Special Section
The Therapeutic Community in the 21st Century

INTRODUCTION

Sandra L. Bloom, M.D., and Kingsley Norton, M.D.
Guest Editors

The practice of psychiatry in the United States today is driven by the burgeoning knowledge about the biology of the brain. As beneficial as this knowledge is, a primary focus on psychopharmacology in training programs can lead young practitioners to believe that helping troubled and troubling human beings is somehow more straightforward and simple than it actually is in practice. Young psychiatrists and other mental health practitioners new to the field can find themselves overwhelmed in the face of the enormous complexity of judgment and discretion demanded of them when they actually are confronted with an individual mired in misery, a criminal offender with a terribly traumatic history, or a family that is tearing itself apart. In our fast-paced world of the "managed care" environment, it is relatively easy to be lulled into the notion that the way psychiatry is practiced now is the way it always has been and the way it needs to be.

The principles that guide the democratic therapeutic community—as distinguished from "concept therapeutic communities" so common in the United States for the treatment of substance abuse—are rooted in Moral Treatment of the 18th century and the fundamental ideals of the Enlightenment—apparent in both the U.S and the U.K. In this special section of papers on the therapeutic community we wish to remind our professional community of this rich heritage, which is otherwise forgotten, denied, or ignored. A wide range of settings including residential treatment settings for children or adults, acute care inpatient units, substance abuse programs, domestic violence shelters, homeless shelters, group homes, day hospitals, and intensive outpatient programs all have an opportunity to create environments that are intrinsically humane, as well as healing and health promoting. In an era of tightening

budgets and bottom-line focus, finding methods to aid recovery from overwhelming experiences that are environmental and not solely dependent on expensive individual forms of treatment are even more critical than ever.

Although the movement in the last few decades has been away from institutional types of care and toward community placement, many people in the social services have come to believe that a certain level of institutional care is not only inevitable but important, that until there is some form of radical change in the way our societies are constructed, the ideal of community placement will fall short of a reality that is far too often characterized by disenfranchised, alienated, wounded people living in boarding homes or other unhelpful situations, repeatedly hospitalized for brief periods with little change or improvement over time. This is especially true for those who are labeled with "personality disorders." These clients frequently place great strains on the present mental health care system because they demand time, attention, investment of resources, and because they require skillful interventions. However, once the underlying reasons for these disorders become visible—very frequently a past history of physical or sexual abuse and neglect—it becomes possible to pursue forms of treatment that can further personality change and growth so that people who have previously been a burden on an overly-taxed system can become contributing and productive citizens.

Such fundamental change, however, does not come without a cost. Until we collectively decide to stop promoting the conditions that allow children to be abused, neglected, and otherwise violated, and adults to be repeatedly exposed to interpersonal violence, we will continue to be confronted with the refugees of our own domestic warfare. The ideas of the therapeutic community based on several hundred years of psychiatric endeavor, represent a vital attempt to provide environments that are deliberately designed and operated to counter the devastating effects of this warfare. In the United States, in the United Kingdom, and in other parts of the world, the therapeutic community impulse furthered the idea that a community created in the "reverse image" of a society at large can be therapeutic for the casualties of that society (1).

The therapeutic community is in many ways a subversive idea in that the goal of the TC is not to maintain an unhappy status quo but to create the "heat" that generates change. This change is generated largely through the democratically informed interactions between staff and clients and clients with each other. And today, the institutionally-based practice of this "deep democracy" is itself a subversive notion in that it seeks to subvert the militaristic, hierarchical, and frequently

punitive and retributive control structures that typically characterize most of our social systems and replace them with an environment offering different styles of relating that seek to avoid the repeating of past traumas.

In fostering such subversion, we have gathered together a variety of eminent authors in the TC field. All except one are from the United Kingdom where the National Health Services has grasped the notion that the treatment of people who have had their personalities and development altered by unjust and abusive environments often require intensive and long-term forms of treatment (2). In the first article, Dr. Stuart Whiteley, (Director of the Henderson Hospital from 1966–1988) describes the history of the therapeutic community concepts. Henderson Hospital's present Director, Dr. Kingsley Norton, and the developer of the Sanctuary Model of inpatient treatment in the U.S., Dr. Sandra L. Bloom, present details of the way a therapeutic community and its cousin, the therapeutic milieu, actually function in practice in the second paper. In the third paper, Dr. Rex Haigh and researcher Sarah Tucker describe an action research based system of standardization, peer-review, and audit, with its principles and methods based on therapeutic community practice, called "Community of Communities." The fourth paper by the research group of Jan Lees, Nick Manning and Barbara Rawlings reviews the existing research on the methods and outcomes of the therapeutic community. Dr. David Kennard finishes the section by describing the various ways that therapeutic community principles are being applied in different settings. We hope that the reader may derive something of worth from our "special," albeit transient, U.S./U.K. relationship!

REFERENCES

1. Kennard, D: An Introduction to Therapeutic Communities. London, Karnac Books, p. 34, 1988.
2. National Institute for Mental Health & Department of Health: Personality Disorder: No longer a diagnosis of exclusion. London, Department of Health, 2003.

THE EVOLUTION OF THE THERAPEUTIC COMMUNITY

Stuart Whiteley, FRCPsych

The creation of Therapeutic Communities in the Military Hospitals of the UK for the treatment of psychological casualties of war during the Second World War is described. The personnel and the methods utilised are discussed and the lessons learned are summarised. It is argued that this was not an entirely new phenomenon. The author describes previous usage of similar methods in residential communities for disadvantaged or delinquent youth in the period between the two world wars and, prior to this, the eighteenth century "era of moral treatment" in mental hospitals in the UK and USA.

SOME ANTECEDENTS OF THE THERAPEUTIC COMMUNITY

Moral Treatment of the Mentally Ill

In France, in 1792, Phillipe Pinel, Superintendent of the Bicêtre and Salpétrière Asylums in Paris is reported to have struck the chains off some of the inmates of these places and set them free and is commonly regarded as a pioneer of a more humanitarian treatment of the insane.

Address correspondence to Dr. Stuart Whiteley, Wheelwrights Cottage, Wheelers Lane, Brockham, Surrey RH3 7LA, United Kingdom; e-mail: stuart.whiteley@virgin.net.

In this same year, a revolution in the treatment of the mentally ill was about to take place in England. The Tuke family of merchants, resident in York, dismayed by the unfeeling treatment and ultimate death of a mentally ill fellow-Quaker set out to build a hospital for the insane which would be run on humanitarian principles. Due respect would be given to the patient and the comforts of good living and friendly relationships would be provided (1). The name of this method was finally settled upon as *moral treatment,* which was taken by Tuke from a translation of a treatise written by Pinel. However, K. Jones points out that Pinel's *traitement morale* does not translate strictly as the *moral treatment* which was at that time being established at The Retreat, the Quaker foundation of the Tuke family which was eventually opened in 1796. The Pinel phrase refers to a treatment through the emotional self whilst the moral management of the Tukes refers to the attitude of respect for human rights and the values of relationships (2). The first American doctor to visit the Retreat was John Francis of New York who wrote in the Visitors Book in 1815 that *"The New World cannot do better than imitate the old so far as concerns the management of those who labour under mental derangement"* (3).

In the first half of the nineteenth century many other asylums for the mentally ill, both in England and America, followed the system commenced at The Retreat. Towards the close of the nineteenth century, David Hack Tuke, a descendant of Samuel Tuke, the founder of The Retreat, advocated occupation as a part of treatment saying that *"the immediate object is not the value of the labour but the benefit to the patient."* In his *Dictionary of Psychological Medicine* (4) he also notes that *"nursing their fellow patients is a valuable occupation for both sexes."*

Charles Dickens, the nineteenth century author, was a social commentator as well as a novelist. In his book, *American Notes*, (5) he describes how he observed the Superintendent of the Boston State Hospital sitting down to dinner with the patients and how *"moral influence alone restrains the more violent,"* thus doing away with restricting devices. Samuel Woodward, of the Worcester State Hospital, wrote that, *"if the physician could manipulate the environment he could thereby provide the patient with new and different stimuli, thus older and undesirable patterns and associations could be broken or modified and new and more desirable ones could be substituted in their place"* (6).

In Germany in 1803, Reil, of the University of Halle, advocated that each asylum should have its own theatre with the *"roles in the plays distributed according to individual therapeutic needs. The fool, for instance, would be given a role making him aware of the foolishness of*

his way of behaving." He, too, saw work as an essential aspect of therapy progressing from the requirements to maintain physical health, through artistic creativity, to mental activity (7).

In summarising the nineteenth century experiences throughout Europe, we find many basic truths concerning the social psychology of large residential groups in hospitals which have been "rediscovered" by more recent sociological observation, namely: 1) That when the leader interacts at the level of the group his power can be magnified rather than dissipated; 2) That it is not so much the occupation of the group but the participation in the group activity which is the curative factor; 3) That responsibility-sharing and mutual self-help leads to a decrease in passivity and dependence and to abandonment of the sick role; 4) That when the aetiology of the illness is placed outside the influence of the patient a state of hopelessness is engendered in both therapists and patients; 5) That the mental hospital is a microcosm of society with mental symptoms being no more than exaggerations or acted-out representations of so-called normal social behaviour; 6) That role playing experiences can lead to insight into the individual's abnormal behaviour; 7) That negative sanctions are less effective than positive reward in changing behaviour.

Living and Learning Communities for Disadvantaged Youth

In the period between the two world wars there were a number of well-known "*living-and-learning* experiments" with adolescents and young adults throughout the world, which have been extensively reviewed by Bridgeland (8). Examples of such well-known projects are Homer Lane and the Little Commonwealth (9) in England, and which itself emanated from Lane's experience in Father Flanagan's Boys Town in USA; Aichorn in Austria and Makarenko and the Gorki Republics in post-First World War Russia and the Q Camps in England. These latter were short-term, residential communities, which were called Q Camps where Q stood for Query or Quest, and the philosophy on which they were based was Planned Environment Therapy. This latter approach was initiated in the nineteen thirties by Marjorie Franklin, a psychoanalyst working with children. Planned Environment Therapy (10) was based upon identifying the remaining "healthy" aspects of the personality in the subjects studied and utilising such in an attempt to restructure the individual's attitudes and function within a social and community environment. David Wills became an important figure in the Camps and later set up Hawkspur Camp (11), which was based on the Planned Environment principles.

The participants in these diverse and internationally generated residential communities were, for the most part, offenders, homeless, or otherwise socially handicapped young people. However, the concepts of *shared responsibility* for the physical maintenance of the living space, *participation* and *democratic decision-making* in the governance of the project, were common to all of these projects. All seem to have arisen relatively independently of each other and at the inspiration of some interested individual which suggests a philanthropic philosophy common to the human race.

Although not directly linked to the Northfield or Mill Hill developments during World War II, described below, there are some associations which have been brought to recent light by the diligent work of Craig Fees, Archivist to the Planned Environment Therapy Trust and to the Association of Therapeutic Communities (12). At a joint conference of the ATC and PETT in the 1950's, a participant listening to Maxwell Jones' account of his own practice, remarked with some indignation at the nonreference to the earlier work, that "it's just Hawkspur all over again." Similarly, a Commanding Officer at Northfield, in the early war years, having just read a small monograph published in 1943, entitled *Q Camp: An Experiment in Group Living with Maladjusted and Anti-Social Young Men,* commented to the officer in charge of the Psychiatric Unit, *"that's what we ought to do here."* He was quite unaware that Dr. Denis Carroll, the officer in charge of the Psychiatric Unit, had been the Chairman of the Q Camps Selection and Treatment Committee and had himself suggested that the monograph quoted be published! (12).

THE MISFORTUNES OF WAR

In the foreword to a recent book on the Northfield Experiments (13) Hinshelwood writes, *"The legend of Northfield is one of those myths of creation."* The specialist units in the United Kingdom for the treatment of psychiatric casualties of the Second World War are repeatedly cited as the originators of the Therapeutic Community, but perhaps the true seeds of the Therapeutic Community were already dormant in our society. The fortunes (or misfortunes) of war had thrown together personnel from many different professional backgrounds and schools of thought. In addition to the varied clinical approaches that these diverse professionals brought with them, these latter were also the bearers of the decades of moral, cultural and social attitudes, which have contributed to the development of our civilised society. In the early years of the war,

the need was established to find methods to cope with the psychiatric casualties of war that had led to the masses of so-called "shell-shock" victims of the First World War and their mishandling by the authorities; varying from punitive excesses to long-standing invalidism. Two hospitals were set up primarily for this task, at Northfield in Birmingham and Mill Hill in London.

Northfield

The medical staff at Northfield were largely psychoanalysts with a Tavistock Clinic background. The hospital came into being in 1942 when an old Victorian Asylum was taken over for Military Psychiatric Casualties. Only patients who had a reasonable chance of return to military service were admitted and the conduit for return to the army was the Training Wing, of which the psychoanalyst Wilfred Bion was appointed Director at the end of 1942. Bion, had witnessed the traumas of war when he had served with distinction as a tank commander in the First World War (14).

Together with Rickman, he instituted a disciplined programme of daily parades, a period of which was spent in group discussion. Rickman was a psychoanalyst who had had some experience of a psychoanalytic approach to war trauma at the smaller Wharncliffe Hospital, in Sheffield, where a feature had been to use military drill as a form of "occupational therapy" and as a reintroduction to the "normal" work of a soldier. He was also a former colleague and analysand of W. H. Rivers (15), the psychiatrist who had pioneered the humane and psychotherapeutic treatment of some of the psychological casualties of the First World War. What was an innovation, in this First Northfield Experiment, were the discussion groups which Bion initiated. The task of the group was to *study its own internal tensions*, which stood in the way of the individuals performing their military duties. Although this may seem a common therapeutic task to us today, it was not a procedure which was familiar to the more traditional doctors in the hospital nor was it what the military authorities expected of the Training Wing. Bion and his colleague Rickman were soon in conflict with both the medical and the military hierarchy and they were dismissed from their posts after six weeks despite an improvement in behaviour and morale in the Training Wing.

A few weeks after Bion left, Foulkes arrived at Northfield and instituted ward-based sessions of group therapy according to the model that he had been developing in his civilian practice. He had been influenced by the teachings of the American psychoanalyst, Trigant Burrow, who

first used what he termed *group-analytic* methods during the 1920's. Burrow's viewpoint was that disorders in human behaviour were essentially social or interrelational and demanded observation and study in a dynamic group setting (16). Drawing also upon the theories of Lewin (17), Foulkes came to view the whole hospital as the current "social field" and the behaviour of the individuals within it as being subject to the forces inherent in that field. In his first book, Foulkes, (18) diagrammatically illustrated the relationship between traditional individual *Psychoanalysis*, formal *Group Analysis* and what he calls *Open-Air Psychiatry*, or working in the *Life-Space* of the patient. *Psychoanalysis* is at the centre of the circle and the other areas are the successive enveloping layers; firstly *Group Analysis* and then a covering layer devoted to *Open-Air Psychiatry* or dealing with the issues of everyday life in a social setting. De Mare, who was at Northfield in a junior medical officer capacity and was later to pioneer the practice of therapy in the large group, has commented that what Foulkes did not do was to bring the small groups in the various hospital wards and departments into face to face contact and discussion with each other (19). Such a community meeting, bringing together all involved in the project, is an essential component of any Therapeutic Community today.

With the arrival of Harold Bridger at Northfield, a few months after Foulkes, the concept of the *hospital-as-a-whole* became more manifest. The differentiation between the Training Wing and the Hospital Wing was discarded. Activities were introduced, both in the hospital and in external projects, not as a means of occupational therapy but as a means of *studying, and increasing the opportunities for, participation in group interaction*. Bridger was drawing upon his awareness of the Peckham Experiment, which was an experiment in social cohesion carried out at Peckham, in working-class London, just before the Second World War. By giving free access to a swimming pool, local residents were encouraged to participate in a number of neighbourhood schemes and discussion groups affecting daily life in the area (20). Additionally, he drew upon his experience before the war as a teacher of mathematics when he introduced real and practical tasks (such as following the fluctuations of the Stock Market) into the classroom as a way of learning, rather than relying solely on didactic lectures. He was also utilising the methods to which he had been introduced in the *leaderless groups*, which were a wartime feature of officer selection. In these latter, a group of soldiers would be given a task—such as construction of a bridge over a stream—and would be observed as to the way they worked co-operatively, by whom leadership was undertaken, and how others responded to whatever form of leadership emerged.

Main arrived towards the end of the war, having had experience in the early treatment of 'battle exhaustion' and also of the resolution of a threatened mutiny by a battle-weary battalion on the Italian front. He supported the concept of the hospital-as-a-whole and encouraged Foulkes to act as a kind of roving organisational consultant who visited various departments in the hospital where problems were arising, in order to study the situation in a group setting and facilitate the emergence of a group resolution. The major contribution of Main was perhaps to acknowledge the wider concept of the *interrelated systems* at work in this setting, and which needed clarification of the issues involved, and then resolution of the conflict through negotiation. Thus, rather than coming into confrontation with the existing order in the hospital, as Bion had done, he recognised the needs and expectations of the military system and the *status quo* of the conventional psychiatric treatment system as well as facilitating the newer psychoanalytic way of working with the group. Nevertheless, he made the *primary task* the restoration of the soldier patients to military service. He was somewhat critical of Foulkes and some others on the staff, whom he designated as 'treaters', in a situation which he clearly regarded as secondary to the real task in this time of war (21).

Mill Hill

During the war years, Maxwell Jones, was at the other Hospital for military personnel at Mill Hill, in London, and which was staffed primarily from the Maudsley Hospital, the premier psychiatric teaching hospital in UK, with a tradition of a multidimensional approach of organic, social and genetically-based psychiatry.

The Mill Hill hospital was located in the public school of that name, from which the pupils had been evacuated. It was like a civilian mental hospital in its range of psychiatric treatments; from the currently utilised physical treatments to occupational therapy and social activities. Jones was in charge of the *Effort Syndrome Unit* and began by lecturing to his patients on the aetiology of neurotic symptoms through neural pathways; but his audience was less concerned with physiology than with their "here and now" situation in the hospital and being drafted into military service. Gradually, the lectures became group discussions—in a large-group setting—of the current situations which faced these soldier-patients and from this experience he developed his ideas for the future task of the psychiatric hospital as a Therapeutic Community and the place within such for a community meeting.

THE LESSONS LEARNED FROM NORTHFIELD
AND MILL HILL

Northfield

Under the leadership of Main, the Second Northfield Experiment flourished.

It drew the attention of a visiting group of distinguished American psychiatrists in 1945, which resulted in the well-known collection of original papers being published in the *Bulletin of the Menninger Clinic* (22). These Northfield papers were reproduced with comments from contemporary sources in a special edition of the journal *Therapeutic Communities* in 1996 (23). The American visitors were impressed by their visit to Northfield and the extent of group therapy in the UK. However, Karl Menninger comments in a foreword to the original edition that, *(group therapy) "is not as yet the preoccupation or method of preference in the leading psychiatric hospitals of America whereas it actually is in England."* In the Menninger papers, Main had set out a vision for the psychiatric hospital of the future in which the hospital *"will be run as a community with the immediate aim of full participation of all its members in its daily life . . . there must be no barriers between the hospital and the rest of society. . . . the anarchical rights of the doctor must be exchanged for the more sincere role as a community member."* Whilst Main is regarded as the originator of the term Therapeutic Community, Harrison (24) points out that the term was previously used by Harry Stack Sullivan in 1939. According to Main, an aim of treatment in such a hospital would be *"the socialisation of neurotic drives, their modification by social demands within a real setting, and ego-strengthening. The increased capacity for sincere and easy social relationships and the socialisation of super-ego demands provide the individual with a capacity and a technique for a stable life in a real role in a real world."*

Mill Hill

Maxwell Jones postulated for the mental hospital of the future the establishment of *open communication*, with *flattening of the staff hierarchy*, and in order to facilitate such, *role blurring*, whereby the therapeutic input would not be restricted to the professional staff, daily large group *community meeting*s to discuss the real issues of the moment,

democratic decision making and *"a single therapeutic goal, namely the adjustment to social and work conditions outside without any ambitious psychotherapy"* (25).

It was a further visit to a Therapeutic Community in England in the early 1950s by a senior U.S. Naval Psychiatrist, Harry Wilmer, which inspired the visitor to establish a similar group-oriented approach in the Naval Hospital at Oakland, California. This time, a visit was made to Maxwell Jones at Belmont Hospital in Sutton, where the postwar Therapeutic Community, later to be renamed as Henderson Hospital, was located. On his return to USA Wilmer set about establishing a similar community in the Oakland base. Dennie Briggs, who was then a clinical psychologist in the Naval service and had joined Wilmer's team, believes the Oakland unit to be the first Therapeutic Community in the USA. He has deposited an account of the working of the Oakland Naval Therapeutic Community with the Planned Environment Therapy Trust Archive (26). After his Naval service, Wilmer continued to utilise the Therapeutic Community approach in many different projects and with varied client groups in the USA and taught and wrote extensively about the method (27). On the advice of his senior, Briggs had made a visit to Belmont in 1956, following which he was to become a friend and collaborator with Maxwell Jones on many projects in the USA, which included extending the Therapeutic Community ethos into schools and into Penal Institutions (28).

On the whole, however, what emerged from these two innovative experiences at Northfield and Mill Hill was very similar in terms of the concentration on the functioning and well-being of the hospital community, with less emphasis on the individual as the primary therapeutic target. Out of Northfield came a *philosophy* of the Therapeutic Community and from Mill Hill a *method*. Strange as it may seem, in a professional activity where communication is regarded as paramount, there was little or no exchange of ideas between the protagonists, Main and Jones, in these two wartime experiments. Bridger alone, (the nonpsychiatrist), seems to have visited other units concerned with the rehabilitation of service personnel before taking up his duties.

POSTWAR DEVELOPMENTS OF THE THERAPEUTIC COMMUNITY ETHOS

After the war, Main was appointed as Director of the Cassel Hospital, where there was a tradition of psychoanalytic treatment (29), and

here he established his model of the Therapeutic Community, which might be called a *psychotherapeutic* community. Patients were treated in individual and analytic group sessions as well as being involved in community activities, which latter were largely directed by specially trained and often psychoanalytically experienced, nursing staff.

Maxwell Jones continued to develop his more *sociotherapeutic* community methods at Henderson Hospital in Sutton (30), where the patients upon whom the method was primarily utilised were young personality disordered clients. He interested an American social anthropologist, Robert Rapoport, in exploring the community. Rapoport had just returned from an investigation of tribal life with the Navajo Indians and he and his team took on a participant-observer role to explore life in the Belmont Therapeutic Community. The experiences of the Rapoport team were reported in the book *Community as Doctor* (31). Initially, the book had a mixed reception from the psychiatric profession, who were perhaps beginning to tire of the Therapeutic Community saga, and Max himself was disappointed with the findings. Rapoport pointed out a number of contradictory or negative factors in the therapeutic community process as it then was. For example: a) it could be *damaging to those with poor ego-functioning*; b) there seemed to be a *conflict of aims* between staff with a *rehabilitative aim* (assisting the damaged patient to survive life's traumas) and those with a *curative aim* (eradicating the psychological symptoms); c) despite the assertions that "we are all equal here" there was a prominent *dependency on the professional staff*, who continued to see patients for individual sessions, and Rapoport pointed out that those patients who had the better outcome were those who had formed close relationships with key staff figures.

Maxwell Jones later came to terms with the Rapoport findings and was to write, *"for me to discover the discrepancy between what I thought I was doing as a leader and what trained observers saw me doing was frequently a painful—but almost always a rich learning experience"* (32). Most well known from the Rapoport report, are the four ideological themes he extracted from his observations, namely, *permissiveness, communalism, democracy and reality confrontation*. These often-quoted principles have been critically scrutinised by many authors; Morrice (33), Haigh, (34) Birch et al, (35) among others. They are frequently taken as being the essential ingredients of the Therapeutic Community and for many who seek to create a Therapeutic Community the assumption is that, once added, the true Therapeutic Community will inevitably result. This, of course, is not the assured outcome.

Curative Factors in the Therapeutic Community

An understanding of what is contained within these ideological principles of Rapoport is necessary so that they can be applied or facilitated to develop productively. In an investigation at Henderson Hospital (36) we explored the relevance of the generally agreed *curative factors in group psychotherapy* (37) as applied to the Therapeutic Community. In summary, we asked patients to denote what had been for them the most important factor in the previous week in terms of advancing their therapy. Looking at when such factors occurred, we found that in the early stages of treatment the new patient looked first for *acceptance* and the *instillation of hope*. Later came *learning from interpersonal actions* and *self-understanding*. The Rapoport principles are not in themselves the curative factors in the therapeutic community process. They are either therapeutic techniques or conditions in which change can occur, but they probably contain within them certain more discrete curative factors. Thus, *permissiveness* allows for catharsis, self-disclosure and the assumption of self-responsibility. *Reality confrontation* can promote self-awareness and the development of identity and self-concept and learning through interpersonal actions. *Democracy* allows self-management to emerge and altruism to flourish as a patient is allowed to contribute meaningfully to the treatment of others. *Communalism* promotes interaction with others, responsibility-sharing, the abandonment of fixed social roles and attitudes, and the development of new relationships. When we asked patients to say where these important events occurred we found that, although they could arise in any of the group therapy structures in the treatment day, slightly more of these important and beneficial incidents took place within the community boundaries but outside the formal therapy groups.

Attachment Theory and the Therapeutic Community

Although Maxwell Jones appeared to exclude any *"ambitious psychotherapeutic programme,"* evidence that psychodynamic factors were present in his concept were illustrated by Rapoport's finding that those patients who responded best were those who formed strong relationships with key staff figures. Indeed, a feature of the Therapeutic Community is the attachments that patients are enabled to make within the community. Often it will be the first successful attachment that a patient will have made after repeated failed attachments in his earlier personal development. He will test out, act-out, but finally take the

risk of attaching to the community as a whole, to the staff and to other patients (38).

In this respect the Therapeutic Community has something of the features of Winnicott's *Potential Space* (39) . The term *Potential Space* was used by Winnicott to describe the metaphorical space between mother and child in which both experimented in an interactive way with closeness and distance, separation and togetherness, boundary setting and boundary keeping. It was a learning experience for both, but particularly for the child who was venturing out into the new experience of independence. Similarly, the *Potential Space* of the Therapeutic Community recreates a learning experience for both patients and staff. The daily community meeting is a primary focus of interaction for observation of, and intervention within, the field of sociotherapy. Such meetings are the very heart of the Therapeutic Community process. This is the *Open-air Psychiatry* of Foulkes.

Peter v. der Linden, writing of a Therapeutic Community in the Netherlands, has commented *"this setting* (i.e. the Therapeutic Community) *possesses its own creative value, it's own educational moments, that have no counterparts in ambulant therapy. The therapeutic community is both a physical space with working, eating, sleeping, leisure, and creative areas such as the art room or gym and also, through its rules, customs, and expectations, it is a psychic space."* (40).

THE UTILISATION OF THE THERAPEUTIC COMMUNITY IN GENERAL PSYCHIATRY

In the immediate years following the Second World War and the awareness of the Northfield and Mill Hill experiences, the concepts of the Therapeutic Community were enthusiastically taken up by psychiatrists returning from the war and impressed by the success of war-time psychiatric interventions, whether in the above specialist Therapeutic Communities or in the early-treatment "group" interventions for Battle Exhaustion, set up in the combat areas and avoiding the necessity for transfer back to base hospitals. However, the principles of the Therapeutic Community that were developing in the postwar years, were not readily transferable to civilian mental hospitals, with the diversity of psychiatric diagnoses within such, and so the take-up was limited.

Clark (41) distinguished between the Therapeutic Community *Proper*, such as at Belmont Hospital (Maxwell Jones), the Cassel Hospital (Main) and a very few smaller units treating personality and neurotic disorders, and the Therapeutic Community *Approach*, which

embodied some of the more generalised "living and learning" techniques of psycho-social therapies. Such latter hospitals utilised group discussions on the daily life of the hospital community and limited participation in ward management.

On the whole, these were embodied in the "Open Door" hospitals which followed a tradition of not locking all the wards and providing a free access to social and occupational amenities within the hospital and grounds. This less controlling approach was also named "the return to moral treatment" and echoed the traditions of some of the mid-nineteenth century asylums already alluded to above. It is interesting to note that Dingleton Hospital, in Scotland, was one of the pioneers of the first (nineteenth century) Open Door policy and a hundred years later was the hospital to which Maxwell Jones was appointed as Medical Director in 1962. At Dingleton he developed a system which spread outside the hospital community itself and incorporated local authority social workers, general practitioners and members of the wider public (42).

The further development of the Therapeutic Community *Proper* has included the establishment of the Association of Therapeutic Communities (ATC) in 1970 and its expansion into an international membership, the Journal of Therapeutic Communities, and an internet-based discussion group. There is now a specialist library of Therapeutic Community publications produced by Jessica Kingsley Publications in London. Therapeutic Community Training courses and Conferences are regularly held, notably the annual Windsor Conference, which has become an international meeting point. The ATC and PETT (Planned Environment Therapy Trust) have moved administratively and professionally, closer together, with the latter largely concentrating upon residential communities for children but utilising similar techniques to the Therapeutic Communities for adults.

CONCLUSIONS

The Therapeutic Community is more than just a specialist method of psychiatric treatment and I would like to feel that the issues explored in this overview of the evolution of the Therapeutic Community give us some evidence of a *democratic tendency* in the human race, as Winnicott described (43) or building upon that, of a *therapeutic community impulse* as Kennard has postulated (44). In the 1st Maxwell Jones Memorial Lecture, in 1997, Professor John Cox, President of the Royal College of Psychiatrist spoke of an inherent *community obligation* to support

and assist our fellow men and support and maintain the society in which we live (45).

The Therapeutic Community is the resource through which such drives can find expression.

A POSTSCRIPT: MACONOCHIE'S EXPERIMENT

In 1836, Alexander Maconochie, a former naval officer, the first secretary of the Geographical Society and the foundation Professor of Geography at the University of London, took up the post of secretary to the Governor of Van Diemen's Land (later Tasmania). He was a prodigious pamphleteer and writer of reports to Parliament and for learned Journals and during his appointment to the colony he was invited to prepare a report for *The Society for the Improvement of Prison Discipline.*

He was disturbed by the negative and punitive conditions under which the transportees from England, who had been sentenced to terms of imprisonment in Van Diemen's Land, were held. Drawing upon the experiences of man-management that he had utilised in the Navy, in which he involved all concerned in the resolution of conflicts that arose below decks, he campaigned for a new philosophy of rehabilitation to be applied within the Penal Colonies. He was given the opportunity to put his words into action by being appointed as Prison Governor on Norfolk Island, a notorious settlement for the "scum of the prisons."

First of all he did away with the instruments of harsh punishments such as the gallows and the flogging racks and encouraged the prisoners to look to their future as free men. His system of rehabilitation was based on four stages in which the convict first worked in the prison or on the land and earned marks which could be exchanged for food and other comforts. When the subject had shown that he could budget satisfactorily, he was paired with a fellow convict and they worked together for the same benefits. Thirdly, the individual joined a group, which now had to look primarily to the welfare and sustenance of the group as a whole. Last of all, a successful outcome would be to leave the prison and live and work within the colony as a (relatively) free man until his sentence was expired.

Contemporary mores regarding the punishment of offenders did not agree with this innovative and spirited attempt at "moral education," despite its apparent success in the rehabilitation of many convicts. Maconochie was dismissed from his post and recalled to England. A similar project, which he set up at Birmingham Prison, also fell foul of the powers that be and once again was terminated.

With hindsight, we could see *Maconochie's Experiment* as an early example of an inspiration to make the community therapeutic. Regrettably, the innovator's enthusiastic reforming zeal set him up *against* the ruling establishment rather than seeking to work *within* such. The fascinating and detailed account of *Maconochie's Experiment* is given in the book of that title written by John Clay, a former staff member of a Therapeutic Community for adolescents (46).

REFERENCES

1. Glover M: The Retreat, York. An Early Experiment in the Treatment of Mental Illness. York, William Sessions, 1984.
2. Jones K: Foreword to Description of the Retreat, by Samuel Tuke (1813). Reprinted London, Process Press, 1996.
3. Hunter R, Macalpine I: Introduction to Description of the Retreat, by Samuel Tuke (1813). Reprinted London, Process Press, 1996, p. 4.
4. Tuke H: Dictionary of Psychological Medicine. London, J. & S. Churchill, 1892.
5. Dickens C: American Notes for General Circulation. London, Chapman & Hall, 1842.
6. Grob G: The State and the Mentally ill: A History of Worcester State Hospital, 1830–1920. Chapel Hill, NC: University of North Carolina Press, 1966.
7. Harms E: Modern psychotherapy—150 years ago. Journal of Mental Science: 103(433):804–809, 1957.
8. Bridgeland M: Pioneer Work with Maladjusted Children. London, Staples, 1971.
9. Wills WD: Homer Lane. A Biography. London, George Allen & Unwin, 1964.
10. Franklin M: The Use and Misuse of Planned Environment Therapy. Psychological and Social Series. Edited by Schmideberg M. London, 1945.
11. Wills WD: The Hawkspur Experiment. London, George Allen & Unwin, 1941.
12. Fees C: From the archives. Therapeutic Communities 18(4):310–311, 1997.
13. Hinshelwood R: Foreword, in Bion. Rickman, Foulkes and the Northfield Experiments. Harrison T, London, Jessica Kingsley Publications, 2000.
14. Bion F, Editor: W. R. Bion War Memoirs 1917–18. London, Karnac Books, 1997.
15. Slobodin R: W. H. R. Rivers. New York, Columbia University Press, 1978.
16. Pines M: Forgotten Pioneers: The unwritten history of the therapeutic community movement. The 2nd. Maxwell Jones Memorial Lecture. Therapeutic Communities 20(1):23–42, 1999.
17. Lewin K: A Dynamic Theory of Personality. New York, McGraw-Hill, 1935.
18. Foulkes S: Introduction to Group-Analytic Psychotherapy. London, Heinemann. Reprinted, London, Karnac, 1983.
19. De Mare P: Michael Foulkes and the Northfield Experiment, in The Evolution of Group Analysis. Edited by Pines M. London, Routledge & Kegan Paul, 1983.
20. Pearse JH, Crocker LH: The Peckham Experiment: A Study in the Living Structure of Society. London, Allen & Unwin, 1943.
21. Harrison T, Clark D: The Northfield Experiments. British Journal of Psychiatry 160:698–702, 1992.
22. Bulletin of the Menninger Clinic: 10(3): May 1946.
23. Commemorative Issue of the Bulletin of the Menninger Clinic. May, 1946. Therapeutic Communities 17(2): Summer 1996.

24. Harrison T: Footnote p. 215, in Bion, Rickman, Foulkes and the Northfield Experiments. London, Jessica Kingsley Publications, 2000.
25. Jones M: The concept of a Therapeutic Community. American Journal of Psychiatry 112:8, 1956.
26. Briggs D: In the Navy. Therapeutic Community Experiment at the U.S. Naval Hospital, Oakland, California. Toddington, England, Planned Environment Therapy Trust, Archive and Study Centre, 2000.
27. Wilmer H: Social Psychiatry in Action: A Therapeutic Community. Springfield, IL, Charles C. Thomas, 1958.
28. Briggs D: A Life Well Lived. Maxwell Jones—A Memoir. London, Jessica Kingsley Publishers, 2002.
29. Main T: On the history of the Cassel Hospital. Therapeutic Communities 23(4):229–246, 2002.
30. Whiteley S: The Henderson Hospital. International Journal of Therapeutic Communities 1(1):38–58, 1980.
31. Rapoport R: Community as Doctor. London, Tavistock, 1960.
32. Jones M: Beyond the Therapeutic Community. Cambridge, MA: Yale University Press, 1968.
33. Morrice K: Basic concepts: A critical review, in Therapeutic Communities: Reflections and Progress. Edited by Hinshelwood R, Manning N. London, Routledge & Kegan Paul, 1960.
34. Haig R: The Ghost in the Machine: The Matrix in the Milieu. Proceedings of Windsor Conference on Therapeutic Communities, 1996.
35. Birch S, et al: Democratisation, reality confrontation, permissiveness and communalism. Themes or anachronisms? An examination of therapeutic agents using factor analysis. Therapeutic Communities 20(1):43–49, 1999.
36. Whiteley S, Collis M: The therapeutic factors in group psychotherapy applied to the Therapeutic Community. International Journal of Therapeutic Communities 18(1):27–37, 1987.
37. Bloch S, Crouch S: Therapeutic Factors in Group Psychotherapy. Oxford, Oxford University Press, 1999.
38. Whiteley S: Attachment, loss and the space between: Personality disorder in the Therapeutic Community. Group Analysis 27(4):359–387, 1994.
39. Winnicott D: Playing and Reality. London, Routledge, 1971.
40. Van der Linden P: How does the large group change the individual? International Journal of Therapeutic Communities, 9:1, 1988.
41. Clark DH: The Therapeutic Community—Concept, Practice and Future. British Journal of Psychiatry, 111:947–954, 1965.
42. Jones M: Beyond the Therapeutic Community. Cambridge, MA: Yale University Press, 1968.
43. Winnicot D: Some thoughts on the meaning of the word 'democracy.' Republished in Home is where we start from. Harmsworth, Pelican Books, 1986.
44. Kennard D: The Therapeutic Community Impulse: A recurring democratic tendency in troubled times. Changes 9(1):33–43, 1989.
45. Cox J: Reflections on contemporary community psychiatry: Where is the therapy? The 1st Maxwell Jones Memorial Lecture. Therapeutic Communities 19(1):3–10, 1998.
46. Clay J: Maconochie's Experiment. London, John Murray, 2001.

THE ART AND CHALLENGES OF LONG-TERM AND SHORT-TERM DEMOCRATIC THERAPEUTIC COMMUNITIES

Kingsley Norton, M.D., and Sandra L. Bloom, M.D.

This paper, cowritten by Kingsley Norton, since 1989 Director of Henderson Hospital (a therapeutic community founded by Maxwell Jones in 1947 in the United Kingdom), and Sandra Bloom, Founder of the Sanctuary Model in the United States, compares and contrasts the practice of the democratic therapeutic community (TC) as applied to the notion of long-term care (up to twelve months), to that of the democratic therapeutic milieu (TM) as applied to short-term care (up to one month).

Kingsley Norton, M.D., is Director, Henderson Hospital, Surrey, UK.

Sandra L. Bloom, M.D., is President, Community Works, Philadelphia, PA.

Address correspondence to Kingsley Norton, M.D., Clinical Director, Henderson Hospital, 2 Homeland Drive, Brighton Road, Surrey, SM2 5LT, United Kingdom; e-mail: kingsley.norton@swlstg-tr.nhs.uk.

THE CHALLENGES

Psychotherapy and Sociotherapy

The democratic therapeutic community (TC) represents the pooling of available human resources to facilitate the psychosocial maturation of its resident members—the clients (1). To achieve this ambitious aim requires equal attention to both the formal therapy programme (the psychotherapy) and the time in between (the sociotherapy)—the "other twenty-three hours" (2). Ideally, psychotherapy and sociotherapy complement one another (3).

Functioning effectively with (up to) twenty-nine clients in therapy at any one time in Henderson Hospital's democratic TC requires the pooled resources—eyes, ears and noses—of clients as well as staff members. The challenge for staff is to set up good communication networks within the TC so that what goes on during psychotherapy and sociotherapy interconnects.

Drawing on the TC and its underpinning ideology (4,5), principles can be identified that can be applied to a variety of target populations including various kinds of longer-term residential treatment programs for adults, children, substance abusers, group homes, many homeless shelters and domestic violence shelters (6,7). Democratic therapeutic milieus (TM) refer to settings that are shorter-term and more acute and include inpatient psychiatric settings for children and adults, day hospitals, and intensive outpatient programs. In the service of maximising the therapeutic potential of any setting, we argue that wherever and whenever people gather together in groups long enough to develop relationships and a group identity, the basic principles that underscore the therapeutic community can—and arguably must—be applied.

Staff and Clients—Collaboration Versus Confrontation

Both the democratic TC and TM comprise two main subsystems—the clients and the staff. To be effective, these two systems need to engage and harmonise, in spite of their inherent differences. Staff attempt to dismantle or more accurately to "flatten" the conventional hierarchy between themselves, both within and between the different disciplines (1). On the client side the opposite applies, i.e. there is a deliberate structuring of the clients into a hierarchy that is stable and predictable but also changing regularly (monthly), according to fixed rules, democratically applied (8,9). Clients at the top of their hierarchy liaise directly with the staff subsystem on behalf of their peers. The aim is both to strengthen

the bonds between clients (to maximise the positive influence of peer support and pressure) and to provide clients with experiences of being alternately on both sides of the power divide.

In the TM, the staff hierarchy must be flattened but only as much as is practicable, safely, to maintain the function of the program. Usually embedded within the medical model, and subject to all of the legal and accreditation pressures of the modern hospital setting, the typical top-down, doctor-to-nurse-to-other staff pyramid is not structurally changed but is continually modified according to everyday fluctuations related to individual and collective risk management, so that it becomes safe for staff to challenge authority figures and mutually supervise each other. Because of the constantly changing nature of the client population and their inherently unstable psychosocial state as a subsystem, any naturally democratizing influence within the client community is reinforced by staff to promote peer support and the positive use of peer pressure (10,11). At the same time staff act to ameliorate clients' tendencies to scapegoat, especially those of their peers who inhabit the margins of society (12).

Delegating Power Safely

The TC model represents an attempt to erode the traditional hierarchy existing between clients and staff, replacing this with a more collaborative and power-sharing relationship. When successful, the effect is to produce a more "equal" and symmetrical state of affairs. Each of the parties knows where it stands in relation to the other, in terms of role expectations and, importantly, also the limits of these. Achieving this reciprocity comes via the delegation to the clients of much of the authority conventionally invested in the professional role. In practice, power and authority is never truly relinquished by staff but "loaned" to clients under particular circumstances and conditions. So, if a client commits a serious criminal act or is at risk of serious violence (to self, property or others), this could trigger the medical, nursing and social work staff to regain immediately their formal roles as dictated by wider society in relation to risk assessment and management.

In the democratic TM, by comparison, power is usually not as devolved because the time it takes to socialize clients into a different kind of normative community is not available and because the make-up of the community is altering far more rapidly that in a TC. Nonetheless, the pursuit of daily life within the TM provides multiple opportunities for clients and staff to engage in dialogue about the uses and abuses of power as these are inevitably enacted in the treatment setting. This

is extremely important since most of the clients who enter treatment in either the TC or TM will have been exposed to the routine abuse of power and will not have acquired the skills (especially verbal skills) to use their own power in constructive ways.

Balancing Rights and Responsibilities

One effect of being treated (or indeed working) within this democratic TC model is to have assumptions and values about the delivery of healthcare challenged. In its operation, the TC is often far from the "medical model," which at its most extreme can imply that caring is an activity done *by* professionals *to* patients. Clients in a TC can expect to be cared for, but with this "right" come "responsibilities." Repeated failures to deliver on the latter mean that the client's place in the TC is potentially forfeit, as the result of a democratic vote by all clients and staff. This democratised treatment paradigm was defined at Henderson Hospital in the 1950s by a visiting team of social anthropologists led by Robert Rapoport (4), who coined the term "Community as Doctor" to denote the dispersal of the doctor's traditional authority to the collective whole and noted, among others, ideological themes of "democratisation" and "communalism" within the staff team. All members, staff as well as clients, are thus required to yield to the over-arching authority of the treatment model.

In the democratic TM, a heavy burden is placed on the staff to balance the demands of the "medical model" with the promotion of a more democratic and power-sharing environment. Acute settings often must contend with frequent crises and the rapid escalation of situations that can lead to violence, since frequently they cannot exert much selective influence on who is admitted. A crisis-focused environment may result, which can become increasingly hierarchical, controlling and autocratic, unless deliberate steps are taken by leaders and staff to restore power and authority to the collective whole immediately after each crisis or threat to milieu integrity (13). As a result, the expected "community" norms of shared power and responsibilities must be clearly articulated through spoken and written communications, constantly repeated via community meetings, and non-verbally reinforced via community rituals, artwork and signs (7,10).

Real Tasks and Real Relationships

Ideally, all activity in the TC and the TM is carried out in the spirit of collaboration using teamwork—communalism—both within and between

the staff and client subsystems. Each day has a predictably structured timetable of domestic, administrative and clinical events that really are required for the effective making of this particular environment (14). Both client and staff members therefore need to know what is planned and why. This important information is not simply the preserve of the professional subsystem. (Clearly, new clients have a less sophisticated knowledge than those further along. Crucially, knowledge passes from senior to junior client so that there is a "fast-tracking" new members to achieve what is a steep learning curve regarding the TC—the "letter" is absorbed much more quickly than the "spirit").

Structure and teamwork are equally important in the TM. But the difference between "senior" and "junior" clients in the TM may span days instead of weeks or months. Nonetheless, the mechanism of knowledge transmission from one peer to another remains of great value even in very short-term situations.

Clients are to expect many of the conditions that prevail in outside life to exist on the inside of the democratic TC. This is so that "normal" interpersonal and social situations are encountered, thereby potentially evoking clients' habitual, often destructive or self-destructive, responses. Only by encountering "social reality" (as opposed to a highly artificial environment) can the real problems and conflicts that clients experience as difficult to contain and articulate in outside life be authentically communicated. The challenge facing the TC and TM therefore is to effect this communication as safely as possible, through close attention to risk assessment and management, and to speed the translation of any physical "acting out" into its verbal equivalent. There is a range of structural elements in the TC designed for this purpose.

The rules represent one element. These include the proscribing of violence to self, others or property and the forbidding of alcohol or unprescribed/illicit drugs being taken or indeed brought into the TC. Even minor transgressions of these are taken seriously and dealt with swiftly by the TC. Transgressors potentially forfeit their place in the community and may be discharged or referred to another treatment setting. There is a limited tolerance of maladaptive behaviour and attitudes ("permissiveness"—another ideological theme of Rapoport) but only if there is a collective sense, as judged by the TC membership, that a member is authentically engaged in a therapeutic process or, at least, struggling to be so.

In a TM, the structural elements of the program are critically important in establishing clear social norms, the limits and boundaries of expectable behaviour and the expectable consequences when these are overstepped. However, the involuntary nature of admissions to many

acute inpatient settings limits the responses (e.g. grounds for discharge) that the program staff can use to express intolerance for maladaptive behaviour. Because this is the case, programs may underestimate (hence underutilise) the powerful influence of group pressure, even among a group of involuntarily committed patients. In acute settings, twice-daily community meetings added on to a rigorous group therapy regimen can be used effectively to de-escalate and contain episodes of rising tension and the spread of contagious negative affect among other members of the community (7).

Responses to Rule-Breaking

Within the democratic TC model, rule-breaking activity, its serious threat and untoward personal or interpersonal distress all dictate the convening of an emergency meeting. Everyone who is present in the community at the time comes together, at very short notice, to attend to the business that has threatened the psychological or physical safety of any of its members. In both the TC and TM, self-harm and, much less frequently, physical violence would be reasons for bringing the whole community together in an emergency session, regardless of the time of day or night. The matter is explored in order to manage the immediate risk posed, through identifying and offering appropriate support to provide containment. The aim is to enable the issues to be further explored within the formal treatment programme, i.e. the matter is not usually examined in depth outside of the formal therapeutic program, since appropriate resources are not then available to enable this to be achieved safely. Overall, the challenge is to facilitate the understanding of destructive or aggressive attitudes and behaviour neither simply condoning nor condemning (15).

   In a therapeutic community, unlike a short-term therapeutic milieu, the ultimate judges of premature discharge are (by virtue of their superior numbers), the client's peer group. Thus there is peer pressure to conform to the majority view. In a therapeutic milieu, by contrast, the rule-making and rule-breaking domain is managed largely by the staff. The entire community becomes involved in an episode, via community meetings, with the main goal of providing information, containment and a corrective emotional experience.

Validation and Internalisation

Those who, in their formative years, are unused to self-validating experiences, having been emotionally or physically neglected and abused,

find it hard to accept that they could be in a "new" (hence validating) relationship with others. They tend to deny or ignore the fact that these new others do take notice of them and are affected by their behaviour (positively and negatively). Such denial or ignorance thus tends to elicit both supportive and challenging responses. The latter can be harsh but the "other" is for the most part similar, i.e. similarly struggling with the same basic issues, hence there is also much accurate empathy (15). Repeated validating feedback, over the course of the year-long treatment, about the client's strengths as well as confrontation of weaknesses (often expressed via defensive and aggressive behaviour), can be internalised, leading to enduring change (16). Many clients find a place in such a system and a sense of belonging not previously experienced. As a result, leaving is hard to do. Therefore, just as there are separate structures to support joining there are those to support leaving, including attendance at a "transition group" which lasts for 6 months following discharge (17).

In a TM setting, the main form of validation is through an intensive psychoeducational experience that validates the client's past negative experiences and provides a conceptual framework for beginning to view themselves both as injured parties and also as parties who can participate actively in recovering from those injuries, rather than as solely "sick" or "bad" or "defective" individuals (10,11). Given the attenuated nature of the short-term stay, there is little time for the development of a mature therapeutic relationship. There is however time for an intensive and collaborative assessment of the client's situation, the development of short- and long-term treatment goals, and awareness of inhabiting a system (albeit temporarily) that provides a coherent and radically different cognitive framework for understanding what has happened to them and that might also imply a capacity for change (10,18).

Interaction, Exploration and Experimentation

Encountering the range of group meetings and real tasks that comprise the psycho- and sociotherapeutic programme of the TC entails the taking on and relinquishing of multiple roles, even throughout the course of a given day. In effect, this provides a relearning or resocialising opportunity—a "living-learning" experience (1). The aim is to focus attention both to current and past events in the client's life, in the service of delivering an improved adaptation in the future (19). This derives from an exploration (especially in the thrice-weekly small group) of the issues and problems, many of which were hitherto buried. A cycle of interaction (leading to the usual reactions emanating from the client's
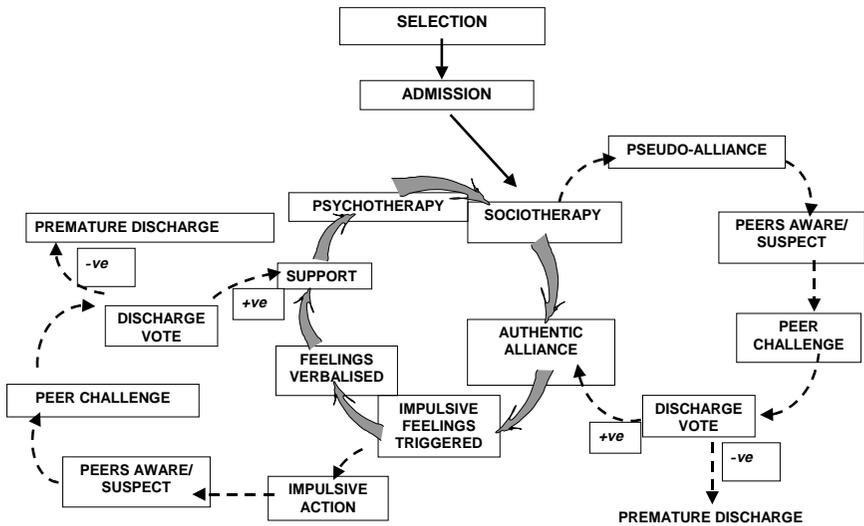
FIGURE 1. In-patient sociotherapeutic and psychotherapeutic processes.

past coping strategies and internal working models), exploration and experimentation (especially in psychodrama, art therapy, work groups and the social times in between groups) is set up (20) (Fig. 1).

In a TM, the pace of this interaction, exploration and experimentation may be significantly speeded up with two community meetings and several group therapy experiences each day, while the length of time that the person actually can stay in the setting may be only one week. It is not unusual, however, for patients to experience a number of inpatient admissions to the same setting and, with consistency of service delivery, the client can be enabled to build upon their social learning experience with every new admission.

Sustaining Countertransference Reactions

As Main has argued, the best patients are those whom the doctor has rescued from serious illness and who are grateful for such help (21). Departures from this straightforward type of clinical transaction increase the risk of personal disappointment and frustration for staff (22). This may be difficult to express openly, especially if there is a blaming of the patient for failing to recover (evoking guilt or shame in the professional) and/or a blaming culture of staff management. Clients diagnosed with personality disorders are renowned for their ambivalence about seeking

help and being helped and for their difficulties with engaging gratefully in relationships that might serve their healthy interests.

Dealing with disappointment with oneself or dislike of a client is a frequent and arduous part of TC work for staff involved with such clients. Staff members are often at odds with one another, for example, disagreeing about whether or not a given client is "doing well" or merits such labour-intensive treatment. Supporting these differences of opinions and their expression, during appropriate staff meetings, is a crucial aspect of the TC model. Facilitating such openness thus represents a key skill for those in senior clinical positions to acquire and exercise. Sustaining counter-transference reactions, often strong and usually negative, may be key to the success of the therapeutic process (23). Understanding the origins of these reactions, especially where they also find their complement in another member(s) of the staff team, can shed light on the internal world situation of the client (24). Overly positive countertransferences exist that can be equally as disabling professionally if not apprehended as such.

In the TC, to counteract any tendency to keep silent about such reactions, there is co-facilitation of therapy groups and "aftergroups," which follow each formal group meeting in the programme. This provides opportunities for dialogue about what has just occurred. In addition, there is formal weekly supervision. This, as with the weekly team awareness meeting that considers the impact of staff-staff relationships on treatment and vice versa, is convened by an external professional. Together, all of these structures help to maintain the staff team's objectivity, hence focus on appropriate clinical business. There is no individual therapy thereby minimising staff the possibility of isolation and potentially damaging "secrets."

The accelerated pace of a TM means that countertransference reactions will occur regularly but will often be conflated with the here-and-now pressures of the immediate situation. This necessitates the maintenance of a strong sense of teamwork, a network of mutual support and supervision, and frequent and open communication among staff members. Although group experiences are of primary importance in such a setting, individual attention is required at least at the level of case management, if not actual therapy, because discharge planning and dispositional challenges must be confronted from the time of admission.

Roles of Leaders

One of the TC leader's roles is to maintain the integrity, and preserve the meaning, of the above staff structures, to ensure that they do not

depart too far or too long from their intended purpose, for example, degenerating into interprofessional power struggles. This is easier said than done (25). Another role is to straddle the interface with the outside world, including those systems that fund and monitor the performance of the service. Janus-like qualities—a capacity of the Roman god to look forwards and backwards, inside and out, simultaneously—are important to acquire (26). More and more restrictive and risk-averse health service policies make democratic TC work harder to achieve and less rewarding for staff. Such policies are presented as being in the interests of the client—contributing to their safety and protection—but may be more about staff "covering their own backs."

These difficulties are especially relevant to the practice of the democratic TM and contribute significantly to the deterioration of many inpatient settings in the U.S. today. As leaders become pressured they tend to become more autocratic, sacrificing democratic decision-making for punitive control measures. Such reactions weigh heavily upon staff who frequently tend to vent their frustration on their clients (13). These pressures make it increasingly important for the leaders and staff to participate in democratic decision-making. As the level of complexity within any situation increases, the need for collaborative, calm, diverse and intelligent problem-solving logarithmically increases and can only be accomplished in an atmosphere that values mutual respect and open communication.

Outcomes

At any given moment, nobody ever knows for sure or can capture totally what is going on in the microcosm of society that is the TC or TM. Indeed, tolerating "not knowing" is a key skill for staff to acquire. However, evidence for this negatively-defined attribute is hard to gather reliably. "Not knowing" may be hard to distinguish from burnout and, behaviourally, indolence may masquerade as the required "masterly inactivity." In the absence of clear evidence on a daily basis that clinical progress is being achieved, knowing that staff activity and (masterly) inactivity is achieving its goals, it helps to have data regarding long-term benefits of treatment. Seventy per cent of those enduring the full course (approximately 50 per cent if those who leave prematurely are included) derive a variety of psychosocial gains (27–30). This TC programme has also been shown to be cost-beneficial (31). A thorough review of therapeutic community research is available in this issue (16).

There is some evidence that TM principles applied to the residential treatment of abused and neglected children using a trauma-sensitive

approach does have benefit, although much more research is required (32,33). In the application of TM principles to short-term treatment it is important to take a broader approach to the treatment of people with very complex problems. One short-term stay is unlikely to be sufficient and rehospitalization should not be labelled as "recidivism" or "treatment resistance" or "treatment failure." Instead, each admission should be viewed as a vital part of the continuum of care, particularly useful during times of crisis. The yardstick for measuring progress, rather than whether the person has needed treatment or not, should be whether the person has managed some improvement between admissions, improvement that can be built upon for the next step in recovery.

THE ART

So wherein lies the artistry? Well, there is a tendency for the hoped for harmony both between and within the two major subsystems of staff and clients to be lost or only briefly sustained. "Clashes" and other discordant outcomes appear on a daily basis. Some require little intervention from senior staff, while others need the combined might of all staff and clients to get the community back to singing from the same hymn sheet! The art of therapeutic containment lies in knowing when to intervene and when not. It is the skill of the "good enough" parent (34). It requires dedication and skill to deploy such sensitivity in the workplace to adult clients who suffer from personality disorders.

Too easily the "words" of the therapeutic model are remembered at the expense of the "tune" and this applies with equal relevance both to staff and clients. Too often, treatment programs claim to be using therapeutic community principles when they are failing to pay attention to the nature of the therapeutic culture. It is the culture, rather than the structure, which is decisive therapeutically (35). Those with leadership responsibilities within the TC thus must strive to remain attuned to the subtle shifts of tempo and pitch and to the multiple, at times competing and contradictory, voices within the TC and outside in the embedding systems' environment. Within a TM setting, artfulness is similarly practiced in the constantly changing harmonizing of staff and clients, a form of musical engagement more like jazz than a classical form. But regardless of the musical structure, all of the musicians—even when playing solos—must keep in mind their vital connection with the entire orchestra, that the whole is always greater than the sum of the parts (36).

REFERENCES

1. Jones M: Social Psychiatry: A Study of Therapeutic Communities. London, Tavistock Publications, 1952.
2. Norton K: Inpatient psychotherapy: Integrating the other 23 hours (Comment). Current Medical Literature 8(2):31–37, 1997.
3. Edelson M: Sociotherapy and Psychotherapy. Chicago, University of Chicago Press, 1970.
4. Rapoport R: Community as Doctor. London, Tavistock Publications, 1960.
5. Haigh R: The Quintessence of a Therapeutic Environment—Five Essential Qualities. London, Jessica Kingsley, 1999.
6. Kennard D: The therapeutic community as an adaptable treatment modality across different settings. Psychiatric Quarterly 75(3), in press.
7. Bloom SL, Bennington-Davis M, Farragher B, et al: Multiple opportunities for creating sanctuary. Psychiatric Quarterly 74(2):173–190, 2003.
8. Norton K: Personality disordered individuals: The Henderson Hospital model of treatment. Criminal Behaviour and Mental Health 2:180–191, 1992.
9. Norton K: A culture of enquiry: Its preservation or loss. International Journal of Therapeutic Communities 13(1):3–25, 1992.
10. Bloom SL: Creating Sanctuary: Toward the Evolution of Sane Societies. New York, Routledge, 1997.
11. Bloom SL: Creating Sanctuary: Healing from systematic abuses of power. Therapeutic Communities: The International Journal for Therapeutic and Supportive Organizations 21(2):67–91, 2000.
12. Roberts JP: Destructive processes in a therapeutic community. International Journal of Therapeutic Communities 1(3):159–170, 1980.
13. Bloom SL: There's an elephant in the room: The impact of trauma on individuals, institutions and societies. Psychotherapy and Politics International, in press.
14. Main T: The hospital as a therapeutic institution. Bulletin of the Menninger Clinic 10(3):66–70, 1946.
15. Norton K, Dolan B: Acting out and the institutional response. Journal of Forensic Psychiatry 6(2):317–332, 1995.
16. Lees J, Manning N, Rawling B: A culture of enquiry: Research evidence and the therapeutic community. Psychiatric Quarterly 75(3), in press.
17. Norton K: Joining and leaving: Processing separation, loss and re-attachment, in Therapeutic Communities: Past, Present and Future. Edited by Haigh R, Campling P. London, Jessica Kingsley, 1998.
18. Bloom SL: The Sanctuary Model: Developing generic inpatient programs for the treatment of psychological trauma, in Handbook of Post-Traumatic Therapy, A Practical Guide to Intervention, Treatment, and Research. Edited by Williams MB, Sommer JF, Westport, CT, Greenwood Publishing, 1994.
19. Whitely JS: Sociotherapy and psychotherapy in the treatment of personality disorder. Discussion paper. Journal of the Royal Society of Medicine 79:721–725, 1986.
20. Norton K, Vince J: Outpatient psychotherapy and mentally disordered offenders, in Care of the Mentally Disordered Offender in the Community. Edited by Buchanan A. Oxford, Oxford University Press, 2002.
21. Main T: The ailment. British Journal of Medical Psychology 30:129–145, 1957.
22. Norton K, Smith S: Problems with Patients: Managing Complicated Transactions. Cambridge, Cambridge University Press, 1994.

23. Gabbard GO: A contemporary perspective on psychoanalytically informed hospital treatment. Hospital and Community Psychiatry 39:1291–1295, 1988.
24. Davies R: The inter-disciplinary network and the internal world of the offender, in Forensic Psychotherapy. Edited by Cordess C, Cox M. London, Jessica Kingsley, 1995.
25. Smith S, Norton K: Counselling Skills for Doctors. London, Open University Press, 1999.
26. Norton K: The significance and importance of the Therapeutic Community working practice. International Journal of Therapeutic Communities 11(2):67–76, 1990.
27. Whitely JS: The response of psychopaths to a Therapeutic Community. British Journal of Psychiatry 116:517–529, 1970.
28. Copas JB, O'Brien M, Roberts JC, et al: Treatment outcome in personality disorder: The effect of social, psychological and behavioural variables. Personality and Individual Differences 5:565–573, 1984.
29. Dolan BM, Evans C, Wilton J: Therapeutic community treatment for personality disordered adults: Changes in neurotic symptomatology on follow-up. International Journal of Social Psychiatry 38(4):243–250, 1992.
30. Dolan B, Warren F, Norton K: Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder. British Journal of Psychiatry 171:274–279, 1997.
31. Dolan B, Warren F, Menzies D, et al: Cost-offset following specialist treatment of severe personality disorders. Psychiatric Bulletin 20(7):413–417, 1996.
32. Rivard JC, Bloom SL, Abramovitz RA, et al: Assessing the implementation and effects of a trauma-focused intervention for youths in residential treatment. Psychiatric Quarterly 74(2):137–154, 2003.
33. Rivard JC, McCorkle D, Duncan ME, et al: Implementing a trauma recovery framework for youths in residential treatment. Child and Adolescent Social Work, in press.
34. Winnicott DW: The use of an object and relating through identifications, in Playing and Reality. London, Tavistock Publications, 1971.
35. Main TF: The concept of the therapeutic community: Variations and vicissitudes, in The Evolution of Group Analysis. Edited by Pine M. London, Routledge & Kegan Paul, 1983.
36. Norton K: Henderson Hospital: Greater than the sum of its sub-groups. Groupwork, in press.

DEMOCRATIC DEVELOPMENT OF STANDARDS: THE COMMUNITY OF COMMUNITIES—A QUALITY NETWORK OF THERAPEUTIC COMMUNITIES

Rex Haigh, MRCPsych, and Sarah Tucker

As the inevitability of regulation and accountability dawned on the British Therapeutic Community movement at the end of the 1990s, a polarised debate took place. The product of that debate is now an action research based system of audit, with its principles and methods based on therapeutic community practice. This paper is written four years after the discussions started, and describes how the "Community of Communities" was conceived, what its methods are, some of the results from it first year of operation, and reflection about the nature of the process itself.

KEY WORDS: therapeutic community; milieu therapy; audit; quality assurance; standards; empowerment; service user involvement; democratization; institutional dynamics.

Rex Haigh, MRCPsych is Chair, Association of Therapeutic Communities.

Sarah Tucker is Project Manager, Community of Communities Project, Royal College of Psychiatrists Research Unit, London.

Address correspondence to Sarah Tucker, Project Manager, Royal College of Psychiatrists Research Unit, 6th Floor, 83 Victoria Street, London SW1H 0HW.

INTRODUCTION

Conceived in Conflict

In the wake of highly publicized medical negligence cases increasing public mistrust of professional autonomy led to a considerable pressure for higher standards of accountability and openness (1). This included close scrutiny of professional standards, extensive development of Governmental regulatory bodies and withdrawal of support for clinical practice which was not evidence-based.

In 1999, Association of Therapeutic Communities (ATC) approached one of the newly formed Governmental regulatory agencies, the "National Institute for Clinical Excellence" (NICE) (2), asking for guidance in developing an appropriate professional profile for therapeutic community practice. Their reply was to suggest we seek help from our professional bodies. ATC approached the Royal College of Psychiatrists Research Unit (CRU), who had experience in managing clinical quality networks, and were prepared to work with us in developing one based on therapeutic community practice, in both content and process. In 2000, the Chair of ATC, Rex Haigh, put a proposal to the membership in advance of the Annual General Meeting, that the Association should work with CRU to prepare a bid to fund "The Community of Communities" (3).

A Living-Learning Audit Cycle

The proposals emphasized the emancipatory and democratic way in which it should work: "a system of openness and accountability which adheres wholeheartedly to TC principles." In this way it would be able to take ideas such as Rapoport's four themes (4), the "culture of enquiry" (5) and the developmental model of therapeutic environments (6) out of a purely clinical domain, and apply them at the "organization of organizations" level. It was envisaged as an action research project which would identify and describe good practice, support communities who admitted to having problems, and provide a framework for progressive engagement and the development of a strong network of supportive relationships. It was felt important to be inclusive rather than exclusive, so as wide a range of input as possible was sought, in a way which recognized and valued the differences brought to the process by communities with different theoretical orientations, and which involved the users and ex-users of therapeutic community services in all its stages.

These ideas are well reflected in Rapoport's four themes. Permissiveness is the acceptance of communities that work in different ways; communalism is the building of trusting and open relationships between communities; democratization is the way in which the whole process is organized, run and "owned" by the communities themselves; reality confrontation is the understanding that practice will be scrutinized within and beyond the project, and consensually unacceptable practice will not be tolerated.

How Would the Community of Communities Have Teeth?

From the first debate onwards, there were differing views about the way in which the Community of Communities could have powers of enforcement, and the way in which that "consensually unacceptable practice" would be managed. This has been referred to as the problem of having teeth: the fears were that a process too soft would be ineffectual and not recognized beyond the TC movement; if too hard, it would be "yet another inspection" which members would find an unwanted burden. The project strategy is to take the helpful features from both ends of this spectrum, and minimize the drawbacks. A key phrase was that it is "a process of engagement, and not one of inspection," and the aim was to integrate it as a beneficial part of reflective practice. But, in direct parallel to a clinical community, change would be brought about through a judicious mixture of support and challenge, followed by reflection and action, with help from others whenever asked for. And if a community was not willing to engage in the process sufficiently to bring about agreed change, they would cease to be members. They would either leave because they found the process unhelpful or, in the limit, they could be asked to leave.

The other level at which the process could "have teeth" would be by linking it to the regulatory and inspection processes that are required of all public service and voluntary sector communities: the Commission for Health Improvement in the health service, the Correctional Services Accreditation Panel in the prison service and the National Care Standards Commission for TCs in the voluntary sector. In this way, recognition of a unit as a therapeutic community would come through participating in the project as part of the required audit processes of the larger organization of which they are a part. The ethos of the TC part of the audit would remain as a facilitative, discursive and nonjudgmental exercise, but it would be part of a larger process which itself had the "teeth." As one of the responses to the initial consultation suggested, the mechanism for doing this could be to work towards having a "kite

mark" standard which the Community of Communities could award to participating communities.

In these ways the project was designed to provide a distinctively therapeutic community-like framework for quality improvement, with a systematic but challenging and supportive forum for exchange, a democratically agreed and published "definition of TC-ness," and an organization which could relate to the external bodies developing wider regulatory structures.

Born in London

Throughout 2001, various consultation exercises were undertaken to draw up a first draft of standards which were sufficiently robust and meaningful to be acceptable to staff and service user members of all the therapeutic communities we could contact. On 26th October, the first "community meeting of the Community of Communities" was held, with 77 delegates representing 38 communities meeting for a day at Friends Meeting House in London, to hear about the project and have discussions about their various communities based on the draft standards. On 3rd December 2001 the project team heard from the Community Fund (which uses profits from the National Lottery to support "good causes") that its bid for funding was successful, and had been awarded £151,000 over a three year period. The first annual cycle took place in 2002, and the second is taking place throughout 2003.

METHODS

The network uses an annual review process that places an audit cycle within the context of a network of peer-review (Figure 1). Each year member therapeutic communities participate in an iterative process of reviewing their service against the Service Standards for Therapeutic Communities (7,8). Emphasis is placed on participation in self-reflection and dialogue with peers as a means of working towards change.

Agreeing the Standards

The standards are developed and agreed in consultation with members on an annual basis. This is a pivotal part of the annual process, for it is against these standards that member therapeutic communities are subsequently reviewed. The process of consultation provides
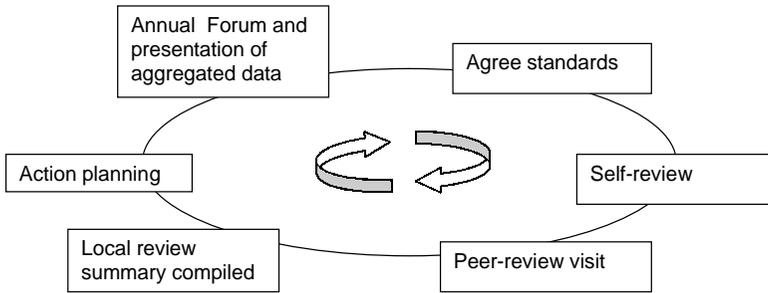
FIGURE 1. The annual review process.

member ownership of the standards. Annual consultation also ensures that the standards reflect contemporary therapeutic community practice, and that they document the ongoing revision of the statement of central elements of practice. This dynamic and iterative nature of the standards is a fundamental tenet of the approach of the Community of Communities.

The annual process has three parts: review of key documents, consultation, and editing. The review of documents in the production of the standards has drawn information and standards from a number of sources including those specifically for therapeutic communities (9–11) and some with more general relevance (12,13). The consultation process has two parts: The "Standards Working Group" and a postal consultation. The working group is a one-day workshop with task of revising the current standards, focusing on the therapeutic community ethos, categorization, clarity of the language and omissions. Staff and client members from participating member communities are invited to join the group, as well as other experts in the field.

On the basis of the written records of discussions the most recent edition of the standards is edited to provide a new consultation draft. This is circulated by post to all members who are asked to rate the standards as, "not important," "important" or "very important" to the quality of their community. Low rated standards were removed. Other editing criteria include ease of measurement; achievability and local adaptability.

Self-Review

The self-review questionnaire is a set of questions directly derived from the standards supplemented with exploratory items and arranged into

a workbook. It encourages open discussion of achievements and areas of difficulty. Members are asked to complete it prior to the peer-review with representation from both staff and client members. The question-naire initiates the process of reflection and enables members to become more familiar with the standards in preparation for the peer-review.

External Peer-Review: "Community Visits"

A peer-review tool is developed which consists of the completed self-review questionnaire and guiding questions based on the standards. Members are asked to prepare a timetable for the day and are offered a sample for guidance. The visiting peer-review team consists of a peer-review lead (from the Community of Communities team or Advisory Group), two staff members and two client members from the visiting community. The emphasis is on participation in open dialogue and ex-change about areas of achievement and areas of difficulty in relation to the standards. Action points are agreed in relation to the areas of dif-ficulty. While the peer-review provides the benefit of an external view-point, it importantly offers an opportunity for members form relation-ships, to openly discuss their community and ways in which they might wish to develop it.

Local Review Summaries

Each member receives a review summary based on information from the self-review and discussions taking place during the peer-review. For each main area of standards action points are recorded enabling the community to start action planning. Member communities and the peer-review team are sent consultation drafts for comments usually within one month of the peer-review. The review summaries are confidential and are intended to serve as a record of the review process.

Annual Members Forum

The first annual forum took place on 13th February 2003. It was well attended by over 80 staff and client members and provided a stimu-lating place for exchange between therapeutic communities. Following a presentation of selected key findings, participants divide in to small groups to discuss their experience of the review process and begin ac-tion planning. The plenary forum at the end of the day provides a space for members to participate in the planning of the process for the next

annual cycle and reflects the intention that this event should serve as the Community of Communities annual community meeting.

Annual Report

An annual report is written consisting of collated data in relation to each standard. This provides a way of "benchmarking," allowing communities to compare their activity with other members.

RESULTS

The Participating Communities

The 2002 self-review included 38 member communities, in mental health (residential and day, all for treatment of personality disorder), in prisons and in the voluntary sector. There was one overseas community: an acute psychiatric unit at a military base. Figure 2 shows the breakdown by sector and Figure 3 by predominant diagnosis. 20% only took members from a local area, 54% had national catchment and the rest were a mixture.
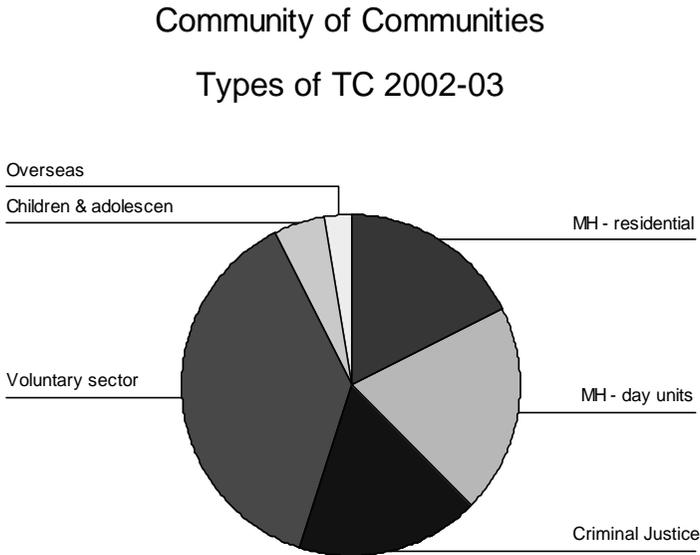
Community of Communities

Types of TC 2002-03

FIGURE 2. Types of communities involved.

Community of Communities
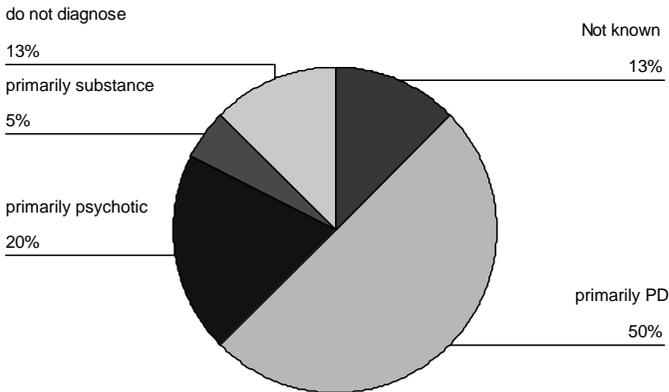
Diagnostic categories 2002-03

FIGURE 3. Diagnostic categories in communities involved.

What Happens in Therapeutic Communities?

Each community marked itself against the standards it felt relevant as "fully met," "partially met" or "not met." This gave a good idea of what actually happened in participating TCs. Using results from a sample of the 116 standards (to reflect a good spread across different themes, and to show a range of standards across the whole spectrum of adherence) three charts were prepared. Figure 4 shows a selection of standards which were marked as met or partially met in more than three quarters of communities; Figure 5 shows met or partially met in 65%–75% of them; Figure 6 in less than 65%.

  Those lacking physical facilities were short of toilets, kitchen and dining areas, and group therapy rooms. Some communities shared other facilities, such as for creative therapies, with other services. Those which were satisfied with their staffing levels commonly commented that the ethos of the community was for members to be responsible for the community. Understaffing was recognized as a problem at times of sickness, annual leave and training, and when the communities' changing needs could not be met.

  There was a range of practice in involving potential members in admission decisions, and communities frequently commented that
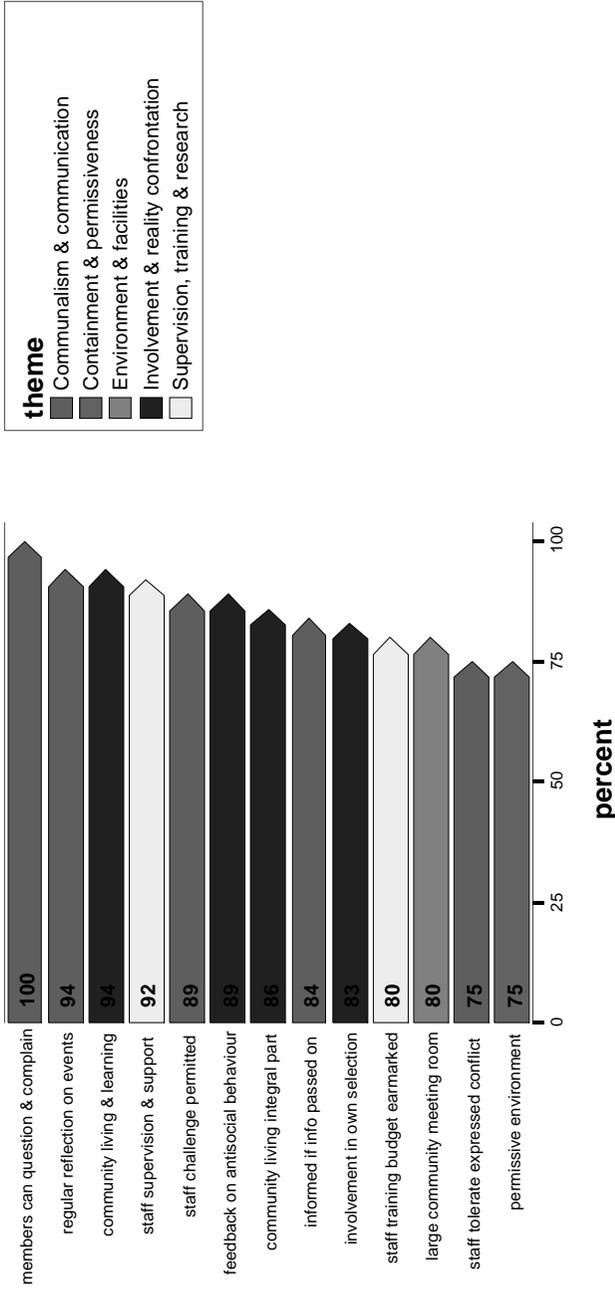
theme
- Communalism & communication
- Containment & permissiveness
- Environment & facilities
- Involvement & reality confrontation
- Supervision, training & research

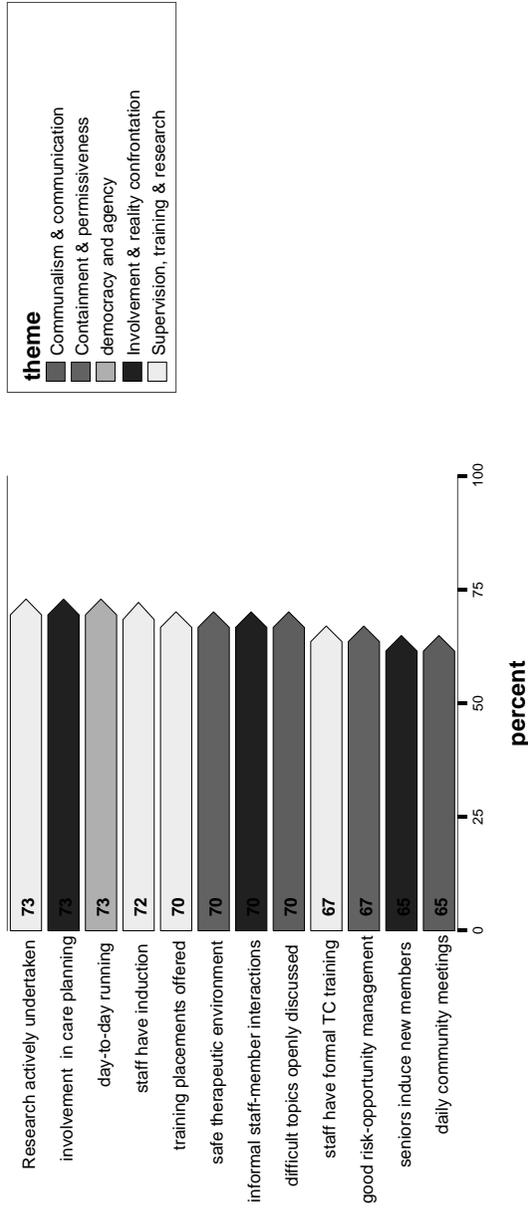| standard	percent
members can question & complain	100
regular reflection on events	94
community living & learning	94
staff supervision & support	92
staff challenge permitted	89
feedback on antisocial behaviour	89
community living integral part	86
informed if info passed on	84
involvement in own selection	83
staff training budget earmarked	80
large community meeting room	80
staff tolerate expressed conflict	75
permissive environment	75

percent

FIGURE 4. Standards met in more than 75% of participating communities.

FIGURE 5. Standards met in more than 65–75% of participating communities.
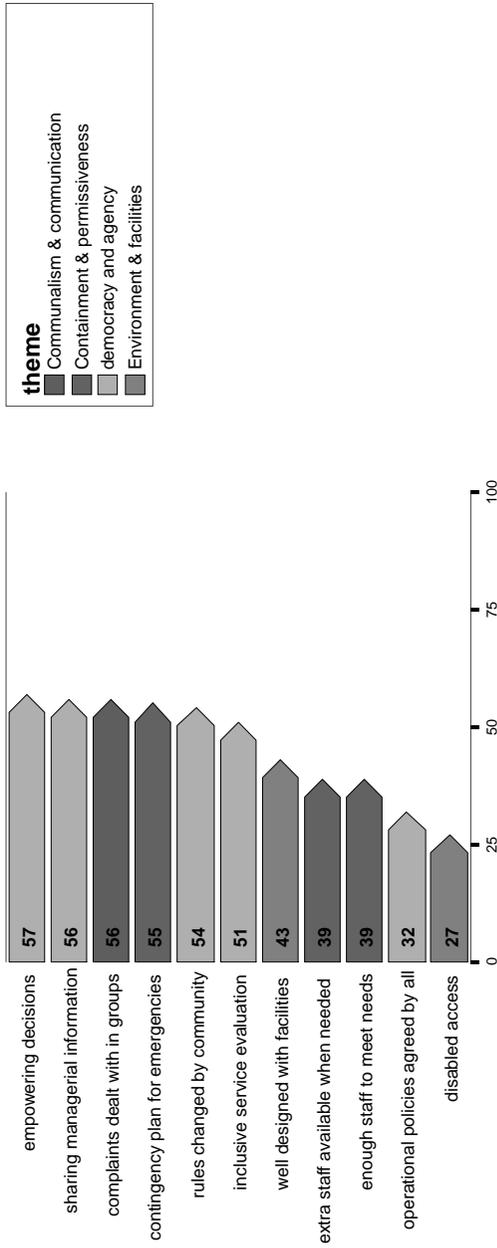
theme
■ Communalism & communication
■ Containment & permissiveness
□ democracy and agency
■ Environment & facilities

empowering decisions	57
sharing managerial information	56
complaints dealt with in groups	56
contingency plan for emergencies	55
rules changed by community	54
inclusive service evaluation	51
well designed with facilities	43
extra staff available when needed	39
enough staff to meet needs	39
operational policies agreed by all	32
disabled access	27

0   25   50   75   100

FIGURE 6. Standards met in less than 60% of participating communities.

planning for after members' leaving was an integral part of the programme. Disabled access was the standard most frequently not met. The communities that did not have daily community meetings generally had less frequent ones, or less formal meetings that were not designated as "community meetings." Informal contact between staff and members was said to vary between staff, and was somewhat restricted in some prison settings. It was commented that "everyone is everyone else's therapist."

The balance between support and challenge can be illustrated by examining the responses to four standards: whether positive feedback and supportive identifications were given (as support) and whether feedback on antisocial attitudes and impulsive and self-defeating behaviour was given (as challenges). Less than 1% of responses indicated that any of these standards were not net, with 82% of the supportive ones and 86% of the challenging ones fully met.

Some community reviews mentioned lack of guidance as to where queries and problems should be taken, and some uncertainty about when information is passed on. Comments were raised about the difficulties of managing the balance between risk and therapeutic opportunity, and how it is an aspiration towards which communities strive, and which often needs to be managed by staff. There was some feedback that staff did not bring relevant issues to community meetings, and that community meetings sometimes raised issues without resolving them.

Client member involvement in the day to day running of communities was sometimes restricted, for example including chairing of meetings but excluding shopping, cooking, and showing people around. A number of the units recognized that the Community of Communities was a way to undertake shared service evaluation. Limitation in availability of places to those who would be suitable was said to be due to service changes, waiting lists and lack of disabled access. Training places were offered in 70% of communities, and most commonly to nurses, social workers and junior psychiatrists.

Other Findings

Figure 7 shows staffing levels in different types of TC. In 67% of communities the standard for staff providing an emotionally safe environment is fully met (in the other 33% it is partially met), while only 44% respond positively to the standard "Is the number of staff sufficient to safely meet the needs of the client members at all times?" with 18% claiming it is not met at all.
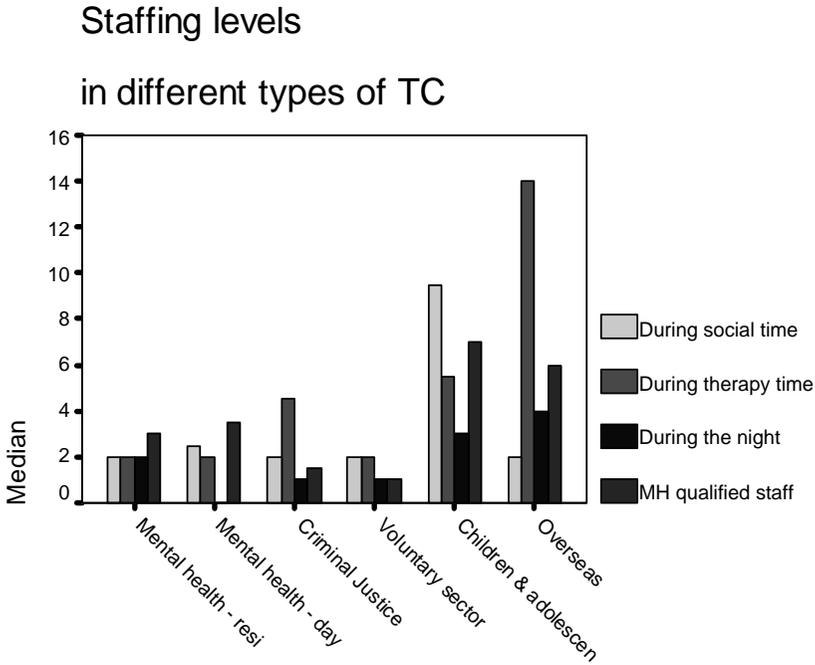
Staffing levels

in different types of TC

FIGURE 7. Staffing levels in participating communities.

Premature dropouts showed a wide range of variability: in one community more than two thirds were said to drop out, and the rest were evenly split between one third to two thirds, a tenth to a third, and no data. This is shown in Figure 8.

REFLECTIONS ON THE DYNAMIC PROCESS
OF THE COMMUNITY

The community has begun to function well in a number of ways. There has been a high level of participation by staff, clients and ex-clients of member therapeutic communities. These members have been involved in each of the stages of the annual cycle described, as well as in the Advisory Group. This meets quarterly and has 14 members including ex-client members and representatives from the NHS, Prison Service, Voluntary sector and children and young people's therapeutic communities. During peer-review visits a growing culture of trust has begun to emerge as is reflected by staff feedback.

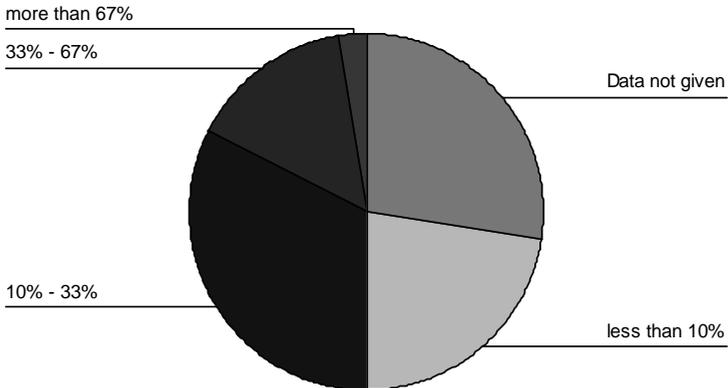## Community of Communities

Premature dropouts

FIGURE 8. Premature dropouts in participating communities.

Further, an ex-client member reflecting on the first Annual Members Forum commented that:

> *Instead of professionals coming together . . . there was a real sense of whole communities being involved, with staff, current and ex-community members sharing and discussing their experiences . . . It felt right, healthy, like a therapeutic community on a very large scale.*

REFERENCES

1. Smith R: All changed, changed utterly. BMJ 316:1917–1918, 1998.
2. Rawlins M: In pursuit of quality: The National Institute for Clinical Excellence. Lancet 353:1079–1082, 1999.
3. Haigh R: The Community of Communities. Association of Therapeutic Communities, 2000. Available from www.therapeuticcommunities.org/community-of-communities. htm.

4. Rapoport RN: Community as Doctor. London, Tavistock, 1959.
5. Main TF: The Ailment and Other Psychoanalytic Essays. London, Free Association Press, 1989.
6. Haigh R: The quintessence of a therapeutic environment, in Therapeutic Communities: Past Present and Future. Edited by Campling P, Haigh R. London, Jessica Kingsley, 1998.
7. Worrall A (Editor): Service Standards for Therapeutic Communities, 1st ed. London, Royal College of Psychiatrist's Research Unit, 2002.
8. Tucker S (Editor): Service Standards for Therapeutic Communities, 2nd ed. London, Royal College of Psychiatrist's Research Unit, 2003.
9. Kennard D, Lees J: A checklist of standards for democratic therapeutic communities. Therapeutic Communities 22:143–151, 2001.
10. Day L, Scanlon C, Worthington A, Tucker S, Palmer N: Criteria for the Accreditation of Training. Association of Therapeutic Communities, unpublished, 2001.
11. The Charterhouse Group: The Charterhouse Group Value Added Standards. London, The Charterhouse Group, 2001.
12. O'Herhily A (Editor): Service Standards for Quality Network for In-patient CAMHS, 1st ed. London, Royal College of Psychiatrist's Research Unit, 2001.
13. Worrall A (Editor): Structures and Strategies: Clinical Governance Support Service. London, Royal College of Psychiatrist's Research Unit, 1999.

A CULTURE OF ENQUIRY: RESEARCH EVIDENCE AND THE THERAPEUTIC COMMUNITY

Jan Lees, Nick Manning, Ph.D., and Barbara Rawlings, Ph.D.

This paper presents data from a systematic review and meta-analysis of 29 published studies of therapeutic community effectiveness using controls, including 8 randomised control trials. Meta-regressions suggest that the two types of therapeutic community, democratic and concept-based, and the age of the study, are the key sources of heterogeneity in the collection of studies analysed. Otherwise, heterogeneity is low and the meta-analysis confirms the effectiveness of therapeutic community treatment with overall summary log odds ratio for the 29 studies of -0.512 (95% ci -0.598 to -0.426).

KEY WORDS: systematic review; meta-analysis; therapeutic communities; effectiveness; evidence.

Jan Lees is Research Associate, Francis Dixon Lodge, Leicester, United Kingdom.

Nick Manning is a Professor of Social Policy and Sociology, University of Nottingham, United Kingdom.

Barbara Rawlings is Honorary Research Fellow, Department of Sociology, University of Manchester, United Kingdom.

Address correspondence to Jan Lees, School of Sociology and Social Policy, University of Nottingham, Nottingham, NG7 2RD, UK.

HISTORICAL ANTECEDENTS

The literature on therapeutic communities refers mainly to democratic psychiatric settings, originating in Britain during the second world war, or to concept-based houses, originating in the USA in the late 1950s. The early literature on British therapeutic communities was descriptive, usually single case studies, and penned by therapeutic community practitioners themselves, rather than impartial or rigorous evaluations (1–5); this sort of "practitioner research" continues today (6,7). The literature then moved to more sociological, anthropological studies of therapeutic communities, conducted by outsiders (8). Although more impartial, these studies were not always well received by practitioners (9), a negative reaction itself then studied by sociologists (10). However, Rapoport's study of the Henderson Hospital in England became recognised as a seminal text on democratic therapeutic communities, and some of it's classifications, for example the four "pillars" of democratisation, permissiveness, reality confrontation and communalism were regarded as criteria to be achieved and standards to maintain. These criteria have been reworked recently to fit in with contemporary democratic therapeutic community practice (11). Subsequently, there were some comparative, again sociological, studies (12), but more recently there has been a growing body of evaluative research in the UK on the effectiveness of the democratic therapeutic community, particularly in mental hospitals and prisons (13–19).

In the United States, a different type of therapeutic community—the "concept house"—emerged, with the founding of Synanon by Charles Dederich, and then Daytop Village, aimed at the treatment of drug addicts. Here again, the early literature was descriptive, but also anthropological and sociological, and mainly written by outsiders to the therapeutic community, more interested in organisational than practice issues (20,21). However, the focus of therapeutic community literature in the USA changed quite quickly, from the early 1970s, to concentrate on the evaluation of effectiveness as in De Leon's long series of evaluations of therapeutic community treatment for drug abusers (22,23). Although similar studies were carried out in some UK concept-based therapeutic communities (24,25), the trend for such work there did not continue. In the USA however, evaluation research became central to the therapeutic community movement in the community (23) and in prisons (26). The positive results demonstrated through these evaluation studies have played a large part in developing the therapeutic community into a major global player in the drug treatment field.

So, research on therapeutic communities generally has moved through a series of stages, beginning with the early descriptive, informative accounts of the therapeutic community pioneers, through the qualitative, ethnographic accounts of the early outside researchers, into the quantitative, evaluative studies of more recent times. In addition, therapeutic community research has become more sophisticated in terms of research designs and methodologies, and understanding of the complexity of the issues is greater. The questions "does it work?" and "who does it work for?" have become increasingly more urgent as funding has become more and more tied to results. The question "*how* does it work?" is still largely unanswered, since it is difficult to tease out the mechanisms at work inside such a complex and multi-faceted treatment as a therapeutic community. A current study in England and Scotland, sponsored by the Association of Therapeutic Communities, is partially directed at this latter question, as well as the former two—it involves a national comparative study of the effectiveness of 19 democratic, and 2 concept-based, therapeutic communities in treating people with personality disorders, in secure and nonsecure, residential and day, settings, and will use multilevel modelling to analyse the data (27). (A more detailed overview and description of therapeutic community research can be found in Lees (28)

METHODOLOGICAL ANTECEDENTS

In the research field generally, the medical model for the hierarchy of quality of research evidence has prevailed—with initially, the randomised controlled trial being seen as the most rigorous way of obtaining hard evidence of effectiveness, and latterly meta-analyses being viewed as the apex of research and evidence-based practice. In the UK, the National Health Service hierarchy of evidence, as stated in the National Service Framework for Mental Health, is:

- *Type I evidence*—at least one good systematic review, including at least one randomized controlled trial
- *Type II evidence*—at least one good randomised controlled trial
- *Type III evidence*—at least one well designed intervention study without randomization
- *Type IV evidence*—at least one well designed observational study
- *Type V evidence*—expert opinion, including the opinion of service users and carers

NATIONAL HEALTH SERVICE CENTRE FOR REVIEWS AND DISSEMINATION—SYSTEMATIC LITERATURE REVIEW

In 1997, the English Department of Health commissioned a systematic, international literature review of therapeutic community effectiveness, focussing primarily on in- and post-treatment outcome for people with personality disorders in democratic therapeutic communities in secure and nonsecure, psychiatric and other settings (29), but also including the relevant post-treatment and in-treatment outcome studies of the effectiveness of concept-based therapeutic communities, usually for substance abusers, and particularly those in secure settings. Concept-based therapeutic communities were included because of their powerful presence in the research literature on therapeutic community effectiveness, in general, but particularly in the United States of America, Canada, and other parts of the world.

Systematic reviews differ from other types of literature review, in that "they adhere to a strict scientific design in order to make them more comprehensive, to minimise the chance of bias, and so ensure their reliability. Rather than reflecting the views of the authors or being based on only a (possibly biased) selection of the published literature, they contain a comprehensive summary of the available evidence." (30).

FINDINGS FROM THE SYSTEMATIC LITERATURE REVIEW

The published literature search began with the Cochrane Library databases, to ensure no other similar review was being undertaken. Although there was no fixed start date for the searches, most of the research and effectiveness literature is post World War II (1946–1997). Citation searches were undertaken of a number of books on therapeutic communities, published between 1974 and 1997, and of the *International Journal of Therapeutic Communities/Therapeutic Communities*. Twenty six electronic databases were selected for inclusion in the review, and searched using predesigned search strategies, based on a preselected list of keywords (itemised in the review)—inevitably, these were the main source of information for this review. Hand-searches were also undertaken of a wide range of journals (both English- and foreign-language), and other relevant publications, including "grey literature." Visits were made to a number of key sites (libraries, therapeutic communities and the Internet).

These searches produced 8,160 book, conference and journal article references, which included very little "grey literature." While

considerable effort was made to include foreign-language references in the review, it was difficult to locate and gain access to these, and the preference of the majority of databases for English language journals, and a bias towards North American scholarship are factors recognised by researchers in the field of bibliometric analysis (31,32). Most references retrieved for the review are from the UK and USA, and most therapeutic communities identified are in the UK and USA. However, looking at the types of therapeutic community, the UK has produced more articles about the democratic therapeutic community than the USA, while referring to roughly the same number of therapeutic communities, whereas for the concept-based therapeutic community, the USA dominates the field, in terms of the number of articles and the number of therapeutic communities referred to, while, in turn, the articles about concept-based therapeutic communities are dominated by both a few concept-based therapeutic communities, such as "Stay'n out" and CREST (prison therapeutic communities), and by a few authors, such as DeLeon, Wexler, Inciardi and Condelli.

The 8,160 retrieved references were then catalogued by two members of the research team working independently, and according to predetermined inclusion/exclusion criteria, based both on the type of study design, and whether or not the study was evaluative, with an emphasis on post-treatment outcome studies (29, pp. 34–40). The team set an upper limit of 300 as workable, but in fact this level of sorting actually produced 294 references for the final review.

These 294 articles/books were scanned to ensure they were of sufficient quality to include in the final report, and/or that they included sufficient relevant information for data extraction. Those articles or books providing information on post-treatment or in-treatment outcome of therapeutic community treatment in secure or nonsecure democratic therapeutic community settings for people with personality disorders or mentally disordered offenders were selected for more in-depth analysis, together with those for secure concept-based therapeutic communities. These latter came to 113, of which 18 are review articles. The final number of studies included is less than the number of articles found, because some articles relate to different aspects of the same study. The overall spread of these studies is outlined in the review (29, p. 40).

The review then concentrated on the post-treatment outcome findings—there were 10 randomised controlled trial studies, 10 cross-institutional, cross-treatment or comparative studies, and a further 32 using some kind of control or comparison group. The latter were taken as the minimum level of rigour that is acceptable, which left a total of

52 acceptable studies, all of which are discussed in some detail in the review (29). Of these 52, 41 relate to democratic therapeutic communities, and 11 to concept-based therapeutic communities.

Although many of the findings are presented in narrative form, the review also provides a systematic meta-analysis of some of the studies, using odds ratios. Because of the quality of the data presented, and of the analyses of this data in the studies, the meta-analysis only included 29 studies in total, dated between 1960 and 1998, including 8 of the randomised controlled trials. Where there was a choice of outcome measures and control groups, emphasis was placed on conservative criteria, such as reconviction rates rather than psychological improvements, and on non-treated controls. The meta-analysis is discussed in more detail below.

META-ANALYSIS

Twenty-nine studies are included in the meta-analysis [see (29) for a list of these]. The standard way to combine these studies into a summary measure of the effectiveness of the treatment (the therapeutic community, in this case) is slightly more complex than simply adding up the number of studies "for and against." This is because the importance of each study varies, depending on: the size of each sample; the confidence intervals around each result; the size and direction of the result; and, most importantly, the extent to which there is systematic variation between the studies as a group—the "heterogeneity" of the whole collection of studies being considered. These factors are systematically taken into account by calculating the summary odds ratio of the group, and running a number of tests ("meta-regressions") to look for and account for any heterogeneity in the whole group. The summary odds ratio can be of two types–"fixed" or "random" effects—depending on the assumptions made about the representativeness of the study samples to the overall population.

The log odds ratio for each study is calculated by constructing a two by two table comparing the numbers of those with a successful outcome, and the rest, in the separate treatment and control groups in the study. A summary odds ratio combines the results of the whole group taking into account the variations in sample size, effects, and so on. This was calculated and the variance estimated for each of the 29 studies, using the Woolf method (the sum of the reciprocals of the cell counts (33)). For one study there was an observed zero, and 0.5 was added to each cell before performing the calculations. Figure 1 shows a
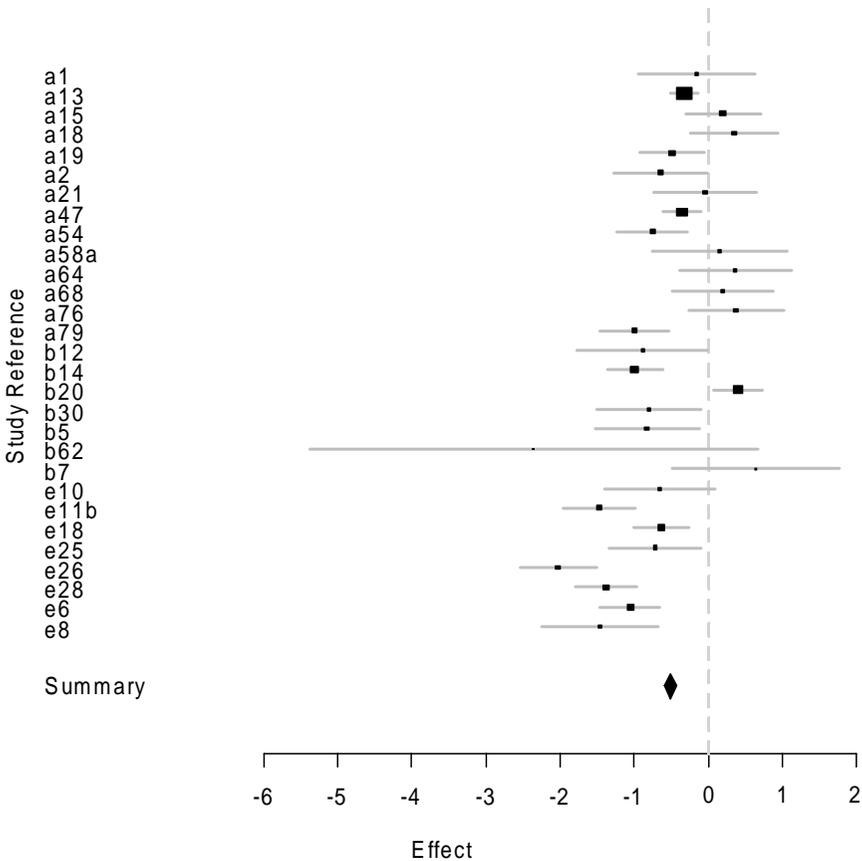
FIGURE 1. Forest plot.

"forest plot" of the study effects—each study is identified by the number [see (29) for references]. Each horizontal line represents the results of one trial; the shorter the line, the more certain the result, with the position of the black square indicating the odds ratio; the bigger the square, the more weight is given to the study, taking into account sample size, range of confidence intervals, etc.; the bottom diamond represents their combined results expressed in a summary odds ratio. The vertical line indicates the position around which the horizontal lines would cluster if the two treatments compared in the trials had similar effects; if a horizontal line touches the vertical line, it means that that particular trial found no clear difference between the treatments. The

position of the diamond to the left of the vertical line indicates that the treatment studied is beneficial. Horizontal lines or a diamond to the right of the line would show that the treatment did more harm than good. The overall summary log odds ratio is −0.512 (95% ci −0.598 to −0.426), which indicates a strong positive effect for therapeutic community treatment.

Meta-Regressions

Two key measures of the quality of any meta-analysis are: the extent to which the variation between the study results can be accounted for by factors other than the variable effectiveness of the treatment under study; and whether there is evidence that only "successful" results have been published—implying that there might be a hidden set of unpublished "unsuccessful" studies that, if included, might reduce the overall positive outcome. If there is large variation that cannot be accounted for, the implication is that the studies are too dissimilar to be combined— for example, they may not be using the same treatment method. In this particular case, there is some possibility of this, since therapeutic community treatment is multidimensional and complex, and may vary from one setting or time period to another. This is conventionally examined by looking at the extent and sources of heterogeneity (i.e. variation) between the studies. Tests can be done for both heterogeneity and publication bias through "meta-regression."

A "fixed effects" analysis of the log odds ratios, which does not assume they are representative of any wider population, revealed considerable heterogeneity ($\chi^2 = 170.2$ with 28 df) which is significant at any reasonable level. Rather than simply trying to accommodate this extra variance with a "random effects" model, it was suspected that the heterogeneity was caused by two factors: the combination of democratic and concept TCs in the group, and age of the studies—spread across 40 years. We therefore tried to account for it with various predictor variables in a set of "meta-regressions."

The following predictor variables were used: whether the study was a randomised controlled trial (RCT) or not (2 levels); whether the therapeutic community was a democratic or concept type, and if democratic, whether it was in a secure environment (e.g. prison) or not (all the concept-based therapeutic communities were in a secure environment) (thus a factor with 3 levels); year of publication (as a variate—in years since 1960, as the earliest study was in 1960); and the study precision (as a variate—measured by the standard error—to check for publication bias). Details of this modelling approach can be found in (34). We

TABLE 1
Effect Sizes from Model with Therapeutic Community Type

Effect	Log odds	SE
Intercept	−0.29	0.057
Secure, democratic	Reference category	
Non-secure, democratic	−0.04	0.122
Concept	−0.86	0.106

present a series of fixed effects meta-regressions using each predictor singly:

a) Whether the study was an RCT or not accounted for relatively little of the heterogeneity, $\chi^2 = 0.74$ with 1 df.

b) The therapeutic community type (democratic, concept, secure) accounted for much of the observed heterogeneity. Overall $\chi^2 = 70.2$ with 2 df. The effect sizes are shown in Table 1, indicating that while nonsecure therapeutic communities are slightly more effective than secure therapeutic communities, the key difference is that concept-based therapeutic communities are markedly more effective in this collection of studies than democratic therapeutic communities:

c) The year of publication also accounted for much of the heterogeneity, $\chi^2 = 42.6$ with 1 df. It is of course confounded with therapeutic community type, since the concept TC studies were in general published later than the democratic TC studies. The effect sizes are shown in Table 2, indicating that later studies have a stronger effect size by about 0.03 per year:

d) Figure 2 shows a "funnel plot" of the effect sizes, based on Egger et al (35). To check for publication bias, whereby negative outcomes had not been written up for publication, it is necessary to look for an uneven pattern, or gap, to the right hand side of the

TABLE 2
Effect Sizes from Model with Year of Publication

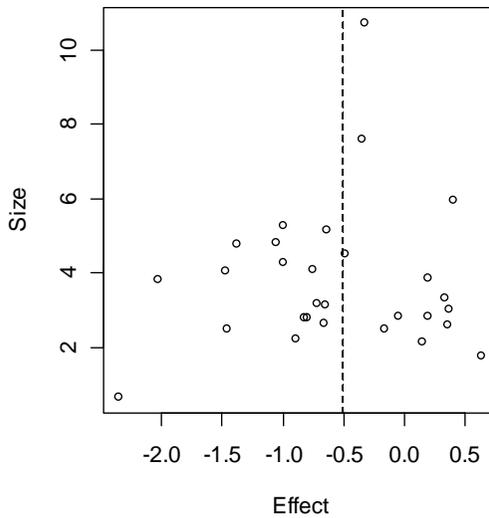| Effect	Log odds	SE
Intercept	0.30	0.132
Year of publication (per year)	−0.03	0.004

FIGURE 2. Funnel plot.

vertical dotted line, where those studies are "missing." Visually there do not seem to be any such gaps, and formal analysis using the standard error as a predictor (which is equivalent to the Egger method) shows that there is little evidence of publication bias, overall $\chi^2 = 1.52$ with 1 df.

In conclusion, the sources of heterogeneity are largely accounted for by the differences between types of therapeutic community, with concept-based studies being generally reported in recent years. Having an explicable account of this heterogeneity allows to conclude more confidently that the overall summary odds ratio generated by this set of studies does provide evidence for the effectiveness of therapeutic community treatment for personality disordered patients. This is Type I evidence, according to the UK National Service Framework for Mental Health—at least one good systematic review, including at least one randomised controlled trial.

DISCUSSION

Systematic literature reviews like this provide very useful information on an overview of therapeutic communities research literature, and are well respected as a research tool, particularly within the NHS in

Britain. The work involved in a systematic review of this kind is considerable. The number of potential sources of material, and possible studies for inclusion, was amplified by the wide scope of the review, since it included not merely high quality randomised controlled trials, but also the many descriptive studies that have been published over the years. This ensures the integrity of the final result. Lees et al (29) did not feel that any material, including "grey literature" and unpublished work, exists that was not found for this review. However, the review was commissioned with the assumption that there were very few, if any, high quality comparison studies or randomised controlled studies to find, but the broad remit to include descriptive studies probably might not have been given, had it been suspected that there were so many high quality research studies to include.

Lees et al (29) found several trends in terms of the general scope of the literature. Although there were studies from more than 30 countries, the best evaluations have come out of the USA in recent years, many of which are focussed on concept-based therapeutic communities. Democratic therapeutic communities are more common in Europe, where the most useful studies are typically older than those in the USA. The target treatment populations are people with addictions in the USA, and personality disorders in Europe. Personality disorder itself is a rapidly expanding psychiatric and forensic category, on the back of which there is now a resurgence of interest in and government funding for therapeutic communities, both democratic and concept-based, in the UK, which work with people with personality disorders. However, the definitions and meaning of 'personality disorder' have changed rapidly and dramatically over the last 25 years (36, p. 12), as has the name—from character disorder and psychopath. Reed has argued that these diverse meanings have undermined the effectiveness of treatment evaluation (37, p. 34); certainly these conceptual expansions make judgements about research reports difficult, particularly if they are more than 15 years old. Manning has presented sociological analyses of the way in which these definitions have changed (38,39). In addition, in Britain, the Mental Health Acts (1959, 1983) separated psychopathy from other conditions, defined it behaviourally, and presented a pessimistic view of treatment interventions, although this view is changing.

Several methodological conclusions are also highlighted in the review (29). The difficulties presented by the randomised controlled trials reported in the literature include treatment complexity, treatment dosage and treatment integrity, population selection, dropouts, effects decay, and diagnostic shifts. Fundamentally, the nature of the treatment and the nature of the disorder need to be clearly understood and articulated.

Evaluating the effectiveness of therapeutic communities depends crucially on a clear understanding of what the therapeutic community is, the setting (whether secure or nonsecure) in which it is delivered, and at which client groups it is aimed. These elements are all evidently contestable, both within a largely sympathetic literature, and within a smaller, hostile literature.

There is a further complication for the evaluation of therapeutic communities, in that members accepted for therapeutic community treatment are normally both self-selected (in terms of application to join) and community-selected (in terms of the whole community, not just staff or consultants). This means there is no independent decision that can guarantee referral and acceptance, and consequently randomisation is difficult to set up and sustain.

The definition of therapeutic communities has also been difficult. The two main types of therapeutic communities—democratic and concept-based—emerged from quite separate origins. For some writers, these were variations on a basically common theme (21), one dealing with deeper intrapsychic change and the other with initial behavioral control; for others they have nothing in common but the name (40); while more recently, De Leon has argued that, in North America at least, the early differences between the two main variants of the therapeutic community have receded (41, p. 91). In addition, democratic type therapeutic communities developed in prisons or secure settings are inevitably modified by the requirements of prison regulations concerning security and control.

Moreover, since one of the criteria identified above for the definition of a therapeutic community is that of self-identity, there is a difficulty over treatment integrity—how do we know that the self-identity of a particular programme is not erroneous; and what happens when therapeutic communities, as they have been known to do, go through periods of disruption, or sluggishness; how pure is the therapeutic community; and how representative is it of a therapeutic community treatment modality? This question about one point at which the treatment itself is compromised is raised by Clarke & Cornish (42) in their study of an English therapeutic community. These issues are currently being addressed in the UK by the Association of Therapeutic Communities' peer-review process, known as the Community of Communities (27).

Treatment in therapeutic communities takes time—typically around six to twelve months. This heightens the possibility that patients will leave prematurely. In fact, dropouts from therapeutic community treatments are commonplace, and present difficulties for research studies. The US literature on addiction therapeutic communities contains

numerous articles on such "splittees." In treatment terms, there is a clear association between in-treatment improvement and length of stay (43), leading to a concern with retaining patients in the program. In research, sustaining comparable dosage is an essential prerequisite for evaluation, which can be seriously compromised by dropouts.

Even if randomisation is achieved and treatment is successfully delivered and measured, the problem remains of identifying the point at which improvement should be measured. In penal research, it has been possible to follow up failures over quite long periods of time through the use of criminal records, for example for five years or more. However, many studies have looked at change while still in treatment, at the end of treatment, or at a year post-treatment. Clearly, given the likely effects of post-treatment experiences and effects, sustained effects over long periods even if smaller, may be more convincing than larger effects early on which are not sustained. The solution to this problem was felt to be the measurement of intermediate change during and soon after treatment, and the use of cross-institutional designs (see 27) to capture changes during treatment.

Although the difficulties of undertaking randomized controlled trials are widely appreciated, there is still a case for trying to undertake them for democratic therapeutic community treatment in the UK, since the most recent randomized controlled trials have been undertaken in the USA on concept-based therapeutic communities. The randomized controlled trial is undoubtedly a powerful design, where appropriate, and has in many respects become the gold standard for evidence-based medicine. The alternative, as Clarke & Cornish (42) argued, is a large scale cross-institutional study of therapeutic communities in the field, and such a study is now ongoing in the UK (see above, and 27).

CONCLUSION

In the past, therapeutic communities, at least in the UK, have been ambivalent about both the need for, and the usefulness of, research, and concerned about the impact of its execution on members of the therapeutic communities involved. Lees et al's systematic literature review concluded that therapeutic communities have not produced the level or quality of research literature that might have been expected, given the length of time they have been in existence, and the quality of staff known to exist in therapeutic communities. This may be due partly to a lack of emphasis placed on research in the early days of therapeutic community development, and more recently to a lack of

resources, in terms of finance, staff and adequate research methodologies, designs and instruments. However, these attitudes have changed in recent years. The medical model of research has come to dominate this field of activity, because the medical research emphasis on evidence-based practice, in a time of scarce resources and funding, has made it imperative for all treatments to prove their effectiveness and efficiency, in order to survive. This has meant that evaluative research has come to take primary importance. It is clear that therapeutic communities need more, and more good quality, and comparative, research in order to counter the charge that there is not a proven case that therapeutic communities are effective, and that they are expensive. There is clinical evidence that therapeutic communities produce changes in people's mental health and functioning, but this needs to be complemented by good quality qualitative and quantitative research studies.

Lees et al's (29) systematic review furnished a substantial number of studies of sufficient quality to undertake a meta-analysis. This analysis, taking careful account of sources of heterogeneity and possible publication bias, shows a clear and positive treatment effect for therapeutic communities.

Lees et al concluded that future research on the effectiveness of therapeutic communities should include further randomised controlled trials. However, these have to overcome the difficulties posed by therapeutic communities controlling their own intake, and the multidimensional and volatile nature of the treatment intervention. Future research should also include more complex, cross-institutional studies in the field, together with further cost-offset studies to complement those few already developed (29).

REFERENCES

1. Jones M: Social Psychiatry. London, Tavistock, 1952.
2. Bion WR: Experiences in Groups. London, Tavistock, 1960.
3. Foulkes SR: Introduction to Group Analytic Psychotherapy. London, Heinemann, 1948.
4. Main T: The Hospital as a Therapeutic Institution. Bulletin of the Menninger Clinic 10:66–70, 1946. (Reprinted in Therapeutic Communities 17(2):77–80).
5. Harrison T: Bion, Rickman, Foulkes and the Northfield Experiments. Advancing on a Different Front. London, Jessica Kingsley, 2000.
6. Black T: Sound and fury: Grief and despair in the large group, in Therapeutic Communities: Past, Present and Future. Edited by Campling P, Haigh R. London, Jessica Kingsley, 1999. pp. 107–115.
7. Coombe P: Glimpses of a Cassel Hospital Outpatient Group. Australian and New Zealand Journal of Psychiatry 29:309–315, 1995.

8. Rapoport RN: Community as Doctor. London, Tavistock, 1960.

9. Jones M: Beyond the Therapeutic Community. New Haven, Yale University Press, 1968.

10. Rapoport RN, Manning N: Rejection and re-incorporation: A case study in social research utilisation. Social Science and Medicine 10:458–468, 1976.

11. Haigh R: The quintessence of a therapeutic environment: Five universal qualities, in Therapeutic Communities. Past, Present and Future. Edited by Campling P, Haigh R. London, Jessica Kingsley, 1999, pp. 246–257.

12. Bloor MJ, McKeganey NP, Fonkert JD: One Foot in Eden. London, Routledge, 1988.

13. Chiesa M, Fonagy P: Cassel personality disorder study: Methodology and treatment effects. British Journal of Psychiatry 176:485–491, 2000.

14. Chiesa M, Iacoponi E, Morris M: Changes in health service utilization by patients with severe personality disorders before and after inpatient psychosocial treatment. British Journal of Psychotherapy 12(4):501–512, 1996.

15. Cullen E: Grendon: The therapeutic prison that works Therapeutic Communities 15(4)301–311, 1994.

16. Marshall P: A Reconviction Study of HMP Grendon Therapeutic Community (Research findings no. 53). London, Home Office Research and Statistics Directorate, 1997.

17. Newton M: Changes in Test Scores During Treatment at Grendon. Research and Development Unit, Grendon Underwood. Bucks, UK, HMP Springhill and Grendon, Unpublished research paper, 1997.

18. Shine J: A Compilation of Grendon Research. Aylesbury, UK, HMP Grendon, 2000.

19. Warren F, Dolan B: Perspectives on Henderson Hospital, 2nd ed. Sutton, Surrey, Henderson Hospital, 2001.

20. Yablonsky L: Synanon: The Tunnel Back. New York, Macmillan, 1965.

21. Sugarman B: Daytop Village: A Therapeutic Community. New York, Holt, Rinehart and Winston, 1974.

22. De Leon G: The Phoenix House Therapeutic Community: Changes in psychopathological signs. Archives of General Psychiatry 28:131–135, 1973.

23. De Leon G: Residential Therapeutic Communities in the Mainstream: Diversity and issues. Journal of Psychoactive Drugs 27:(1):3–15, 1994.

24. Ogbourne AC, Melotte C: An evaluation of a Therapeutic Community for former drug users. British Journal of Addiction 72(1)75–82, 1977.

25. Wilson S, Mandelbrote B: The relationship between duration of treatment in a therapeutic community for drug abusers and subsequent criminality. British Journal of Psychiatry 132:487–491, 1978.

26. Wexler H: Therapeutic Communities in American prisons, in Therapeutic Community for Offenders. Edited by Cullen E, Jones L, Woodward R. Chichester, Wiley, 1997.

27. Lees J: Practice evaluation of Therapeutic Communities, in A Culture of Enquiry. Research Evidence and the Therapeutic Community. Edited by Lees J, Manning N, Menzies D, Morant N. London, Jessica Kingsley, 2004, pp. 76–90.

28. Lees J: 'Research. The Importance of Asking Questions,' in Therapeutic Communities. Past, Present and Future. Edited by Campling P, Haigh R. London, Jessica Kingsley, 1999, pp. 207–222.

29. Lees J, Manning N, Rawlings B: Therapeutic Community Effectiveness: A Systematic International Review of Therapeutic Community Treatment for People with Personality Disorders and Mentally Disordered Offenders (CRD Report no. 17). York, NHS Centre for Reviews and Dissemination, University of York, 1999.

30. CRD (Centre for Reviews and Dissemination): Undertaking Systematic reviews of Research on Effectiveness (CRD Report no. 4). York, University of York, 1996.
31. Artus HM: Science indicators derived from databases. Scientometrics 37:297–311, 1996.
32. Seglen PO: Why the impact factor of journals should not be used for evaluating research. British Medical Journal 314:498–502, 1997.
33. Kahn HA, Sempos CT: Statistical Methods in Epidemiology. Oxford, Oxford University Press, 1989.
34. Thompson SG, Sharp SJ: Explaining heterogeneity in meta-analysis: A comparison of methods. Statistics in Medicine 18:2693–2708, 1999.
35. Egger M, Davey Smith G, Schneider M, Minder C: Bias in meta-analysis detected by a simple, graphical test. British Medical Journal 315:629–634, 1997.
36. Gunderson JG: Building structure for the borderline construct. Acta Psychiatrica Scandinavica 89(suppl. 379):12–18, 1994.
37. DoH/HO: Report of the Department of Health/Home Office working group on psychopathic disorder. London, HMSO, 1994.
38. Manning N: Psychiatric diagnosis under conditions of uncertainty: Personality disorder, science, and professional legitimacy. Sociology of Health and Illness 22(5):621–639, 2000.
39. Manning N: Actor-networks, policy networks and personality disorder. Sociology of Health and Illness 24(5):644–666, 2002.
40. Glaser AN: Therapeutic communities and therapeutic communities: A personal perspective. International Journal of Therapeutic Communities 4(2)150–162, 1983.
41. De Leon G: The research context for therapeutic communities in the USA, in A Culture of Enquiry. Research Evidence and the Therapeutic Community. Edited by Lees J, Manning N, Menzies D, Morant N. London, Jessica Kingsley, 2004, pp. 91–108.
42. Clarke RVG, Cornish DB: The Controlled Trial in Institutional Research—paradigm or pitfall for penal evaluators. London, HMSO, 1972.
43. Nieminen P: Therapeutic community research and statistical data analysis. Acta Universitatis Ouluensis Medica, Oulu: University of Oulu Printing Center, 1996.

THE THERAPEUTIC COMMUNITY AS AN ADAPTABLE TREATMENT MODALITY ACROSS DIFFERENT SETTINGS

David Kennard

Simple core statements of the therapeutic community as a treatment modality are given, including a "living-learning situation" and "culture of enquiry." Applications are described in work with children and adolescents, chronic and acute psychoses, offenders, and learning disabilities. In each area the evolution of different therapeutic community models is outlined. In work with young people the work of Homer Lane and David Wills is highlighted. For long term psychosis services, the early influence of "moral treatment" is linked to the revitalisation of asylums and the creation of community based facilities; acute psychosis services have been have been run as therapeutic communities in both hospital wards and as alternatives to hospitalisation. Applications in prison are illustrated through an account of Grendon prison. The paper also outlines the geographical spread of therapeutic communities across many countries.

KEY WORDS: therapeutic communities; children; psychosis; prison; learning disability.

The author is Head of Psychological Services, The Retreat, York, England. Address correspondence to David Kennard, The Retreat, York, YO10 5BN, United Kingdom; e-mail: dkennard@ntlworld.com.

This is a paper about different adaptations of the basic therapeutic community idea. A detailed account of the principles and practice of therapeutic communities associated with the work of Maxwell Jones (1) and Tom Main (2) is given elsewhere. For our purpose it may help to have in mind a few simple core statements that mark out the common ground of this treatment modality, but which allow for the variations found in applications in different settings and with different populations.

- "What distinguishes a therapeutic community from other comparable treatment centres is the way in which the institution's total resources, staff, patients, and their relatives, are self-consciously pooled in furthering treatment. That implies, above all, a change in the usual status of patients" (1, pp. 85–86).
- The therapeutic community is a "living-learning situation" where everything that happens between members (staff and patients) in the course of living and working together, in particular when a crisis occurs, is used as a learning opportunity.
- Permissiveness is one of the four principles identified by Rapoport (3) and is perhaps the most central of the four: that all members should tolerate from one another a wide degree of behaviour that might be distressing or seem deviant by ordinary standards.
- There is a "culture of enquiry," a phrase that highlights the need not only for efficient structures but for a basic culture among the staff of "honest enquiry into difficulty," and a conscious effort to identify and challenge dogmatic assertions or accepted wisdoms.
- The basic mechanism of change can be described as this: the therapeutic community provides a wide range of life-like situations in which the difficulties a member has experienced in their relations with others outside are reexperienced and reenacted, with regular opportunities—in groups, community meetings, everyday relationships and, in some communities, individual psychotherapy—to examine and learn from these difficulties. The daily life of the therapeutic community provides opportunities to try out new learning about ways of dealing with difficulties.

CHILDREN AND ADOLESCENTS

Therapeutic communities for children and young people go back at least 90 years, to the founding of the Little Commonwealth by Homer Lane in 1913. Lane was an American who had experience as an educator at the George Junior Republic, a reformatory system developed in the

United States, and was invited to advise on the setting up of a home for delinquent adolescents in Dorset in south west England. For 5 years the Little Commonwealth housed around 50 youngsters, mostly aged 14–19, who participated in a carefully structured system of shared responsibility. Lane wrote that

> the chief point of difference between the Commonwealth and other reformatories and schools is that in the Commonwealth there are no rules and regulations except those made by the boys and girls themselves. All those who are fourteen years of age and over are citizens, having joint responsibility for the regulation of their lives by the laws and judicial machinery organized and developed by themselves. The adult element studiously avoids any assumption of authority in the community, except in connection with their duties as teachers or as supervisors of labour. (The individual and the whole community are free) to make mistakes, to test for themselves the value of every law and the necessity for every restraint imposed on them (4).

This remarkable venture ran for 5 years but came to a premature end after two young female "citizens" claimed that Lane, who had become an enthusiastic proponent of psychoanalysis and was attempting to apply it in the community, had immoral relations with them. However his innovative work inspired the educational pioneer A S Neill who founded Summerhill, and who in turn influenced the whole progressive school movement.

The term therapeutic community was not applied directly to residential work with children until the 1960s. However from the 1920s onwards a number of residential schools and projects for seriously disturbed or "unschoolable" children, which had many of the key features of therapeutic communities, were created by charismatic figures. These included Leila Rendell (Caldecott Community), George Lyward (Finchden Manor), Otto Shaw (Red Hill School), John Aitkenhead (Kilquhanity School), and the hugely influential Marjorie Franklin and David Wills, whose 1930s Hawkspur Camp laid the foundation for Planned Environment Therapy, described by Kasinski (5) as "probably the first unified model for the therapeutic community work with young people."

In his recent review of the history of therapeutic communities for young people, Kasinski (5) writes that "Planned Environment Therapy proposed that the child's social needs could be addressed through the experience of shared responsibility within the community; their emotional needs through attention to relationships with staff members and through individual psychotherapy; and their educational needs through measures designed to increase motivation for learning such as voluntary lesions and an emphasis on creative work."

Wills shared Lane's belief in the therapeutic value of love combined with shared responsibility. Love in this context meant that no matter how repelling a child's appearance, habits or disposition he or she was seen as basically worthy of esteem and affection, and punishment was never to be used to inflict hurt or humiliation. Unlike Lane, Wills separated the environmental and the psychoanalytic aspects of the therapeutic work, thereby creating a more contained and sustainable way of working. For many establishments this became the accepted model, while others developed a model that used the relationships within the large group as the therapeutic focus

Therapeutic communities today can draw on the full range of knowledge and theories available about emotionally deprived and abused children from Winnicott, Rutter, Alvarez, Bowlby and Bettelheim, as well as the models for adult therapeutic communities. They have developed ways of working that aim to provide the vital balance between the need for care and the need for control, between offering love and affection and setting limits. A recent issue of the journal *Therapeutic Communities* was devoted to papers on this topic. Rollinson, director of the Mulberry Bush School, described this as "*real living* and learning in the therapeutic community (where) so much of the work is in the "living alongside" the children, focussing on helping individuals and groups to learn to live with themselves and increasingly with one another" (6). The publication in 2003 of *Therapeutic Communities for Children and Adolescents* (7) provides further indication of the current conceptual and practical activity in this field in the UK, where The Charterhouse Group of Therapeutic Communities also has an informative website at www.charterhousegroup.org.uk.

THE THERAPEUTIC COMMUNITY APPROACH FOR PEOPLE WITH LONG-TERM PSYCHOSIS

The application of therapeutic community principles to work with the chronic mentally ill is in many ways the closest version of the therapeutic community modality to one of its most important predecessors, Moral Treatment. This was the term used to describe a model of care first developed in 1796 by the Quaker William Tuke at The Retreat in York. In keeping with Quaker ideology, the mentally ill were accorded the status of equal human beings to be treated with gentleness, humanity and respect. This was quite revolutionary at the time, and The Retreat also gave priority to the value of personal relationships as a healing

influence, to the importance of useful occupation, and to the quality of the physical environment (8,9). Much of this early vision of a humane treatment for mental illness was lost as the 19th century progressed and the mentally ill were housed in increasingly large and impersonal asylums. Although the first half of the 20th century saw some attempts to humanize these institutions, it was not until the 1950s that the zeitgeist for the mentally ill began to change. Factors which can be seen to have contributed to this included the founding of the English National Health Service, the emergence of sociological studies of the toxic nature of large institutions, and the (re)discovery of a humane and egalitarian model of care in the shape of the therapeutic community experiments during and following the second world war.

Right from its early days Maxwell Jones' experiment at Belmont Hospital, just outside London, attracted the interest of psychiatrists in England and around the world. This way of running a hospital that gave equal status to the views of staff and patients, that encouraged patients to take the decisions about things that affect their daily lives, that gave responsibility to patients for many aspects of ward activities, appealed to psychiatrists faced with large hospitals filled with people living totally dependent, featureless lives in drab, overcrowded wards. Jones inspired them to think that when Boston psychiatrist Bockoven described "the heavy atmosphere of hundreds of people doing nothing and showing interest in nothing" in American hospital wards in the 1950s (10), it did not have to be this way. The concepts of "institutional neurosis" (11) and "total institution" (12) were emerging, and Europe and America were ready for a revitalization of the institutions that formed the core of mental health provision. One of the things noted elsewhere (13) is that the therapeutic community approach often seems to be embraced when a county is going through democratising changes: England at the time of the NHS forming, Israel in its formative years, Cuba in the early years of the revolution, Italy in the years following its heroic hospital closure legislation. It isn't easy to overcome the inertia Bockoven found. It takes a charismatic and determined leader, and the following wind of a culture change.

In its early days the therapeutic community approach was very much about changing organizations in the way vividly described by Clark (14,15). Staff who for decades had managed patients with a mixture of control and protectiveness, and sometimes abuse, and who had run the institution in ways that suited their own convenience, were suddenly asked to give patients responsibility, to consider the social and personal needs of patients and how these could be met, and to adjust their work

patterns to meet the needs of the patients. Anyone who has tried this knows the time and tenacity and politicking it requires, but also if they see it through, the satisfaction of seeing institutionalised patients gradually blossom and in many cases leave hospital for independent or sheltered accommodation and a life in society. These were often the patients who were no longer ill or could now have their symptoms controlled by the newer medications, and whose continued hospitalisation was due at least partly to a loss of the skills and confidence to manage their own lives. However as these patients left hospital, those who remained were those whom today are sometimes referred to as the "difficult to place," whose combination of treatment resistant symptoms and difficult personalities keep them in need of 24-hour care. Thus although the crusading aspect of the therapeutic community approach to chronic mental illness is relevant where total institutions are still found, today there are other important applications in community-based housing projects for the long term mentally ill, and the work of community mental health teams.

Small domestic households of between 5 and 12 residents live with staff support (either 24 hour or office hours depending on the level of need). For people with more integrated or recovered psychoses there are regular community meetings, service users help to draw up and review their own care plans and those of their fellow residents, and help in running the household. Where an individual's symptoms prevent him or her from being actively involved, staff adopt a psychoanalytically informed style of "working alongside" the resident, carefully facilitating a degree of involvement through the relationship, seeking to avoid the twin defaults of leaving the resident isolated or doing things "for" the resident. (16)

For the difficult to place patient Shepherd (17) has described the concept of the "ward in a house," which is closer to the original model of Moral Treatment, and aims to combine the best features of hospital care and community-based residential care (18).

Although the therapeutic community is primarily a modality of residential or daytime living environments, it has also been identified as an appropriate perspective for all community-based services. The emphasis on respect for the individual, the recognition that service users have therapeutic skills, the importance of a containing environment and awareness of the potential for splitting within teams and organizations have been noted as some of the contributions that the therapeutic community approach can make to the work of community mental health teams (19,20).

ACUTE MENTAL HEALTH PROBLEMS

Although therapeutic communities grew out of work with people with long term problems in their patterns of behaviour and relationships, they have also been developed in a number of countries for people suffering from acute or first onset psychoses, including England, Switzerland, Finland and the United States. These have included both hospital admission wards and alternatives to conventional psychiatric services.

In England a small number of psychiatrists used the opportunities created by the National Health Service to make over whole mental hospitals, including their admission wards. These included Fulbourn Hospital in Cambridge, where Pullen developed a therapeutic community admission ward with an average length of stay of 17 days (21) and Littlemore Hospital in Oxford where Mandelbrote developed the Phoenix Unit as its acute admission ward (22). These and similar units adapted the core values of shared responsibility and democratised decision making to meet the needs and capacities of this client group, but maintained the practice of open communication, information sharing, informal relationships and, most importantly, staff self-examination within a culture of enquiry.

In an acute psychiatric ward the therapeutic community is not the primary agent of change but creates a structure and atmosphere which can greatly enhance the quality of care in a number of ways:

- In a busy ward some patients may get overlooked. Daily community meetings ensure that every patient is noticed and given some thought, even if they don't attend, because someone will ask where they are.
- The community meeting encourages patients to be aware of and taken an interest in others, with mutual sharing of experiences and giving and receiving information and feedback.
- There can also be groups to help with particular needs e.g. coping with positive and negative symptoms of psychosis; assertiveness and confidence building; cognitive therapy for depression; relaxation training.

The general ethos of the therapeutic community promotes a sense of empowerment—patients are given information about the effects of treatment, can question staff decisions, are consulted about aspects of the daily life of the ward, are encourage to take useful roles within the ward such as chairing meetings, showing round new patients, and

sometimes simple domestic tasks. The increased involvement can boost patients' morale and increase their willingness to engage with specific treatments such as medication and behavioural programmes. Working in an acute service can be extremely stressful for staff, and the therapeutic community model ensures that the concerns and anxieties of the staff are given serious attention—for example in a regular staff group with an outside facilitator.

A different version of the therapeutic community has been used to treat young people with first onset schizophrenia in noninstitutional settings without the use of medication. The best-known example is Soteria House, developed by Loren Mosher in San Jose, California, inspired by the ideas of R D Laing. It operated from 1971–83, in a controlled research programme comparing it with good quality hospital based treatment. Soteria House had places for 6 patients (smaller than the usual therapeutic community) and two sleeping in staff. The emphasis was on interpersonal support in a normal homely environment by staff that were tolerant and enthusiastic, who had no formal professional training but did have good and regular supervision for their work. No medication was prescribed in the first six weeks but it was used after this if required. The study found that Soteria was as effective as neuroleptics in reducing the acute symptoms of psychosis in the first six weeks, and that longer term therapeutic outcomes were as good or better than those of hospital treated control subjects in terms of independence, autonomy and peer based social networks. Mosher also noted that 80% of the experimental group had little or no risk of tardive dyskinesia as they used little or no antipsychotic medication over the follow up period (23,24). Surprisingly the success of this experiment has not spawned a host of replicas, pointing up the conservatism of the professional establishment, the reluctance to use the natural healing properties of normal relationships, and the hold that the drug industry still has over treatment models.

OFFENDERS

The hierarchical (concept house) therapeutic community is the type most widely used in prisons, mainly for offenders with histories of addiction, and prison may seem an unlikely setting for a treatment model based on democratic decision making. Yet democratic therapeutic communities have been run in prisons since the 1960s with positive results, and today there is an increasing number within the English prison system. The first and best known of these is Grendon Prison, 30 miles west

of London, which opened in 1962 and takes long-term male prisoners towards the end of their sentence. Violence, sex offences and robbery are the most common types of offence. Prisoners are referred from other prisons by prison medical officers and have often requested the transfer themselves. In a majority of cases they have had previous psychiatric treatment at some stage.

On arrival inmates live in the Assessment Unit for up to three months to assess their motivation to change, degree of psychological minded-ness, their intellectual ability to deal with group psychotherapy, and personality problems that would benefit from therapeutic community methods. Once accepted a prisoner moves to one of 5 wings of 40 men, each run as a separate therapeutic community, where he may stay for up to 2 years. Extensive reconviction studies have found that length of stay at Grendon is correlated with reduced reconviction rates (25,26). Given the obvious limitations of running a therapeutic community in prison, considerable thought is given to how the key therapeutic principles can be adapted (27). A range of significant decision making opportunities is available, from allocating members to community jobs such as cooking and gardening, to voting a member out of therapy for a serious rule vio-lation. Although there are limitations, the learning principle involved— to share responsibility for decisions and their consequences—are still operative. It is also accepted that prisoners must be allowed to behave as they normally behave rather than as model prisoners, so creating the possibility of "offence paralleling" behaviour which can provide the material for group therapy. As in all therapeutic communities prisoners can act as auxiliary therapists for one another, giving feedback on the impact of each others' attitudes and behaviour and confronting one an-other on the basis of their own experience and self knowledge. This can be particularly valuable in cutting through rationalisations or denials of the offence and its consequences.

In the experience of the author and other experienced practitioners in both the USA (28) and Europe (29) therapeutic communities in prisons can be surprisingly effective in creating a culture of openness and explo-ration of personal issues, in direct contrast to the conventional prison culture, and also in reducing the incidence of violent disturbances. Per-haps the major limitation is the acceptability of the model to prison staff and administrators. For some staff the relaxation of the "them and us" polarisation of officers and inmates provides a welcome opportunity to do something worthwhile, for others it is seen as a threat to their author-ity and control. Small therapeutic communities within larger prisons are particularly vulnerable to a sudden all round tightening of security when there is a security alert.

PEOPLE WITH LEARNING DISABILITIES

As in other forms of therapy that rely on verbal understanding, therapeutic communities generally require their members to have at least average intellectual ability. There are however many communities for those with learning disabilities which follow similar principles. Many of these are run by organizations in the voluntary sector. One of the largest, with a hundred centres worldwide, is Camphill Communities, which promote the ideal of a community life where each person contributes what they can towards the well-being of their fellows. These communities, which are in the tradition of Christian mission and philanthropy, focus more on the practical work tasks available rather than on verbal exchange, but as in other therapeutic communities emphasize the equal status of all members and the healing value of everyday relationships and activities. In some ways these reflect the original priorities of moral treatment with little use of the therapeutic community's potential for analytic understanding or social learning. However Schneider and Schneider (30) have described a modified therapeutic community for learning disabled adolescents that uses a psychodynamic developmental model, and in a rare example of a randomly controlled trial in this field Miles (31) found that young males with behaviour problems and borderline intellectual functioning changed from identifying with the trouble makers in the group to a more accepting attitude towards authority over 12 months in a therapeutic community ward, with no such change in the conventional ward.

THE GEOGRAPHICAL SPREAD OF THERAPEUTIC COMMUNITIES

The idea of a community as a place of healing for the troubled mind is probably universal and as old as society itself. One of the earliest recorded intentional uses of a community in this way was Geel in Belgium, which became a place of pilgrimage for "lunatics" in the fourteenth century. With more roots, as we have seen, in the Quaker Retreat at York and in schools for maladjusted children, the modern therapeutic community is generally recognised to have emerged from the work of a group of psychoanalysts, psychiatrists and social psychologists in England during the 1939–45 war and immediately afterwards. What seemed to happen at this moment in history was that a particular constellation of humanitarian ideology, wartime necessity, psychoanalytic insights and open minded pragmatism came together and coalesced

into a new form of treatment. Following the war, the flagship for this new approach was Maxwell Jones' unit at Belmont Hospital, later Henderson Hospital, which was visited by numerous psychiatrists in the 1950s and 60's (and still is). In 1998 I was able to identify 11 out of 15 member countries of the European Union that had developed therapeutic communities of the democratic type for mental disorders. These included.

- Holland, where from the 1970's to 90s therapeutic communities formed a major part of mainstream psychiatric provision.
- Finland, where thanks in particular to the work of Isohanni (32) therapeutic community principles were brought into acute psychiatric care, prisons, and even the care of the elderly.
- Norway, where a network of psychiatric day hospitals for personality disorders has been developed and evaluated (33).
- Germany, where residential psychotherapy has been a central part of health provision (34), and where various applications of therapeutic community principles have been made, including sheltered flats for former psychiatric patients and social-therapeutic prisons.
- Italy, where a law passed in 1978 required the closure of all the country's mental hospitals and their replacement with a range of community based facilities, many of which have turned to the therapeutic community for an appropriate model of care.
- Greece where Tsegos (35) and others have developed a comprehensive range of therapeutic services and professional training programmes based on therapeutic community and group analytic principles.

It is difficult to estimate how many therapeutic communities there are worldwide. One guide may be the source of papers published in the journal *Therapeutic Communities*. During my own seven-year period of editorship (1992–98) only 5% pf published papers came from outside Europe or the UK. However a recent bibliography of all papers published between 1986 and 2001 throws an interesting new light by placing papers into various categories. Of 41 papers published in the category "Models, innovations and developments in therapeutic community practice" 44% came form the UK, 34% from mainland Europe, and 22% from other countries, namely the USA, Canada, India, Nigeria and Malawi. This could be read to suggest that although the volume of therapeutic community activity is relatively small outside Europe, it may be more pioneering and innovative.

CONCLUSION

The therapeutic community is a surprisingly hardy plant that can be cultivated in a wide range of terrains. Elsewhere I have written of the "therapeutic community impulse" (36) as something that flows through many forms of institutional care, including hospitals, schools, prisons and other settings created by societies for their ill, disabled or troublesome members (and sometimes for their brightest too). This impulse comprises a tolerance of the expression of conflict, a desire to enable people to take responsibility for their lives, a natural sense of democracy (not necessarily of the one vote per person variety) where everyone has the right to information and to contribute to decisions that affect them, and "a kind of shirt-sleeves informality about the business of helping people." I believe it is a hardy plant because once experienced, the capacity to work with people in this way becomes an inner benchmark of the most humane and effective way of delivering mental health care.

REFERENCES

 1. Jones M: Social Psychiatry in Practice. Harmondsworth, Penguin Books, 1968.
 2. Main T: The concept of the therapeutic community: Variations and vicissitudes, in The Evolution of Group Analysis. Edited by Pines M. London, Routledge and Kegan Paul, 1983.
 3. Rapoport RN: Community as Doctor. London, Tavistock, 1960.
 4. Lane H: Talks to Parents and Teachers. London, George Allen and Unwin, 1928, (quoted in Bridgeland M: Pioneer Work with Maladjusted Children. London, Staples Press, 1971).
 5. Kasinski K: The roots of the work: Definitions, origins and influences, in Therapeutic Communities for Children and Young People. Edited by Ward A, Kasinski K, Pooley J, Worthington A. London, Jessica Kingsley, 2003.
 6. Rollinson R: Issues of care and control in the residential treatment of children. Therapeutic Communities 19(2):147–158, 1998.
 7. Ward A, Kasinski K, Pooley J, Worthington A (editors): Therapeutic Communities for Children and Young People. London, Jessica Kingsley, 2003.
 8. Tuke S: Description of The Retreat. First published York, 1813. Facsimile reproduction with foreword by Jones K, London, Process Press, 1996.
 9. Borthwick A, Holman C, Kennard D, et al: The relevance of moral treatment to contemporary mental health care. Journal of Mental Health 10(4):427–439, 2001.
10. Bockoven JS: Moral treatment in American society. Journal of Nervous and Mental Diseases 124:167–194, 1956.
11. Barton R: Institutional Neurosis. Bristol, Wright, 1959.
12. Goffman E: Asylums. New York, Doubleday, 1961.
13. Kennard D: The therapeutic community impulse: A recurring democratic tendency in troubled times. Changes 9(1):33–43, 1991.

14. Clark DH: Administrative Therapy. London, Tavistock, 1964.
15. Clark DH: The Story of a Mental Hospital: Fulbourn 1853–1983. London, Process Books, 1996.
16. Tucker S: Community care: The therapeutic approach and learning to care, in Therapeutic Communities: Past, Present and Future. Edited by Campling C, Haigh R. London, Jessica Kingsley, 1999.
17. Shepherd G: The "ward in a house": Residential care for the severely disabled. Community Mental Health Journal 31:53–68, 1995.
18. Leff J (editor): Care in the Community: Illusion or Reality. Chichester, UK, Wiley, 1997.
19. Cox J: Reflections on contemporary community psychiatry: Where is the therapy? Therapeutic Communities 19(1):3–10, 1998.
20. Hinshelwood RD: Communities and their health. Therapeutic Communities 17(3):173–182, 1996.
21. Pullen GP: Street: The seventeen day community. International Journal of Therapeutic Communities 2(2):115–126, 1982.
22. Mandelbrote BM: The use of psychodynamic and sociodynamic principles in the treatment of psychotics. Comprehensive Psychiatry 6(6):381–387, 1965.
23. Mosher LR, Menn A: Community residential treatment for schizophrenia: Two-year follow up data. Hospital and Community Psychiatry 29:715–723, 1978.
24. Mosher LR, Burti L: Community Mental Health: A Practical Guide. New York, Norton, 1994.
25. Marshall P: A reconviction study of HMP Grendon therapeutic community. Research Findings 53, Home Office Research and Statistics Directorate, 1997.
26. Taylor R: A seven-year reconviction study of HMP Grendon therapeutic community. Research Findings 115, Home Office Research and Statistics Directorate, 2000.
27. Cullen E: Can a prison be therapeutic? The Grendon template, in Therapeutic Communities for Offenders. Edited by Cullen E, Jones L, Woodward R. London, Wiley, 1997.
28. Toch H (editor): Therapeutic Communities in Corrections. New York, Praeger, 1980.
29. Cullen E, Jones L, Woodward R (editors): Therapeutic Communities for Offenders. London, Wiley, 1997.
30. Schneider S, Schneider A: A modified therapeutic community programme for learning-disabled adolescents. International Journal of Therapeutic Communities 7(2):111–119, 1986.
31. Miles A: Changes in the attitudes to authority of patients with behaviour disorders in a therapeutic community. British Journal of Psychiatry 115:1049–1057, 1969.
32. Isohanni M: The therapeutic community movement in Finland: Past, current and future views. Therapeutic Communities 14(2):81–90, 1993.
33. Karterud S, Pederson G, Friis S, et al: The Norwegian network of psychotherapeutic day hospitals. Therapeutic Communities 19(1):15–28, 1998.
34. Janssen P: Psychoanalytic Therapy in the Hospital Setting. London, Routledge and Kegan Paul, 1994.
35. Tsegos IK: Training: Establishing a professional identity, in Therapeutic Communities: Past, Present and Future. Edited by Campling P, Haigh R. London, Jessica Kingsley, 1999.
36. Kennard D: An Introduction to Therapeutic Communities, 2nd ed. London, Jessica Kingsley, 1998.