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

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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.

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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

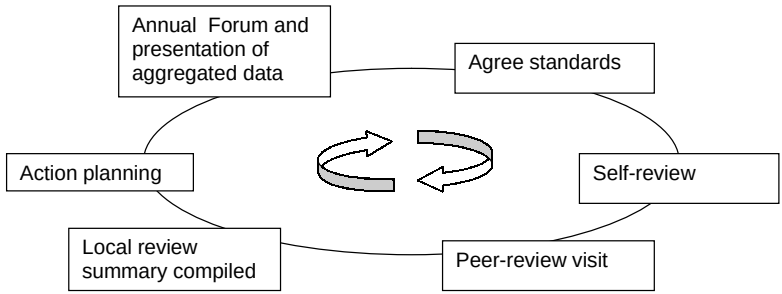

FIGURE 1. The annual review process.

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 questionnaire 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 exchange about areas of achievement and areas of difficulty in relation to the standards. Action points are agreed in relation to the areas of difficulty. While the peer-review provides the benefit of an external viewpoint, it importantly offers an opportunity for members form relationships, 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 stimulating 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 action 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.

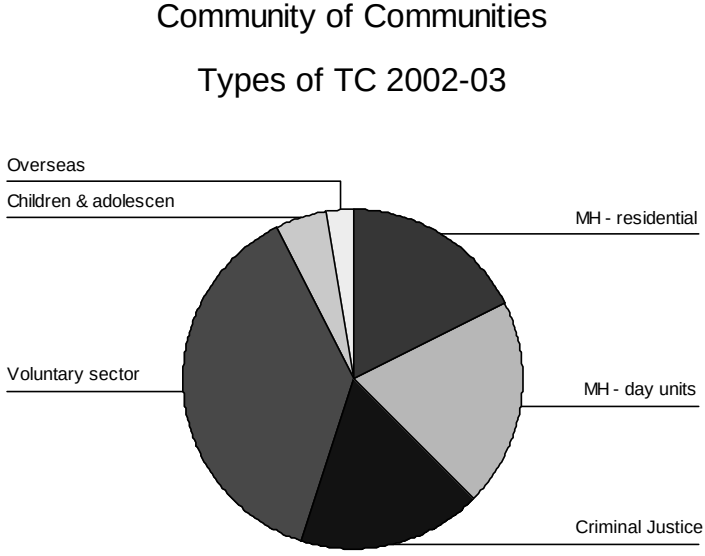

FIGURE 2. Types of communities involved.

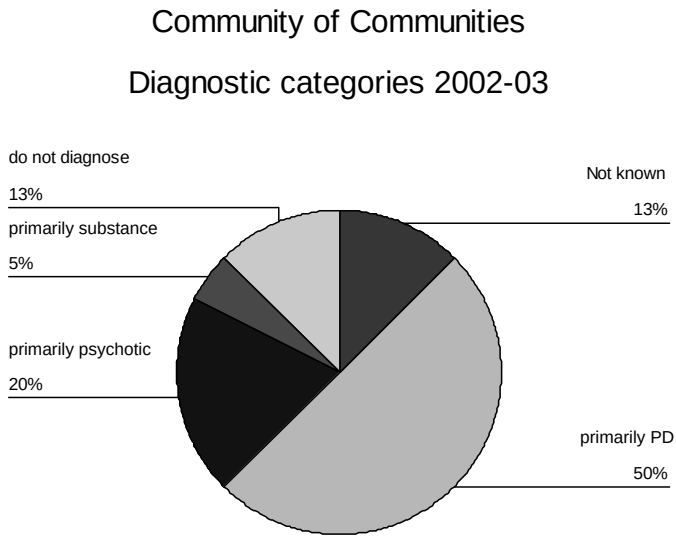

FIGURE 3. Diagnostic categories in communities involved.

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

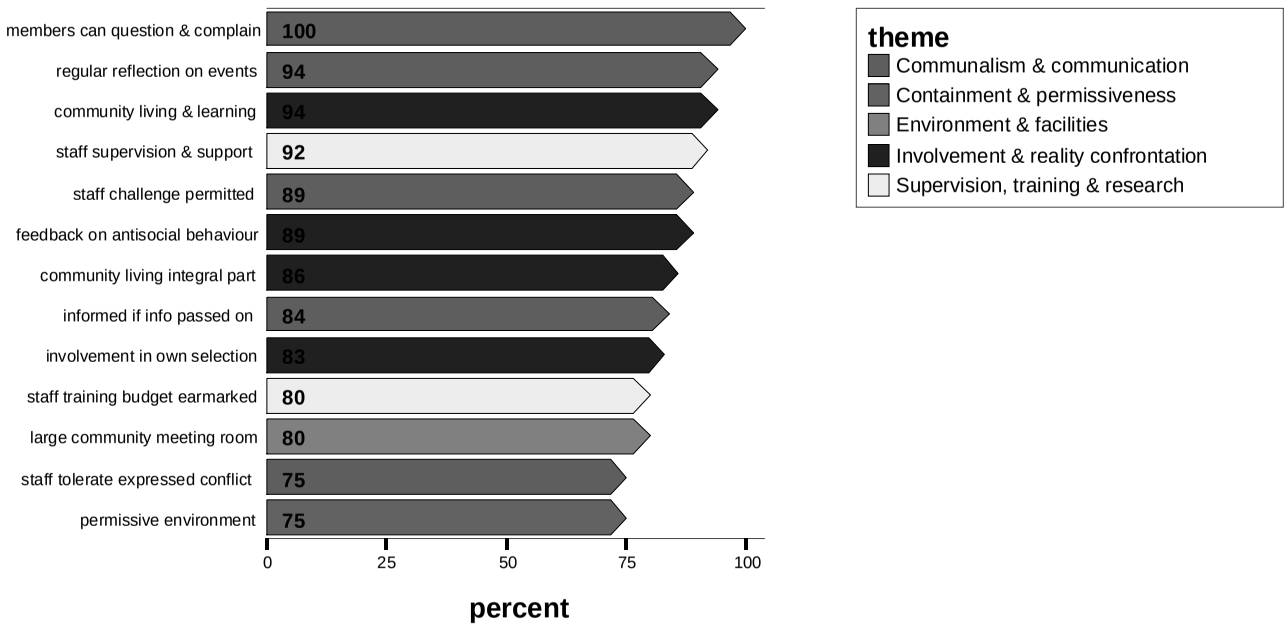

FIGURE 4. Standards met in more than 75% of participating communities.

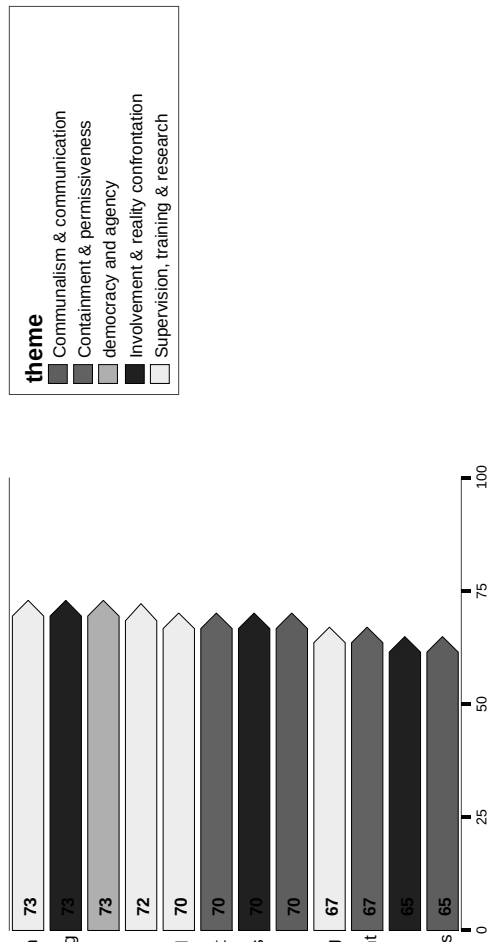

FIGURE 5. Standards met in more than 65–75% of participating communities.

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.

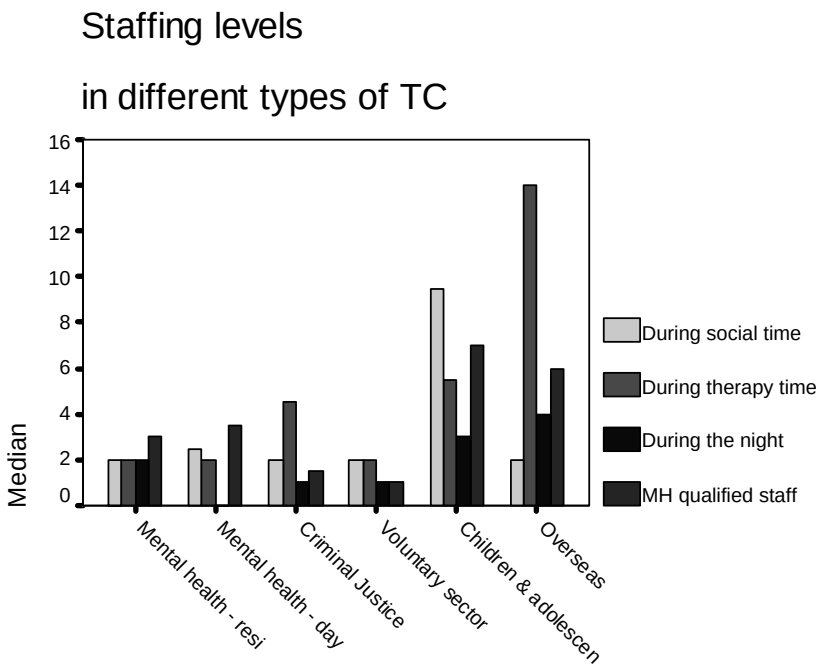

FIGURE 7. Staffing levels in participating communities.

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.

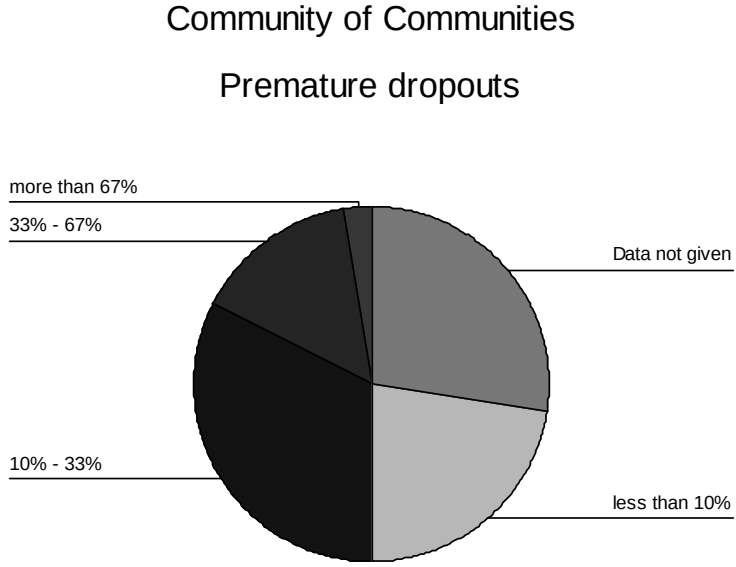

FIGURE 8. Premature dropouts in participating communities.

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.*

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