

Written out of History: Invisible Women in Intellectual Disability Social Work

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Abstract

The field of intellectual disability is an important field of social work practice in both Britain and Australia. Yet this is also a multidisciplinary field in which the role of social workers, particularly women, in contributing to the lives of people with intellectual disability and their families has largely gone unnoticed. Focusing on England and Victoria, Australia in particular, this paper uses oral history interviews with long standing social workers and documentary evidence including government reports and newspaper coverage to explore the similarity in the roles of social workers in intellectual disability. It covers the period between the beginning of social work in this field, which in the case of Britain was 1929 and in Victoria 1952, until the end of the 1990s. Work with families is identified as being central in both countries, as well as mediating relationship between institutions/services, families and the community, and service development and advocacy. The paper concludes by asking questions about the disappearance of identified social work positions in this field and how their previous roles are fulfilled.

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In Britain and Australia, despite different early legislative provisions, the policy and program directions that have provided the context for social work with people with intellectual disability, have followed parallel paths (Walmsley, 2006; Bigby & Frawley, 2009). In both countries institutional provisions dominated until the mid to late 1970s when new ideas about normalisation and human rights began the drive towards community care. For the next three decades institutions were gradually closed and replaced with smaller community based accommodation such as hostels and group homes, and a range of family and individual support services developed to enable people to participate in the 'ordinary life of the community' (Welshman et al., 2005; Walmsley, 2006).

This paper explores the very similar contributions to intellectual disability social work made by women social workers on opposite sides of the world from its inception until the mid 1980s. Our focus is on women because their contribution to the lives of people with intellectual disabilities, and their families, has gone largely unrecognised and unrecorded. Using documentary and oral sources this paper revisits and reclaims their contribution and makes it – and the social workers themselves – visible in the social history of intellectual disability. The more specific focus of the paper on England and Victoria reflects other historical research which has drawn parallels between past provision for people with intellectual disability in Lancaster, England and Melbourne, Victoria (Monk, 2007).

In the British context, there seem to be two possible reasons for the invisibility of women social workers. Firstly, although social workers who trained in psychiatric social work, from 1929 onwards, also studied 'mental deficiency' few chose to work in this field (Timms, 1964; Browne, 1982; Rolph et al., 2003). Instead, most psychiatric social workers (PSWs) opted for child guidance clinics and mental health settings, eschewing the then less fashionable intellectual disability field (Timms, 1964). Secondly, although social work generally in the 20th century was regarded as predominantly a female profession, mental health social work (of which 'mental deficiency' was a branch) was seen as 'a man's job' (Rolph et al., 2002). As a result, women who were trained *and* were willing to work in this field were a rarity. The switch to generic social work qualifications from 1970 had limited impact, a point

noted by Younghusband (1975, p.175) who reported 'little social work interest' in intellectual disability and Anderson (1982, p.2) who described social work as being 'on the sidelines' during the 'exciting developments' of the 1970s and early 1980s.

The Australian contribution to this paper is concerned with qualified social workers who worked in the State of Victoria in intellectual disability social work from the time the first post was established in 1952 until the end of the 1990s. Most of these social workers were women, a situation lamented by both the media and the profession when issues of recruitment, retention and pay arose (Lawrence, 1965; Downes, 1970). In 1988, along with other social workers employed in government services, those in intellectual disability lost their title and became just one group among many who bore various generic labels such as 'client coordinator' 'social welfare worker' or 'case manager' (Markiewicz, 1996; Van Brummelen, 2005). From this time on, though much of its 'facilitative' work had always been hidden, social work as a profession became invisible in most government welfare services.

Early Origins of Social Work in Intellectual Disability

The British history of social work in intellectual disability can be traced back to the 1913 Mental Deficiency Act (Gilbert, 1985, p.59). Although ushering in a nationwide system of institutional care, this legislation also marked the start of community care for people with intellectual disabilities and their families. As well as the 'ascertainment' of people needing care and the provision of suitable institutions, local authorities were also responsible for the care of people in the community. In practice, in the first half of the 20th century much of the voluntary and statutory supervision of people with intellectual disabilities living in the community was undertaken by workers from the Central Association for Mental Welfare acting on behalf of local authorities (Jones, 1972). The origins of casework and counselling in this field may be seen in this work (Browne, 1982), a form of social work which persisted into the later years of the century.

The history of social work in intellectual disability starts in Australia in the 1950s, much later than in Britain. This is due to the later development of social work as a profession in Australia. For example, the first qualified social worker arrived in Australia from the UK in 1929, the same year as the formation of the Victorian Institute of Almoners, which in 1946 became the Australian Association of Social Workers. Unlike Britain there was no early legislative framework that mandated

anyone to oversee either the care or control of people with intellectual disability in institutions or the community. Attempts were made in 1926, 1929 and 1939 to impose a regime of control in the form of mandatory classification and institutionalisation of people with intellectual disability, but the Victorian Mental Hygiene Act that was finally passed in 1939 was never proclaimed; due not to a lack of support but a lack of resources (Jones, 1999).

In the absence of specific legislation in Victoria the provisions of the 1867 Lunacy statute and subsequent Mental Health Acts were used to certify babies, children and adults as 'insane', detain and provide care for them in mental hospitals and specialist institutions or wards for 'idiots or 'defectives'. Placement in institutions such as Kew Idiot Asylum, established in 1887, were the only form of government funded assistance for families with a child with intellectual disability until the development of day centres from the late 1940s. Initially reliant on the volunteer work of parents, these centres became the backbone of education services for more severely impaired children and latter for the day support and employment of adults. The first social work position was established in 1952 by the Victorian Mental Health Authority to work in Kew Cottages, the largest institution for people with intellectual disability. This was followed in 1966 by a post established by a voluntary parent-run association, the Victorian Council for Mentally Retarded Children.

Parallel paths: Developments in Intellectual Disability Social Work in Britain and Australia

This section of the paper is in two parts. The first part uses oral history interviews with three retired social workers combined with documentary sources, including contemporary social work texts, government policy papers and records of the Central Association for Mental Welfare to explore the British context. Three key areas of social work were identified: community control (later support) of people with intellectual disabilities and their families as an alternative to institutional care; acting as the 'go-between' linking the institution with the community; and working directly with people re-settled into the community to enable them to lead 'ordinary lives'. The second part explores the Victorian context identifying and discussing similar but not identical key areas of social work; managing the interface (acting as go-between); working with families and; facilitating community and service development. It draws

on oral history interviews with four social workers, whose experience spanned from 1952 to 2000, coverage of social work by Melbourne newspapers between 1952 and 2000, and annual government department reports and other documents from 1952 to 2000¹.

The British Context

There is a rough chronology to the three identified aspects of the British social worker's role – the community care role being the earliest and longest established, and traceable in different forms from the 1920s onwards. The go-between role was a feature of the 20 year period from 1971, as the emphasis in policy changed from hospital to community care, and social workers were needed to set the wheels in motion. This coincided with the beginning of the resettlement of people into the community, a process which accelerated from the 1970s onwards and led to direct work with people resettled into the community as 'someone to turn to'. This part of the paper will explore the three roles in turn.

Community care for people and their families

In England from 1913, the care and support of individuals and families in the community was part of the remit of the Central Association for Mental Welfare; its secretary for many years was Miss (later Dame) Evelyn Fox, a social worker herself. Her entry into social work was via the Women's University Settlement in Southwark (London), where she trained, and the Charity Organisation Society where she gained experience of voluntary work. The Central Association was instrumental in training social workers and many local associations carried out casework (Welfare, 1955; Bowtell, 1972; Jones, 1972). In Buckinghamshire, for example, there was 'an impressive network of local visitors', overwhelmingly female who visited the homes of families with intellectually disabled sons and daughters (Walmsley, 2000, p.112). Some of these women, following the passing of the 1959 Mental Health Act, were recruited into the ranks of the newly emerging mental health social work profession in the post war years (Walmsley, 2000; Rolph et al., 2002). As early as 1930 it was accepted that 'the majority of defectives will always remain in the community' and

¹ Some of the research for this paper was undertaken as part of ARC funded project 'Great and Crying Need the History of Kew Cottages' LP0455016.

that 'large numbers of these will require training and supervision' (Lewis, 1930, p.100).

What sort of worker was required for this task? According to one speaker at a national conference held by the Central Association in London in 1930, 'she' should be experienced in general social work, that is 'in work that has given her knowledge of working class homes and the conditions under which various classes in the community live'; she should also have specialist training in 'mental deficiency and work with adult patients'; and she should herself 'be thoroughly well balanced, of calm and sympathetic temperament, yet never sentimental and never emotionally involved in the patients' difficulties' (St Clair Townsend, 1930, p.24).

Alongside the work that was being done by voluntary social workers with individuals and families in the community in the first half of the 20th century, the local authority Relieving Officers (ROs), later (from 1948) the Duly Authorised Officers (DAOs) were undertaking statutory duties which included institutional admissions. Following the 1959 Mental Health Act, many of the existing (predominantly male) DAOs became Mental Welfare Officers (MWOs) overnight, and were joined by ex-psychiatric nurses (male), making this very much a man's job. However, some women were recruited from the local branches of the Mental Welfare Association (as the Central Association was now called) and, in the 1960s, small numbers of women graduates, trained in psychiatric social work, also joined the ranks (Rolph et al., 2003).

Two of these graduate PSWs working as MWOs in the 1960s (quite a rarity) were interviewed about their role for this paper. What made them – Christiana Horrocks and Anne Holding – even more of a rarity was their interest in intellectual disability at a time when this field was overshadowed by developments in mental health care. Their qualifications, background and personalities ('we're both quite tough') meant they became senior MWOs and later, when mental health departments were subsumed into Social Services, continued to operate at senior levels in their chosen area in the 1970s. Looking back on their early professional lives they characterised the social worker's role in community care in terms of direct work with individuals and families; innovations in practice; and advocacy/ lobbying for resources on behalf of clients.

Direct work ranged from enabling people with intellectual disabilities to travel independently, to instituting regular programmes of supportive visits to families, initially on their own case loads, but later on the case loads of their (expanding) staff teams. Innovative practice included early involvement (via paediatricians) in supporting families with young children and, later, the personal delivery of letters telling parents their child was ‘ineducable’ (rather than the more usual postal delivery) so that help and advice could be offered when sons and daughters were excluded from school. Their advocacy/lobbying work involved them in representing the needs of families for resources. Their view was that, having spent time with parents, they gained some insights into their needs, enabling them to act as advocates; ‘you began to get through to other people the needs and the pressures’. The provision of respite care was one very practical outcome, but the process of achieving real change had led them into conflict, particularly with the medical profession:

Doctors found that they were more used to people saying, “Yes, doctor” and “No, doctor” and obviously if you were saying, “Well, I really do think this family is under considerable stress” you would find it could cause some conflict.

The go-between

The role of ‘go between’ – the social worker’s role as the link between the hospital and the community – although acknowledged by the 1926 Royal Commission as important, failed to attract social workers. In general, PSWs opting for hospital social work preferred mental health settings (Gilbert, 1985; Timms, 1964). The National Development group’s report, *Helping Mentally Handicapped People in Hospital* (1978) also stressed the need for ‘social work input’ into hospitals to ensure they functioned effectively (Section 7.6, p.75). The 1971 White Paper, *Better Services for the Mentally Handicapped*, had already signalled the eventual wholesale move from hospital to community care that was to follow and social workers were appointed to hospital posts in the 1970s. A woman graduate – Ann Symes – initially untrained but seconded for social work training during her term of office, was appointed to a long stay institution near Birmingham. Ann Symes was interviewed for this paper on her role as a social worker in a hospital setting. Looking back, she identified three aspects

of her job; linking with families; supporting individuals to leave hospital; and acting as an advocate on their behalf.

The loss of contact with, and consequent lack of support, from families was a feature of the lives of many long stay residents in the 1970s. Part of the social worker's role, therefore, was:

....to link up with some of those families to see if they wanted to re-establish the contact. Some did, some didn't. I also ran a group for parents who wanted to or had started to establish contact; the group talked about some of their difficulties.

Ann Symes also referred to the hospital's 'big push to get people out' in the 1970s. This had implications for her role:

My job was to find accommodation or to find situations where people could go. We got quite a few out into the community, either living independently or into a hostel.

The looking outwards – to families and to new lives in the community – involved direct work with people with intellectual disabilities but it also meant being an advocate for people and, where necessary, taking a stand against the (sometimes) hostile views of doctors and nurses. Part of Ann's advocacy role was to act independently, a stance that brought her into conflict with one of the psychiatrists:

He said I was working for him. I said, "No, I will not do as you say. I am working with you not for you, Dr X, and kindly remember that".

The male nurses, meanwhile, found her a threat to their own jobs and livelihoods:

Most of the charge nurses, what they saw was the more patients you took out into the community, the more chance they would lose their job. So they were very against all this...they didn't want to co-operate...You could imagine that I was not the most favourite person in the hospital.

Someone to turn to

The resettlement of people from the long-stay hospitals which began in earnest in the 1970s created a new social work role – in the words of the 1971 White Paper the social worker was needed in the community to be ‘someone to turn to for help with the problems of ordinary life’ (para. 165, p.35). What did it mean to be that ‘someone to turn to’? It meant direct work with people with intellectual disabilities: ‘a doing, teaching and having fun role, but also a personal counselling role and use of casework skills in imaginative and innovative ways’ (Atkinson, 1989, p.18).

The role as it emerged in its earliest manifestations was to offer practical help, financial advice and emotional support to enable people to live ‘an ordinary life’ in the community. However, working together in this way could be complicated particularly where close ties, built up between social workers and clients, over time could be experienced as supportive or threatening – and a source of ambivalence (Atkinson, 1989, p.64). To support people in living an ordinary life meant considering all aspects of life, including employment and friendship. This required both practical and emotional input involving, as Gilbert (1985, p.74) noted, a personal counselling role and the imaginative use of casework skills.

The Victorian Context

Although initially conceptualised as a ‘go between’ by formal authorities, the social workers interviewed for this study indicated they had significant opportunities to carve out their own roles, and seize opportunities as they arose. For example, Irena Higgins (1960) the first social worker employed by the Victorian Mental Health Authority to work in an institution for children with intellectual disability wrote, ‘there was no plan of work or activity set out for me ...the superintendent asked me to find areas of the greatest need and design my work accordingly’ (p. 52). In Victoria, unlike the UK, the roles played by intellectual disability social workers remained remarkably similar from the first appointment to the 1990s. The blend of casework, community development and advocacy that Irene Higgins carved out for the Social Work Department at Kew Cottages between 1952 and 1969, was reflected in the work of later institutional social workers, the centralised social work service established in 1971 and the multidisciplinary regional teams of 1980s. The nature of intellectual disability social work during the twentieth century very much reflected Norma Parker’s conclusions about early Australian social work, that despite having an

orientation to casework it did not have a 'narrow casework orientation' (Parker, 1979, p 20).

Acting as go-between

The early social work role was cast in terms of a 'go between' managing the interface between institutions and families. For example, the report of the Official Visitor, P. O. Spicer Esq, to the Metropolitan Mental Hospitals for the December quarter 1950, pointing out the absence of a social worker stated:

...no social worker seems to be employed as a contact between relatives and the cottages. On humanitarian grounds alone there should be proper public relations contacts with relatives to minimise fear and mistrust. Apart from that I have no doubt that the medical staff would find such contact useful in treating cases. Recommendation: A social worker should be employed.

Although, in his letter of reply to the Minister, the Superintendent of Kew Cottages wrote 'I cannot agree the appointment of a social worker is desirable', Irena Higgins, a social worker trained in Poland, was appointed in 1952. A decade later, this comment in the 1962 Annual Report of the Victorian Council for Mentally Retarded Children (p. 34) preceded the appointment of its first social worker in 1966:

....family difficulties are not uncommon in this field and there are times when the work of the centres has to be interpreted to the home, and in the occasional case of employment placement the support of the social worker would be most valuable.

The institutional social workers saw the importance of bringing to nursing staff a greater understanding of children's backgrounds, to 'get them onside'. Irene Higgins, for example, helped ward staff to reinterpret families, by organising them to spend a day at the home of a child with intellectual disability. Fran Van Brummelen who worked at Kew for 23 years from 1969 to 1992 said 'you more or less had to sell the child and the family and get the nursing staff to focus on the positive attributes'. On the other hand she also set out to:

present the child to the family in a more positive way...as social workers we always picked up those small achievements so that parents could recognise progress

The institutional social workers played a key role in finding educational or vocational placements for residents out in the community, especially those whom they thought had no place in an institution. Fran Van Brummelen recalled for example, that after giving a talk one day to a community based day centre, the director offered to admit 12 Kew residents.

Social workers acted as a conduit between institution and community, helping to move people out from as early as the 1950s. For example, Irene Higgins who left Kew Cottages in 1969 said, 'any children that were suited to live in the community I tried to get out and I did for many of them'. The 1968 Annual Report of the Victorian Mental Health Authority noted that at the social work department at the Sunbury institution there had been, 'an increase in the search for accommodation and provision of after care for patients and long term support for operators of nursing homes and boarding houses', in which residents had been placed. By 1969 this social work department had been incorporated into the community placement team (Mental Health Authority, 1969). At Kew Cottages during the 1970s social workers and case aides supported residents to live semi independently in houses on the perimeter of the institution and Fran Van Brummelen recalled, 'throughout the '70s and the '80s, before the government started providing the houses, we were just moving people out to wherever we could find a place'.

By the 1980s many residents as well as a few social work posts had moved out of Victorian institutions. Gill Pierce talked about the role of social workers in the early 1980s in establishing and running Middle Park, an innovative drop-in community centre for ex institutional residents:

The social work service was an important component. It provided crisis intervention and assistance with financial management and housing to try and keep people in the community and maximise their independence. We set up a number of co-resident homes, using the open market and people's own resources. The guidance provided included assistance with household management and living tasks such as shopping and meals, and assistance with managing financial matters.

Working with Families

Though many faceted, work with families was central to the contribution of social workers in this field. The practice of the social worker visiting and compiling a social history of every child whose family sought access to an institution was initiated by Irene Higgins in 1952, replicated by social workers in other institutions and lasted until the 1980s. No child could be admitted without a full social history and this assessment gave the opportunity for interim support to be provided to families. For example, Fran Van Brummelen talked about her casework during the 1970s, ‘some families we had contact with for years, children never came to the Cottages, but [we stayed in contact] because there was no one else to support them’. During the 1950s, 60s and 70s, social workers organised volunteer help to families in conjunction with voluntary service auxiliaries associated with institutions. Talking about these volunteers Fran Van Brummelen said, ‘they would go into homes and help support the mums, they might look after the child so mum could go off and have day in town’. The position of volunteer coordinator at Kew Cottages, established in 1971, though not always occupied by a social worker, remained for many years under the auspices of the social work department.

The practice of visiting every applicant established social workers as institutional gate keepers, who helped avoid, what they deemed to be inappropriate admissions, and assessed the urgency applications. Prior to the appointment of social workers, Irene Higgins suggested that children ‘were placed straight from orphanages and they weren’t assessed properly, later on we didn’t have that sort of children’. The social histories compiled by social workers also meant that residents could be better matched to units within the institution, and decisions about applications for transfers better informed. For example, Fran Van Brummelen said, ‘we made every effort to fit the child to the vacancy without moving another one to another ward’. The interviews with and correspondence from institutional social workers suggests their views were both sought out and influential in admission and transfer decisions.

Social workers were responsible for the rationalisation, centralisation and maintenance of waiting lists, which provided a powerful indicator of unmet need and stimulus for advocacy. Reference to the waiting list and the shortage of accommodation places was a recurring theme in Annual Reports of the government

departments responsible for intellectual disability services, from 1952 and continues to be so at the time of writing (Auditor General, 2008). For example,

...there remains a pressing need for many more beds for this type of patient [children with intellectual disability], of whom there are more than 450 whose need for admission can be described as urgent. (Mental Health Authority, 1968)

..it is simply not possible for Community Services Victoria to provide for a satisfactory level of comprehensive services to all Intellectual Disability Service clients given current resources. (Community Services Victoria, 1991)

Supporting families to cope whilst the waiting for placement and finding short term alternatives to permanent placement were important social work roles. For example, the 1969 Annual Report of the Victorian Mental Health Authority, referring to the Sunbury Institution states, 'a great deal of the work of the social worker is arranging temporary admissions to alleviate the difficulties of parents of children who cannot be admitted permanently'. The 1970 Annual Report referring to St Nicholas Hospital² states, 'most of the social work time is spent visiting families whose children are in the urgent and most urgent waiting lists.' (Mental Hygiene Authority, 1970). The high numbers of social work students on placement increased the capacity of the institutional social work departments whilst at the same time exposing a generation of new graduates to this field of practice. For example, in 1966, nineteen students from the Department of Social Studies at the University of Melbourne were placed in the Social Work Department at Kew Cottages (Mental Hygiene Authority, 1966).

Facilitating community and service development

Casework and family support provided the spring board for other roles including group work, community and service development, volunteer coordination and advocacy. Work with families helped to break down their isolation from each other, gave opportunities for mutual support, strengthened their links with services and led to significant parent advocacy aimed at the wider community about the needs of people with intellectual disability. The establishment of the Kew Cottage Parents Association in 1957 by Irena Higgins, demonstrates the multiple beneficiaries of

² An institution for children with intellectual disability and or complex health needs

social work's facilitative and community/service development role. In her first six months of work she had noted the isolation of parents from each other and referred her work with the Parents Association as 'an experiment in group work and social action' (1960). In an interview in 2007 Irena Higgins said that her aim had been:

....for the parents to get involved with their children and to fight for better conditions...as a lobby group and self help group and almost a therapy group for themselves, and it's what happened – they're still there.

Later she set out the social worker role in the institution in her undated lecture notes as:

....that of a liaison between the community and her particular place of work. She must keep in touch with new developments in social services, community facilities and community attitudes. It is her responsibility to bring to the notice of appropriate authorities the gaps and inadequacies of existing resources and take an active part in promoting new facilities. (Higgins, n.d circa 1960)

In the 1970s and 80s similar work with families in the community supported the formation of voluntary committees and the acquisition by them of government funding to establish day centres and later residential programs. For example, talking about the work of the central social work service of Mental Retardation Division of the Victorian Health Commission in early 1970s, Gill Pierce, then senior social worker, said:

Each of the social workers had a project to do that would contribute broadly speaking to the development of community services. I always believed that there are other things to do, but you also need to do your casework to keep grounded.

Talking about her later role in 1977 as the founding coordinator of the Western Regional Intellectual Disability Team Gill Pierce said: ³

³ The first regional teams were formed in 1977 as part of an attempt to decentralise State government intellectual disability services. The early teams were multidisciplinary with a mandate both for direct work and service development.

The social workers tended to do most of the community development and program development work. We worked closely with the Western Region Residential Planning Committee which had been established [by parents] with a view to developing supported community housing.

Gill Pierce herself was a member of the Premier's Committee (Victorian Committee on Mental Retardation) whose report in 1977 halted the building of the next stage of a 500 bed new institution in Colac, and introduced for the first time into Victoria ideas about normalisation. She was one of the prime instigators of the closure of St Nicholas Hospital, the first wholesale institutional closure in Victoria. She recalled:

It was an interesting experience because at that stage the key players on the committee were psychiatrists and senior administrators. They did not always have strong skills in social policy, planning or services development. A lot of the work of developing that report [Report of the Victorian Committee on Mental Retardation, 1977], and exploring international literature was done by a few members including me, and Ethel Temby [parent activist] and a representative from the Education Department.

.....I had read about international initiatives which sold valuable institutional land and, with bridging finance, used the proceeds and the existing recurrent funding to establish community housing systems for the residents. It seemed that if a scheme such as this could be effectively implemented in relation to St Nicholas Hospital, it would demonstrate that community living was possible for even very severely disabled people. I put a proposal to the new Director of OIDS [Office of Intellectual Disability Services], who explored the feasibility of such devolution of St Nicholas, and decided to proceed.

Conclusion: Social Work Today

The various documents consulted for this study have attested to the forward looking intellectual disability policy developed in Britain and Australia from the late 1970s (Cocks, 1982; Rimmer, 1984; Towell, 1908/82; Victorian Committee on Mental Retardation, 1977; Victorian Government, 1986; Ward, 1992). In Victoria, for example, the goal became 'tailor made' local flexible services as far back as 1976

(Mental Health Authority), as services moved from a health to community service portfolios. In the following decade family support came to the forefront:

... the family will increasingly become a focus for intellectual disability services and the Office of Intellectual Disability Services will look to new ways of supporting families to look after children with intellectual disability at home (Community Services Victoria, 1989, p. 83)

Yet at the same time, as the focus shifted to families, in Victoria the positions titled social worker whose *raison d'être* had been work with families disappeared; why this was so, who filled their shoes and performed their roles, and how well is another a story yet to be told. In England, the move to care management and commissioning of services has led to a similar loss of the social work role in intellectual disability.

By way of contrast, the social workers we interviewed for this paper were clear about their role and its value to people with intellectual disability and their families. As social workers in intellectual disability prior to the 1990s they saw themselves, and were seen by others, as autonomous professionals. As such, they could act as advocates, challenge existing practice and implement new ideas. And yet, their particular contribution to enable people with intellectual disability to lead 'ordinary lives' has long been overlooked.

In both Britain and Australia the quest for an ordinary life continues into the twenty-first century. The 2001 British White Paper, *Valuing People* (and subsequent policy documents), the Victorian 2006 Disability Act and the foreshadowed National Disability Strategy still aspire to this goal. Social workers – men and women – are rarely mentioned in such documents and it seems the ordinary life goal has been entrusted to the health and social care workforce- the largely untrained and non-professional workers in the mixed economy of domiciliary, day and residential services. Social workers are invisible again.

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