Democracy in practice in fourteen UK psycho-therapeutic communities

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ABSTRACT: In order to gather baseline data about 'democratic' practice in psychiatric treatment centres a multi-centre survey was carried out examining various aspects of clinical practices in fourteen units. Eleven of the participating communities described themselves as therapeutic communities (TCs) and covered a range of TC modalities: day, residential and secure. The remaining three sites were general psychiatric units that applied TC principles in their practice (but did not refer to themselves as TCs per se*). The sampling for the study was purposive and aimed to gather a cohort that covered a range of traditional TC orientated approaches in the UK between 'democratic' (often Social Services led) and 'hierarchical' (often psychiatric or NHS led). A semi-structured self-completion questionnaire inquired about various aspects of democratic engagement from everyday decision making to the more formal structures deployed in tasks such as employing staff, discharging and admitting patients. The results of study were: i) all communities had some degree of democratic engagement with patients in at least three arenas of clinical practice and ii) there was widespread use made of systems of patient representation. A provisional classification system of therapeutic democracy is proposed.*

Impetus

In re-iterating the context of democracy in psychiatry the new plan for the National Health Service (DoH, 2000) is of particular relevance insofar as it aspires to an ambitious agenda of participant relations between patients and staff (often couched in terms of 'users' and 'providers'). Challenging the orthodoxy of medical pedagogy; "medicine is not an exact science" (NHS Plan: 8.29), the plan argued that a new philosophy needed to succeed the old one because; "the relationship between service and patient is too hierarchical and paternalistic" (NHS Plan 2.33). The NHS plan asserted that the key to the new order for health care lay in the

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process of patient involvement from grass root to board level where "Patients forums will elect representatives to sit on every NHS trust board" (NHS Plan: 10.24). The report argued that: "Giving patients new powers in the NHS is one of the keys to unlocking patient centred services" (NHS Plan: 2.34) aiming to establish "by 2002 a Patient Advocacy and Liaison Service [PALS] in every trust" (NHS Plan: 10.17). The NHS plan went some way, in principle at least, to realising Will Hutton's (1999) interim report calling for "greater levels of democratic accountability in the NHS to prevent the further erosion of public confidence".

To some extent we can track the way that this aspiration has been manifest in more focused guidelines for clinical practice. Take, for example, the following guidelines on acute in-patient care (DoH, 2002) which impressed the democratic agenda be given scope even in the psychiatric environs where patient participation might be least expected:

"4.42 Many inpatient services are inadequately structured or resourced to allow effective therapeutic engagement of service users. Inpatient nursing and related care depends primarily on relationships; staff need to have the time to talk with and listen to service users and carers. Ward arrangements need to be organised to foster a milieu and culture of engagement and to maximise the time that staff spend therapeutically engaged with service users. Activities that detract from therapeutic time should be reviewed. Each inpatient service needs to have a clear focus on the timetabled accommodation of therapeutic activity and engagement of service user, both on and off the ward.

4.43 There must be regular means and forums for encouraging service user involvement in determining how the ward is run, what rules of conduct apply and what activities are available. Each ward should have regular time tabled user/staff meetings with advocacy input as requested.

4.44 Attention must also be paid to the interpersonal consequences of service user behaviour on the ward. A code of conduct should be drawn up identifying clearly unacceptable behaviour such as racial or sexual harassment, theft etc. This code of conduct should also cover ward rules, negotiated with service users, regarding housekeeping issues such as management of noise (TVs, radios etc.) and how disputes over such matters are to be resolved.

4.4.20 Overall there must be absolute commitment to service user and staff collaboration in running the inpatient ward. Reshaping the inpatient service and ward arrangements around the needs of service users and their families/carers cannot be done without robust means for the ongoing encouragement and facilitation of service users to voice views and concerns. (Similar but not necessarily the same forums/means are needed to ensure effective carer input.) There should be clear arrangements and support to facilitate service users giving feedback, raising concerns and agreeing ways of making improvements to the organisation of the ward.

> *Eileen Skellern Ward, Brixton*: A patient community meeting is held once a week to help discuss and resolve people's concerns and as many decisions as possible are made democratically, from changes in physical environment of the ward to asking ex-patients to participate actively in staff interviews."
>
> from: *The Mental Health Policy Implementation Guide for Adult In-Patient Care Provision [DoH, 2002]*

Staff working in milieus which already pay attention to some of these items of negotiated ward administration will recognise the principles of therapeutic community practice in these guidelines. There are some grounds to claim TC practice and its methods have at last emerged as central aspired maxim of universal practice in the NHS, albeit in the form of a type of consumer model of democracy where the principles of user involvement in the form of choice, voice and product loyalty are relevant (Hirschman, 1970). Two questions might be: i) how will this agenda be followed through in practice and ii) how will it be evaluated?

Scoping study of democracy in practice

The aim of the present scoping study was to gather some broad based descriptive data about democracy-in-practice across several sites – an attempt at generating multi-centre comparative data from psychiatric milieus about democracy. The cohort for the study was recruited from the Association of Therapeutic Communities [ATC] directory of TCs and from the researcher's own knowledge of other NHS psychotherapeutic communities operating with an inclination towards deploying TC principles in practice. The sites were *selected* with the objective of covering the range of psychotherapeutic community approaches in the UK from secure to non-secure settings, day to residential services, addiction to adolescent units. In this way the sampling frame can be described as 'purposive' (Stake, 1994). The choice of a purposive sampling frame was dictated by the fact that the research was carried out on a part-time basis so a randomised sampling frame would have been beyond the scope of the project both in terms of time and financial support. The focus was centrally that of describing the practice of milieus known already to be committed to democratic practice. In such circumstances of limited time and financial backing Stake (1994) argues that small focused studies are well adjudged to be more purposive in their approach. The aim was not to gather data from a random range of psychiatric settings to gauge the possible range of non-democratic to democratic practice, but rather to advance a typical rendering of a 'good' standard of practice in order to advance a map of what has been achieved by a particular group of practitioners. Within the cohort there were a range of TCs which spanned the traditional divide of 'hierarchical' versus 'democratic' TCs. Twenty-two sites were initially selected and included well established NHS TCs like Henderson (Surrey) and Cassel (Richmond) to more recently established TCs like Francis Dixon Lodge (Leicester) and Main House

(Birmingham). Four of the sites in the selected cohort were psychiatric units which were not on the ATC register but were units which were known to employ principles of TC practice: Wickham Park House (Bethlem Royal Hospital), Cawley Centre (Maudsley), Halliwick (St Anne's, London) and Brookside Adolescent Unit (Essex). Purposive sampling was based on consideration of broad typologies of psychotherapeutic communities (see table below) in order to generate a representative map of approaches.

Table 1:
Typology matrix of psychotherapeutic and therapeutic communities in the UK based on the Association of Therapeutic Communities directory of UK TCs

Programme Type	Estimated number in the UK
Secure (prisons)	12
Day	4
Child and adolescent	18
Addiction (secure and non secure)	12
Residential – social care led	21
Residential – psychiatric led	7
Principled psychiatric/social milieus	Unknown

The aim of the survey was not to undertake a comprehensive vertical nor horizontal analysis of democracy in TCs, but rather to provide a brief initial spectrum overview of approaches. The study can therefore be considered as an extended pilot study and the findings can only be considered intrinsic to the survey sites and a basis for developing more exacting hypotheses later.

Senior members of staff at each site were contacted prior to the study to ascertain if they would be willing to participate. A self-completion semi-structured questionnaire was designed specifically for the project and tested at a day TC in Reading (Winterbourne House) and was then sent to the 22 sites that had expressed willingness to participate in the study. The questionnaire contained eight items that combined open-ended questions with closed questions followed by tick-boxes. The aim of the questionnaire was to glean information about the following four areas:

i) Which aspects of the therapeutic programme were subject to negotiation between staff and patients.
ii) What systems of patient representation (if any) were in place in the community.
iii) Whether or not there were guidelines or protocols that described the democratic or decision-making processes in the community.
iv) How decisions were made (eg show of hands, secret ballot, verbal consensus etc).

The questionnaire was sent to each named individual senior member of staff. Two copies of the questionnaire were sent to each site with a recommendation that the patient group complete one questionnaire and the staff group the other. It was also recommended that the questionnaires be completed collaboratively among patients and/or staff (the mode of completion was then recorded at the beginning of the questionnaire before being returned to the researcher). Fourteen (out of twenty-two) questionnaires were returned (see Table 2).

Table 2: Returned questionnaires

Type of community	Number Returned
Addiction	1
Day Hospital (TC principled)	2
Day TC	2
Child and Adolescent Unit	1
Residential (non-secure)	5
Prison (secure)	3

Out of the eight that did not respond one TC had closed down. Only one unit returned two questionnaires (one each for staff and patients). One unit completed the questionnaire collaboratively with staff and patients. Eight questionnaires were returned stating that the questionnaire was completed in discussion with staff colleagues. The remaining four questionnaires were completed by a single staff member. The results for the four major areas of study are presented diagrammatically below:

Results Table 1:
What are the areas of patient involvement in decision making?

	Food menu	Goals of therapy	Everyday (eg TV)	Admission decisions	Discharge decisions	Formal policies	Who is employed
No	2	1	0	8	4	4	4
Some	3	0	0	1	3	0	0
Yes	9	13	14	5	7	10	10

One community scored 'yes' to all of the listed items. The other thirteen units mixed and matched the areas of patient involvement, that is to say, they scored a combination of 'no', 'some' and 'yes' throughout the range of questions. *All units*

scored yes to at least three areas or more. Perhaps most strikingly ten units purported to involve patients in various levels of discussion about the admission and discharge of patients and the employment of staff. However, it was not always possible to ascertain from the questionnaires whether this involvement was 'official' where the patients had a 'vote' on the decisions (eg on the appointments panel or at the point of admission) or whether patients were 'consulted' about their opinions and then the staff made the decision.

The comments highlighted that there was a limited range of actual democratic mechanisms whereby patients/residents were involved in decision-making processes (show of hands voting) but that there was an overall leaning towards talking about issues in group meetings, suggesting that 'dialogical democracy' was a ubiquitous component of engagement. The question as to whether staff maintained the power of veto was a recurring theme that appeared in the comments. For example one of the secure TCs reported: "*Any member accused of rule infringements (drugs, violence) will be answerable to the community who will then vote. The community will decide whether the person's commitment to the community is in doubt. The staff group will take the result of these two votes into consideration when deciding what action to take regarding the incident. The staff group will take note of the community's vote but will not be bound by it.*"

Another secure setting concurred that the power of veto was explicit although it did not necessarily compromise democracy: "*Security places obvious limits on democratisation although paradoxically security actually makes therapeutic work possible. It is remarkable how democratic it can seem. Inmates vote on matters but staff maintain power to over-ride a vote*". In distinction a residential community reported that; "*the staff do not have the power of veto when someone is discharged*". In one of the day hospitals the power of staff veto over patient decisions was noted: "*Staff have a theoretical power of veto over decisions that are taken by the community but it has never been invoked*".

Results table 2: Are there formal systems for patient representation?

	Yes	No
Representatives	10	4

Ten units reported that they had a system of patient representation of one sort or another. These mostly took the form of elected chair-persons who were nominated and voted in with varying time frames (from one week to three months). An example of the system of patient representation was described by a patient commentary on one of the day TCs: "*There are often two to three nominations for chair. It rotates every eight weeks. You have to have been in treatment for nine*

months and have been a deputy chair before you can be chair. There are lots of other jobs like treasurer that are not listed anywhere".

Other units had a more informal system of patients chairing meetings on a spontaneous basis. The following comments were made about the role of the chairperson on a secure unit: *"Wing chair and deputy chair are voted in by the community and are responsible for acting as figureheads for the community, they are consulted about calling cabinets to sort out crises or special groups to deal with difficulties. Chairs often make impressive speeches/comments".*

Results table 3: Are there guidelines or policies for voting?

	Yes	No
Guidelines or policies	6	8

Six sites answered that they had formal guidelines for voting. Half of these were secure TCs (no copies of guidelines were sent as requested). One TC had started to write their guidelines for voting but reported that *"the patients had lost enthusiasm"*. Two units (both day TCs) commented that they were operating with *"unwritten constitutions"*.

Results table 4: Types of democratic procedures

	Show of hands	By proxy	One person one vote	Verbal consensus	Secret ballot	Others
Number	11	0	8	7	0	0

Eleven out of fourteen TCs used an open show-of-hands voting system for deciding on a range of issues. Eight units said that they had a philosophy of one-person-one-vote. Seven said that they used a system of verbal consensus. Voting in one of the secure TCs was described thus: *"One person one vote. No abstentions are allowed. If you cannot make up your mind you give the benefit of the doubt to the person concerned"*. Formal voting procedures in a day TC were also described as 'compulsory': *"If the issue is discharge or suspension everyone has to say what they think before a vote can be taken. Anyone can propose discharge or suspension. The chair-person leads the vote; those for/those against. Everyone has to vote, no-one is allowed to abstain"*. This type of 'compulsory' voting resembles the way that members of the jury have to vote; jurors cannot abstain, they have to vote either 'guilty' or 'not guilty'. This type of compulsory democracy might be said to signify an affinity between the procedures of social

justice and group dynamics both in the jury and the TC (Winship, 1998; 2000, 2003). There was a less stringent line on abstaining in some of the other secure TCs: *"The chair person does not vote but the chair person has the casting vote in cases of ties. Abstaining is allowed but must be explained"*.

A provisional system of classification of democracy in therapeutic practice

The intrinsic findings of this limited study point towards a general proclivity towards democracy in all of the psychotherapeutic communities in the form of 'dialogical democracy'. Indeed, in the TCs traditionally referred to as 'democratic' there was little evidence to suggest that they were palpably or constitutionally more democratic than the hierarchical or secure TCs. The fact that hierarchical TCs have democratic processes and democratic TCs have hierarchies may not be news at all. However, we might venture to suggest that the orthodox differentiation between 'democratic' and 'hierarchical' TCs is reductionist and what actually happens in practice is that there is a more complex interweave of authority and democracy in all settings. Moreover, the simplified delineation of hierarchical and democratic approaches may curtail the establishment of a coherent ideology for psychotherapeutic communities which may be the collective pre-condition to securing TC approaches in psychiatric and social services. The study suggests that it would be more accurate to talk about 'degrees of democratic engagement' based on clear clinical profiles of democratic devices in situ in different milieus. From here we may then be able to classify democratic levels of practice. Unfortunately we can only draw tentative inferences from the data gleaned from the self-completion questionnaires so the development of a classification system of democracy can only be speculative at this stage. Nonetheless, a classification system of democratic practice may be a provisional basis for developing more in-depth multi-centre comparative study and quality scrutiny. The following provisional system for classifying democracy in psychiatric milieus is therefore suggested.

Table: A provisional classification of democracy

Level	*Description*
Level 1: ***Atmosphere of dialogical democracy***	There is no formal procedure for a system of democracy, no evidence of voting etc. However, the staff foster a democratic atmosphere by seeking opinions of patients about the treatment milieu or regime. There is an incline towards what might be called 'dialogical democracy'.

Level 2: The Aye vote ("Ayes to the left/right - the ayes have it!")	Most decisions can be achieved without resorting to a formal vote, consensus in the UK House of Commons is mostly achieved by the utterances of the members and formal voting is deployed only when it is not clear from the utterances. In group meetings (particularly business meetings) the consensus is clear from the opinions expressed by members in the foregoing discussions. The chair person of these meetings (or member of staff) may gauge the atmosphere and decisions are reached by consensus without formal balloting. In treatment settings that have more formal community structures, the meeting chair person may ask; "all those in favour say Aye. All those against say nay". The decision is mediated in this way.
Level 3: Formal Open Ballot	Following a discussion if the general consensus is not clear a formal ballot system is often employed. The ballot is usually carried out by a show of hands after a one or a number of proposal are made. The count is carried out by either the patient representative or chair person, member of staff or in some settings there are nominated 'tellers' (as in Parliament) whose job is to count the show of hands.
Level 4: Formal Closed Ballot:	As above in Level 3 except a ballot system using voting slips and a ballot box is employed. In this system members are able to cast their vote anonymously.

Level 5: Referendum	Very little evidence of what might be called a "referendum vote". Most of the democratic work of the community takes place on a day to day basis. It is rare therefore that all of the staff and all of the patients ever vote on a single matter. While this means that democracy has a everyday quality, there may be some decisions that have such wide implications or ramifications that there needs to be a system whereby all members of staff, including administration and support staff, can register their vote. This system might be described in terms of referendum. That is to say the discussion may take place over a number of weeks and the voting system is organized as such that everyone is able to register a vote (either in person or by proxy). An example of referendum issue may be making decisions about external decoration to the work place. The organization of the referendum would involve producing quasi-official voting slips and a ballot box where the voting slips can be returned.
Level 6: The Community/Patient Jury/representative committee	Some issues that the community vote on have a gravity that merits a much more carefully considered process of democracy - for instance when the community votes on sanctions for someone if they have contravened a boundary, or voting on whether a patient is to be suspended or discharged. The current system of open voting, by a show of hands, where the deliberations about the patient are carried out in the presence of the patient, is rather too much like a public humiliation that evokes the image of stocks in the town centre. A more human and fairer process might be to use a patient/staff jury system to undertake this task.

Discussion: dialogical democracy

Levels 1, 2, 3 and 5 are those which are currently practised in TCs. Levels 4 and 6 are not currently practised as far as this study suggests. Further consideration of alternatives to the orthodox procedures of democracy seem limited in practice such as proportional representation and referendum, for instance. However, that there appears to be limited use of cumbersome or convoluted democratic devices (such as would be required by PR and referendum voting – see below) is not necessarily to be bemoaned and it would appear to be the case that democracy exists in each setting at a day to day level of dialogical engagement. From the above baseline study, we might say that there is a general application of democratic talking therapy.

The milieus in the above descriptive study might be said to be environments where democratically orientated therapists have sought to engage, by varying degrees, the involvement of patients' opinion in a range of events in the treatment environment. There is also some evidence in the study cohort of recourse to the use of veto by staff members in communities and this may reflect some of the intricacies of managing the acting out and the working through of transference dynamics. Therapists may be placed wittingly or unwittingly in a role of authority that is experienced by the patient, in light of previous experiences of authority as persecutory. For instance, if the therapist enforces a rule that no alcohol is allowed into the community, or in a case where there is an imminent threat of self harm, the therapist is obliged to intervene and patients may feel their democratic right to be self-directive has been overridden. A democratic pact of negotiation may need to be superseded by a morale obligation to act. Democracy may not only collapse in light of a negative transference, for instance transference may result in the staff member (or members) being perceived rather idealistically. Staff views may then be given more merit than is desirable as the patient sacrifices any sense of autonomy in order to act in concert with the wishes of the idealised staff.

A paternalistic model of power and authority in therapy, understood with recourse to psychoanalytic theory, may be necessary to underpin a concept of dialogical democracy (Hinshelwood, 1999). A willingness on the part of the staff to engage with the questions of authority and even to uphold authoritarian duties offers the containment necessary to provide a secure base from which maturing levels of democratic engagement can occur. These type of dynamic events, where democratic attitude in the patient is subsumed either by idealisation or denigration, might well be diagnostically viable. For instance, in such transference exchanges the patient and therapist can identify and re-locate prior psycho-developmental fault lines. It is at this intersection that procedural democracy and psychotherapy meet. Arguably if the patient is to re-experience a benign authority that supersedes previous malignant or abusive internal authority, in terms of transference the non-democratic aspects of parenting may need to be embraced. The ebb and flow between autocracy and democracy may be as necessary as facets of parenting as they are as contingencies of therapy.

The moral and ethical bases of individual psychotherapeutic practice are useful to map onto the shared morality and ethical basis of group therapy or milieu settings. Here the complexity of devolved or power-sharing agencies needs to be gauged against the fact that groups have both the hindering capacity to demoralise and obfuscate as much as they can engender democratic ethicality and prudence. That is to say at best groups can operate like juries; at worst they can behave like lynch mobs. And a milieu has the potential to create a sense of familial belonging through democratic engagement, as much as it might become a destructive and coercive environment as Goffman (1961) noted. But even in the most extreme circumstances when a patient's liberty is limited, via a section of the Mental Health Act, for instance when a patient is sectioned and consigned to a locked ward or secure institution, there is to some extent still a contingency in place for at least a certain degree of democratic transparency. For instance, in the sectioning procedure there are social workers, doctors and family members who collect together to make a decision. The patient is involved to varying degrees even if they are disabled by acute illness. Where there are disputes and doubts about what action to take, the professionals, the family and the patient engage in a discussion that takes the form of dialogical democracy. The same can be said of the process of negotiating the terrain of rescinding a section at a mental health tribunal; a collective process compelled by the stringency and sensibility of professional, political and familial joint decision-makers. At the most serious cusp of psychiatry the Mental Health Act relies on contributions aimed at locating democratic consensus. The healthy milieu might be said to be characterised in the first place by the rubric of dialogical engagement as a crucial contingent in creating the sense of belonging. One of the most curative aspects of therapy may simply be the experience of voice for the disenfranchised patient who has previously felt alienated and socially dislocated.

We may surmise from the survey that dialogical democracy exists as a component of the psychotherapeutic communities in the cohort where 'voice' is credited and encouraged. The emphasis is therefore in 'voice' and not necessarily in the democratic moment or event. The discussion that proceeds any formal democratic device is probably the real fodder of therapeutic purchase, a point that Maxwell Jones (1976) made when he argued that the popular idea of achieving 'group consensus' was secondary to the important 'process' of arriving at the decision. Jones believed that the need to vote often arose as a result of the failure of discussion. Sustaining the dialogical process is not always easy, it must be said, because the temptation is often to move for a vote to curtail conflict. A conflict free milieu may be the most peaceable for all; however, avoiding dissonance may compromise a necessary lever in assuaging therapeutic gain; the psychodynamics of 'working through' as it is commonly called. In other words, discussion might make for discomforting polemics but voting can neutralise therapeutic transformation. It is the discussion that contains the more complex notion that resolution is not always simple and, in terms of the therapeutic process, that a tension evoking problematic can be faced squarely.

The absence of democratic alternatives

While the descriptive study revealed the ubiquity of dialogical democracy in the sampled cohort, it showed that open or show-of-hands voting was the sole 'formal' decision making procedure. This may, of course, be welcome. We might say that the spirit of openness in voting arguably counters a narcissistic social disengagement that may have characterised the patient's formative experiences. The patient who has kept abusive and secretive information to themselves is given a new synthesis of openness (particularly in secure TC wings). Maxwell Jones (1968) did in fact note that there would probably be different outcomes if a vote in a TC were held as a secret ballot rather than the more usual open voting style of a show of hands. According to the descriptive study closed balloting (Level 5 in the classification system) is not in practice although there may be grounds to argue that closed ballots represent a more maturing model for democratic clinical engagement (adopted to good effect in trade unions, it is said, and in aspiring democratic countries).

However, even though 'open' show of hands voting democracy is widespread there is no evidence as to its therapeutic value nor its democratic reliability compared to other procedures for voting. Indeed, personally I have had occasion to question the probity of 'show of hands' voting. Individuals may be unwilling to represent their own opinion on matters for fear of being seen to vote against a popular or feared individual (patient or staff) who may wield power and influence. This may be particularly the case on secure or prison wing TCs. We had such problems on the in-patient drug at the Bethlem where we felt that there were occasions when patients were unwilling to be seen to vote against certain individuals for fear the vote may arose suspicion of disloyalty. Individuals were sometimes called to vote against their old dealer or supplier knowing that they might well require his services in the future. Thus the potential for personal vendetta was diminished by closed ballots. When we later experimented with a system of anonymous balloting (using voting slips) for matters of suspension of passes and discharge, everyone concerned found the closed balloting system much safer and reported that they were able to vote with a greater sense of personal integrity. Another example of the problem of an open voting system was apparent when a patient was presented in a case conference seeking admission to a day hospital TC. Following case presentation there was an open vote (with the patient present) during which several people (including a member of staff) voted against the patient joining the community. The majority, however, were in favour of admission and thus the patient joined the TC. The staff member who voted against the patient later found herself working with him in a twice weekly small group and reported that she felt that her 'open' vote against him had impeded the development of their working alliance initially and had locked him into a hindering overly-negative transference towards her.

Another finding in the study; that simple consensus voting is the sole democratic method, might also be mentioned. The system of simple majority or consensus voting does, of course, not serve to represent the views of the minority in decision-making procedure. To be out-voted on a matter may be a learning curve of sorts but the experience may serve to alienate a patient or a group of patients. The idea of a 'proportional representation' system where minority opinions may be represented is not present in any of the study sites. The idea that democracy reaches its pinnacle in a simple majority may be reductionist. Proportional representation might be found to have a capacity to maturely hold oppositional forces together more than majority rule. A recent example I have from practice is not an example of PR but may be used to illustrate a point that PR democracy might have been utilised as a procedure. The Winterbourne TC voted on whether or not to disband the bell system. The bell system involves the patient chair ringing a bell in the communal area at an allotted time to denote that there were two minutes to go before the beginning of the next community activity or therapy session. Many patients had expressed the opinion that the bell functioned to limit the sense of responsibility of patients and staff in getting to the groups on time. There was a group of patients and staff who wanted rid of the system and tabled a motion to the whole community that the bell system be disbanded. The proposal was presented in the appropriate community planning meeting. In the meeting a second group tabled a counter motion that the system not be disbanded permanently but be tried for an experimental phase. There were three options on the table then: i) discontinuation, ii) experimental phase of three months and iii) continuation as normal. The chairperson carried out the voting procedure (show of hands for each of the proposals), the result of which was eight voted in favour of disbanding the system, five in favour of keeping the system, and four for an experimental phase. At the end of the vote the chairperson said that the result was that the bell system was voted out for good. One of the staff then pointed out that in this case the majority vote, even though it was split, was not in favour of disbanding the bell system entirely (eight had voted for disbanding while nine people had voted for the other options). There was a further discussion and it was decided that the issue that had attracted the smallest number of votes should then be removed from the equation and a further vote should be held. This was done and the two motions that were left were i) keep the bell system or ii) disband it. In the next show of hands vote the majority vote were then in favour of keeping the bell system. Those who had voted for an experimental phase had voted conservatively. In this particular case there was a missed opportunity. Simple majority democracy in the end rather cramped what might have been an interesting, though more complex, problem of finding a solution to the three way split.

Finally, another democratic device which was absent in the practice of the study cohort was the use of *referendum*. Quite often it is usually staff members who are excluded from community decision-making procedures if these are taken on a day to day basis. If one were to include all staff who have a stake in the community

including administrative, managerial and research staff for instance, then a system of referendum voting for certain matters would need to be developed. No study site reported a system where postal voting or voting by proxy happened. Thus full participatory democracy is prevented. Although fairly protracted discussions among staff and patients may have taken place about a particular issue or problem, there would seem room to develop a slower, more considered, process of deliberation and referendum which would ultimately be more inclusive.

Towards sharper democratic profiles

There are a number of methodological problems which limit the scope of the conclusions that can be drawn from the above study. The study cohort were not randomly sampled so general inferences about TC practice can only be made tentatively. The use of a semi-structured self-completion questionnaire was never likely to yield in-depth data in the same way as direct field study. And nearly half of the questionnaires were completed by individuals (as opposed to collaborative or co-operative primary data collection) so there were problems about confidence rating in the primary data. Finally, the clinical focus of the questionnaire failed to draw any attention to the organisational context of user involvement (eg patient representative systems in the wider institution). As a comment from a day TC pointed out: *"Pressure to provide continuing care (eg CPA) can threaten democracy. Trust bureaucracy generally threatening democracy eg patient loans, donations have to be approved by trust accountant"*.

However, it was never the intention of the baseline study to gauge individual TCs with a view to providing a sharp democratic profile per institution. The aim was to undertake a broad brush-stroke that would give an impression of the democratic inclination among a certain sector of psychiatric communities. Returning to the DoH guidelines mentioned at the outset of this paper it is not possible, of course, to comment on the general proliferation of democracy in NHS psychiatry. It is possible, however, to assert that there are a number of sites of practice which might be said to serve as 'models of practice' where user-involvement has reached a high level of organisation. And given that the sites in the sample covered a range of patient presentations (personality disorder, general acute psychiatric, addictions and adolescence) it can be argued that democratic devices can be potentially applied to a range of clinical diagnostic groupings.

In relation to the democratic process within TCs themselves, it appeared that democratic practice was no more or less apparent in psychotherapeutic treatment centres describing themselves as 'democratic' than in those identified as 'hierarchical'. While democracy might be classified in terms of graduating inclination, it would seem necessary to develop a more eclectic and inclusive vision of democratic ubiquity, rather than saying that 'some TCs are democratic' and 'some are not' as is currently the case. The provisional classification system for democratic practice in psychiatric milieus proposes tentative working definitions

describing the variety of decision-making procedures applied to the therapeutic encounter, including some democratic levels that are not currently applied in practice but might be considered.

References

DoH (2000) *The NHS Plan*. HMSO. London.

Goffman, E. (1961) *Asylums*. Penguin, Harmondsworth.

Hinshelwood, R.D. (1999) *Therapy or Coercion*. Karnacs. London.

Hirschman, A.O. (1970) *Exit, Voice and Loyalty*. Harvard University Press. Cambridge.

Hutton, W. (1999) Personal communication. Interim report of the committee on accountability in the NHS. HMSO. London.

Jones, M. (1968) *Social Psychiatry in Practice*. Tavistock, London.

Jones, M. (1976) *The Maturation of the Therapeutic Community*. Human Sciences Press. NY.

Stake, R. (1994) Case studies. Chapter in: *Handbook of Qualitative Research*. Ed: Denzin, N. and Lincoln, Y., Thousand Oaks. CA.

Winship, G. (1998) Justice as an inherent characteristic of group dynamics. *Free Associations*, 7,1: 64-80.

Winship, G. (2000) Jury deliberation: an observation study. *Group Analysis*, 33,4: 547-557.

Winship, G. (2003) The democratic origins of the term 'group analysis' - Karl Mannheim's 'third way' for psychoanalysis. *Group Analysis*, 36, 1: 37-51