" and "bad" to this. The ugly part of this is that it will be used for good and also it will be used to "control". Don't ever think they won't be checking to see what's going on in the system.

Another participant stated,

> They are doing it every six months, the Substance Abuse Bureau, and they are sending [data] it directly to the Ministry without even us seeing it.

Another provincial database program is in the process of being implemented throughout all of the Ontario hospitals. This system is called MIS [Management Information System]. Not only is this another layer of data collection expected for all hospital systems, it is also another lens being used to "gaze" into organizations. One manager described this system stating,

> I believe that through MIS, they will be looking at workload measurements. It's going to become the operating system for all data.

The managers were concerned that the implementation of MIS and other provincial databases will directly impact their sovereignty and their decision-making ability in the local agency. They were concerned that the more information available to the province, the more likely it is that the province will try to direct their operations. Agencies will no longer be completely directed by directors and their management teams but instead they will be governed, micro managed, and directed by the Ministry of Health. Managers recognize the inherent power and implications of agency numbers that are extracted by the province from Provincial databases. The province will have the ability to influence policies and practice within individual organizations. One manager described how agency data will be used by the province to direct the local agency.

> decisions are going to be taken out of individuals' hands, agencies hands. We are going to be based on data that is collected from an MIS system or a provincial system. So, our goal at our agency was to get ready for that beforehand and make sure that our ducks were all in a row here; that we weren't having any glaring discrepancies, say retention or length of stay or whatever or at least we address this before we go on to an MIS system. Staff need to understand that its not going to be me making that decision, it's going to be a ministry person saying; well, I guess we can close five beds at our agency, right. That's what we are all concerned about.

According to Foucault (1977, p.200), prisoners in Bentham's panopticon were aware that they could be watched by the guards at any time without their knowledge, so they would monitor and police themselves. Agency statistics play a role similar to that of the panopticon: because the province can monitor the

agency at any time without its knowledge, agency managers feel the need constantly to monitor themselves and the numbers they create. One result was to contract a statistician to ensure that the right data would be produced. Employing a statistician gave the agency the skills and knowledge to construct its statistics more carefully. This new position became a powerful internal continuation of the "gaze". It was up to this person to make sure that data entered by frontline staff was being done correctly and completely. One manager described the importance of this position and the reasoning behind its creation in saying,

> that is all this person does, so its not like here we are attending to you clinically or whatever and at the same time we're saying, get your data in, right, we can do that but its easier to have someone like our statistician – she is the data police to do that because that's all she does.

The statistician was originally contracted to produce agency numbers for the provincial database. This role was expanded from merely tracking clients to include monitoring and tracking staff through data. Numbers were being used beyond the purpose of meeting provincial reporting requirements; they now became a tool to "gaze" into the activity of the worker and measure their performance. Staff performance and effectiveness became operationally defined by data. Staff members who have lower completion rates than their co-workers are perceived as not doing their job as well. The "gaze" into the worker's activity through collected data has become a means to construct new perceptions about the individual worker and the quality of care he or she provides. One manager described this by stating,

The management team does run reports comparing caseloads and other things for the workers so they can have a feel for the workload of each worker and who is doing what. It might not look good for some who maybe had a 60% completion compared to someone who had 80% - so this becomes a performance review issue.

Getting Recognition

Historically, addiction services in Niagara were viewed by agency staff and managers as being under-funded compared to other urban areas such as Hamilton and Toronto, which received better funding. These latter areas understood how data could be used to increase their funding levels over other demographic areas. One managers stated that they quickly realized that statistics were important in order for the agency to be noticed by their funding bodies. Data constituted the direct voice to the Ministry of Health and those who had the statistics were the ones who were heard. One manager captured this in stating,

It was the squeaky wheel who got the grease. So Toronto and Hamilton got all these programs and Niagara got squat. The manager became aware that quantitative research methods were being used to forge closer connections with funding bodies. Agencies that could generate large amounts of research data skilfully used it to their advantage over other agencies that had less awareness or lacked the resources to produce data. One manager said, they had more connections and they were doing research and they could produce statistics. They could bombard them and Niagara was a little behind the times I'm guessing.

Questions were raised regarding the fairness of the distribution of funds amongst provincial agencies. Prior to standardized data collection, one manager reported that funding was not equally shared. Receiving government funding had more to do with the director's personality characteristics and the degree of their

36

relationships with members of funding bodies. One manager described data as an objective way to ensure that money is distributed fairly. The manager said that data became a way of filtering out or even eliminating funding nepotism leaving a fairer and more equitable means of receiving funding dollars. Numbers replaced personal faces and characteristics, linguistic skills, ties to close relationships and other influencing factors that disadvantage some organizations. One participant described this by saying,

> we got to track those stats because that's all people listen to now. They're not going to listen to me say, well this is what I think you should do. Its only stats and data, so yes, we've put a ton of resources into it. Is it the right thing to do? I'm not going to comment on that but I do understand that that is the need because that is what they are basing their decisions on because it is not based on how well you speak, on your charisma or the fact that you know so and so's brother-in-law, which is how it used to work with the old boys network and now that whole system is based on data.

Managers perceived that specific types of client statistics strengthen and legitimize funding requests. The degree of support that the numbers give to a proposal is unclear, but the perception was that it provides tangible reasoning for ongoing funding requests. Managers believed that reporting specific numbers on the operational plan strengthened their financial needs and requests. This was evident when one participant suggested,

> I don't know how far it influenced the proposal but it certainly supported them because I knew what kind of people they were statistically from the database. I knew how long they stayed. I just knew lots.

One manager, who had an interest in basic statistics, recognized the value of collecting and organizing data. During the earlier years, nobody was capturing

37

statistics. Statistics became a means for the agency to change its image by having information that nobody else had. This manager started collecting data that the funding bodies themselves did not have. By doing this, the agency became the source of information for the ministry. Its statistics became a powerful tool, elevating the status and recognition of the agency by funding bodies. One manager describes this in stating,

> we literally had the Ministry of Health asking us what we were doing and a lot of it was bullshit to be quite honest with you. Numbers are like that. You know what I mean, but we had them and that's all there was to it. We had a massive database at that time. When at the time, the OSAB [Ontario Substance Abuse Bureau] was going to put together a program, when it was going to tool itself up to keep numbers. Remember nobody kept numbers at the time, the Ministry of Health didn't have a clue how many people we were seeing, not a friggen clue what they were doing. They didn't know nothing about that stuff because they didn't keep a database and we did. So, they called us and so whenever they were going to do it they called us.

The agency was identified as being an expert in data collection methods. Even though the strength and legitimacy of the data was never questioned, this title was not difficult to inherit when nobody else, including the Ministry of Health, was collecting statistics. Although numbers were being tracked for client outcomes for funding purposes, they actually became a more powerful tool in raising the agency's profile and status provincially. One manager was invited to sit on a newly formed provincial committee that focused on establishing data collection practices for addiction services throughout the province. A participant described this experience stating,

I sat on that committee. There was a meeting in London in 1993 of people from the Ministry of Health and OSAB to start to talk about a database for the OSAB. I walked in hanging my head, these were all the heavy hitters. I was involved in the whole process of the database that you guys are now using. I was on the ground floor of all that and it was fun to do. We had quite a profile for quite a while there at the Ministry of Health.

What Do Numbers Really Do?

What numbers mean and what they are used for are two different things. Managers use numbers as a tool for justifying changes to policies. One example of this arises from the notion that poor retention statistics are interpreted to mean that the agency is not functioning well. New policies are then written to create higher retention rates by eliminating precontemplators, shortening the program, providing a menu treatment approach, and having no definitions of completion.

Admission Criteria

In order to increase client retention rates, one manager began to notice what types of clients were producing bad statistics. The matching of client typology with residential treatment is a variable that influences the retention count. One cohort group known as precontemplators [early stagers of change] seemed to negatively influence client retention rates and required a lot of staffing resources. Managers identified this population as being a poor treatment investment. One manager described this group in stating,

> we have a client population that is taking up a lot of resources and not well matched to residential treatment.

As a means to justify changes to client eligibility for treatment, one manager suggested that the literature on early stagers suggested that they were not a match for residential treatment. In order to invisibly change poor retention rates and fix the statistics, evidence-based literature became the visible justification and rationale for admission policy changes. One manager stated,

> we've now said this is not good. It is affecting our retention and its affecting our length of stay and the literature told us this.

Changing policies based on client typology was the initial response to rectifying the data. The new admission policy is structured in a way that the agency admits only clients that give it favourable retention numbers. This means that more action driven service users will be admitted to treatment as compared to precontemplators.

Shortening the Program

One manager, who tracked the average length of stay of clients, began to notice a trend where clients were typically leaving treatment on day 21 of a 28 day program. Because this trend consistently, negatively impacted retention rates, management decided to restructure the treatment from a 28 day to a 21 day program, with the goal of immediately "fixing" the data. Statistics on length of stay led to shorter treatment-stay policies, improving retention data and increasing the number of clients serviced within a fiscal year. Servicing more clients in a fiscal year caught the attention of the Ministry of Health. These

numbers were looked upon favourably by the Ministry of Health with regard to the

funding of addiction services. Without the Ministry of Health looking into the

quality or validity of the agency data, they were beginning to consider decreasing

the number of treatment days for all provincially funded short-term residential

programs. One participant describes the ministry's reaction to the discovery of

these new numbers.

> The Ministry of Health called us up. We had this interesting thing
> going on because the numbers came to our door. I talked about the
> profile. We had this interesting thing; good for the ego too that the
> Ministry of Health, think about the Ministry of Health, as being the
> people of the know. Wrong. They just keep their ear to the ground.
> They called us and said we hear you're doing this three week
> treatment and been doing it for a while, because they probably saw
> the numbers or whatever and of course they are impressive seeing
> twice the clients serviced. Well not quite twice the clients, but for
> sure a lot more and they asked; how's it going?

Management's decision to reengineer their retention data by shortening

treatment days became externally powerful in reshaping provincial policies

regarding short-term residential programs throughout Ontario. One manager

states that all short-term residential addiction agencies in the province are now

funded for 21 days. The Ministry of Health has viewed these data as a way to

increase agency efficiency using them to support their cause. One participant

described the sweeping power of these unverified data and the profile they gave

the agency saying,

> Lo and behold, it wasn't more than two or three months later, the
> big hammer came down that this was what was going to happen
> through the Province and then they hired us on the implementation
> team and people sort of knew that we had done this. We were not

damn popular for a while because most people were invested in the 28 day model. We didn't back down.

Managers' responses reflect how retention data were used to change policies within the agency. As a result of their policy changes the agency became recognized by larger governing bodies. The voice of data was a powerful, influential tool that enhanced the profile of the agency and its ability to direct policy at a macro level.

Menu Approach

Literature reported the benefits of providing treatment options, improving the matching of needs for clients: matching client needs with programming leads to higher retention (Hser, Polinsky, Maglione & Anglin, 1999). In the newly restructured 21 day program, managers directed a menu treatment approach. Instead of having a singular treatment program model with no option, new programming policies were established allowing the service users the choice of picking their programming from a menu of options running at any given time. It was thought that a menu approach would improve the meeting of clients' needs and would allow for personal choice, giving individuals more control of their treatment experience. Managers felt that this would increase their retention rates based on the belief that matching programming with client needs would create satisfied clients who would want to stay until the last treatment day thus producing "good" data.

No Definition of Completion

The Ministry of Health has not established a definition for treatment completion. In fact, it is in the funding body's and agency's best interest to avoid defining treatment completion. A narrow definition for treatment completion would likely negatively impact the data produced. There would be more client treatment non-completion revealing the system as inefficient and ineffective. Treatment drop outs can currently be discharged as complete. Having clients leave early yet still reporting them as being completed presents a better image of the agency than clients who leave early and are reported as incomplete. One manager stated,

> Well, there is no actual definition from the Ministry [of treatment completion]. All they have done is make it a mandatory field that they have created in the Catalyst system.

Without a standard definition of completion, it is now up to each individual worker to define treatment completion for their clients. In an agency of 15 frontline addiction workers, this creates many inconsistencies in the way data are defined and entered into the database. One participant said,

> I don't know what they are collecting. That field [completion of treatment] is not being collected in a standardized way across the province. They're trying, but in practice, it's up to the individual worker who closes out that program to make the call and that is how it has been left.

Having inconsistent definitions of treatment completion can be beneficial in the way data are reported. Poor retention rates are redefined by reporting high completion rates for early leavers. Inflated completion rates, based on the

absence of a clear definition of completion, works to elevate the agency's image

as effective and efficient with funding bodies. One participant responded by

saying,

> So if you have that fluctuation definition, it also affects what
> happens in the community [residential clients in the agency] and I'm
> not sure if individual workers picked up on that but I saw it going
> through the lists for three of four communities in a row that our
> average length of stay was down to about 12-13 days compared to
> being up at 13, 14, 15 and 16, which it usually is. It was mostly
> because they were being let go earlier but still being discharged as
> complete.

Managers are aware that agency data is monitored by a provincial

database, especially completion and length of stay rates. The ongoing tracking of

these figures evaluates the agency and its effectiveness in providing service. A

subjective definition of treatment completion allows for the agency to produce

data that reflects effectiveness. One participant revealed that the way one reports

treatment completions versus discharge or termination can give a positive

perception of the agency.

> if you have to justify your funding and you have to show to your
> funders that we've had 800 people this year and 30% have been
> discharged versus you know what, 90% completed, I think there is a
> big difference how funders might view your program and how is that
> program meeting the client's needs. I think it is manipulation of
> data.

The emphasis placed on retention and other organizational data has an

impact on addiction counsellors in their everyday work. The next section will focus on

how collecting and entering client treatment information into the database affects frontline staff. Organizational expectations regarding the entering of data causes tension and frustration for staff as working on data continually competes with direct clinical time.

Impact on Frontline Practice

Frontline staff shared their frustrations of collecting data. The continual emphasis placed on staff to capture numbers and the time required to do this compete directly with frontline practice. The following section will review this struggle.

Additional Work on Frontline staff

Frontline workers are directly impacted by the continual emphasis placed on them to collect and input data. Inputting data is labour intensive, affecting frontline staffs' workloads and elevating their job-related stress levels. Frontline staff indicated that how there has been a gradual increase in the amount of data that gets collected. This increased expectation is evident in the use of two database systems, MIS [Management Information System] and CATALYST, within the organization. As the Ministry's expectations of data collection increase, tension escalates for frontline staff as their direct clinical time is being reduced in order for them to enter data. Staff have begun to resist these pressures and expectations. Operating dollars are not being provided for data entry; therefore all

45

data entry funding comes out of existing operational funding. Operating these database systems out of existing funds means that resource dollars earmarked for direct clinical services are being removed to fund data entry. One participant observed,

> I think at times we do need to fight it. They don't give us resources but they still want the data and it does cut into clinical services. It definitely does.

Frontline staff experience added stress resulting from the agency's continual focus on increasing its bed utilization count. Frontline staff noted that there have not been any increases to their staffing resources. As staff leave the agency for new opportunities, they are not replaced. One frontline staff member commented that the agency has not replaced seven positions lost through attrition. Having fewer staff while continually pushing up bed utilization rates causes added tension and stress for the frontline worker who is left to manage the program. One staff described this by stating,

> The problem is our funding. Our staffing isn't increased, so when we go from an average of 28 beds filled to trying to fill all 35 beds, it is essentially one and a half more staff people to cover those extra seven or eight people and haven't had any staff increases. In fact we have been cutting back.

The resulting impact of the organization's need to electronically count clients has led to chaos for frontline staff who are trying to manage client care with competing data entry responsibilities. Several participants described their tension in trying to manage both of the roles they are expected to fulfill by management. One stated,

> We get pulled out to do other people's programming who are sick or whatever. We get pulled out because maybe we would like to have you at this or that. This happens all the time. You can't count on that because your time is not actually reserved for data because something always comes up.

Staff mentioned the tension of trying to manage their daily work in addition to entering data. Organizationally, the producing of numbers is deemed to have a high degree of importance, yet those that collect and enter data are not allocated time in order to enter them. Staff were being asked to fit this into their daily workloads. In response to the lack of time to enter data, staff were beginning to push back against organizational pressure to complete their data entry. As the agency attempted to offload data collection expectations to frontline staff, responses of resistance were becoming apparent. This was evident when one participant stated,

> because I felt pretty pressured and if you don't respect, being the powers to be don't feel its important enough to give us adequate time to do it then you know the attitude OK. I'm going to do only what I have to do and that's it, so I think there is a little bit of pushing back there. I think that if I don't have the time, I'm going to do the best that I can.

Staff identified that management does not have any personal experience in doing data entry. Staff feels that managers do not fully understand the added pressure placed on them to have to fit data entry into an already busy day. Staff attributes managements disregarding for allocating time to a lack of awareness. Managers have never taken the time to fully learn the database system. They are personally disconnected and uninformed about the amount of time it takes to

47

collect and enter data. This disconnection creates ongoing tension between frontline staff and management.

> I think that part of that is that the executive director has never learned how to use a database. I don't think she has any appreciation for how long it takes to enter an appointment or how long this data entry work is.

The agency has an internal surveillance mechanism to ensure that every relevant and important statistic is entered into the provincial database. The statistician fills this role in making sure that each caseworker gets his or her required data into the database. The statistician runs reports to find out what data has not been properly entered, is incomplete or not entered at all. Pressure is placed on workers through notes and tracking reports which are placed in their interoffice mailboxes and copied to all the managers requesting that the identified data be cleaned up by a certain date. Along with notes, voicemail messages are left for caseworkers confirming what was placed in their mailbox. If the data entry is not complete within a couple of days, the process begins again. This internal tracking system evokes anxieties in workers who are having difficulty juggling client care and data entry. Workers struggle to maintain the "client-centeredness" of their work in a system that is "number-centered" and number-driven. One worker describes this difficulty in stating,

> I'm tired of the phone calls – well you know, you haven't got any of your pre-admit done with this client and I got to have that in there, right when you are in the midst of a very difficult community. You're very busy. My primary concern is not entering your data. My concern is my client and so I feel I'm at odds a lot with the data person, understand that that is her role but she does not

understand what our role is and data is my last. Data is a concern and I understand that. Data has to be done but if its coming between data and clients, my clients are coming first.

Surveillance of Frontline Workers

Numbers continue to take on significance beyond what one might suppose they were created for. They take on the new dimension of surveillance. In the same way that the clients are closely tracked by numbers, staff feel their performance is also being closely tracked and measured by the surveillance of the numerical "gaze" of retention data. They believe that their performance comes into question when their clients leave early, diminishing the retention statistics of the clients assigned to them. How many service users complete treatment on your caseload? "How many left early? What does this say if your caseload statistically has lower retention and completion rates to your co-workers? What are you doing wrong? Why does everyone else have higher retention than you?" are questions which seem to demand answers.

There was a general agreement by the frontline staff interviewed that numbers are used as a tool to evaluate the effectiveness of their clinical practice skills. Good clinical skills are equated to clients remaining in treatment for the full 21 days. If clients leave treatment early, impacting the retention rates, questions are directed towards individual frontline staff about their clinical skills. Were there enough one-on-one encounters with those who left treatment early? There is an implicit perception imparted to the worker by managers that something was missed regarding the care of a client who exited treatment early. Some staff

spoke of implicit messages they received from managers to the effect that low

client retention numbers translates into staff not working hard enough. One staff

member described it this way,

> The perception is that something hasn't been done. Somebody
> has not done something or they have done something that people
> are leaving or if you don't have clients around and if your group is
> only three people and you only have three people in your group
> then you're not working as hard as someone else with a full
> caseload. So the lower the numbers the less you are working,
> which isn't necessarily the case.

Staff members are aware that numbers are being used to evaluate them

and compare their effectiveness, practice and performance to those of their co-

workers. The perception is that staff who have higher client retention rates are

performing better and have better clinical skills. A client's early departure has an

impact on staff members self-perception and creates tension for them within their

own practice. Some even begin to question their own clinical skills. Staff feel they

become negatively labelled by management when their clients leave early. This

labelling is evident by messages and statements they receive in meetings and

supervision sessions that question why their retention rates are so low as

compared to other staff members. Staff are deeply and personally affected by

retention data and how it is used to measure their performance. Although the

collecting of retention data was originally started for evaluating effectiveness of

treatment and for funding purposes, it is now being used in ways that go far

beyond the clients, efficiencies or funding. It is being used to measure the

performance of the frontline worker. One staff member described the tension of

being compared to other staff by retention data in saying,

> You can tell when you hit a bone for me. It's almost that you get
> labelled as a hard ass and that kind of thing. We'll get asked how
> come four of your clients were discharged and counsellor "b's",
> theirs are all completing?

The continual implicit messages and comparisons of retention rates

between co-workers evoke unsettling emotions for staff. The struggle of self-

question and even doubting one's own performance and abilities as care

providers is described by a worker by stating,

> I've discharged two clients this community. You only had seven to
> begin with. What's going on? That's how I feel. Am I right? Am I
> paranoid? I don't think so.

These implicit messages from managers lead to staff feeling as if their

work is in question and being negatively judged. One frontline staff described this

by stating,

> Well, I feel, oh my gosh, what kind of clinician are you. It's a
> judgement call on my work.

The importance management places on retention rates, and the pressures

staff experience from this, including being critically and professionally misjudged

by data, has forced staff to find new interventions to keep their clients in

treatment. Staff use interventions to pressure clients to remain in treatment in

order to secure their own caseload client retention rates, which is the benchmark

used to measure staffs clinical effectiveness, skill level and performance. The

emphasis placed on data has directly impacted how worker interacts with clients.

One staff member described the pressure to hold on to their clients in saying,

> I feel pressure or tension that as soon as people start leaving for whatever reason, that you know, in some way I need to do something or change something to keep them there such as holding a letter and saying, I'm not going to give a letter because the person left twenty four hours early, prior to the official leaving time.

This clinical dilemma that counsellors feel results from the surveillance of "number-centered treatment" which conflicts with their desire to be of help. Retention numbers become a mechanism of control. They control clinicians and the way they approach practice. Not only do retention numbers control staff, they eliminate choices from the client. The following of retention data can lead to oppressive social work practices. These practices conflict with the social work values of client self-determination, client-centeredness, empowerment and client choice. One worker described this struggle in relation to clients, who want to leave treatment early in stating,

> Oh, it creates quite a conflict for me because recognizing that clients are self-determined and able to make those choices and you know for whatever reason, clients make many different choices for reasons we often times won't know about.

Analysis of Findings

This research study set out to explore the influence of retention statistics within a short-term residential substance abuse treatment facility. The findings support previous literature in that numbers have power and play a role in controlling agencies and workers and in justifying he decisions they make (Klasien, 2000). Although numbers have a powerful role in the agency, it is not in the way one would expect. These findings have uncovered the organizational role of numbers from two perspectives, managerial and frontline and the pressures that result from these statistics. First, the collection of numbers is rapidly increasing to the point where collecting data is for purposes beyond retention statistics. New required agency data such as MIS are compounding pressures on the organization. In following agency numbers, new difficulties arise for the frontline staff. Pressure is being placed on staff to practice in a way that produces the right numbers for funding purposes. Literature has reported that social statistics have two purposes; public and hidden (Best, 2001). These two identified areas suggest that retention statistics are not just simply about public organizational accountability, but there are also hidden uses of data. The following summarizes the implications of these two areas of findings.

Beyond Retention to Bed Utilization

This study set out to uncover the influence of retention statistics within an addiction agency. Provincially funded addiction treatment systems only use one data base system [CATALYST] to track and report client retention rates to the government. Tracking retention is the way the provincial government measures treatment success (Carroll, 1996). A large proportion of staff hours are spent producing and entering data for this one database system. As addiction systems are forced to amalgamate with hospitals as a way to secure their own existence, they are now going to be expected to produce the kind of data that are required within all provincially funded hospital systems. As this research unfolded, new statistical pressures became evident as hospital based residential addiction programs are now required to collect two sets of data - hospital based data and addiction network data. The sets of data are from two separate funding bodies within the one provincial ministry - Ministry of Health. The requirement to collect more data is creating and compounding systemic pressures for hospital based addiction treatment agencies who have not received any substantial funding increases for the last 10 years.

Management Information System [MIS] is a provincial database system used to track hospital efficiency provincially. Bed utilization is a measured efficiency outcome of performance for hospitals (De Jesus, 2001). MIS tracks bed utilization on a weekly basis. The impact of MIS has been substantial for addiction facilities because they are now expected to collect and report client

retention and bed utilization rates. In order to fulfill the requirements of two different database systems, more resources are being allocated for collecting and entering data. Resources being used to support hospital database systems are being taken from direct client services.

This study has identified the difficulty that hospital based addiction services are now confronted with in having to focus on keeping retention rates high while at the same time ensuring occupational bed utilization. Having to manage bed utilization will be a challenge for addiction services as their programming currently operates under the structure of a closed intake system. This means that up to 35 clients start on the same day and they complete treatment on the same day. If clients leave treatment early, their beds are not backfilled because of the closed intake structure of the program. Thus, in some cases, beds can be sitting empty for two to three weeks depending on when some clients choose to leave. Unoccupied beds suggest lower efficiency, which potentially impacts funding. In order to compensate for this, the agency has been forced to over-book clients for treatment as a way to ensure beds remain full in the event that some clients leave treatment early. Keeping beds full is another layer of pressure that has been added to the existing statistical requirements of tracking retention rates. The focus placed on tracking statistical retention rates presents a different challenge to the agency as they need to find ways to keep individual clients in treatment for the full term. Therefore, the hospital system's bed utilization efficiency measurements are not concerned with who or how many people occupied a bed

over a 21 day period, just that it is occupied, and the provincially funded addiction system measures efficiency outcomes for individuals in treatment on the basis of how long they stay. Hospital based residential addiction programs are being subjected to two competing definitions; one measures effectiveness (addiction system), the other efficiency (hospital systems). These competing definitions can be described as one focuses on keeping clients in treatment for as long as possible while the other focuses on keeping a bed filled continuously regardless of how many individual have occupied it within a treatment rotation. Other non-hospital based residential addiction treatment programs do not have the same rigorous expectations placed on them.

The Responding Frontline Pressures to Numbers

Collecting retention statistics and other compounding data has created new pressures for frontline staff and has directly impacted the way agency services are delivered. It is difficult to practice such social work values as client-centeredness within addiction services, since, demonstratively, greater emphasis is placed on "number-centeredness" approaches than "client-centeredness". Agencies which do not ensure number-centered approaches to treatment will not secure their ongoing funding. Programs are supposedly developed to improve client service. However, looking deeper into how programs are funded, it would appear that programs that produce the "right data" are more likely to get noticed

and funded. My study suggests that agencies are aware of this and therefore they adapt their programs to support the numbers they require.

"Number-centered treatment" presents new pressures for frontline staff. All programming and clinical interventions are directed towards keeping clients in treatment. Literature describes this as a "keepology" approach (Fyock, 2000). Keeping clients in treatment is vital in producing retention data that shows the agency as efficient. Staff are left to manage the dilemma of producing these numbers. When a client indicates the intention to be ready to go home early, staff intervene by trying to convince the client to stay. Pressure is placed on the clients to make decisions that support the agency's goal of good retention data and keeping beds filled. If staff feel that an individual is not a match for residential treatment, management encourages them to continue to work with the individual rather than discharging him or her. This study has identified that staff end up feeling as if their professional opinion is not valued. Keeping the individual no matter what was perceived to override staff's professional opinion.

This study identified a policy change that helped to improve client length of stay. Originally provincial residential treatment programs operated on a 28 day cycle. The agency shortened its treatment days from 28 to 21 days after noticing that clients wanted to leave or left treatment around the 21 day mark. Recognizing when individuals are naturally ready to leave treatment and then tailoring treatment services to this helped to improve retention outcomes and help keep bed utilization numbers up.

However, confining people in treatment for even 21 days creates psychosocial problems. Clients begin to feel confined and in some cases miss loved ones by the second week in treatment. This lead to people wanting to leave treatment early. The agency decided to change the policy, allowing clients to have a pass on the second weekend from Friday afternoon until the following Monday morning. (This actually lessened the duration to a seventeen day program when factoring in the weekend pass.) Clients are informed of this pass prior to their coming and in most cases they have planned for it prior to their arrival. Addressing feelings of confinement, missing loved ones and lessening actual program days have increased clients' motivation to stay in treatment, thereby enhancing retention rates.

Retention statistics are a means of surveillance of the individual program worker. The efficiency of each worker is defined by his or her retention rates. Management is aware of the retention and completion rates for each staff member without the worker necessarily being aware of the scrutiny. Management meets to review addiction worker retention rates in order to find out who might be impacting the agency statistics. Where this becomes a problem, management then meets with the frontline staff member(s) in order to raise their awareness of this and identify reasons for the low retention rates. Low retention statistics are individualized to the worker implying that they are doing something wrong. Retention data was initially developed to monitor and track program effectiveness outcomes, yet in reality it has become a means of surveillance into the

performance of the worker. These numbers have immense power. They watch more than the client. Retention statistics are used to watch provincially funded addiction agencies and agencies use this data to watch their workers.

In evaluating the impact of retention data on clients, only clients who provide good data will be admitted and receive services. Clients with severe and complex needs, who are marginalized and oppressed, and perhaps less aware of their substance abuse problem, will not receive admission to this service. The emphasis placed on producing good organizational retention numbers means that many in society who really require help will continue to be met with institutional barriers. Only individuals having higher functional skills and stability will be admitted, thereby excluding a large amount of the population.

Although following data has presented many difficulties, it has also led to some positive changes for clients. Today they have more options than they have had in the past. Clients now are able to have a choice in what type of programming they receive through a menu selection approach. Weekend passes provide an opportunity for individuals to leave the agency for two days, giving them a break from the institutional environment, which is often perceived as being confining. The program has been shortened making it less intrusive and time consuming for those who accessing the service. It is easier for some to get three weeks off work than four. These changes have allowed for more flexibility, opportunity and choice for those using the service.

However, the use and implication of numbers goes far beyond those for whom it was intended. Statistics have power and their power is two dimensional - public and hidden (Best, 2001; Horstman, 2000). In addictions, the public purpose for retention data is to measure program effectiveness, but in reality it is being used in many invisible or hidden ways to track clients, workers and agencies. Those who produce and track data use numbers as a means to evaluate performance and accountability. Although organizational statistics are established for a specific reason, over time they end up being used to make new claims. Organizational statistics need to be critically analyzed for the claims being made and then for what is not being said. As Best (2000) states, "Being critical requires more thought, but failing to adopt a critical mind-set makes us powerless to evaluate what others tell us. When we fail to think critically, the statistics we hear might just as well be magical" (p.171). In concluding, this research was considered to be an early phase exploratory study. This study has provided an opportunity for development of future research on the influence of statistics within organizations.

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Appendix A

INDIVIDUAL INTERVIEW CONSENT TO PARTICIPATE FORM

The influences of retention statistics on addiction practice within a substance abuse inpatient residential treatment setting.

You are being asked to participate in a research study conducted by Ian Robertson, a student from the school of Social Work at McMaster University, Hamilton. Results of this research project will be submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Master of Social Work.

If you have any questions or concerns about this project, please contact my research supervisor;

- Dr. Roy Cain
  (905) 525-9140 ext.27960
  cainr@mcmaster.ca

PURPOSE OF THE STUDY

This study will investigate the tracking of retention statistics and its impact on clinical practice. In analyzing these questions, the researcher will investigate how statistics, specifically tracking retention data influences clinical practice in a substance abuse residential treatment setting.

PROCEDURES

If you volunteer to participate in this study, I would ask you to do the following things:

Participate in a single interview that will last one hour. This interview will be conducted solely by the researcher who will ask a series of questions relating to the tracking of statistical retention rates and then its influence on practice itself. With your permission this interview will be taped and transcribed.

CONFIDENTIALTY

Any information obtained in connection with this study that can identify you will remain confidential and will be disclosed only with your permission or as required by law.

Participants will not be named individually in this study. The names of the participants and the agency's where they are employed will be changed to secure

confidentiality. The audio tapes will be secured in a locked environment within the researcher's home and will be destroyed after successful completion of this research project. Data will be accessed by the researcher, Ian Robertson and the Faculty Supervisor, Dr. Roy Cain.

POTENTIAL RISKS AND DISCOMFORT

Your name, agency and its location will not appear in any part of this project. Your confidentiality will be secured by changing your name and the agency that you are connected to. People may be identifiable by the views they express. For this reason you can choose the level of your participation. You are not required to respond to anything you do not want to. You may decline to answer any questions that you so choose. You can voluntarily withdraw from the study at any time without any reprucussion. You may request not to be tape recorded during any part of the interview and any data collected will not be used for the study.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR SOCIETY

The potential benefits expected from the research are:

1. To increase understanding of organizational statistics and their influence on addiction practice.
2. To gain knowledge of the influence of retention statistics on policies, procedures and practice within a substance abuse residential treatment setting and lastly its impact on client service.

PAYMENT FOR PARTICIPANTS

Participants in this research study will not receive any form of compensation.

PARTICIPATION AND WITHDRAWAL

You may choose whether to participate in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may exercise the option of removing your data from the study. You may also refuse to answer any questions you do not want to answer and still remain in the study. The researcher may withdraw you from this research if circumstances arise which warrant doing so.

RIGHTS OF THE PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without reprisal. You are not waiving any legal claims, rights or remedies because of your participation in this research study. The study has been reviewed and received ethics clearance through the McMaster Research Ethics Board (MREB). If you have questons regarding your rights as a research participation, contact:

MREB Secretariat
McMaster University
1280 Main Street W., GH-306
Hamilton, ON L8S 4L9

Telephone: 905 525-9140, ext. 23142
E-mail: srebsec@mcmaster.ca
Fax: 905 540-8019

SIGNATURE OF RESEARCH PARTICIPANT

I understand that the information is provided solely for the study of "The Influences of Retention Statistics on Addiction Treatment" as described herein. My questions have been answered to my satisfaction, and I agree to participate in the study. I have been given a copy of this form.

_____
Name of Participant

_____   _____
Signature of Participant   Date

SIGNATURE OF INVESTIGATOR

In my judgement, the participant is voluntarily and knowlingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

_____   _____
Signature of Investigator   Date

Appendix B

Retention Statistics and Their Influence on Addiction Practice

(Individual Interview)

I, Ian Robertson, am currently working on a project that is focused on understanding how tracking retention statistics influences clinical practice and decision-making within a residential substance abuse facility. This study consists of a single session off-site interview during non-working hours that will last one hour. I believe that your knowledge and experience on this topic will be a valuable asset to this project. Your participation will assist in providing new knowledge and insight to the use of statistical data on addiction practice. At the completion of this research, the findings will be made available to you in a project summary report.

I would like to invite you to participate in this study. Your name and the agency's name and location will not be mentioned in this study. ***Your name will be protected and remain confidential.*** Information shared in the individual interviews will be kept confidential, but your identity may be known, given the small size of the sample and roles people play in the agency. People may be identifiable by the views they express. You can choose the level of your participation and you are not required to respond to anything you do not want to. You have the right to withdraw from the study at any time and in doing so, you can request to have your data withdrawn from the study without reprisal. For the purpose of accurately transcribing information the interview will be recorded. If at any point you do not want to be recorded, these wishes will be respected without any repercussions and the data will not be used in the study. Any produced written transcripts and tapes will be stored in a secure area. At the completion of this study all transcripts and tapes will be permanently destroyed.

If you agree to participate, this project will be investigating general data collection methods, the reasons and use of statistical retention data within the agency, the influence of retention on client completion and clinical decision-making.

It is important that you feel **no obligation** to participate in this study. If you are interested in participating in this study, please sign your name to the identified area provided at the end of this information/invitation form and place it into the envelope provided. Your sealed letter can then be forwarded to my office mailbox. Only those who submit their signed information/invitation form will be approached for this study.

This research project is being supervised by Dr. Roy Cain, Director of the Health Studies Programme and Professor of the School of Social Work. Results of this research project will be submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Master of Social Work.

Should you need any more information regarding this study, please contact:
- Dr. Cain (905) 525-9140 ext. 27960 or email cairn@mcmaster.ca
- Ian Robertson (905) 680-2452 or email sueian@niagara.com

If you have any inquiries regarding your participation in this study, please feel free to contact McMaster University Research Ethics Board Secretariat at (905) 525-9140 ext.23142 or email rsebsec@mcmaster.ca

I _____ am interested in participating in this research project.
            Name

Tentative Questions for the Interviews
With Administrative Staff

This interview is being conducted as part of an evaluation method to assess your understanding of the influence of statistical data in residential substance abuse treatment. You have received, reviewed and signed a consent form to participate in this interview. This interview will be taped and transcribed.

1. I am interested in knowing what data is being collected at the agency?
   a. What role does data play in the agency?
   b. How is statistical data used?

2. Did the agency always collect data?
   a. What might have been the reason(s) for collecting retention data initially?

3. Based on your understanding, how would you define "retention" data?
   a. What is considered to be <u>good</u> retention rates?
   b. What is considered to be <u>poor</u> retention rates?
   c. Who decides what acceptable/unacceptable retention is?

4. What is statistical data on client retention used for within the agency?
   a. What is statistical data on client retention used for outside of the agency (i.e. other governmental organizations)?

5. In general, what are the benefits of assessing client retention?
   a. What are the difficulties that arise from tracking client retention rates?
   b. What clients might benefit from the tracking of retention?
   c. Which client might not benefit from tracking retention?

6. As a result of tracking client retention rates, what do high and low outcomes suggest about;
   a. the agency
   b. the programs
   c. the staff
   d. the clients

7. Does retention influence the definition of client completion?
   a. Have there been any changes in the definition of treatment completion as a result of collecting data?
   b. What is treatment completion?
   c. If changes have occurred, how has this evolved over time?

Appendix D

Tentative Questions for Frontline Worker Interview

This interview is being conducted as part of an evaluation method to assess frontline staff's understanding of the influence of statistical data in residential substance abuse treatment. You have received, reviewed and signed a consent form to participate in this interview. This interview will be recorded and transcribed.

1. I am interested in knowing what data is being collected at the agency?
   a. What do you know about the data that is being collected?
   b. How are statistics and data used?
   c. How might the role of statistical numbers influence the shaping of the organization?
   d. What might have been the reason(s) for generating retention data initially at the agency?

2. Based on your understanding, how would you define "retention" data?
   a. What is considered to be "good" and "poor" retention data?
   b. Who decides acceptable/unacceptable retention rates?

3. What <u>good</u> reasons might there be for collecting retention data?
   a. Are there areas of concern for you regarding the tracking of retention statistics?
   b. What clients benefit from collecting data on retention?
   c. Are there clients who do not benefit from tracking retention?

4. As a result of tracking client retention rates, what do high and low retention outcomes suggest about;
   d. the agency
   e. the programming
   f. the staff
   g. the clients

5. Does retention data influence how completion is defined with clients?
   a. Has there been a change in the definition of treatment completion as a result of tracking retention data?
   b. How is client completion determined?
   c. If changes have occurred, how has this evolved over time?

6. In what way has the collection of retention data impacted your clinical decisions at a frontline level regarding client service?