Intentional communities of attachment

‘Intentional communities of attachment’ are communities where people with a disability and non-disabled people live together outside of professionalised care arrangements or family obligation. They can demonstrate a very different approach to meeting the needs and aspirations of disabled people. The experiences of such communities can provide important indications for the practice and development of community care generally, according to a study by Richard Grover. He examined a range of such communities and concludes:

- Most communities see interdependence as being at their heart, largely replacing ‘professionalised care’ by building upon a strong mutuality of interest which overrides the categorisation of people according to any ability or disability.

- The mutuality of interest is demonstrated through the active participation of people with a disability in a wide range of community undertakings which would otherwise be difficult to sustain.

- These activities in the social, work, domestic and, sometimes, religious realms, often offer a wider range of opportunities than people would experience in professionalised care settings, for example, by being involved with children living in the community.

- No one model of community predominates, although they have certain basic characteristics in common. Communities varied with regard to such things as the legal status of residents, their involvement with the wider community and their approach to the holding of money in common.

- Such communities are few in number (47 being identified). This reflects a lack of funding, developmental and continuing support which is in part due to the difficulties in understanding created by the fundamentally different philosophies and practice of the communities and of professionalised care. There is also a lack of people coming forward with the necessary skills and commitment.

- The researcher concludes that ‘intentional communities of attachment’ offer a valid third option in community care outside formal (professionalised) care and informal care (from obligated families). This option is small but thriving, demonstrating a radically different approach to meeting special needs while offering a range of good quality opportunities.
What are intentional communities of attachment?

The communities looked at in the study displayed a number of key characteristics in common:

- a community of place - which may be a house, a group of houses, a village or a number of houses spread over a defined area;
- a community of identity - whereby the people concerned acknowledge willing membership of the group;
- a community of interaction - whereby members join together in specific activities that originate from within the community;
- existence outside of the family;
- an engagement of people commonly labelled as disabled and those seen as without disability on as equal a basis as possible, with the focus on interdependence rather than the dependence of one group on another or the categorisation of people as staff and clients;
- the use of money most commonly as a means of supporting the communities rather than as a reward to individuals for services rendered.

Historically such communities are seen as being rural enterprises, but this no longer represents the pattern of development: newer communities are increasingly being established in the inner city and the urban fringe. All the communities exist outside the statutory and private sectors. It is probably not possible for these sectors to incorporate the philosophy that underpins such enterprises because of their dependence upon the clear division between clients and professionalised carers.

Disabled people as contributors and not just as receivers of services is a common theme within a wide range of practice. For example, they can be full working members of such communities and undertake a wide range of practical work or they may contribute significantly to the personal development of young people who come to support them.

Children are often seen as important members of communities, bringing a sense of completeness and fulfilment to the home that is likely to be difficult in professionalised care settings where children have no place.

The diversity of practice

Despite this framework of common characteristics there is also a great diversity of practice with no single model predominating:

- Levels of internal integration range from communities where most aspects of daily life are shared within communal households to those with a loose structure and the expectation of close 'neighbourliness' between people living in self-contained accommodation. Those with less internal integration tend to offer their disabled members fewer opportunities for identifying and meeting their needs and aspirations.
- Integration with the surrounding locality is equally variable. Some communities are actively involved with local concerns and also invite people from outside the community to join in internally arranged activities. At the other end of the spectrum are communities that neither create activity to which they might invite others nor seek any significant joint activity with the locality except on the basis of supporting an individual in using pre-existing facilities. None of the communities studied adopted a deliberately isolationist stance.
- Residents vary in their legal status in relation to the communities. Some are licensees under the terms of funding agreements with statutory authorities, whilst others are members of a fully mutual housing co-op with security of tenure.
- The ratio of people with disabilities to those who have not ranges from 1:10 to 2:1. The higher ratio of people with disabilities to non-disabled people tends to be found in the communities with the higher levels of internal integration.
- The approach to money is often a reflection of the level of internal integration. The more highly integrated the community, the more money is held in common and distributed according to overall need. Some communities regard this breaking of the wage relationship as a key element to sustaining the community way of life. Others feel it possible to work within a wage system and yet retain the commitment they seek. The less integrated projects hold little or no money in common.
Continuity of membership of non-disabled people seems to be related to the strength of the underlying ethos within the community. Where the objectives are most limited then ‘support residents’ usually stay for not more than 12 months. The continuity then tends to be provided by the disabled members. Where there is a more holistic approach to community life then all residents tend to stay much longer and continuity is not a major issue.

Conditions for success
This research did not seek to judge one form of community against another or to argue that one approach is more appropriate than the rest. But the study suggests that certain common factors affect a community’s ability to achieve its goals.

• There needs to be a clear sense of both the goals to be pursued and the process involved. In the most stable communities this clarity is carried forward by a commonly shared ethos and practice to which new members can be introduced. Where there is no such ethos and a relatively high level of turnover in the membership, then the goals and processes may need to be written down, taught and regularly reviewed.

• Concern for physical security and direct personal care is only a starting point for enabling people to address their social, work, cultural and, sometimes, spiritual life. The development of these aspects requires well thought-out opportunities to overcome the limitations commonly placed upon people with disabilities and requires effective links with statutory and non-statutory agencies, relatives, friends and the locality within which a community exists.

• Communities are often founded by people who are seen as ‘charismatic’. Social projects built around such people sometimes flounder when they leave or when the organisation outgrows the control of one person. The larger communities that have avoided this trap have done so by creating a strong social grid within which they operate, where responsibilities are shared amongst many and where authoritarian leaders have no place.

Policy implications
‘Intentional communities of attachment’ present a third path that lies outside of professionalised care or obligated family provision. They have been effective in creating and maintaining different forms of social, work and cultural networks. This path needs to continue to expand and share its experiences with the other sectors.

• A key focus in community care should be the fostering of interdependence between people with and without disabilities. The experience of communities suggests that the concern for individual rights must be at least matched by an understanding of the power of mutual interest.

• New forms of contracting agreement between purchasers, inspectorates and providers are necessary to support the development of opportunities that fall outside traditional service provision.

• Communities gain strength from following their own path of development, but there is also the risk of isolation. There is a need to encourage and facilitate the sharing of experiences, knowledge and support with the professionalised sector.

About the study
The study looked at 33 communities in Great Britain that seek to include people with a learning disability or mental illness. At least 14 others are known to exist within Great Britain. Of the 47 communities, 21 are members of the Association of Camphill Communities, 7 are L’Arche Communities and the remaining 19 are all independent of each other. Their size varies from 6 to over 300 people.

The report is based on a postal survey of 149 communities identified from a wide range of sources. The initial survey produced 99 responses of which 33 were assessed as being relevant communities. These were sent a second, more extensive questionnaire. Twenty-nine communities returned the questionnaire and 15 were then visited. The visits involved semi-structured interviews with people both with and without disabilities. Limited use was also made of explanatory material published by individual communities.
Further information
A full report, Communities that Care: Intentional communities of attachment as a third path in community care by Richard Grover, is published by Pavilion Publishing, 8 St George’s Place, Brighton BN1 4GB, Tel: 01273 623222, Fax: 01273 625526 (ISBN 1 871080 18 5, price £7.50 plus £1.50 p&p).

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Related Findings
The following Social Care Findings looks at related issues:

57 Living in the community after leaving long-stay hospital (Oct 94)
58 Aftercare of black ethnic minority people discharged from psychiatric hospitals (Oct 94)
64 Moving from hospital into the community: an evaluation by people with learning difficulties (Mar 95)
66 Housing and support for people with learning difficulties (Apr 95)

For further information on these and other Findings, contact Sally Corrie on 01904 654328 (direct line/answerphone for publications queries only).