Abstract

Introduction

The Therapeutic Community (TC) is an intervention which uses principles of working together democratically to enhance self-agency. While availability of inpatient NHS TCs has declined, shorter or alternative interventions using core TC approaches have shown promise in enacting change. In this paper, we report and reflect on a pilot nano-TC

Method

Foundations Group was a two-hour therapeutic community (TC) group intervention set up and run within the NHS for eighteen months in 2021-2022, and taking place in a City Farm. The group was convened as part of the Complex Emotional Needs service in a mental health NHS Trust in the South West of England. Over the study period, the group comprised eleven members, one peer member and three staff members. We present here a description of the characteristics and processes of the group and give our reflections on each aspect.

Results

We reflected on the TC stance of working democratically with a fluid hierarchy, taking a non-expert approach, and using support and challenge to enhance self-agency and belongingness. We have detailed the structure of the group session including use of community meetings, psychoeducation, creative sessions, and reviews. Members took on roles within the group including chairing sessions.

Discussion

This group was a novel service within the Trust where it was conducted and may represent a standalone therapeutic group. We hope it will show that core TC principles can be applied in shorter interventions than have previously been used.

Declaration

The authors declare that this work is original, represents their own work and no versions of it have been published previously elsewhere.

Introduction

Therapeutic Communities (TCs) are environments where the relational use of collective decision-making can build self-agency amongst people with a range of difficulties to change behaviour and allow members to live their lives in a way that is meaningful to them. Building on principles learned from therapeutic groups developed during the second world war, clinicians such as Maxwell Jones and Tom Main distilled their experiences into an intervention they saw as being a community within a hospital (Whiteley, 2004). Four principles of the TC were described by Rapoport (1960) as democracy, communalism, permissiveness, and reality confrontation, and more recently Haigh (2013) has described the 'quintessence' of the TC in terms of attachment, containment, communication, inclusion and agency; these being seen as important in emotional development.

The approach has been characterised by a number of features, described in Pearce and Haigh (2017a). The intervention is residential with group members living together as well as spending social and meal times together. Tasks are completed together and decisions are made by discussion and voting between all members. A flattened hierarchy means that staff have an equal vote within the group and take a non-expert stance. All members are expected to bring and hear feedback on their own experience and views of others, and there is an emphasis on personal responsibility with challenge when this is seen as not taken. A timetable of psychotherapeutic, creative and communal activities is strictly held, with unstructured open spaces within some of these sessions where members can air their views and comment on the experience.

Since the 1940s, TCs have been used in a variety of settings, including prisons, substance use centres, inpatient health care services and the community (Whiteley, 2004). TCs have been recommended by the UK government for the treatment of Personality Disorder (e.g. National Institute for Mental Health in England, 2003). Pearce and Pickard (2017) have suggested that the key attributes of positive change in TC treatment for Personality Disorder may be the optimisation of belongingness and self-agency which may be lacking amongst this group, often as a result of past trauma, neglect, or insecure attachment styles.

Over time, residential TCs in the health services of the United Kingdom have been closed, with only one remaining open in West London. In more recent years, less intensive models have been used as a pragmatic and cost-saving intervention in non-residential settings but which are designed to maintain the key TC principles. Although awaiting formal accreditation from the Royal College of Psychiatry Community of Communities, one-day non-residential TCs labelled 'Mini-TCs' and even a 'Micro-TC' have been developed (Pearce and Haigh, 2008) with positive outcomes reported (e.g. Barr *et al*, 2010). Furthermore, alternative interventions have been adapted which use elements of TC principles in other formats, such as the Mentalising-Based TC (Ruscombe-King *et al*, 2017), adaptation of ward environments such as the Enabling Environments or Psychologically Informed Environments programmes, and other uses of the TC 'milieu' (Pearce and Haigh, 2017b).

Assimilation of quantitative research evidence can be somewhat difficult in the TC intervention for a number of reasons – the intervention is relatively long, goals and outcomes are different for each member with no clear (or desired) identification of what they will be at the beginning of treatment, a curriculum decided live during the intervention rather than in advance, and formation of a control group is challenging. Nevertheless, Pearce *et al* published the first Randomised Clinical Trial of a TC in 2017 showing improvements in self- and other-directed aggression and satisfaction with care compared with a group receiving treatment as usual. More research with robust methodology and large size will be needed to demonstrate the benefits of core TC principles amongst other evidence-based interventions, to make no mention of adaptations.

In this study, a group of clinicians with experience or interest in the TC intervention co-created a novel TC-based group in one NHS mental health trust in the South West of England. This intervention was shorter than both the Mini-DTC and Micro-DTC model and was therefore named the 'Nano-TC'. We will here describe and reflect on the Nano-TC's formation and history as well as the possibility of future NHS TC approaches.

Method

The Nano-TC was named Foundations Group and convened weekly for two hours. We developed an initial timetable of a 45-minute community meeting, a 15-minute break, a 45-minute session alternating between psychoeducation, creative, or review sessions, following by a final 15-minute community meeting. The group voted twice to change aspects of the timetable during group review sessions; to move the longer community meeting after the break, and again to change it back to the original configuration. Community meetings consisted of an individual check-in which included any contacts with health services or each other, then an open space for members to talk about what they heard or said in check-in, responses from the previous week, or any other thoughts. The timetable and chair's script were developed using examples given in Pearce & Haigh (2017) then laminated for use by the group in sessions. Timings were held consistently, including start and finish times.

Members could join for up to twelve months, and the overall length of the pilot group was eighteen months. The group began with five members, and additional members joined every three months or so. We were not able to offer the final two cohorts a full twelve month experience; instead they joined for a maximum of 10 months and seven months respectively. We took this into account when considering selection and were explicit with potential group members in the assessment process. In total, eleven members joined the group over the 18 months period.

Results

In this section we will describe various aspects of the group, then reflect on our experiences in the paragraphs in italics.

Location

The group took place at a local City Farm in a relatively central location of the city. Room hire was funded by the Trust's Complex Emotional Needs team for the duration of the group. The location was a working farm with a large number of staff and volunteers and education and training groups facilitated. The group convened in the same room on farm grounds throughout.

We felt it was very important to be away from NHS premises not only due to the relatively inorganic and neglected environment, associations with past treatments and traumas, as well as an attempt to reduce the power differential. The location was new to all of us, meaning that we as NHS staff had no more control over the environment than group members. The farm itself was a green and nurturing place to be, including a working farm with volunteers and a children's nursery on site. We felt it represented genuine options to group members working towards leaving mental health services to volunteer and take on peer roles. It has to be said, there was also a great cafe.

Staffing

Staff group members initially comprised a higher trainee in Medical Psychotherapy and General Adult Psychiatry trained in psychodynamic psychotherapy, group analysis, MBT and CAT and a Complex Emotional Needs Senior Practitioner with social work core profession and background in MBT, case management and therapeutic groupwork. We had a backup member of staff who attended if one of the above staff could not make a group, and this person was also a Complex Emotional Needs Senior Practitioner with occupational health core profession and attachment therapy background. Later in the group we were joined by another senior trainee in Medical Psychotherapy and General Adult Psychiatry.

The multidisciplinary and multi-modality experience of the staff allowed for a wide variety of therapeutic approaches. We as staff could learn from each other within the group and play with ideas alongside members. Having a backup staff member helped us to optimise consistency when there was staff absence the group. The back-up staff member often talked about the differences she had seen in members between the sessions she attended, offering an outside witness role. Later when one original staff member had to leave the group and was unable to return, the back-up member joined full time which allowed for a level of continuity during a difficult loss. When some new group members were initially unsure who were staff members within the group, we took this as a sign of success in our equalizing stance (see below).

Peer Inclusion

We were joined by a member of staff in the trust with lived experience who during the project was promoted to Band 7 Senior Lived Experience Practitioner. The role of peer member was designed to allow group members contact with someone who self-identified with a diagnosis of Personality Disorder, who had been through therapy herself, and who was successfully working as a professional in the same field. Our peer member did not have experience of Therapeutic Communities so learned about the concept alongside group members. She shared her ongoing successes and challenges in life and took part in activities as did group and staff members. She also joined staff in debriefing and supervision (see below). We had originally planned to involve more people with lived experience early in the group, but found there were a number of challenges involved in the role which we wanted to understand further before inviting others.

We found it incredibly valuable to have a peer member in the group. Group members could talk and open up to her in a different way than towards staff. Sharing her own difficulties allowed members to discover they did not have to aim to be perfect and not have any problems, and that this was an unrealistic target. At times she disagreed with staff or declined to take part in an aspect of an activity and this showed group members they also had agency in their engagement and could speak up. The approach felt collaborative and rigorous, and we enjoyed the challenge. We

were also keen to show group members that they could be valued in both the experiences they had and in how they had worked hard to manage their difficulties. We took time to understand the difference in relationships and the need for support both within and outside the group.

Our peer member writes: I initially felt a pressure to be a role-model and show that I was "well" and had overcome all the challenges of having a personality disorder. But with time, I realised this was less helpful than demonstrating there were times when I did struggle, both inside and outside of the group. It was a challenge to share this side of myself as it reminded me of my past as well as ongoing difficult experiences. I found it quite exposing sharing my experiences, perhaps more so with the staff members who I worked with professionally, but it was interesting to see how the staff members used their therapeutic backgrounds differently and I was able to use some of the concepts in my own life. Having been through various therapies, I had to get used to this shift in role which was not quite staff and not taking part in therapy myself, and this was new for us all. Being in this group helped me see how far I had come in my own recovery, but I could also identify with many of the difficult times people in the group were describing which could be triggering. It took a while to find a comfortable balance for responding from outside the group member or staff member role.Ultimately, I was proud to be able to support the group with my own experiences, and also be supported by members.

Membership

We wanted to invite people to join the group who felt stuck within mental health services, either because they were seen as 'not ready for therapy', or who had tried other approaches and not found a benefit. We initially approached those from the two senior practitioner staff members' caseloads who they felt may be interested and discussed it with them directly. Later, care coordinators elsewhere in the service could refer to us. We sought diversity in terms of demographic variables (including age, gender, ethnicity, sexuality) and also in presentation, for example people with a range of interpersonal styles and differences in how they expressed their difficulties. We coproduced a flyer and longer leaflet for potential members emphasising our core values of promoting strengths, choice, and self-agency. We had 'information

sessions' rather than assessments as our main inclusion criteria was a willingness to engage and we wanted to support those who wished to attend.

We had identified a group of people who had not made progress in mental health services and where it appeared that services had located difficulty in the person themselves. They were people 'stuck' in the system or who had deteriorated within it due to chronic high risk patterns or relational 'malaise'. We wanted to provide hope and the possibility of change that we believed in ourselves. The recruitment process was much more straightforward for those with whom we already had an established relationship as there was a level of trust in what was being offered. When we opened up to referrals for people we did not know, this was a more demanding process. It could be a challenge to explain our principles to staff who would be making the first approach, and we had to offer several meetings and involve our peer member to build trust. There were more people from this group who declined to join than amongst our pre-known members, but we felt that for some, declining was an act of empowerment since several people let us know that that had felt pressure to agree to join. While we made efforts to optimise diversity and this improved over the course of the group, we felt we could have done better on this, especially given the poorer outcomes and experience relating to epistemic violence, racial discrimination and profiling experienced by non-white service users.

Stance

Staff members took on the familiar TC stance of acting as equal group members who are 'non-expert' but who may have relevant knowledge and experience, in common with all members. Staff members also practised self-disclosure in sharing some details of their lives and difficulties. This was in the context of strict self-determined boundaries as to what could and could not be shared, and discussed regularly in briefings and supervision. We also used a stance of support and challenge.

Our experience of this stance was very freeing, especially amongst staff trained in psychotherapy modalities where self-disclosure is strongly discouraged. We felt we were able to bring our 'whole self' into the work and this was a different way of being to what we were used to in a formal NHS professional role.Our practice felt more

robust and relevant with the constant requirement to be available and reflexive in group time while responding to challenges from the group. Although this was emotionally and physically tiring, we felt as though we grew in our work and also in ourselves, much more than in traditional therapy settings. As it was a new stance, we committed to remaining curious together about our involvement, self-disclosure and boundaries. Group members let us know it was helpful to see us as human with our own challenges rather than as 'perfect professionals', which was seen as alienating and an unachievable ambition for themselves. Members responded with pride and self-esteem when they were able to support us as staff with demonstrable results, for example in supporting one staff member to complete a half-marathon and another to drive on motorways for the first time. Our enduring stance of support allowed us to make therapeutic challenge, which seemed an effective method for increasing self-agency while limiting feelings of criticism and judgement.

Support

Staff and our peer member met immediately before the group started, briefly during the break (staff only, allowing the peer member to socialise with the group members), and again after the group finished. We came to realise that our emotions could be high immediately after the group and we felt we needed a further check-in on another day between groups. We also had monthly external supervision. Initially this was from Dr Steve Pearce, consultant medical psychotherapist in the Oxford Health Complex Emotional Needs team who volunteered his time to support us. Dr Pearce sadly died during this project and a member of his clinical team kindly stepped in to provide supervision for the remainder of the group.

We realised during the planning stages of the group that we would need to meet frequently, and to be as open as possible about our own thoughts and emotions as well as how these related to each other. We felt a need to model what we were asking of our group members in our own professional relationships, and acknowledged these were complex and dynamic. We committed to each other to say what was on our minds, and to receive this from each other with curiosity. In our meetings we talked about how the group had gone, what we noticed from individual members, thoughts about unconscious processes in the group, but just as much

about our own relationships and what had been brought up for us. We believed this was essential for safely maintaining our authenticity and boundaries. We highly valued the external supervision from another service which was using a similar stance but which was well-established. It allowed us perspective and context on what we were trying to achieve, as well as a view on the wider context of our team and place in the mental health services. At times the latter enacted complex dynamics on our group both directly and indirectly, and there were some difficult implications for us as clinicians within the service. We felt our group and the stance within it provoked an uneasiness within the context of our local services which we interpreted as relating to anxiety, projection and paranoia. This discussion is outside the scope of this paper, but requires further exploration when thinking about prospective service commissioning and redesign.

Roles

There were four formal roles in the group, taken on each week by different members. The Chair kept sessions to time and read from a prepared script at designated times to introduce each part of the session. The role of 'Diary' kept the group diary of forthcoming sessions, absences and group roles. The role of 'Writing' took brief notes during community meetings which comprised the process notes for the group. Finally two members on 'Environment' sanitised surfaces, put the chairs away and otherwise tidied up after sessions ended. Members volunteered to take on these roles a week in advance. Those who were reluctant to take on any or a particular role were challenged on this once they had settled in. Group members proposed and voted for a rule which required members to take on roles 'when the time was right for them', with an expectation that this would occur after their three month review.

All group members took on the above roles during their membership. Very few were keen to take on the role of Chair and needed encouragement to do so. Invariably they discovered it was not a difficult job and spontaneously volunteered thereafter. Again, self esteem appeared to be raised when completing a role (especially Chair) which was always associated with positive feedback from other members. We felt the roles increased the sense of purpose and belongingness in the group. Quieter

group members appeared to gain in confidence which we observed in reviews and community meetings, but also socially and in group games.

Content: Community Meeting

At the centre of the group was the community meeting, well-established in Therapeutic Community practice. We had an opening meeting which included a check-in, attendance and apologies, plan for the day and announcements, following by an extended period of unstructured time where the group were invited to comment on anything from check-in, reflections from the last week, or anything else they wanted to say. We also had a short closing community meeting which included group roles for the following week, reflections on the day, and a final 'support slot' where members could offer support to other members, for example with upcoming events or difficult feelings.

The community meeting seemed to epitomise Foundations Group in terms of the unstructured space and stance of staff members. Group members found this difficult at first and described an awkwardness of what to talk about, and how difficult it seemed to be to make decisions (democratically). It took time for members to establish what they could share with others safely, and often members said they were afraid of causing distress to others in the group by talking about difficult material. As members became experienced with the format, community meetings were more smooth and provided members an opportunity to negotiate speaking more about themselves, supporting others, and making suggestions within the group. This created a culture which was then easier for newer members to join, though there was still a period of adjustment for all new members including staff. Members could set priorities for conversation without guidance from staff which felt radical to all. We staff often felt drawn to step in, make decisions, or otherwise manage the group to save time or reduce anxiety and worked hard to avoid this. The draw came from members but also from ourselves and we felt it was unsettling for us to withdraw from an expert stance as taken in other psychotherapies or therapeutic interventions, but in time this became fulfilling.

Content: Psychoeducation and Creative Sessions

The second half of the group rotated between ‘Psychoeducation’, ‘Creative’ and Review sessions. In Psychoeducation sessions, staff members introduced an idea or exercise from a modality of psychotherapy and group members practised and/or discussed this. Didactic elements were kept to a minimum in favour or experiential or interactive activities. Members were free to speak openly about whether they found this helpful and how they could relate it to themselves or others. Handouts were often given but there was no set ‘homework’, rather members were encouraged to continue thinking about or using the concepts and reporting back to the group in the following weeks. We took concepts from Mentalization-Based Treatment (Emotional Thermometer), Compassion-Focussed Therapy (Emotion Regulation Systems), Transaction Analysis (Drama Triangle), Dialectic Behaviour Therapy (DEAR MAN interpersonal effectiveness skill), and many others. Creative sessions involved group members working individually or together with a theme using modalities including art, collage, poetry, creative writing, memes or simply playing a game. Members were encouraged to share what they created and speak about what it meant to them, but not required to do so. Many sessions incorporated both psychoeducation and creative elements, for example from Narrative Therapy (Tree of Life) and Psychodrama (Circle of Strengths). There was no set curriculum of topics and future content was discussed and agreed during group review sessions.

We found that group members were often more relaxed in these sessions especially at an earlier stage of their membership. In contrast to community meetings, psychoeducation and creative sessions were more familiar ground from other environments or interventions with a clearer ‘facilitator’ who set the scene and ran the session. We encouraged a more democratic process however, supporting members to ‘take or leave’ the material or to complete or interpret it in their own way. In particular, members were animated when our peer member took facilitator suggestions in a different way or occasionally declined to take part in an activity and became more able to use their self-agency with the format. Between us we had a wide variety of therapeutic approaches and could draw from all of these when planning sessions. We were responsive in developing sessions based on dynamics and content of the group, as well as explicit group suggestions, and attempted to relate content to what was happening in the group as well as individual material. This

helped us to support members' strengths and interests and allowed us all to get to know one another better. Our sessions were designed to allow for spontaneity and to reflect group dynamics and needed careful planning and running. However, mistakes were named and discussed in the group to show we could work through difficulty through curiosity and collaboration, an integral aspect of relational service delivery.

Content: Review Sessions

Group reviews were scheduled at regular intervals to discuss the rules, vote on any changes in structure, and to think about future session content. During the life of the group, members voted to reverse the structure (community meeting-break-session) and later back again. Additional rules were voted in as above. Occasionally the group voted on session content when there were differences of opinion, for example having a mindfulness session which was proposed by one member and voted against by the group.

Individual reviews were scheduled for three months and nine months into membership. Members were expected to work towards these and the process was discussed regularly. A set of questions was given to members in advance for each of these reviews asking about engagement, strengths and challenges, and what they had learned about themselves. Members were encouraged to prepare answers to the question and would answer them verbally during their review, though some chose to respond spontaneously at the time of review. Reviews lasted around twenty minutes, decided at the beginning of a session. After the set questions were answered, group members could ask questions or give feedback to the member under review. This included staff feedback on their participation and questions aiming to extend the member's self-reflection.Three month reviews focused on getting to know members and how they saw the group, while nine month reviews focused more on endings and plans following membership.

Group reviews became more dynamic as time went on and members became more established in the process. They became more able to comment on existing processes and suggested additional rules. Voting in group reviews provoked a variety of reactions. Some members expressed irritation that decision-making took a

long time and wanted staff members to decide for them, as in previous experiences of mental services and some psychotherapies. Others were pleased to have a say in the structure. We noticed some quieter members increase the ability to hold opposing viewpoints throughout their membership which felt important in their development of self-agency.

Individual review sessions were seen as difficult and stressful by group members, particularly in the period leading up to them. We observed that the three month review seemed to be a transition point for members where, if they completed it, they made an unconscious decision to attach to the group and allowed themselves to be vulnerable amongst members. Reactions were often transformative, including those who shared experiences they had not previously talked about, or simply from being a focus of attention for a sustained period and receiving individual feedback. Members reported that the aftermath of a review could be challenging and were encouraged to take care of themselves over the following week. Most also said they were pleased with what they achieved in sharing more about themselves, and that the group's reaction had encouraged them to continue with this process.

Endings

The open group format meant that later group members experienced endings in the group before their own. Ending dates were made explicit from the point of joining and we referred to them frequently throughout. Endings were marked by departing group members choosing an activity in advance for their last session. Group members wrote in a card and time was given in both community meetings on an ending day for words and reflection between members.

We were alert to endings being potentially difficult and our members agreed with this sentiment. By clarifying the ending dates and talking about them we felt we were preparing members and ourselves for them leaving. Although these were often sad days, they were also often a time of celebration and discussion for members' time in the group and shared experiences. Leaving members talked of their fear for the future but gratitude for the group's support and often hopes and plans. We found these leaving sessions difficult too as members who made it to the end of the year

had embodied the group culture and we were concerned how the group would be after they left. Endings tended to be followed by a period of disquiet in the group as we had to find our identity again.

Discussion

The Foundations Group represents a 'nano-TC' using core principles of the therapeutic community in a brief two-hour weekly group. We hope that our description and reflection above will demonstrate that it is possible to design and implement TC interventions in the 21st century NHS. We were able to run the group with little interference from within or outside our service and engage members with high complexity and risk who had previously been stuck. As staff members we noticed the difference stance from other therapies, with an emphasis on human connection, democratic processes and therapeutic challenge over rigid protocols, professional detachment and a didactic perspective. Group members noticed the focus on sharing aspects of our life and opinions as helping them in authentic communication and modelling of vulnerability. The flattened hierarchy was initially confusing but later deeply appreciated, particularly by members who had felt controlled by services or who had lost their self-agency in a service which relied on responding to crisis reactively.

We felt that the relatively short duration of the group session and overall length of 12 months' attendance could represent a standalone intervention aimed at preparing members for the next stage in their journey of recovery, whether that was in leaving mental health services, engaging in some in-depth psychotherapy, or as several members did, running their own groups in the voluntary sector. Demonstrating this will take careful evaluation using quantitative and qualitative methodology, and our reflections have also allowed us to consider using creative means in addition to traditional research practices. Group members all developed different goals and were supported by the group to make the changes that were important to them. We found that most group members (including us) were not able to predict the type or scale of changes that were desired or ultimately made. This presents a challenge for evaluation (and how engagement is perceived by mental health services) but one which needs to be faced to develop the contextual culture of inquiry which the TC model requires.

We as staff and peer members felt that Foundations Group offered us a profound experience of togetherness and therapeutic intimacy that we will take with us in our future careers. We felt that the TC stance was more in keeping with how we wanted

to work than other therapeutic modalities. We appreciated being able to bring our authentic selves to the work and sharing our minds with group members in a democratic environment where power differentials were reduced. It was rewarding to see group members who had felt stuck and hopeless gain confidence and skills before our eyes. Seeing them support each other and us was a very valuable experience and one that we would wish for other clinicians to have. The process was extremely tiring and provoked emotional responses and we felt we were working just as hard as group members in developing ourselves.

The process of creating and running this nano-TC was complex and required a high level of planning, reflection and support throughout. We found we needed a number of regular meetings where we could discuss not only the content and dynamics of the group, but our own issues and needs. External supervision was essential to keep and outsider perspective on our activity and we greatly appreciated the opportunities we had to achieve this. It was very useful to have staff from a variety of professional backgrounds and therapeutic modalities. Our peer role was also extremely valuable and we would recommend this remain a key part of TC-related endeavours, again with careful planning, monitoring and feedback. We underestimated the difficulties inherent in this role which fell between staff and ‘patient’ and delayed bringing less experienced peer workers to that role until we had explored this further.

We hope to embed this form of TC-based group with our services but also to widen the therapeutic approach which focusses on self-agency and relational continuity in the wider mental health service. We would like to integrate Foundations Group with existing NHS processes and including medical roles, for example by staff members taking the roles of care coordination and responsible clinician to allow continuity of care, appropriate deprescribing, and graduation from mental health services. We also feel there is an important opportunity for this approach across levels of intensity and need including in the voluntary and third sector, as well as in collaboration with the NHS. The erosion of TC services has excluded many people from the relational care and focus on self-agency which they need to progress in their lives, and we should be both brave and innovative in designing practical interventions without compromising the core principles on which they are based. This will require collaboration between clinicians and commissioners, as well as a genuine co-

production with people who have lived experiences of the difficulties we are aiming to address.

In conclusion, we hope we may be able to inspire contemporary NHS and third sector contexts to develop collaborative and relational therapeutic approaches like Foundations Group. It has been a pleasure and a privilege to be part of this work and would recommend the experience to all.

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