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**Title:** A critical insight into practitioners lived experience of Payment by Results in the alcohol and drug treatment sector

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**Abstract:** Since George Osbourne described reducing public spending as ‘the great national challenge of our generation’ (Her Majesty’s Treasury, 2010:12) the Government have demonstrated a profound interest in Payment by Results (PbR) as a mechanism to improve service quality, value for money and innovation (Audit Commission, 2012). Although PbR is not a new initiative, it has been rebranded and sold as a vehicle that can steer ongoing strategies for reform, particularly in the field of criminal justice and drug/alcohol treatment (Her Majesty’s Government, 2010; Ministry of Justice 2013). Despite such assertions, the initiative has become synonymous with budget cuts (Community Links, 2015), the privatisation of public services (Policy Exchange, 2013) and controversy. Drawing upon the findings of a focus group with staff who work in a Therapeutic Community, this paper highlights the lived experience of practitioners as PbR takes hold of the alcohol and drug treatment sector. The findings suggest that outcome-orientated incentives, such as PbR, hold the potential to transform welfare-orientated sectors into a financial, market-focused milieu.

**Key words:** outcome-based commissioning, Payment by Results, Therapeutic Community

## **A CRITICAL INSIGHT INTO PRACTITIONERS LIVED EXPERIENCE OF PAYMENT BY RESULTS IN THE ALCOHOL AND DRUG TREATMENT SECTOR**

**Abstract:** *Since George Osbourne described reducing public spending as ‘the great national challenge of our generation’ (Her Majesty’s Treasury, 2010:12) the Government have demonstrated a profound interest in Payment by Results (PbR) as a mechanism to improve service quality, value for money and innovation (Audit Commission, 2012). Although PbR is not a new initiative, it has been rebranded and sold as a vehicle that can steer ongoing strategies for reform, particularly in the field of criminal justice and drug/alcohol treatment (Her Majesty’s Government, 2010; Ministry of Justice 2013). Despite such assertions, the initiative has become synonymous with budget cuts (Community Links, 2015), the privatisation of public services (Policy Exchange, 2013) and controversy. Drawing upon the findings of a focus group with staff who work in a Therapeutic Community, this paper highlights the lived experience of practitioners as PbR takes hold of the alcohol and drug treatment sector. The findings suggest that outcome-orientated incentives, such as PbR, hold the potential to transform welfare-orientated sectors into a financial, market-focused milieu.*

**Key words:** Payment by Results, Therapeutic Community, outcome-based commissioning

### **A LEAP INTO THE DARK?**

The Spending Review (2010:05) outlined how the then Coalition Government planned to reduce welfare costs and ‘wasteful spending’ through a radical reform of public services across England and Wales. Since 2010, we have witnessed significant changes to the design, delivery and commissioning of alcohol and drug treatment (to name just one sector) as the pursuit to demonstrate ‘value for money’ has become an overarching priority for front-line practitioners, commissioners and politicians alike. Although not a new concept, Payment by Results (PbR) has been utilised as a way in which increasingly scarce funding is allocated within and between such public services. Generally speaking, PbR is designed to pay service providers on the basis of the outcomes that they achieve rather than the activities that are undertaken (Department for International Development, 2014). It is a system of outcome-based commissioning, which transfers financial risk (or reward) to service providers. The idea behind PbR is that by commissioning outcomes rather than outputs, commissioners allow service providers to work in a way that they see fit, safe in the knowledge that if specific outcomes are not achieved, they do not have to make a payment (Webster, 2015). For some, PbR is considered to be a form of financial innovation with the potential to provide access to new capital and incentivise providers to develop innovative solutions to intractable social problems (National Audit Office, 2015). For others, it is counterintuitive fiscal endeavour that stifles innovation and enhances accountability at the coal face of service delivery (Gosling, 2015; 2016).

In theory, the fundamental aim of PbR 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 by staggering payments over longer periods of time (National Council for Voluntary Organisations, 2013). Despite such positive rhetoric, given the relative infancy of PbR (particularly in the alcohol and drug treatment sector) there is, in fact, a limited evidence based to draw robust, generalisable conclusions about whether this technically challenging form of contracting is an effective commissioning tool for public services (Audit Commission, 2012; Hunter and Breidenbah-roe, 2013; National Audit Office 2015) that can perform better than other (more established) payment systems, in terms of money saved or improved outcomes (McNeil et al., 2015). Notwithstanding the uncertainty which surrounds PbR, it has become an increasingly common commissioning model across both sides of the Atlantic.

### **THE CASE OF DELAWARE**

In America, up until 2002, Delaware's Division of Substance Abuse and Mental Health (DSAMH) utilised cost-reimbursement contracts to fund alcohol and drug treatment services in the region. DSAMH licenses, monitors, funds, provides training and technical assistance, and oversees an array of services that include detoxification, outpatient, residential and methadone treatment programmes across the state of Delaware, United States of America (McLellan et al., 2008). Generally speaking, under a cost-reimbursement contract the final cost of service delivery is determined when the contract is complete, or at an established date in the contracting period. A total cost estimate is usually established, which allows a given service provider to set a budget for the task in hand. Cost-reimbursement contracts are usually implemented where the nature and/or scope of the work that is to be undertaken cannot be accurately and reliably defined at the outset. However, since 2002 cost-reimbursement contracts have been replaced with performance-based contracts which reward service providers who achieve specified outcomes. In Delaware, earned incentives are provided on a monthly basis, dependent upon three performance indicators: programme admission, participation and completion. DSAMH agree to pay one-twelfth of the total annual operating costs for each service at the end of every calendar month, contingent upon the service successfully maintaining an 80% utilization capacity rate. Utilization rates of 70-79% for the month

received 90% of full payment; 60-69% utilization received 70%; and utilization rates below 60% received only 50% of the monthly payment (McLellan et al., 2008).

McLellan et al., (2008) found that between 2001 and 2006 the average capacity utilisation went from 54% to 95%. Furthermore, the average number of service users meeting participation requirements increased, from 53% to 70%. Although this would suggest that performance-based contracts have a positive effect on capacity utilisation, it is important to recognise that during this time many services began to streamline their admission procedures (reducing the data collection burden on practitioners); increase their hours of operation, making it easier for service users to attend early morning and evening classes; and three out of the eight programmes opened additional satellite offices to make the service more accessible in previously under-served areas. Thus, the changes that were made to the administration and delivery of alcohol and drug treatment during this time means that we are unable to eliminate the possibility that such initiatives were at least partly responsible for the increase in recruitment and engagement.

It is also important to recognise that services did not provide additional opportunities (that may have been more aligned to an individual's needs) for service users to gain different outcomes and/or experiences to those outlined and funded by the DSAMH. Rather, improvements were most rapid in respect of recruitment targets, which, perhaps coincidentally, also attracted the greatest amount of funding. Together these trends suggest that services primarily respond to financial incentives, putting in the greatest effort where the financial reward, as opposed to individual rewards, are greatest. Not necessarily seeking to excel in other ways (McLellan et al., 2008) or adopt innovative interventions that may be of more use to the individuals and what they need to help address their substance use. Subsequently, a potential side effect of performance-based contracts is the engendering of a mentality of doing just enough to gain financial rewards whereby the reward becomes the objective that is worked towards as opposed to service user progress (McLellan et al., 2008).

## **THE CASE OF ENGLAND AND WALES**

On the other side of the Atlantic nearly a decade after performance-based contracts were introduced in Delaware, the then Coalition Governments 2010 Drugs Strategy outlined plans to introduce PbR to the drug and alcohol treatment sector in England and Wales (Her Majesty's Government, 2010). 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 specified outcome measures (Department of Health, 2012). Although a generic PbR model was designed, each area went on to adapt and modify the proposed model. 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, 2012). In an attempt to create a degree of consistency across the areas, a co-design group which consisted of service representatives, central government departments and 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).

The Department of Health published a report which collates eleven months of data from the start of the pilot in April 2012, to the end of February 2013. As each pilot area utilised a different approach, the evaluators created a performance framework that ‘mirrors as closely as possible the outcomes that decided PbR payments’ (Department of Health, 2013:01). The framework consists of five outcome measures: abstinent from all presenting substances, successfully completed treatment free of dependency, resolved housing issues, stopped injecting and improved quality of life. All of which were employed to establish the effect PbR had on performance within the pilot areas, in comparison to the rest of the country. The evaluation not only sheds light on the complex nature of drug treatment but brings into sharp focus the nuanced ways in which ‘successful treatment outcomes’ are defined and measured with the findings suggesting that the performance of drug dependent clients (in terms of achieving abstinence from all presenting substances) was 5% higher than the national average, yet the overall performance of clients (in terms of successfully completing treatment free of dependency) was significantly below the rest of the county (Department of Health, 2013).

In May 2013, a national service provider's summit was held in London to bring together representatives from the pilot areas to discuss their experiences of PbR over the first 12 months. The findings suggest that 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 recognized 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). Similarly, the National Audit Office (2015) found that the reducing reoffending pilots (based in HMP Doncaster and HMP Peterborough) were also hampered due to comparable issues.

Between 2010 and 2015, an intervention called the One Service provided through-the-gate and post-release support to adult males, released from HMP Peterborough, who had served a prison service of less than 12 months. The project sought to reduce reoffending amongst short term prisoners by providing a range of co-ordinated advice and support. It was intended to operate until 2017 (funded on a PbR basis) but was prematurely cut short due to the Coalition Government's Transforming Rehabilitation agenda which introduced mandatory statutory supervision for short-term offenders – the initiatives intended target group. The pilot was operated by Social Finance, funded via a social impact bond, and operated by a partnership led by St. Giles Trust. The target was a reduction of 10% in the frequency of reconviction rates within each cohort of around 1000 prisoners (calculated by comparison with a match group). Findings from the first 18 months of the pilot suggest that for those released from Peterborough between July 2012 and December 2013 there were an average of 155 re-conviction events per 100 offenders. A decrease of only 3% compared to an average of 160 re-conviction events per 100 offenders released between July 2008 and December 2009.

Although it has been more than six years since the concept of PbR was first introduced to the alcohol and drug treatment sector, and numerous practitioners (across a broad range of public services) have been subject to PbR-esque initiatives, there is a distinct lack of insight into the practitioners lived experience of such arrangements. For the purpose of this paper, a lived experience is defined as personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other

people (Chandler and Munday, 2011). Rather than recognising and learning from the experience and knowledge of practitioners, conversations about outcome-based commissioning and its impact on practice have been dominated by academics and policy makers alike. Despite the fact that such lived experiences are able to inform, develop and refine high-level policy directives so that they are more in tune with, and respectful of, the realities of service provision. In an attempt to add a new dimension to this highly politicised debate, this paper will critically assess the impact of PbR on both the personal and professional lives of practitioners who currently work in a Therapeutic Community for substance use.

### **RESEARCH DESIGN**

The main aim of focus group research is to understand and explain the meanings, beliefs and cultures that influence the feelings, attitudes and behaviours of individuals (Powell et al., 1996; Rabiee, 2004). Compared to individual interviews, focus groups elicit a multiplicity of views and emotional processes within a group context (Gibbs, 1997). The interaction that can take place within a group setting also enables participants to ask questions of each other, as well as to re-evaluate and reconsider their own understandings of their specific experiences. Although focus group research has many advantages, as with all research methods there are limitations. The researcher (who is also typically the facilitator) has less control over the data that is produced than in either quantitative studies or individual interviews (Morgan, 1988; Gibbs, 1997). This is because the role of the focus group researcher is to allow participants to talk to each other about the topic under investigation, ask questions and express doubts and opinions while having limited control over the interaction (Gibbs, 1997). By its nature, focus group research is limited in terms of its ability to generalise findings to a whole population, mainly because of the small numbers of people participating and the likelihood that the participants will not be a representative sample.

In March 2016, the author facilitated a focus group with 11 drug and alcohol practitioners who currently work in a Therapeutic Community (TC) for substance use in the North of England. Generally speaking, the term Therapeutic Community, or TC as they are colloquially known, is used to describe a setting in which people with problems associated with substance use live together in an organised and structured way in order to promote change and make possible a life whereby they no longer rely on substances (Scott and Gosling, 2015). Each TC forms a



miniature society in which staff and service users, colloquially referred to as residents, are expected to fulfil distinctive roles that are designed to support the transitional processes that individuals embark upon during their residency. Although day-to-day activities and therapeutic interventions vary depending on the population and the setting of the programme, all TCs use a holistic ‘community-as-method’ (DeLeon, 2000) approach based on principles of self-help and mutual aid that emphasises the need to encourage constructive participation amongst all its members and engage with people’s problems whatever they may be.

Focus group participants performed a variety of roles with varying responsibilities in the host TC. There were two admission officers, a manager, apprentice key worker and seven key workers who are directly responsible for overseeing residents care and progress during their time in treatment. All participants had extensive experience of PbR in the drug and alcohol field. Eight out of the eleven practitioners had experience of a PbR pilot scheme that took place in the host TC in 2011 (see Gosling, 2015 for further information about the PbR pilot scheme). Another had experience of working under PbR in a prison drug treatment programme (abstinence-based unit). One had previously worked for a drug and alcohol service where the Governments 2010 national recovery PbR pilot took place (see Department of Health, 2013 for further information), and another worked for an ex-offender mentoring service that attempted to introduce a voluntary PbR scheme. The focus group was based around three themes, which according to the Audit Commission (2012), typify what a PbR scheme should consist of. The areas include: improving outcomes or service quality, reduce costs or improve value for money and stimulate or transform change. The discussion lasted just under two hours, was recorded on a Dictaphone, transcribed and subject to content analysis.

To open up the data, line by line coding was applied in an attempt to identify themes and key phrases. 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. Broad themes were then coded and sorted into a more specific theme. In total, the analytical strategy produced three broad themes: competing commitments, accountability and managerialism. Each of which are critically reflected upon in the next section. Although such methodological and 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 generalizability of this study is somewhat limited. Despite the methodological limitations which surround this study, providing an opportunity for practitioners to have their voice heard is particularly timely given the lack of discussion between commissioners and service providers at all stages of the PbR design and implementation process (Lagarde et al., 2013).

### **PbR: A WOLF IN SHEEP'S CLOTHING?**

Although PbR is becoming an increasingly common commissioning model across the public sector, one of the most consistent shortcomings of the incentive is the inherent disparity between its proclaimed aspirations and the actualities which surround its design and delivery (Gosling, 2015; 2016). It has been claimed (on a predominately political level) that outcome-based commissioning is a method for improving outcomes, yet in practice, PbR merely provides an alternative, more stringent, way to pay for the same service (Hunter and Breidenbach-Roe, 2013). Additionally, it is also alleged that PbR encourages innovation and creativity amongst practitioners to do 'what works,' yet the very nature of the incentive means that it is impossible to (re)secure a contract without substantive evidence of effectiveness. Furthermore, as PbR heightens the use of target / outcome driven practices, attempts to be innovative and creative are diluted as meeting contractual obligations and specified outcomes are prioritised.

An ‘implementation gap’ – whereby a set of policies exist on paper but are absent on the ground - is particularly apparent in the alcohol and drug treatment sector as high-level policy directives, such as PbR, are increasingly championed as a vehicle that will steer ongoing strategies for reform, despite the initiatives abject failure to recognise and appreciate the context (and indeed contested nature) of recovery. The respective, incremental nature of recovery from substance use is widely documented (White, 2004). As are the complexities which surround defining what the term actually means (The Betty Ford Institute Consensus Panel, 2007), what it consists of (abstinence, maintenance and/or moderate substance use), and more recently, what recovery ‘looks like’ (Best et al., 2015). Although the term recovery is widely used, particularly within and around the health care sector, the lack of a standard definition has hindered public understanding of the process and research within and around the area (The Betty Ford Institute Consensus Panel, 2007). Although existing research in and around abstinence-based treatment services, such as the TC, have produced a robust body of knowledge that has contributed to the creation of empirically-informed theoretical models (DeLeon, 2000) and explicit methods by which service users have become abstinent from substances of choice (Borkman et al., 1998; De Leon, 2000; Flynn et al., 2003) there are currently no reliable, standardised measures of recovery or prevailing concepts which typify what the term actually means (The Betty Ford Institute Consensus Panel, 2007).

Although precise definitions of recovery are lacking, broad themes which outline what constitutes as recovery - on a political level - are clear. Some of the most troubled individuals are expected to ‘move-on from their problem drug use towards a drug-free life and become an active and contributing member of society’ (The Scottish Government, 2008: VI). As a result of these political themes, PbR in its most basic form, expects service providers to evidence how they have helped service users to achieve a series of pre-determined key performance indicators, colloquially referred to as ‘outcome’ measures, which demonstrate (albeit on paper) that individuals are free from dependency and ‘contributing’ to society within a relatively short space of time. The aforementioned themes are not only aspirational, but based upon a political desire for alcohol and drug treatment services to support service users towards some kind of ‘fixed state,’ characterised by a series of ‘outcome’ measures that can be bought and sold within an increasingly competitive market. Attempts to commission alcohol and drug treatment services based upon an archtype version of recovery that gives precedent to the creation of a marketable version of recovery as opposed to a meaningful individual-centric recovery

experience is counterproductive, ill thought through and detached from the realities of service provision and more importantly, the multi-faceted nature of individual change. Rather than creating a mode of commissioning that complements existing service provision, PbR introduces competing commitments to the sector, imposing series of socio-political key performance indicators upon service providers and service users alike.

As past history shows it is so difficult to define a positive outcome. They are specific to services and to each individual for that matter because every single person has different individual needs. You can use care plans and risk management plans to identify what their support needs are but it's so hard to define from one individual to the next. But what they [*commissioners*] want is a set way to do things and I just don't think it works.

(Participant 1)

Recovery from substance use is an ongoing journey of improvements rather than an accomplished state (McLellan, 2010; Best and Lubman, 2012), yet PbR sets out a clear mission to standardise service delivery through a series of all-encompassing 'outcome' measures. Although key performance indicators (such as those adopted by the Government's PbR recovery pilot in 2012) are legitimate concerns for the sector, they are not necessarily a conclusive nor definitive indicator of recovery, best practice or indeed value for money (Gosling, 2015). Standardised performance indicators may be financially valuable to an organisation, given that they are able to generate an income, but they are by no means able to accurately capture the realities of recovery or 'what works' at the coal face of service delivery. This is due to the fact that the notion of value for money and effective practice have a fundamentally different ethos; one focused upon saving money, the other on saving people. Value for money, according to the National Audit Office, is fundamentally about 'spending less', minimising the cost of resources used or required to achieve intended outcomes (National Audit Office, 2016). Whereas discussions about effective practice in the alcohol and drug treatment field tend to focus upon the value, and subsequent impact, of the therapeutic alliance between practitioners and service users (Meier et al., 2005) as well as a client's readiness, motivation and commitment to change (DeLeon, 2000).

Rather than complementing existing practices and providing a genuine way in which already stretched services can demonstrate value for money, PbR fuels one of the fundamental and arguably most longstanding controversies which surround the drug and alcohol treatment sector; how to define and measure recovery from substance use. Rather than introducing an initiative that is grounded in genuine understanding and foresight, we are witnessing the emergence of a policy that has been introduced to ensure services, that are already overstretched and under resourced, are working towards the creation of a product (service users who ‘achieve’ a series of socio-political key performance indicators, disguised as ‘outcome’ measures) that has considerable financial value within a competitive consumer market. The marketization of recovery not only converts a highly-person journey into a neo-liberal activity, characterised by competition, economics and inequality, but transforms the alcohol and drug treatment sector into a recovery free-market, whereby services compete for work (and service users) with the promise to perform (achieve specified outcomes) for the cheapest amount of financial investment.

Mulgan et al., (2010) suggest that PbR is a key accountability mechanism for the Government as they are only committed to pay for services that are able to produce *evidenced* results. The emphasis that is placed upon the production and dissemination of ‘evidence’ – as a way in which to demonstrate who has the best product on the market – re-iterates how neo-liberal ideals are able to further penetrate the sector under the guise of PbR. More broadly, despite claims that outcome-based commissioning will help to unlock ‘professionalism’ and place ‘trust’ in the hands of front-line practitioners (Ministry of Justice, 2013), PbR continues to deconstruct professionalism at the coal face of service delivery; eroding flexibility and individual autonomy. Rather than unlocking professionalism, PbR stifles innovation and creativity as practitioners have a series of key performance indicators to work towards in addition to their daily duties.

The biggest impact that this has is on the quality of work that you can provide because it isn’t so much about them [*service users*]. It was all about that set specific work that you have to do to ensure that we got paid.

(Participant 4)

The degree to which meaningful, individualised relationships between practitioners and service users can exist and thrive within a financially-driven landscape is subsequently questionable. Although in a different context, Annison et al., (2014) suggest that humanistic and personalised approaches are in direct conflict with new and emerging practices (such as PbR) that are competitive and profit driven. The discussion presented here illustrates how the commodification of recovery transforms the role and responsibilities of all those involved in the alcohol and drug treatment sector. Service users are transformed into fiscal subjects that can be bought and sold within an increasingly competitive market (Author, 2016). Practitioners are transformed from facilitators of recovery to an administrators of recovery; charged with evidencing the creation and production of a marketable version of recovery that has a financial value rather than humanitarian value; and services / organisations adopt a role that is more in line with a brokerage firm; doing little more than facilitating the buying and selling of products to the market for a profit.

My phrase to sum this up is that it becomes like a cattle farm; get them in, get them out as quickly as possible. The mentality become that as soon as a client got to that point of a positive outcome get them discharged and that's when overdoses and all kinds started happening because they literally finished their detox, were discharged from treatment because of that positive outcome and three days later they were dead.

(Participant 1)

It doesn't matter how passionate you are, how caring or how much you want the best for your clients, that person centred approach then gets lost because your too busy focusing on a business model in the back of your head. You just think I've got to do this work to make sure that we get this money so we can remain in jobs. You just lose the essence of what we do and it doesn't matter whether it is residential, prison or community. It has the same impact right across the board.

(Participant 2)

Transforming practitioners into administrators of recovery, working within a financial rather than person-orientated framework whereby service users become 'passive recipients of care' (Ryan et al., 2012:2) provides an opportunity for the State and private investors alike to literally and figuratively call to account those who are required to meet the standards and contractual obligations of PbR. Although a number of practitioners spoke about the official disciplinary procedures which surrounded one's failure to meet PbR objectives, the majority of the

discussion during the focus group focused upon the idea that practitioners adopted a sense of fear, internal pressure and self-blame if they were unable to achieve given outcomes.

I saw that many staff go off with stress and depression because of the amount of pressure that they were put under.

(Participant 5)

Payment by Results is designed to ensure that certain outcomes are being achieved and with that comes a lot of stress and a lot of negativity. It becomes a negative environment to work in. I actually worked in a service that was pretty much a guinea pig for the country back in 2010. It created a very difficult working environment, staff were being pressured by management for outcomes and management were being pressured by commissioners.

(Participant 1)

PbR creates a clear dichotomy between what practitioners feel they *should* be doing in order to 'do a good job' and what they were *expected* to do in order to 'get things done.' This tension is further compounded as practitioners develop a morally ambiguous relationship with PbR. On one hand it was recognised that PbR may be a way in which services could survive within an increasingly competitive field. Whereas on the other hand, it was felt that PbR could force practitioners and service providers alike to conduct 'ability audits' of potential clients before engaging with them to establish whether they are able to achieve specified key performance indicators and associated funding. So much so that a number of practitioners began to critically reflection upon their experience of PbR in light of the demands of the initiative.

We're only gonna go for the fruit that's hanging on the lower branches anyone higher up the tree with more complex needs could end up an addict for life.

(Participant 6)

That's a fair point because I had a case load of 74 and I would park the bus with those who were on large amounts of medications: 90mls, 100mls of Methadone; Benzos; all that kind of stuff. They just got left. I don't mean literally left. It was a case of here's your script, how are you doing, write out a sheet to say that they had been in and that was it. I was more focused on the people that were obviously able to achieve those positive outcomes. Not everyone gets the same type of care and support that they should because there is pressure.

(Participant 1)

It's promoting us to look at the needs of those that aren't considered to be complex cases. So if you have had a chaotic life and underlying needs that have never been met, it is going to take that little bit more time to develop you, but we can't do it because we haven't got the time and we don't want to take a gamble because there might not be a payment there.

(Participant 6)

The auditing of potential clients provides a way in which practitioners and service providers alike can identify financial assets (those able to achieve specified outcome measures) and locate those who are considered to be a 'gamble' or particularly 'risky.' This subsequently enables practitioners to consciously locate and divide their time, energy and resources amongst service users; with those deemed to be a financial asset attracting the most investment from practitioners given the anticipated fiscal return. The implementation of high-level policy directives, such as PbR, creates a series of micro-practices that holds the ability to change the professional climate and ethos of service delivery as humanity, dignity and intrinsic worth of individuals are replaced with neo-liberal principles and prescriptions. Introducing a series of bureaucratic, financially driven processes that focus upon the documentation of a standardised version of recovery removes practitioners further from the coal face of service delivery and in some instances, encourages practitioners to take a more 'proactive approach' to their profession.

I was probably one of the most consistent workers in terms of meeting targets because I took a very proactive approach. I was going in at 7 in the morning and getting home at 9 at night which had a big impact on my personal life.

(Participant 1)

The above quotation illustrates how the tensions and dilemmas which surround PbR had an impact upon both the professional and working lives of practitioners. During the focus group, many practitioners felt that their ability to maintain a healthy work-life balance was undermined as they, although not asked to do so, were spending an increasing amount of time in the work place in an attempt to meet the needs and demands of PbR as well as their clients. The competing commitments and increased sense of accountability which descended over practitioners, as PbR was introduced, had a longstanding impact on how practitioners, involved in the aforementioned focus group, define their role within the sector as they prepare for the next policy directive which attempts or provide 'value for money'.



## CONCLUSION

The findings that are presented here are original and bring something new to the discussion about PbR in the public sector, particularly for services in and around the alcohol and drug treatment field. The discussion highlights some of the competing commitments and contradictions that arise as PbR is implemented at the coal face of service delivery. Notably the neo-liberal (re)construction of welfare-orientated practices into a market-driven activity. The marketization of an individual's alcohol and/or drug treatment experience contributes to broader debates about the privatisation of public services, in particular the viability of broadening, extending and diversifying agents who, under outcome based commissioning, can financially punish service providers, as the state becomes further decentralised. The idea that private companies in and around the Criminal Justice System 'profit from punishment' has been discussed elsewhere (Prison Reform Trust, 2005) but the notion that profit can be made from alcohol and/or drug treatment is yet to be highlighted and critically discussed. In light of the findings presented within this paper, it is possible to suggest that PbR (particularly in the alcohol and drug treatment sector) introduces a more discrete way in which the Government, commissioners and/or private investors alike, can regulate and control (in one form or another) an individuals' access to, and experience of, alcohol and/or drug treatment, through a nuanced socio-economic system of micro-governance that is able to punish services and service users alike who are unwilling and/or unable to meet specified goals and key performance indicators of said political, social and economic authorities.

The aforementioned socio-economic system of micro-governance is legitimised through PbR. As practitioners at the coal face of service delivery and service users alike, are becoming increasingly held to account for a task (in this instance, the recovery process) which requires social support and equal opportunities for all members of society. Putting outcome-based commissioning mantras at the forefront of the political agenda distracts attention away from the social pressures and differential opportunities that exist between people and communities, which prevents individuals from accessing help and support in the first instance. Rather than tackling the nuanced issues which surround social equality and available treatment opportunities, PbR schemes are targeted at intractable multi-faceted social problems with the hope that an outcome focused approach will somehow solve longstanding individual and social issues.

PbR is undoubtedly a growing mode of commissioning in and around the United Kingdom with private probation contracts, a large proportion of new contracts in the homeless and alcohol and drug treatment sector all containing an element of PbR, with income dependent on reaching specified outcome targets (Webster, 2015). Although the findings that are presented here are not generalizable to all practitioners' experience of PbR, the discussion has the capacity to contribute to broader social and criminal justice policy debates about the increasing marketization of the management and supervision of public services, particularly those that work alongside individuals trapped in a vicious cycle of substance use, criminal activity, punishment and marginalisation. The paper also provides a significant contribution to ongoing discussions in and around the marketization of the welfare state more broadly. Whitfield (2015) suggests that PbR and current trends in social investment is primarily driven by financial institutions whose motivation is to privatise the welfare state and open up new markets for global corporations. The findings that are presented here support this point, illustrating how the reconfiguration, decentralisation and marketization of public services within and around the alcohol and/or drug treatment sector (for example) demonstrates a firm commitment to market, financial and economic values rather than welfare / humanistic values. Putting financial profit before people; forcing services to attribute 'value' to what they are asked to measure – through initiatives such as PbR – rather than measure what they and their service users consider to be valuable.

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