REGULATION

The unintentional destruction of intentional communities

A Discussion Paper in association with LivesthroughFriends and Vanguard

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Contents

SUMMARY

The current social care system is based on a false model of what helps people have good lives. It treats care as a commodity which can be purchased and regulates it in ways which will often make things worse.

The kind of intentional communities developed by Karl Konig (inspired by Rudolf Steiner) had offered an alternative to this dehumanised model. However these communities seem to have come into conflict with the current regulatory regime and are being transformed into much more institutional systems.

It is important that the community and its leaders wake up to the crisis that is happening and try to resist these changes, and renegotiate their relationship with regulators and commissioners. More broadly it is important that we all wake up to the dangers of treating care as if it were just another industrialised product.

1. INTRODUCTION

This paper is based on conversations and analysis of public documents. It offers a critique of the current UK's social care system, and in particular the system of regulation which oversees that system. In our view there is a strong case for questioning the coherence and competence of regulation in social care.

More specifically this paper is based on the experiences of people who live and work in the Camphill communities - what are sometimes called intentional communities. These communities have a long history of trying to support people with disabilities in ways which are focused on human flourishing and the value of relationships. It seems that such an approach is now deemed incompatible with a regulated social care system. This is very worrying indeed, both for the Camphill communities, but also more widely.

As the authors we are not members of the Camphill communities nor are we advocates of its specific approach. However we believe that there is a good case for allowing such communities to exist. Moreover we believe that the general principles of love, trust and contribution which are central to the Camphill community are generally applicable to how we all develop good lives. The fact that the regulatory system struggles to recognise this fact presents us all with a major problem.

2. THE CAMPHILL PHILOSOPHY

In the early summer of 2013 we were contacted by several people in Gloucestershire who have had long associations with the Camphill movement. They explained that the Camphill Village Trust (CVT) is the charity established to provide overall governance to a number of communities that used to be self-managing. Its role had been to realise the challenging vision of interdependence and inclusive community living that had been set out by Rudolf Steiner and Karl Konig.

Those with a long experience of Oakland described how things used to be:

At Oaklands there used to be around 50 house parents and co-workers, including couples with around 30 children, and maybe 50 disabled people. Now there are no children, no community and just an institutional care home.

Everyone lived in a small family group; including people with disabilities, long and short-term (volunteer) co-workers, and, quite often, children. Everyone made their contribution to the well-being of all. People were not encouraged to consider only their own needs.

Great pride was taken in ensuring that family groups lived in beautiful and homely houses and ate healthily and well. Mental health and behaviourally related difficulties were usually successfully accommodated in a relational context (as in a family) rather than in a managerial way (as in a service).

There was a very strong work ethic. Farms and gardens were cultivated and many workshops flourished. 'Written off' people found and basked in their unlocked talents and took a pride in being a farmer, gardener, weaver, cook or recycler.

Often a couple would 'run' a house with one of the partners sharing a trade or craft skill and also running a workshop, garden or livestock venture. There was a rich and diverse cultural life both within the village and in the wider community.

Celebration of festivals provided a constantly unfolding backdrop for active communal life.

Mistakes were made and sometimes things were got wrong; but the common striving and cohesion of the community overcame many difficulties. Indeed we heard criticism that the work ethic was too strong at times.

Indeed the Charitable Aims of The Camphill Village Trust could not be clearer in setting out how the Trust should set about supporting people with disabilities:

...in which beneficiaries live and/or work and/or to which they otherwise resort, in community with persons providing support.

And the nub of the philosophy underpinning this was made explicit by Camphill's founder, Karl Konig:

The fact that none of us receive a wage or a salary is not an economic arrangement but part of our social endeavour to create the right environment for the disabled person. We are convinced that we could not do our work in the same manner if we were employees and received a salary, because we know that work that is paid loses its social value. To give and to take is a matter of mutual human relationships. The true relationship is lost as soon as wages intervene. Paid service is no service, paid love is no love, and paid help has nothing to do with help.

However they were deeply concerned that the Trustees had abandoned the central aim and principles of the movement after sustained pressure from social care commissioners and regulators. In response to wide-ranging criticisms from the social care system the Trustees had decided to import managers from mainstream social care system and had then set about converting Camphill communities into compliant care homes.

According to those who approached us Camphill's compliance with the social care system has been purchased at a very high price:

- The translation of talented, socialised and contributing disabled community members into passive, dependent and de-skilled service users
- The destruction of natural communities that included families, children and neighbours
- The emergence of behavioural and self-care problems amongst disabled people who had not previously presented these difficulties, or had been inclusively supported before the recent changes
- The replacement of long-term volunteer co-workers and shorter tenure young volunteers by agency and shift working support staff

- Stories of bullying and victimisation of volunteers
- Examples of managerial neglect and incompetence

The general impression is, that in sweeping away the Steiner-Konig principles, the new management is more interested in being able to evidence regulatory compliance than in the happiness and well-being of its beneficiaries. This means replacing the longstanding and successful purpose of 'encouraging people to contribute and grow in a rich and equal community' with 'being safe and compliant'. Replacing a low cost system based on principles and knowledge with a high cost system based on procedures and risk protection protocols.

It seems that Konig's original aspirations have no place in our contemporary care market. This is partly an unintended consequence of the growth of well-intentioned regulations. But it also seems to be driven by institutional beliefs and practices that predominantly serve the needs of commerce. Care seems, above all, to be a transaction which now appears to be only legitimised when it follows generalised and prescriptive principles derived from consumerism. In particular, the notion of choice is especially prone to careless or ill-considered application.

While very concerned about the prospects for the Grange Community at Newnham, the folk who contacted us were also very exercised about Oaklands Park. With only two co-workers remaining, they feared that the community would never be restored. They were particularly upset that Oaklands was being 'lost silently', with the wider world unaware of the 'destruction'. This they attributed to the gentleness and personal values characteristic of long-term co-workers and a divisive reign of intimidation and fear generated by managers.

As the issues raised chimed loud with the concerns surrounding the dysfunctionality and inefficacy of so many public service institutions we undertook to listen to and record peoples' stories and to produce one or more discussion documents or articles for publication. During the course of the ensuing interviews we were also contacted by The Botton Village Families and Friends' Support Group whose contributions have enabled us to accumulate a much wider perspective.

In August 2011 the CQC undertook a routine review of Botton Village. In November it published a scathing report, by which time North Yorkshire County Council had produced its own damning *Collective Care Report - Botton Village* (October 2011). It seems likely that what was presented in these reports as earth shattering revelations of non-compliance were in fact long standing norms within the community of which the statutory commentators had been long aware. This report is based on what people who approached us have told us and our analysis of the public documents.

3. BOTTON VILLAGE AND CQC

Set out below are extracts in orange from the The Care Quality Commission's (CQC) *Review of Compliance for The Camphill Village Trust, Botton Village Domiciliary Care Group November 2011*. **Following this review CVT were given just 14 days to come up with a plan to comply with their demands.**

3.1 OVERVIEW

People who live at Botton told us that they enjoy the freedom of being able to live in a community where they can move around without fear of being abused, or shouted at. Several people said they particularly enjoyed working on the farm, whilst another person said they had been able to slow down because of their age. People also said they were disappointed they hadn't been able to watch the World Cup last year on their own TV. Another person said they go in to the nearby village and watch the football in the local pub. Everyone spoken with said that the house coordinators were supportive and friendly. Co-workers spoken with expressed their concerns that any changes would mean the ethos of the village changing.

In short, from the introduction, it would seem that Botton Village is a kind and inclusive place where some community members are a bit peeved about the community's misgivings about the impact of television. It seems that, despite recording a brief summary of the aims and principles of Botton/CVT in the piece which follows, the inspectors seem to neither understand nor respect the simple fact that they are visiting family-style groups of people living in an intentional and largely self-sustaining community and not a service. They seem to be stuck applying the assumptions of contracts and commerce quite inappropriately to a system that functions in quite another way and to be unable or unwilling to conceive of the possibility that some other performance criteria could possibly apply to arrangements based upon the belief that, 'the true relationship is lost as soon as wages intervene. Paid service is no service, paid love is no love, and paid help has nothing to do with help'. They, no doubt, explained that, 'the law is the law' and that they had no authority to vary the 'standards'.

What follows is the Inspectors' opening summary in orange. Their key observations in respect of the 'Standards' inspected follow on with our questions and comments interspersed. Some words and phrases are in blue in order to draw attention to underlying assumptions in the system.

Some villagers spoken with said that they had not made the choice to live at Botton; this decision had been made by their carer. However, all those spoken with said that they liked living at Botton as it gave them a sense of freedom. Several of the younger villagers spoken with said that they were disappointed that they did not have access to a television in their house, especially last year when the world cup was on. Another person who likes watching the Soaps said they catch up with their television when they visit their parents.

The Camphill Village Trust provides a community based setting for people who need guidance and support with their daily lives. Information about the community is available on the internet and can be provided to people in a booklet. The community works together as a cooperative and values the contributions by everyone in the community. People who require support and live at Botton are known as villagers.

They can move safely around the village with minimal support. Many of the villagers have lived at Botton for over twenty years. Each villager has a timetable of activities, which covers the waking day with little flexibility. If someone wanted to spend the day doing something different or have a lie in on a morning they are not aware that they can do this. The activities available during the day include; working on a farm, working in the bakery, the printing shop and cleaning the houses. During the evening they have social groups that they attend. This can include eurhythmy, a movement therapy, singing, going to the church and a film night. None of the houses has a permanent television so any film nights have to be organised by the film group and can take place either in the person's house or in the main hall. Co-workers were concerned that if people had access to a television they would stop participating in the community. In speaking with co-workers it is clear the ethos of Botton is firmly based in the value of the community and community activities and it seems Botton is run more in line with the Trust's philosophy rather than what the villagers want.

A recent survey of villagers asked them what they wanted to keep, create and drop. Some of the things they wanted to keep included walks, going to Whitby, eurhythmy, contact with families, going out to places for meals, farming, and cricket. Some of the things they identified as wanting to drop included: being treated like kids, people nagging at them, eurhythmy, too many meetings, not enough free time and understanding the foreign

workers. Some of the activities they wanted to create included learning how to use a computer, to learn how to cook, to have access to more types of music from pop to Mozart, a TV/DVD in the house and a Botton Olympics. The management at Botton has created an action plan from this survey and are hoping to implement some changes specifically looking at flexibility within the community, identifying who wants a TV and organising aerial points, and the workshops. This survey is now going to be carried out every year and the action plan is to be reviewed every three months. Co-workers spoken with were concerned that any changes made will affect the ethos and philosophy of the village.

3.2 STANDARDS

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People receive a service that is based on the application and interpretation by the individual community of the ethos of the Camphill Village Trust rather than a service they have determined by their choice, the result of this is people do not understand their right to choose how they live their lives.

It seems to us that it might equally well be argued that the Standards that provide the framework for how the CQC inspects, predetermines, and limit the choices available to disabled people may also be evaluated as operating against their interests (as the Oaklands Park stories that follow indicate). This seems to us to be in part because the Standards are not very concerned with helping folk get the lives they want but are essentially about regulating services and ensuring contractual compliance. They seem oblivious to the dynamics of reciprocity, where selfish choice is subordinated for the sake of mutuality and relationship and to the possibility that disabled people might perform essential roles in the interactions of communities where everyone contributes according to their gifts (a central precept of the Welfare State that has been long abandoned).

Trust should always partner responsibility and does so in the context of relationships but not, so it seems, when Standards are to be applied. Taking the apparent 'requirements' of individuals out of the context of their community is a nonsense but the notion of Standard means 'one size fits all' and it fundamentally fails to help people in their real community context.

3.3 RIGHTS

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

People who use the service are not enabled to make decisions about their own care and support and are not confident that their human rights are respected and taken in to account.

Files and accurate recordings are essential accoutrements of services – especially acute health treatment services where lots of different people who do not know the person well undertake coordinated complex tasks in pursuit of that person's best interests. They are not usually part of family life where people are in caring relationships, advocate for each other, and know each other well. Files and proforma are central to the culture of 'contracted ordinary living' because the institutional culture is imposed upon disabled peoples' far from 'ordinary lives' and as an unintended consequence of counter-productive budget controls that lead directly to a low paid, unstable and unskilled social care workforce. A further unintended consequence of this system is that maintaining records assumes greater importance than the activities that are recorded.

3.4 PLANS

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The care plans in place do not always reflect the level of support required, they are not reviewed regularly and they are not signed by the person using the service.

The commentary in the Review implies the chaos that is likely to ensue when a 'family' lifestyle attempts to comply with contractual demands to perform like a service. CVT is, from our perspective, clearly culpable in not being alert to the incremental imposition of institutional non-negotiables that are in conflict with its own proven and valued methods and principles, and vigorously promoting these while developing and negotiating the implementation of indicators to demonstrate the value arising from public funding of intentional communities. The observation made about care plans

can, in our experience, be made of more that 90% of plans we've reviewed across a breadth of settings that are almost exclusively concerned with the limited contribution that services can bring to peoples' lives.

3.5 COORDINATION

Outcome 06: People should get safe and coordinated care when they move between different services

The care and support people receive is not always coordinated with other agencies and so their needs are not always being met appropriately.

So, what's new?

3.6 ABUSE

Outcome 07: People should be protected from abuse and staff should respect their human rights

Staff are not sufficiently aware of potential abuse issues or protection processes to provide the necessary support to ensure people's safety.

Unpaid, vocational community members who are variously described as house coordinators, house parents and co-workers are simply NOT staff. The use of the term in the report clearly indicates no understanding of what motivates people to commit their lives to either community living or the filial philosophy that underpins these life choices. This is not to imply that there is no scope for abuse in such communities, far from it, but that there is, given the relational dynamics of communal life amongst some highly principled people, a greater possibility of reporting and intervention than obtains in many mainstream environs. It is interesting that Villagers' opening observation about the safety of their community is quite inconsistently disregarded: "People who live at Botton told us that they enjoy the freedom of being able to live in a community where they can move around without fear of being abused, or shouted at."

It is arguable that intentional communities, with their relational safeguards, support and enable far safer and less limited lives for disabled people than are achieved by often bureaucratic, disempowering, clumsy, insensitive and risk-averse 'protection processes'. This is because they

understand people in context and can act on probable issues – i.e. what does happen. Procedural regulation has no knowledge underpinning it and relies on what might happen.

3.7 STAFF

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People who use the service are supported by staff who care for them and have empathy with them but don't always have a good understanding of the conditions they are affected by. This means the care they receive is not always the best it could be.

Reading the summary findings one could easily come to other conclusions. It is a huge failure of logic to assume that because a person has been exposed to training or information, which is often a series of pathological descriptions or generalisations, concerning various diagnosed disabilities that this leads to better 'care'. The Skills for Care requirements – which in our judgement are far from adequate to ensure person-centred, enabling and empowering practice in commercial care settings – are designed for the marketplace, not for intentional communities that, by their very nature, need to function in a far less institutional way.

Their findings seem to confirm that, in response to institutional or contractual demands – of the sort that require the personal and associational world to adopt and comply with the hierarchical, systematised and contractual norms of the institutional sector – an intentional community, well out of its comfort zone, had clumsily attempted to comply and, in doing so, had become neither fish nor fowl.

3.8 CHECKING

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

People who use the service are consulted about how they would like the service to develop.

The record demonstrates how far along the road away from an intentional community and in the direction of a consumer service the Botton culture had already travelled. The inspectors are explicitly concerned with the 'quality of service provision', which in turn had elicited what was largely a review of the range of the activities on offer, and not with the quality of life experienced by the community at Botton.

Quality control principles (checking) lead to poor quality because the specifiers and checkers are de facto responsible for quality. A 'moral hazard' is attained whereby everyone thinks they are safe because we have 'procedures and checks' but are in fact less safe as a direct consequence. True quality is achieved through principles and active leadership.

3.9 RECORDS

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

Records containing confidential and personal information are not always stored securely and they are accessible to anyone who walks in to the house.

We compromise our notion of relationship, belonging and home in 'serviceland' and permit, many would say to the great harm of disabled people, folk's homes to be primarily peoples' workplaces. Intentional communities are, by definition, not peoples' work places but rather working, interdependent communities. Here again, it is possible to adduce that the community was, probably in search of a 'quiet life' trying to 'render unto Caesar' and making a pig's ear of something that is addressed quite differently in caring and well-ordered families.

4. OAKLANDS PARK AND CQC

The extracts above are from a report that was interpreted as highlighting serious and perhaps 'life-threatening' concerns about an intentional community that, according to the report itself, did not seem such a bad place to live. What follows below are extracts in orange from another report by CQC Inspectors about another Camphill Community: *The Oaklands Park Domiciliary Care Service Report of February 2013*.

This report gives Oaklands Park a glittering bill of good health. But, as we shall describe, responsible people who enjoy long term relationships with and knowledge of Oaklands have very different and very worrying conclusions. Some words and phrases are in blue in order to draw attention to underlying assumptions in the system.

4.1 OVERVIEW

We carried out a visit on 19 September 2012, checked how people were cared for at each stage of their treatment and care, talked with people who use the service and talked with staff.

We found that the provider was providing a service which had respected the privacy and dignity of people who used their service. Assessment and reviews conducted by the agency had consulted with people who use the service and recorded how they wished to be supported. People told us that: "staff are excellent" and how "I really enjoy living here and that staff listen to me."

Monitoring by senior staff had ensured that staff followed support plans and respected the wishes of people using the service. There were sufficient skilled and experienced staff to safely meet the needs of people who use the service, and to enable the agency to accept new referrals. The standard of induction and subsequent training for staff was of a good standard. Unpaid staff who work at the service are known as co-workers or guest volunteers. We were told that they did not provide support with personal care.

In summary, this inspection found that the Oaklands Park Domiciliary Care service was providing a good standard of care and support to the people using their services.

However, someone who has been involved with Oaklands Park for many years and knows people well gives a very different perspective:

An elderly man who has lived at Oaklands Park for more than 30 years lived for many years in the mansion. He was at home there – as part of a group of exceptionally forgiving, tolerant and understanding people who were paragons of mutual care and respect. During his working life he had worked hard in the garden and was a much loved and respected contributor to the community.

Managers deemed that he would be better placed in a vacant independent living unit at the other end of the village. He was asked if he wanted to move and said, "No thank you." Nonetheless a week later he had been installed in the flat.

It was soon evident that he felt lonely, isolated and miserable living on his own. He was desperate for companionship and looked for this with the group living next door. It was not long before they were locking the door to keep him out. He was, they said, "too demanding, talked too much, and repetitive." The paid support staff (there were no co-workers living with the group next door) simply saw the solution in terms of excluding him. In his old age he should not be exposed to arbitrary decisions by people who neither know nor care for him.

The underlying message is all too obvious. 'Volunteers' – people committed to living the intentional community philosophy who cannot be controlled through an employment contract – are neither what CVT is about any more nor to be trusted. There are no longer house parents or co-workers. These are re-designated as **unpaid staff** (which they are not) who are unfit (within the regulations applying to the **service**) to support people with personal matters. The Inspectors accepted what they were told about 'adequate skilled and experienced staff to resume touting for business again' without it seems observing and researching how life was changing for the folk they would say they were protecting. In other words, the system does not meet specified standards and, therefore, must be wrong.

4.2 MONEY

Fees. The provider was meeting this standard. People who use the service knew how much they were expected to pay, when and how.

People using the services, or those acting on their behalf, knew the cost of the services and when they were expected to pay those charges. We reviewed, with the provider, how the information regarding fees was given to people using the service, their families or representatives. We saw evidence that each person, who was responsible for paying for the costs of their care, had been provided with a statement and schedule which provided a breakdown of the costs. Additionally, each of the files seen contained a tenancy agreement. The general manager told us that the contract and statement of terms and conditions was being reviewed. Each of the tenancy agreements had been signed by people using the service. Receipted records had been maintained of the payments made by people using the service. Information had been provided to people using the service, and their representatives who were paying in part for their care, that they may become eligible for additional local authority funding support.

Craig's story offers a very different perspective:

Craig is now in his 70s. He has Down's syndrome and has been part of the Camphill community for nearly half a century. Craig has quite marked learning difficulties but has been consistently supported to contribute in valued and adult ways to the life of the community. Amongst a range of roles, Craig has been the community postman, the eggshell collector and recycler, and a kitchen assistant.

In later life swallowing difficulties have been of some concern – although there have not been any serious incidents. A Speech Therapist from the local CDLT assessed him and decided that he should be closely supervised at mealtimes. It is here that real lunacy kicks in! As CVT is not registered to provide 'personal care' commissioners now require them to contract in an agency worker at £18.50 per hour plus expenses 3 times a day (as if Craig only ever puts anything in his mouth at mealtimes!). One assumes that families are not registered to provide 'personal care' too and so are also sources of income for care agencies? (Yes, we are being ironic.)

And the consequence is that Craig now presents himself as childish and

dependent, non-contributing, and addicted to childish attention. So much for personalisation and progress? One wonders if Craig knows or understands the extent of public funds being wasted in order to serve a dysfunctional system or if he was one of just four people interviewed by the inspector prior to issue such a glowing bill of institutional health?

The matter of fees seems fundamental to the institutional system's difficulties with intentional communities. While politicians and public servants seem not to be unduly exercised about funding systems that pay salaries, bonuses and dividends – generally in small measure to those who do the delivery and in big chunks to those who have institutional or financial power – they balk at 'public money' being applied to deliver an outcome rather than a sequence of simply reported inputs that may or may not secure any valued outcomes.

It seems to us that a principled implementation of self-direction and individual/personal budgets could provide the means to secure the accountability the system requires – providing of course that Local Authorities can fundamentally change, and trust the citizens for whom they say they work. Three decades now of 'modernising' commissioning has been postulated on the notion of commissioning for outcomes. Is this just window-dressing? What is increasingly evident to us is that the current commissioning system (based on payment by results more than outcomes) is crippling the public sector.

4.3 CARE

People should get safe and appropriate care that meets their needs. The provider was meeting this standard. People experienced care, treatment and support that met their needs and protected their rights.

We saw the care plans for four people. The care plans contained assessments and had been reviewed on a regular basis or, as appropriate, to reflect changes in need. The care plans also reflected choices of how people wished to be supported. We saw evidence that the provider was reviewing needs and how care was centred on the people using the service, their individual needs, preferences and diversity. Care plans contained risk assessments to provide guidance for staff which had allowed them to care for people safely and respect their welfare. Records also showed how staff were able to recognise changes in physical/mental health which they had reported to senior staff.

A continuity of staffing had allowed them to recognise changes in need. The general manager provided us with written evidence which stated that only suitably trained staff had provided support with personal care.

We saw an example of the 'domiciliary care file' which was kept in the rooms of people using the service. The files had recorded the support provided with personal care on a daily basis. The files had also recorded how people wished to be supported and their likes and dislikes. The files had been developed in conjunction with allocated keyworkers.

Compare the CQC's perspective with these observations from a visiting healthcare professional:

Up to 3 years ago I would have wanted any disabled loved one of mine to live at Oaklands or The Grange. Now they are just bloody Care homes and I get to go into plenty of those!

It used to be a joy to go to Oaklands. There would be lots of interaction, enquiries about my family, about what's going on in the village, around the festivals, events and plays. People were busy, learning skills, working, making music. Now it's like everywhere else; people sat around the TV.

There's no light in peoples' faces.

I saw Tom and it reduced me to tears. They moved him to flat on his own. He hated it and went downhill quickly. Before, he loved church where he played the organ. He was a nice guy, sociable, a conversationalist who was interested in people and families. He was so calm, a peacemaker and solution finder. The last time I saw him he was shouting, growling; totally out of character. They have robbed him of his home – because they aren't interested in what home means to him. They denied him choice – because they have a perverted idea of what choice is.

Jean is a skilled and artistic carpet weaver. They made her go to college – so that she would be included and out in the community – where the teacher gave her a paper template to sew, just like a toddler.

Oaklands Park was a real community. All age groups, all abilities, lots of children – alive and civilised. You know; children bring out the nurturing in everyone. That's essential to natural life. It certainly was at Oaklands. It makes you wonder whether the experts know anything about life!

Tina has lived for 30 years at Oaklands. She dotes on children and

throughout has lived with families with children, often looking after babies. Now there are no children on the site and she's bereft – and I don't think that people who don't know her have a clue.

There seems to be no good reason to believe that some visiting inspector is likely to understand what is really going on in this community. There would seem to be more sense in contracting visiting professionals and citizens who know people well – or dare we moot the idea of intentional networks of families and friends of people living in regulated settings – to undertake monitoring and outcome reviews/inspections in settings where people make their life.

It seems to us particularly naïve to equate the existence of care plans and records with performance – other than relating to performance in the production of care plans and records, with these tasks undertaken in time that might have been more positively spent living and working in the company of the subjects of the documents?

4.4 ABUSE

Safeguarding people who use services from abuse. The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

This should make us wonder whether we really understand the meaning of abuse. Take for example this story:

Paddy is in his early 30s and said to be quite severely 'limited'. Nonetheless, working with a co-worker with whom he had a strong relationship, he became a competent gardener and a confident composter with a round of customers. He took a pride in his work.

In the new regime, where you can work if you want to but don't have to and where the come-in support staff are neither keen on nor skilled in the growing and crafts that tend to characterise community living, Paddy, without encouragement, 'chooses' to do nothing.

Now Paddy appears devalued – looking severely disabled – "his vigour is gone, he looks depressed, and he's acquired the 'subnormality shuffle'. All in the name of choice and independence. Oaklands has become a latter day mental handicap hospital!"

4.5 MEDICINE

Management of medicines. The provider was meeting this standard. People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

There were systems in place to ensure that medicines were safely administered by appropriately trained staff.

We briefly reviewed, with the provider, the systems which had been employed to provide personalised care through the effective use of medicines. The general manager confirmed in writing that whilst neither guest volunteers or co-workers provided personal care, co-workers (but not guest volunteers) had assisted with prompting to support residents taking their medication. The general manager also confirmed that volunteers had received training in 'awareness of medication' and that all residents had been assessed for their ability to self-medicate.

Could it be that inspectors are more interested in how drugs are administered rather than whether they should be at all?

For example, here is a story from sources who wish to remain absolutely anonymous:

People with autism used to have really good lives in our community. There was predictability, calmness, strongly forged relationships, real attention to finding a niche for everyone and the security of communal dining, the succession of festivals, and a stable, dependable co-worker presence.

Now it's we are seeing the obverse of this. Late, hectic and disjointed mealtimes; no pattern to community life; few established relationships and widespread ignorance of who people really are.

The consequences are very evident. Massively increased stress, lots more incidents, increased compulsive and obsessive rituals, lots more drugs, more pathologising, and exclusions.

4.6 PEOPLE

Supporting workers. The provider was meeting this standard. People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The health and welfare of people using the service was protected by being supported by competent staff. Training records showed that new staff had received a comprehensive induction following national standards. Staff had completed the 'Skills for Care Common Induction Standards'. All new and existing staff had received health and safety and training specific to their role. Learning and development needs had been assessed in supervision meetings with senior staff. The provider told us that there was a training and development plan which was being updated to reflect the training needs of all staff. We saw a training matrix which showed when staff had completed and when they would need to refresh their skills and knowledge. There was evidence from training records that staff received appropriate opportunities for professional development. Most of the recently recruited staff had already achieved a NVQ level three in care. Similar opportunities were available to existing staff.

So, how has all this 'professionalisation' and institutionalisation impacted on people?

"It is also a period of transition for CVT. We are working to align our values and achievements with the requirements of 21st century social care. Like other social care providers we exist in a time of economic austerity and regulatory scrutiny"

Huw John, CEO

Compare this to the perspective of a mother:

Robert has lived at Oaklands since the 1980s. He had a job as a labourer where his Dad worked for 4 years but we decided to get him settled before we got too old. We chose Oaklands with Robert because of the communal and spiritual culture he experienced when he came for trial stays and the dynamic social life. Initially Robert worked in the gardens and the kitchen, becoming a really good cook. Later on he took to carpentry too.

But now there are no co-workers – there used to be a mature couple with children plus young volunteers and Oaklanders – no evening activities, no crafts, no plays, and no festivals. All they do is sit and watch TV. Robert's late Dad and I used to come down for a couple of weeks every year and muck in, doing maintenance and decorating. We always felt part of Robert's 'family' but now I'm not allowed to stay on the site.

A year ago Robert suffered a broken back when a farmer let his rams out and one knocked him over. Since then Robert's life has deteriorated further and, worst of all, he's been labelled a sex-pest. Nick, a former co-worker, says that this is just rubbish. He raised two daughters living with Robert and they think the world of him.

I wrote to the Chairman, Chris Cooke, but he didn't bother to reply. I had planned to will my estate to Oaklands for the benefit of Robert and his friends, but I've reconsidered. The caring is gone.

Here again we find the CQC enforcing and reinforcing a commercial, contractual set of assumptions about what constitutes care and its 'measurement' on a system that ought to be 'chalk and cheese' different. We cannot hold the inspectors wholly responsible – though from professionals in the field we might expect a more reflective analysis – because they work in a system that has lost or rejected any notion of diversity; especially if any manifestation of diversity challenges the silence around the inappropriate primacy of the market in 'care'. There is something of the night in the concept that peoples' health and welfare is best served by mechanical dependency on regulation compliant 'competent staff' – particularly when competence is defined by qualifications and experience rather than performance and outcomes for disabled people.

The Inspectors clearly do not appreciate that when the new 'leadership' of CVT uses the term community they are referring to congregate institutional living and one is compelled to question whether any of these powerful actors entertains any prospect of disabled people pursuing ordinary, contributing lives or having any realistic expectation of this. CVT, despite an honourable

history of communal striving, sees itself as just another 'social care provider in a time of economic austerity and regulatory scrutiny'. The 'leaders' who could (and we would assert should be) vociferously campaigning for and demonstrating the proud history of a proven other way just have not. And those who would are defined as the problem – to be replaced by more compliant, employed staff or patronised or ignored. Above all, this section of the report reinforces the notion that the natural and voluntary is incompetent; when it is not and offers qualities and possibilities that professional services cannot.

4.7 QUALITY

Assessing and monitoring the quality of service provision. The provider was meeting this standard. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

We saw evidence in people's care plans of continuous monitoring to analyse and review risks, events, incidents and near misses. Following accidents, or near misses, there had been reviews of risk assessments to prevent a reoccurrence and to protect the person and staff involved.

Think about this understanding of risk and quality in relation to this observation:

Nowadays one hears people referring to staff as 'my carer' rather than using their name. The trouble of course is that there are so many people in and out of the house that some folk haven't had the chance to learn everyone's name. Therefore, they have all become 'my carer'. How institutional is that! Time was when everyone knew everyone else's name ...and not their name only but the person inside the name.

So here it is! The defining criteria for care services are protection and the avoidance (they will insist, management) of risk. In other words not getting things wrong is more important that getting things right – that is enabling people to pursue a good life. One wonders how it can serve safety, security and protection for hosts of 'come-in' staff who frequently don't know the folk they are supporting to replace stable, long term, family-like relationships?

5. CVT AND GROUNDSWELL PARTNERSHIP

Camphill is dedicated to creating communities where the values of service, sharing, spiritual nourishment, and recognition of each individual's gifts and contributions offer a model of renewal for the wider society. In Camphill communities, daily life is shared with children, youth, and adults who have disabilities – in ways that are both intentionally therapeutic and intentionally personal. The result is that Camphill offers all community members a life of accomplishment, celebration, and meaning.

From the website of the International Camphill Movement

The legacy of Steiner, Konig and, in the wider sphere, inspirational proponents of community living such as Jean Vanier, enjoys weighty international leverage.

So, to us at least, it is a little surprising that, instead of turning to that wider movement for advice and assistance in managing the regulatory and commissioning threats to the integrity of its work, CVT turned to a consultancy agency called Groundswell Partnership (which is made up of three consultants: Sam Bennett, Simon Stockton and Helen Sanderson). This agency has worked very closely with the English Government's personalisation programme but it does not have any obvious links to Christian social movements or intentional communities.

It is then not surprising that their overarching recommendation, while paying lip-service to their client's USP, was:

The main risk (which we think would be very high) is of external rejection in the short to medium term by external commissioners in particular and potentially by regulators.

Indeed this was a foregone conclusion given that the Terms of Reference presented to the consultants strongly implied that Camphill's essential values and practice are not well aligned with the 'personalisation agenda' (or should that be rephrased as the 'marketisation and consumerisation agenda'?). One can only assume that the Terms of Reference were drafted by the CVT Trustees who set out from a perspective that they should 'explore the sustainability of CVT's provision in the context of external commissioning

and other developments', rather than provide the evidence by which CVT might demonstrate the unique and valued alternatives offered by intentional communities to people with disabilities and their families.

In healthy market conditions participants celebrate their unique selling propositions and the benefits arising. It seems that the Trustees of CVT are not enthusiastic proponents of the Memoranda and Articles of Association they are supposed to espouse. More tellingly we would suggest that they are victims of the same social silence that gave rise to the banking crisis, which is submission to the notion that the only reality deserving of attention is that defined by a self-serving hegemonic system, its implicit veracity and unassailability, and, most insidiously, the perception that, by standing up to its assertions, one may be denounced as reactionary, ill-informed, uneducated, and out-of-step – an uncomfortable and 'uncool' place to be.

In the light of this it is hardly surprising that their advisors concentrated their attention upon how CVT might comply with rather than reform 'the market'. Any dispassionate observer of the governance of Camphill Village Trust must query why Trustees who find themselves out of sympathy with the most fundamental principle of the Charity have not resigned? Could it be that few if any of them have invested in intentional community living themselves?

Here is the perspective on an international young volunteer co-worker:

I was lied to. I came to a Camphill Intentional Community that does not exist. I travelled half way around the World, paid my own way and applied for my own visa, in order to be marginalised and neglected. They can't wait for me to go. The disabled people are anxious. They've noticed that when co-workers and volunteers leave they are not replaced.

They may justify their continued presence by arguing a 'modernisation' agenda and assert that what they are doing is about protecting the interests and well-being of CVT's 'clients' but, in researching this essay, we have been presented with too many examples of the deleterious impact of this process on the lives of intended beneficiaries and the wider culture of various communities too find this credible. Indeed, it is frequently alleged that Trustees have been deaf, blind and frequently unresponsive to or in denial of the evidence placed before them.

Yet, in hearing these stories, and in reading the extensive literature arising from CVT itself, the CQC, external advisors, and various commissioners we sense a pervasive background noise of, 'there is no alternative', which, as it is far from the truth, leaves us sad and not a little angry.

6. SOME QUESTIONS

Let's start with the obvious question. Can we, as a society, for whatever reason, permit our public institutions, intentionally or not, to unilaterally limit our options as to how we apply community funds to care for each other?

More explicitly, are we happy for our public servants to decide that our options should be limited to those that can be made subject to simple, contracted, economic transactions?

Mike Green, co-author of *When People Care Enough to Act* and thinker and practitioner about the application of Asset Based Community Development and thinking to the social care field, offers some powerful insights to, in particular, leaders and practitioners (managerial and professional) in public institutions. He explains that working institutions are necessarily hierarchical, proceduralised, bureaucratic and rules and systems-laden and compares this with community or associational life which is inevitably focused around common interest, voluntary contribution and the sustenance of working and personal relationships. He draws attention to how both 'ways of being' are essential to the nurturing of a healthy and resilient society but warns that it is in the nature of institutions and professions to impose their world-view and mechanisms on everything they 'touch'.

He counsels all who work in the institutional milieu to keep this awareness at the front of their minds and to function as 'Gappers' – working intelligently to maximise the societal benefits of both cultures and to ensure that the institution does not inadvertently attenuate those communities it should be strengthening. As we work quite often in Wales, we tend to describe this in terms of the competent 'Gapper' needing to be bi-lingual.

Following on from this insight, we would ask an even more disconcerting question. Is it possible to buy 'care'?

We would assert that the constant flow of high profile scandals and gnawing personal experiences repeatedly remind us that it is not.

Is it true to say that most of us don't pay much attention to the issues of disability, old age, or chronic physical or mental ill-health until they touch us personally? It may be true that we get a little exercised when scandals like Winterbourne View, Mid-Staffordshire Hospital, and recurring exposures of the shortcomings of both home and residential care for our elders hit the media but there are always 'them' – politicians, professionals, folk who make money out of others 'needs', and public institutions – to blame, hold

to account, and, against all reason, expect to remedy the situation. In doing so we increasingly distance ourselves from how this thing called 'care' is defined (and publicly specified and purchased) and, when our time comes to interact with the system, discover that what we expect is now absent.

The reasons for this are many but the over-riding difference resides in two very different interpretations of the term 'care'. For the relative, friend and neighbour it constitutes activities undertaken in the context of knowledgeable, emotional and long mediated relationships; for the institution and professions it comprises tasks performed within the purview of a contract specified against rules and procedures. Inevitably the latter tends towards the mechanistic while the former is more organic and intuitive.

Human services have the unintentional effect of pulling suffering away from the family and neighbourhood and into the domain of the marketplace. This strikes at the heart of community competence, and it occurs because we have given care over to the professionals.

Professionalisation is the market replacement for a community that has lost or outsourced its capacity to care. The loss of community competence is the price we pay for the growth of the service economy.

Care is the freely given commitment from the heart of one person to another. It is the most powerful aspect of our relationships. When we put it into words, we say, "I care for my family ...my community ... above all" "for my Dad to the day he dies" "I will never leave..." These words tell us that care is within us.

In the consumer ecology, the word 'care' has been coopted by systems, businesses, agencies and governments... We know it is not care, because genuine care cannot be paid for. It is given, free of charge.

John McKnight and Peter Block (The Abundant Community, 2010)

It seems to us that the Camphill philosophy, predating as it does the wholesale marketisation and outsourcing of our familial and communal responsibilities and personal entitlements, constitutes a powerful reminder of the potential goodness and competence implicit in the familial and associational world; and hence a threat to institutional and commercial interests as well as incomprehensible to mono-lingual systematisers.

We would also worry about the cost. Putting in 'checkers', (i.e. managers), means that the community is no longer responsible for itself. The checking fails, by definition, and then always requires more 'checking' and, therefore, more managers and more levels of manager. The system becomes dangerous but also economically unstable. How long before someone (ironically, the 'checker') questions the economic viability of Camphill?

The fundamental problem that CVT has to consider is the nature of the government's system. It is based on a market whereby providers are invited to compete. In order to know what they are competing for the commissioning system predetermines what matters to citizens in order to specify the service that provides are competing for. This probably bears no relationship to what actually matters to citizens. Having specified what the providers will supply the system then charges the inspectorates (CQC in this case) to identify what is being complied with and whether or not the specified services are being supplied. The specification is broken down into particular activities and themes that are based on assessment of needs. In the current system this breakdown creates a fragmented view of the individual – it does not focus on what mattes to them in terms of their life choices. It could but it doesn't. The logic of the Steiner community runs counter to this, focusing precisely on the person as a whole and on how they live their lives within a transparent ethical framework.

Additionally, as evidenced within the foregoing analysis of inspection reports, it would seem to be indisputably the case that the inspection regimen attaches far greater importance to compliance with prescribed administrative and accounting protocols than it does to getting seriously to grips with the lives experienced by the assumed beneficiaries of this market-place.

Together this conspires to place CVT trustees are in a difficult position. We naturally assume that they wish to be a responsible board and protect the interests of the Trust. The consequences of their actions are inadvertent and prime responsibility lies with the 'rational' and inherently mindless approach to regulation of recent governments.

We believe they do have choices:

1. If the primary wish is to protect the culture of Camphill and be true to the Steiner principles then they can negotiate a sensible regime with the regulators ('sensible' requires definition: in our view a 'sensible' inspection regime must major upon satisfying everyone that the recipients of support are on a journey towards enjoying the best life possible for them given the cards they have been dealt). The regulators are not inherently stupid people; they just run a stupid system. They should be open to negotiation around protecting the principles as long as the benefits to the residents and co-workers are made clear. The current location leaders are not steeped in Steiner principles but are fully conversant with the government logic. CVT would have to recognise therefore that the role of leaders would need to be changed. They could also re-define the role of managers from 'ensure we are compliant' to 'work with residents and co-workers to ensure that

the principles are explicit and operating competently and that the community is doing what it does safely'. This latter would ensure that responsibility is designed into every role and that the culture of quality control becomes one of learning and improving against evidence. Is CVT willing to have that conversation with CQC and is CQC likely to respond?

2. If the primary wish is for the business to be safe and compliant then it needs to be understood that, in the current regulatory climate, this is inconsistent with Steiner principles and CVT might simply run a competent set of very large care homes and be honest with everyone that these are no longer Steiner communities. If CVT is inclined to this solution then it raises the question of what the constituent parts of their organisation (residents, families and carers/co-workers) would want to do. Would CVT be willing to explore the option of 3) below:
3. A third, more radical but in the long run more sustainable and coherent, option may be to explore either winding-up the Trust or enabling the decoupling of 'sites' where the majority of stakeholders are not in sympathy with the direction being pursued by Trustees and where credible local governance and constitutional arrangements that are in accord with Steiner-Konig principles are forthcoming. It seems to us that social care businesses and intentional communities are fundamentally incompatible and that there is no future in trying to sustain Steiner-Konig inspired communities by applying the 'logic' of the social care market. It will take committed leadership from folk who are wedded to those principles to, in the contemporary ecology, devise and implement ways of sustaining communities without compromising the ethos.
4. Would CQC be willing to entertain this? And, crucially, would the regulator (and involved Commissioning Authorities) be open to working with CVT or its Successor Governance Bodies, using the opportunity afforded as a joint learning opportunity through which a regulatory regime relevant to full-blown intentional communities might be developed? We are convinced that this would have wider spin-off implications for the improvement of the wider regulatory regimen.
5. One very obvious further option is for CVT or its constituent communities to actively live, demonstrate, explain and promote its unique selling proposition directly to the people and families it is constituted to embrace – people who, according to the government, have every right to self-direct, elicit a personal budget, and exercise meaningful choice.

CONCLUSION

We are not members of the Camphill community and we did have some concerns about intentional communities taking people out of the mainstream of ordinary life. But our journey has left us deeply saddened by the ongoing destruction of communities that once understood what really matters in life.

Not only are we losing these diverse and value communities but we are also seeing the same destructive force at work across society: social care as commerce, mindlessly and incompetently regulated by central government. If we are to protect ourselves from this we are going to have to find ways of talking more confidently of the true meaning of care, the centrality of love and the real character of communities and families. Unless we do this all of us will find ourselves living in an increasingly cold and heartless world.

ABOUT US

Richard Davis studied psychology at UCL and then did a masters at Lancaster in Behaviour in Organisations with a particular interest in research methods.

For the last 22 years he has been researching and consulting with Vanguard in the public, private and voluntary sectors. Vanguard's main interest has been to understand how the assumptions about a 'good' organisation drive design and behaviour. We have been seeking to change that thinking from mass production command and control logic to a systems view based on what matters to the citizen or customer.

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Bob Rhodes is co-founder of LivesthroughFriends which is dedicated to building interdependent communities, helping people (especially those with 'challenging' labels) who are dependent upon 'social care' to 'get a life' and the people and agencies that assist them to be effective contributors to this outcome. In 1991 he founded TACT UK– building over 15 years a nation-wide organisation that supported people with very challenging reputations to live in inclusive and contributing ways. He led its development until his semi-retirement (unrealised) in 2006. Along this journey he 'woke up' to the limitations inherent in dependency upon professions and institutions and the need for services to integrate themselves within and contribute to the neighbourhoods in which they operate.

Bob strives to work at both the grassroots and strategic levels in respect of social inclusion and strengths-based social development and concurrently advises Governments and helps people with disabilities to self-direct; founds and grows organisations and helps people build personal relationship networks; researches and writes challenging social policy books and papers while crafting humorous or ironic verses about the absurdity of institutions and the professions to which he belongs; and assists people with very challenging reputations to refute their reputations and battle-worn professionals to rediscover both their empathy and their creativity.

LivesthroughFriends is a coming together of folk who are concerned with the realisation of an inclusive society and kinder, more interdependent and gift centred communities. Bob was an Ernst & Young Social Entrepreneur of the Year in 2003 and is the author of *Much More to Life than Services* (2010). His new book, written collaboratively with Colin Campbell and members of families supported by LivesthroughFriends, *The Green Book – Sustainable Care for Each Other* was published last year (2013). Inter-alia, Bob is a Fellow of the Centre Welfare Reform, an FRSA, a Trustee/Adviser to several domestic and international NGO's, and continues to practice in the UK and speak and consult internationally.

www.livesthroughfriends.org

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