

# Community of Communities

*A Quality Network of Therapeutic Communities*



## National Report

2005-2007



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CRTU: 056

## Foreword

### Accreditation becomes a reality

This report describes the fourth and fifth cycles, for which all the reviews have been completed and reports written. Although it has now become normal to accept this as part of the normal year's business, it does not do justice to the vast amount of work done by the Communities themselves, staff and members, all the planning and travelling involved, the effort of the lead reviewers, and the coordination by the Community of Communities team themselves. So although all the communities will be aware of this, they need to make their managers, commissioners and colleagues aware of the significance of the learning and service improvement that has happened as a result of all this effort. In the public services much more attention is paid to performance management than quality – but Community of Communities is an intensive and robust type of quality initiative that few other mental health services undergo.

It is worth noting that this period covered the embedding of the prison audit process: the second and third years of prisons being part of the Community of Communities, but the second and third cycles in which all the democratic prison TCs were formally audited by this process. It was also the time over which the NSCAG commissioning standards were piloted for the NHS. In 2005-06, the standards (the 'five fives') were piloted without an accreditation process. At the 2006 Annual Forum, the decision to proceed to a formal NHS accreditation process was made, and in 2006-7 this was undertaken in seven NHS TCs who took the brave decision to subject themselves to it. The volume of work this entailed was considerable, so again many thanks must go to those communities. The system has been described as *“one of the most sophisticated audits in mental health to provide clinicians with information they need to commission services”*, and although the standards and procedures are written in a language which many people in TCs find somewhat forbidding and alien, they have not caused any major problems – and should ultimately go some way towards justifying the spending of public money on a quality assured and sophisticated service.

With all this work being done, and hard evidence accumulating about best practice, we are going to start producing practice guidelines in partnership with ATC. These will be “position statements” about practice which will be published in the Annual Review, debated at the Annual Forum, reviewed after three years and kept in a prominent place on our website.

### Behind the scenes

A great deal of thought has gone into the particular types of networks that will be needed for TCs in addictions, learning disabilities and for children. We now have a good sum of money from the Lottery to develop these projects, and they are being planned and implemented with great care and thought by Sarah Paget, Adrian Worrall and the Community of Communities team. We have recruited an excellent group of people to work on the project, and although they are administratively all different networks now, they will all be managed under one approach and ethos. This is perhaps best summarised by the phrase we often use, that “Community of Communities is a process of engagement, and not of inspection”.

The “original” Community of Communities (now in its sixth cycle), and the NHS accreditation (now in its second full cycle) will be organised by Katharine; Natalie will be taking on the addictions network, and will also be working with the learning disabilities project. The work with children's TCs will be done by John. Emma will be the project administrator across the network, and all will be managed by Sarah. If you ever visit the Community of Communities office, on the 4<sup>th</sup> floor of Standon

House near Aldgate tube station, do look in and say 'hello'. You will find they are a very friendly team and extremely hard-working (they are often out of the office because they are halfway across the country doing a review!). We are also grateful to our specialist registrars attached to the unit, for contributing to the community as part of their research secondments. Other specialist registrars and suitably trained professionals wanting research experience are welcome to apply for this role.

### **The big bang**

All too often it seems that we have to run faster and faster to stay still, and there is no doubt that Community of Communities will be running faster each year. Hopefully not running faster so that we are left with no time to reflect and enjoy the process, but certainly faster in the major expansions of our work: formal accreditation for NHS TCs, and three new networks.

For all of these, we will need a steady nerve and a steady hand. Steady nerve because the changes in the "systems above us" - particularly various aspects of modernisation of our working environment - are coming thick and fast. Unless we keep abreast of them, not being either intimidated or worn down, we may end up with external systems having more say about what happens in TCs than fits with our democratic and inclusive treatment philosophy. We need a steady hand so that we do not react too quickly and lose sight of our own ethos, values and ways of working that make therapeutic communities the creative force they are.

Rex Haigh  
Project Lead

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## Introduction

The Community of Communities (C of C) was set up in 2002 as part of the Association of Therapeutic Communities' (ATC) work to improve the professional profile of Therapeutic Communities (TCs). The ATC worked closely with the Royal College of Psychiatrists' Centre for Quality Improvement to establish a network of therapeutic communities using a systematic, standards-based, quality improvement process that incorporates self- and peer-review.

The Service Standards for Therapeutic Communities provide a platform for staff and clients to participate in an annual cycle of self- and peer-review (appendix 1). The project aims to engage TCs and their staff and clients in quality improvement activities, rather than to impose and inspect. The benefits of the process are well documented and in addition to a rigorous and honest evaluation of services, TCs develop external links, share best practice and improve knowledge and skills.

This National Report provides an overview of the performance of member TCs across cycles 4 and 5 compared with cycle 3. The project team believe that a focused bi-annual report enables us to better analyse areas where TCs do well, as well as identifying areas where the Community of Communities can support TCs to improve or adapt.

The Community of Communities has been very active over the past two years developing a range of opportunities and services as well as broadening the membership:

### **The Development of the Service Standards for Therapeutic Communities, 5th Edition**

The Service Standards for Therapeutic Communities have been reviewed each year for the past five years as part of the annual cycle. These revisions do however complicate the annual process of analysing the data for trends and improvements in overall performance year on year, as even the slightest change to a standard can change its meaning. Therefore the advisory group agreed to a major revision and overhaul of the standards to produce a more concise set of measurable and achievable standards which would remain unchanged and reviewed after three years. The most significant change to the standards was the inclusion of a set of 'core standards' which are intended to identify structures and processes critical to being a TC (Service Standards for Therapeutic Communities 5<sup>th</sup> edition).

### **Core Standards**

The need for a set of 'core values' was recommended in the National Report 2004-2005. The analysis of TCs' performance in cycle 3 showed that TCs were struggling to meet a number of standards which have been associated with TC practice e.g. eating and cooking together. It was posited that the central tenets of TC practice had changed and that it was necessary to debate the conditions for being a TC. This process led to an agreed set of core standards which are essential criteria for being a TC. Work on the underpinning "core values" for the Service Standards is planned for 2008.

### **New Service Standards for Therapeutic Communities**

In 2005 the C of C was awarded a Big Lottery grant to develop the network to include TCs for Children and Young People, TCs for addictions and communities working

with People with learning disabilities. Over the past year we have worked with experts in these three areas to develop three distinct sets of standards.

### Accreditation for Therapeutic Communities

The partnership with HM Prison Service to accredit TCs in prison remains in place with all prison TCs now accredited. The success of this initiative and the impact on staff and residents has added further impetus to accreditation for other TCs especially those in the NHS.

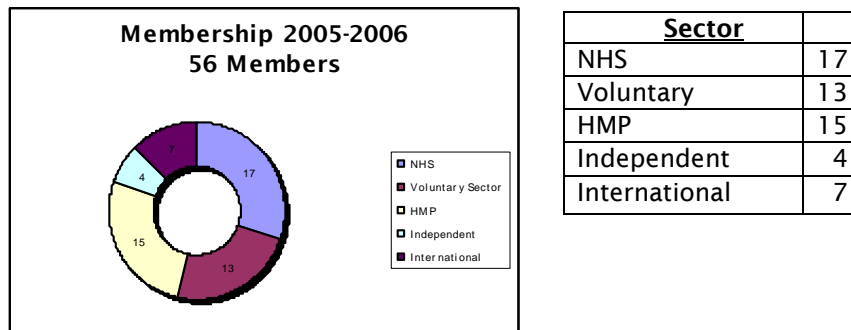
Since the late 1990s, there has been a lively debate amongst the staff of therapeutic communities about whether the “essence” of therapeutic communities would be lost by agreeing to a process of accreditation, and indeed whether the TC way of working would become impossible with the regulatory requirements of all modern services.

Following a mandate given by the members at the 2005-2006 Annual Forum, NHS TCs were invited to participate in the pilot accreditation process in cycle 5. The standards for accreditation differ from the usual Service Standards for Therapeutic Communities and are based on the Core Standards and the ‘Five Fives’ commissioning standards, although on-going participation in the Community of Communities annual cycle is a condition of accreditation (see Accreditation Document 2006). Eight NHS TCs participated in the initial phase.

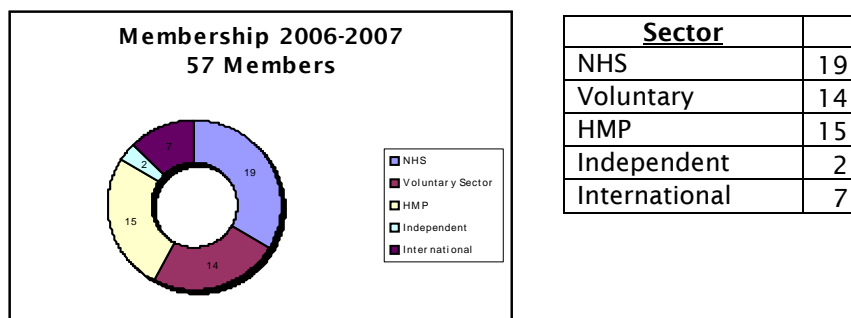
### Membership of Community of Communities

Fifty-six therapeutic communities fully participated in cycle 4 (2005-2006) and 57 in cycle 5 (2006-2007). The number of members has remained relatively constant over the past three cycles (53 fully participating in cycle 3) although individual TCs do change year on year. Figures 1 & 2 detail the spread of TCs by sector.

**Figure 1** Breakdown of Membership for cycle 4 (2005-2006)



**Figure 2 –Breakdown of Membership for cycle 5 (2006-2007)**



## Reading this Report

This report describes the findings of the Community of Communities annual cycle of self- and peer-review for members of the network in cycle 4 and 5. A comparison of the data from the same 35 TCs from cycles 3, 4 and 5 was conducted to measure performance with previous years, specifically recommendations from cycle 3 and provides an overview of areas of achievement along with identifying priorities for improvement. Interestingly, the 35 TCs are representative of the spread of TCs by sector, as shown in Figure 2 (see appendix 2).

Sections one and two of this report focus on the findings from 35 TCs across 65 common standards. Section one compares the overall performance of TCs across cycles 3, 4 and 5 and section two describes the themes and key findings from cycles 4 and 5 using both qualitative and quantitative data from the self-and peer-reviews. Section 3 displays the performance of all TCs (53) in cycle 5 against the Core Standards. This is the first cycle that included these standards therefore measuring members' performance against them was deemed necessary. Section 4 provides a discussion of the areas for consideration, posing a number of important questions.

## Method

### Data Collection and Analysis

Each TC completed a self-review against all the standards, and received a peer-review visit by another member TC. The data from the self- and peer-review was then compiled into a local report for each individual TC. The data used in this report is based on peer-review scores wherever possible; where this is unavailable self-review scores are used. Each standard is scored as either met (score = 2), partially met (score = 1) or not met (score = 0). Where a standard is not applicable a score of 9 is awarded and this is not included in the numerical analysis. Percentage figures always refer to the percentage of TCs fully meeting a standard, i.e. a score of 2. Self- and peer-review comments are also collected and included in the analysis of performance where the numerical scores do not adequately reflect discussion or concerns.

As in previous years, areas of achievement and good practice are derived from those standards where compliance was greater than 80% (appendix 6) and key challenges from those standards where compliance was less than 60% (appendix 7). It is suggested that a difference of 5% or below is probably not meaningful in terms of noticeable differences in clinical outcomes, safety, client member experience or satisfaction.

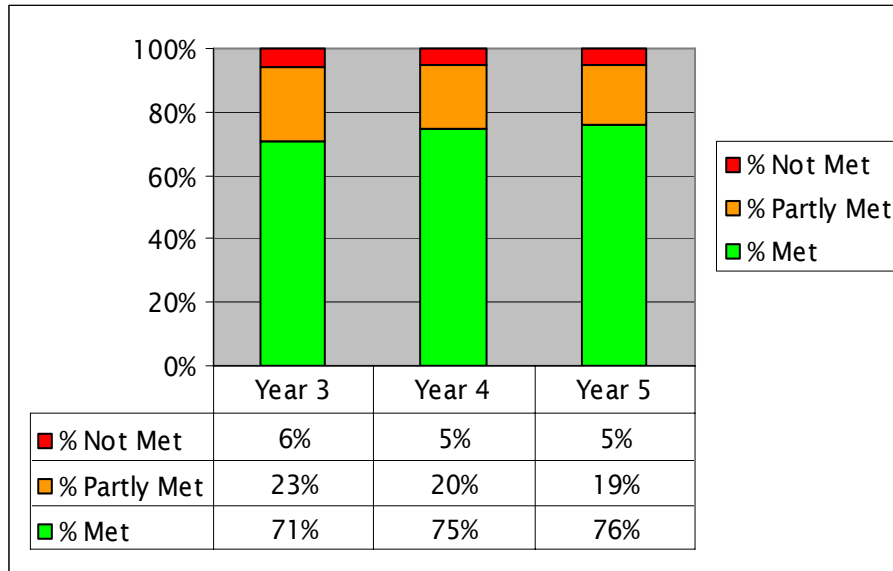
## **Limitations**

The Community of Communities is an organic, iterative process and the annual revision of the standards forms a central part of this process. This means that standards can be changed and/or removed making it difficult to mark any changes in performance across cycles, especially as even small changes can significantly affect meaning. This is especially the case for cycle 5 where the standards were thoroughly revised. For this reason the analysis in this report has been conducted for the same 35 TCs from cycles 3, 4 and 5 against a common set of 63 standards (see appendix 2 and 5). The only exception to this is in section 3 as explained above.

## 1 Overall Performance of TCs across Cycles 3, 4 & 5

This section compares the overall performance of TCs across cycles 3, 4 & 5 using common members and common standards. Figure 3 also charts the ratio of standards 'met', to those 'partly met' or 'not met'. See appendix 5 for full results.

**Figure 3: Average % Compliance for Comparable Standards and TCs across cycles 3, 4 & 5**



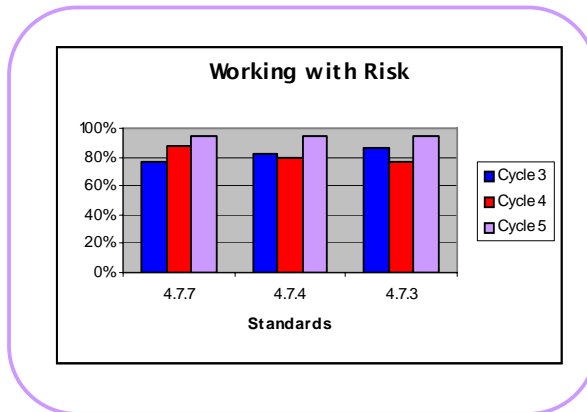
Overall, the performance of TCs remains relatively static with no clear improvement; however with scores above 70%, TCs demonstrate the quality of their services as defined by the standards. A more thorough analysis of the data comparing performance year-on-year from cycle 3 shows some shifts in performance against individual standards and highlights a number of issues that require further discussion.

## 2 Themes and Key Findings from Cycle 4 & 5

The themes and key findings have been grouped into the following categories: Dialogue and Reflection; Community Participation; Therapeutic Opportunities; Staff Skills; Training and Supervision; Leaving and Transition; Optimal Use of Facilities and Research and Data Collection. These themes emerged from the analysis of the numerical data and peer-review comments during cycles 4 and 5. The standards were also compared against cycle 3 to mark trends and direction of change.

### Dialogue and Reflection

TCs continue to demonstrate their strengths in this area and are consistently found



to encourage a sophisticated level of reflective practice. The greater majority of TCs hold discussions which encourage members to learn and gain understanding from everyday living including informal interactions with staff and each other (4.7, 85% in cycle 3 and 86% in cycles 4 and 5) and to encourage members to identify parallels between their relationships, behaviour and perceptions and similar situations within the community (4.7.2). In cycle 5, over 90% of TCs worked

towards members putting thoughts and feelings into words rather than to act on them (4.7.1) and to talk openly about issues arising in the community that generate strong feelings (4.7.6). Tension between risk and therapeutic opportunity is increasingly managed by the whole community (4.7.7) with a 13% improvement from cycle 3. This is supported by improvement in members feeding back on each other's behaviour (4.7.4) and offering advice on coping strategies (4.7.3).

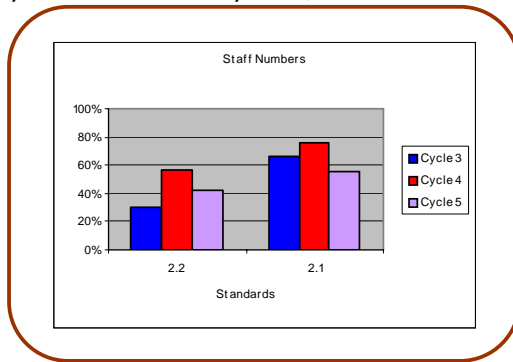
### Community Participation

Analysis of peer-review comments showed that the most commonly reported area of achievement was the sense of cohesion and solidarity within TCs, highlighting community participation as central to life in a TC. This is demonstrated by improvement in the integration of the informal aspects of everyday living with the overall work of the community (CS6), 48% in cycle 3 increasing to 61% in cycle 4 and 86% in cycle 5. However, it seems that opportunities for engaging in every day activities is decreasing with only 74% of communities involving members in the day to day running of the community, down from 94% in cycle 4. Community members, it appears, are no more likely now to be involved in the selection of staff (CS11) with only 41% and of communities meeting this standard in cycle 5. Despite considerable improvement in the number of TCs involving members in the selection process for new clients (CS12) it remains an area for improvement (41% in cycle 3, 44% in cycle 4 and 57% in cycle 5). Most worrying is that community members are less likely to be involved in agreeing the communities operational policies and procedures (4.4.4) in cycle 5 (60%) than in cycle 3 (62%), despite improvement in cycle 4 (71%).

### Therapeutic Opportunities

In cycle 5, over 90% of TCs have a planned therapeutic programme (4.6) and a large number have improved the range of therapeutic opportunities available (4.6.4), 63% in cycle 3, 85% in cycle 4 and 89% in cycle 5. Nearly all of communities (96%) now have provision for calling crisis meetings (4.6.5), up from 74% in cycle 3 and 85% in cycle 4. TCs have also worked hard to improve the boundaries, limits and rules

understood by all members (CS16) with 86% meeting this standard in year 5 (77% in year 3 and 60% in year 4).



TCs provide good availability of staff during informal therapeutic activity (2.1.1) but there is a need to flag up the reduced number of TCs that have staff available during the formal therapy timetable (2.1.2), down to 74% in cycle 5 from 88% in cycle 4. Whilst this is still a reasonable result it should be watched carefully given the poor scores for TCs filling vacant staff posts quickly and with suitable candidates (2.2) and having enough staff for the community to operate effectively (2.1), 42% and 56%

respectively. These scores are more worrying for the fact that performance has decreased after initial improvements in cycle 4.

### Staff Skills and Training

In cycle 5, peer-review teams observed that TCs are staffed with highly qualified and/or experienced staff who are described as dedicated, and committed to their work and colleagues. A further indicator of the levels of commitment is the number of staff working towards qualifications in their own time and who are self-funding. Training and supervision for staff in TCs is generally widely available and a number of comments recognised that TCs provide ongoing training for staff. TCs provide regular space for supervision which is reflective and integrates theory, practice and experiential learning (2.3.2). However it appears that space available for sensitivity (2.4.4) and after-groups (2.4.5) is decreasing, down to 69% for both standards in year 5, a reduction of 10% and 16% (respectively) from cycle 4.

[We] have set up a series of training workshops offering good quality, relevant in-house training to the team and others

*Self-review comment of an area of achievement from a members' local report*

It was a recommendation from cycle 3 that TCs develop training in the theory of therapeutic communities (2.7) and despite some improvement in cycle 4 (82%) this has reduced in cycle 5 (74%). A number of comments advised TCs to provide time for reading papers and journals which would be an inexpensive way to address this issue but the availability of material to support this learning has decreased to 71% in cycle 5 (from 86% in cycle 3 and 91% in cycle 4). In addition the time available for community members to write, present and publish TC papers (5.4.4) remains low at 42% (31% in cycle 3 and 41% in cycle 4).

### Optimal Use of Facilities

There has been a marginal increase in performance for Physical Environment this year. However there are still a number of standards which TCs continue to have difficulty in meeting. Most importantly, only 60% of TCs have the facility for a dining area big enough for all community members and visitors to sit together (1.1.4). The availability of kitchens continues to be a difficult area in discussions with teams and peer-review comments show that inadequate space or facilities was an area for improvement in a number of TCs during peer-review visits. There is a debate about the specific requirements of the physical environment for

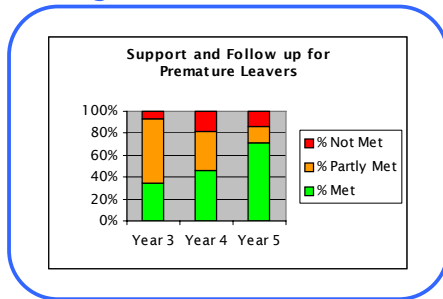
Staff recognised that there were necessary facilities which would determine whether a space was acceptable. These included:

- Good toilet facilities
- Kitchen
- Minimum 3 rooms and 1 large room
- 9-5 access
- TC is accessible by public transport
- Close to shops
- Not too isolated

*Comment from itinerant TC in the process of looking for a venue*

a TC which was identified in the previous report (2004-2005) and which will be central to the next review of the standards. Members state that improving standards regarding physical space is out of their control. But the fact that 94% of TCs manage to maintain a room large enough for the whole community (1.1.2) and that there has been a 25% increase over three years in the number of communities which are involving members in personalising their environment (1.3.2) recognises the importance of some features.

### Leaving and Transition



By far the biggest improvement in cycle 5 is the provision of support and follow up for members leaving the community prematurely (3.5.3), 34% of TCs met this standard in cycle 3 and this has risen to 71% in cycle 5. This demonstrates real commitment to improve the quality of TC practice and to bring about change. The transition from the TC has been identified as an area where TCs' continued efforts are needed. Members need to be more involved in identifying support networks

beyond the community in cycle 5 (62%) than in cycle 3 (74%).

### Research and Data Collection

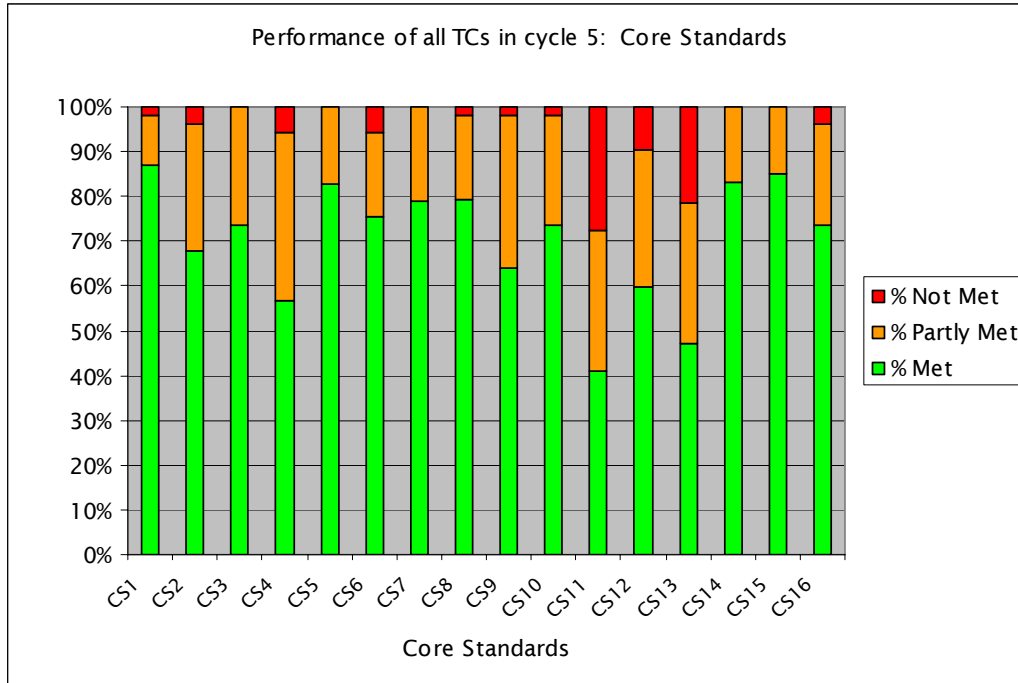
Consistent with previous cycles, TCs have performed least well in External Relations. There is a considerable reduction in community members providing written material for potential residents, referrers and other professionals (3.1); 63% in cycle 5, down from 82% in cycle 4. However, a number of TCs were commended for involving staff and clients in sharing their experiences of being a community member as part of a strategy to educate multi-disciplinary teams, referrers and families. Overall, TCs are recognised as publicising the work of the TC and for developing better links with external services and agencies. There is a real need for TCs to improve their evidence base. Worryingly, only 55% of TCs routinely collect data via environmental measures to demonstrate the therapeutic qualities of the community (5.3.4). This has improved since cycle 3 (33%) but is still a poor performance given the growing links between research and funding. It is also vital that TCs routinely collect basic data on client members and their social background (5.3.2) to be used in measuring equity of access and as part of larger research studies on outcomes. Despite 70% of TCs meeting this standard in cycle 5, there is room for improvement.

Presentations involving group members has been important in publicising the work of the community

*Peer-review comment of an area of achievement from a members' local report*

### 3 Performance against the Core Standards

Figure 4: Performance of all TCs in cycle 5 against the Core Standards



The development of the Core Standards followed discussion from previous cycles about the changing nature of TCs. TCs have consistently struggled to meet standards that traditionally were central to TC practice (National Report 2004-2005) and there was a need to identify some core features that one would expect to find in a service described as a TC. These standards would be essential requirements and would define a service as a TC. The standards were the product of feedback, expert consensus and wide consultation with members (for further information see Service Standards for Therapeutic Communities, 5<sup>th</sup> edition).

This was the first time that these standards have been reviewed in their current form and Figure 4 shows the results for 53 TCs who fully participated in the 5<sup>th</sup> Annual Cycle.

Overall performance against the standards is a mixed picture with only four core standards scoring 80% and above (see table 2), and four scoring 60% and below (see table 1). Given that these standards have been described as critical for being a TC, performance is lower than expected and TCs will need to work hard to improve.

Table 1 – Core Standards 60% and below

CS4	All community members share meals together	57%
CS11	All community members are involved in some aspect of the selection of new staff members	41%
CS12	All community members participate in the process of a new client member joining the community	60%
CS13	The whole community is involved in making plans for a client member when he or she leaves the community	47%

Three of the standards (CS11, CS12, CS13) which TCs find difficult to meet are comparable across the three cycles as they have been adapted from previous versions of the Service Standards, and are included in the analysis in the previous section. However discussions regarding members sharing meals together will be further stimulated by this standard being in the most poorly performing group.

**Table 2 - Core Standards 80% and above**

CS1	The whole community meets regularly	87%
CS5	Community members take a variety of roles and levels of responsibility	83%
CS14	There is an understanding and tolerance of disturbed behaviour and emotional expression	83%
CS15	Positive risk taking is seen as an essential part of the process of change	85%

It is excellent that two of the best performing standards are related to risk. Tolerance of disturbed behaviour and working positively with risk are central to the TC ethos and concern has been expressed in previous years regarding statutory approaches to managing risk preventing TCs working in a more open way.

## 4 Areas for Consideration and Discussion

This section discusses the achievements and challenges facing TCs.

### **Threats to informal time**

TCs clearly demonstrate a strong and improving therapeutic environment that ensures a high degree of reflective practice. They are committed to open and honest dialogue which provides a structured and safe environment enabling community members to engage in each others' therapy and to develop a greater understanding of their behaviour and its effects on others. There is a strong commitment to community participation and member involvement in all aspects of the running of the TC and informal settings are important elements in the therapeutic programme. Communities have improved the overall availability and types of formal therapy, including crisis meetings, but this may have had the effect of reducing the opportunities for more informal contact. It does appear that opportunities for engaging in everyday activities as a community are decreasing with staff shortages, increased pressure on existing staff and with shorter therapeutic days. It is apparent on peer-reviews that external demands on the TC take precedence over local operational priorities which members feel helpless to challenge. This may be demonstrated in the reduced number of TCs who involve members in the management of the TC, such as staff and resident selection and policies and procedures, as this can feel tokenistic. However, there has equally been reluctance on the part of members to engage in these aspects of the TC, many describing community involvement in recruitment and assessment as inappropriate. This is also the case with regard to a formally essential element of life in a TC, community members cooking and eating together, which many communities feel is an unwelcome and unnecessary feature of TC practice.

### **A Changing Physical Environment**

The changing face of TCs is nowhere more obvious than in the physical environment and the changing needs of TCs will impact on essential criteria for physical space. If, as noted above, many communities do not see the process of cooking and eating together as important in TCs then the lack of kitchens and dining areas for community members ceases to be important. This has been discussed previously (National Report 2004-2005), however it remains a real issue for the work of Community of Communities and for the relevance of the standards. TCs are no longer predominantly residential, with day TCs often being set up solely in premises that are not dedicated to the TC, which means they may have little control over the physical environment. Some TCs have no specific building and are described as itinerant or dispersed, and it is important that we find a way to accommodate their differences whilst still valuing the importance of suitable physical space, especially when setting up a TC.

### **Leaving the TC**

It is a considerable achievement that TCs have improved the processes in place for members leaving the TC, despite the fact members' feel there is room for improvement. It is vital to engage community members in this process for there to be a continued sense of group responsibility beyond life in the TC.

### **Staff training and pressures on staff**

Staff continued to be well supported through the regularity and quality of supervision appropriate to a TC. However pressures on staff are increasing and TCs are aware that there are often not enough staff and that vacancies are not always filled. Spaces for staff to meet as a group need to be protected, and training needs to be provided that equips staff to work in these challenging environments. There is a need for recognised TC training, and it is important that the Community of Communities engage with members and other organisations in the field, such as the

Association of Therapeutic Communities, to support the development or recognition of suitable courses.

### **Research and promoting TCs**

The promotion of TCs and their approach is an important element in the work of TCs at this time and the threats to the model can only be countered by external understanding of the work and its effectiveness. The NHS personality disorder sites are commended for involving staff and clients in sharing their experiences of being a community member as part of a strategy to educate multi-disciplinary teams, referrers and families, and yet, overall, TCs are saying that members are less engaged with helping to produce written information. Equally TCs remain poorly served by research and do not help themselves by not consistently collecting routine data such as environmental measures, or basic data about client members.

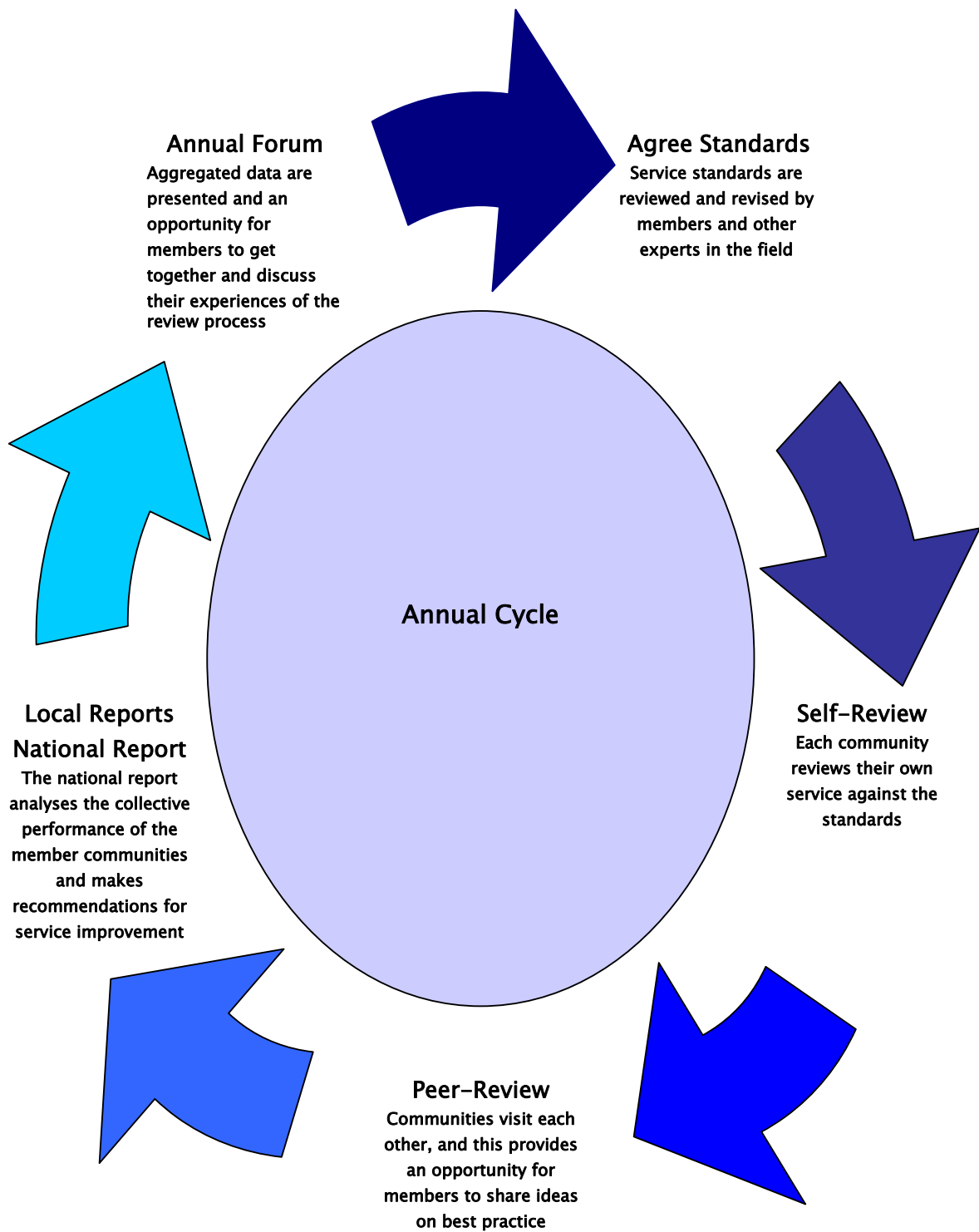
### **Changing Core Standards?**

The introduction of the Core Standards, based on common values and agreed by experts in the field, is an important step for TCs. It enables TCs to better define their service especially for external professionals, commissioners and potential clients. Despite the differences between TCs, the Core Standards provide members with a clear set of criteria which describe what a TC is. The value of the Core Standards rests on them being met by the majority of the membership, so it is surprising and worrying that some members struggle to do well in this section. One reason may be that TCs have evolved. Another reason may be that Core Standards have become eroded. This provides a dilemma for the Community of Communities: if standards deemed as essential are not met, then should we accept that TCs have evolved and change the standards to enable communities to meet them? Or should we help and support TCs to meet them despite some often overwhelming obstacles? Before answering these questions it is interesting to consider whether the biggest threat to TCs may not be high profile closures or lack of commissioning, but the systematic erosion of TC core values and standards.

### **Questions Arising**

- **How important is informal time to us? What is it replaced with, and is this a good thing?**
- **Do standards need to better reflect the increase in ‘rented’, ‘dispersed’ or ‘homeless’ TCs?**
- **Where do people go after TCs? Where should they go?**
- **What are acceptable demands on TC staff time? How can the standards help with this?**
- **How can we agree to co-ordinate our research efforts to build a recognised portfolio of evidence?**
- **When is a TC not a TC? How much can we change but still keep our clinical identity?**

## Appendix 1 – Annual Cycle



## Appendix 2 – Common members from cycles 3, 4 & 5

### NHS

Acorn  
 Brenchley Unit  
 Cawley Centre  
 Diverse Pathways  
 Francis Dixon Lodge  
 Garden Villa  
 Henderson Hospital  
 IPTS  
 Main House  
 Red House  
 Winterbourne

### Social Care

(Inc. Independent and Voluntary)

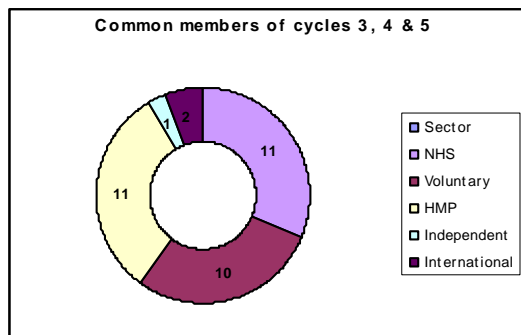
Christ Church Deal  
 Clearwater  
 Connect  
 Dainton House  
 Dumbarton House  
 Glencarn  
 Homebase  
 Lytton House  
 Mount Lodge  
 Pele Tower  
 Sofia

### Prison Service

HMP Bluneston  
 HMP Dovegate TC A  
 HMP Dovegate TC B  
 HMP Dovegate TC C  
 HMP Dovegate TC D  
 HMP Gartree  
 HMP Grendon TC A  
 HMP Grendon TC B  
 HMP Grendon TC C  
 HMP Grendon TC D  
 HMP Grendon TC G

### International

Daily Psychotherapeutic Community  
 Gruppcenter



Sector	
NHS	11
Voluntary	10
HMP	11
Independent	1
International	2

## Appendix 3 - Member Services Directory

### Member Services Directory – Cycle 5

#### UK

1. Acorn Programme
2. The Brenchley Unit Psychotherapy Service
3. Bridger House
4. Cawley Centre
5. Chikara House
6. Christ Church Deal
7. Clearwater House (Threshold)
8. Connect Therapeutic Community
9. Dainton House (CHT)
10. Denbridge House
11. Diverse Pathways
12. Dumbarton House (Threshold)
13. Francis Dixon Lodge
14. Garden Villa
15. Glencarn House (Threshold)
16. Henderson Hospital
17. HMP Blundeston
18. HMP Dovegate Assessment Unit
19. HMP Dovegate High Intensity Programme
20. HMP Dovegate therapeutic community A
21. HMP Dovegate therapeutic community B
22. HMP Dovegate therapeutic community C
23. HMP Dovegate therapeutic community D
24. HMP Gartree
25. HMP Grendon Assessment Unit
26. HMP Grendon A Wing
27. HMP Grendon B Wing
28. HMP Grendon C Wing
29. HMP Grendon D Wing
30. HMP Grendon G Wing
31. HMP Send
32. Home Base (CHT)
33. Intensive Psychological Treatment Service
34. Khara-Minn
35. Lexham House (CHT)
36. Lothlorien Community
37. Lytton House (CHT)
38. Main House
39. Mandala Therapeutic Community
40. Millfield
41. Mount Lodge (CHT)
42. New Horizons.
43. North Cumbrian PD Therapeutic Community
44. Oxford Therapeutic Community
45. Pele Tower
46. Red House
47. Rotunda Therapeutic Community
48. Sophia House (Threshold)
49. St. Andrews
50. Winterbourne House

#### Abroad

51. Athma Shakti Vidalaya (India)
52. Daily Psychotherapeutic Community, OPC (Greece)
53. Foundain Hosue
54. Gruppcenter (Sweden)
55. Kypseli
56. Raymond Gledhill (Italy)
57. Thalassa Haz

## Member Services Directory – Cycle 4

### UK

1. Acorn Programme
2. Aylesbury Young Offenders Institute
3. The Brenchley Unit Psychotherapy Service
4. Buckinghamshire
5. Cassel Hospital
6. Cawley Centre
7. Chikara House
8. Christ Church Deal
9. Clearwater House (Threshold)
10. Connect Therapeutic Community Ltd
11. Coolmine Therapeutic Community
12. Dainton House (CHT)
13. Diverse Pathways
14. Dumbarton House (Threshold)
15. Francis Dixon Lodge
16. Glencarn House (Threshold)
17. Henderson Hospital
18. HMP Blundeston
19. HMP Dovegate Assessment Unit
20. HMP Dovegate therapeutic community A
21. HMP Dovegate therapeutic community B
22. HMP Dovegate therapeutic community C
23. HMP Dovegate therapeutic community D
24. HMP Gartree
25. HMP Grendon Assessment Unit
26. HMP Grendon A Wing
27. HMP Grendon B Wing
28. HMP Grendon C Wing
29. HMP Grendon D Wing
30. HMP Grendon G Wing
31. HMP Send
32. Home Base (CHT)
33. Intensive Psychological Treatment Service
34. Khara-Minn
35. Lancaster Lodge (CHT)
36. Lexham House (CHT)
37. Ley Community
38. Lytton House (CHT)
39. Main House
40. Mandala Therapeutic Community
41. Mount Lodge (CHT)
42. North Cumbrian PD Therapeutic Community
43. Oxford Therapeutic Community
44. Pele Tower
45. Red House
46. Royal CornHill Hospital
47. Sophia House (Threshold)
48. Willowgrove House
49. Winterbourne House
50. Young People's Service

### Abroad

51. Ashburn Clinic (New Zealand)
52. Athma Shakti Vidalaya (India)
53. Daily Psychotherapeutic Community, OPC (Greece)
54. Gruppcenter (Sweden)
55. Phoenix House (Bulgaria)
56. Raymond Gledhill (Italy)

## Appendix 4 – Acknowledgements

### Project Team

Rex Haigh  
Jan Lees  
Sarah Paget  
Adrian Worrall

Natalie Wood  
John O’Sullivan  
Katharine Larkin  
Emma Race  
Sinéad Keenan (left Jan 07)  
Deepa Shah (left Jan 07)  
Ed Beveridge

Project Lead  
Prison Service Lead  
Programme Manager  
Joint Head of Centre for Quality  
Improvement  
Quality Improvement Worker  
Quality Improvement Worker  
Quality Improvement Worker  
Project Administrator  
Quality Improvement Worker  
Quality Improvement Worker  
Special interest registrar on  
placement

## Project Advisory Group Cycle 5

<b>Name</b>	<b>Job Title</b>	<b>Representing</b>
Diana Menzies <b>(Chair of the advisory group)</b>	Consultant Psychiatrist in Psychotherapy - Henderson Hospital	NHS
Steve Pearce	Consultant Psychiatrist/Programme Director	NHS
John Gale	Chief Executive of Community Housing and Therapy	Social Care
Heather Maxwell	Service Director - Threshold	Social Care
Chris Holman	Consultant Psychiatrist and Psychotherapist/ Medical Director	Independent Sector
David Lynes	Director of Therapy: HMP Dovegate	HMP
Judy Mackenzie	Director of Therapy: HMP Gartree	HMP
Tina Fullerton	Prison Officer at HMP Send	HMP Officers
Roland Woodward	Head of PD and Forensic Services at Affinity Healthcare	Forensic TCs
Kevin Healy	Chair of the Association of Therapeutic Communities	Members of ATC
Gordon Gunnarson	Expert by Experience	Service Users
<b><u>CofC experts</u></b>		
<b>Rex Haigh</b>	CofC Project Lead	The Community of Communities
<b>Jan Lees</b>	C of C consultant with special responsibilities for Addictions and HMP TCs	The Community of Communities
<b>Adrian Worrell</b>	Head of College Centre for Quality Improvement	CCQI

#### Project Advisory Group Cycle 4

<b>Name</b>	<b>Job Title</b>	<b>Representing</b>
Diana Menzies <b>(Chair of the advisory group)</b>	Consultant Psychiatrist in Psychotherapy - Henderson Hospital	NHS
Steve Pearce	Consultant Psychiatrist/Programme Director	NHS
John Gale	Chief Executive of Community Housing and Therapy	Social Care
Heather Maxwell	Service Director - Threshold	Social Care
Chris Holman	Consultant Psychiatrist and Psychotherapist/ Medical Director	Independent Sector
David Lynes	Director of Therapy: HMP Dovegate	HMP
Judy Mackenzie	Director of Therapy: HMP Gartree	HMP
Tina Fullerton	Prison Officer at HMP Send	HMP Officers
Roland Woodward	Head of PD and Forensic Services at Affinity Healthcare	Forensic TCs
Kevin Healy	Chair of the Association of Therapeutic Communities	Members of ATC
Gordon Gunnarson	Expert by Experience	Service Users
<b><i>CofC experts</i></b>		
<b>Rex Haigh</b>	CofC Project Lead	The Community of Communities
<b>Jan Lees</b>	C of C consultant with special responsibilities for Addictions and HMP TCs	The Community of Communities
<b>Adrian Worrell</b>	Head of College Centre for Quality Improvement	CCQI

**Appendix 5 – Performance of members against common standards for cycles 3, 4, & 5**

Standard Number in Year 5	Standard	Year 3			Year 4			Year 5		
		% Met	% Partly Met	% Not Met	% Met	% Partly Met	% Not Met	% Met	% Partly Met	% Not Met
CS6	Informal aspects of everyday living are integral to the work of the community	48%	52%	0%	61%	36%	3%	86%	11%	3%
CS11	All community members are involved in some aspect of the selection of new staff members	42%	35%	23%	39%	39%	23%	41%	38%	21%
CS12	All community members participate in the process of a new client member joining the community	41%	41%	19%	44%	29%	26%	57%	34%	9%
CS16	The therapeutic community has a clear set of boundaries, limits or rules which are understood by all members	77%	23%	0%	60%	40%	0%	86%	11%	3%
1.1.1	The internal and external physical environment is comfortable and welcoming	40%	54%	6%	66%	34%	0%	66%	31%	3%
1.1.2	There is a room large enough for community meetings where everyone can see and hear each other	86%	11%	3%	89%	11%	0%	94%	6%	0%
1.1.3	There is a kitchen for preparing meals, available for use by all community members	64%	24%	12%	66%	14%	20%	68%	29%	3%
1.1.4	There is a dining area big enough for all community members and visitors to sit together	63%	23%	14%	62%	21%	18%	60%	26%	14%
1.2.1	Single, shared or dormitory sleeping accommodation allows members to have personal privacy	96%	4%	0%	80%	20%	0%	89%	7%	4%
1.2.2	Residential client members can wash and use the toilet in privacy	88%	0%	12%	77%	19%	4%	93%	7%	0%
1.2.4	Client members have use of a telephone in private	41%	47%	13%	56%	25%	19%	64%	30%	6%
1.3.1	Community members decide on appropriate décor and furniture	65%	35%	0%	79%	18%	3%	68%	32%	0%
1.3.2	Client members can personalise the private and shared spaces	69%	31%	0%	88%	12%	0%	94%	6%	0%
2.1	<i>There are enough staff members for the community to operate effectively</i>	66%	34%	0%	76%	24%	0%	56%	35%	9%
2.1.1	During informal therapeutic activity there is at least one member of staff available and	83%	17%	0%	79%	21%	0%	80%	20%	0%

	others available if needed									
2.1.2	During the formal therapeutic programme there is at least one member of staff in each group and activity and others available if needed	83%	17%	0%	88%	12%	0%	74%	26%	0%
2.2	<b><i>Vacant posts are filled as quickly as possible, ideally with suitably qualified and experienced candidates</i></b>	30%	48%	21%	56%	31%	13%	42%	42%	15%
2.2.1	There are clear criteria for staff selection based on therapeutic community principles	72%	25%	3%	70%	30%	0%	70%	21%	9%
2.3.3	Staff who have been working in the TC for less than six months have additional support and are also able to contact a senior colleague as necessary	65%	21%	15%	79%	9%	12%	79%	15%	6%
2.4.4	There is a regular staff sensitivity or dynamics group	77%	20%	3%	79%	18%	3%	69%	23%	9%
2.4.5	There are staff after-groups following all therapeutic, community or group meetings to discuss issues that have arisen	77%	20%	3%	85%	15%	0%	69%	29%	3%
2.5.2	Staff members, as a group, tolerate the expression of conflict among themselves	79%	21%	0%	70%	30%	0%	79%	21%	0%
2.5.4	The staff team examine their relationships to the employing organisation and external professionals	80%	20%	0%	88%	12%	0%	78%	22%	0%
2.6.2	A skills audit of the staff group is conducted and reviewed regularly	50%	23%	27%	58%	23%	19%	68%	18%	15%
2.6.5	Staff have access to material to support their professional development (e.g. internet, books, journals, video tapes)	86%	11%	3%	91%	9%	0%	71%	29%	0%
2.7	<b><i>Staff receive theoretical training appropriate to their role in the therapeutic community</i></b>	69%	31%	0%	82%	18%	0%	74%	21%	6%
2.8	<b><i>Staff receive clinical training appropriate to their role in the therapeutic community</i></b>	75%	22%	3%	79%	18%	3%	75%	22%	3%
2.8.1	Induction training is provided for all temporary and permanent staff, including students and volunteers, before they have unsupervised contact with client members	76%	24%	0%	79%	21%	0%	82%	12%	6%
3.1	<b><i>Community members provide written material about the community which is</i></b>	77%	23%	0%	82%	18%	0%	63%	26%	11%

	<b>informative for prospective client members, referrers and other relevant professionals</b>									
3.2.1	Prospective client members can visit the community before joining	69%	19%	13%	63%	29%	9%	77%	14%	9%
3.2.2	Prospective client members are involved in the process of deciding whether they join the community	71%	26%	3%	69%	23%	9%	77%	14%	9%
3.4.3	The community is involved in identifying a support network beyond the community before planned leaving	74%	19%	6%	76%	24%	0%	62%	32%	6%
3.5.3	Provision is made for support and follow-up for those client members that leave the community prematurely	34%	59%	7%	45%	36%	18%	71%	14%	14%
4.1	Community members treat one another with respect and consistency	63%	37%	0%	60%	37%	3%	66%	34%	0%
4.2.2	Confidentiality and its limits are understood and respected by all members	74%	23%	3%	0.8	0.2	0	74%	20%	6%
4.2.3	Staff and client members' complaints are initially dealt with in community and group meetings	74%	23%	3%	79%	21%	0%	80%	17%	3%
4.2.4	Individual client members are involved in all decisions about their own care and treatment	54%	43%	3%	63%	34%	3%	86%	14%	0%
4.3.1	Problems and their solutions are discussed in the community before action is taken. The discussion is regarded as a learning opportunity	77%	23%	0%	69%	31%	0%	83%	17%	0%
4.4.1	All members of the community share the task of the day-to-day running of the community	83%	17%	0%	94%	6%	0%	74%	20%	6%
4.4.2	Client members are involved in the process of allocating members to community roles and jobs	94%	6%	0%	94%	3%	3%	91%	6%	3%
4.4.4	Community members are involved in the process of agreeing the therapeutic community's operational policies and procedures	62%	38%	0%	71%	26%	3%	60%	37%	3%
4.5.2	The therapeutic community has a written complaints procedure known and understood by all members	74%	9%	17%	59%	24%	18%	79%	15%	6%
4.6	<b>The community has a planned therapeutic programme</b>	97%	3%	0%	97%	3%	0%	94%	6%	0%
4.6.3	Time each working day is spent in therapeutic groups, as well as in	94%	6%	0%	97%	3%	0%	86%	11%	3%

	community meetings									
4.6.4	A range of therapeutic opportunities are available	63%	37%	0%	85%	15%	0%	89%	9%	3%
4.6.5	There is provision for crisis meetings, with a recognised procedure for calling one, that can be used by staff or client members	74%	17%	9%	85%	12%	3%	96%	4%	0%
4.7	<b><i>Discussions take place from which members learn and gain understanding from everyday living</i></b>	85%	15%	0%	86%	11%	3%	86%	11%	3%
4.7.1	Members are encouraged to put their thoughts and feelings into words rather than to act on them	94%	6%	0%	94%	6%	0%	97%	3%	0%
4.7.2	Community members are encouraged to identify parallels between their relationships, behaviour and perceptions and similar situations within the community	89%	11%	0%	94%	6%	0%	83%	17%	0%
4.7.3	Community members offer each other advice on constructive ways of coping with conflict and frustration	86%	14%	0%	77%	23%	0%	94%	6%	0%
4.7.4	Members give each other feedback about their behaviour and the way that it affects others	83%	17%	0%	79%	21%	0%	94%	6%	0%
4.7.5	Members encourage each other to share their life experiences with the community	91%	9%	0%	85%	15%	0%	82%	12%	6%
4.7.6	Members encourage each other to talk openly about issues arising in the life of the community that generate strong feelings	91%	9%	0%	85%	15%	0%	91%	9%	0%
4.7.7	The tension between risk and therapeutic opportunity is safely managed by the whole community, and is used as a learning process	77%	23%	0%	88%	12%	0%	94%	6%	0%
4.8	<b><i>There is a regular process for the community to review the quality and effectiveness of the therapeutic community process</i></b>	77%	11%	11%	77%	23%	0%	84%	10%	6%
5.1	The therapeutic community contributes to effective multidisciplinary and multi-agency working between health, education, probation services, social services and voluntary organisations	74%	23%	3%	80%	20%	0%	79%	15%	6%
5.1.3	There is an active programme involving client and staff members, for publicising	69%	31%	0%	80%	20%	0%	60%	31%	9%

	the work of the community to referrers and other professionals									
5.1.4	The community belongs to a national body of therapeutic communities (e.g. Association of Therapeutic Communities, Charterhouse Group)	91%	9%	0%	97%	3%	0%	94%	3%	3%
5.2	Members of the community regularly meet with managers of the employing organisation	65%	19%	16%	64%	24%	12%	61%	33%	6%
5.3.1	The community is currently participating in a research project concerning effectiveness as a therapeutic community (e.g. outcome and process research using qualitative and/or quantitative methods)	74%	11%	14%	77%	14%	9%	74%	14%	11%
5.3.2	The community routinely collects basic data on client members and their social background, in order to evaluate equity of access to the community (e.g. age, sex, ethnicity, religion, marital status, housing circumstances, education, employment, health history)	68%	16%	16%	63%	23%	14%	70%	21%	9%
5.3.4	The community routinely collects data via environmental measures in order to demonstrate therapeutic qualities of the community (e.g. WAS/COPES, GAS, RESPPi)	33%	22%	44%	59%	9%	32%	55%	16%	29%
5.4.4	Staff and client members are given time to write and publish papers concerning therapeutic communities and present at the attend conferences	31%	37%	31%	41%	53%	6%	42%	36%	21%

## Appendix 6 – Compliance of common standards above 80% in cycle 5

Standard Number in Year 5	Standard	Year 5		
		% Met	% Partly Met	% Not Met
CS6	<b>Informal aspects of everyday living are integral to the work of the community</b>	86%	11%	3%
CS16	<b>The therapeutic community has a clear set of boundaries, limits or rules which are understood by all members</b>	86%	11%	3%
1.1.2	There is a room large enough for community meetings where everyone can see and hear each other	94%	6%	0%
1.2.1	Single, shared or dormitory sleeping accommodation allows members to have personal privacy	89%	7%	4%
1.2.2	Residential client members can wash and use the toilet in privacy	93%	7%	0%
1.3.2	Client members can personalise the private and shared spaces	94%	6%	0%
2.1.1	During informal therapeutic activity there is at least one member of staff available and others available if needed	80%	20%	0%
2.8.1	Induction training is provided for all temporary and permanent staff, including students and volunteers, before they have unsupervised contact with client members	82%	12%	6%
4.2.3	Staff and client members' complaints are initially dealt with in community and group meetings	80%	17%	3%
4.2.4	Individual client members are involved in all decisions about their own care and treatment	86%	14%	0%
4.3.1	Problems and their solutions are discussed in the community before action is taken. The discussion is regarded as a learning opportunity	83%	17%	0%
4.4.2	Client members are involved in the process of allocating members to community roles and jobs	91%	6%	3%
4.6	<b><i>The community has a planned therapeutic programme</i></b>	94%	6%	0%
4.6.3	Time each working day is spent in therapeutic groups, as well as in community meetings	86%	11%	3%
4.6.4	A range of therapeutic opportunities are available	89%	9%	3%
4.6.5	There is provision for crisis meetings, with a recognised procedure for calling one, that can be used by staff or client members	96%	4%	0%
4.7	<b><i>Discussions take place from which members learn and gain understanding from everyday living</i></b>	86%	11%	3%
4.7.1	Members are encouraged to put their thoughts and feelings into words rather than to act on them	97%	3%	0%
4.7.2	Community members are encouraged to identify parallels between their relationships, behaviour and perceptions and similar situations within the community	83%	17%	0%
4.7.3	Community members offer each other advice on constructive ways of coping with conflict and frustration	94%	6%	0%
4.7.4	Members give each other feedback about their behaviour and the way that it affects others	94%	6%	0%

4.7.5	Members encourage each other to share their life experiences with the community	82%	12%	6%
4.7.6	Members encourage each other to talk openly about issues arising in the life of the community that generate strong feelings	91%	9%	0%
4.7.7	The tension between risk and therapeutic opportunity is safely managed by the whole community, and is used as a learning process	94%	6%	0%
4.8	<i>There is a regular process for the community to review the quality and effectiveness of the therapeutic community process</i>	84%	10%	6%
5.1.4	The community belongs to a national body of therapeutic communities (e.g. Association of Therapeutic Communities, Charterhouse Group)	94%	3%	3%

## Appendix 7 – Compliance of common standards below 60% in cycle 5

Standard Number in Year 5	Standard	Year 5		
		% Met	% Partly Met	% Not Met
CS11	All community members are involved in some aspect of the selection of new staff members	41%	38%	21%
CS12	All community members participate in the process of a new client member joining the community	57%	34%	9%
1.1.4	There is a dining area big enough for all community members and visitors to sit together	60%	26%	14%
2.1	<i>There are enough staff members for the community to operate effectively</i>	56%	35%	9%
4.4.4	Community members are involved in the process of agreeing the therapeutic community's operational policies and procedures	60%	37%	3%
5.3.4	The community routinely collects data via environmental measures in order to demonstrate therapeutic qualities of the community (e.g. WAS/COPES, GAS, RESPPi)	55%	16%	29%
5.4.4	Staff and client members are given time to write and publish papers concerning therapeutic communities and present at the attend conferences	42%	36%	21%
5.1.3	There is an active programme involving client and staff members, for publicising the work of the community to referrers and other professionals	60%	31%	9%

## Appendix 8 – Performance of all members against the core standards in Cycle 5

Standard Number	Core Standards	Total No.	% Met	% Partly Met	% Not Met
CS1	The whole community meets regularly	53	87%	11%	2%
CS2	All community members work alongside each other on day to day tasks	53	68%	28%	4%
CS3	All community members share social time together	53	74%	26%	0%
CS4	All community members share meals together	51*	57%	37%	6%
CS5	Community members take a variety of roles and levels of responsibility	52*	83%	17%	0%
CS6	Informal aspects of everyday living are integral to the work of the community	53	75%	19%	6%
CS7	All community members can discuss any aspects of life within the community	52*	79%	21%	0%
CS8	All community members regularly examine their attitudes and feelings towards each other	53	79%	19%	2%
CS9	All community members share responsibility for each other	53	64%	34%	2%
CS10	All community members create an emotionally safe environment for the work of the community	53	74%	25%	2%
CS11	All community members are involved in some aspect of the selection of new staff members	51*	41%	31%	27%
CS12	All community members participate in the process of a new client member joining the community	52*	60%	31%	10%
CS13	The whole community is involved in making plans for a client member when he or she leaves the community	51*	47%	31%	22%
CS14	There is an understanding and tolerance of disturbed behaviour and emotional expression	53	83%	17%	0%
CS15	Positive risk taking is seen as an essential part of the process of change	53	85%	15%	0%
CS16	The therapeutic community has a clear set of boundaries, limits or rules which are understood by all members	53	74%	23%	4%

\* There was no score available or a score of '9' (not applicable)



**Community of Communities**

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COLLEGE CENTRE FOR QUALITY IMPROVEMENT

