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### Article

**Citation** (please note it is advisable to refer to the publisher's version if you intend to cite from this work)

**Gosling, HJ (2016) 'All this is about is money and making sure that heads are on beds. ' Perceptions of Payment by Results in a Therapeutic Community. Probation Journal: the journal of community and criminal iustice. 63 (2). pp. 144-152. ISSN 1741-3079**

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# **‘All this is about is money and making sure that heads are on beds.’ Perceptions of Payment by Results in a Therapeutic Community**

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**Abstract:** *The aim of this paper is to critically reflect upon some of the practical difficulties which surround the implementation of an outcome-focused payment initiative, colloquially referred to as Payment by Results (PbR), in a drug and alcohol service situated in the North of England. Drawing upon the findings of a longitudinal study in a residential rehabilitation service, the discussion illustrates some of the tensions and dilemmas which surround the introduction of increasingly business-orientated decisions within a person-centered environment that is designed to work alongside some of societies most troubled and troublesome individuals. To conclude, the article suggests that financially-driven processes (such as PbR) commodify the rehabilitative ideal, making service users and practitioners alike increasingly accountable to a counterintuitive fiscal endeavor.*

## **Introduction**

The central document which outlines the vision behind the Transforming Rehabilitation (TR) agenda is the Ministry of Justice paper *Transforming Rehabilitation: A Strategy for Reform* (Ministry of Justice, 2013). The fundamental aim of TR is to extend rehabilitation to more (ex)offenders by changing the design, delivery and commissioning of services that work alongside those who are involved in the Criminal Justice System in England and Wales (Ministry of Justice, 2013:06). To achieve the aims and objectives of the strategy new payment initiatives, colloquially referred to as Payment by Results (PbR), have been introduced in and around the Criminal Justice System in an attempt to provide a degree of flexibility to do ‘what works,’ promote freedom from bureaucracy and encourage services to focus ‘relentlessly’ on reforming (ex)offenders (ibid). Although PbR is a relatively untested concept in the field of criminal justice (Hedderman, 2013:43) the Government claim that it will contribute to the implementation of effective ways of rehabilitating (ex)offenders and reward providers that deliver the most effective rehabilitation programmes (Home Office, 2015).

Whilst PbR is a relatively new addition to the criminal justice arena, it is not a new concept. It was introduced to the United Kingdom in 2000 by the Labour Government’s National Health Service (NHS) plan, which set out to link the allocation of funds to the activities that hospitals undertook.

This marked a clear departure from previous funding arrangements whereby hospitals were paid according to block contracts, which involve a fixed payment for a broadly specified service (Battye and Sunderland, 2011). Generally speaking, PbR is designed to pay providers on the basis of the outcomes that they achieve rather than the activities undertaken. The fundamental aim of PbR, in theory, is to improve service quality by offering bonuses to service providers for performance improvement or withholding payments for poor performance, improve transparency around spending by putting a tariff on service user needs and ease pressure on public spending budgets by staggering payments over longer periods of time (National Council for Voluntary Organisations, 2013).

The idea that the Government should pay services according to the outcomes that they achieve rather than the activities that are undertaken has obvious attractions, particularly in the current economic climate (Hedderman, 2013). However, as the findings that are presented here suggest, the implementation of such a financially-motivated policy directive contributes little more than additional pressures and strains at the coal face of service delivery. Not only ‘transforming rehabilitation’ but commodifying the rehabilitative ideal (more so than ever before) as service users and practitioners become increasingly accountable for the shortcomings of a misguided, counterproductive payment system.

### **Implementing Reform**

The 2010 Drug Strategy *Reducing demand, Restricting supply, Building recovery: Supporting people to live a drug free life* outlined the Coalition Government’s approach to tackling substance use in the United Kingdom (Her Majesty’s Government, 2010). The Strategy called for more responsibility to be put on the individual, placed more power and accountability into the hands of local communities and advocated a whole person approach to substance use in which an individual’s level of recovery capital is recognised as one of the best predictors of sustained recovery. To achieve the aims and objectives of the Strategy, the Government outlined plans to introduce PbR to the sector in an attempt to reform the way in which programmes that cater for substance users were paid for their services.

In April 2011, after a bidding process which involved several Drug and Alcohol Action Teams (DAATs) across England, the Department of Health announced that eight areas had been selected to pilot PbR over a two-year period: Bracknell Forest, Enfield, Kent, Lincolnshire, Oxfordshire, Stockport, Wakefield and Wigan. The PbR pilot scheme aimed to aggregate existing funding streams, align overlapping services to increase available funds for providers and test the assumption that commissioning service providers on an outcome-focused basis would lead to improved efficiency as well as a transparent funding system based on the achievement of high level, long-term and interim outcomes (Department of Health, 2012).

In an attempt to create a degree of consistency across the eight pilot areas a co-design group, which consisted of representatives from local partnerships in the pilot areas, central government departments such as the Department of Health, the Home Office, Ministry of Justice, Department for Work and Pensions and the National Treatment Agency for Substance Misuse (NTA, now part of Public Health England), as well as experts from the field, established a set of high-level outcome measures that spread across four domains. The four domains were: free from drug(s) of dependence, employment, offending, and health and well-being. The domain which covered employment was later removed before the PbR pilot scheme went live in April 2012 (Department of Health, 2012). Although a generic PbR model was designed, each pilot area went on to adapt and modify the proposed model, which allowed for considerable local discretion. Such variability has since contributed to a limited central repository of knowledge and absence of a robust evidence base to refer to, which has subsequently limited the credibility of the payment mechanism on a local as well as national scale (National Audit Office, 2015).

Despite a clear inability to arrive at a general consensus about the design, delivery and efficacy of PbR in and around the alcohol and drug treatment field, the agenda continues to progress at a steady pace, particularly in the criminal justice arena. Even though we are yet to develop a robust evidence base which supports outcome-based commissioning (in the aforementioned sectors) we have witnessed the marketization of PbR as a vehicle that will steer ongoing strategies for reform (Her Majesty's Government, 2010; Ministry of Justice, 2013). The following discussion will now draw upon some of the tensions and dilemmas which surround the introduction of PbR into the

day-to-day delivery of alcohol and drug treatment in a residential rehabilitation service, operating as a Therapeutic Community (TC), to illustrate this point in further detail.

TCs are structured, psychologically informed environments characterised by a community-as-method treatment approach which directs an individual's attention towards their thoughts, feelings and relationships with significant others (Ravndal, 2003). They are places where social relationships, day-to-day occurrences and therapeutic activities are all deliberately designed to help improve health and well-being (The Consortium of Therapeutic Communities, 2015). TCs provide holistic, person-centred interventions which offer intense support for some of the most complex and vulnerable members of society who usually have a history of involvement with the care system and/or Criminal Justice System. They have an alternative conception of individuals who are deemed to be 'problematic' which is much more positive than current dominant beliefs about substance users.

Generally speaking, a TC consists of three programme stages; welcome house, primary and senior. In a six month programme, the welcome house stage lasts a minimum of four weeks and maximum of eight weeks and is designed to provide a warm welcome to new arrivals. The primary stage lasts a minimum of twelve weeks and maximum of twenty-two weeks. During the primary stage residents are expected to comply with the rules of the programme, demonstrate a practical knowledge of TCs, display limited personal disclosures in group sessions and reveal a degree of self-awareness and motivation. The senior stage lasts a minimum of ten weeks and maximum of eighteen weeks. At the senior stage residents are expected to take on a greater level of responsibility and use the skills that they have learnt and developed during their time in the programme to plan for their re-entry into the wider community.

The ethos which underpins all of the daily activities that take place in a TC is based on promoting human dignity, respect for all members of society and human liberation, rather than moral condemnation (Scott and Gosling, 2015). Programme participants are recognized as a person, as an individual, not a problem, number, risk or financial commodity (Gosling, 2015). Instead of governing from a distance, TCs provoke questions of the self, but in so doing, also provide an 'invitation to change' (Gosling, 2015) which involves a safe and supportive environment in which

longitudinal support, friendship and recognition of one and others' struggles and needs are embraced in the journey away from substance use and related harms.

Between August 2010 and March 2013 the author conducted a longitudinal study in a residential TC in the North of England. The service provides a six-month, stage-based programme which can cater for men and women over the age of 18 who have a history of substance use. During fieldwork a voluntary PbR scheme, which took place over a 6-month period, was piloted in an attempt to prepare the organisation for the anticipated changes to the commissioning environment (see Gosling, 2015 for further details). The PbR scheme was available to all local authorities who made referrals to the service. Rather than paying a flat-rate weekly fee, the PbR model required local authorities to pay a weekly product fee and a results payment. The product fee was the amount that the service charged for each of the three programme stages and the results payment was the fee charged to local authorities when a client had achieved a specified outcome by an agreed date. In this instance, the service would receive a results payment if a client 'progressed' to the next treatment stage before a contractually agreed date (negotiated before a client entered treatment and without their consent) was reached. If a client had not progressed to the next stage of treatment, by the specified date, the service would not receive the results payment. This meant that before a client had even entered the TC, their progression through the programme was already decided and directed by contractual obligations and financial motivations as opposed to individual need and personal development.

All clients, regardless of how they were funded by their local authority, were set a number of individualised targets that they were expected to achieve during each programme stage. The targets attached to each of the phases were similar for both flat-rate and PbR residents as they were directly influenced by a client's Outcomes Star<sup>1</sup>. The only difference was the stringent deadlines within which the targets had to be reached. The introduction of a high-level policy directive, characterised by fixed deadlines and absolute measures within a setting based on humanistic principles and

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<sup>1</sup> The Outcomes Star explores aspects of an individual's life such as physical, emotional and mental health, substance use, offending behaviour, money management and so on. It can be used by professionals to help establish short and long term goals with clients, address areas of need, and identify personal growth over a given period of time

incremental processes created an array of adverse consequences due to the contrasting philosophies of PbR and the TC.

We could fall down massively here because it could take away the integrity of the programme. Residents may be kept regardless of their progress and commitment to change because we need them for the money and this will have an impact on other people and how they see it here.

(Staff, August 2011)

It makes me angry when they blatantly do things for money. You feel that you have a price tag on your head sometimes and that is just as bad, if not worse, than the other labels that I am trying to get away from.

(Resident, May, 2012)

The introduction of PbR, albeit for a brief moment in time, brought with it questions about the integrity of the programme as well as the extent to which clients were defined and treated as individuals or financial assets. Staff members, believed that PbR would dilute the therapeutic integrity of the programme if it were to become a permanent commissioning tool and clients felt that the initiative forced them to become part of a process whereby services are able to profit from people's misfortune and vulnerability. In addition to the oppressive practices that PbR introduced to the setting under study, it became clear how such financially-driven processes hold the ability to undermine rather than facilitate *genuine* individual progression.

Showing that someone has progressed *on paper* isn't hard when you really think about it, so that bit of PbR won't be the problem, it's the deadlines. It's going to be so hard, especially in here, because you just never know what's around the corner.

(Staff, July, 2011)

Retention was the over-arching aim of PbR in this case. If the service retained clients who were funded via PbR, then they would receive all of the product fee and results payments. Although retention is a legitimate concern, it is not necessarily a conclusive or definitive indicator of a successful outcome in a TC (or indeed any recovery-orientated service) due to the array of methodological and conceptual issues which surround its definition and measurement (Gosling, 2015). More broadly, the very notion of retention as an indicator of success fails to recognise that an unplanned discharge from a TC does not necessarily mean that an individual's participation was a failure or indeed ineffective (National Institute on Drug Abuse, 2004; National Treatment

Agency for Substance Misuse, 2009; National Institute on Drug Abuse, 2009). For those who live and work in TCs, the definition and representation of a successful outcome is complex, given the multi-faceted, personal nature of the recovery process.

You've got to remember that being a junkie isn't just about drugs, it's about your whole way of life; how you behave, how you think, how you feel, what makes you tick. Recovery isn't just about doing a programme to get off drugs. That's the easy bit; you will detox just lying on your bed. It's everything else that surrounds the drugs that's hard coz you've actually got to work on them. Being here gives you the space to start doing that.

(Resident. August, 2011)

It's about each individual and their journey through the programme, not ticking a box. I do this job because I want to see people change their lives.

(Staff. April, 2012)

The above quotations provide a stark contrast to the fixed deadlines and bureaucratic processes which underpin PbR. A process clearly driven and focused on establishing how much a dictated 'successful outcome' should cost commissioners, rather than understanding and appreciating the value of socially-just responses to substance use which not only recognise, but appreciate, that recovery is a life-long process not a stand-alone end of story event which consists of a definitive 'end product'.

All this is about is money and making sure that heads are on beds.

(Resident. August, 2011)

Employing programme completion, as opposed to individual progression, as a successful outcome measure provides an early indication that this seemingly new and innovative payment initiative is not only detached from the realities of the work that takes place on the ground, but, able to transform some of the most complex and vulnerable people in society into a commodity that can be bought and sold within an increasingly competitive market.

At the end of the day everything comes down to money. I know this place has got to make a profit, but we're people and chaotic people at that. Half of us don't even know what you're on about when you're talking about paying by results or whatever it is.

(Resident. August, 2011)



This illustrates how incentives such as PbR dehumanize the TC experience as an individual is removed from the epicenter of their programme and replaced by a series of bureaucratic processes that bear no positive effect whatsoever upon their journey to recovery (Gosling, 2015). Thus undermining rather than facilitating genuine individual progression. Findings also suggest that PbR introduced an air of uncertainty amongst staff members. This was because they felt that the contractual obligations and business-orientated nature of the initiative would add an oppressive, financial dimension to their workload and day-to-day duties if the scheme were to become a permanent feature of the drug and alcohol treatment landscape.

Not only do I have to think about my client's needs but now I have to think about the financial implications of what I do. If I fail to have paperwork completed and sent by a certain date then we lose out. What happens if I'm off sick or on annual leave? Is it my fault if a report is due in but I wasn't here to do it and we end up losing money?

(Staff member. July, 2011)

This point re-iterates a number of concerns that have been raised by service providers (involved in the national PbR recovery pilot project) who have questioned the implementation of PbR in the alcohol and drug treatment field given the general lack of knowledge which surrounds the incentive as well as its ability to provide 'value for money' (National Audit Office, 2015:08). The aforementioned points illustrate how the short-sighted nature of PbR has generated a new set of questions and concerns for those working within already demanding environments alongside difficult to reach populations.

## **Conclusion**

The discussion presented here illustrates (albeit briefly) some of the tensions and dilemmas which surround the introduction of increasingly business-orientated decisions within an environment that is designed to work alongside some of society's most complex and vulnerable people. It has been suggested that PbR is detached from the realities of the work that takes place at the coal face of service delivery in one situated TC. This is due to the fact that it is fundamentally based upon dated concepts and ideological representations of a successful treatment outcome. Rather than

encouraging innovation and promoting reform, vulnerable people and under-resourced staff are not only lost but totally overlooked as financial gain is prioritized over individual need.

Fox and Albertson (2012) suggest that PbR has a place in the commissioning of services, but its role in the Criminal Justice System is likely to be limited. The findings presented throughout this article build upon this point and suggest that although the role of PbR may be limited, the impact of such a counterproductive initiative, if adopted as a standardised mode of commissioning services within and around the Criminal Justice System, is potentially monumental. Hunter and Breidenbach-Roe (2013, cited in Webster 2015) suggest that in certain cases, PbR has been used *purely* as an alternative way of paying for the same service, rather than a method of improving outcomes by developing new forms of service provision. In this instance, PbR was utilized as an alternative way of paying for a service. Rather than improving outcomes, the initiative created a series of unintended consequences due to the introduction of a misguided ‘outcome’ measure within an environment that works with some of the most complex and vulnerable people in society. Indeed, PbR has the ability and momentum to help create new forms of service provision, but the likelihood that such services will be in a position to provide genuine care, compassion and support to those attempting to take a different path in life (whatever that may be) is highly unlikely given the prioritization of financial gain and commodification of some of the most hard to reach people in society.

With this in mind, it is absolutely vital that politicians, practitioners, academics and service users come together to develop a clear, informed rationale that can explain *why* PbR is the right commissioning model for the Transforming Rehabilitation agenda (and indeed any other strategies for reform), *how* it will operate in practice, taking into consideration the experience of PbR schemes thus far, and consider alternative ways to support an outcome-focused approach that is fundamentally driven by a grounded understanding of practice, rather than a politically motivated, financially driven agenda.

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