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The end of social work: neoliberalizing social policy implementation

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Over the last few decades, the human services have been transformed, not just in the United States, but also in other countries where pressure grows to emulate the United States in a globalizing world. Neoliberal organizational reforms, like devolution, privatization and performance management, have been joined with paternalist policy tools, like sanctions, or financial penalties for noncompliant clients, to create a flexible but disciplinary approach to managing the populations being served. Neoliberal paternalism represents a society-wide movement to marketize the operations of social service organizations more generally, so that they inculcate in clients a market compliant orientation aimed at making them less dependent on the shrinking human services and more willing to accept the positions allotted to them on the bottom of the socio-economic order. This analysis compares welfare-to-work in Florida and drug treatment in Delaware. We find numerous parallels, including most especially: (1) deskilling in staffing patterns associated with relying on former clients as case-workers; (2) marketizing of administrative operations stemming from the institution of neoliberal organizational reforms; and (3) disciplining of clients via paternalist policy tools. By examining two very different states and two very different areas of service provision, we suggest the broad impact of neoliberal paternalism in transforming the human services today.

Keywords: neoliberalism; paternalism; social work; human services; welfare-to-work; drug treatment

Over the last few decades, the human services have been transformed, not just in the United States, but also in other countries where pressure grows to emulate the United States in a globalizing world (Ferguson and Lavallette 2006). Commentary abounds among diverse researchers (Fabricant and Burghardt 1992, Stoesz 2000, Young et al. 2006, McDonald and Marston 2006, Aronson and Smith 2010, Wallace and Pease 2011). In fact, this transformation is not limited to a select set of specialties or modalities of treatment, but covers multiple areas of social service practice. Nonetheless, there are distinctive parallels across different areas of human service provision. Neoliberal organizational reforms, like devolution, privatization and performance management, have been joined with paternalist policy tools, like sanctions, or financial penalties for noncompliant clients, to create a flexible but disciplinary approach to managing the populations being served (Soss et al. 2011). What we can call neoliberal paternalism represents a societal wide movement to marketize the operations of social service organizations more generally so that they inculcate in clients rationally responsible behavior that leads them to be market compliant actors.

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who will be less dependent on the shrinking human services and more willing to accept
the positions allotted to them on the bottom of the socio-economic order (Brown 2003).
Organizations are being disciplined so that they can be held accountable for disciplining
their clients in this more market-focused environment. Neoliberal paternalism is transform-
ing the human services into a disciplinary regime for managing poverty populations.
This transformed environment is bound to be debilitating for new entrants into the human
services workforce. The ideal of altruistic service to those in need is that much more dif-
cult to sustain under these conditions. Today, students in the allied helping professions
often energetically enter their fields following the ideals and values set by the powerful
change agents that came before them, only to become disillusioned by the transformed
organizational environment and new ways of working with clients. In response, students
are increasingly questioning the disjuncture between their altruistic intentions and the goals
of the neoliberal-paternalist organizations where they currently intern or work. Given these
experiences, students often worry that diminishing opportunities for professional uses of
discretion to help clients, either as frontline workers or program administrators (Lipsky

In the analysis that follows, we contrast prior research on the negative consequences
of neoliberal paternalism for welfare-to-work programs with initial considerations from
reports about how similar changes are occurring in an entirely different field of practice –
drug treatment. These distinctively different areas of human service provision demonstrate
the wide reach of neoliberal paternalism across fields. The analysis that follows starts with
an examination of welfare-to-work in Florida as provided from prior research and then
turns to a discussion based on secondary sources of how drug treatment is being similarly
transformed in the state of Delaware. We find striking parallels involving: (1) deskilling
in staffing patterns associated with relying on former clients as caseworkers; (2) marketiz-
ing of administrative operations stemming from the institution of neoliberal organizational
reforms; and (3) disciplining of clients via paternalist policy tools. These examples provide
evidence of the transformation of the work environment where those involved in human
services, primarily as professionals in management positions, requires them to not only
discipline their clients but also staff in ways that call into question their ability to act con-
sistent with the most altruistic ideals of the helping professions. By examining two very
different states and two very different areas of service provision, we suggest the broad
impact of neoliberal paternalism in transforming the human services today.

Disciplining the poor: welfare-to-work

Our case study of welfare-to-work comes from Florida – frequently mentioned in hear-
ings in Congress as an innovator regarding welfare policy implementation (Soss et al.
2011). Florida’s Welfare Transition (WT) program is designed to move welfare recipi-
ents into paid employment and is integrated into the workforce system administered by
24 Regional Workforce Boards (RWBs) under the Workforce Investment Act of 1997. The
prior research we report on drew from field interviews with frontline case managers in four
purposively selected regions of the state. As our Florida case suggests, US welfare policy
today reflects the emergence of a neoliberal-paternalist regime of poverty governance (Soss
et al. 2011).

Since 1996, Florida and all other states have been implementing welfare reform. From
the demise of the welfare rights movement in the early 1970s, until the passage of welfare
reform legislation in the mid-1990s, the welfare rolls remained at relatively high levels,
and recipient families came to have essentially entitlement rights to assistance under the
Aid to Families with Dependent Children (AFDC) program, albeit that aid was modest and often attached to moral censure. While opposition to growing welfare rolls built over this period, gridlock over how to address the welfare issue did not break until passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). This law formalized reforms that had been developing in the states, codifying them in the Temporary Assistance for Needy Families (TANF) program. TANF ushered in time limits for the receipt of cash aid, accompanied by work and behavioral requirements, as well as sanctions that impose financial penalties for failure to comply with these requirements.

Welfare policies have long been entwined with multiple purposes including strategies to instill mainstream values regarding work and family (Katz 1997). Further, as Frances Fox Piven and Richard Cloward (1971) contend, welfare policy has historically served to ‘regulate the poor’, effectively undermining their potential as a political or economic threat. The stigmatization of welfare recipients as undeserving people who need to be treated suspiciously has not only deterred many welfare recipients from applying for public assistance, but also communicated to the ‘working poor’ more generally that they should do whatever they can to avoid falling into the censorious category of the ‘welfare poor’. Welfare reform in the 1990s, however, put in place a more intensified approach to getting the poor to behave in market compliant ways.

During the debates leading up to the passage of reform legislation, President Bill Clinton rather infamously touted his determination to ‘end welfare as we know it’. His success in this aim can be judged by at least three indicators. First, and most obviously, the number of welfare recipients has plummeted under reform: a 72% decline in the number of welfare recipients from 1996 to 2008. Second, by 2001, over half of the federal TANF block grant funding to the states paid for non-cash services, rather than for direct cash assistance to families in need (Allard 2009).

Yet, the most profound changes associated with welfare reform occur at the deeper level of its underlying logic (Brown 2003). Welfare reform is more than reducing the number of recipients and shifting expenditures from cash assistance to work support services. That is because both of these trends are reflective of a much more fundamental neoliberal-paternalist restructuring of public assistance to create a system to hold service providers accountable for getting recipients off welfare and into jobs (Soss et al. 2011).

The shift to this new system for managing the welfare poor was facilitated by a concerted campaign by conservative political leaders to replace poverty with welfare dependency as the primary problem to be attacked (Schram 2000, Schram and Soss 2001). Welfare reform became not only about a ‘new paternalism’ associated with teaching the poor what to do, but about labeling the poor as sick and in need of treatment (Mead 1997). In the run up to welfare reform, welfare dependency came to be seen as similar to a chemical or drug dependency; clients needed to be treated for their addiction and weaned from its source. At the height of the reform campaign, then-Speaker of the US House of Representatives, Newt Gingrich, based his support of welfare reform on the argument that a ‘sick society’ encouraged further sickness with its failed anti-poverty policies (Carroll 1995).

With this heightened rhetoric about welfare dependency, the importation of behavioral-health models of treatment and associated organizational and staffing patterns came to be seen as not only plausible but desirable. As a result, welfare reform has re-made the delivery of welfare-to-work services along lines that parallel of addiction recovery (see the drug treatment example below) programs. Welfare agencies have instituted services that are the social welfare policy equivalent of a 12-step program: individuals learn in the new ‘work-first’ regime to be ‘active’ participants in the labor force rather than ‘passive’ recipients of welfare (Schram 2006).
Such a view of welfare dependency has led to the importation of a ‘recovery model’ into welfare reform, one aspect of which is the staffing of welfare-to-work contract agencies with ‘recovered’ former welfare recipients. Several studies of welfare reform have in recent years noted that the agencies studied had about one-third of the case managers as former recipients (Ridzi 2009, Watkins-Hayes 2009). This proportion indicates numbers that go beyond the mere tokenism (Turco 2010). One of the virtues of the recovery model is that it is consistent with longstanding calls for a representative bureaucracy (RB) (Meier 1975) that can practice cultural competence (CC) concerning the unique needs of its clients (Brintnall 2008): a culturally competent bureaucracy is one ‘having the knowledge, skills, and values to work effectively with diverse populations and to adapt institutional policies and professional practices to meet the unique needs of client populations’ (Satterwhite and Teng 2007, p. 2). A representative bureaucracy that draws from the community it is serving is seen as furthering the ability of an agency to practice cultural competency in ways that are sensitive to community members’ distinctive concerns and problems (Carrizales 2010). In other words, RB=CC. The recovery model holds out hope that a more representative bureaucracy will be more sensitive to the ways in which its welfare clients are approaching the unique challenges that have brought them to the agency’s doorstep.

Yet, there are ironies in this way of moving toward realizing the RB=CC formula. Former recipients, as indigenous workers from the community, under the medicalized version of welfare are seen as former addicts in recovery. If welfare is seen as a dangerously addictive substance, then the implementation of a disciplinary treatment regime is a logical next step. The decentralized service delivery systems and private providers that so characterize welfare reform are fertile ground for the importation of medical models of dependency treatment. The use of performance management systems is also entirely consistent with the need to track measureable outcomes resulting from the provision of services or the application of treatment to clients. Under this scheme, case management is a routinized and deskilled position focused largely on monitoring client adherence to program rules and disciplining them when they are out of compliance. There is, in fact, evidence that with the shift to a more decentralized, privatized system of provision, local contract agencies have gone ahead and moved to a more deskilled welfare-to-work case management by replacing civil servants, social workers and other professionals, with former welfare recipients (Ridzi 2009, Watkins-Hayes 2009). In the process, a form of community self-surveillance is put in place that Cathy Cohen (1999) calls ‘advanced marginalization’, where some members of a subordinate group get to achieve a modicum of upward social-economic mobility by taking on responsibilities for monitoring and disciplining other members of that subordinate community.

While this staffing pattern may at times be relied upon for less controversial reasons as a simple cost-saving measure consonant with the business model, it is also entirely consistent with a recovery model philosophy that puts forth former recipients as behavioral role models. These former recipients are frequently referred to in the literature as ‘success stories’ (Schram and Soss 2001, Cherry 2007). Yet, recovery model suggests they are hired for another reason. The recovery model is grounded in the philosophy that underpins the 12-step program of Alcoholics Anonymous (AA) and it predecessors, which over time has spread to other areas of drug treatment and mental health services, along with the core conviction that clients must be willing to support one another in overcoming their addictions (AA 1953).

Government programs now run more like businesses and the application of the business model to welfare involves getting case managers and their clients to internalize the business ethic as well. Policy changes emphasize case managers using cost-saving techniques to
get clients to move from welfare to paid employment as quickly as possible regardless of whether they and their children undergo improvements in their wellbeing.

Florida’s WT program is designed to integrate welfare recipients into the workforce. To that end, Florida has actually closed welfare offices across the state requiring applicants to sign-up online, using public libraries for internet access if necessary. Once approved by the Department of Children and Families (DCF), applicants must report to a local one-stop center that is run by a contract agency on behalf of a regional workforce board as part of Florida’s implementation of the Workforce Investment Act. The state has 24 workforce regions where a combination of public officials, private employers, and citizen and worker representatives sit on the local RWB to decide local policies for implementing federal and state programs including the WT welfare-to-work requirements. The boards most often contract for-profit providers to run one-stop centers where case managers monitor the progress of clients moving from welfare to work. Essentially Florida has abolished welfare and integrated it into the workforce system.

In the Florida WT program, local devolution and privatization emerged alongside one of the nation’s leading systems of performance management. Each year, a state board negotiates with each RWB to establish region-specific performance goals. Goal-adjusted performance measures are then used to determine state-level evaluations of the regions and service providers. Provider ‘pay points’ are tied directly to statewide performance goals, which local contracts often specify in distinctive ways. There is wide variation among states, which have autonomy over how they arrange service provision. The Florida case is important analytically, because of the extraordinary extent to which it has elaborated contracting and performance arrangements, not because it is ‘typical’ of all states. The Florida case reveals aspects of this new performance regime that may be more difficult to discern elsewhere. As case managers’ interviews consistently invoked a dichotomy that distinguished a repudiated old approach as ‘social work’ to be replaced by a much more preferred ‘business model’.

Performance in the WT program is tracked on a monthly basis and focused squarely on goals related to work promotion. Results are reported at regular intervals in a competitive format via ‘the red and green report’ – so called because it uses colors to indicate the rankings of the 24 regions: red for the bottom six, green for the top six, and white for the 12 in between. Rankings on the red and green report have significant material consequences. Green scores can qualify a region for substantial funding supplements, while red scores can result in the termination of a local service provider’s contract. Between these extremes, providers typically lose pay points and draw unwanted scrutiny when their performance falls below expectations.

Proponents of neoliberal organization reform predict that local organizations will respond to this system by innovating in ways that advance statewide goals and improve client services. Devolution will provide the freedoms they need to experiment with promising new approaches. Performance feedback will provide the evidence they need to learn from their own experiments and the best practices of others. Performance-based competition will create incentives for local organizations to make use of this information and adopt program improvements that work.

Previous studies suggest several reasons why organizations may deviate from this script in ‘rationally perverse’ ways. Performance indicators provide ambiguous cues that, in practice, get ‘selected, interpreted, and used by actors in different ways consistent with their institutional interests’ (Moynihan 2008, p. 9). Positive innovations may fail to emerge because managers do not have the authority to make change, access learning forums, or devise effective strategies for reforming the organizational status quo (Moynihan 2008).
Performance ‘tunnel vision’ can divert attention from important-but-unmeasured operations and lead managers to innovate in ways that subvert program goals (Radin 2006). To boost their numbers, providers may engage in ‘creaming’ practices, focusing their services on less-disadvantaged clients who can be moved above performance thresholds with less investment (Bell and Orr 2002).

The Florida field research confirms the primacy of neoliberal preoccupation with performance outcome measurement as an organizing principle for WT implementation. Regional personnel working for private contract agencies must of necessity expect to be held accountable for their outcomes. They scrutinize performance reports and keep a close eye on other regions. Most express a strong desire to improve performance through evidence-based reforms. Indeed, local officials routinely describe performance numbers as the heart of the business model that organizes service provision in the WT program. In a contract-centered system such as Florida’s, where performance is exchanged for payments, performance management becomes inseparable from, and is ultimately a form of, revenue management for the for-profit and non-profit entities that invest in service provision. As one program manager put it: ‘If we make it [the performance standard] we get paid. Then if we don’t, we get zero’. The Florida study showed these pressures were present for non-profits and for-profits but for-profits were more likely to engage in increased sanctioning when behind in meeting performance goals (Soss et al. 2011).

With state officials stressing the need for every region to ‘make its bogey’ (i.e. meet its benchmarks), regional personnel rely heavily on performance measures as guides for action. Interviews with case managers indicated that performance anxiety is a pervasive feature of organizational culture in the WT program. Its effects on implementation, however, deviate considerably from the optimistic predictions of the New Public Management (NPM). Consider, first, the double-edged nature of performance competition and its relation to trust. In theory, competition should encourage regional managers to learn from one another’s experiments. Yet it also encourages them to view other regions as competitors who have a stake in outperforming them. Our site visits quickly taught us that the latter dynamic tends to undermine the former. Policy learning and diffusion require a modicum of trust, and this trust can be undermined by highly competitive performance systems. Echoing others we spoke with, one local manager explained that regions try to maintain an edge by guarding their best ideas as ‘trade secrets’ and, in the same interview, asked us not to tell other regions about new techniques being tried at her one-stop. Another explained how high-stakes evaluations undermine learning by fostering suspicions of cheating: ‘They can’t tell you their “best practices” because their practice is cheating [to win the] competitive game’. In these and other ways, competition works at cross-purposes with policy learning. It encourages local actors to distrust the numbers that other regions produce, the best practices they recommend, and the wisdom of sharing their own positive innovations.

Policy learning also founders on a second dynamic that flows from the discursive tensions between devolution and performance management. Statewide performance reports and efforts to publicize best practices function as parts of a discourse of generalization, suggesting that ‘what works there can work here too’. By contrast, the discourse that justifies local devolution and problem-solving trumpets the idea that communities have radically different needs, populations, and capacities. Not surprisingly, these two mindsets clash in the consciousness of the local manager. When presented with success stories from elsewhere, local officials cited a litany of traits that distinguish the region of origin from their own. Managers in rural regions often cited resource differences in this regard. The broader tension, however, is between a discourse that denigrates ‘one size fits all’ ideas by celebrating local uniqueness and a discourse that treats localities as comparable and seeks to
generalize innovations across them. Local officials interviewed generally rejected the practice of inter-regional performance competition, saying it did not make sense to compare different regions that operate under different circumstances.

In addition to these problems, three other dynamics flow from the fact that local managers hold discretion over how to respond to performance incentives. Proponents predict that performance pressures will encourage local actors to select more effective and efficient program strategies. At the street level, however, managers often select one strategy over another for a more practical reason: from an organizational perspective, it is simply an easier path to pursue. The best-known form of this response, documented by many studies, is for organizations to count the same old things in brand new ways (Radin 2006). Efforts to improve poverty and employment outcomes are usually seen as arduous campaigns with uncertain consequences for performance numbers. In the short run, strategies of ‘creaming’ suffice; it is far easier to change how one counts existing conditions. Thus, local officials report that ‘people game the numbers all the time’ by classifying in creative ways. To illustrate, one regional official interviewed related that a client took her pastor to church on Sunday and the case manager arranged to have the pastor say it was community service so that they could count what the client was already doing.

In this environment, case managers are under constant pressure to get their clients to stay in compliance with welfare-to-work rules and failing to penalize them with sanctions that reduce their benefits. This preoccupation with monitoring clients for compliance represents a change in the role of the case manager as part of the administration transformation of welfare policy implementation.

The rise of neoliberal paternalism in fact associated with a shift in the nature of casework, marked by the passage of federal welfare reform in 1996 (Lurie 2006). The prime directives for TANF case managers today are to convey and enforce work expectations and to advance and enable transitions to employment. Efforts to promote family and child wellbeing are downplayed in this frame, but they are not entirely abandoned. Under neoliberal paternalism, they are assimilated into efforts to promote work based on the idea that ‘work first’ will put clients on the most reliable path toward achieving a self-sufficient, stable, and healthy family.

Thus, case managers today initiate their relationships with new clients by screening them for work readiness and delivering an ‘orientation’ to describe work expectations and penalties for noncompliance. In parallel with individualized drug treatment plans, welfare-to-work case managers then develop ‘individual responsibility plans’ (IRP) – or ‘contracts of mutual responsibility’ – to specify the steps that each client will take in order to move from welfare to work. These rites of passage establish a relationship in which the case manager’s primary tasks are to facilitate, monitor, and enforce the completion of required work activities. In celebratory portrayals of the new system, case managers are described as being deeply involved in their clients’ development, as ‘authority figures as well as helpmates’ (Mead 2004, p. 158).

In Florida, this ethos is expressed by the neoliberal relabeling of caseworkers as ‘career counselors’. The label evokes images of a well-trained professional who draws on diverse resources to advise and assist entrepreneurial jobseekers. In practice, however, few aspects of welfare case management today fit this template. None of the over 60 case managers we interviewed in four workforce regions we studied had a social work degree of any kind. Many did, however, have management degrees from Strayer, DeVry, Capella, or other vocationally-oriented schools that line the strip malls in cities around Florida (and across the country). About one-third of the case managers were also former recipients who qualified for their jobs by virtue of their experience with the system. Under the business
model of service provision, the relationship between client and case manager is rooted in an employment metaphor: the client has signed a ‘contract’ to do a job and should approach the program as if it were a job.

The case manager’s job is now to basically enforce that contract, often using the threat of sanctions to gain compliance. Case managers spend most of their time enforcing compliance to IRPs and very little time counseling clients (Soss et al. 2011). The change is palpable. One former recipient case manager in Florida stressed in a most poignantly metaphorically way that welfare in Florida is no longer a social service. She suggested it was now herding cattle instead of tending to sheep, where a shepherd takes care of the sheep, a cattle herder just runs the herd through a pen in an insensitive fashion.

Under these circumstances, case management gets deskilled and routinized. And staffing reflects these changes. In Florida, as in other states, case managers who are former recipients are working at low pay and feeling vulnerable about their improved status. Other workers are almost as marginal in their status. In the end, WT case management is reactive and clerical. It focuses primarily on documenting client activity hours and entering the results into the One Stop Service Tracking (OSST) data system. Indeed, managers at several levels argued that the data-entry fields of OSST function, in daily organizational routines, as the real policy on the ground. Interviews with the case managers indicated that the people on the frontlines see the computer screens as the policy. Given their marginal status, either as former recipients or otherwise, case managers are less likely to risk challenging the neoliberal-paternalist system on behalf of their clients. They are likely to follow the computer as if it is a program manager.

The automated nature of case workers’ obligations to monitor and discipline clients comes through in the interviews. When asked to describe their workday, case managers consistently report that they begin by logging on to the information system so they can address the slew of new alerts that arrives each morning. The alerts focus on two kinds of actions: documenting work participation hours for clients and pursuing disciplinary actions when such documentation is lacking. From this point forward, the daily round consists mostly of efforts to do one or the other, punctuated by face-to-face meetings with clients that often focus on the same two issues. Case managers spend most of the day either seeking documentation for work-related activities (a key performance indicator) or taking next steps in the sanction process such as sending out a ‘pre-penalty’ warning letter, requesting a sanction, or working to bring a sanctioned client back into compliance. In short, performance and sanctioning are two sides of a single coin in the work life of the case manager and, together, they stand at the center of the job.

The resulting stress felt by case managers can be traced partly to their belief that performance numbers matter for job security and trajectory. WT case managers make modest wages in a job with few guarantees. They often struggle to make ends meet and, as a result, tend to view performance through the prism of their own anxieties as breadwinners. In a system of for-profit contracting, most are keenly aware that performance numbers drive profits, and declining profits could lead their current employer to downsize the staff or even to sell the operation to another company whose retention of old employees is uncertain. At a less absolute level, most expect that if they produce weak numbers, they will be subjected to greater supervision in a way that will make their work more stressful and harder to do.

Buffeted by performance pressures and lacking the tools to respond to client needs, case managers experienced their workdays as a series of frustrations and disappointments. The results of all this performance anxiety is not better outcomes for clients. The Florida study found that most clients remained poor after leaving welfare and sanctioned clients
fared the worst of all. To turn a phrase, the preoccupation with discipline just made the worse off worser (Soss et al. 2011).

Further, Florida might be a leader in implementing the neoliberal-paternalist regime, but that also means it leads in corruption associated with such a parceling out of the state’s welfare operations. Scandal has wracked the system from its inception and continues today. In July 2011 it was reported that: ‘[Florida] Governor Rick Scott today confirmed that the U.S. Department of Labor has launched an investigation into Florida’s 24 regional workforce boards to determine if they have been improperly awarding contracts to companies controlled by board members or their relatives’ (Klas 2011). Scott himself previously was able to propose and sign into law legislation requiring all welfare recipients to undergo drug testing (even though he came under attack for possible conflicts of interest since he had been the primary investor in the largest drug testing company in the state which was now under his wife’s control). The corruptions of privatization aside, the neoliberal-paternalist welfare-to-work regime in Florida represents an elaborate shift to get the poor to accept more responsibility for their poverty without providing the necessary support for them to do anything about it. It is a new regime that imposes strict performance outcomes monitoring, deskills the case management associated with the program, routinizes client treatment, puts the focus almost exclusively on imposing discipline on clients in the name of program compliance, and does so in ways that do not lead to improved well-being for those clients in ways that track closely by race. It represents a stark example of neoliberal failure. It is the end of social service work on this end of the human service work continuum.

**Neoliberal-paternalist drug treatment**

Drug treatment delivery is also characterized both by neoliberal organizational reforms and paternalist policy tools. As the following case study of changes in drug treatment services in Delaware indicates, the parallels in drug treatment stem from sharing the practical concerns of welfare reform, i.e. getting clients to be ready, willing and able to work.

While drug treatment is often privatized, practice is heavily constrained by public policy and regulatory guidelines. Following a neoliberal marketized approach, the federal government has provided guidance to states to ensure efficiency with recommendations for the utilization of measurable evidence-based practices (EBPs), it is the responsibility of each state to ensure that these recommendations are implemented and measured. In 1999, NIDA (National Institute on Drug Abuse) published a guide ‘Principles of Drug Addiction Treatment’ describing 12 ‘efficacious scientifically based treatment approaches’. In 2006, the Institute of Medicine’s (IOM) Report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions* identified a critical need for quality and measurement improvement of healthcare provisions within both mental health and drug treatment (IOM 2006). Recommendations from the report, acknowledged the importance of permitting states to redesign their grant-based financing systems but that they do so incrementally. This would include adding specific goal oriented performance measures (IOM 2006). As a result, performance measurement contracts have become commonplace with a specific neoliberal focus on the use of incentives or rewards.

Drug treatment’s relationship to the health insurance system has undoubtedly provided a conduit for innovations in medicine to seep into its practices. The broader medical field has in fact adopted similar practices, such as Medicaid programs incentivizing primary care providers who assist their patients in illness management by awarding end of year bonuses
when costs (even projected) of expensive chronic illnesses can be reduced. This system of reinforcement has been referred to as ‘provider contingencies’ (McLellan et al. 2008).

The use of incentives and rewards is not new to the field. According to Higgins and Petry (1991), ‘contingency management’, a treatment model where patients receive rewards based on their behavior, such as adherence to program rules and achieving treatment goals that are reinforced with incentives and sometimes even punished for non-compliance, has become one of the most effective treatment strategies applied in drug treatment. What is new is its application to treatment providers, where funding sources are now using this system of behavior modification on the agencies they contract with. The neoliberalization process extends contingency management to incentivizing providers to act more like private for-profit agencies in competition with each other. These requirements, mandated by the funding sources, extinguish all opportunity for creative and responsive management. Trained social service professionals are restrained, compelled to deliver services as prescribed, and involuntarily consumed by the neoliberal forces beyond their control.

Many states have indicated the use of performance incentives to improve service provider behavior in general; however, only a few states report using financial incentives (Marton et al. 2005). More broadly referred to as ‘purchasing levers’, incentives are viewed as successful delivery strategies for ‘value-based financing’ of drug treatment that maximizes the states purchasing power to ensure high quality services (Marton et al. 2005). These purchasing-lever strategies can include contract requirements that mandate the utilization of EBPs by linking them to financial performance incentives (Marton et al. 2005). According to a report produced in 2003 by Join Together, a policy panel at the University of Boston School of Public Health, ‘the panel’s primary recommendation is that purchasers of treatment services should reward results – an idea that is very consistent with other leading edge efforts to improve the quality of health care for other diseases’ (Join Together Policy Panel 2003).

In Delaware drug treatment providers are typically licensed, funded, and monitored by a single state agency within the Department of Health and Social Services (DHSS) known as the Division of Substance Abuse and Mental Health (DSAMH). Using both state and federal funds, DSAMH contracts with private agencies to provide direct service while maintaining responsibility for training, technical assistance and outcome oversight to ensure that funds are used efficiently. In this context, Delaware represents a leading-edge state to neoliberalize drug treatment. In response to the federal pressures to attain fiscal accountability and improved clinical management, Delaware’s DSAMH took a cue from Delaware’s Department of Transportation, whose contracts included provisions for financial rewards for work completed ahead of schedule as well as penalties for failing to meet deadlines. ‘That same thinking was applied to the purchase of the addiction treatment services in Delaware’ (McLellan et al. 2008, p. 4).

Historically, drug treatment provider contracts in Delaware had been based on cost-reimbursement or fee-for-service and were calculated based on the costs associated with the specified level of treatment. While DSAMH was committed to the adoption of EBP, there was no way to enforce their implementation or hold providers accountable for improving client outcomes. In 2001, Delaware changed their payment process; an experiment with their outpatient treatment providers by creating performance based contracts where providers became eligible for financial incentives and subject to financial penalties. While there was flexibility built into the contracts, this new performance measurement system was designed to alter the managerial practices of providers by including significant financial incentives for meeting or exceeding target areas and financial penalties for failing to
meet them (McLellan et al. 2008). According to Jack Kemp, a leader in neoliberalizing drug treatment administration in Delaware, ‘this approach was adopted to test whether or not “financial incentives” for better “program performance” might offer the conditions under which the adoption of new evidence-based therapies might be feasible and indeed a good business investment’ (McLellan et al. 2008, Stewart 2009).

In Delaware, a new set of managerial tools had not only been suggested but also required to mandate the implementation of performance measurement and evidence based practices. DSAMH’s effort to improve accountability and effectiveness included ‘behavioral contingencies’ in the performance contracts based on the provider’s ability to attract, retain, and ‘graduate’ outpatient drug treatment patients. The funds would then be tied to the agreed upon indicators (McLellan et al. 2008).

Within this neoliberalized contracting system, Delaware became a trailblazer in the movement towards a performance management accountability system. Programs are now rewarded for achieving three goals. (1) Increased client admission and engagement. If the program meets 90% of their utilization goal, they are rewarded 100% of the contract amount. If less than 90% is achieved, deductions to the contract amount are made accordingly. (2) Active participation: dictated by the specified number of sessions and varies based on the stage of treatment. Incentive payments or bonuses are made for exceeding this goal with a maximum of 5% over target. (3) Program completion which includes graduation, abstinence and achievement of treatment goals. An additional financial incentive is paid for each ‘graduation’ with a maximum limit in each contract (McLellan et al. 2008).

The neoliberalization process was furthered when the State of Delaware took part in the Robert Wood Johnson Foundation’s (RWJF) Advancing Recovery: State/Provider Partnerships for Quality Addiction Care national initiative from 2006 to 2009 (http://www.advancingrecovery.net/Home/Home.aspx). This initiative represents cooperation among the Network for the Improvement of Addiction Treatment (NIATx), the Treatment Research Institute (TRI) and RWJF. The goal was to restructure existing administrative and clinical systems for drug treatment to produce more successful outcomes by providing funding opportunities for local programs to receive technical assistance to improve their systems, remove barriers to treatment entry and increase retention. The project promoted the use of EBPs through innovative partnerships between drug treatment providers and the state to foster the sharing of business model strategies. Delaware was one of six state–provider partnerships that participated in a learning network that provided tools to improve the delivery of addiction treatment.

These new conditions led to innovations being treated more like trade secrets of the for-profit ‘business model’ than just use of community resources. The external changes led to obvious internal modifications to traditional service delivery. With increased pressure from funding agencies for greater accountability, there is a rising demand for program use of EBPs. As a result, working with clients has changed to emphasize achieving the specific outcomes related to performance measures. While drug treatment clients have always been held personally accountable for their choices, even once ‘addiction’ was determined a ‘chronic disease’, there is now pressure on the agencies and their staff to enforce such ‘contracts’ on clients.

With competition for funding ever rising, drug treatment providers must establish their capacity and understanding of the proposed model in their applications for funding. This includes the mention of the latest buzzwords related to the empirical research and assurance that their agency personnel have been appropriately trained in the next greatest life-changing model being popularized. This can lead to funding awards and contracts that
pigeon hole the agency and the staff into using the one specified EBP they proposed to execute.

This is extremely problematic for several reasons. With the threat of suffering financial penalties for under-performance, employees must be trained in the new model. First, forced training attendance leads to lost time that would otherwise be used to manage high client caseloads. Second, brief ‘basics-only’ trainings often omit details necessary to effectively apply the models to practice. Third, training is expensive and often offered only one time over one or two days. Finally, money is rarely invested in follow up training, such as supervision to ensure the EBP is properly implemented. When an agency is contracted to use a specific EBP, this inevitably puts pressure and anxiety on personnel who are then forced to implement it regardless of their preparation to do so.

Just as our case study of welfare-to-work in Florida highlights how neoliberal paternalism has encouraged the medicalization of welfare dependency, our analysis of secondary sources in Delaware shows the welfarization of drug treatment. Drug treatment providers in Delaware are increasingly required in a routinized fashion to apply the associated prescriptions and proscriptions of an EBP for all clients served within a given program. Counselors are handcuffed to the stipulated intervention models, their time is measured and their sessions are nearly scripted. This practice robs the clinical staff from using their professional discretion and forces them to work within the limits of their power and control, which has already been established by the funder. When an agency selects new EBPs, there are changes in service delivery patterns, program designs and paperwork that inevitably create a great deal of confusion and anxiety among the staff. They are taught to be ‘client centered’ while simultaneously expected to deliver one intervention (as if it is one size fits all).

The combination of increased caseloads with pressure to use specific interventions while documenting measurable outcomes is unfortunately likely to have a negative impact on client care. The preference is for time-limited interventions that are often rushed as clinicians struggle to manage their client caseloads alternating between quality face time and an opportunity to draft accurate and thorough documentation. Pressure to provide evidence of success conflicts with the need to follow the specified evidence-based model with a prescribed timeline. This conflict intensifies since payment is tied to using these scripted forms of treatment while still trying to deliver the intervention at a pace that corresponds with the client. The lack of flexibility this system engenders becomes even more problematic when a clinician becomes wedded to one model, that model is always applied and when it fails, the clinician blames the client labeling the client ‘noncompliant’ or ‘resistant to treatment’ (see Gowan and Whetstone 2012). This result is analogous to the welfare worker pathologizing the client’s social circumstances.

When a clinician realizes that the ‘one size (meant) to fit all’ EBP may not work for a particular client they become concerned that they will be penalized for not utilizing the EBP leading to anxiety or even falsifying of records, forcing an outcome or at least documenting one when it is not really there. Further, when the counselors want to explore more of their client’s environmental obstacles, there is no time in the session that is designed to be clinically focused, thus diminishing the human service worker’s ability and power to impact the client’s environment or social policies that stand in their way.

The parallels with welfare-to-work extend to staffing and workload issues. Today, drug treatment providers are faced with a myriad of personnel issues in general such as an insufficient workforce to meet the increasing demands for drug treatment, an increased utilization of medically assisted therapies, challenges related to stigma associated with addiction, and the shift to mostly public funding. When agencies are under pressure to
perform with limited resources, they respond like all businesses do, they need to get the most bang for their buck. While the delivery of evidence-based life-saving interventions would seem like something worth investing dollars, time and resources to support the most qualified clinicians, an agency under economic pressure must make tough decisions.

In addition to the enormous burden on the staff to operate within the new financial constraints associated with a system of rewards and penalties without sufficient resources to manage the ever increasing demand as mentioned, there is equal pressure on the provider to hire and train qualified staff while still saving money. When it makes the best sense to hire the most highly trained and experienced, but it costs less to get a lesser credentialed or newly minted clinician, the decision is made. As long as they have the minimum credentials necessary for billing, they are hired. This practice of skimping on workforce quality can have devastating effects on client care, staff morale, and agency practices.

The complexities of staffing with neoliberal-paternalist drug treatment are demonstrated in the case of the movement to what is increasingly called ‘behavioral health’. There has been greater awareness and understanding, albeit many questions still exist, around the idea that chemically dependent clients are often simultaneously suffering from an additional mental illness such as anxiety and depression. There is a great deal of emphasis on treating clients with what is referred to as ‘co-occurring disorders’ or ‘dual diagnosis’. The field is increasingly concerned with its reputation and perceived competence to treat more complex populations. Rather than fighting stigma, the field has taken an alternative position by strategically re-branding itself as ‘behavioral health’ to position their eligibility for funding and reimbursement by Medicaid and private insurers. Administrators are working hard to repackage themselves as ‘behavioral health providers’ with marketing efforts similar to those used in big business to shed their old reputations that limited their options as the field makes way and prepares itself for health care reform. Morphing the name and services is suggested necessary to stay in ‘business’. With health care reform, parity for mental health and substance abuse treatment, and increased emphasis on qualifying as experts in ‘behavioral health’ drug treatment, agencies are laboring to make it appear as if they are treating clients more holistically, offering more services in one place, and hiring more qualified staff (Hall et al. 2000).

Staffing challenges reflect the history of drug treatment. It began as a self-help campaign, born out of the 12-step movement and tenet that there is great value in ‘one alcoholic helping another’ (AA 1953). Former users began working in the field as drug counselors with little training, only life experience. Academia still lags behind; majors such as psychology, counseling, human services, and social work often include one class or even worse only one week that covers addiction specific material. While researchers continue to try and explain addiction and find a cure (treatment) by looking at medications to curb cravings or reverse one’s desire, the personnel in the field today are often under qualified to meet the outcomes-oriented expectations of the neoliberal regime. They are often without the tools and resources to meet the real needs of their clients while trying to game the system to get the level of care/treatment dosages that are reimbursable.

The behavioral health approach intensifies these tensions especially given the complexity of problems confronting clients. As these once-were drug treatment centers grow and change as they follow the money trail, all in the name of providing more ‘holistic’ services, they are adding more in-house programs to create ‘one-stop shopping’. These programs can include vocational rehabilitation, primary care, family planning, and dentistry. On its face removing obstacles to improve health outcomes is the obvious answer, but this can be dangerous to the clients as well. By offering all services under one roof, there is a risk of sending unwarranted further stigmatizing messages, such as ‘this treatment center is the
only place where they belong’. This type of practice and messaging only affirms notions of deviance and the other.

All the while, contract agency personnel are stretched ever further beyond the breaking point. Meeting the bottom line is the driving force for drug treatment today. Service providers are guilty of creating categories that determine whether or not someone deserves treatment that are based on the ‘bottom line’. Administrators determine who is eligible for services based on their ability to be reimbursed for service. In the non-profit sector, clients are rarely denied treatment and waiting lists are discouraged. Drug treatment administrators are likely to ensure easy access and admission for the uninsured because the state pays for them in full.

Among for-profit drug treatment providers this type of cherry picking happens but very differently. They are often most interested in the retention of privately insured clients. For example, when a third party payer is known to authorize a longer stay in treatment, the treatment provider may adjust its practices to best accommodate a client with that insurance. This could include kinder treatment and relaxed enforcement of the rules in an effort to keep the client happy and less likely to leave treatment. There is great financial interest in retaining those clients for the duration of their recommended length of stay. This type of discursive practice also exists in the reverse; clients are discharged immediately when coverage is denied regardless of whether or not their symptoms persist.

Another progressive development being subverted by neoliberal implementation in Delaware is the newly re-ignited emphasis on prevention. Prevention programming relies heavily on ‘street outreach’ that has been historically implemented using a peer led approach. In fact, the most widely utilized EBP designed for street outreach is known as the NIDA Model: The Indigenous Leader Outreach Model (NIDA 2000). In practice, drug treatment programs hire former drug users from the targeted community to engage active drug users and offer information and referrals to treatment. This ‘recovery model’ of staffing which relies on former clients, as behavioral role models, has become increasingly popular and has been imported into welfare-to-work and other areas of social service provision. And while it has the potential to improve agency staff and client collaboration, it also offers the prospect to promote a more effective neoliberal-paternalist regime via self-policing by target populations (as was also found in the welfare case).

Yet, the major problem of utilizing the indigenous leader outreach model is not so much with the theory; instead, it is with its application in a neoliberalized structure. As drug treatment is changing to meet the demands of the market, it is becoming even more important for agencies to implement the most cost-efficient versions of the NIDA model. With more pressure to justify expenses comes a new labeling, credentialing, and even legitimating the ‘outreach worker’ and forcing new qualifications that are relatively still easier to obtain than any academic degree. In Delaware, eligibility for prevention dollars has been limited to providers who employ individuals who are credentialed Certified Prevention Specialists. This forced certification for personnel with limited training requires staff to apply for a fee, obtain a range of continuing education credits, and incur recertification costs to maintain the credential. This has resulted in a disgruntled group of outreach workers and needless to say this has negatively affected their performance without any evidence of improvement.

The certification requirements are further evidence that deskill not only reduces costs of operations, it does so in ways that require legitimating rationalizations like new superficial credentials for under-trained staff. These requirements only serve to undermine the whole idea of employing indigenous workers. The community-based workforce becomes more reluctant partners in an effort to rationalize a more cost-efficient approach to providing services.
A final example is the new behavioral contracts adopted in relation to individualized treatment plans (ITPs) for clients. An ITP is an agreement between a caseworker and a client that reflects a strong parallel with the similar practice to enforce personal responsibility in welfare-to-work programs through what are called individual responsibility plans. In Delaware, drug treatment behavioral contracts are included in ITPs to specify an agreed upon set of practices or behaviors with clearly defined elements such as length of treatment, how behavior change will be measured, and reinforcements and penalties for adhering or not adhering to the agreement. There is some research to support the notion that these contracts are effective techniques to reduce problem behavior among clients in drug treatment (Diaz 2010). The contract is commonly used in clinical social work practice to document agreed upon boundaries between the client and the clinician as well as outline specific treatment goals. In drug treatment, clients are often required to sign contracts that stipulate the agency rules and expectations (Kerson et al. 2010).

The use of contracts, however, can undermine prior understandings in the drug treatment community to treat clients as partners working with clinicians to achieve recovery (see Gowan and Whetstone 2012). Contracts are often used to withhold privileges or even put time limits and expectations for change that are in fact not client driven. These contracts are used to not only regulate the clients but produce the outcomes that are expected of the providers. In this context, the clients are ‘empowered to act but in ways that are limiting and confining’ (Schram 2002, p. 19). Furthermore, the contract erroneously projects the idea that there is a shared understanding and agreed upon arrangement. While clients are often provided an opportunity, or ‘appeal’ process, to bring their concerns to the administration if they want to reverse a decision made by the clinical administration regarding a rule or expectation outlined in their contract, this process only intensifies the adversarial tensions introduced with enforcing behavioral contracts (see Gowan and Whetstone 2012). The emphasis on cost-efficiency, however, inevitably makes ITPs neither individualized nor much about treatment. They are more about enforcement. Deskilled workers, using routinized, manualized procedures to treat clients, facing excessively high caseloads, are in no position to individualize treatment effectively. One size fits all programming is more likely, as we have mentioned regarding several other aspects of the neoliberalization of drug treatment in Delaware. Clients end up agreeing to contract requirements they do not understand or cannot remember and counselors end up having time to enforce contracts but do little else. Under neoliberalism, the structural roots of the drug crisis are long forgotten and treatment of individuals to practice personal responsibility becomes paramount. Yet, in practice, the shift toward individualized treatment itself falls prey to the market insinences of neoliberalism and clients do not get the individualized treatment that is promised. With this sort of treatment regime in place, we are inclined to suggest that the neoliberal-paternalist regime comes to drug treatment as much as by default as by explicit intention.

Conclusion
The similarities we have examined between two widely different areas of human service provision in two very different states demonstrate the broad reach of neoliberal paternalism. The parallels between welfare-to-work in Florida and drug treatment in Delaware are suggestive of the ongoing shift toward a disciplinary regime of poverty management in the human services today. Neoliberal organizational reforms and paternalist policy tools appear in both and are associated with changes in who are the frontline workers, how organizational expectations affect their work, and how policy tools shape their treatment of
clients. At the core of these developments are innovations that put the emphasis on routinized practices for screening, diagnosing and treating clients in ways consonant with the overriding objective of the neoliberal paternalist regime to enforce personal responsibility cost-efficiently. Whether this brave new world of human services policy implementation will lead to better outcomes for clients is an urgent question in need of increased attention. While recent research suggests that frontline workers often do not endorse the philosophy that undergirds these changes (Aronson and Smith 2010, Wallace and Pease 2011), we would argue that this is perhaps beside the point. Frontline workers today work in a regime that they transgress at their peril. While there may be opportunities for subversive actions to help clients, participating in this ‘moral underground’ as Lisa Dodson (2011) calls it is a risky venture under neoliberal paternalism. It is our conclusion that the emerging system of human service policy implementation makes the transgressive use of caseworker discretion more challenging today.

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