Payment by Results. Challenges and Conflicts for the Therapeutic Community

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Abstract

Drawing upon the findings of a 31month ethnographic study in a residential Therapeutic Community (TC) for substance use, this article sheds light on the challenges and contradictions which surround the introduction of increasingly commercial/business orientated decisions within the alcohol and drug treatment field. The aim of this paper is to critically reflect upon the implementation of an outcome-orientated policy directive, typically referred to as Payment by Results (PbR), in a residential rehabilitation service, and consider the implications which surround the initiative for those at the coal face of service delivery. The fundamental principles of PbR and the TC are discussed, as are the tensions and dilemmas which surround the implementation of a high-level policy directive that is fundamentally dissimilar to the theoretical ambitions and practice that takes place on the ground in a residential rehabilitation service. To conclude, the article suggests that incentives, with a clear focus on saving money rather than saving lives, provide little more than additional pressures and strains at the coal face of service delivery, transforming individual progression into a financially-driven bureaucratic process. The findings not only illustrate the dehumanising properties of outcome-based payment schemes but bring mainstream representations of effectiveness into sharp focus.

Keywords

Payment by results, therapeutic community, recovery, outcome-based funding.

A change in the tide

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[1]. To achieve the aims and objectives of the Strategy, the Government outlined plans to reform the way in which programmes that cater for substance users were paid for their services. Although not an entirely new initiative, the Government made clear their interest in an outcome-based payment scheme, known as Payment by Results, colloquially referred to as PbR.

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PbR was first 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 departure from previous funding arrangements in which hospitals were paid according to block contracts, which involves a fixed payment for a broadly specified service (Battye and Sunderland, 2011). Generally speaking, PbR was designed to pay providers on the basis of the outcomes that they achieved rather than the activities undertaken. The fundamental aim of PbR was 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 2010 Drugs Strategy has attempted to build upon these ideals and outlined plans to introduce PbR to the alcohol and drug treatment sector. 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, 2012a).

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, 2012a)[2]. 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. In theory, this meant that each model reflected the needs of the

population engaged with services in the local area, the maturity of the local system of support and the different speeds at which each area was expected to achieve full implementation (Department of Health, 2012b). However, in practice the principles and prescriptions which surround the implementation PbR has contributed to a limited 'central repository of knowledge' as well as the absence of a robust 'evidence base to refer to' which has subsequently limited the design, delivery and credibility of the payment mechanism on a local as well as national scale (National Audit Office, 2015:08).

In May 2013 a national service providers' summit was held in London to bring together representatives from the eight pilot areas to discuss their experiences of PbR over the first 12 months. The purpose of the summit was not to revisit the general arguments about PbR but to focus on emerging implementation issues. During the summit there was a general consensus that PbR had been introduced too rapidly and as a result there was still a need to explain the initiative to the workforce and provide support for staff on how it worked. It was also recognised that PbR placed significant burdens on service providers, commissioners and service users, and data requirements to demonstrate outcomes and confirm payments were more onerous in pilot areas (DrugScope, 2013). Despite such findings alcohol and drug treatment services continued to prepare for the seemingly inevitable introduction of a largely misunderstood and arduous initiative. Before the discussion explores the challenges that were faced when PbR was implemented in a Therapeutic Community, we must first explore the origins, values and theoretical priorities of the TC.

The Therapeutic Community

The origins and development of the Therapeutic Community, or TC as it is colloquially known, can be traced to two independent traditions: the American concept-based TC and the British democratic TC. The democratic TC most famously began with the work of Maxwell Jones during the Second World War and was developed at the Henderson Hospital during the 1960s (Rawlings, 1998). It specialises in the treatment of moderate to severe personality disorders as well as complex emotional and interpersonal issues. On the other hand, there is the concept-based or hierarchical TC which derives from Synanon, a self-help community for recovering substance users that was established by Charles Dederich, an ex-alcoholic, in 1958 due to the perceived limitations of Alcoholics Anonymous (Rawlings and Yates, 2001).

TCs are typically situated in a residential setting. They are holistic, person-centred interventions which offer intense support for some of the most complex and vulnerable members of society. A TC is 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). Service users are known as residents and are part of the programme 24 hours per day, 7 days a week. The design and delivery of treatment in a TC is guided by a generic theoretical framework which organises the therapeutic mechanisms used on a day-to-day basis into three components: the perspective, the model and the method (DeLeon and Ziegenfuss, 1986). The perspective describes the TCs view of substance use, the individual, recovery and right living. The model outlines how the programme is structured and the method describes how the treatment approach should be applied to everyday life in a TC (see DeLeon, 2000 for further discussion).

Generally speaking, a TC has an alternative conception of individuals deemed to be 'problematic' which is much more positive than current dominant beliefs about substance users (Gosling, 2014). TCs work with the person, not the socially constructed problems that surround them, such as criminal and deviant labels. TCs do not rely on, nor support, the use of diagnostic criteria's or proposals which suggest that substance users have a disease or some kind of faulty thinking that requires adaptation and modification. The ethos which underpins all of the daily activities which take place in a TC is based upon recognising a person as an individual, not a problem, number, risk or financial commodity (Gosling, 2015). The TC is a recovery orientated programme. This means that abstinence is not the primary goal of treatment; it is a serendipitous outcome of the change process. The fundamental goal of treatment in a TC is to incite individual change by addressing the behavioural, attitudinal and lifestyle factors that contribute to an individual's substance use (DeLeon, 2000). This means that a 'successful outcome' is very much defined and measured on an individual, rather than collective basis by those who work and reside in a TC (Gosling, 2015).

The person-centred approach that can be found in a TC creates a number of issues when it comes to defining and measuring individual (and programme) success. As a result of the practical need to evaluate whether or not the TC 'works' a number of pragmatic research approaches have developed. For example, although it has been suggested that treatment success

should be defined and represented through the individual change that people make during and after programme participation (DeLeon, 2000) attempts to represent success though crude outcome measures such as relapse, reconviction and retention dominate existing empirical evidence (Ogbourne and Melotte, 1977; DeLeon, Wexler and Jainchill, 1982; Condelli and Hubbard, 1994; Page and Mitchell, 1998; Smith *et al*, 2006; Malivert *et al*, 2012; Vanderplasschen *et al*, 2013). The utilisation of absolute, standardised measures to demonstrate the success of a complex life-long process that begins within a person-centred environment has not only produced research with an array of conceptual and methodological issues but maintained the air of ambiguity which surrounds the day-to-day workings of a TC (Gosling, 2015). With this in mind, it is possible to suggest that the introduction of a payment scheme which utilises an outcomes-framework that is characterised by nationalised standards will compound rather than alleviate the difficulties which surround the programmes pursuit to demonstrate success and introduce a further financial dimension to such endeavours (Gosling, 2015). The challenges and conflicts which surface as a result of the implementation of a financially-driven bureaucratic process within a therapeutic environment will be discussed in further detail after a summary of the research design, methodology and analytical strategy has been provided.

Research design and methodology

Between August 2010 and March 2013 the author conducted an ethnographic study of a hierarchical TC in the north-west of England. The aim of the research was to explore the design and delivery of treatment in TC as outcome-based initiatives, such as PbR, were introduced to the sector. Longitudinal fieldwork provided a way in which the author was able to explore the organisation, structure and operation of a TC according to the TC perspective (see DeLeon, 2000) and contextualise the day-to-day practices that take place within a broader social and political landscape. Fieldwork was conducted as part of a doctoral thesis (the researcher was not a staff member nor a resident of the TC under study) and commenced once full approval from the Research Ethics Committee (REC) at Liverpool John Moores University and the organisations Quality and Clinical Governance Committee (QCGC) was obtained. Before full access to the TC was granted an enhanced Disclosure and Barring Service (DBS) check was also obtained.

The service provides a six-month, stage-based programme which can cater for up to 32 men and women over the age of 18. The programme stages are as follows: welcome house, primary and senior. 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 residents. The primary stage lasts a minimum of twelve weeks and maximum of twenty-two weeks. During the primary stage residents are expected to demonstrate a practical knowledge of TCs, make personal disclosures in group sessions, set an example for other residents and reveal a reasonable level 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. Generally speaking, the stage format reframes an individual's long-term objectives (what they want and need to achieve during their residency) into short term goals that can be defined, perceived and pursued (DeLeon, 2000)[3].

To maintain the anonymity of the setting and population under study the name and precise location of the service has been omitted. Before conducting fieldwork Gold's (1958) typology of research roles was considered and the decision to adopt the participant as observer role was made. As the participant as observer role utilises formal and informal research methods to study groups, programmes and organisations it seemed the most appropriate given the nature and purpose of ethnographic fieldwork. The participant as observer role has the advantage and disadvantage of the researcher being known to the population under investigation. On one hand questions can be routinely asked and if a good rapport has been established with those being observed a wealth of information can be obtained. However, on the other hand, the presence of the researcher can alter the behaviour of those being observed (Kurz, 1984). Although claims have been made that observer caused effects have been somewhat overemphasized (Mulhall, 2002), such effects are an obvious drawback of the participant as observer role. To overcome the observer caused effects a substantial amount of time was invested in the setting. Fieldwork was conducted over 31 months and consisted of evening visits, weekend visits, early morning visits and overnight stays. This was done in an attempt to avoid observing an atypical period in the TC.

Given the inductive, longitudinal nature of the study, fieldwork consisted of two stages: an explorative stage and a main fieldwork stage. The explorative stage lasted approximately 10 months. During this stage observations and informal discussions with staff and residents were employed to open up the subject area and explore avenues for further research. All experiences, programme-specific information and questions generated during this stage were recorded as field notes. Field notes are an important tool for the ethnographer able to communicate engagement in the field and provide a source from where an array of quotations and empirical evidence can be generated (Mulhall, 2002). During fieldwork key words, abbreviations, significant phrases, unconnected sentences and notations of events were manually recorded. After a period of observation, usually within 24 hours, an expanded account was written up using the notations made during fieldwork as a guide. Mulhall (2002) suggests that such reflection could provide a different gloss on the day's events. However, given the elongated nature of fieldwork and the ability to cross-reference observations with other methods of data collection this method of data recording was considered to be appropriate and necessary given the longitudinal nature of the study.

After approximately ten months of explorative fieldwork it was felt that the researcher had developed a reasonable understanding of the programme, established rapport with the population under study and the novelty of an 'outsider's presence' had diminished. Although the explorative stage did not have a definitive end, it was felt that the fieldwork had naturally evolved into a more intense form of fieldwork, which consisted of semi-structured interviews, analysis of official documentation (group therapy session plans, resident care plans and programme handbooks / manuals), more refined observations and informed discussions guided by the aims and objectives of the study. During this phase the researcher began to track a number of residents (who volunteered to participate) during their time in the TC and the immediate period following on from their departure[4]. A series of semi-structured interviews were conducted with 18 residents; 12 males and 6 females between the age of 32 and 46. Due to the non-proportional sampling strategy seven residents started the follow up process during the welcome house stage, four started during the primary stage and seven started during the senior stage. In total, each respondent was interviewed three times. Residents who volunteered to take part in the follow up process during the earlier stages of fieldwork were tracked over a longer period of time than those who took part at a later date. The longest follow ups took place over 15 months, with an interview conducted at five month intervals. The shortest took place over 11 months, with a follow up interview conducted at approximately three and a half month

intervals. Follow up interviews were conducted with all respondents except for one who died of an overdose during fieldwork. In addition to the follow up process a number of one-off interviews were conducted with residents, ex-residents and staff members. Semi-structured interviews were conducted with two males who completed the prison fast track programme[5] before admission to the service, six residents (three male and three female) who had a history of alcohol use, ten residents (seven male and three female) who elected to leave the programme early and nine members of staff. In total 81 semi-structured interviews were conducted, transcribed and subject to conventional content analysis which is a process through which data sets are given meaning.

Content analysis was carried out manually with the aim of exploring and comparing themes within and between the data that had been collected. To open up the data line by line coding was applied in an attempt to identify themes and key phrases. This method of analysis allowed the researcher to go through the data to firstly get an overall impression, then refer back to specific passages and make notes and comments about what might be taking place. Creating a wide-ranging set of initial codes gives the researcher a road map to the data, allowing for further dissection of each data set while understanding the general ideas and concepts within the data (McGrain, 2010). The advantage of this type of coding scheme is two-fold. First, starting with a list of general codes is a good way of providing the researcher with something to work with; and the creation of additional codes means that the coding can become limitless, allowing the researcher to get everything that they can from the data. The next coding phase, which is referred to as here focused coding, is considered to be more abstract than line by line coding as it helps to verify the adequacy of the initial concepts developed (Strauss and Corbin, 1990). As phrases and key words were identified, broad labels which described the content of each passage were recorded[6]. Broad themes were then coded and sorted into a more specific theme[7]. Although ethnographic studies and qualitative analytical strategies are able to provide a rich detailed insight into how people make sense of and respond to their setting and social world, given the small sample size, qualitative nature of the study and subjective nature of the findings, the generalisability of this study is somewhat limited.

Do you get what you pay for?

From the 1st April, 2011 to the 30th September, 2011 the TC under study piloted a voluntary PbR scheme which was offered to all local authorities who referred people 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 programme stage. In the welcome house stage 10% of the total fee paid to the service was based on 'outcomes', in the primary stage 20% of the total fee was based on 'outcomes' while in the senior stage 30% of the total fee was based on 'outcomes'. As a product fee and a results payment were attached to the completion of each programme stage, TC staff and local authorities would establish specific dates in which a resident was expected to complete each phase by. This meant that before a resident had even entered the service, their time within each programme stage had been decided. The negotiation of programme progression prior to an individual's admission, without the individuals consent and knowledge, illustrates the business-orientated, rather than person-orientated nature of the incentive. For example, holding contractual discussions before a resident enters treatment does not take into consideration that unidentified/unanticipated needs may arise during their time in the programme that were not previously known to the service provider. This oversight provides just one illustration of the dehumanising properties of PbR as some of the most complex and vulnerable people in society are transformed 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. From the minute you come through the door to the minute you leave that's all people think about; 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)

The day-to-day implementation of PbR provided a further illustration of how financial gain is prioritised over individual need when outcome-orientated frameworks are introduced into a therapeutic environment. As long as a resident progressed through the programme stages, the service would receive the product fee and a results payment. In this case, the definition and measurement of a 'successful outcome' was solely determined by the retention of a resident. This was due to the fact that programme completion would ensure that the TC received all of the product fees and results payments from the local authority. In terms of PbR, a 'successful outcome' was not defined, or indeed led, by individual progress or personal achievements made during programme participation. Thus, it is possible to suggest that PbR transforms personal progression into a bureaucratic financially-driven process.

> All this is about is money and making sure heads are on beds.
>
> (Resident. August, 2011)

While 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 the definition and measurement of the term (Gosling, 2015). There are conflicting views which surround how long residents should be programme involved for before treatment can be considered to be 'successful'. For example, DeLeon *et al.,* (1982) suggest that a four to six month stay in a TC is needed before an absence of opiate use and criminal behaviour can be achieved, whereas Simpson and Sells (1982) suggest that a minimum of 90 days is needed to achieve this. On the other hand, there is a body of research which suggests that individual progress rather than time spent in a TC can best explain improved functioning following exit from the programme (Toumbourou *et al.*, 1998). Thus, the level of individual progress on exit is a better predictor of positive outcomes than the actual time spent programme involved. 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, 2008; National Treatment Agency for Substance Misuse, 2009; National Institute on Drug Abuse, 2009, Aslan, 2015). The utilisation of retention as an indicator of success not only transforms individual progression into a bureaucratic process but provides an early indication that this seemingly 'new and innovative' payment system is actually a dated concept founded upon ideological representations of treatment success.

According to the Coalition Government, PbR will incentivise the alcohol and drug treatment system to improve the delivery of recovery outcomes (National Treatment Agency, 2010). However, in practice the implementation of such an ideological framework introduced uncertainty and a financial dimension to the day-to-day therapeutic activities that take place in a TC.

> All this has done is add a financial dimension to my work. 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)

There was a clear air of uncertainty which surrounded the rather short-sighted introduction of PbR into the TC. Staff believed that the initiative added a financial dimension to their work load, increased the amount of bureaucratic processes which surrounded key working residents and felt that the values and principles of PbR would dilute the therapeutic integrity of the programme.

> I've heard the word but I don't really know much about it. I think people have to reach certain targets and when they do they get some kind of retaining money where a referrer pays a service X amount of money. It's all dependent on that person getting through the programme which is purely financially driven. We could fall down massively because it could take away the integrity of the programme because 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 member. August, 2011)

> I think all PbR does it give a funder, with an eye on the bank balance, a reason not to pay. I think it lessens the value of what we do if you are getting paid by results. How do you quantify success here?
>
> (Staff member. August, 2011)

The above findings have been recognised and raised beyond the TC under study as service providers (involved in the national PbR recovery pilot project) have also questioned the implementation of PbR in the alcohol and drug treatment field given the general lack of knowledge which surrounds the incentive and ability of such an outcome-orientated payment scheme to provide 'value for money' (National Audit Office, 2015:08). In addition to the aforementioned points, the financial dimension added to the day-to-day duties of those who work in a TC courtesy of PbR raised a further point for consideration; are front-line staff going to become *financially accountable* for the work that they do? If we take the case of the TC for example, if a resident fails to progress through the programme as outlined in the contract will the member of staff tasked with a resident's case be held financially responsible? Will there be adverse consequences for the workforce if they do not meet the needs and demands of PbR? In addition to the emerging and potential financial implications of PbR it is also possible to suggest that the incentive holds the ability to divert attention away from the *genuine achievement* of 'successful outcomes', towards an *administrative demonstration* which indicates that a series of pre-defined outcomes, deemed to be measures of success have been attained.

> Think about it because PbR is linked to the Outcomes Star it isn't hard to show that a resident has improved. Their physical health improves because they aren't using, they're eating three meals a day and seeing the doctor every week. They're not offending because they're off the streets and stuck in here for six months. Showing that someone has progressed on paper isn't hard when you think about it so that bit of PbR won't be the problem, it's the deadlines.
>
> (Staff member. July, 2011)

PbR creates a clear dichotomy between the achievement of a successful outcome and demonstration of a successful outcome. This financially-orientated process dehumanises an individual's recovery journey. It does not reward service providers for supporting residents to achieve what they *need* to achieve as the focus of the initiative is on the production of data which illustrates that a standardised pre-defined and agreed 'successful outcome' has been reached. Thus, reinforcing rather than breaking away from the status quo which surrounds what alcohol and drug treatment programmes are *expected* to achieve.

Punishing by Results

The implementation of PbR in the alcohol and drug treatment field is not only 'in danger of reinventing the wheel' (National Audit Office, 2015:08) but is on the verge of providing another way in which the state can punish already stretched public services and condemn substance users even further. By focusing on a definitive outcome measure, we ignore the absolutely crucial processes which take place on the ground in alcohol and drug treatment services that help people along the road (not a once in a life time event) towards recovery. For instance, an individual's ability to accumulate recovery capital, which is considered to be 'one of the best predictors of recovery' (HM Government, 2010:18) is completely overlooked by PbR, despite it contributing to the breadth and depth of internal and external resources that an individual can draw upon to initiate and sustain recovery from substance use (Granfield and Cloud, 1999).

Ultimately, PbR is 'poorly designed and implemented' (National Audit Office, 2015:08) because it is based upon a series of ideological expectations which anticipate that participation in an alcohol and drug treatment service is a standalone end of story event which can produce a polished, socially productive end product. The end product being a commodity which is free from substance(s) of choice and offending behaviour with an improved level of health and well-being. Rather than recognising the realities of recovery, which consists of an ongoing journey of improvements rather than an accomplished state (McLellan, 2010; Best and

Lubman, 2012) PbR attempts to force a socially desirable expectations framework upon service providers and service users which will financially and morally punish those unable to meet the targets that they have been set.

The alcohol and drug treatment field will be financially punished as services will not receive the payments that they are entitled to and service users will be ostracized (and potentially unable to access support from public services) for not being able to conform to the expectation framework that has been imposed upon them. Ultimately, PbR is a state-operated vehicle of responsibilisation. It is a financial mechanism which contributes to the construction of substance users as blameworthy agents and attempts to continue to demystify the realities of the 'drugs problem' and what is needed on an individual, social and political level to help people desist from a lifestyle that is troubled by substance use. The outcome-measures that are currently utilized by the Government's PbR scheme demonstrate a firm commitment to individualise social and economic problems by diverting attention away from the impact of poverty and structural disadvantage onto the individual (Gillies, Tolley and Wolstenholme, 1996; Muntaner and Lynch, 1999). Encouraging people to engage with already existing public services is cheaper than attempting to reduce poverty and social inequality and distracts from the social pressures and differential opportunities that exist between communities, which prevent people from accessing help and support for substance use in the first instance.

Conclusion

The introduction of PbR into the TC has created several significant financial, conceptual and moral challenges which threaten to undermine the day-to-day workings of programmes that aim to help those who wish to embark upon the road to recovery to do so. The discussion that has been presented here illustrates how PbR is detached from the realities of the work that takes place at the coal face of service delivery as it is fundamentally based upon dated concepts and ideological representations of a 'successful outcome'. Innovation is suffocated rather than promoted, vulnerable people are not only lost but totally overlooked as financial gain is prioritised over individual need. The outcome-orientated nature of PbR is not only ill-thought through but counterproductive as state-defined expectations responsibilise people during a time that they ought to be supported, integrated and included within every decision that is made with regards to their programme involvement and progression.

As it stands, it seems that PbR is here to stay. With this in mind it is imperative that genuine person-centred outcomes rather than socio-political expectations are prioritised on a theoretical, practical and political level. It is important to recognise that PbR is not always an appropriate model and significant challenges remain in applying this approach to services for those facing multiple and complex needs. It is therefore imperative that commissioners have a clear rationale for why PbR is the right commissioning model and reflect on the experience of PbR schemes so far in considering alternative ways to support an outcome-focused approach (Revolving Door Agency, 2015). Rather than reinventing the wheel of expectation and maintaining the status quo service users, practitioners, commissioners and researches alike should seek to develop PbR so that it is a practice-orientated (rather than politically-orientated) framework grounded in recovery capital (Gosling, 2015). If we conceptualise effectiveness in incremental, rather than absolute measures and look at recovery from substance use in relation to an individual's level of functioning (recovery capital), taking a strengths-based approach to recovery, we see the definition of success assume another form.

> Yeah it's one house, one generic model, but there are thirty-two different programmes going on at any one time in here. There's no one size fits all when it comes to recovery.
> (Resident. August, 2010)

A more open-ended framework which moves away from the current focus on objective socially desirable outcome measures towards subjective outcome measures such as emotional well-being, quality of life and social relations (for example), would allow a more accurate evaluation of individual's personal growth and well-being after participation in a TC (Vanderplasschen *et al*,. 2013). Thus complementing rather than competing with the values and ethos of the work that takes place at the coal face of service delivery in a TC. Although such outcome measures do not quite fit with the longstanding socially and politically desired outcomes of reduced (re)offending, retention and relapse they provide a much more realistic representation of the work that takes place within and around settings such as the TC. It is therefore possible to suggest that a recovery-orientated rather than payments-orientated framework could go some way in contributing to the reorganisation of mainstream conceptions of treatment success and alignment of high-level policy directives with the practice that takes place in a TC.

Due to the extensive and time intensive nature of ethnographic research, alongside its inability to provide quick quantifiable answers, it continues to be under-utilised by policy makers to inform and develop policy (Walker, 2011). This is despite the fact that findings generated as a

result of ethnographic fieldwork can help to avoid the construction of simplistic high-level policy directives and 'go behind the data and help to tell us what we *should* be looking for and trying to measure' (Payne, 2010:04). Given the conceptual and methodological limitations which surround current attempts to understand the application of PbR in the alcohol and drug treatment field it is important that we continue to develop our understanding and knowledge of outcome-orientated incentives. As the findings presented here focus on one situated residential rehabilitation unit, it is important to expand and develop such research on a much larger scale, in different alcohol and drug treatment settings with different treatment populations so that more generalizable and representative findings can be obtained.

Notes

[1] Robert Granfield and William Cloud devised the term recovery capital to describe the breadth and depth of internal and external resources that an individual can draw upon to initiate and sustain recovery from substance use. Granfield and Cloud (1999) suggest that the concept of recovery capital can be refined as four individual, though overlapping components which are as follows: social, physical, human, and cultural. Social capital is affected by the environmental context in which an individual is embedded and comes about through changes in relations among persons that facilitate action. Physical capital includes savings, property, investments and other financial assets. Human capital covers a wide range of human attributes that provide an individual with the means to function in society (Granfield and Cloud, 1999; Best and Laudet, 2010). Human capital includes skills such as problem solving, self-esteem and interpersonal skills, educational achievements, physical, emotional and mental health and aspirations; as well as personal resources such as commitment and responsibility that will help an individual to manage everyday life (Daddow and Broome, 2010). Cultural capital refers to an individual's attitudes, values, beliefs, dispositions, perceptions and appreciations that derive from membership in a particular social or cultural group. The quality and quantity of recovery capital that an individual has is both a cause and a consequence of recovery from substance use as it can hold substantial implications for the options available to the individual when attempts to desist from substance use are made (Granfield and Cloud, 2001; 2008; Lyons and Lurigio, 2010).

[2] To date, no official reason for this has been provided or published in any document that is freely available to the public.

[3] The staff team in the TC under study consisted of a residential manager, programme manager, department head, therapeutic workers, care workers and an administrative support team. The residential manager is not involved in delivering the programme as they are the interface with external agencies to promote the service. It is the responsibility of the programme manager to ensure that the service is run correctly and to a high standard. The department head is responsible for the day-to-day running of the service. Therapeutic workers are responsible for delivering behavioural groups as well as key working residents. The day care worker is responsible for designing and delivering activities for the residents, dispensing medication and ensuring that appointments with external agencies were facilitated. The night care workers are responsible for delivering the evening programme, which includes community activities, the administration of medication and sleepover duties. The support team manage the administration of the service and are responsible for taking referrals to the service and ensuring that the residents' benefits are correct.

[4] As the programme utilises a series of programme-specific stages a non-proportional quota sampling strategy was employed to ensure that the research sample consisted of residents from all three stages.

[5] The prison fast track programme is designed for newly released prisoners who have completed a prison-based TC.

[6] Broad themes consist of the following: community separateness, peers as role models, a structured day, programme stages, work as therapy and education, the encounter group, emotional growth and awareness training, planned duration of stay, continuity of care, resources, tools, payment by results, client change, outcomes, effectiveness, commitments, re-entry and the therapeutic alliance.

[7] The following five themes were identified as a result of the analytical strategy: community as method, emotional growth training, community engagement, retention and payment by results and continuity of care.

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