



**Milieu approaches and other adaptations of therapeutic
community method: past and future**

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	TC	TC milieu	'Community as Doctor'	TC influenced inpatient wards	Community of Communities	Enabling Environments	PIPES	PIES	AIMS	Notes
Open communication	✓✓	✓	~	✓	✓✓	✓✓	✓✓	✓✓	x	Includes 'Culture of Enquiry' and 'Freeing of communication'
Reflective Space	✓✓	✓	~	✓	✓✓	✓✓	✓✓	✓✓	✓	Includes 'the analysis of all events'
Social pedagogy	✓✓	✓	✓✓	~	✓✓	✓✓	✓✓	✓✓	x	Includes 'learning experiences' and 'reality confrontation'. Different to 'social learning': see Broekaert
Democracy	✓✓	✓	✓✓	x	✓✓	✓	~	✓	xx	Includes flattened or fluid hierarchy, and democratisation
Staff cohesion	✓✓	✓	~	x	✓✓	✓✓	✓✓	✓	~	Includes role examination and staff groups
Community meetings	✓✓	✓	~	✓	✓✓	x	~	x	✓	Held regularly and open to all
Permissiveness	✓	~	✓✓	x	✓	~	x	x	xx	Does not include allowing emotion to be showed, only behaviour
Social learning	✓	✓	✓✓	✓	✓✓	✓	✓	~	~	Includes 'reality confrontation'. Different to 'social pedagogy'; grounded in behaviourism: see Broekaert
Communitarianism	✓	✓	✓✓	~	✓✓	✓	✓	✓	~	Includes 'communalism', and sharing of amenities and tasks.
Anti-paternalism	✓	~	~	x	✓✓	✓	✓	~	~	Opposes passivity, 'kind firmness' or 'indulgence', and supports 'rights and responsibilities'
Agency and empowerment focus	✓	~	~	~	✓✓	✓	✓	✓	~	Includes autonomy, self-efficacy and individualtion
Therapeutic responsibility	✓	x	~	x	✓✓	~	✓	x	xx	Shared responsibility for self and others
Relational focus	✓	✓	~	x	✓✓	✓✓	✓✓	✓	x	Implies 'quality of relationships' is more salient than individual symptoms or characteristics
Psychotherapy groups	✓	x	~	x	✓✓	x	x	x	x	For example, analytic small groups, psychodrama, gestalt, transactional analysis, creative arts, etc
Individual psychotherapy	xx	x	~	~	xx	x	x	✓	x	Does not include irregular case management meetings
Whole system	x	xx	~	xx	✓✓	✓✓	~	✓	xx	Implies that attention and thought is actively given to the superordinate system
Seen as specific treatment	✓✓	xx	~	xx	✓✓	xx	~	~	xx	Only applies when there is no or minimal use of adjunctive treatments
Needing specialist staff	✓	x	~	~	✓✓	✓	✓✓		x	Meaning specialist for the environmental approach
Has discrete premises	✓	✓✓	~	✓✓	✓	~	✓✓	✓✓	✓✓	Excludes networks and distributed operations, or 'TCs without walls'

KEY:
 ✓✓ definitely present
 ✓ commonly present
 ~ not relevant/unclear
 x uncommonly present
 xx definitely absent

Milieu approaches and other adaptations of therapeutic community method: past and future

Abstract

Purpose. The paper provides an overview of the application of therapeutic community (TC) method in non-TC environments.

Approach. Milieu treatment is defined and differentiated from TC 'proper'. Literature is reviewed covering attempts to use TC methods in inpatient wards, across hospitals, and more recently in the criminal justice system and more widely through the enabling environments initiative.

Findings. It is unclear whether TC milieu treatments proved helpful in acute ward environments in their heyday in the 1950s, 60s and 70s, in particular those involving people suffering from acute psychosis, and the changing landscape of psychiatric provision may make further investigation difficult. The reasons for this, and for the difficulties reaching a firm conclusion, are outlined. In contrast, TC milieu interventions appear to be demonstrating usefulness more recently in less mixed populations without the implementation of full TC 'proper'.

Limitations. Much of the original research is old and the methodology poor, which limits the conclusions that can be drawn.

Practical implications. Recent innovations pick up in a more accessible way principles of therapeutic communities that can inform and improve care in a variety of contexts. They are sufficiently well defined to lend themselves to research, which should now be a priority.

Keywords: milieu therapy, therapeutic community, inpatients, enabling environments, psychologically informed environments.

Introduction

The therapeutic community (TC) approach has flourished in different settings across the lifecycle. One of these areas is the application of TC principles to residential environments for adults that fell short of the highly structured 'TC proper'. Clarke labelled this range of techniques the 'TC approach' (Clarke 1965). More widely known as the TC milieu approach, it became widespread on psychiatric wards in the 1960s and 1970s, falling into disuse in the 1980s only to re-emerge recently in initiatives such as Enabling Environments, Psychologically informed environments and Psychologically informed planned environments, which apply the approach to settings beyond hospital wards. In this paper we examine the historical trajectory of this set of techniques, and consider modern developments and their impact on wider systems.

Therapeutic communities can be thought of as *proper*, *approach* and *influenced*. Many of the psychiatric wards known as TCs were probably TC approach, and recently most health TCs 'proper' have become non-residential. For the sake of consistency, *TC approach* environments will be referred to here as TC milieu treatments, and *TC proper* as simply TC.

The origins and development of the milieu approach

Defining milieu treatment

Milieu treatment or therapy has in the TC literature often been used synonymously with therapeutic community (see for example Abrams 1969 and Schwartz & Farmer 1968). In the general psychiatric literature it is used in a much more general sense to refer to a variety of approaches that try to use the environment to contribute to recovery, most of which were probably not related to therapeutic community approaches; Price & Moos (1975) identified six varieties of ward treatment environments, of which four were milieu oriented, but only one of which had more than a few TC elements akin to Clark's 'therapeutic community approach'. A complicating factor is that the word milieu is a synonym of environment, and there is no accepted definition or term for milieu treatment based on TC principles of empowerment, democracy, and communitarianism. Thus the 'Guide to the Order Sheet' in use at the Menninger Clinic sets out an approach to a 'therapeutic milieu' based on psychoanalytic principles, in which a doctor stipulates interventions and approaches to be used by all staff in contact with patients, tailored according to each patient's difficulties understood in psychoanalytic terms

(Menninger 1982). Although including structured activities, there is no sign of democratisation, flattened hierarchy or a culture of enquiry in this approach, and attitudes such as 'kind firmness' and 'indulgence' probably ran counter to a TC conception of a milieu treatment. On the other hand there are approaches that use TC principles without an apparent connection to the TC movement or TC theory. An example of this is The Borde Clinic in France, which since the 1950s has used principles of examined living, flattened hierarchy, 'living alongside', democratisation and devolved responsibility within the tradition of institutional psychotherapy (Mackie 2016). The lack of a definition for TC milieu treatment fatally hampered efforts to identify, implement and research the approach at the time when it appeared to be widespread in the 1950s and 60s (Zeitlyn 1967), a problem that continues to the present.

Quoting Rioch (Rioch & Stanton 1951), Ellsworth et al (Ellsworth, Maroney et al. 1971) define milieu treatment as the 'modification of the environmental part of the patient-environment process with a view to facilitating more satisfactory patterns of interaction'. Lansen identified three types of milieu treatment programmes (Lansen 1982); in addition to a social therapeutic model, which he related to the work of Maxwell Jones and David Clark, he identified a supportive model based on psychoeducation and work and discouraging regression, based on the work of Cumming and Cumming (Cumming, Cumming 1969), and a reconstructive model based on regression occurring in small groups. We are interested here not in the broad group of approaches involving environmental manipulation in the interests of patient treatment and wellbeing, but the subset derived from, or incorporating, therapeutic community principles, Lansen's 'social therapeutic' intervention. These programmes aimed to create a society for the benefit of its members, as opposed to applying principles of management via the environment and staff-patient interactions. They generally had the following elements in common, which differentiated them from more generic milieu approaches:

Table 1: Features of TC milieu treatment.

1. Giving patients responsibility in day to day tasks, and some elements of ward management (Hyde & Solomon 1950)
2. Some element of devolved responsibility for treatment decisions and an emphasis on self-management
3. Encouraging all staff and other patients to see themselves as agents of change in a patient's treatment
4. Decreasing hierarchical and professional barriers between patients and staff in order to encourage agency and involvement from patients and discourage passivity (Zeitlyn 1967).
5. Attention to 'reflective living' (see for example the Austen Riggs website <http://www.austenriggs.org/therapeutic-community-program>): the encouragement of mentalising in day to day interactions on the unit, and the attempt to understand behaviours as communications (social analysis, see for example (Lansen 1982)).
6. The use of regular community groups to promote reflection and address administrative manners in a democratic way. Holmes regards this use of what he calls group therapy, along with staff support groups, as essential to solving the problems of acute wards by implementing a psychotherapeutic culture (Holmes 2002).
7. Staff reflection, normally via staff (sensitivity) groups.

Such TC-approach milieus would also include some elements shared with other milieu approaches. Thus they often incorporated structured group activities, generally including some kind of productive work and skills acquisition. Similarly the principle of examined living was shared with other approaches. In TC milieu approaches, the examination would typically be by the group as a whole (Main 1977a), whereas in other milieu environments this would usually have been by the staff, and the nature of their observations and conclusions may not have been communicated to the patients. Many of the more psychoanalytic milieu approaches, such as the Menninger Clinic in the US, included individual psychoanalytic therapy in addition to group meetings. This appears to have been unusual, as it was in residential TCs at the time with the exception of The Cassel Hospital in the UK and The Austen Riggs Centre in the US.

In contrast, therapeutic communities operated a more rigorous and contained system, with members having responsibility for running the programme and administration as far as is practical, including

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3 having input into admissions and discharges. Clark thought the essential elements of 'TC proper' were
4 the freeing of communications, the analysis of all events, the provision of learning experiences,
5 flattening of the authority pyramid, role-examination, and the regular occurrence of a community
6 meeting. (Clark 2013, originally published in 1964). He defined the 'TC approach' by its not having all
7 six of these elements, rather than by the presence of any specific one.

8
9 Several elements of TC are difficult to implement in a heterogeneous inpatient environment. TC
10 features that are less prominent or less likely to occur in TC milieu treatments include a *culture of*
11 *enquiry* incorporating role examination. While a certain amount of flattening or fluidity of traditional
12 hierarchies does seem to have been a feature of TC milieu approaches, the robust challenge of
13 accepted procedures and norms is more characteristic of a therapeutic community. Tom Main, who
14 coined the term (Main 1977b), originally applied it to institutions, thinking of it as an analytic attitude
15 that is necessary to maintain a therapeutic culture. It can be uncomfortable for staff, and is therefore
16 one of the most challenging TC methods to apply to normal inpatient wards, although the widespread
17 adoption of elements of democratisation noted by Winship (2004) indicates elements were
18 implemented in some TC milieus. For similar reasons, Clarke's *analysis of all events* is likely to be
19 severely curtailed in milieu treatment. Some acutely ill patients may be made worse by robust
20 feedback and frequent reality confrontation, which can come to resemble the elements of high
21 expressed emotion that appears to promote relapse in psychosis (Miklowitz & Johnson 2006).
22 Therapeutic community methods have been found in some studies not to benefit inpatients with
23 schizophrenia (Van Putten 1973), presumably for this reason. The use of regular *large and small*
24 *groups*, the latter with a more explicitly psychodynamic focus (as opposed to community groups,
25 which are central to both TCs and TC milieu treatments), is also challenging in TC milieu treatment. In
26 mixed diagnosis psychiatric wards, very disturbed or psychotic patients are likely to have difficulty
27 engaging in depth psychological work. *Elected leadership* as a concrete demonstration of devolved
28 governance also poses challenges. Winship (2004) noted elements of democratisation in the 1990s in
29 inpatient wards in the UK, and there was at times patient involvement in administrative tasks and
30 higher level decision making, but this generally requires a more cohesive culture such as is likely to
31 develop in a TC. Finally, *permissiveness*, which is possible in very contained environments such as TCs,
32 may lead to violence or disorder in environments with frequent turnover of psychotic or manic
33 patients.

34 **The differences between TC milieu treatment and therapeutic community.**

35 This question is made difficult by loose definitions of the two ideas in the historical literature. Some
36 hospital programmes labelled therapeutic community seem to have been TC-proper, catering for a
37 particular patient group in a discrete unit. Francis Dixon Lodge in Leicester and Winterbourne TC at
38 Fairmile Hospital seem to fit this description. Other places described as therapeutic communities
39 appear to have had a looser structure better described as TC milieu treatment (Myers, 'The mental
40 hospital therapeutic community in recent years', in Hinshelwood and Manning, 1979). This might
41 include whole hospitals, such as Dingleton, and wards with high turnover and little control over
42 admissions, such as Street Ward at Fulbourn Hospital and Ward 6 at the Bethlem Hospital. In 1966
43 Myers and Clark report finding only six units that could be described as 'TC proper' in the UK (Myers &
44 Clark 1972). They list the features of a TC proper used in their survey as small face-to-face intensive
45 treatment unit concentrating on continual analysis of events, community meetings, role examination
46 and blurring, and flattening of the authority pyramid.

47 **Research on the milieu treatment in psychiatric and neurological wards**

48 Milieu treatment was investigated in some depth in the 1960s and 1970s, often in comparison to
49 token economies, another systems approach to inpatient environments more common at the time.
50 Results were generally good. Reasons for the decline in the popularity of token economies since that
51 time are likely to be partly applicable to milieu treatments. Glynn (1990) reviews the literature, and
52 gives the reasons for the decline of token economies as the rise of community treatment and
53 decrease in length of inpatient stay, staff unwillingness, financial constraints, and legal and ethical
54 difficulties. There may in addition be a general problem implementing a system that is at odds with
55 the wider hospital philosophy (Hall & Baker 1973). A Cochrane review (McMonagle 2000) found only
56 3 high quality randomised studies and concluded that the benefits of a token economy approach in
57 schizophrenia were unclear and may not persist after discharge, but this may have been due to the
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age of the studies, two of which were from the 1970s. There have been similar problems conclusively demonstrating the effectiveness of TC milieu treatments (Trauer 1984). Differentiating between TC milieu treatment and behavioural programmes in the research can at times be difficult, and some investigators have used the term 'milieu treatment' to refer simply to a set of rules and requirements that are applied to all residents of a ward (see for example (Berglas & Levendusky 1985)).

Research on TC milieu treatment can generally be divided into studies populated by mixed psychiatric populations, in which schizophrenia was a common diagnosis, and those of smaller units which often described themselves as TC wards but which probably conformed more closely to a definition of TC milieu treatment for the reasons given above. Results from the latter were generally positive, but are often reported along with results from TCs in review articles from the times (for example Clark 1977) as well as more recently (Lees, Manning et al. 1999).

Research on TC milieu treatment in mixed psychiatric populations gave more mixed results. In an early study in 1971, Ellsworth et al (Ellsworth, Maroney et al. 1971) found a correlation between involving patients in ward administration and low subsequent readmission rates, but noted that many chronic psychiatric patients prefer an authoritarian and low involvement ward. Authoritarian wards in this study led to quicker discharge, but higher readmission rates. Letemendia (Letemendia, Harris et al. 1967) compared results in schizophrenic patients at Littlemore Hospital in Oxford, in which a TC milieu ward operated in half the hospital (The Phoenix Unit). They found no significant differences with patients treated in the non TC part of the hospital.

Two decades later, Armstrong et al. compared a psycho-educational ward with a 'traditional psychiatric milieu', by which they meant a group therapy approach which encouraged informal social interaction (Armstrong, Cox et al. 1991). They describe the latter as based on therapeutic community principles, using a socialization milieu to encourage social learning from informal interactions, a supportive and accepting environment, with informal outings and social contact between formal activities, volunteering for chores, and self-help skills building. They also describe ways in which the environment would deviate from TC milieu treatment; empowerment was tolerated rather than encouraged (called 'choice making'), there was no flattened hierarchy between patients and staff or emphasis on authenticity and staff-patient informal mixing, and the intervention was aimed at adjusting to current circumstances rather than promoting a return to normal roles. The way the study was described and constructed illustrates some of the problems that stem from the lack of an operationalized description of milieu treatment. The study found broadly similar outcomes between the two wards in a mixed group of psychiatric patients, some of whom suffered from schizophrenia, except in self-esteem, in which the psycho-educational programme was superior. Interpretation is made difficult by the fact that the description of the psycho-educational programme also bears similarities to a TC milieu approach, being described as providing a structured social milieu to enhance patients' abilities to interact with others, choice making being actively fostered, and patients being encouraged to work towards returning to normal roles.

These two studies give an indication of the methodological difficulties older studies now pose. Vaglum et al (Vaglum, Friis et al. 1985) reviewed a number of these studies, concluding that for TC milieu treatment to be beneficial for psychotic patients they require a number of major modifications, in particular that individual treatment should be more prominent, and groups more structured. They note that many of the variables that are likely to influence outcome, such as ward atmosphere measures, were not investigated. There are notable exceptions, such as Myers et al, (Myers & Clark 1972) who probably used more robust implementation of TC milieu treatment (bordering on TC) and found advantages over a traditional ward in a mixed diagnosis general psychiatric inpatient population.

A parallel strand draws attention to a group of patients with personality disorder who regress or deteriorate in milieu environments that are permissive without clear and consistently enforced boundaries. Although this is not a feature of properly constituted TC milieu treatments, several of the programmes that adopted some TC principles in the 1950s, 60s and 70s emphasised permissiveness at the expense of boundaries and containment. So Goldberg et al identified five patients who deteriorated in such a milieu but recovered rapidly when transferred to state hospitals that had a

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3 more custodial or neglectful approach (Goldberg & Rubin 1964). They postulated that the lack of
4 therapeutic intent (benign neglect) combined with substandard conditions combined to motivate
5 patients to recover. Pardes et al likewise identified 5 out of 107 patients who deteriorated on a
6 milieu ward that emphasised permissiveness (Pardes, Bjork et al. 1972). The patients were all women,
7 and the authors identified among them a tendency to somatise, to act out, and to carry out
8 'ineffectual suicide attempts'. Quoting Main (1957), they identified a feeling that 'someone other
9 than herself should be responsible for her', and with Main noted that their group of patients stirred
10 up strong emotions in staff.

11 **Why TC milieu treatment on wards declined**

12 Many of the improvements brought about by TC milieu treatment quickly became mainstream.
13 Although improvements to the environment such as unlocking doors started on milieu units, the
14 introduction of antipsychotics such as chlorpromazine may have made similar advances possible
15 across the rest of the mental health estate (there is disagreement about this; Letemendia et al
16 thought it unlikely (Letemendia, Harris et al. 1967)). Having not been prominent in some areas, the
17 principles of moral treatment - the humane treatment of patients - spread gradually, possibly partly
18 under the influence of the antipsychiatry movement and popular cultural attention such as to RD
19 Laing and Ken Kesey. The related, but more explicit and countercultural, emphasis on self-help and
20 empowerment arising from the TC movement (Hollander 1981), was also spreading at this time. By
21 the 1980s, a survey of 23 wards at the Maudsley Hospital found all but one used patient groups and
22 had elements of democratisation (Winship personal communication), and in the 1990s and 2000s
23 patient representation in the administration of health resources became policy (Winship 2004). In
24 2000, the UK NHS plan noted "the relationship between service and patient is too hierarchical and
25 paternalistic" (quoted in Winship 2004), a statement expressing therapeutic community principles
26 that had been widespread in the NHS for most of the preceding 50 years. In 2002 the inpatient
27 guidelines at the Maudsley Hospital gave as an example of good practice a weekly community group,
28 encouraging democratic decision making, and patient involvement in staff interviews (Winship 2004).

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30 Milieu treatments probably declined after their clinical and research heyday in the 1970s for some of
31 the same reasons that token economy approaches did. Large asylums began to close, and the
32 numbers of inpatients declined rapidly (The Commission to review the provision of acute inpatient
33 psychiatric care for adults, 2015). Inpatient stays became shorter, making it more difficult to
34 implement thoughtfully and carefully constructed programmes, and resources shifted to community-
35 based treatments. Milieu wards require more resources in terms of staff time and training, and the
36 emphasis during inpatient stays shifted to drug treatment and rapid turnover. Some of the reasons
37 for the decline in token economic approaches were probably less significant for milieu treatments, for
38 example staff resistance and legal and ethical challenges (Glynn 1990). Belinda Mackie refers to a
39 psychoanalytic explanation for the difficulty institutions have in implementing a therapeutic culture
40 (Mackie 2016). Quoting Bott-Spillius (Bott-Spillius 1990), she proposes that the need to keep madness
41 contained and separate defeats attempts to understand people in disturbed ward environments. She
42 proposes staff often prove unable to tolerate the anxiety of understanding and closeness, leading to
43 an initial enthusiasm for therapeutic interventions which later founder and are abandoned.

44
45 An additional challenge to the persistence of TC milieu treatment was the relative paucity of high
46 quality outcome evidence. The precise nature of the approach was sometimes described, for example
47 by use of a ward atmosphere scale, but not manualised in a reliable way (Vaglum, Friis et al. 1985).
48 This was also a problem for other milieu approaches, such as that espoused by Cumming and
49 Cumming (Cumming & Cumming 1969), whose handbook does not allow the reliable recreation of
50 their method. Most of the quantitative research was carried out by behaviourists, and favoured
51 token economic approaches. The milieu approach as implemented with long stay in-patient
52 populations in the 1960s and 1970s would have been dealing to a great extent with patients with
53 schizophrenia, the only diagnosis mentioned with any regularity in the research cited above, and one
54 which as noted above poses particular risks in TC milieus beyond the difficulties of engaging acutely ill
55 patients. Nevertheless more recently research has indicated the possibility of benefit in this group;
56 Gaskin et al identified a number of modifications to psychiatric inpatient units that appear to reduce
57 the need for seclusion, including TC milieu treatment (Gaskin, Elsom et al. 2007). The research they
58 refer to also demonstrated reduced staff sickness (Mistral, Hall et al. 2002).

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4 There is a wider question over the suitability of TC milieu treatment in wards accommodating very ill
5 patients. Manic and psychotic patients are unlikely to be able to participate in devolved governance in
6 a way that benefits either them or the rest of the ward community, and elements of milieu treatment
7 such as examined living may have little impact on such patients, running the risk of provoking a
8 deterioration. The relatively higher proportion of very ill patients in modern acute psychiatric wards is
9 likely to require a modification of the TC milieu treatment. Some attempts have been made to bridge
10 this gap, for example by the Acute Inpatient Mental Health Service (AIMS) quality network, an
11 initiative of the Royal College of Psychiatrists in the UK. The AIMS programme includes a section
12 entitled 'Therapeutic milieu', and recommends staff support groups, that staff be trained in group
13 methods, that a patient community meeting be held regularly, shared decision making, and
14 spontaneous staff-patient activities.

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16 In addition to the changing nature of inpatient provision and the lack of research, overapplication and
17 the lack of a technology or precise definition of TC milieu treatment have been cited as reasons for
18 the decline of the method (Trauer 1984, Delaney 1997). Several authors have noted that differently
19 constructed ward environments benefit different patient groups (see for example Moos 1967, Van
20 Putten 1973), and that a TC milieu treatment is therefore unlikely to be universally useful. The
21 problem of technology includes the lack of central concepts/propositions, and the failure to identify
22 critical processes that bring about change (Delaney 1997). In TCs these problems are being addressed
23 (see for example Pearce & Pickard 2013, Pearce & Haigh 2017), but TC milieu treatment approaches
24 continue to suffer from a lack of clarity of definition (Zeitlyn 1967).

25 26 **The parallel decline in 'therapeutic communities proper', and adaptations of the TC method**

27 Like TC milieu treatment, therapeutic communities experienced their greatest expansion and spread
28 in the 1960s and 1970s, in part fuelled by the countercultural social revolution which made mental
29 health a public issue. The subsequent reduction in number of TC programmes was influenced by some
30 of the same systemic pressures as those affecting TC milieu treatments, in particular the need for
31 shorter and cheaper interventions. This has led to the remaining health TCs becoming day
32 programmes rather than residential (Pearce & Haigh 2008), and an increasing emphasis on outcomes.
33 A number of innovative ways of delivering TC treatment that have arisen from these pressures are
34 outlined below.

35
36 New TCs have arisen which use adaptations to ensure efficiency and accessibility. A central 'hub' is
37 now often used as the main centre with a full programme, with spokes providing less intensive
38 treatments which are locally accessible. Staff and resources are efficiently shared, and coordinated
39 pathways offer suitably phased treatments. This is the model used in the Oxfordshire and
40 Buckinghamshire Complex Needs Service, subject of the first modern randomised controlled trial of
41 democratic therapeutic community treatment (Pearce, Scott et al. 2016) and accompanying cost (and
42 carbon) offset study (Maughan, Lillywhite et al. 2016). This clinical model is described in detail by the
43 authors (Pearce & Haigh 2017).

44
45 Another adaptive approach within a smaller town is to have a 'hub' community, which meets for two
46 or three hours per week, closely connected to other therapeutic opportunities in the town. In this
47 way members can construct an individualised programme tailored to their own needs. The group
48 process in the 'hub' community establishes an experience of continuity and containment across the
49 different elements, as long as the staff are in good communication across the professional,
50 organisational and sector boundaries. Inclusion of nature-based groups, such as ecotherapy or
51 greencare, can enrich such programmes, reduce stigma and become a normal part of general
52 community activity in the town (Haigh 2017, in press).

53
54 'Enabling Environments' is a portfolio-based award process which recognises and identifies locations
55 in which 'relational practice' – derived from therapeutic community method – is taking place (Haigh,
56 Harrison et al. 2012). These locations can be mental health units, prison wings, day centres, church
57 groups or any other setting in which the relationship between 'recipient' and 'provider' is open to
58 scrutiny and change. The standards are based on values distilled from several years' data from the
59 Community of Communities quality network:
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1	1	BELONGING	The nature and quality of relationships are of primary importance
2	2	BOUNDARIES	There are expectations of behaviour and processes to maintain and review them
3	3	COMMUNICATION	It is recognised that people communicate in different ways
4	4	DEVELOPMENT	There are opportunities to be spontaneous and try new things
5	5	INVOLVEMENT	Everyone shares responsibility for the environment
6	6	SAFETY	Support is available for everyone
7	7	STRUCTURE	Engagement and purposeful activity is actively encouraged
8	8	EMPOWERMENT	Power and authority are open to discussion
9	9	LEADERSHIP	Leadership takes responsibility for the environment being enabling
10	10	OPENNESS	External relationships are sought and valued

This award is also part of the criminal justice sector's 'Psychologically Informed Planned Environments' ('PIPEs') programme. A similar relational environments initiative has been developed for the housing and homelessness sector, and these have been called 'Psychologically Informed Environments' ('PIEs') (Johnson & Haigh 2010).

In the field of children's therapeutic communities, changes in commissioning and funding arrangements, as well as policy against units which could be seen as 'institutional', has allowed a new type of unit to emerge. These commonly have less than six members in a domestic-scale house, with a multidisciplinary staff team. They are run by third sector or private organisations and are referred to under the umbrella term of 'therapeutic child care'. Larger communities with more than a dozen children or adolescents are now uncommon and only a small number of them still exist as more highly specialised units.

A different approach which has many values and practices in common with therapeutic communities is that of 'greencare' or 'ecotherapy' (Haigh 2012). Here nature is included as an integral part of the therapy, and the foundation ethics of permaculture (people, planet and democratically agreed fair shares) give TC clinical practice added dimensions of sustainability and, possibly, spirituality.

There are many units and services, in all sectors, which informally adhere to models of psychologically informed care or relational practice. It could be considered unfortunate, now that all health and care services are subject to rigorous regulation and adherence to standards, that these regulations and standards do not generally include any measures to encourage relational practice or to promote enabling / therapeutic environments. They may sometimes do the opposite.

Table 2 here.

Table 2 shows the key features of the various therapeutic community definitions and adaptations discussed in the text. Note features of specific projects, such as the Acute Inpatient Mental Health Service quality network, will depend on implementation.

Conclusion

Some of the current difficulties in psychiatric inpatient provision, such as staff inaccessibility and poor environments (Baker, Sanderson et al. 2014a), high levels of assault and intimidation, and patients feeling unsafe (Baker, Sanderson et al. 2014b), are likely to be related to the loss of elements of TC milieu practice outlined here. TC Milieu approaches are now successfully being implemented in hostels (as PIEs) and prisons (as PIPEs), and in other areas as enabling environments. There is room for a more robust development of TC milieu techniques in inpatient units and other settings, including through the Acute Inpatient Mental Health Service (AIMS) quality network, which incorporates some elements of TC milieu technique.

There is an urgent need for research into the essential elements of TC milieu treatment, and their impact, both in traditional settings such as psychiatric wards, and in PIPEs, PIEs, enabling environments, and the 'hub' community network with ecotherapy described above. It is difficult to

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3 tell how effective these approaches were in their initial implementation in the 1960s and 1970s, and
4 elements of those early experiments have entered mainstream provision without necessarily having
5 good data on their impact. In some cases, such as patient choice and the promotion of
6 empowerment, outcome data may be less important than ethical considerations. However, a number
7 of potentially important elements of milieu treatment and relational practice are no longer
8 widespread, for reasons which may have more to do with resources and regulation than impact and
9 outcome.

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