Democratic therapeutic communities for the future.
How can we face epochal changes without distorting our mission?

Rex Haigh
John Turberville

Abstract

Today therapeutic communities live in a condition of uncertainty and precariousness, due to a tangle of epochal changes, from a cultural, political and economical angle. The financial trouble led to cuts in mental health services, increasing regulation and administrative demands. The fact of facing this phenomenon of increasing stiffening, particularly on a political and institutional ground, pushed the therapeutic communities to implement an additional effort to "adapt" to this situation in a reasonable and sustainable way, without putting at risk the principles and values on which their clinical practice and research was founded.

The authors examine these issues talking briefly about the organisations who are all members of an extended family, then analyse some of the difficulties we all face and examine in depth the peculiarities of Community of Communities project.

Ultimately, the paper intends to outline the processes through which UK TC movement is trying to cope with internal and external pressures. Taken as a whole, it is a process of "sustainable adaptation" to the world in which we're living, that has to be grounded on a full respect of those democratic values and clinical principles the therapeutic community has always been founded on.

Keywords: accreditation, sustainable adaption, peer-review, self-review, therapeutic community, therapeutic community cultural movement, Community of Communities, network

We live today in a world which forces the therapeutic communities to live in a condition of uncertainty and precariousness, due to a tangle of epochal changes, from a cultural, political and economical angle. We all know how financial trouble led to cuts in mental health services, increasing regulation and administrative demands. The fact of facing this phenomenon of increasing stiffening, particularly on a political and institutional ground, pushed the therapeutic communities to implement an additional effort to "adapt" to this situation in a reasonable and sustainable way, without putting at risk the principles and values on which their clinical practice and research was founded.

Behind all this are forces beyond our understanding such as globalisation and neoliberal economics – and, underneath those huge social and political changes, we suspect an increasingly insidious scepticism on the possibility of developing respectful and enriching relationships between human beings. We so hope that mental health will become a social movement again – but that is beyond what we are going to talk.

We'd like to make an introduction to these issues talking briefly about the organisations who are all members of an extended family, then we will analyse some of the difficulties we all face and examine in depth the peculiarities of Community of Communities project.

Our link to the Community of Communities Project is indubitably strong. Rex has been involved in it since it started, before moving over to lead the spin-off project called Enabling Environments, while John Turberville is still the lead person for CoC's Project. Community of Communities is one project out of many that are run by the Royal College Of Psychiatrists, in a department called the College Centre For Quality Improvement, to improve the quality of

all UK mental health services. Most of the people involved in the two projects are from several different professions.
The national organisation for therapeutic communities in the UK is now called The Consortium of Therapeutic Communities (TCTC) – it was called the Association Of Thereapeutic Communities until five years ago, when it merged with the national organisation for children's TCs. We think it is equivalent to Mito & Realtà Association, probably the most important association in the field in Italy. Another international organisation, International Network Of Democratic Therapeutic Communities, INDTC, was set up by John Gale who was chief executive of a London-based TC charity called Community Housing And Therapy. John has now retired and the charity is working out what to do with INDTC.
Growing Better Lives is an Ecotherapy Social Enterprise that also runs the TC training courses and workshops. That part is called Living And Learning, and it has now developed an international programme, called the International Network Of Living-Learning Experiences. Our social enterprise is somehow similar to what is known as a 'cooperativa' in Italy.
We passed in review some of the projects and enterprises started and developed to keep the culture of therapeutic community alive and lay the foundations for its future adaptation.

Now we'd like to describe what we are trying to do to cope with internal and external pressures to the cultural movement of therapeutic community, to which we have referred at the beginning of this paper. We think of a process of "sustainable adaptation" to the world in which we're living, that has to be grounded on a full respect of those democratic values and clinical principles the therapeutic community has always been founded on.

We would outline four different working areas, which are crucial for a constructive future.

1. Need to… Know what we're doing and doing it well : quality improvement, what we have been doing with Community of Communities for the last 13 years.
2. Need to… Show it is worth doing, and that it works: this is producing the research evidence in the right way for people who run and pay for mental health services.
3. Need to… Offer training which can convey the unique experience of having the sort of relationships people have in TCs, which is difficult to describe without experiencing it
4. Need to… Be willing to do TCs differently, and to spread the ideas beyond TCs – and join up with others who have a similar therapeutic philosophy.

So the four themes for today are **Quality, Research, Training and Innovation**.

1. Knowing what we're doing and doing it well - Quality
This is where we started from with Community of Communities in 2002 – the method we wanted to use was going back to the methods at the beginning of ATC in the 1970s, but doing them in a way that was 'TC-friendly' and accepted by the big organisations and institutions which we relate to. Forty years ago, it was to visit each other's TCs and pick up ideas and share what we were doing ourselves, and generally feel less isolated about the way we were working.

For the modern version, fourteen years ago, we also incorporated the idea of standards – so we could be fairly objective, and have the authority of the College behind us. But the standards were democratically developed, using TC principles. This meant that everybody was involved in the discussion, and agreeing and voting on the first version of the standards.

This meant that we as TCs felt we owned the standards, and that they were meaningful to us – and not that they were some persecutory instructions delivered from above, as quality standards and inspection processes can so often be.

So it became a recognised quality improvement process as well as a way for TCs not to feel isolated or not knowing if 'they were doing it right' – and we could be quite comfortable with language like 'sharing best practice' and 'benchmarking' and 'action planning'. We had done the modern thing, called 'quality improvement' - but in a therapeutic community way, that we could live with.

We would maintain that – just by being TCs and believing in the central importance of relationships – we had also produced something that was more meaningful than a treatment manual (in a relational way), and brought a bit of a Trojan horse – spreading a message of gentle subversion and quiet revolution - into the dry and technical world of the Royal College of Psychiatrists. We are introducing something that is more like a humanity and an art than a pure science – and not all psychiatrists believe that is a good thing (though we think it is essential, so we remain human and can have therapeutic relationships).

But we will explain more details about how our process works, in his talk. So onto the next of our four themes, training.

2. The only way is experiential: the "Living-Learning experience"

There is something about the 'atmosphere' or 'culture' of a TC that is very difficult to put into words, in any language. It is about the quality of relationships – the way people are with each other – that is experienced in a preverbal way. Books or lectures of theory can try to explain what it is – but they can never recreate the experience. Personal therapy might give some idea, perhaps more so if it is in a group, but this will still not give a realistic experience of what it is like in a therapeutic community. People who are trained in psychoanalysis or existential psychotherapy will probably have some idea of it – but not the continuous 'edginess' of it, or the 'hurly burly' that it often feels like.

So this experience for staff, of being in a TC themselves, is something that we have been doing for 20 years now. We call it the 'Living-Learning Experience', and it is a three day course run as a therapeutic community - for 15-25 strangers and 3-5 experienced staff. In England, we usually run it in a large house on an organic farm study centre – and for the last 15 years, Italian colleagues have also been holding exactly the same courses. We have had them in Rome, Bologna, Florence, Verona and many in Sicily more recently. We have also helped some colleagues to set them up on an organic farm near Bangalore in India, where they hold one four times each year, and we are doing a first one in Portugal next month. We have about fifteen full staff members on our website, some of whom are bilingual or multilingual and we take it in turns to conduct the courses. Details are on our www.inlle.org website.

So in this way, and maybe only in this way, can workers really come to understand what their patients and clients and service users feel like when they start in a therapeutic community. They have to make decisions about what to do together, to have small groups with strangers who they live with in the same house, and to make meals for each other. Usually it is also quite playful, and people have fun together too. And then on the third day, everybody says goodbye - and might never see each other again. Our experience as staff members is that it is extraordinary how far the people and the group come in such a small period of time.

We always evaluate the courses with questionnaires at the beginning and the end, and then after one month – to be able to understand how people feel that they benefit, and so we can see what needs to be changed. More recently, we have also been doing qualitative research using ethnographic methods. This has already shown us that the courses would meet most of the 'Community of Communities' standards, and the results are now starting to show interesting differences from other types of group relations events. We hope this work will develop and grow into something that can be published in the scientific literature to help understand the theoretical basis of therapeutic communities.
We have mentioned some research we are doing based on our training, but there is a bigger aspect of research that is really much more important for the future of therapeutic communities.

3. Showing it is worth doing, and that it works
We think it is a product of globalisation that medical research has become very standardised across the world – and the only 'language' that everybody understands is *numbers*. Statistics and graphs can be understood without much translation. And those of us who work in complex interpersonal and relational systems do a lot of things that can't be measured in numbers. Also, many 'scientific' or 'biomedical' psychiatrists say that the only evidence that is good enough' in the so-called 'hierarchy of evidence' is 'Type 1 evidence'. That means a meta-analysis of high quality randomised controlled trials (or 'RCTs'). And the British Government's chief psychiatrist – who used to work in the same office as the 'Community of Communities' - once called therapeutic communities an 'evidence-free zone' because of this.

We have always been worried about RCTs in our field, because there are so many ethical problems and methodological difficulties in doing a meaningful experimental study on therapeutic communities – as well as the bluntness and coarseness of the whole 'yes or no' results that they give. But we are also aware that without it, influential people can go on saying things like we are an 'evidence-free zone'. Rex Haigh was on the group that wrote the government's ' NICE guidelines' for Borderline Personality Disorder in 2009, and NICE is a very influential process in the whole of the British health system. But we soon saw that no equivocal evidence, or doubt, or shades of grey are tolerated in what the committee can call satisfactory evidence. In fact, because there wasn't much 'high quality evidence' for Borderline Personality Disorder, we think we wrote quite a useful and sensible guideline without being too prescriptive. That's because it was based on a good consensus between the experts by experience, the clinicians and the researchers on the panel – but it was not very 'high quality' evidence in the 'hierarchy of evidence'.

But the volume of research is growing – particularly for psychotherapy treatments for emotional instability - and TCs will become invisible unless we produce our own acceptable evidence. We used to say that '*no evidence of effectiveness* does not mean *evidence of no effectiveness'*, just that the research has not been done – but nobody who runs or commissions services listens to that any more. So we have come round to thinking that we need to treat it like an annoying game we must play in order to communicate that TCs work, as a scientific fact, to the important people and organisations we depend on for our existence.

Personally, we have no doubt that people benefit from time in TCs in some way or others, and that people who might be harmed by them can be helped to get out and not be harmed. But we're not at all confident that RCTs and standardised questionnaires will pick that up in a way that is meaningful. But we live in a digital world where the only possible answers are

'yes' or 'no' – and we think we're expecting more than experimental methods can achieve. So we need good qualitative research alongside the data from RCTs, so we can start to understand what the numbers do not tell us.

For the last few years, in Oxford, Steve Pearce, previously Chair of the Community of Communities, has been learning the rules of that evidence game - and running the first ever RCT for democratic TCs. The first results are being published in the British Journal of Psychiatry. They are generally positive, and we expect the longer-term follow up results to be even better when they come out in a year or two.

In a very different frame of reference, we also support Nick Manning, the sociologist, who asks difficult questions about what he calls 'the Politics of Data' – and where the real power is, about how funding decisions are made. But, luckily for all of us, Steve Pearce has learned the rules and played the game. However, we need to join the game too. All of us now need to follow it up, and do whatever data collection or research we can. There are at least two reasons for this.

The first is that there will need to be more trials in the next few years to back up the first one. Research is never finished – there is always more to know, as well as needing to test out the first results, and gather enough data to do a meta-analysis of several studies. TCs need to get together to plan this, so that it can make a real impact by doing large and multi-centre clinical trials. As well as doing the qualitative research to complement it, as we have already mentioned.

And the second one applies to absolutely all TC: unless you can justify the existence of your TC, in hard-line objective and numerical terms, you may be harshly called into question. we don't know if it is the same in Italy, but this is certainly the case in the UK. It means collecting, analysing and communicating outcome data – at least as service evaluation, if not formal research – like an annual report to demonstrate what you are doing and how it helps.

So, we think that if therapeutic communities want to preserve themselves in the long-term they must show that they are doing something that works. And that they can further develop their methodology and organisation to thrive.

4. Doing TCs in the future, between the need of adaptation and development potentialities

Partly from within, and partly from external pressure, a lot has changed.
Some 'total immersion' residential TCs from the British mental health services faced some trouble and were downsized (1)[1]. But there are a few, including new types, growing up as charities and cooperatives (as you have here in Italy). The state sector – the NHS in the UK – is very highly regulated and risk-managed, and is becoming increasingly difficult for TCs to position in this overall stiffening of the health system. But these charitable or social enterprises, or sometimes commercial, facilities now sell their places to the state system when the local services have no suitable facilities to help. And we think that's probably how it will go: a range of different places for those who need a therapeutic environment but different levels of physical containment, with types of therapy programmes suited to their particular

[1] The most known examples are the Henderson Hospital that closed, and Francis Dixon Lodge, which has become a 3-day per week unit.

circumstances. Anyway, these therapeutic units will maintain many of the features and qualities – and the underlying values which are typical of TCs.

Non-residential TCs, which have some analogies with psychiatric day hospitals even if they implement many of the group and therapeutic activities developed in decades by the TCs, have also 'reduced the dose' – and gone from 5 days per week to three, to one, or even less. They are very specific units in which you try to adopt a methodology typical of TCs extending it to non-residential setting, in a very flexible way. In this case, the culture and the awareness of the complexity of human relationships, developed by TCs in decades of experience, is declined into daily-services, in the whole of a locality's mental health and social care services.

In 2007, we started to look in earnest at what have become our 'core standards' – the special things that we as TCs all do, and not many other sorts of service do. And they are still the central part of the annual Community of Communities process, and the TC accreditation. We then developed, with the British Association of Therapeutic Communities, what we called the 'core values'.

These were the values that underlay the core standards – you didn't have to be a TC to have those values, but all TCs did have them – and many other places that looked and felt like therapeutic environments did too. This was the starting point for the Enabling Environments project, which is now an award from the Royal College of Psychiatrists – and a successful one which has nearly two hundred units signed up to it. It has been most successful in the criminal justice world – where the staff are finding a new purpose in their jobs, there is much less violence on prison wings, we expect reoffending to be reduced, and morale of prisoners as well as staff is demonstrably higher.
Because of its success, the head of the UK Prison Service is now saying that all prisons should be Enabling Environments. We are now working on a plan to do a similar programme for all British hospitals – to make them into 'enabling environments'. Money is short and we don't think it will start for a year or two yet – but the right people seem interested.

So, to sum up, we have said what we have been doing in Britain to safeguard and validate the therapeutic community movement:

- do it well and share that
- train people to really understand what groups and TC are
- play the research game and
- use the underlying TC ideas in new ways

We think that what we have in our history – which goes back hundreds of years in some ways – is too valuable to lose in the modern world of regulation and audit, of mistrust and fear, so we need to work as hard as we can to show there is a different way to live our lives and a better way to be with each other.

How does Community of Communities support the quality improvement of Therapeutic Communities?
The Community of Communities is a service managed and delivered by a small team based in the College Centre for Quality Improvement (CCQI) at the Royal College of Psychiatrists in London. A small team with a big reach!

The service was created to focus on supporting the quality improvement of Therapeutic Communities and now provides Standards based quality improvement and accreditation service to therapeutic communities across a number of user sectors; Children and Young People, National Health Service for personality disorder, severe and enduring mental health problems, prison service or offender services and addiction services.
There is a team of four coordinating the service at the CCQI and the model very much relies on member participation through attending as peer reviewers as well as taking up 'expert' roles. John Turberville chairs the advisory group, which comprises an impressive range of talent and expertise. Our aim is for the group to support the direction and development of the Community of Communities.

Community of Communities Membership
The membership now totals 81 organisations across the sectors with Children and Young People being the largest at 37 organisations, Her Majesty's Prisons with 16, then Adult Mental Health TC's with 14, National Health Service TC's with 10 and Adult Democratic TC's with 4. There are currently 5 different types of membership:

1. Accreditation Membership
2. Full Membership
3. Developmental Membership
4. Associate Membership
5. Pilot Audit Membership

These different membership levels reflect differing levels of service access to members and this is reflected in the fee paid by the member organisation. We have found that many organisations are keen to start off with developmental membership whilst they 'test the water', using the Standards to introduce a therapeutic culture to their organisation. This then leads onto full Membership and sometimes accreditation.

The Services Offered
Membership
Membership itself provides value and support. Having access to and contact with like-minded individuals and organisations helps reduce the sense of isolation and increases the idea that members are part of a wider group looking to achieve similar goals in similar ways. Members are encouraged to attend the regular Sector reference groups. These get together are an invitation to sector members to meet and discuss together both their challenges and successes as organisations as well as ideas for development of the Community of Communities services. These ideas are then fed into the Advisory group which also meets regularly to challenge and support the Community of Communities Team. Members also then have access to and benefit from the Standards, Peer Review, Training, Conferences and the National Report. Most recently we have also been offering a computerised data collection and analysis system to accredited members. (POD - or Patient Owned Data)

Standards
The Community of Communities have developed their service offer around a common set of standards. These standards were originally developed through a number of consultation exercises during 2001. These standards are reviewed regularly with members so that they reflect current practice and national standards across the sectors. This process also promotes owners membership of the Standards.
Although since its inception Community of Communities has developed five different sets of standards for a range of client populations, the 7th Edition of the Standards took 2 years to amalgamate these into one cohesive document. Whilst addiction TC's retained an additional

section focussing on evaluating their Therapeutic Approach, all member TC's agreed that the 7th Edition focussed on what is central to being a TC regardless of sector or client population. The most recent 9th Edition of the Standards increases clarity and cohesion of the service standards and includes a glossary of the terminology used as well. The Service Standards contain a total of 130 elements, broken down into 30 Standards and 97 supporting criteria. These criteria are given as examples of good practice to demonstrate meeting the standard, - but are not exhaustive!
There are five sections to the Standards:

1. Core Standards
   These are the essential requirement for all Therapeutic Communities:

   - There is a clear Therapeutic Community model of practice that is consistently applied across the service.
   - Community members are aware of the expectations of Community membership.
   - Community members are encouraged to form a relationship with the Community and with each other as a significant part of community life.
   - Community members work together to review, set and maintain Community rules and boundaries.
   - There is a structured timetable of activities that reflects the needs of Community members.
   - All behaviour and emotional expression is open to discussion within the community.
   - Community Members take part in the day to day running of the community.
   - Everything that happens in the Community is treated as a learning opportunity.
   - Community members share responsibility for the emotional and physical safety of each other.
   - Community Members are active in the personal development of each other.

2. Staff
3. Joining and Leaving
4. Therapeutic Framework
5. External Relations and Performance

Quality Improvement?
The Standards themselves available to members are intended to provide a means to improve quality. They are offered as an addition to any statutory requirements placed by government and support those organisations with aspirations to develop their TC approach to do so. The standards represent ideal practice and therefore provide something to work towards.
Peer Review
The foundation of the quality improvement service is the Peer Review model. This provides multidisciplinary groups of individuals from different organisations, sometimes across the sectors, being brought together to visit an organisation and explore with them their alignment with the Core Standards. This model provides benefits for both the organisation being visited and group members, who experience the sharing of best practice using data and stories. Although there is a formality to the visits, the peer review members report there being as

much benefit from the informal time alongside the visited TC staff and resident members as from the formal. The challenge in running such a system is to avoid the sense of it feeling like an inspection. We have too much of that in the UK already!
Models of Peer Review are now becoming far more common place in the UK and adopted and encouraged by Government departments in their management of sector development and quality improvement. Perhaps here we are staying ahead of the curve!
Increasingly in recent years, members and commissioners were asking whether they could use membership and participation in the peer review as a guarantee of quality of service. This was not possible based on the peer review model and so led to the development of a more rigorous accreditation service.

Accreditation
Again the accreditation membership and process is based around the peer review. There is a comprehensive self-review standards document for completion by the organisation to be accredited, covering all the standards, - not just the Core Standards. An 'expert' team then visits over one or two days alongside a peer review team. The process ensures close scrutiny of the organisation using the self -review document as a reference for understanding whether the organisation and its community members have an accurate understanding of their alignment with the standards and in which areas they do not meet, meet or exceed the standards. The process is inclusive of staff and resident members. Scores are identified by the Therapeutic Community Specialist alongside the peer review team and a comprehensive report provided.
Accredited members report that this quality mark is helpful for commissioners seeking reassurance of the quality of their service.

Training
In order to increase the consistency of the quality of the visiting peer review teams and experts, training is being provided for peer reviewers and lead reviewers. There is also training in the delivery of the Core Standards. This provides a more skilled peer review deployment and a more consistent experience for the visited organisation. It also helps to develop the understanding of therapeutic milieu practice across the sectors.

Effectiveness
The effectiveness of the quality improvement and accreditation is brought together in the annual National Report, produced in April of each year. This report uses the data from the peer review and accreditation reports to look at performance of sectors and organisations against the Core Standards and the different sections of the standards. It tracks changes over time with sectors and so informs members of their effectiveness in relation to others. This has led over recent years to a general improvement in the performance of members in meeting the core standards which suggests the services provision is effectively providing quality improvement.
The analysis of the data from the national report allows the community of communities team to identify areas that require improvement in certain sectors or across the sectors and training is then provided supporting the quality improvement.

The Current Context
Over the past two years, the pressure to change and the pace of change in the UK has increased dramatically with the global recession and consequent cuts to budgets. All services have felt under threat and many have fought closure. Never has it been more important to be able to articulate your service model and show its effectiveness in helping some of the most vulnerable in our society. We are all managing change, - it is the core of our work in our TC's with our client members, but the pace of change in our sectors can feel relentless. We all know that managing change is hard!

However, it seems so important when we are all managing so much change that there are organisations and their systems to help us remain focussed on the quality of the services we provide. The peer review process continues to challenge and support members in their service development and their ambitions to become more effective as TC's. It is during these pressurised times very easy to fall into standardising what we offer to satisfy inspectorates or commissioners yet we all know that our members benefit from the creativity, the relationships, community involvement and sense of family that therapeutic community membership provides.

Over this last year we have tried a different approach to encouraging participation in the Reference Groups for the different networks, with them meeting four times a year during the morning, sharing a lunch together and then with the themes from the morning feeding into the advisory group in the afternoon. All member organisations are invited to attend. Attendance has been disappointing and so we have moved more recently to an open forum during the morning for members from any network to share thoughts and ideas. Members attending have said that this new structure provides an opportunity to learn about Community of Communities.

The National report brings together the findings from across the different TC networks and shares areas of collective strength and areas where perhaps more focus is needed. Comparing the performance of networks against the different standards provide a useful reminder of the value of getting involved in the peer review or accreditation of other networks within Community of Communities. We have a great deal we can learn from one another.

The Future?
The advisory group have recently been discussing how we might extend the benefit of the quality improvement process to a wider range of services. There are a number of networks that have been born from or created through thinking about the TC standards and what they

have to offer. Bringing this diversity together under a 'family of networks' seems a sensible next step and we are at the early stages of thinking what this might look like.

The Ambition is to have one family of 'Positive Environments' (PE) with an advisory group overseeing them. There would be one overarching budget, within which there would be some flexibility to develop new ideas related to the fundamental relational principles as described by the Enabling Environment standards. There would be a common point of entry into the family – based on the Enabling Environment standards, but not necessarily involving the award process. Different networks and services would relate to differing client group needs. Within the PE family there would be different routes for different services, but no hierarchy of adherence or compliance – for example, there would not be bronze, silver and gold standard, nor marks of 'outstanding', 'good', 'adequate' etc. The PE family would benefit from the depth and range of provision across members with increased learning opportunities. Members would feel a part of this PE family, even though their service may as part of their development wish to move between networks as their services develop and adapt to client need. The system would provide credibility about the quality of provision across the range of Positive Environments.

Our hope is that building a broader offer to embrace this wider family of services will enhance and add value to the member services, their individual and collective approaches, and the outcomes for client members: 'the whole is greater than the sum of its parts'.
Some of the work in developing different standards networks to meet the needs of many of these service family members is well advanced, whilst others are in their infancy. The family could include:

- Therapeutic Community Standards (CofC)
- Psychologically Informed Physical Environments (PIPES)
- Psychologically Informed Environments (PIEs)
- Therapeutic Child Care Standards (TCC)
- Enabling Environments (including the NEEP programme and adaptations for an NHS equivalent)
- Green Care and Ecotherapy services for mental health
- Faith-based Communities
- Personality Disorder Specialist Services
- Staff support processes and networks (reflective practice / Balint Groups / Schwartz Rounds / VBI)

It is clear from the work that has been done to date that there are common principles and values that bind the services together as family members. We are well aware that the work across these potential Positive Environment members has followed a variety of different paths. Some are quality improvement focussed peer review networks, others accreditation focussed and some award based standards systems. Although we generally welcome the diversity of approaches and recognise the benefits that may come from binding them together we are also concerned about the potential tensions and difficulties from the diversity of methods might pull them apart. Our next step is to provide some clarity about what change would be required to bring them under one family heading. This is an exciting new venture that we hope will embrace the diversity of the psychosocial models developed in the UK, providing a common quality improvement and accreditation system serving the best interests of our vulnerable population.

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Notes

(1) The most known examples are the Henderson Hospital that closed, and Francis Dixon Lodge, which has become a 3-day per week unit.

Rex Haigh is an NHS Consultant Psychiatrist in Medical Psychotherapy. He has been fascinated by therapeutic communities since landing in one as a medical student; he has subsequently qualified in general practice, psychiatry, psychotherapy and group analysis. He is a past Chair of the Association of Therapeutic Communities, was Clinical Advisor for the National Personality Disorder Programme and a founding member of 'Emergence', the service user organisation for personality disorder. He set up the Royal College of Psychiatrists 'Community of Communities' quality network and now leads their "Enabling Environments" project. He is a 'critical psychiatrist' and is a member of several organisations that aim to promote a more open-minded and balanced approach to mental disorder.

Email : rex.haigh1@nhs.net

John Turberville has a BSc, an Int. Cert. in Family Therapy and an MA in Therapeutic Child Care. He's director of the Mulberry Bush and chair of the Community of Communities project, at the College Centre for Quality Improvement, which is part of the Royal College of Psychiatry. He is a Therapeutic Community (TC) specialist in the auditing of TC Prisons. His focus and interest remain in the development of high quality integrated therapeutic services for children and young people.

Email : jturberville@mulberrybush.org.uk