Community of Communities

A Quality Network of Therapeutic Communities

CCQI
COLLEGE CENTRE FOR QUALITY IMPROVEMENT

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Service Standards for Addiction Therapeutic Communities

First Edition

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CRTU045

EFTC
European Federation of Therapeutic Communities
European co-operation in the field of drug treatment, prevention and research

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Foreword

This first edition of therapeutic community service standards for Addiction TCs is the product of a collaboration led by the Royal College of Psychiatrists and the Association of Therapeutic Communities (ATC) through their Community of Communities Network and including senior and practitioner representatives from the European Federation of Therapeutic Communities (EFTC) and the Australasian Therapeutic Communities Association (ATCA).

The working party had as its starting point, the work of Community of Communities in the development of an audit and evaluative system for therapeutic communities for the treatment of mental illness and personality disorder. These standards, building upon the strengths and existing capacities of the therapeutic community movement, were characterised by their inclusivity and their peer-led approach to audit.

That development has been warmly welcomed, both by practitioners and providers in the field and by commissioning agencies. Some 60 therapeutic communities have become active participants in the scheme and this has not only provided a means of establishing and enhancing service quality, but has also offered a channel of communication between these therapeutic communities and encouraged a vibrant exchange of ideas and experiences.

The Community of Communities Addictions Advisory Group was anxious to ensure that these principles also underpinned the development of standards for therapeutic communities for drug users also.

Of course this is only the beginning of the journey. Community of Communities, EFTC and ATCA are committed to a continuing programme of upgrade and improvement. We are aware that this first edition will contain mistakes and omissions and that, inevitably we will need to revisit some areas, add others and clarify yet others. We welcome your input in this respect.

In the past two decades, Addiction TCs have worked extremely hard to establish the scientific credibility and the evidence base for the work that they do in a world that appears continually beguiled with “silver bullet” solutions and an overwhelmingly medical view of the addictions. These standards, we believe are another step in that journey.

I would encourage all those involved with Addiction TCs – both programme planners and commissioners; managers and administrators; main grade staff and volunteers; and residents or community members themselves to take part in this exciting and potentially groundbreaking venture.

Rowdy Yates
Chair – Community of Communities, Addictions Advisory Group
Vice President – European Federation of Therapeutic Communities (EFTC)

Introduction

The Community of Addiction Therapeutic Communities (CATC) is one of four networks within the Community of Communities (C of C) programme of quality improvement based at the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). CATC works closely with other networks within the Community of Communities and in collaboration with the European Federation of Therapeutic Communities (EFTC) and the Australasian Therapeutic Community Association (ATCA).

CATC was developed in 2006 with funding from the Big Lottery and grew out of the Community of Communities network for Adult Democratic Therapeutic Communities (appendix 4). The network is a systematic, standards-based, quality improvement process that incorporates self- and peer-review and brings together Addiction Therapeutic Communities (TCs) in the UK and abroad (for more information about Addiction TCs see Appendix 1). These standards are the foundation for the annual cycle (appendix 5) and a basis for staff and clients to share best practice.

The Development of the Standards

The standards have been developed out of the work of the advisory group, chaired by Rowdy Yates, Vice President of the EFTC and Senior Research Fellow at the University of Stirling. The advisory group is a selected group of addiction TC experts which includes practitioners, researchers, managers and service users from Addiction TCs in the UK and across Europe (appendix 7).

The standards are adapted from The *Service Standards for Therapeutic Communities, 5th Edition* (www.communityofcommunities.org.uk) which have been developed for TCs working with adults in the field of mental health in NHS or voluntary sector or offending behaviour in prison. In addition they are informed by a review of key documents (appendix 3) and consultation with TC staff and service users.

The first draft of the Service Standards for Addiction Therapeutic Communities was sent to 120 communities, including client members and other experts in the field, for consultation. Communities were asked to rate the standards as "not important" "important" or "very important" to providing a good quality service. They were also asked to suggest any new standards.

The full responses of the consultation also contained written comments. There was generally a good consensus with most standards being rated as either very important or important to the quality of the service. Low rated standards were removed or reworded. Other editing criteria included ease of measurement; achievability, and local adaptability. Contentious issues raised were discussed and resolved within the Advisory Group. The terminology used within the standards was agreed as part of this process; a glossary is provided for terms that caused any confusion (appendix 2).

The process of consultation has ensured that this first edition of the Service Standards for Addiction Therapeutic Communities reflects contemporary TC practice and that these standards represent developing views on the central elements of TC practice in the UK and across Europe.

The Standards

The standards are organised around seven sections:

- Core Standards
- Physical Environment
- Staff
- Joining and Leaving
- Therapeutic Environment
- Treatment Programme and
- External Relations

The core standards are consistent with other networks within the Community of Communities. These standards represent the basic requirements for being a TC and connect all members of the Community of Communities regardless of client group or sector. The following six sections are specific to Addiction TCs.

Each section contains general statements as standards written in bold text, and more specific statements as criteria within these. Each standard has typically four or five criterion statements. Criteria are not comprehensive, but are generally given as examples of good practice relating to the standard.

Finally, the standards have been allocated unique identifier numbers, indicated in the right hand column. These are in addition to the standard numbers that are indicated in the left hand column.

Using the Standards

These standards are not intended to replace any existing statutory requirements but describe the specialist practice of addiction TCs.

The standards represent ideal practice and it would be unusual if services met every standard.

This document is provided for reference and not for data collection. Data collection tools adapted from these standards will be provided with guidance notes to members. A selection of the standards will be measured.

Number	Core Standards	Unique ID No
CS1	The whole community meets regularly	1
CS2	All community members work alongside each other on day to day tasks	2
CS3	All community members share social time together	3
CS4	Members of the community share meals together	4
CS5	Community members take a variety of roles and levels of responsibility	5
CS6	Informal aspects of everyday living are integral to the work of the community	6
CS7	All community members can discuss any aspects of life within the community	7
CS8	All community members regularly examine their attitudes and feelings towards each other	8
CS9	All community members share responsibility for each other	9
CS10	All community members create an emotionally safe environment for the work of the community	10

CS11	**Community members are involved in the selection of new staff members**	11
CS12	**All community members participate in the process of a new client member joining the community**	12
CS13	**Community members are involved in making plans with a client member for when he or she completes the programme**	13
CS14	**There is an understanding and tolerance of disturbed behaviour and emotional expression**	14
CS15	**Positive risk taking is seen as an essential part of the process of change**	15
CS16	**The therapeutic community has a clear set of boundaries, limits or rules which are understood by all members**	16

Number	1: Physical Environment	Unique ID No.
1.1	**The internal and external physical environment is comfortable and welcoming**	17
1.1.1	The environment is clean and well maintained	18
1.2	**The therapeutic community has the necessary environmental facilities and resources**	19
1.2.1	There is an area large enough for community meetings where everyone can see and hear each other	20
1.2.2	There is a kitchen for preparing shared meals, available for use by all community members	21
1.2.3	There is a dining area big enough for all community members and visitors to sit together	22
1.2.4	There is suitable recreation space indoors	23
1.2.5	There is suitable recreation space outdoors	24

1.3	**Client members' personal space is respected within the boundaries of creating a safe and secure environment**	25
1.3.1	A range of rooms is available with opportunities for increasing levels of privacy	26
1.3.2	Residential client members can wash and use the toilet in privacy	27
1.3.3	There are quiet areas in the community	28
1.4	**Community members are involved in maintaining the physical environment**	29
1.4.1	Community members are involved in maintaining a safe physical environment	30
1.4.2	There is a notice board displaying information about the structure of the community, where everyone can see it	31

Number	2: Staff	Unique ID No
2.1	**There are enough staff members for the community to operate effectively**	32
2.1.1	During informal therapeutic activity there is at least one senior community member available and others available if needed	33
2.1.2	During the formal therapeutic programme there is at least one senior community member in each group and activity and others available if needed	34
2.1.3	At night, in a residential therapeutic community, there is one staff member available	35
2.2	**Vacant posts are filled as quickly as possible, ideally with suitably qualified and experienced candidates**	36
2.2.1	There are clear criteria for staff selection based on Addiction TC principles	37
2.2.2	The staff team includes a proportion of graduates from a TC	38
2.3	**New community members are monitored by more experienced senior community members for the first six months**	39

2.3.1	Induction training is provided for all temporary and permanent community members, including students and volunteers, before they have unsupervised contact with client members	40
2.4	**Community members, who are involved in directing the therapeutic process, receive regular clinical supervision from a suitably trained person**	41
2.4.1	Community members, who are involved in directing the therapeutic process, attend regular group supervision	42
2.4.2	Community members, who are involved in directing the therapeutic process, attend regular individual supervision	43
2.4.3	Supervision involves discussion of client material in which theory, practice and experiential learning are integrated	44
2.5	**There are regular forums for all staff to reflect on their experience of the work**	45
2.5.1	There are regular meetings to examine how the community is dealing with events/ issues	46
2.5.2	There are regular staff business meetings	47
2.5.3	There is a daily handover process	48

2.5.4	There is a forum for a staff only reflective space	49
2.5.5	There are staff debriefing sessions following all therapeutic, community or group meetings to discuss issues that have arisen	50
2.5.6	There are staff debriefing sessions following any critical incidents	51
2.6	**Therapeutic community staff work effectively as a team**	52
2.6.1	The staff team explore the relationships that exist between them and the impact these have on their work	53
2.6.2	Staff members, as a group, tolerate the expression of conflict among themselves	54
2.6.3	Staff challenge each other's perceptions of events in the therapeutic community and work to understand the difference between them	55
2.6.4	The staff team examine their relationships to the employing organisation and external professionals	56
2.7	**Staff function in a manner that is consistent with the philosophy and practice of the TC**	57

2.7.1	Staff members conduct themselves as mature positive role models at all times	58
2.8	**Staff members are adequately trained**	
2.8.1	There is an adequate budget for training relating to working in a therapeutic community work	59
2.8.2	The training needs of all staff members are assessed in supervision and appraisals	60
2.8.3	A skills audit of the staff group is conducted and reviewed regularly	61
2.8.4	All staff participate in continuing professional development	62
2.8.5	There is suitable TC training for support and administrative staff	63
2.8.6	Staff have access to material to support their professional development (e.g. internet, books, journals, video tapes)	64
2.9	**Staff receive theoretical training appropriate to their role in the therapeutic community**	65

2.9.1	Training provided includes the theory of therapeutic communities, including history and defining principles	66
2.9.2	Training provided includes the concept of "Community as Method"	67
2.10	**Staff receive clinical training appropriate to their role in the therapeutic community**	68
2.10.1	Training is provided in a range of appropriate therapeutic interventions	69
2.10.2	Staff know the evidence and theory underpinning the therapeutic intervention	70
2.10.3	Training is provided in group facilitation skills	71
2.10.4	Training is provided about the effects of medication (where medication is used in the community)	72
2.10.5	Training is provided in risk assessment and management	73
2.10.6	Training is provided in the management of imminent and actual violence	74

2.10.7	Training is provided in identifying and understanding the symptoms of substance-induced behaviour and its effects	75
2.11	**Staff receive experiential training appropriate to their role in the therapeutic community**	76
2.11.1	Staff have the opportunity to experience being a client member of a therapeutic community (e.g. a period of residency for non ex-graduate staff)	77
2.11.2	Staff have the opportunity to participate in an exchange programme with another community	78
2.12	**Appropriate methods are used to ensure the quality and effectiveness of staff training**	79
2.12.1	Trainers have suitable professional qualifications and/ or experience e.g. social work, psychiatry	80
2.12.2	The training provided has clear criteria of assessment corresponding to learning outcomes for each component	81

Number	3: Joining and Leaving	Unique ID No
3.1	**Community members provide written material about the community which is informative for prospective client members, referrers and other relevant professionals**	82
3.1.1	Written information provided contains a simple description of therapeutic community philosophy, principles and their rationale	83
3.1.2	Written information provided contains a clear description of the aims of the community and the current programme and modes of treatment	84
3.1.3	There are written admission criteria	85
3.2	**Prospective client members are involved in the process of deciding whether they join the community**	86
3.2.1	Prospective client members can visit the community before joining	87
3.3	**There is a clear and written procedure for joining the community which is understood by all new members**	88
3.3.1	All clients are provided with information about their rights and responsibilities	89

3.3.2	Where new client members are searched, there is consideration for their dignity, respect and safety at all times	90
3.3.3	All client members have basic privileges and understand that privileges are earned through progression through the community structure	91
3.4	**Community members share responsibility for helping new client members join the community**	92
3.4.1	Community members help new members to understand and adapt to the therapeutic community culture and practices	93
3.4.2	All community members are introduced to the history and defining principles of therapeutic communities	94
3.4.3	New client members are provided with a 'buddy', 'mentor', 'host' or similar support	95
3.5	**All new client members agree and sign a contract upon arrival**	96
3.5.1	The contract sets out a list of fundamental rules and consequences	97
3.6	**All client members are properly assessed for their therapeutic needs**	98

3.6.1	It is made clear to prospective client members when and how their therapeutic needs will be assessed	99
3.6.2	Client assessments takes into account relevant history, problems, issues and risks	100
3.6.3	There are written records of assessments	101
3.6.4	All assessments are made in collaboration with the client member	102
3.7	**There is a written procedure for leaving the community, which includes those clients who leave prematurely**	103
3.7.1	Before leaving the therapeutic community, client members' continuing needs are reviewed	104
3.7.2	The TC has effective links with multidisciplinary agencies which supports the transition from the TC where necessary	105
3.8	**The community celebrates planned leavings or graduations with an event or ritual**	106
3.9	**The community is involved in ensuring client members leave the community safely**	107

3.9.1	Community members discuss premature leaving with the whole community	108
3.9.2	The community has an information pack for those people who leave in an unplanned way	109
3.9.3	Client members are advised on the risks associated with relapse	110
3.9.4	Premature leavers are advised on alternative treatments and provides guidance on whether they may return to the therapeutic community in the future	111
3.9.5	The community is involved in ensuring a support network beyond the community has been identified before planned leaving	112
3.10	**Community members are encouraged to maintain contact with the TC after leaving**	113
3.10.1	Community members are welcomed back to the TC after leaving to an event that celebrates their drug-free life	114

Number	4: Therapeutic Environment	Unique ID No
4.1	**Community members treat one another with respect at all times**	115
4.1.1	The community is sensitive to all diversity issues and respects and facilitates religious observance	116
4.2	**The therapeutic community promotes a culture of openness**	117
4.2.1	The therapeutic community promotes an environment of open and honest feedback	118
4.2.2	Confidentiality and its limits are understood and respected by all members	119
4.2.3	Problems and their solutions are discussed in the community before action is taken. The discussion is regarded as a learning opportunity	120
4.2.4	Potentially difficult topics can be openly discussed	121
4.2.5	Managerial information and issues that affect the community are shared with the whole therapeutic community	122

4.3	**The therapeutic community has a written complaints procedure known and understood by all members**	123
4.3.1	Community members' complaints are initially dealt with by the community	124
4.4	**Community members are involved in the day-to-day running of the community**	125
4.4.1	Community members are involved in the process of allocating members to community roles and jobs	126
4.4.2	Community members are involved in the decision making process	127
4.4.3	Community members participate in identifying, maintaining and changing non-fundamental community rules	128
4.5	**Community members are encouraged to put their thoughts and feelings into words rather than to act on them**	129
4.5.1	Discussions take place from which community members learn and gain understanding from everyday living	130
4.5.2	Community members encourage each other to talk openly about issues arising in the life of the community that generate strong feelings	131

4.5.3	Community members are encouraged to identify parallels between their relationships, behaviour and perceptions outside of the community and similar situations within the community	132
4.6	**Community members are involved in reviewing each others care and treatment**	133
4.6.1	Individual client members are involved in all decisions about their own care and treatment	134
4.6.2	Community members offer each other advice on constructive ways of coping with conflict and frustration	135
4.6.3	Members give each other feedback about their behaviour and the way that it affects others	136
4.6.4	Members encourage each other to share their life experiences with the community	137
4.6.5	The tension between risk and therapeutic opportunity is safely managed by the whole community, and is used as a learning process	138
4.7	**The community maintains a drug-free environment, with the exception of prescribed drugs**	139
4.7.1	Staff members do not use or support the use of recreational drugs	140

4.7.2	Contact with individuals outside the TC is limited and closely monitored by the TC	141
4.7.3	There is a well documented system (e.g. sign in/sign out logs) that keeps the continuous track of the whereabouts of all residents	142
4.8	**There is a regular process for the community to review the quality and effectiveness of the therapeutic community process**	143
4.8.1	The review is take into account the views of external people or agencies (e.g. families, carers, multidisciplinary teams, commissioners)	144
4.8.2	The review includes written information about the community (e.g. accident and incident records, key performance data such as drop-out rates, waiting times, referral information, occupancy, non-attendance, the findings of key audits)	145

Number	5: Treatment Programme	Unique ID No
5.1	**The community has a planned therapeutic programme**	146
5.1.1	Community members are encouraged to apply a simple element of CBT: to think and act as if they have progressed as a means of developing a positive attitude	147
5.1.2	The programme is designed into at least three main stages: induction, primary treatment and leaving	148
5.1.3	Each stage of the programme has clearly defined written goals, activities and expectations	149
5.1.4	Completion of each stage of the programme is celebrated as a rite of passage	150
5.2	**There is a structured and consistent daily schedule of group activities**	151
5.2.1	Time each working day is spent in therapeutic groups, activities and informal time	152
5.2.2	The program includes a encounter/conflict group	153

5.2.3	There is provision for crisis meetings, with a recognised procedure for calling one, that can be used by all community members	154
5.3	**All client members have a written care plan**	155
5.3.1	The care plans are agreed with the client members and subject to regular reviews	156
5.3.2	The care plan involves strategies for work or education upon leaving the community	157
5.4	**The community prepares members for independent living in the wider community**	158
5.4.1	The community offers appropriate educational and vocational training	159
5.4.2	The community offers relapse prevention training	160
5.4.3	The community offers appropriate health education training in both prevention and control of threatening diseases	161
5.5	**The community has an explicitly structured hierarchy**	162

5.5.1	There is a hierarchical structure of community members which establishes levels of responsibility and status by job function	163
5.5.2	Senior client members take a responsible role in relation to junior members	164
5.6	**There are clearly defined privileges with a rationale and process for allocating them e.g. status advancement, more desirable living space**	165
5.6.1	Actual choices of privileges are supportive of recovery, self-enhancement, positive behaviour, and acceptable social behaviour	166
5.7	**There are clearly defined sanctions with a rationale and process for allocating them e.g. status advancement, more desirable living space**	167
5.7.1	Client members agree to be the subject to sanctions for infractions of rules that may involve the loss of status or privileges	168
5.7.2	Client members are given the opportunity for input regarding behavioural sanctions to be imposed by staff	169
5.7.3	Sanctions for violations of rules are well defined, and known by all community members; including learning experiences	170
5.7.4	The community protects members from public humiliation or physical punishment	171

5.8	**The community takes responsibility for improving and maintaining client members' physical health**	172
5.8.1	Client members have a medical examination	173
5.8.2	Client members dietary needs are met	174
5.8.3	Community members are provided with training in nutrition	175
5.9	**Where client members are offered a methadone treatment programme, there is a written policy**	176
5.9.1	The policy includes details of who supplies and administers the methadone	177
5.9.2	The policy recognises the medical protocols involved	178

Number	6: External Relations	Unique ID No
6.1	**The therapeutic community contributes to effective multidisciplinary and multi-agency working, between health, education, probation services, social services and voluntary organisations**	179
6.1.1	The community liaises with other relevant services and has a good working relationship between disciplines and departments to enable continuity of client member care (e.g. local employers, education and housing providers)	180
6.1.2	Community members are involved in the promotion of the work of the TC	181
6.1.3	The community belongs to a national body of therapeutic communities (e.g. EFTC, WFTC, ATC)	182
6.1.4	The community provides training placements for students and post-qualifying professional development opportunities for qualified practitioners	183
6.1.5	The TC pro-actively engages with the wider community	184
6.2	**Community members regularly meet with the senior members of the parent organisation**	185
6.3	**Managers and/or the employing organisation support research about therapeutic communities**	186

6.3.1	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)	187
6.3.2	The community routinely collects and collates 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, disability)	188
6.3.3	The community routinely collects data in order to demonstrate severity and complexity of client member problems (e.g. EuropASI, the Maudsley Addiction Profile, Christo Inventory)	189
6.3.4	The community routinely collects data via environmental measures in order to demonstrate therapeutic qualities of the community (e.g. WAS/COPES, GAS, RESPPI)	190
6.3.5	At least one member of staff is responsible for research	191
6.4	**The community is part of a research network**	192
6.4.1	There is a process for ethical and methodological scrutiny for all research	193
6.4.2	The community participates in the national drug data collection database	194

Appendix 1 - Addiction Therapeutic Communities

Numerous authors over the years have traced the origins of the therapeutic community (TC) through three distinct developmental threads:

- Therapeutic communities for children, often including elements of alternative approaches to education and growing out of the work of August Aichorn, Rudolph Steiner, Homer Lane, David Wills and others in the first half of the twentieth century;
- Therapeutic communities within the National Health Service pioneered by Tom Main, Maxwell Jones, Bertram Mandelbrote and others and often influenced by radical psychiatry in the 1960s;
- Therapeutic communities for drug users growing out of the work of Synanon (a Californian utopian community for addicts) under the leadership of the now discredited Charles Dederich.

This last thread was hugely influential throughout the 1970s as countries across the world began to develop responses to the growing problem of addiction to illicit drugs such as heroin and cocaine.

In Europe (and in Australasia), "Addiction TCs" tended to be pioneered by psychiatrists already enthused by the work of Maxwell Jones (and to a lesser extent, by the work of R. D. Laing and David Cooper) and, as a result, took on elements of the two traditions. What has happened in most European countries is that the spontaneity and creativity of the so-called "democratic" TC has been overlaid with the structure provided by the American-style TC for drug users.

Additionally, huge changes have been generated within Addiction TCs as governments around the world have introduced changes in respect of how such treatment interventions are paid for and the standards – of human rights, individual responsibility and protection from mistreatment – which are expected of them.

Much has been written about the differences between the three traditions, but most authors have also recognised the fundamental similarities, with all three TC types recognising self-help as a critical element in the recovery (or learning process); the power of the group to achieve and sustain change; and the importance of creating a therapeutic environment – at times challenging and stressful and at other times safe and secure – within which such changes can occur.

Thus, whilst Addiction TCs are "recognisably TC", they do routinely employ some practices which are not normally found within the other two traditions and which are generally a pragmatic response to the particular nature of the addiction experience and the need to protect the community as a drug-free environment.

Since the object is recovery and enhanced maturity and responsibility, many of the restricted liberties, which characterise this approach, are used as privileges to mark the resident's progress towards his/her personal goals. Indeed, this is not simply about restrictions on outside communication and personal spending money etc., but includes the hierarchical structure of the community itself; with the hierarchy functioning as a dynamic and very real reminder, not only of what progress has been made, but crucially, what is ultimately possible.

It is for this reason that most Addiction TCs employ a number of former drug users who have themselves graduated through the system or a similar programme in another TC. This use of role models is not unique to Addiction TCs of course, the Henderson has for many years used a small group of senior residents for precisely this purpose, but it is generally more central to the process in Addiction TCs.

It would be wrong to over-emphasise these differences from the other TC traditions; although they do undoubtedly set Addiction TCs apart and they are generally central to the aims and objectives of the organisations which employ them. But there is an underlying and very fundamental set of similarities which are a common and precious legacy of the TC tradition generally.

More detailed information regarding the work and beliefs of Addiction TCs can be found in the following core texts:

De Leon, G. (1992) *The Therapeutic Community: Theory, Model, and Method*. New York: Springer Publishing Company.

Kooyman, M. (1992) *The therapeutic community for addicts: intimacy, parent involvement and treatment outcome*. Lisse: Swets & Zeitlinger.

Rawlings, B. & Yates, R. eds (2001) *Therapeutic Communities for the Treatment of Drug Users*. London: Jessica Kingsley.

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Appendix 2 - Glossary

Act as if: Act as if, Think as if, and Be. A simple form of Cognitive Behavioural Therapy that brings the simple elements of human psychology (i.e. affect, behaviour and cognition) together in a positive way to change mood and adapt to difficult situations.

Care Plan: A plan that requires client assessment (qualitative or quantitative) that identifies deficits in the areas of cognition, affect, behaviour, social aspects, physical/medical, education/career path and finance. The plan is developed and agreed between the staff member and the client forming the basis of client objectives which is reviewed regularly.

Client members: All residents receiving treatment in the community.

Community members: both staff and client members.

Privileges: Rewards earned by client members for appropriate contributions to the community and their treatment.

Sanctions: Penalties used as reinforcements of community rules and boundaries. Sanctions should be related to the inappropriate behaviour and reflect real life and the broader community so that clients can make the connection between their past transgressions in society and repeated patterns of behaviours; that behavioural choices do elicit or result in certain consequences and that a process of extinction relative to negative responses and behaviour should begin to be internalised and implemented.

Senior Community Members: Staff members and/or clients members in the final stage of the programme with additional responsibilities.

Staff Members: All contracted staff (paid or voluntary) working in the community.

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Appendix 4 – What is the Community of Communities?

- Community of Communities (C of C) is a standards-based quality improvement network which brings together Therapeutic Communities (TCs) in the UK and internationally.
- Member communities are located in Health, Education, Social Care and Prison settings. They cater for adults and children with a range of complex needs, including:
    - Personality Disorders
    - Mental Health Problems
    - Offending Behaviour
    - Addictions
    - Learning Disability
- C of C is part of at the Royal College of Psychiatrists' Centre for Quality Improvement and works in partnership with the European Federation of Therapeutic Communities (EFTC), Association of Therapeutic Communities (ATC), the Charterhouse Group (ChG) and the Planned Environment Therapy Trust (PETT).
- Funding is from members' subscriptions and a Big Lottery grant.

What do we do?

- Develop specialist service standards in an annual consultation process with members.
- Manage an annual cycle of self- and peer-review where the emphasis is on engagement as opposed to inspection.
- Provide detailed local reports which identify action points and areas of achievement.
- Publish an annual report which presents an overview of collective performance, identifies common themes and allows for benchmarking.
- Host a number of events and opportunities for members to share their experiences, learn from others and gain support.

What are our aims?

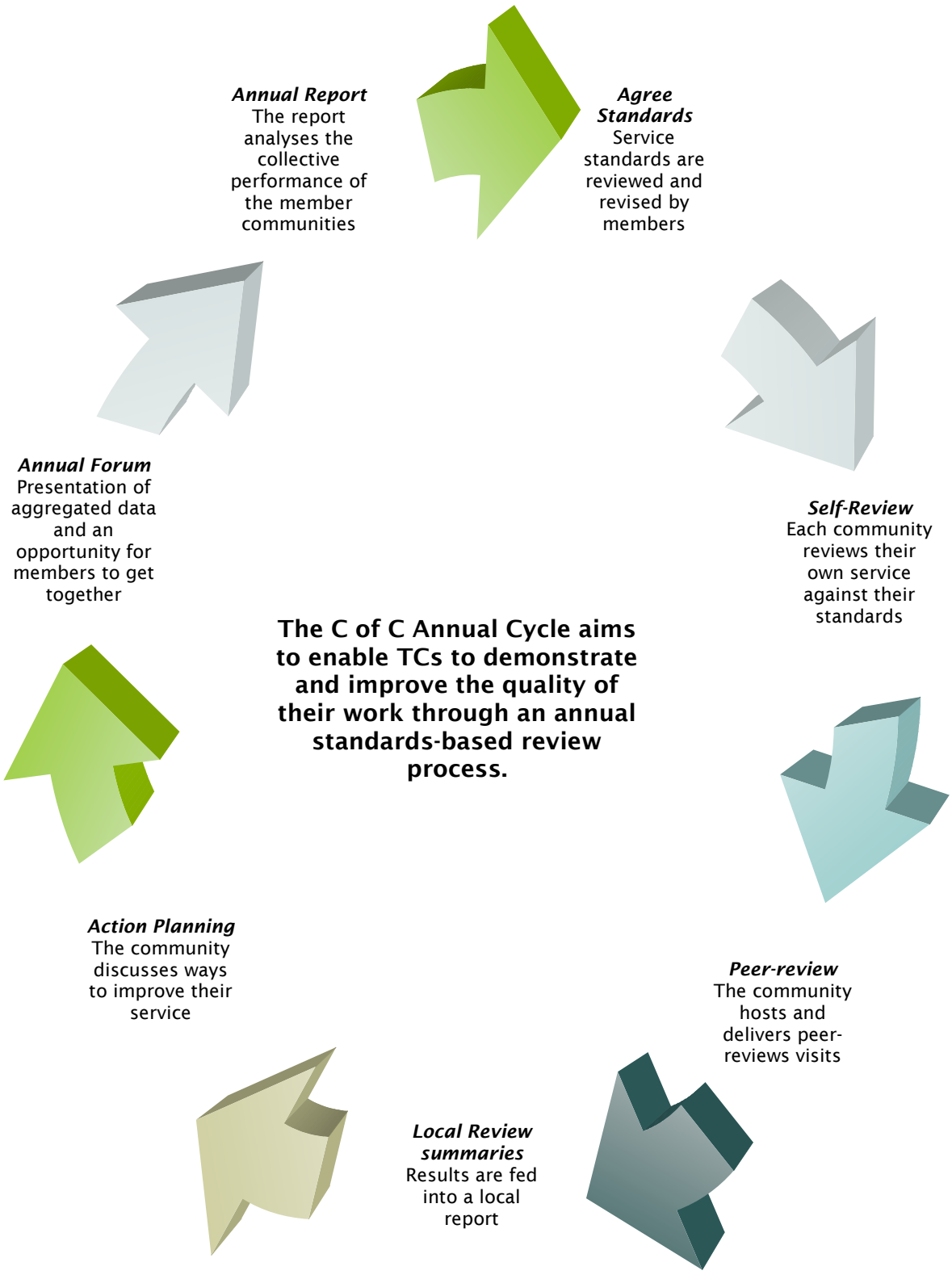
- Provide specialist service standards which identify and describe good TC practice and provide a democratically agreed definition of the model.
- Enable therapeutic communities to engage in service evaluation and quality improvement using methods and values that reflect their philosophy, specifically the belief that responsibility is best promoted through interdependence.
- Develop a common language which will facilitate effective relationships with commissioners, senior managers and the wider world.
- Provide a strong network of supportive relationships.
- Promote best practice through shared learning and developing external links.

Members Feedback

"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."

"Useful (process) because it makes you question how you are performing, what you are actually working toward and face up to shortcomings. It is important to keep asking why things are being done the way they are"

Appendix 5 – The Annual Cycle



Appendix 6 – Standards Feedback Form

We hope you have found the Service Standards for Addiction Therapeutic Communities useful and we would appreciate your feedback. Your comments will be incorporated, with the approval of CATC members, into future editions of this publication.

1. Have you found these standards useful? ☐ Yes ☐ No

Comments:

2. Do you have suggestions for new sections/topic areas or new standards or criteria you would like to see included in future versions?

3. Do you have any general suggestions about this document that would improve its usefulness?

4. What is your interest in these standards e.g. service user, carer, professional?

Thank you for taking the time to complete this form. Your comments will be considered carefully.

Please photocopy and return to: The Community of Addiction Therapeutic Communities, The Royal College of Psychiatrists' Centre for Quality Improvement, 4th Floor, Standon House, 21 Mansell Street, London E1 8AA. Fax: 020 7481 4831.

Appendix 7 - Acknowledgements

The Community of Communities would like to thank the members of the Advisory Group:

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Community of Communities

A Quality Network of Therapeutic Communities

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