THE NAKED TC:
Can a TC prosper without finance, buildings or staff?

Peter R Holmes, PhD
Susan B Williams PhD
(Christ Church Deal. Kent, UK)

(Published in Therapeutic Communities 2010, 31 (3))

ABSTRACT
Without funding, without its own building and without any paid therapeutic or medical staff, Christ Church Deal is a TC with a difference. For twelve years it has relied on its social and relational processes for the continuity of the therapeutic dynamic in the community. The authors, who were co-founders of the community, suggest that equipping members to carry personal and mutual responsibility has been a core element in the maintenance of the life of the community. They also highlight several other aspects of the TC that have contributed to its survival without the support of finance, buildings or staff.

INTRODUCING CHRIST CHURCH DEAL

Christ Church Deal is an independent church affiliated to the Evangelical Alliance, while also being a TC with membership of the Association of Therapeutic Communities. It has been a peer-reviewed member of the Community of Communities network at the Royal College of Psychiatrists' Centre for Quality Improvement for the last 5 years. We are located in Deal, Kent, UK, a sleepy seaside town on the extreme east coast of Kent, overlooking the French coast a few miles north of Dover.

Without funding, without our own building and without any paid therapeutic or medical staff Christ Church Deal is a TC with a difference. Some may see missing these elements as a handicap for a TC, but then we had not set out with the intention of forming this type of community.[1] Without the institutional, financial and traditional psychiatric frameworks that many TC's have, we have been free from normal external structures and processes that might have shaped our behaviour. Instead our practices have simply evolved out of the momentum and enthusiasm of the members. We have been on a learning journey, exploring how to create a salugenic[2] (wholeness-inducing) environment shaped primarily by the needs of the members.

Our realisation that we were a therapeutic community was one of the outcomes of our research (Holmes 2005, Williams 2002, 2007). Rigorous analysis of focus group and questionnaire data led to a number of findings that were surprising to those of us who had been founder members of the community.

Amongst those findings was the discovery that what members appreciated most about being part of CCD was that it was successfully enabling transformative change[3] in their lives. Furthermore members consistently reported that it was 'the community' of CCD that was the most effective agent of change in their lives, whilst also being the most challenging part of membership of CCD. As we explored the implications of this finding there was little precedent in theology or ecclesiology. But Haigh's (1999) quintessence introduced us to the possibility that CCD could be viewed as a TC. Further research, together with discussions with numerous TC specialists[4] confirmed our preliminary findings that although somewhat unconventional, CCD was indeed a therapeutic community.

OUR GOAL

In Christ Church Deal (CCD) we take a holistic approach to the idea of being healed or becoming more whole. We teach a journey that concurrently includes not just personal therapeutic aspects, but education, life skills, re-establishing family ties on a healthy basis and 'finding one's place' in society. Together these can bring about such positive change that the person becomes able to provide for themselves, initiate and sustain long-term mutual relationships, and achieve full citizenship in society in any way they choose. Experiences of healing occur within an ongoing journey toward greater wholeness.

This holistic goal has evolved over many years and is based not so much on a medical or therapeutic model, but more on human need and hunger to change. We treat the therapeutic process as just one part of sustaining an ongoing improvement in members' quality of life. Unless all areas of a person's life are sensitively addressed, any one of them has the capability of undermining their wholeness journey.

We have come to believe that such a broad goal is at the heart of the TC mission. This contrasts with the prevailing viewpoint among some agencies that the best that can be hoped for is to teach the person to cope with the damage in their life. Our unremitting long-term priority in CCD is to heal and train a person to be both independent and interdependent with others, equipping them to be able to support, love and care for themselves as well as for those around them. This includes enabling them to pursue their dreams. The processes of our TC involve both undoing the damage of the past and equipping a journey of 'becoming'.

THE LIFE OF THE COMMUNITY

The absence of formal funding means members are able to participate in the life of the community over an extended period of time, integrating its various activities into their daily life as a way of life – all without time limits. We have a full social programme, family events, regular activities focusing around a mixture church life and the therapeutic dynamic of the community. These include a weekly therapeutically-oriented informal church service, weekly small groups prioritising the healing and growth needs of members, weekend training and support workshops, and numerous self-initiated meetings for more intensive therapeutic support. However, having no money means there are no paid staff. We have never formally retained therapists or other more typical TC team members. We describe ourselves as a 'lay' therapeutic community for this reason.

With a membership over the years from 50-120 adults + children, we have varying levels of participation. Some members have adaptable diaries and significantly draw from or contribute to the daily dynamics of community life. Others have family, employment or educational commitments and their level of involvement is limited to their spare time. Some have significant need, others equally significant experience accumulated in the community and perhaps professionally over the years. Each is expected to share what they have, when they can. This creates a flexible timetable, continually changing relationships, and at times chaotic periods of instability.

We do not have one dedicated building or programme for a daily meeting which all members must routinely attend. Nor can we rely on employed staff to take responsibility for oversight of the therapeutic process on a daily basis. Instead, if people do not open their homes we have nowhere to meet during the week. If we are not willing to support each other, there is no-one to support us.

As a result of these dynamics, even we have been forced to question what it is that keeps our TC alive? Our research in our community over the last decade or more has allowed us to accrue a growing longitudinal perspective on the processes and dynamics that are central to the life of the community. Although not exhaustive this has given us the framework for better understanding what is going on, psychologically, sociologically and theologically.

THE KEY DISTINCTIVE – A SHIFT OF RESPONSIBILITY

A key distinctive of our model is the marked shift of responsibility, in both personal journeying and community life, away from a more normal reliance on medical and professional practice toward a mutuality of members. Without professional staff and the framework that comes with this, there can be no direct dependence on a professional team who might take responsibility for the individual.

From day one it is assumed the new member is joining the community in order to change. This is also helped by the small number of third-party referrals. Most members come entirely on their own initiative, introduced to the community through friends or local connections. Once in the community a client/member cannot ever presume of the 'staff' that '*it's your job to get me well'*, as there is no one to say this to. Although initially quite frightening, for the many whose reliance on staff expertise is an approach that has failed in the past, it can be refreshing and full of hope to know they are personally responsible and will be themselves equipped to learn how to positively change. When the newcomer realizes, in due course, that they are perhaps their biggest obstacle in the process of change, personal responsibility becomes even more significant.

Another consequence of this shift of responsibility is that it creates a greater reliance on the existing 'experts by experience' (Holmes & Williams 2009) within our community. These community members

act as the equivalent of voluntary staff in whatever situations they are needed. Experiencing their first moment of transformative change qualifies each member to begin their journey as an expert by experience. This builds a 'therapeutic IQ' (Holmes & Williams 2009) enabling the person to accept and become even better equipped to take up ongoing responsibility for themselves, as well as supporting others to do the same.

The mutuality of the shared ongoing pursuit of such wholeness contributes significantly toward the resource necessary for the successful continuity of the community. Without professional expertise members are encouraged to involve several others in joint responsibility for support through diagnostics, mentoring and small groups. This builds the 'therapeutic *group* IQ' (Holmes and Williams 2009) that is at the heart of the community.

Using this 'lay' approach of experts by experience is not unlike Tom Main's at the Northfield military hospital, where he put groups of men together with no professional input and told them to talk to each other about their problems and experiences. For many this simple initiative proved life-giving and life-changing (Main 1946). Other very famous TCs follow a different type of lay model, like the Geel community that began in 1250, where residents in the town still offer hospitality to those with mental illness (Roosens 1979). In CCD, members live in their own homes in a small town, often sharing homes with each other. The close geographic proximity clearly contributes to our therapeutic dynamic. But instead of simply providing hospitality our experience is specifically a mutual journeying shared by every member of the community. The life of the community is in the range of relationships committed to simultaneously giving and receiving the expertise accrued from transformative change.

RESPONSIBILITY IN PRACTICE

A shift in responsibility undergirds the life of the community in several ways:

- Each person must find their own personal reasons for wanting to become well. Where a professional team is not available to rely on, the individual is required to decide for themselves whether they really do have the hunger to change – that is, identifying if they are willing to pay the price to change? Change is not someone else's initiative – it must be self-motivated. Encouragement is provided from others in the community with similar background who themselves are a living demonstration of the potential for healing and its benefits, thus increasing the motivation.

- A shift in responsibility also requires mutual learning. In the absence of a staff team, should a person conclude they need to change, they must themselves then learn the necessary tools for such change and growth (Martin 1962:150). This prioritises their own personal responsibility to go through two forms of change, firstly learning how to 'be' in the community, then in time learning how to appropriate the truth and skills to internalize these tools (Watzlawick *et al.* 1974:10). This heightens the importance and value of learned experience – theirs and others – on the journey to possessing more wholeness. Each person needs to learn from everyone else, and then to pass on that learning.

- Openness is also a key dimension of responsibility. When another person is holding up a mirror to you and that friend also welcomes you doing the same for them, transparency become spontaneous and mutual, so that trust is established. For responsibility to be mutual, such openness is essential. Our confidentiality policy relies explicitly on planned disclosure.

- Once trust is built, truth becomes less diluted. In a more traditional medical model an individual can persistently continue to blame others or circumstances for their plight. However, in an environment that prioritises responsibility a person's own admission of their (often unintentional) complicity in their disorders is more naturally and spontaneously shared. This makes personal responsibility very much 'in your face' (Jones 1973:326, Bishop 1985:12).

- Responsibility for the 'naked' TC processes in the community rests with members of the community, rather than with any staff or structure. Although the community has had various leadership teams and styles over the years, leaders have always been clear that without members' mutual responsibility, leadership would be powerless to maintain the life of the TC. Although exceptions are made for newcomers and for those in temporarily heightened need, all members are expected to play their part. When any one member doesn't take responsibility, the whole community suffers.

OTHER CONTRIBUTORY DYNAMICS

Several other dynamics appear to contribute to the sustaining of the life of the TC when there are few externally imposed structures.

Flexibility, diversity and common journeying: As a voluntary, open and long-term community our membership is very diverse. This brings a richness of both relationship and experience to the community, thereby deepening its resources. It allows each member to contribute their own, often newly-found, strengths, in a way that suits their changing interests and commitments. The continual growth of all members is explicitly encouraged.

Yet our research has shown that although everyone's needs and experience are unique, some issues are common to almost everyone, e.g., the need for acceptance, the power to choose, experiencing a healthy balance of safety and freedom. So it is the combination of diversity and commonality that brings balance to our community, making it more reflective of the wider social environment that members continue to engage in normal day-to-day life.

Success is contagious: Rather than technique or qualification, members' own experience becomes the means of change. Each person talks openly about what they are achieving and how it is happening. In CCD no damage is considered healed until others can see the positive change. Once spoken about and visible such success is supportively 'gossiped' throughout the community. So each member has available to them from other members a range of experience and insight on how to begin to identify their own damage, their baggage and its scripts (Haigh 1999:254). No excuses are possible, neither are they tolerated long-term. If someone is seeking change and if it has worked for nine other people who are willing to offer support the way others supported them, then there is no choice but to get real and deal with it! Our research demonstrated that this 'positive peer pressure' can contribute significantly to the momentum for change in the community.

A holistic approach: We are explicit about encouraging development of a balance of IQ, emotional intelligence (EQ) (Goleman 1995), social intelligence (Goleman 2006) and SQ (spiritual intelligence) (Zohar and Marshall 2000). We consider all of these to be of equal importance, although emotional and spiritual intelligence are often the most neglected in day-to-day life. Members continue their daily lives, including study or career development (supported by psychometrics) when they choose. They will often have other members of their immediate family also participate in the life of the community (e.g. partners, children etc.).

The holistic approach also brings a balance to the life of the community, ensuring it is healthy for people to participate as long-term members. Without it we would expect members to leave once they feel their therapeutic journey is complete, which in turn would make the community less viable. Whilst some members do choose to leave as their need for the support of the community gradually lessens, many continue in active membership, being long-term culture-carriers that support the life of the community. Others become occasional 'fringe' members, keeping friendship with the community but participating less.

Moving from emotional damage to emotional health: We have adopted the perspective that human disorder and its baggage, in part at least, is rooted in the neglect and lack of *emotional* health. This can be epitomised in the tendency to place much more importance on cognition, but far less on the emotional drives. As a result some of the 'primary drives' that contribute to personal need often

remain hidden 'below the waterline'. When community life has a holistic dimension, emotion refuses to be silenced. Feelings may often be talked about, they may even be understood, but at CCD members teach each other how to cathartically engage with the feelings, to actually feel them. This helps in the process of letting go of the damage of the past and prepares the way for building emotional health.

Catharsis or abreaction brings greater integration to growing wholeness, particularly for men who can sometimes find expression of their feelings a challenge. Finding tears and letting go of toxic trauma can be very positive to emotional healing and wholeness. In CCD it is common, in groups or with mentor support, to engage the raw emotion from historic trauma, as often as necessary and until its toxicity has gone. Such shared cathartic moments build deep relationships and are easily transferrable skills, enabling each person to help each other without extensive training.

Members will often arrive in the community with a suspicion or fear of their emotion, perhaps having found it unhelpfully overwhelming at times in their past. Teaching is provided and numerous testimonies shared about the healing members have experienced as a result of a cathartic approach. Precision is encouraged through our process of 'diagnostics' to identify the underlying issue 'below the waterline', so the person can choose which specific area of damage they feel ready to engage emotionally. A first experience of such catharsis will often mean the person can then take responsibility for a systematic supported pursuit of greater emotional health.

Relationships damage us, so it is relationships that must help make us well: One of the single biggest challenges facing a new member to the community is the question of whether they are going to open up and trust others? The therapeutic culture of a TC emphatically adheres to the idea that we cannot heal ourselves privately. In CCD this is even more essential, since we cannot rely on a one-to-one model. Instead we invite everyone to walk the more risky and often more difficult pathway of relational transparency and belonging (Haigh 1999:247). The help of others becomes essential for each person's own journey. The integrating of wholesome supportive relationships is something we all need to (sometimes painfully) learn to embrace into our daily life. The daily relational dynamic of TC life becomes the essential means of change and the primary means of finding wholeness (Erikson and Erikson 1997:8).[5]

Mentoring and training others creates in us a range of life skills: Our holistic approach to wholeness means that we teach a person whatever they need to know and learn in order for them to become a more engaged citizen of society. In this sense there is never a point at which a person's journey is ever complete. Instead, as a community we contribute to each other's building and learning of relationships and skills for our future, whatever direction that takes. This could mean a person needs to learn a great deal, from personal hygiene to cooking, reading and writing to ironing, and running a home and/or a car, and all be achieved within a budget! Others are grappling with the challenges of job interviews, postgraduate qualifications or buying their first home. But with no staff, each person learns these skills from others who generously give of their time and experience. The profound gratitude for such life-changing learning most often produces in us a commitment to make available to others the same gift.

Taking your time on your journey: One of the greatest gifts that CCD offers to newcomers is the gift of the unhurried chase. With no financially-imposed time constraints, it will typically take a person six months before they begin deeply engaging their 'homework', even though they will be talking about it as though they are doing it long before this. The stress and constraints of a twelve session, three month or even twelve month program are unnecessary. Many who find their way to us have not fitted well into these structured programmes.

Those of us who have done a therapeutic journey know that it will usually get worse before it gets better. This is a particularly unpopular message in an age that promises instant answers and the idea that we all have the right to be free from our pain. But to a person trapped in the 'revolving door' of unremitting damage or abuse, this can be good news. It offers an explanation for the ongoing battles and apparent lack of improvement, and therefore increases their commitment in the difficult times.

They can see the hope of some real healing on the other side, as they learn the bruising facts of why they have not done this journey before! The freedom to participate in the community long-term allows greater investment in the relationships that are the fabric of the community.

Helping one another redeem education: Mental and emotional problems tend to steal from our education and professional development. Yet because we are all unique we must all find our natural skill set and our emotional and spiritual gifting. So although our education and training will be unique, as will our gifting and personhood, we all need to learn what we are good at, and develop this to the level we need. It is not unusual in our community for members to discover a new field of expertise, and pursue it to postgraduate or even doctoral level or become a vocational specialist. As a result of involvement with the community we have 8 PhDs and 22 other postgraduate qualifications in process or completed. In addition numerous members have completed 1st degrees, vocational qualifications or taken other steps to commence recover lost educational potential. This expertise becomes an additional resource for the community.[6]

The value of human life: Behind much of our community's motivation is the belief in the value of any one individual – 'one matters' - as well as the sacredness and value of all human life. This often proves very important, as it encourages us to give full support to each individual, but when they slow down, quit, or revert to former habits it is then much easier to let them take 'time out', and for others to forgive and still honour them. Participation remains voluntary, so the members involved at any one time are those who are most committed to the change processes. This continues to promote ongoing change at the heart of the community, provoking a continuous cycle of personal and organisational development.

Creating a safe place: Believing you are in a safe place is an essential precursor to change in our community as well as others (Williams 2007, Campling 1999). Without such a 'safe place' it is hard to open up and learn how to change. In CCD the capacity of the members themselves to keep the processes of the community safe is even more important, since there are no staff to turn to. In those seasons of our community when we fail to maintain the level of safety we need, the visible resulting weakening of the therapeutic process has stimulated a surge of recommitment to mutual support. In CCD there are few formally established routines and structures to hide the reality of what is happening. Members know they need to act themselves in order to maintain the vigour of community life. No-one is paid to keep the community alive.

Being a faith community: We are aware that as a faith community we benefit from an additional dynamic. Whilst personal faith is not a requirement for participation in the community, a majority of members are explicitly seeking simultaneous growth in their spiritual life. This brings a combination of meaning and values that we have found to be coherent with TC life.

However in our data collection members were surprisingly explicit in their explanations for their enthusiasm for CCD in comparison to their experiences of previous faith communities. Rather than attributing CCD's success to a traditional church-related dynamic, they emphasised its capacity to help them change, to deal with damage from their past, to support them in their journey of personal growth. Our research led us to the conclusion that the characteristics they highlighted closely corresponded with TC practice. We are aware therefore, that without the TC dynamic as a fundamental part of the life of this faith community, it would need more formal and traditional structures of leadership and process.

THE VULNERABILITIES

In a community where the TC culture is maintained by process and relationships instead of by structure, there are a significant number of vulnerabilities. Most notably our research has highlighted the fragility of the change-enabling 'atmosphere'. The emotional safety of the environment is the shared responsibility of all members. If this is ignored by a majority the community begins to become less effective. We have observed a number of such seasons in CCD. They have been self-remedying – when members feel the core values of the community are under threat several will begin to take an

initiative to rectify this and a new season begins. But this ebb and flow is perhaps more exposed because of the lack of traditional TC structures.

This type of TC is most suitable for those who are able to intentionally choose to pursue wholeness. A personal commitment to change is required for the process to be beneficial. We have discovered the community has grown 'permeable boundaries' of membership, allowing participants to have a loose affiliation (a fringe membership) with the community until they are ready to make a commitment for the next step in their journey of change. Members will step out of community life for a time and then return several months (or years) later. This pattern has been more common of men than of women. It has become an accepted part of the dynamic of the community.

The process of leaving is challenging in most TCs and CCD is no exception. In some ways the permeable boundaries and long-term membership of the community help to minimise this problem. However those who choose to leave completely do so without a clearly defined 'end of programme'. This can cause complexities, misunderstandings and feelings of betrayal. Whilst an uncommon occurrence it often creates a challenging moment when relationships feel more fragile.

Our suspicion is that most of our other vulnerabilities are shared in common with more traditional TCs. We are saved crises of funding, threats from external agencies, imposition from others sharing the same facilities, etc. However the need to continually ensure authenticity in relationship and mutual commitment to journeying into wholeness are sensitive dynamics that need continual affirmation from members.

AND SO?

So we ask, can a TC prosper without finance, buildings or staff? The answer is an emphatic yes. The relational therapeutic social processes that are at the heart of TC values sustain the life of our community. They are drawn out from among us, for without them in this model there is nothing left that maintains the life of the therapeutic community.

On our own admission however, this is a risky challenging venture. The milieu in our community may at times be more fragile than most TCs, and indeed than most churches, relying as we do on the quality of the voluntary participation of members. We also place a heavy reliance on values such as responsibility and openness, together with a more holistic approach to the wholeness journey in meeting the ongoing needs of our more experienced members. This in turn means they can themselves benefit by becoming a contributor by their expertise. But it remains true that in such a 'naked' atmosphere the essence of TC practice can still flourish.

Peter R Holmes PhD
Susan B Williams PhD
(Christ Church Deal, Windsor 2009)

BIBLIOGRAPHY

Baum, G. (1975), *Religion and alienation: A theological reading of sociology*. New York: Paulist Press.
Bishop, L.C. (1985), 'Healing in the koinonia: Therapeutic dynamics of church community', *Journal of Psychology and Theology*, 13, 1, 12-20.
Campling, P. (1999), 'Boundaries: Discussion of a difficult transition', *in* Campling, P. and Haigh, R. (eds.), *Therapeutic Communities: Past, present and future.* London: Jessica Kingsley, pp. 90-98.
Clinebell, H. (1966/1984), *Basic Types of Pastoral Care and Counselling: Resources for the ministry of healing and growth.* London: SCM Press.
Erikson, E.H. and Erikson, J.M. (1997), *The Life Cycle completed.* New York: Norton.
Goleman, D. (1995), *Emotional Intelligence.* New York: Bantam Books.
--- (2006), *Social Intelligence: The new science of human relationship.* London: Hutchinson.
Haigh, R. (1999), 'The quintessence of a therapeutic environment', *in* Campling, P. and Haigh, R. (eds.), *Therapeutic Communities: Past, present and future.* London: Jessica Kingsley, pp. 246-256.
Holmes, P.R. (2005), *Becoming More Human,* Bletchley, Paternoster Press

Holmes, P.R. and Williams, S.B. (2009), 'Experts-by-experience: Discovering the heart of a therapeutic group IQ', *Therapeutic Communities*, 30, 3.
Jones, M. (1973), 'Therapeutic community concepts and the future', *in* Rossi, J.J. and Philstead, W.J. (eds.), *The Therapeutic Community: A sourcebook of readings.* New York: Behavioral Publications, pp. 325-336.
Kooyman, M. (1993), *The therapeutic community for addicts: Intimacy, parent involvement and treatment success.* Amsterdam: Swets & Zeitlinger.
Main, T.F. (1946), 'The hospital as a therapeutic institution', *The Bulletin Of The Menninger Clinic,* 66-70.
Mischler, E.G., (1999), *Storylines: Craftartists' narratives of identity.* London: Harvard University Press.
Martin, D.V. (1962), *Adventure in Psychiatry: Social change in a mental hospital.* London: Bruno Cassirer Publications.
McNair, J. and Swartz, S.L. (1997), 'Local church support to individuals with developmental disabilities', *Education and Training in Mental Retardation and Developmental Disabilities,* 32, 4, 304-312.
Peck, M.S. (1987), *The Different Drum: Community-making and peace.* New York: Simon & Schuster.
Roosens, E. (1979), *Mental Patients in Town Life: Geel - Europe's first therapeutic community.* Beverly Hills: Sage Publications.
Snyder, H.A. (1996), *Liberating the church: The ecology of church and kingdom.* Pasedena: Wipf & Stock Publishers.
--- (1996/1998), *The radical Wesley and patterns for church renewal.* Eugene, Oregon: Wipf & Stock Publishers.
Watzlawick, P., Weakland, J.H. and Fisch, R. (1974), *Change: Problems of principle formation and problem resolution.* New York: W.W. Norton & Co.
Williams, S.B., (2002), *Journeys of change in a therapeutic community: A congregational study of Christ Church Deal.* MPhil Thesis, Department of Theology, University of Birmingham
Williams, S.B. (2007), *The salugenic place: Relationships that empower transformative change.* PhD Thesis, Graduate School of Education, University of Bristol
Zohar, D. and Marshall, I. (2000), *SQ: Spiritual Intelligence: the ultimate intelligence.* London: Bloomsbury Publishing Plc.

---

[1] Being a church and a TC we may be unusual, but not by any means unique. See McNair & Swartz (1997), Baum (1975), Peck (1987), Snyder (1996, 1996/1998), etc.

[2] The term 'salugenic' was first used by Clinebell, as a contrast to pathogenic (1966/1984:110) and was first applied to CCD by Holmes (2005) in his research. Williams developed this concept in her thesis (2007).

[3] Transformative change is the concept Williams developed in her research (2007) based on Mischler's distinction between formation, re-formation and transformation of identity (1999:80).

[4] We are grateful for the insight from the Chairperson of the Association of Therapeutic Communities (ATC) in leading a peer review team within the Community of Communities programme to clarify that, despite its eccentricities, CCD was a TC. We have also enjoyed stimulating dialogue during presentations and discussions at the Windsor Conference of the ATC and numerous other events, which have helped clarify the common and unique aspects of the TC process at CCD.

[5] Becoming part of a community is especially challenging for those with certain disorders, like addiction (Kooyman 1993) and psychotic breakdown, that have tended to cut them off from social networks.

[6] At the time of data collection 48 people (41%) had commenced formal education since joining the community, whether that was learning to read, an 'Access' programme or undergraduate/postgraduate courses. This was in addition to the 7% who were already studying before joining the congregation. A further 16 had made significant career moves, previously unplanned.