

THE OCCUPATIONAL STATUS OF STAFF IN COMMUNITY RESIDENCES FOR PEOPLE WITH INTELLECTUAL HANDICAPS

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INTRODUCTION

Staff in residential services for people with intellectual handicaps are often exhorted (usually by other professionals) to act in professional ways. In this paper, the particular dilemmas facing residential staff in gaining recognition for their occupation are discussed. It is argued that high performance standards are expected of residential staff yet they enjoy few of the advantages accruing to most professionals. Furthermore, certain aspects of traditional professionalism are antithetical to good residential care. That is, the philosophy and values underlying residential services encourage staff to camouflage, rather than to display expertise. The tension between the needs of clients and the needs of the profession are discussed. The paper proposes a number of strategies to assist residential workers win societal recognition for their occupation and use their enhanced status to effect optimal improvement in the quality of life of residents.

THE MEANING OF PROFESSIONAL

Everyone understands the meaning of "profession" and "professional" until asked to define the terms. Historically, "profession" was reserved for the learned professions of theology, law and medicine. These were considered callings which required special knowledge and special skill.

Freidson (1977) suggests that the word profession is now an illusive concept, continually changing and based on the particular ways in which the division of labour occurred in an industrial nation. The character of a particular profession also reflects the influence of societal features — politics, cultural norms and social structure (Vollmer & Mills, cited in Brown, 1987).

In nineteenth century USA and England, new occupations developed and these were "upwardly mobile", i.e., they coveted the status and power of the older, established professions. "Profession" came to mean a certain status and a disinterested dedication in relation to lay-persons i.e., those who needed the special expertise of the professional.

While there has always been a tacit acknowledgement that such disinterested dedication would be rewarded in a variety of indirect, if not subtle, ways, e.g., through status, absence of controls, freedom from economic competition, etc., the extent of self-interest of the so-called "helping professions" has been highlighted by Illich et al (1977).

Despite Illich's attack on the professions, and his expose of their blatant self-interest at the expense of those they profess to heal/educate or care for, the term "profession" continues to be a valued label in our society (Buckenham & McGrath, 1983). The term suggests expertise, autonomy, commitment and

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responsibility (Vollmer & Mills, 1966) and occupations in the human services seek to be well-placed on the profession/non-profession hierarchy (Buckenham & McGrath, 1983).

MOVING UP THE CONTINUUM

Typically, the first step for an occupational development is to 'corner a market', i.e., to annex some functions of another occupation or to start doing full-time, a task that society believes needs to be done.

The next activity is to establish training programmes and to form a professional organisation. The objectives of these activities are to develop an esprit de corps and provide a focus for the development of members and a mechanism for excluding those who do not meet specified standards in terms of attitude, conduct, knowledge and skill.

Occupations usually change their name at some point and adopt strategies to distance themselves from the occupation from which they developed. For example, "cottage parents" become "social educators" and focus more on rehabilitation and education, and less on care and housekeeping. So, the change in name is accompanied by a re-definition of function. Usually the less interesting, less acceptable, more distasteful aspects of the job are given back to the parent occupation, or new employment classifications are established to take over less attractive features.

Occupations usually engage in political/legal action to win support for licencing, certification or registration. The motivation for such activity ranges from a genuine concern to restrict the activities of charlatans (designated so, by members of the profession) through to ensuring that only those who have been initiated into the profession in an approved way are permitted to practise.

RESIDENTIAL WORKERS AS PROFESSIONALS

This brief introduction to the elements of 'profession' permits an examination of the complications for residential workers in pursuing a professional identity.

Commitment and Responsibility

There is no doubt that residential workers are expected to demonstrate all of the attitudes and values esteemed by the established professions. They are required to show initiative, self-reliance and disinterested commitment (Joachim (1987)). They must also appreciate and endorse the values of normalization and continually seek opportunities to promote the quality of life of residents.

Expectations placed on residential staff in community settings are even more demanding. There is less structure, less supervision, less guidance in community residences. The work of residential staff in the community is more public, more open to scrutiny, and the effects of unprofessional conduct are potentially more serious, e.g., the return of a person to an institution or the loss of community support for the integration of people with intellectual handicaps. Few professionals have to maintain such a level of commitment to such a devalued group in such public prominence as residential workers in community settings. If "commitment" and "responsibility" are the ways in which the entry fee is paid to the professional club, residential workers are full-paying members.

Special knowledge, skills and theory base

Singleton (1978) asserts that "an unskilled job is one which any person can do immediately". Although there are wide differences in the level of knowledge and training of residential staff (Knowles & Landesman, 1986), entry requirements are generally minimal. It is not unusual for advertisements to mention that applicants should hold certain attitudes/values and perhaps have some experience. However, the holding of a current driver's licence is often the only "essential requirement". If training or qualifications are referred to in the advertisement, other professional disciplines are frequently mentioned (special education, nursing, the therapies) implying that there is no specific body of theory, knowledge and skills on residential care.

Although there are some outstanding training programmes for residential staff, these are not readily available (Knowles & Landesman, 1986). One difficulty in producing such programmes is in striking an acceptable balance between the range of perspectives on intellectual handicap e.g., clinical, social, environmental, human rights etc. Current service values de-emphasise medical and professional responses to disability, tending to favour interventions that are naturalistic, unobtrusive, socially acceptable and focused on the environment. The implication for the "duty statements" of residential staff is that the essential skills appear very ordinary indeed.

The United States Federal Government's "Dictionary of Occupational Titles" (Kapp Howe, cited in O'Donnell 1984, p.18) contains the following entry which is ranked lowest, in terms of skill, of all 878 occupational titles listed:

Oversees activities, regulating diet, recreation, rest periods and sleeping periods and sleeping time. Instructs children in good personal and health habits. Bathes, dresses and undresses young children. Washes and irons clothing. Accompanies children on outings and walks. Takes disciplinary action when children misbehave... May work under supervision of welfare agency. May prepare periodic reports concerning progress and behaviour of children for welfare agency.

The occupational title is in fact that of "Foster Mother" but the listing of skills is very similar to the duty statements of staff in community residences for children with intellectual handicaps.

As O'Donnell notes, the occupations that engage in these sorts of tasks are ranked lower than "parking lot attendant", "poultry ofal man" and "mud-mixer-helper". Although a complicating factor is undoubtedly the status of so-called "women's work" (an issue which is discussed later in this paper), the point is that despite the demanding nature of these activities, they are not perceived as complex or needing special expertise and training. To that extent they are devalued and yet they form the core of the duty statement of residential staff.

Length and site of training are other important variables in determining the status of an occupation. When one notes that members of the most prestigious occupations, physicians and dentists, require 17+ years of schooling (Bullough, cited in Hardy & Conway, 1978), the educational background of residential workers is very flimsy. Knowles and Landesman (1986) report that the majority of US states specify no educational requirements for direct care staff on entry. Searl (1987) in a survey of residential staff in rural NSW found that 64% had not completed 12 years of schooling. When university training for physicians and dentists requires a minimum of six years, with additional internships and practical

experience, the 200-hour or 10-day training programmes for residential staff, cited as exemplary by Knowles and Landesman appear inconsequential.

One of the ironies of training programmes for residential staff is that they are usually provided by professionals from other disciplines. Some of these programmes are in-house, uncertificated, and based on curricula that are ad hoc and piecemeal.

One of the hallmarks of the occupations regarded by society as having knowledge and expertise beyond that of the layperson is the development of a unique way of communicating. However, residential staff do not need to resort to special language or jargon for describing their functions. In fact, as the general goal of residential care is the *provision of a normalized life style in as natural a setting as possible*, the use of jargon is discouraged.

A similar situation is evident in relation to specialized equipment — the special tools which only the trained may use, symbols of professional affiliation and status as much as essential requirements for client/patient welfare. Residential staff rarely need stethoscopes, paging devices, or white laboratory coats. Their goal is to provide quality of life experiences in everyday environments using typical, everyday techniques as much as possible. Even when residential staff use specialized techniques, the philosophy of normalization and the principle of least restrictive alternative demand that they be used unobtrusively — camouflaged if at all possible. Such sensitivity scores well on measures of normalization. However only the informed really appreciate the art involved in doing special things in "unspecial" places in "unspecial" ways.

Buckenham and McGrath (1983) assert that our society gives more status to 'thinkers' than to 'doers'. The occupations of thinkers are usually more conducive to planned activities, pro-active interventions and self-directed involvements. Kushlick (1975) aptly referred to the high status consultants in residential services as the "hit-and-runners" and drew a distinction between their contribution — as thinkers — and that of the twenty four hour staff — the doers. Residential care is more needs-orientated than theory driven and good residential care must sometimes be reactive if the real needs of residents are to be met. Unfortunately many of the practical skills of residential care tend to be undervalued by residential staff and by other professionals. They may not even be taught in formal training programmes.

PAY AND INDUSTRIAL ISSUES

Coffee and Ellien describe residential staff as "the workers who spend the most time with the client . . . yet are the least trained, lowest paid and least qualified to provide these services" (cited in Ziarnick, 1980, p.120). These authors point to the obvious lack of status of residential staff.

One of the major indicators of the relative status of occupations is pay. It is well known that the pay of residential staff is low in comparison with many workers in the human services. As indicated earlier, level of pay is partly determined by years of training and by the judgement society makes (usually with some help from the profession itself), of the level of skill required and the importance of those skills to society.

O'Donnell (1984) summarizes research in this area by concluding that wages and occupational status are linked to the following: (i) an ability to gain an industrial definition of particular work as skilled; (ii) an ability to play a part in

defining requirements for entry into a particular area of work; and (iii) an ability to play a part in defining requirements for entry to a particular area of training. This implies that residential staff need to be more tightly organized in an industrial sense, if they are to improve their occupational status.

In Australia, residential workers are also poorly organized in a professional sense. Although there is some variation in their degree of organization, they tend to lack power, often reporting or responsible to members of other professions. This is particularly the case of staff who are part of a larger service system, e.g., a state health department or a major hospital. It is fairly commonplace for residential staff to be accountable to administrators not trained or experienced in residential services or even knowledgeable of the goals and values of services for people with intellectual handicaps.

Other forces also work against appropriate status, payment and career opportunities for residential staff. For example, recent Australian legislation (The Disability Services Act, 1986) will still require voluntary organizations to raise a proportion of the operating funds for residential and vocational services. Thus, an approach to service delivery based on a "charity model" is maintained. Organizations faced with growing deficits find themselves in constant fund-raising activities. Cake stalls and bingo are not the most prestigious ways in which to fund a profession's activities.

Wright and Wallace (1987) point out that in many western countries there is a move towards smaller government, privatization and flat organizational structures. This situation works against the establishment of career ladders, occupational hierarchies, and opportunities for any occupation to improve its placement in the professional hierarchy. Residential workers are endeavouring to establish themselves as a profession at a particularly inopportune time.

It has been proposed that employers may too readily afford staff the label of "professional", not necessarily in recognition of their skill and commitment but as a flattering symbolic reward to conceal poor conditions, poor pay, lack of career mobility and even their exploitation. (Goldmer & Ritti, cited in Freidson, 1977). Many residential staff would be familiar with long hours of work, unpaid work, out-of-duty fund-raising activities etc.

RESIDENTIAL WORK AS WOMEN'S WORK

Though attitudes and employment patterns are changing, residential work is still considered "women's work". Recent Australian studies confirm that the majority of staff in community residential services are in fact women. For example, Shaddock (1987a) reported that 80% of staff in community based residences in rural NSW were women. Unfortunately, work done by women, particularly by those without degrees in the people-orientated area is regarded as the least skilled in our society (Kapp Howe, 1977). In the Health system, for example, those occupations in which women predominate tend to be poorly paid and low in status (Bullough, in Hardy & Conway, 1978). Bullough shows how males (and whites) are more likely to hold positions of prestige, power and financial reward. Males tend to dominate even the typically 'female' occupations (Sampson, 1987). When pursuing the elusive 'professional status', women encounter further complications. Very often a woman's movement towards professionalism is interpreted, even by women colleagues, as a denial or attack on her gender.

It would be erroneous to conclude that these findings signify differential aptitude or ability in relation to the skill requirements of particular occupations, or levels within occupations. Women's versatile occupational performance during wartime and, with legislative backing for 'equal employment', their successful move into a wider range of occupations indicate that male-female disparities in level of status and pay cannot be attributed to gender. O'Donnell (1984) is probably more accurate in concluding that the status of "women's work" is more related to the weaker bargaining power of women. In services for people with handicaps, the relative low status and pay of residential staff also reflect that, despite the rhetoric, society does not value people with handicaps sufficiently highly to grant those who work with them, high status or pay.

The implication for residential workers as an occupational group is that they should acknowledge that society does not confer status automatically on any occupation. Status is achieved by organized and consistent efforts to convince employers, and society at large, that residential staff fulfil valued roles. Strategies for achieving this goal are discussed elsewhere in this paper.

CONTROL OVER ONE'S WORK

One of the hallmarks of the professions is that because of their special expertise, they have autonomy to go about their work (Rueschemeyer, in Dingwall and Lewis, 1985). Although the consumer movement has led to increased external scrutiny and calls for accountability, professionals still largely determine what will happen to patients/clients and laypersons.

In services for people with intellectual handicaps, current philosophies and service values challenge the notion of professional autonomy. It is the residents who are expected to exercise as much autonomy, independence, initiative and responsibility as possible. Furthermore, a participatory democracy approach to the management of community residences is usually adopted and there are many stake-holders — the residents, parents, advocates, neighbours, members of multi-disciplinary teams — and residential staff.

The individual programme plan is a good example of the process at work. Many people contribute to the development of the plan. (Unfortunately, it is often the residential worker who, under the auspices of a 'transdisciplinary model' is left to implement the plethora of brilliant plans devised by the IPP team).

It is laudable that our service delivery values de-emphasize the development of professions and highlight the needs of clients. Bruininks and Lakin (1985) have suggested that the acceptance of normalization necessitates a new look at the relationships among professionals, clients and other caregivers. While agreeing with this position we need to take care that such a singleminded, client-centred scenario does not result in a lack of status for residential workers and ultimately affect the welfare of residents.

HIGH EXPECTATIONS — LOW STATUS

Staff in community residences have many expectations placed on them. To parents, advocates and residents, the staff are the experts — the professionals. However, within the context of the administrative structure or the multidisciplinary team, they are perceived as relatively junior.

Despite this, a study of 60 residential care assistants (untrained staff) in rural NSW found them to be highly optimistic about their role (Shaddock & Batchler, 1987). These staff were relatively young (42% under 25; 72% under 35) and very inexperienced. Forty one (68%) had less than one year's experience and the remaining 19 (32%) had less than five year's experience.

Each participant rated 'Myself as a Residential Carer' on a number of dimensions on a 'semantic differential' scale. Extremely high self-ratings were found on the following: happy, pleasant, bright, comfortable, positive, mature, valuable and useful. Given the complications that have been proposed in the occupation's status, it would be interesting to re-assess the optimism of this group in several years.

It is likely, of course, that many will have resigned as staff turnover tends to be high in community residences and many experience staff shortages (Schallock, 1983). Although turnover need not be dysfunctional for the organization (Cope et al., 1987), it probably reflects the organization's failure to convert 'drop-outs' to 'drop-ins' (Greenwood, cited in Cohen, 1981). Stress and burnout affect employees in residential services as in other human service organisations and Schallock (1983) discusses these and other causes of employee dissatisfaction.

Some of the staff behaviour one observes in residential services could be interpreted as an indication that a staff member or group feels threatened or devalued. For example, essential information is sometimes withheld at case conferences; or programmes (usually the brain child of hit-and-runners like myself) are cleverly sabotaged. On occasions staff appear to attempt to bolster their status by adopting the language or trappings of other professions e.g., 'doctor-talk'. There are also attempts to create levels within the occupation so that so-called low status work is done by others.

It seems logical that it is in the best interests of people with intellectual handicaps to promote the occupational well-being of those who spend the most time with them. As I have argued elsewhere (Shaddock, 1987b), the promotion of feelings of self-worth, autonomy and independence, should not merely be reserved for people with handicaps. In fact, if this occurs, the illogicality of the position will be sensed by residential staff and be reflected in their job performance.

STRATEGIES FOR DEVELOPING IDENTITY AND STATUS FOR THE OCCUPATION

This paper has proposed that the development of residential work as a status occupation will have a positive impact on the quality of life of residents. It has been argued that certain features of residential care complicate the quest for professional status in the traditional sense. However, in the 'post-professional era' envisaged by Illich et al. (1977), a new, less self-serving professionalism is proposed.

A large body of literature exists on the development of workers and of occupational groups. Issues such as discrimination, de-skilling and capital-labour relations are frequently discussed. The various protagonists of theories such as 'human capital theory', 'labour-market theory' and 'technological determinism' argue the validity of their theories in accounting for changes in the workplace.

In the area of disability, authors have responded to issues such as the quality of work life of staff as it relates to institutional reform (Mac Eachron et al., 1985);

the development of appropriate standards (Perske & Smith, 1977); and the ways in which worker stress can be minimized (Schallock, 1983).

The particular needs of residential staff in services for people with intellectual handicaps are now discussed. Ways in which their occupational status can be fostered and maintained are proposed.

PERSONAL SAFEGUARDS AND DEVELOPMENT

Role delineation

Individual residential staff should endeavour to negotiate their role so that it is clearly delineated and not merely a 'catch-all' statement. As far as possible, role ambiguities, incongruities and overload are to be avoided.

Appropriate training

Residential staff should seek to gain recognized qualifications. Important in themselves, such qualifications also permit more career mobility and a degree of self-assurance in dealing with members of other disciplines and the general public.

Research focus

Perske and Smith (1977) argue that 'the single most important prerequisite for all professionals working with the severely and profoundly handicapped is the belief that all individuals can learn, and that their rate of learning is not a justifiable basis for judging the worthwhileness of an individual nor the importance of teaching him' (p.39).

These authors suggest that one of the duties of professionals in this relatively new area is to participate in research and share one's expertise and understanding. Research activities offer personal advantages also, particularly the opportunity to maintain a fresh, enquiring attitude to one's work.

Ships in the night

One of the major barriers to the personal development and morale of residential workers is the isolation in which they work. Although they are ostensibly part of a team, it is a team that 'plays' as individuals. Cross-over at the end of shifts is usually at busy times, when communication is difficult or impossible. If operating budgets do not provide for regular "planning days", staff meetings and inservice training, there will never be opportunities for discussion of fundamental issues, clarification of goals and development of esprit de corps. When the major form of communication is by way of hastily written notes in the "communication book" it is no surprise when formal programmes break down because of inconsistencies. The irony is that many residential staff find themselves in situations not too dissimilar from that of parents — situations that contributed to the decision of parents to place their child in residential care in the first instance.

OCCUPATIONAL SAFEGUARDS AND DEVELOPMENT

Defining the territory

The nature and scope of residential care needs more careful definition. A more systematic delineation of the ways in which residential staff can achieve service goals would be an appropriate start.

There is a growing body of knowledge specific to residential care for people with intellectual handicaps. Specific service values dictate what interventions are

appropriate, e.g., are techniques socially acceptable, unobtrusive, non-intrusive and used in the least restrictive setting? The techniques of other disciplines are not necessarily appropriate for residential workers. For example, the techniques of a classroom special educator may be quite inappropriate in a community setting.

No one would argue that the body of knowledge on which residential care is based is largely derivative. However, the occupation of residential work would be more systematically developed if its members engaged in more 'role-making' and less 'role-taking'. This is not to suggest however, that residential workers, in *professionalizing their occupation, make the mistake of attempting to shed many of their functions to other occupational groups.*

Promotion of role models

In the absence of a tight body of theory, and precise definition of the boundaries of residential work, the occupation needs to give more prominence to role models. If new staff cannot be directed to a body of theory from which is derived a coherent set of procedures, they certainly can be shown staff who are worthy role models. Such people should be made visible in the organization and afforded status, perhaps by being given part time roles in staff development or evaluation.

Promoting "know-how"

Benner (1984) notes that philosophers of science have drawn a distinction between 'knowing that' and 'knowing how'. Sometimes 'knowing how', a practical skill, defies explanation or is developed ahead of scientific description, 'knowing that'.

Whenever the training of residential staff does not involve staff who are experienced in residential work, there is a danger that academic knowledge will be over-emphasized and practical skills will be undervalued and perhaps not taught at all.

INDUSTRIAL ACTIVITY

Small 'p' political activity

In this paper, the view has been expressed that it is not the nature of the work itself on which occupational status depends. Rather it is the cogency with which the workers have argued their case.

Therefore, residential staff should engage in activities that develop the occupation as long as these activities are consistent with positive consumer outcomes. Such activities might include the establishment of more sophisticated and acceptable educational programmes for members and moves towards certification; the improvement of pay and conditions; and the development of career possibilities so that the profession becomes in a very positive sense, a possible terminal occupation.

Standards and evaluation

Residential staff should be actively involved in the development of standards, self and peer appraisal, and be willing to submit their work to external evaluation. While these activities, in themselves, will not be sufficient to convince everyone, especially rivals or vested interests, that the occupation is successful and therefore more deserving of status and other rewards, they are important indicators of the occupation's commitment to the welfare of clients. It is also possible that there will be resistance from some residential staff themselves to internal evaluations,

peer reviews and quality assurance programmes. They may be threatened by the possibility that their own performance will be judged as inadequate and so resist formal attempts at quality control.

Administrative autonomy

Those residential staff who are employed within a larger, non-sympathetic bureaucracy with multiple client groups should endeavour to extricate themselves. Usually such bureaucracies are stratified and occupational status is determined by one's proximity (in terms of theory, practice and training) to the dominant profession). Residential workers have little to gain in such systems — nor do people with intellectual handicap. Particularly in 'health bureaucracies' the relative lack of status for so-called chronic patients may result in poor status for those who work with them and difficulty in maintaining an adequate level of funding.

'Talk-up' the occupation

Hall (1969) argues that 'whether or not an occupation is a profession depends on the way in which it is viewed by society' (p.75). Public opinion is moulded by various forms of persuasion, from promoting a desirable image of residential work to industrial bargaining. In giving their occupation prestige, residential staff should not overvalue their contribution. More importantly, they should not overvalue the knowledge base, years of formal training or claimed expertise of other professions.

HIGH STATUS FOR PEOPLE WITH INTELLECTUAL HANDICAPS

Finally, residential staff will only benefit themselves and their clients by championing the basic human rights of the people with whom they work. Although not always prominent in statements of duty or work contracts, the advocacy and education roles of residential workers are most important.

For those aspiring to professional status in services for people with intellectual handicaps Perske and Smith (1977) advocate ongoing self-evaluation. The evaluation should focus on values, knowledge and performance. This paper has argued that there are mutual advantages to be gained where residential staff promote this type of professionalism in their ranks. The status and quality of life of people with intellectual disabilities will only be enhanced if occupational status is afforded those who work with them.

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