AASW
Australian Association of Social Workers

"What! ...social workers are NOT registered…?"

A submission to government seeking the inclusion of the social work profession in the National Registration and Accreditation Scheme for health professions

August 2025

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Note

The information contained in this document relates to matters already in the public domain. However, the AASW has elected to redact certain individual names and other identifying information.

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EXECUTIVE SUMMARY

The AASW respectfully acknowledges the loss and pain experienced by individuals and families who were involved in and affected by the events reported in coronial inquiry reports and royal commission inquiries, and other cases referred to and documented in this submission.

By reporting these cases, we do not seek to relive past failures, but to understand why they occurred. Our focus is on building safer, stronger standards in social work so that such tragedies are far less likely to be repeated.

The purpose of this submission is to ask Australian Health Ministers to strengthen the regulation of the social work profession and thereby better protect the public by introducing statutory registration for the profession. This submission:

- presents an assessment of the social work profession against the regulatory policy criteria for statutory registration that have been nationally agreed upon by all Australian state, territory and federal governments (the AHMAC Guidance),[1] and
- asks state, territory and federal Health Ministers to agree to progress amendments to the *Health Practitioner Regulation National Law* (the National Law), to bring the social work profession into the National Registration and Accreditation Scheme for the health professions (NRAS).

As the peak body representing the social work profession, the Australian Association of Social Workers (AASW) has repeatedly raised concerns with governments about poor social work practice, unethical behaviour, unqualified or underqualified persons practising as social workers, lack of clinical oversight and supervision of social workers and, most importantly, lack of strategic action to address the problems identified. The last AASW submission to Health Ministers requesting statutory registration for the social work profession was submitted in 2016 (AASW 2016) and was refused, despite strong support from the South Australian Government.

After failing to achieve national agreement,[2] the South Australian Government decided to proceed with statutory registration for South Australian–based social workers. In 2021, the South Australian Parliament enacted the Social Workers Registration Act 2021 (SA). The Social Workers Registration Board (SWRB) was established in March 2024, and the Board was scheduled to begin registering social workers in South Australia from 1 July 2025. The implementation of the scheme has been delayed to a future date made by government proclamation.

While the South Australian legislative scheme represents a significant milestone, it does not solve the broader issues across Australia. It is unacceptable for other governments to delay action to address the problems identified in coronial inquiry reports, royal commissions and other parliamentary committee and government inquiries, particularly given that further regulatory failures likely to result in deaths and injuries are foreseeable and possibly preventable.

While the AASW has established a strong self-regulatory certification regime for our members, one that provides a variety of services of benefit to both members and the public, this submission details the need, the evidence and the rationale for stronger occupational regulation of the social work profession in the form of statutory registration. The aim of registering social workers under the NRAS is to:

- more effectively and efficiently assure the safety and quality of social work services, and thereby

[1] See Australian Health Ministers' Advisory Council. (2018). *AHMAC Information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions*. https://www.ahpra.gov.au/documents/default.aspx?record=WD22/31798&dbid=AP&chksum=W16VRFp6%2bKE9gQghhFI%2bKA%3d%3d

[2] See COAG Health Council Communique 7 October 2016 at: https://webarchive.nla.gov.au/awa/20211005022237/http://www.coaghealthcouncil.gov.au/

- better protect the health, safety and wellbeing of the millions of Australians who rely on the services of a social worker each year, and
- provide Ministers and governments with the tools they need to ensure the workforce is fit for purpose and able to meet health system goals and population health needs.

Section 1 describes the purpose of this submission, the AASW, its role and functions, the methods used to collect and analyse the data presented (see Table 1, page 18), and what has happened to date with respect to regulatory policy, statutory registration and the social work profession. A summary of the Australian Health Ministers' Advisory Council (AHMAC)[3] regulatory policy guidelines (2018) (the AHMAC Guidance) is presented in Attachment 1, including the criteria and process for regulatory assessment, along with a description of the four main types of occupational regulation that apply to health professions in Australia.

Section 2 provides an overview of the social work profession, our practice and our service users. It provides an overview of the government programs that fund social work services. We present what limited workforce data on that social work profession that we have been able to secure, from a variety of sources.

Our research and data collection demonstrates that social work is a health profession. It is, in fact, the largest self-regulating allied health profession in Australia, with approximately 47,700 social workers employed nationally. However, less than half (approximately 17,700) of these social workers are members of the AASW. The remainder are not subject to the qualification and practice standards that apply under the voluntary certification scheme that the AASW oversees.

Section 3 presents a summary of the results of mapping the statutory registration arrangements that apply to social workers in selected international jurisdictions, with further details provided in Attachment 4. This analysis shows that Australia is lagging – social work is a statutory regulated profession in all countries that have similar socio-political histories and regulatory systems, such as Canada, New Zealand, the United Kingdom and the USA. The data from these regulators show the hefty work that these schemes are doing to protect the public. New Zealand is of particular interest because of its recent shift from voluntary to mandatory registration.

Section 4 sets out some of the myths that are common in government and the community about the prospect of national registration for the social work profession. One myth that must be dispelled is that social work is not a "health profession" and that, therefore, Health Ministers do not have principal regulatory policy responsibility for deciding whether statutory registration is required.

We understand that this position was adopted by Health Ministers in 2016, but is untenable. It does not pass the pub test:

- Allied health services are clearly health services, as are mental health services – social workers provide both
- AASW data shows that a majority of social workers are employed in hospitals and other health services
- Wherever they work, social workers are intervening to improve the social determinants of health – every single day
- Our experience is that whenever patients are surveyed, they are surprised to discover that social workers are not registered and think they should be
- Likewise, surveys of members of other professions – medical practitioners, psychiatrists, nurses, psychologists, occupational therapists who work alongside social workers – all support registration of social workers.

Section 5 provides an assessment of the social work profession against each of the threshold criteria for statutory registration in the AHMAC Guidance. It also examines the adequacy of existing regulatory mechanisms, specifically:

- Voluntary certification scheme operated by the AASW

[3] Note AHMAC is now known as the Health Chief Executives Forum (HCEF).

- Co-regulation arrangements operated through a partnership between government and AASW (such as certification of Accredited Mental Health Social Workers)
- Negative licensing: code of conduct and prohibition order powers, as operated by health complaints entities (HCEs) in six states and territories.

As expected by governments, we assess the suitability of various alternative models for the regulation of the social work profession, including whether continuing the status quo (no change in regulation) is a satisfactory option. The findings are:

First, the voluntary certification scheme operated by the AASW, while best practice, fails to provide adequate public protection because it:

- cannot enforce minimum national probity and qualification standards for entry to practise as a social worker.
- cannot make continuing professional development (CPD), professional indemnity insurance (PII) or recency of practice mandatory for the entire social worker workforce.
- cannot adequately monitor compliance of social workers with ethical and practice standards, or require a social worker to undergo performance or health assessments when questions of competence or ill-health risk compromise their practice.
- does not provide statutory offences for unauthorised use of the title “social worker”.
- does not provide a single national trusted source of information (for service users, employers, insurance providers, governments, etc) about who is qualified to practise as a social worker and in good standing or “suitable” to practise.
- does not have statutory powers or protections that underpin and ensure effective complaint handling and disciplinary processes.
- cannot prevent social workers from moving from one service sector to another to avoid disciplinary action, thus cannot remove sexual predators from the workforce.
- cannot generate and refresh annually a minimum national workforce dataset that is essential for governments to plan service delivery effectively and respond to emerging issues such as workforce shortages in mental health, aged care, child protection and family violence.
- cannot generate the national risk data that underpins effective risk-based regulation.

Second, the sample of case studies of regulatory failure presented in this submission show that harms are occurring not just because of unskilled practitioners or social workers who are under stress and working in under-resourced systems – they show the failure of regulators to remove from the workforce social workers who have perpetrated abuse, have engaged in wilful acts of deception, and are clearly unsuitable to work with vulnerable people.

The cases of regulatory failure show that the existing state and territory HCE complaints management systems serve as the “ambulance at the bottom of the cliff” for vulnerable and at-risk service users (those with the personal resources to complain). HCEs are intervening only after damage has been done and, in doing so, are providing a false impression that the public is being protected from social worker misconduct, when the evidence we have gathered shows otherwise. Even if prohibition order powers were applied effectively, that is, coordinated across both health and social care, across every state and territory and with greater transparency and accountability, this would still fall short of the protections that inclusion in the NRAS delivers, for those who require social work services. In reality, HCEs are often shifting the problem rather than solving it, moving unsafe practitioners from health into other sectors such as community services and disability.

Third, we are concerned that governments may conclude that stronger co-regulation in the form of an “accredited voluntary registers program”, as flagged in successive reviews (Snowball, 2014; AHMAC 2014; COAG Health Council 2015; Dawson, 2024), will be sufficient public protection for social work service users. It will not.

The time and resources expended on establishing this model will prolong the essential steps needed to implement effective social worker regulation.

Social workers work with the most disadvantaged and marginalised people who deserve greater protection from misconduct and poor practice. An accredited voluntary registers program will not deliver this outcome. The reality is that, because it is voluntary, the proposed accredited registers program (Dawson, 2024) will deliver, at least for the social work profession, no more or better protections than what currently exist. Social workers who are poorly performing, unwell or engaging in professional misconduct are unlikely to join such a register, in the same way they tend not to participate in the AASW's certification scheme.

International experience, including from both the UK and New Zealand, demonstrates the work that statutory registration boards for social workers are doing to protect the public. In particular, the New Zealand experience shows how a voluntary registration scheme (backed by legislation) that operated between 2003 and 2021 failed to deliver the necessary public protection, with subsequent amendments commencing in 2021 to make registration of social workers mandatory.

Fourth, as the community emerges from more than five years of crisis caused by the bushfires, floods and the pandemic, social workers have been the profession most closely exposed to the decline in overall wellbeing of the community. Social work is the profession most exposed to the critical shortages and demand pressures in the health and community sectors.

Beyond the imperative of public protection, statutory registration of the social work profession would deliver significant benefits for governments. Each year, an estimated $4.76 billion is spent on social worker salaries[4] (estimated using median full-time weekly earnings), most of it funded by taxpayers. Governments need the workforce levers that statutory registration provides to safeguard this investment. Public sector employers and insurance providers also need a single trusted source of information on who is a qualified social worker and who is not. With each employer and insurer responsible for their own credentialing of social workers, statutory registration is justified on efficiency grounds alone. The more duplication, the more gaps, and the more gaps, the more regulatory failures.

Conclusions/Next steps

We stress that most social workers practise in a safe, competent and ethical manner. At the same time, we have compiled in this submission what can only be considered overwhelming evidence of the need for greater public protection, with the many cases of egregious harm caused as a direct result of, or associated with, failures of social work practice – a pattern of harms that extends back over decades.

This submission is informed by a solid evidence base. We have undertaken extensive research, drawing from multiple data sources – from coronial inquiry reports, royal commissions and other government and parliamentary committee reports, HCEs' complaints data, and our own complaints and disciplinary records. It demonstrates that:

- Social work is first and foremost a health profession, and that, therefore, principal regulatory policy responsibility sits with Health Ministers.
- The risk profile of the social work profession is equivalent to and in most cases greater than the majority of health professions that are already regulated under the NRAS.
- The existing mix of regulatory mechanisms – voluntary certification, co-regulation and negative licensing – is unable to provide the level of public protection required for those who use the services of social workers.
- Existing regulatory arrangements are insufficient to protect the public from unqualified or under-qualified social workers or poorly supervised social workers:
    - Voluntary certification and co-regulation have serious limitations, are not mandatory and currently cover less than half the social worker workforce.
    - The code of conduct and prohibition order powers of HCEs in six states provide insufficient public protection because commissioners are generally alerted only after a patient has been harmed.
    - The cases presented in this submission show a pattern of harm that will only continue without stronger controls over social work training and practice.

[4] https://www.jobsandskills.gov.au/data/occupation-and-industry-profiles/occupations/2725-social-workers

- The preferred option of statutory registration is warranted given the risk profile of the social work profession, the range of harms to the public associated with the nature of the practice of social work and the vulnerabilities of the client groups that social workers work with.
- Statutory registration is both practical and possible to implement by applying the NRAS model and will deliver the greatest net public benefit.

We encourage governments to take the same systematic approach – to understand the institutional context within which social workers work, the vulnerabilities of the people we work with and how these factors shape the substantial risk profile of the profession. We ask governments to reach the only reasonable conclusion – that statutory registration of social workers is the necessary next step in assuring the quality and safety of social work services.

While we do not present a detailed cost-benefit analysis of the options (this is the role of governments), we do present a prima facie case that this work needs to be done as a matter of urgency. The longer the delay, the more challenges will arise in the context of implementation of the registration scheme in South Australia.

Our communities cannot afford to wait another 10 years for governments to implement a nationally agreed Code of Conduct or a voluntary registers program, in what can only ever be a piecemeal response that will not deliver the level of protection that is reasonable for the community to expect.

The cost of inaction in terms of the harms identified is high. For instance, the cost of child neglect and abuse over the course of a lifetime was estimated by Deloitte Access Economics to be $78.4 billion, calculated through comprehensive whole-of-life analysis, expanded age ranges (0-24 years), and sophisticated co-occurrence modelling (Deloitte Access Economics, 2019). More recently, the 2023 Australian Child Maltreatment Study (ACMS) found that 62,2% of Australians experienced childhood maltreatment, which is nearly 3 - 4 times higher than previous estimates used in economic studies (Haslem et.al., 2023). The ACMS findings suggest that even the Deloitte study's advanced $78.4 billion lifetime cost estimate may represent substantial underestimation.

Our preferred model is the amendment of the National Law to establish a single national Social Work Board of Australia, structured, financed and operating according to the same legislative template as the other 15 National Boards under the NRAS, with administrative support provided by the Australian Health Practitioner Regulation Agency (Ahpra). We are confident that regulators have the capability to work with multiple ministers in multiple sectors where needed. But Health Ministers must step up and take responsibility.

Below is a summary of the assessment of the social work profession against the AHMAC criteria.

The submission concludes with a recommendation to the Health Chief Executives' Forum (HCEF) and all Australian state, territory and Commonwealth Health Ministers – that statutory registration of the social work profession under the NRAS is crucial to:

- ensure the Australian community can trust the quality and safety of social work practice and practitioners
- safeguard the community and prevent harm to patients, and
- equip governments with the necessary tools for effective workforce planning and the ongoing improvement of the health system.

ACRONYMS

AASW – Australian Association of Social Workers

ABS – Australian Bureau of Statistics

AHMAC – Australian Health Ministers' Advisory Council

Ahpra – Australian Health Practitioner Regulation Agency

AIHW – Australian Institute of Health and Welfare

ANZSCO – Australian and New Zealand Standard Classification of Occupations

CAHO – Chief Allied Health Officer

CBT - cognitive behaviour therapy

COAG – Council of Australian Governments

CPD – continuing professional development

CPP – Australian Government *Commonwealth Prac Payment*

DHHS – Department of Health and Human Services (State of Victoria)

ECMP – Ethics Complaints Management Process

EDMR – Eye Movement Desensitisation and Reprocessing

FOI – Freedom of Information

HCC – Health Complaints Commissioner

HCCC – NSW Health Care Complaints Commission

HCE – Health Complaints Entity

HCEF – Health Chief Executives' Forum

HCPC – The Health and Care Professions Council (United Kingdom)

HMM – Health Ministers' Meeting

HO – Health Ombudsman

IPO – interim prohibition order

ISCO – International Labour Organization *International Classification of Occupations*

MAASW AMHSW – Accredited Mental Health Social Worker

MAASW AFVSW – Accredited Family Violence Social Worker

MAASW ADSW – Accredited Disability Social Worker

MAASW ACSW – Accredited Clinical Social Worker

MAASW ACPSW – Accredited Child Protection Social Worker

MAASW AOPSW – Accredited Older Persons Social Worker

MAASW ASSW – Accredited School Social Worker

MAASW AS – Accredited Supervisor

NDIS – National Disability Insurance Scheme

NRAS – National Registration and Accreditation Scheme for the health professions

NSW – New South Wales

NT – Northern Territory

OHO – Office of the Health Ombudsman (Queensland)

OSCA – Occupation Standard Classification for Australia

PO – prohibition order

PSA – Professional Standards Authority for Health and Social Care (United Kingdom)

QCAT – Queensland Civil and Administrative Tribunal

QLD – Queensland

SA – South Australia

SWRB – Social Workers Registration Board South Australia

TAS – Tasmania

UK – United Kingdom

US – United States of America

VIC – Victoria

WA – Western Australia

ASSESSMENT OF THE SOCIAL WORK PROFESSION AGAINST THE AHMAC CRITERIA SUMMARY

CRITERION 1: ***Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation fall more appropriately within the domain of another Ministry?***

Conclusion: It is **appropriate for Health Ministers to exercise responsibility** for regulating the social work profession. Regulatory policy responsibility for social workers sits principally within the scope of the health portfolio. It does not more appropriately sit within the domain of any other Ministry.

Social work is first and foremost a health profession:

- A majority of members of the social work profession work in health settings, providing "health services" in hospitals and mental health services.
- Social work is classified as a health profession under the Australian Bureau of Statistics *Occupational Standard Classification for Australia* (OSCA) (formerly the ANZSCO).
- Social work is classified as a health profession under the International Labour Organization's *International Standard Classification of Occupations*.
- Social work is a regulated profession in all similar countries, including New Zealand, the United Kingdom, Canada and the USA.
- Regardless of where they work, what social workers do falls within the various statutory definitions of "health service" contained in Australian state and territory laws, including the *Health Practitioner Regulation National Law* and health complaints laws.
- The services provided by social workers are funded under Medicare, the foundation of Australia's health system.
- While social workers work in disability and community services, they work in multidisciplinary teams, side by side with their colleagues from the registered health professions, particularly psychology and occupational therapy.
- Those social workers employed in sectors beyond health are, nevertheless, intervening in ways that address the social determinants of health, aiming to reduce health inequalities and improve the health and well-being of individuals and populations.

Although Ministers from various portfolios have a role and interest in the work of social workers, the majority of social workers are employed in the health sector or deliver health-related services in other settings. As such, Health Ministers hold primary responsibility for overseeing the occupational regulation of social workers. This responsibility obliges Ministers to adopt a system-wide perspective – one that recognises the social determinants of health and supports greater integration between health and social care systems.

Integrated occupational regulation is a key mechanism in achieving this goal. Occupational regulation under the NRAS will provide critical tools needed to facilitate collaborative team-based care and interprofessional practice, both within and between the health and community care sectors.

CRITERION 2: ***Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?***

Conclusion: The activities of the social work profession carry a significant risk of harm to the health and safety of the public.

A range of factors are contributing to a **risk profile** that is **unacceptably high** and comparable to or exceeding many of the health professions that are subject to statutory registration under the NRAS.

Factors exacerbating the risk include the nature of social work practice, particularly the vulnerabilities and challenges of the service users that social workers predominantly work with; the changing context of practice, particularly due to changes in the public/private mix of social work services; and the substantial evidence that existing regulatory measures are failing to contain and mitigate the risk.

These risks are not just theoretical – the data from coroners' inquiry reports, royal commissions, parliamentary committees and government inquiries, and AASW's own complaints data show there is a pattern of harm, with repeated cases over two decades.

CRITERION 3: Do existing regulatory or other mechanisms fail to address health and safety issues?

Conclusion: **Existing regulatory** and other **mechanisms are failing** to address the health and safety issues associated with social work practice.

The risk profile of the social work profession is substantial, and there is a pattern of harm to service users that is not being adequately addressed under current regulations. The existing mix of self-regulatory, co-regulatory, negative licensing and other mechanisms are failing to adequately address the risks of harm associated with the under-regulated practice of social work. Strengthened co-regulation in the form of a quality-assured voluntary registers program (as outlined in the NRAS Complexity Review Consultation Paper No. 2) will provide no greater public protection for consumers of social work services than existing co-regulatory arrangements.

CRITERION 4: Is regulation possible to implement for the occupation in question?

Conclusion: **Regulation is possible to implement** for the **social work** profession.

Regulation is possible to implement for the social work profession – it **is a well-defined and well-established health profession in Australia**. It has an established body of knowledge, modalities, principles and philosophies; education programs at tertiary level accessible across the country; and established education and practice standards. The vast majority of social workers are supportive of statutory registration, and the profession can finance the operation of a self-funded National Board via registration fees. It is possible to implement regulation.

CRITERION 5: Is regulation practical to implement for the occupation in question?

Conclusion: **Regulation is practical to implement** for the social work profession.

There are ample precedents internationally of successful implementation of statutory registration for the social work profession. There are ample precedents in Australia for managing the expansion of the NRAS to include additional health professions.

The AASW has modelled its standards, codes and guidelines, including its accreditation standards, on those of Ahpra and the National Boards. Thus, the standard regulatory model that applies to the 16 NRAS-regulated health professions is appropriate for the social work profession. No specific modifications are required.

CRITERION 6: Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

Conclusion: This assessment provides prima facie evidence of the need for statutory registration of the social work profession and that **the benefits of regulation outweigh the potential negative impacts**.

This assessment demonstrates that existing mechanisms for protecting the public are inadequate and that statutory registration is the only option that will provide sufficient protection from harm, given the risk profile of the profession. Governments are urged to allocate the resources required to undertake a regulatory impact assessment (RIA).

1. INTRODUCTION

Background

The social work profession is the largest self-regulating allied health profession in Australia, with a long history dating back to the 19th century. There are approximately 49,500 social workers nationally[5], with over 17,700 of these social workers members of the Australian Association of Social Workers (AASW).

The social work profession is growing rapidly:

- According to the Australian Government Jobs and Skills Australia, the workforce is currently projected to grow by 3,600 annually.[6]
- The social work occupation was listed on the Australian Skills Priority List 2023 and is expected to grow "very strongly" (23.2% over 5 years).[7]

There are 41 higher education providers of accredited social work programs, with over 21,000 students enrolled. Further growth in enrolments is anticipated with the announced introduction of the Australian Government's *Commonwealth Prac Payment* (CPP) from 1 July 2025, designed to help students manage the costs associated with undertaking a mandatory supervised professional practice placement (also known as a practicum) as part of a higher education course in social work.[8]

Social workers work in a wide range of programs and services, many of which are wholly or substantially funded by Australian state, territory and federal governments. These include but are not limited to hospitals (both acute and subacute), primary health, community health, mental health, disability, education, veterans' health services, refugee humanitarian settlement and migrant services, workers' compensation, social services, child protection, family safety and aged care.

Purpose of this submission

The purpose of this submission is to ask Australian Health Ministers[9] to strengthen the regulation of the social work profession by introducing statutory registration for the profession. This submission:

- presents an assessment of the social work profession against the regulatory policy criteria for statutory registration that have been nationally agreed by all Australian state, territory and federal governments (the AHMAC Criteria),[10] and
- asks state, territory and federal Health Ministers to agree to progress amendments to the *Health Practitioner Regulation National Law* (the National Law) to bring the social work profession into the National Registration and Accreditation Scheme (NRAS).

Attachment 1 provides background information on the criteria and process that Australian Health Ministers have agreed to apply when jointly assessing professions for inclusion in the NRAS (the AHMAC Criteria). A summary of the criteria is set out in Textbox 1.1

[5] https://www.jobsandskills.gov.au/data/occupation-and-industry-profiles/occupations/2725-social-workers
[6] Ibid.
[7] This list has become the Occupational Shortage List, see 'Social Worker 272511'
[8] See the Australian Government Department of Education website: https://www.education.gov.au/higher-education/commonwealth-prac-payment
[9] The Australian Health Ministers comprise the Ministers responsible for the health portfolio in the federal, state and territory governments.
[10] See Australian Health Ministers' Advisory Council (2018). *AHMAC Information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions*. https://agedcare.royalcommission.gov.au/system/files/2020-10/AHP.0002.0001.0001.pdf

Textbox 1.1: The NRAS Intergovernmental Agreement – Regulatory assessment criteria (the AHMAC Criteria)

1. Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?
2. Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?
3. Do existing regulatory or other mechanisms fail to address health and safety issues?
4. Is regulation possible to implement for the occupation in question?
5. Is regulation practical to implement for the occupation in question?
6. Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

Source: AHMAC 1995; COAG 2008; AHMAC 2018

This submission details the need, evidence, and rationale for the statutory registration of social workers in Australia. The submission:

- details the scope and scale of social work practice in Australia
- presents a profile of those who use the services of social workers, the key characteristics of the social work workforce and the programs through which social work services are financed
- presents evidence of the nature and seriousness of the risks associated with the practice of social workers and the pattern of harms that are occurring under current under-regulated arrangements (AHMAC Criterion 2), and
- shows how existing regulatory and non-regulatory measures are failing to provide sufficient protection of the public (AHMAC Criterion 3).

The submission is informed by a solid evidence base. We have undertaken extensive research, drawing from multiple data sources – from coronial inquiry reports, royal commissions and other government and parliamentary committee reports, Health Complaints Entity (HCE) complaints data, and AASW complaint handling and disciplinary data.

We stress that most social workers practise in a safe, competent and ethical manner. At the same time, we have compiled in this submission what can only be considered overwhelming evidence – the many cases of egregious harm caused as a direct result of, or associated with, failures of social work practice, a pattern of harms that extends back over decades.

This submission documents the significant risk of harm to the public associated with the inadequate regulation of the practice of social work. In accordance with the AHMAC Guidance, we assess the suitability of various alternative models for regulation of the profession (AHMAC Criterion 3), including whether continuing the status quo (no change in regulation) is a satisfactory option.

We encourage governments to take the same systematic approach – to understand the institutional context within which social workers operate, the vulnerabilities of the people they work with, and how this combination of factors contributes to the substantial risk profile of the profession. We ask governments to reach the only reasonable conclusion – that statutory registration of social workers is the necessary next step in assuring the quality and safety of social work services, and that the most sensible model is to include social workers under the NRAS.

About the Australian Association of Social Workers (AASW)

The AASW is the peak national professional body for social workers in Australia. It was formed as a national association in 1946, with the amalgamation of state-based organisations founded in the 1930s. It started with 400 members and was administered by volunteers (Miller, 2016).[11]

Today, the AASW has more than 17,700 members (over one-third of the estimated social worker workforce), supported by the AASW Board, volunteers and staff.

The vision of the AASW is "Wellbeing and Social Justice in Australia". Our purpose is "to empower social workers to make a difference" (AASW Annual Report 2023-24). As well as representing and supporting social workers in their essential work, our association sets the benchmarks for professional education and practice in social work.

AASW's membership includes Accredited Social Workers, as well as students, recent graduates and other social workers who may be seeking accreditation in one or more fields of social work practice. Our members work across private practice, government and non-government organisations.

AASW membership has doubled since 2015, reflecting the increasing demand for social workers in government, non-government and communities and the profession's increasing capacity to drive change (AASW 2024: 2).

The AASW has established a robust self-regulatory framework for its members, providing a range of services that benefit both members and the public. See Textbox 1.2 for a list of the member services provided by the AASW.

Textbox 1.2: Member services provided by the AASW

- An online directory – Private practitioners can promote their practice and services on the AASW Find a Social Worker. Members of the community and referring health professionals can use the directory to find practitioners by name, location or services offered.
- A Continuing Professional Development (CPD) Program.[12]
- The AASW Community Hub – an online community for members to network and collaborate with colleagues.[13]
- A Mentoring Program that provides opportunities for social workers to grow and share their professional knowledge.[14]
- A Credentialing Program[15] to support leaders in social work and facilitate a consistent way of assessing and recognising specialist skills, covering the following credentials:
    - Accredited Mental Health Social Worker – MAASW AMHSW
    - Accredited Family Violence Social Worker – MAASW AFVSW
    - Accredited Disability Social Worker – MAASW ADSW
    - Accredited Clinical Social Worker – MAASW ACSW
    - Accredited Child Protection Social Worker – MAASW ACPSW
    - Accredited Older Persons Social Worker – MAASW AOPSW
    - Accredited School Social Worker – MAASW ASSW
    - Accredited Supervisor – MAASW AS.
- Activities to promote professional identity and practice excellence, such as AASW National Awards, National Research Committee, and PhD series.
- Professional Indemnity Insurance and Public Products Liability Insurance coverage.
- Practice groups and networking groups.[16]

[11] See https://www.aasw.asn.au/about-aasw/our-history/
https://aasw-prod.s3.ap-southeast-2.amazonaws.com/wp-content/uploads/2023/04/History-of-AASW-1.pdf

[12] See AASW website: https://www.aasw.asn.au/event/?tax_cpd_category%5B%5D=77&sort_by=
[13] See AASW website: https://www.aasw.asn.au/professional/social-work-community/aasw-community-hub/
[14] See AASW website: https://www.aasw.asn.au/mentoring/
[15] See AASW website: https://www.aasw.asn.au/professional/aasw-credentials/overview/
[16] See AASW website: https://www.aasw.asn.au/about-aasw/aasw-structure/branches/

- *Journal of Australian Social Work* – an international peer-reviewed journal reflecting current thinking and trends in social work.[17]
- *Social Work Focus* membership magazine to inform on innovative practice, reflections, research and advice.[18]
- An Ethics Complaints Management Process (ECMP).
- An Ethics Consultation Service.
- A Practice Standards consultation service.[19]
- Access to free legal advice.

History to date concerning the statutory registration of the social work profession

The AASW has located records dating back to 1968, which show the representations made to state, territory and federal governments requesting that statutory registration be established for the social work profession. Attachment 2 sets out key events in the history of regulatory policy-making relevant to the profession of social work.

The AASW has repeatedly raised concerns with governments about poor practice, unethical behaviour, unqualified or underqualified persons practising as social workers, lack of clinical oversight and supervision of social workers and, most importantly, lack of strategic action by governments to address the problems identified. Attachment 3 lists some of the media coverage associated with this issue in the last 12 months.

The last AASW submission to governments requesting statutory registration for the social work profession was submitted in 2016 (AASW 2016). As we understand, the then South Australian Health Minister Jack Snelling initiated a joint national regulatory assessment process by asking his state, territory, and federal ministerial colleagues to agree to proceed with national registration of the social work profession under the NRAS. This initiative followed a series of coronial inquiry reports in South Australia that were critical of and highlighted serious and tragic failings in social work practice – see Section 4 of this submission. These coronial reports explicitly recommended statutory national registration of social work under NRAS.

After failing to achieve the agreement of Health Ministers,[20] the South Australian Government decided to proceed with statutory registration for South Australian–based social workers. In 2021, the South Australian Parliament enacted the Social Workers Registration Act 2021 (SA). The Social Worker Registration Board (SWRB) was established in March 2024, and the Board was scheduled to begin registering social workers in South Australia from 1 July 2025. The implementation of the scheme has been delayed to a future date made by government proclamation.

While the South Australian legislative scheme represents a significant milestone, it does not solve the broader issues across Australia. It is unacceptable for other governments to delay action to address the problems identified in coronial inquiry reports, royal commissions and other parliamentary committee and government inquiries, particularly given that further deaths are foreseeable and possibly preventable.

The costs of inaction are high. For instance, the cost of child neglect and abuse over the course of a lifetime was estimated by Deloitte Access Economics to be $14.4 million in 2007 – see Attachment 4.

[17] See AASW website: https://www.aasw.asn.au/aasw-news/publications/australian-social-work/
[18] See AASW website: https://www.aasw.asn.au/aasw-news/social-work-focus/
[19] See AASW website: https://www.aasw.asn.au/about-aasw/ethics-standards/ethics-consultation-service/#:~:text=The%20ethics%20consultation%20service%20can,AASW%20website%20here%20and%20below.
[20] See COAG Health Council Communique 7 October 2016 at: https://webarchive.nla.gov.au/awa/20211005022237/http://www.coaghealthcouncil.gov.au/

Our approach to preparing this submission

The methods used to prepare this submission and key data sources are set out in Table 1.

Table 1: Methods and key data sources used to inform preparation of this submission

Method	Description/data sources
Review of regulatory policy context	The regulatory policy context was documented, including: • the history of the criteria and processes for regulatory assessment of professions for inclusion in NRAS; • relevant national registration submissions and documentation reviewed (such as for paramedics, social workers, naturopaths, sonographers and audiologists); and • key events in the history of AASW representations and submissions made to governments.
Review of the South Australian *Social Workers Registration Act 2021*	Key features of the South Australian legislation were documented, and the timeline for implementation and any issues likely to arise with the Act or its implementation were identified.
Review of available workforce and program data	All state and territory governments were requested to provide available data on the social worker workforce. Publicly available data was collected from annual reports and government websites on the social worker workforce and the financing of programs under which social workers work. This data was compiled, presented and used to inform thematic analysis.
Review of reports from government, parliamentary committee inquiries and royal commissions	All relevant state, territory and Australian Government reports contained in AASW archives were collated and reviewed. Thematic analysis was used to identify relevant themes.
Review of state and territory coronial inquiry reports	State and territory coronial inquiry reports for the period 2018–24 were reviewed to identify reports relevant to social workers and social work practice. Thematic analysis was used to identify relevant themes contained in commentary by coroners relating to professional standards of practice and practice failures.
Review of complaints data	Complaints data from various sources was collected and analysed, including from: • HCEs • AASW's complaints and ethics process.

Data collection from HCEs	The AASW wrote to all state and territory HCEs, requesting complaints data relating to social workers. The AASW also questioned staff from HCEs and undertook desktop research to document how complaints about social workers are managed.
Review of regulatory arrangements for social workers in overseas jurisdictions	A desktop review was conducted in 2024 to map the key features of statutory registration arrangements for social workers in a selection of countries, including Canada (Province of Ontario), New Zealand, and the USA (New York State). A comparative analysis was used to identify the similarities and differences between these legislative schemes and Australian statutory registration arrangements.
Review of supervision arrangements for social workers and psychologists	A literature review was undertaken via Google Scholar, and the websites of regulators were searched for information about supervision arrangements. A review was also conducted of professional supervision arrangements for social workers in Australia (AASW, SA), New Zealand, Ontario (Canada), England (UK), and New York State (US) and of psychologists in Australia and New Zealand. 14 Open Access articles were located. Thematic analysis was used to identify relevant themes.
Literature reviews conducted on specific topics of interest	Literature reviews were undertaken on topics of interest, including: • private practice social workers • supervision arrangements for social workers • the health status of high-risk client groups. For instance, the literature review on the risks associated with social workers and health practitioners in private practice aimed to better understand whether social workers working independently or in private practice pose an increased risk of harm to service users and the possible mechanisms for mitigating these risks. The review involved the following steps: • Google Scholar was searched using terms that included “social worker”, “private practice”, and terms such as “risk”, “issues”, “quality”, “harm”, “oversight”, “misconduct” and “regulation”. • Similar searches were performed substituting “social worker” with the terms “midwifery”, “health professional” and “health practitioner” and substituting the term “private practice” with “independent practice” and “dual practice” for some searches. • The *Australian Social Work* journal was searched for articles about “private practice” and “independent practice”. • Open access full text articles were retrieved and reviewed, with preference given to articles published since 2016. In total, 25 full text articles from these two sources were reviewed, of which approximately half were found to have some relevance to the research question. Examples of standards and guidelines were retrieved for reference.

Structure of this submission

Section 1 (this section) describes the purpose of this submission, the AASW, its role and functions, the methods used to collect and analyse data, and the history to date with respect to regulatory policy, statutory registration and the social work profession. A summary of the AHMAC Guidance (2018) and the criteria and process for regulatory assessment, along with a description of the four main types of occupational regulation that apply to health professions in Australia are detailed in Attachment 1.

Section 2 provides an overview of the social work profession, our practice and service users. It provides an overview of the government programs under which social work services are funded.

Section 3 presents a summary of the results of mapping the occupational regulation arrangements that apply to social workers in selected international jurisdictions, with further details provided in Attachment 5.

Section 4 sets out some of the myths that are common in government and the community about the prospect of national registration for the social work profession.

Section 5 sets out an assessment of the social work profession against each of the threshold criteria for statutory registration set out in the AHMAC Guidance of 2018 (see Textbox 1.1 and Attachment 1).

The submission presents data on failures of social work practice that have been highlighted in coronial inquiry reports across multiple states and territories. This data demonstrates serious cases of regulatory failure, which show how the system is failing to protect the most vulnerable people and why urgent action is needed to strengthen the regulation of the profession.

In particular, the case studies of regulatory failure show that harms are occurring not just because of unskilled practitioners or social workers who are under stress and working in under-resourced systems – they show the failure of regulators to remove from the workforce social workers who have perpetrated abuse, have engaged in wilful acts of deception, and are clearly unsuitable to work with vulnerable people.

The submission concludes with a recommendation directed at the Health Chief Executives' Forum (HCEF) and all Australian state, territory and Commonwealth Health Ministers – that statutory registration of the social work profession under the NRAS is urgent and necessary to assure the Australian community of the quality and safety of social work practice and practitioners, to prevent harm to patients, and to provide governments with the tools needed for workforce planning and health system improvement.

As a matter of urgency, we call on governments to legislate for the establishment of a Social Work Board of Australia, structured, financed, and operating according to the same legislative template as the other 15 National Boards under the NRAS, with administrative support provided by Ahpra.

2. THE SOCIAL WORK PROFESSION IN AUSTRALIA

Defining what is social work

The AASW adheres to the global definition of social work jointly agreed by the *International Federation of Social Workers* (of which the AASW is a member) and the *International Association of Schools of Social Work*, that is:

> *Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and Indigenous knowledges, social work engages people and structures to address life challenges and enhance wellbeing.*[21]

Social work is a university-qualified profession dedicated to assisting people to improve their lives, with a focus on their personal and social wellbeing – see Textbox 2.1.

Textbox 2.1: "About Social Work" – Extract from the AASW website

As qualified professionals, social workers have the skills and knowledge to support individuals, families, groups and communities. Social workers take the time needed to build relationships with people so that together they can consider all aspects of their situation, including their strengths and capacities, as well as the areas where they need help. They offer solutions, supports and pathways that make sense in the context of the person's environment, preferences and abilities.

Social work is a profession that advocates for fairness, social justice and human rights.

Although social workers work in diverse roles and settings, they are united by a shared vision of "wellbeing and social justice for all". Striving for this vision means working towards a world where:

- *All people have access to adequate, secure and suitable income, healthcare, housing, education, legal support and social connections, irrespective of location, background or socioeconomic status.*
- *All people have agency in their lives, and the opportunities to exercise choice and fulfil their potential.*
- *An emphasis on inclusion drives positive social outcomes for all.*
- *Poverty has been eradicated because adequate financial support is available for people with disability, or who are experiencing violence, mental illness or hardship.*

Source: AASW website "About Social Work" – https://www.aasw.asn.au/social-work/about-social-work/

Social workers:

- contribute to the greater social good across a range of sectors and work with people of all ages
- work in a wide range of organisations and settings including federal and state governments, hospitals, schools, community services organisations, and in private practice

[21] See https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/

- routinely provide services to some of Australia's most vulnerable, marginalised and at-risk people in the community in relation to their physical and mental health, poverty, housing, disability, family violence, child protection and family support
- help deal with a range of complex issues by providing psychological, psychosocial, and other interventions to vulnerable people across a range of settings, including in healthcare.

Social workers may have expertise in mental health, trauma, abuse, grief and loss, social isolation, disability and a wide range of circumstances that impact the health and well-being of individuals, groups and communities. Their roles include:

- working with individuals to plan, navigate systems, advocate, and resolve conflicts, using biopsychosocial assessments to inform decisions about the most appropriate interventions
- providing focused psychological assessments, capacity functioning and developmental assessments, and risk assessments (for example, in situations involving child protection or family violence)
- providing clinical treatment using a variety of structured therapeutic methods such as cognitive behaviour therapy (CBT), Eye Movement Desensitisation and Reprocessing (EDMR) and narrative therapy.

Social work fields of practice

Figure 1 sets out the main fields of social work practice (noting there are various iterations of this list found in other documents).

Mental health	Health	Disability	Child Protection
Family support	Domestic and family violence	Youth	Aged Care
Addiction, alcohol and other drugs	Sexual violence	Community development	Housing and homelessness
Income Support	Refugee and asylum seeker advocacy	Culturally and linguistically diverse communities	Veterans' affairs
Palliative Care	Schools and education	Gambling	Academia
Leadership and management	Social justice and discrimination	Out-of-home care	Justice and corrections

Figure 1: Social worker fields of practice

Occupational classification of social work as a health profession

Qualified social workers (that is, those who hold an AASW-approved qualification or its equivalent) can sometimes be hard to spot. This is because:

- Their job title may not include the words "social worker".
- They may be employed in a variety of roles, under a variety of job titles, such as counsellor, case manager, mental health clinician, community worker, housing worker, team manager, policy development advisor, policy analyst, youth worker, wellbeing coordinator or child protection officer.
- Not all people who use these various job titles are or are required to be qualified social workers.

This adds to the challenge for service users – they may be in contact with a worker at times of crisis and great vulnerability, and have no easy way of knowing whether their worker is a qualified social worker.

Regardless of the role or the job title used, the Australian Bureau of Statistics (ABS) *Occupation Standard Classification for Australia* (OSCA) classifies social workers as a "health professionals", at occupational "Skill level 1, Bachelor degree or higher", sitting alongside psychologists, counsellors and psychotherapists – see Textbox 2.2.[22] The level of qualification required to be a social worker is equivalent to other health occupations such as registered psychologists, nurses, occupational therapists, optometrists, pharmacists, etc.

Similarly, social workers are classified as "health professionals" under the International Labour Organization's *International Classification of Occupations* (ISCO).[23]

Textbox 2.2: Occupation Standard Classification for Australia 2024 Version 1 – Classification of social workers

Major group 2 – Professionals

***Sub-major group 26* – Health Professionals**

Health Professionals "Assess, diagnose and treat physical, physiological and psychological disorders, and provide nursing care and counselling services to maintain, promote and restore emotional, social and mental health and wellbeing".

***Minor group 261* – Allied Health Counselling, Psychology, Social Work and other Creative Therapy Professionals**

Occupation 2613 – Social Worker

Social Workers: "Assesses the biopsychosocial needs of individuals, families and groups, assists and empowers people to develop and use skills and resources needed to resolve social and other problems, and furthers human wellbeing and human rights, social justice and social development."

Registration or licensing may be required.

Specialisations

Aged Care Social Worker	Child Protection Social Worker
Clinical Social Worker	Disability Social Worker
Family Violence Social Worker	Mental Health Social Worker
School Social Worker	Social Work Supervisor

Skill level: 1 (Bachelor degree or higher)

[22] The Occupation Standard Classification for Australia (OSCA) is a standardised framework for storing, organising and reporting occupation-related information. It has been established by the ABS through a comprehensive review of the Australian and New Zealand Standard Classification of Occupations (ANZSCO) conducted between July 2022 and December 2024. The OSCA replaced ANZSCO in Australia.
See https://www.abs.gov.au/AUSSTATS/abs@.nsf/0/615DE7B733367A63CA2575DF002DA6A6?opendocument

[23] The ILO Department of Statistics is the focal point to the United Nations on labour statistics and helps Member States develop and improve their labour statistics. ISCO is a statistical framework that organises jobs into a clearly defined set of groups according to the tasks and duties undertaken in the job. See https://ilostat.ilo.org/methods/concepts-and-definitions/classification-occupation/

Main tasks

- Conducts biopsychosocial and risk assessments to assist individuals and families to resolve their presented problems.
- Provides case management services, and negotiates and mediates strategies related to clients' needs.
- Works with clients to develop and deliver individualised casework practice, group counselling and support plans.
- Promotes clients' agency and rights to access resources and community services.
- Supports clients in legal and administrative proceedings, including assessment reports and providing information or evidence in court.
- Provides supervision and peer support to other Social Workers to address ethical dilemmas, gaps in practice and areas of avoidance.
- Analyses, develops, promotes and implements social policies to respond to social needs.
- Collaborates with government, community organisations, social agencies, volunteer groups and other stakeholders to improve and develop services, and address structural inequalities.

Source: Australian Bureau of Statistics, OSCA – Occupation Standard Classification for Australia, 2024 Version 1.0

https://www.abs.gov.au/statistics/classifications/osca-occupation-standard-classification-australia/2024-version-1-0/browse-classification/2/26/261/2613

Statutory powers exercised by social workers

Social workers are responsible for exercising a range of statutory powers under various state, territory and federal legislation.

Attachment 6 sets out the state, territory and federal legislation under which social workers are or may be authorised to exercise statutory powers, in areas such as mental health, family services and child protection.

These are weighty responsibilities, particularly where these statutory roles involve the use of coercive powers, such as entering and searching premises, removing a child from harm, or assessing and approving the involuntary admission of a person to a mental health facility. Under these circumstances, it is essential that social workers are well-trained, well-supervised and well-supported to carry out these difficult roles.

Service users

Social workers routinely work with people who are at-risk during circumstances of great stress, complexity and disempowerment. Social workers work with and support:

- people experiencing mental health issues
- people who are at risk of suicide
- adults and children escaping family violence and at risk of harm
- victims of sexual assault
- people who are at risk of offending or reoffending
- people with severe disabilities
- people who are elderly and at risk of or are experiencing elder abuse
- refugees and survivors of torture and trauma
- people who have experienced severe and ongoing interpersonal trauma
- other disadvantaged, vulnerable and/or marginalised groups.

The amount of time that social workers spend with vulnerable service users is substantial – see Textbox 2.3.

Textbox 2.3: Indicators of the extent to which social workers engage with vulnerable, high-risk populations

Social workers provided more than 400,000 occasions of Medicare-funded health services each year for the years 2019–20 to 2023–24. These services were under programs including:

- Better Access to Mental Health Initiative
- Mental health services under the Chronic Disease Management Program
- Non-Directive Pregnancy Counselling Service
- Allied Health Services to First Nations Australians
- Psychological treatment services under the Eating Disorders Program.

Social workers make up an unspecified but sizable portion of Australia's welfare workforce (estimated 662,542 workers in 2022).[24] Specifically, social workers (along with occupations such as counsellors, enrolled and mothercraft nurses, psychologists, welfare, recreation and arts workers, and other community service occupations) comprised 12% of the welfare workforce in 2022.

For the period April to June 2024, more than 23,000 NDIS participants received services from a social worker.

Estimating the size of the social worker workforce in Australia

Estimating the size of the social worker workforce with any accuracy is challenging. There is a dearth of comprehensive and reliable data about the size and composition of the non-regulated workforce across health and community services generally, since, unlike the registered health professions, there is no routine collection of annual workforce data.

Workforce data was collated for this submission, drawing from a variety of sources, including:

- Australian Institute of Health and Welfare (AIHW)
- Australian Bureau of Statistics (ABS) – census data
- Australian Government – Jobs and Skills Australia
- state and territory government health departments (including in response to Freedom of Information [FOI] requests)
- grey literature, including government health and allied health workforce strategies.

Table 2 presents data on social workers employed in Australia, sourced from the Australian Government agency Jobs and Skills Australia (2024) and the Australian Government Department of Health (2022).

Jobs and Skills Australia provides more recent data on its website: it estimates there are 49,500 "social workers" employed in Australia and of these, 83% are female, with a median age of 39 years, 32% work part-time, with median weekly earnings of $1,850, and an estimated annual employment growth 3,600.[25] However, these figures include those who are working in social work roles but do not hold an AASW-accredited qualification – only 40,878 of this workforce report having the minimum educational attainment equivalent to a social work degree.[26]

[24] See https://www.aihw.gov.au/reports/australias-welfare/welfare-workforce
[25] See https://www.jobsandskills.gov.au/data/occupation-and-industry-profiles/occupations/2725-social-workers
[26] See Social Workers | Jobs and Skills Australia

Table 2: Workforce data on social work profession, from data published on the website of Jobs and Skills Australia

What	Jurisdiction	Data	Date	Source	Link
Workforce total	National	46,291	10-Jun-22	Allied health workforce data gap analysis (p 23)	https://www.health.gov.au/resources/publications/allied-health-workforce-data-gap-analysis-issues-paper?language=en
Workforce employed	National	47,700[27]	Feb-25	Jobs and Skills Australia (ANZSCO Classification 2725)	https://www.jobsandskills.gov.au/data/labour-market-insights/occupations/2725-social-workers
Workforce (NSW)	NSW	12,068	Feb-25	Jobs and Skills Australia (ANZSCO Classification 2725)	https://www.jobsandskills.gov.au/data/labour-market-insights/occupations/2725-social-workers
Workforce (VIC)	VIC	15,120	Feb-25	Jobs and Skills Australia (ANZSCO Classification 2725)	https://www.jobsandskills.gov.au/data/labour-market-insights/occupations/2725-social-workers
Workforce (QLD)	QLD	10,446	Feb-25	Jobs and Skills Australia (ANZSCO Classification 2725)	https://www.jobsandskills.gov.au/data/labour-market-insights/occupations/2725-social-workers
Workforce (SA)	SA	4,627	Feb-25	Jobs and Skills Australia (ANZSCO Classification 2725)	https://www.jobsandskills.gov.au/data/labour-market-insights/occupations/2725-social-workers
Workforce (WA)	WA	2,862	Feb-25	Jobs and Skills Australia (ANZSCO Classification 2725)	https://www.jobsandskills.gov.au/data/labour-market-insights/occupations/2725-social-workers
Workforce (TAS)	TAS	1,145	Feb-25	Jobs and Skills Australia (ANZSCO Classification 2725)	https://www.jobsandskills.gov.au/data/labour-market-insights/occupations/2725-social-workers
Workforce (ACT)	ACT	811	Feb-25	Jobs and Skills Australia (ANZSCO Classification 2725)	https://www.jobsandskills.gov.au/data/labour-market-insights/occupations/2725-social-workers
Workforce (NT)	NT	620	Feb-25	Jobs and Skills Australia (ANZSCO Classification 2725)	https://www.jobsandskills.gov.au/data/labour-market-insights/occupations/2725-social-workers

[27] Of this figure, 40,878 workers hold qualifications levels of attainment equivalent to those accepted for the purposes of AASW membership.

Table 3 presents AASW 2025 data on the fields of practice of those social workers who are practising members of the AASW.[28]

Table 3: Number of AASW members by field of social work practice

Field of social work practice	Members[29]	Proportion
Mental Health and Health (including Primary, Community and Tertiary)	9,569	56%
Child, Youth & Family Services	4,287	21%
Disability	2,432	14%
Family & Domestic Violence	1,904	11%
Management & Leadership	1,485	9%
Aged Care/Older Persons	1,149	7%
Child Protection	1,113	7%
Addiction, Alcohol and Other Drugs	1,047	6%
School Social Work	897	5%
Community Development	800	5%
Total membership	**17,064**	**100%**

Social workers in health

It is also difficult to estimate the size of the workforce of social workers in health, since the National Health Workforce Dataset reports only data captured by Ahpra for the registered health professions.[30]

AASW membership data presented in Table 3 shows over half of all AASW members (56%) work in the areas of health and mental health. Other fields of practice in Table 3 may be funded from Health and Mental Health Ministers' portfolios, such as child, youth and adolescent mental health services; sexual assault services; Alcohol and Other Drugs services; and management and leadership within the health and mental health sector.

In an effort to gather more comprehensive data, the AASW wrote to each state and territory health department to request workforce data on social workers employed in public health services (including community health and mental health). We requested data related to any workers employed under the title "social worker", holding social work qualifications and/or undertaking a social work role.

Table 4 presents the results of this data collection exercise, including estimates of the proportion of social workers employed solely in public health as a percentage of the total social worker workforce in each state

[28] AASW membership data as at 6 June 2025.
[29] Members may select more than one field of practice, hence the total in this table is greater than the total AASW member number.
[30] See the website of the Department of Health and Aged Care for details of the National Health Workforce Data set: https://hwd.health.gov.au/resources/information/nhwds.html

and territory. These figures do not include social workers who work in health roles in the private and non-government sectors.

Attachment 7 summarises the difficulties the AASW experienced in attempts to secure workforce data from nine government departments.

Table 4: State & territory health department data on social workers employed in public health

State/ territory	Social workers in public health & mental health [#]	Total number of social workers in state/territory *	% of total social work workforce for each state/territory [$]	Reporting year
ACT	251	606	42%	2025
NSW	2,769	10,272	27%	2021
NT	98	525	19%	2025
QLD	1,244	8,573	14%	2025
SA	827	3,761	22%	2019
TAS	189	970	19%	2025
VIC	2,898	12,860	23%	2024
WA	916	2,911	31%	2025
TOTAL	**9,192**	**40,441**	**23%**	-

*As per data obtained from Jobs and Skills Australia website

[#]All data in this column has been obtained from several sources, including directly from each state and territory's health departments, informal statistics, grey literature such as workforce strategies, and other publicly available information. Data recency ranges from 2019 to 2025. This data varies in terms of how it has been reported. That is, the use of the title "social worker" is not consistent and therefore this data may reflect variations of reporting on this. This data may include practitioners employed with the title "social worker" without a social work qualification, as there is no title protection. Victorian data includes social workers employed by Victorian Public Hospitals, but does not include data from St Vincent's Hospital, Mercy Hospital and Calvary Bethlehem due to funding differences.

[$]Total number of social workers in Australia = 40, 441 (Social Workers | Jobs and Skills Australia – this number discounts those who do not have at least Bachelor degree level education as they do not meet the requirements for AASW membership.)

While there are some shortcomings in the data,[31] it suggests there are well over 9,200 social workers working in state and territory government public health and mental health services.

Textbox 2.4 provides a snapshot of the available workforce data from other sources on social workers working in the health sector.

Textbox 2.4: Social workers in the health sector – A snapshot

- The Australian Institute of Health and Welfare (AIHW) reported[32] in 2021–22 more social workers were employed in specialised mental healthcare facilities than other qualified mental health professions. Overall, allied health represented 19% of the total workforce. Social work represented 8% of this total.
- As of 5 June 2025, there are 3,703 Accredited Mental Health Social Workers (AMHSWs) across Australia. As a group of providers, they are the second largest after the combined group of clinical psychologists and registered psychologists.
- In Victoria, social workers are the third largest public specialist mental health profession (after medical practitioners and nurses). In 2024, the Victorian public hospitals employed a total of 955 social workers. This represented 44% of the allied health staffing (DHHS 2019).
- In 2019, the South Australia Department of Health and Wellbeing employed 47% of SA state-employed social workers, followed by 35% by the Department of Child Protection (Parliament of South Australia 2020: 13).
- In the NSW Public Mental Health system, 5% of the public mental health workforce in 2015–16 were social workers, with 17% constituting allied health professions.[33]
- 31% of the total number of social workers in Western Australia are employed within the WA Department of Health. (WA Department of Health and Jobs and Skills website)
- It is estimated $4.76 billion is spent annually on the salaries of social workers, that is, in government, community and private sectors.[34]

The AIHW reported that in 2021–22, within specialised mental healthcare facilities, there were more social workers (2,780 FTE) than psychologists (1,850 FTE), consultant psychiatrists and psychiatrists (1,780 FTE) or psychiatry registrars and trainees (1,920 FTE).[35]

Some extracts from workforce data supplied by states and territories show the size and importance of the social work workforce in public health and mental health – see Attachment 8.

Attachment 9 provides details of the types of roles social workers occupy in hospitals and other health services, including in:

- intensive care units (ICU)
- burns units
- acute geriatrics
- oncology
- renal units (nephrology)
- paediatrics
- maternity
- discharge planning and support
- acquired brain injury and traumatic injuries
- termination of pregnancy
- voluntary assisted dying (VAD)

[31] The data supplied for Queensland was incomplete and the NSW and SA data were several years old.
[32] https://www.aihw.gov.au/mental-health/topic-areas/facilities
[33] https://www.health.nsw.gov.au/mentalhealth/resources/Publications/mh-strategic-framework.pdf
[34] https://www.jobsandskills.gov.au/data/occupation-and-industry-profiles/occupations/2725-social-workers
[35] See AIHW website: https://www.aihw.gov.au/mental-health/topic-areas/facilities

- Centre Against Sexual Assault in hospitals and health services.

In terms of workforce projections, several trends are evident.

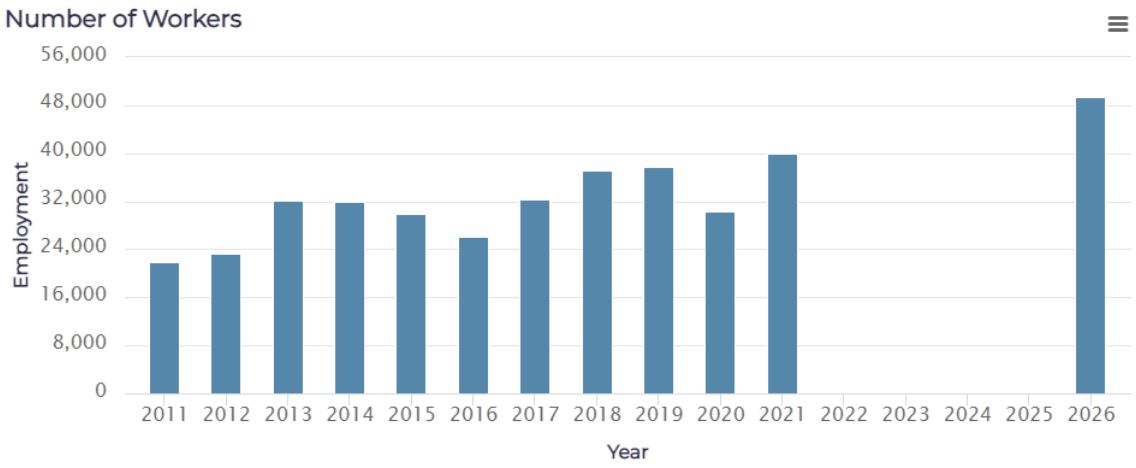
First, while social work is already the largest allied health workforce in the country and the third-largest workforce in mental health, behind medicine and nursing, it is projected to continue growing at a faster rate, particularly with initiatives such as the Australian Government's *Commonwealth Prac Payment* initiative.[36]

Second, there is a significant workforce of AMHSWs that is also projected to grow.

Third, the proportion of the social worker workforce that is self-employed as a sole proprietor or in a small group private practice is projected to continue growing and is likely to comprise a larger share of the workforce.

Social worker workforce is projected to grow

Drawing on data from the *Australian Bureau of Statistics Labour Force Survey* and projections from the Jobs and Skills Australia Employment Projections, Figure 2 shows the projected growth in the number of social workers, through to 2026.[37] Additional projections from Jobs and Skills Australia show the size of the social worker workforce is projected to be 53,652 by August 2029 and 60,096 by August 2034.[38]



Source: ABS Labour Force Survey, ABS seasonally adjusted data to November 2021 and Jobs and Skills Australia Employment Projections to 2026.

Figure 2: Jobs and Skills Australia employment projections to 2026 for social workers

A growing workforce of Accredited Mental Health Social Workers

According to AASW membership data as of 23 June 2025, there were 17,627 AASW members, of whom 3,703 had been accredited as possessing additional skills and experience in mental health required to be granted AMHSW status by the AASW.

More than 3,700 AMHSWs are recognised providers of Focussed Psychological Strategies (FPS) under Medicare's Better Access Initiative.[39] They work with people across the lifespan (including children, adults, and older persons). The advanced training required for accreditation as an AMHSW equips them to work with people with very complex presentations and co-morbidities.

[36] See the Australian Government Department of Education Commonwealth Prac Payment webpage: https://www.education.gov.au/higher-education/commonwealth-prac-payment

[37] See also Jobs and Skills Australia website: https://www.jobsandskills.gov.au/data/employment-projections

[38] See national occupational trend under social work: https://www.jobsandskills.gov.au/data/labour-force-trending

[39] See Better Access initiative | Australian Government Department of Health and Aged Care
Note MN.7.4 | Medicare Benefits Schedule

More than 40% of AMHSWs provide services in regional and remote Australia. Access to public and community clinical services is often limited in these locations, and AMHSWs are often the mainstay of mental health service provision in many rural communities.

Demand is growing. As the scope of practice of AMHSWs is more widely recognised and valued, they are being added as approved mental health treatment providers under a range of funding schemes and programs, including private health insurers, workers' compensation schemes, transport accident schemes, and victim support services.

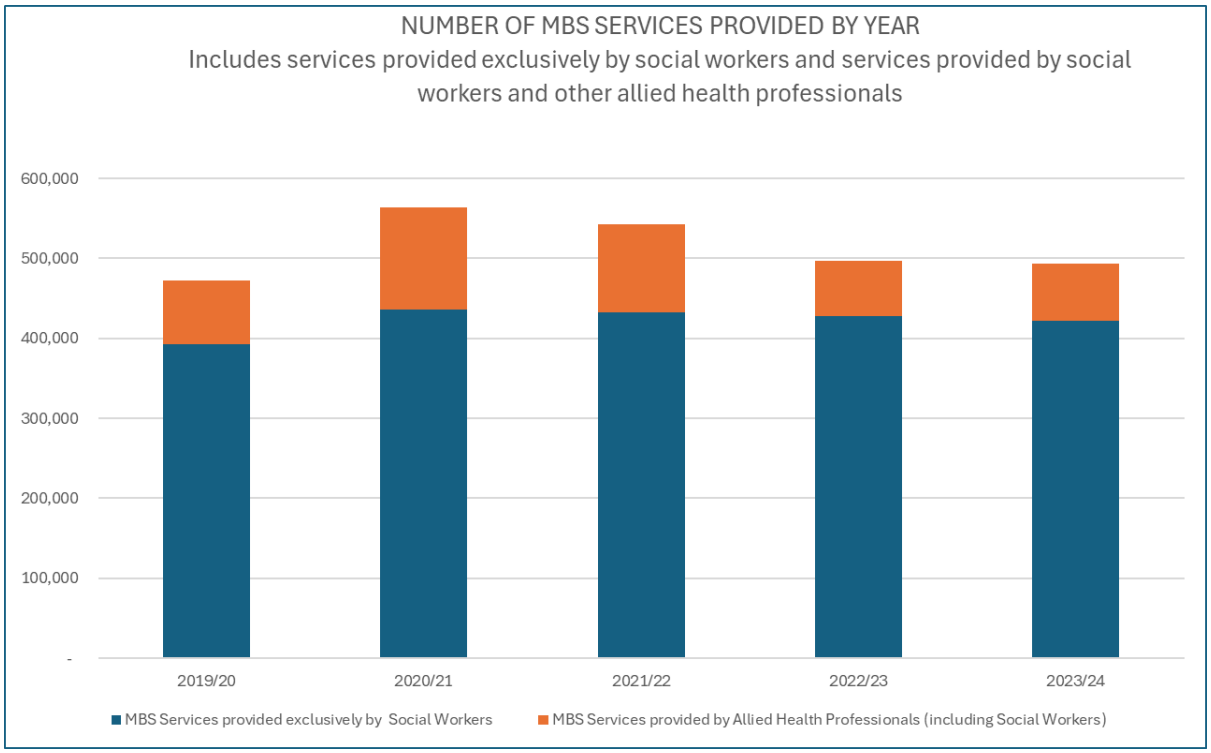


Figure 3: MBS services by year for MBS items that are used exclusively by social workers and MBS item numbers used by allied health professionals (including social workers)

A growing private sector social worker workforce

Private practice is defined as:

> *the provision of clinical social work services by a licensed clinical social worker who assumes responsibility and accountability for the nature and quality of the services provided to the client in exchange for direct payment or third-party reimbursement* (Kourgiantakis et al. 2023: 22).

Historically, social workers have practised primarily in the public and/or not-for-profit sectors, with private practice being rare. For instance, in 2006, there were only about 100 social workers in private practice in Australia (AASW 2012). However, changes in the financing of health and disability services have seen an increasing proportion of social workers providing services as a sole proprietor or in a small group private practice.

Social workers in private practice provide services funded by:

- Medicare
- private health insurers
- compensable funds such as traffic accident compensation, workers' compensation, and veterans' affairs
- the NDIS.

as well as primary care services paid by service users. For instance:

- Patients of AMHSWs may access Medicare rebates for the provision of Focussed Psychological Strategies (FPS) through the Better Access to Mental Health Care initiative and other programs, in accordance with a Mental Health Treatment Plan prepared for the patient by a General Practitioner.
- Medicare rebates are also available for services provided by AMHSWs, such as the Chronic Disease Management program, Non-Directive Pregnancy Support Counselling Health Services, and Eating Disorder Psychological Treatment Services.
- AMHSWs can also provide Medicare-rebated services for patients who require case conferencing for their mental health or complex neurodevelopmental disorder and disability services.

Figure 4 shows the projected numbers of private practice social workers through to 2031/32. This trend is also evident in the AASW's own data. Between the years 2021/22 and 2023/24, 15–17% of AASW's members (more than 17,000 members in 2023/24) identified private practice as their core practice area.[40]

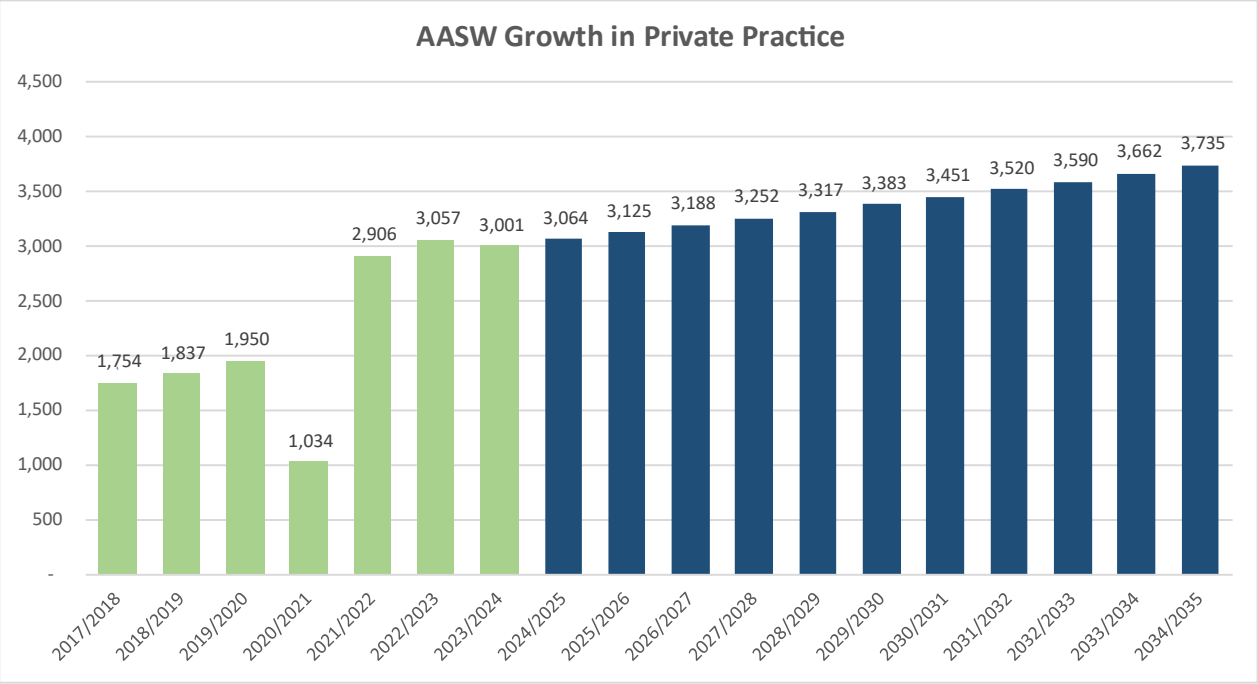


Figure 4: Forecasted growth in private practice - AASW members

Education of social workers

Social work education in Australia has a seven-decade history, with the four-year degree program constituting the standard qualification since the 1960s (AASW, 2012, p. 21).

Today, social workers may complete either a Bachelor of Social Work (four-year full-time university degree) or a Master of Social Work qualifying (two-year postgraduate university degree).

These degree programs include a compulsory, practical component – 1,000 hours of placement, of which 500 hours are direct supervised practice. This provides authentic learning activities that equip graduates with the knowledge and skills to work with vulnerable people, better understand and support them, promote community participation, and advocate for social change. It also qualifies graduates for AASW membership and the professional recognition this brings.

In Australia, there are 41 higher education providers that have been accredited by the AASW to provide entry to practise social work programs – see Attachment 10 for details of the AASW's accreditation standards and processes. Almost half of these social work courses are placed within health schools or colleges that may

[40] AASW membership records

combine medicine, health, allied health, primary health, health management, nursing and midwifery. The next largest group are stand-alone social work schools.

The AASW also assesses international social work qualifications for equivalence with Australian social worker education standards.

All these measures are designed to assure the quality, safety and competence of the Australian social worker workforce.

Funding of social work services

It is difficult to estimate the level of funding allocated by governments to finance the provision of social work services. This is because:

- state and federal funding documents generally report funding by program rather than by specific profession, and social work services are often bundled into general allocations for allied health and other providers.
- The National Health Workforce Dataset does not include social workers as this data is drawn from the annual Ahpra registration process and a voluntary workforce survey completed at the time of registration, neither of which applies to social workers.[41]

Table 5 provides a summary of the funding schemes under which social workers may be credentialled as providers and the associated eligibility requirements.

[41] See the Australian Government Department of Health and Aged Care for details of the National Health Workforce Dataset: https://hwd.health.gov.au/resources/information/nhwds.html

Table 5: Eligibility criteria for social workers by funding scheme

Funding program/provider	Eligibility	Funding program/provider	Eligibility
Medicare			
Better Access to Mental Health (all states)	AMHSW credential	Eating Disorder Psychological Treatment Services	AMHSW credential
Non-Directive Pregnancy Support Counselling	Accredited SWs with training in non-directive pregnancy support counselling	Chronic Disease Management	AMHSW credential
National Disability Insurance Scheme			
AASW membership			
Veteran services			
Department of Veterans' Affairs (DVA) (all states)	Social workers: AASW membership and be registered with DVA AMHSWs: Medicare provider number	Open Arms Outreach Program (all states)	AMHSW credential, Medicare provider number, ABN, registered for GST and Working with Children Check (if required)
Bupa Open Arms (all states)	AMHSW credential		
Workers Compensation Schemes			
Comcare (Commonwealth)*	AASW membership, plus at least 5 years' relevant workplace rehabilitation experience (at least one person from organisation). Additional WRPs must have at least 12 months' relevant experience. If less than 12 months' experience,	WorkSafe ACT*	SWs as workplace rehabilitation providers (WRP):

	a comprehensive induction and learning plan must be completed with at least 12 months' supervision.		AASW membership Experience for WRPs same as per Comcare above
State Insurance Regulatory Authority (SIRA) (NSW)	AMHSWs as counsellors: AMHSW credential SWs as workplace rehabilitation providers (WRPs): AASW membership required, PI/PL insurance, plus at least 5 years' relevant workplace rehabilitation experience (at least one person from organisation). Additional WRPs must have at least 12 months' relevant experience	WorkSafe NT *	SWs as vocational rehabilitation providers (VRP): AASW membership Experience same as per Comcare above Business address and at least one worker's residence must be in NT.
WorkCover QLD	SWs as return-to-work service providers and adjustment counsellors, and *AMHSWs for mental health services:* SW qualification for SW roles, and AMHSW credential for mental health SW services	ReturnToWorkSA	SWs as return-to-work consultants and AMHSWs for mental health services: AASW membership
WorkCover Tasmania	SWs as workplace rehabilitation providers (WRPs): AASW membership required, plus 12 months experience delivering workplace rehabilitation services for WRPs. If less than 12 months' experience, a comprehensive induction program will be completed, and professional supervision provided for at least 12 months.	WorkSafe Victoria	Social workers– eligible for AASW membership/Bachelor or Master of Social Work, $1 million professional indemnity insurance AMHSWs – accreditation and full current AASW membership
WorkCover WA	SWs as workplace rehabilitation providers (WRPs) or consultants to WRPs: AASW membership		

	Experience for WRPs same as per Comcare above		
Transport accident schemes			
State Insurance Regulatory Authority (SIRA) (NSW)	SWs	Transport Accident Commission (TAC) (Victoria)	SWs (and AMHSWs for higher consultation fees) – Eligible for AASW full membership
Schemes in other states do not specifically mention SWs as eligible service providers (requirements vary).	Motor Accidents Compensation Scheme (NT) Motor Vehicle Insurance Commission (MVIC) (QLD) CTP Insurance Regulator (SA) Motor Accidents Insurance Board (MAIB) (Tasmania) Motor Injury Insurance (WA)		
Victim support services			
Victims Services (NSW)	Social workers and AMHSWs*:* AASW member, minimum 3 years' experience as provider of clinical services, professional indemnity insurance, Working with Children Check and National Police Check	Victim Assist (Queensland)	Accredited Social workers and AMHSWs*:* Accredited SWs with demonstrated relevant counselling experience and AMHSWs (reports only by AMHSWs), with PI/PL insurance
Victims of Crime Assistance Financial Assistance Scheme (FAS) (Victoria)	Accredited social workers and AMHSWs		

Private health insurance providers			
Australian Regional Health Group (ARHG) Ancillary Provider Listing	AMHSWs: AMHSW status, hold first aid certificate and provide expiry date within MyAASW (by end of grace period, 1 March 2025), tick Private Health Fund Status Verification declaration within MyAASW	Bupa	AMHSWs: AMHSW status, Medicare provider number, in private practice, ABN, PI/PL insurance
Doctors' Health	AMHSWs: AMHSW status, Medicare provider number	HCF	AMHSWs: AMHSW status, Medicare provider number, in private practice
Medibank Private	AMHSWs	Phoenix Health Fund	AMHSWs: Meet ARHG requirements
St Lukes Health	AMHSWs: Meet ARHG requirements	Teachers Health (including Nurses and Midwives Health and UniHealth)	AMHSWs: AMHSW status, Medicare provider number, in private practice
TUH-Teachers Union Health Fund	AMHSWs: Meet ARHG requirements		

*SWs are not specifically listed as allied health/treatment providers but can still be referred to by GP, WRP or insurer.

Table 6 lists some of these programs and an estimated budget for these services. This table illustrates the lack of available data on funding for social worker services.

Table 6: Government programs that fund social worker services and estimated budget

Program	Year	Funding – Allied health	Social workers	Total program
Australian Government, states and territories' health	2022–23	N/A	N/A	$178 billion
Non-government sources	2022–23	N/A	N/A	$73.8 billion
Veterans Affairs	2020–21	N/A	N/A	$65 million
NDIS	2023–24	N/A	$47.37 million [a]	$46.4 billion
Australian Government Mental Health	2021–22	N/A	N/A	$12.2billion
Medicare[42] mental health subsided services [b]	2022–23	5%	$36 million	$1.561 billion
All Medicare subsidised services	2022–23	N/A	$41 million [c]	$27.3 billion [43]
State & territories' Specialised Mental Health [d]	2021–22	N/A	N/A	$7.4 billion

N/A = data not available

a) 3,000 registered social workers, the amount is only for specific social worker line-item numbers, and excludes other combined allied health line-item numbers that social workers bill for.
b) Other allied health providers (excludes psychologists)
c) Social worker item numbers and other generic allied health items numbers that social workers can claim
d) Mental health program components – community mental health, public acute hospitals grants to non-government organisations, residential mental health services

In 2022–23, the allocation for Medicare mental health services was $1.561 billion. Of this, $1.2 billion (4% of the total Medicare spending) was paid in benefits for Better Access MBS items. Services provided by psychologists were the largest proportion of national spending ($762 million or 49%).[44] The AIHW reported that in 2023–24, under the Better Access MBS item numbers, there were 413,683 Focussed Psychological Strategy (FPS) services delivered by AMHSWs to 94,718 patients.[45]

In 2023–24, $47.37 million was paid under the NDIS for assessment, therapy or training services provided by social workers (item number 15_621_0128_1_3), with over 3,000 social workers providing these NDIS services. This figure does not include the share of funding allocated to social work services for NDIS budget items: Early childhood supports (item number 15_005_0118_1_3) and Specialist support coordination (item

[42] See https://www.aihw.gov.au/mental-health/topic-areas/medicare-subsidised-services
[43] See https://www.health.gov.au/sites/default/files/2023-11/medicare-statistics-year-to-date-dashboards.pdf
[44] See https://www.aihw.gov.au/mental-health/topic-areas/expenditure
[45] See https://www.aihw.gov.au/mental-health/topic-areas/medicare-subsidised-services

number 07_004_0132_8_3), as other allied health professionals are included in these line-item numbers (budget allocations of $584,422,000 and $102,246,000, respectively).[46]

Noting these data limitations, we used available data sources to estimate the total average earnings of employed social workers as a proxy measure of the cost to governments and the community of social worker services.

The *2023 Graduate Outcomes Survey National Report* shows the median full-time employment salary for domestic graduate social workers is $77,300.[47] Note that of the 21 study areas included in the dataset, social work has the third-highest graduate salary, behind dentistry and medicine (2023: 15).

With an employed workforce of approximately 49,500 social workers, we estimate that approximately $4.76 billion is spent on social worker salaries annually (i.e. government, community and private) – see Table 7.

Table 7: Estimated total annual earnings of employed social workers

A.	Number of social workers employed (2025)	49,500*
B.	Social worker median weekly earnings (2025)	$ 1,850
C.	Total weekly earnings (A x B)	$91,575,000
Total annual earnings (C x 52 weeks)		**$4,761,900,000**

* estimated full-time equivalent (FTE)

Source: Australian Government, ABS[48] and Jobs and Skills Australia[49]

Outcomes/impacts of social work practice

Social workers partner with individuals, families, groups and communities, working at the intersection between people and their social, cultural, physical and natural environments. Social workers work to identify and intervene in the social determinants of health – the economic, psychological, emotional, political, social, legal and environmental factors that impact health and wellbeing. They do this in a variety of ways, by:

- providing holistic and person-centred care to improve the well-being of individuals, their families and carers
- enhancing the biomedical focus of other health and allied health professionals and workers, thereby building capacity to provide more holistic care
- reducing health and social service utilisation and costs
- using community development strategies to increase social cohesion in the community
- contributing to systemic/societal change and policy reform by engaging in advocacy, policy development, addressing social justice issues and improving service delivery.

Attachment 12 provides extracts from the South Australian Social Workers Registration Board consultation document, Social Work Services and Scope of Practice Consultation Companion Document (SWRB 2024), on the lived experience of service users and their expectations of regulators.

The impacts of these interventions are evident at the individual, family, community and societal levels.

[46] See https://dataresearch.ndis.gov.au/datasets/payments-datasets (Average support line-item payments data downloads)
[47] See Graduate Outcomes Survey website https://www.qilt.edu.au/surveys/Data-Visualisation/gos
[48] ABS Survey of Employee Earnings and Hours, May 2023, customised report
[49] See https://www.jobsandskills.gov.au/data/occupation-and-industry-profiles/occupations/2725-social-workers

Impacts for individuals and their families and carers

By addressing the psychosocial and health needs of service users and providing holistic care, there is evidence that social work interventions have positive impacts for individuals and their families and carers, in relation to different social issues, for various demographic groups, and in diverse settings.[50] [51] [52] [53] [54]

For instance, in 2024, the University of Canberra published its *Evaluation Report of the Social Workers in General Practice Pilot program*, which was commissioned by the ACT Primary Health Network, Capital Health Network. The report included the results of a patient feedback survey – see Textbox 2.5.

Textbox 2.5: Extract from Social Workers in General Practice Pilot Program Evaluation Report

Patient and carer experience of SWiGP

SWiGP participants' experiences of support and assistance – the patient feedback survey found that the majority of patients and carers reported positive experiences with social workers. Over 80% of respondents felt supported by the social worker to:

- *understand the support they needed (82.6%, n=38)*
- *find support services in the community (85%, n=34)*
- *access appropriate services (84.1%, n=37)*
- *gain access to identified support and follow-up where necessary (90.9%, n=40)*
- *complete forms and letters to access services (89.6%, n=26) (Many respondents indicated that assistance with form completion was not something they required from the social worker.)*

Participants in the SWiGP program felt that social workers offered a higher level of care and support compared to GPs due to time constraints. Patients and carers valued the empathy, caring nature, and dedicated time shown by social workers. They felt supported and acknowledged the effectiveness of social workers in following up on issues and delivering results. Practical supports in navigating My Aged Care (MAC) packages, arranging assessments, and providing guidance on managing home care packages and services were helpful.

These individual impacts can also have a positive effect on other domains, such as reduced health and social service utilisation and cost. Social workers play a crucial role in integrated healthcare settings, improving care and health outcomes throughout the life course by addressing behavioural health, psychosocial, and physical care needs.

Source: University of Canberra 2024: 20

[50] Jani J, Ortiz L and Aranda M (2009). "Latino Outcome Studies in Social Work: A Review of the Literature". *Research on Social Work Practice 19(2)* p179-194. Sage Publications. DOI: 10.1177/104973150831597
[51] Early T and Vonk M (2001). "Effectiveness of School Social Work from a Risk and Resilience Perspective". Children & Schools 23(1) pp 9-31. DOI: https://doi.org/10.1093/cs/23.1.9.
[52] Steketee G, Ross A, and Wachman M (2017). "Health Outcomes and Costs of Social Work Services: A Systematic Review". *American Journal of Public Health 107*. S256_S266. https://doi.org/10.2105/AJPH.2017.304004
[53] Koenig T, Lee J, Fields N and Macmillan K (2011). "The Role of the Gerontological Social Worker in Assisted Living". Journal of Gerontological Social Work 54(5) pp 494-510. DOI: 10.1080/01634372.2011.576424
[54] Lisa de Saxe Zerden MSW, PhD, Brianna M. Lombardi MSW, PhD & Anne Jones MSW, PhD (2019) Social workers in integrated health care: Improving care throughout the life course, Social Work in Health Care, 58:1, 142-149, DOI: 10.1080/00981389.2019.1553934

Impacts for other health and allied health professionals and workers

As integral members of interprofessional healthcare teams, social workers have been shown to enhance the delivery of care, improve patient outcomes and the overall effectiveness of healthcare teams, and reduce healthcare related costs and utilisation.[55] [56] [57] [58] [59]

Collaboration between social workers and community health workers has been shown to improve health and mental health outcomes, demonstrating the value of social work in multidisciplinary settings.[60]

The University of Canberra *Evaluation Report of the Social Workers in General Practice Pilot program* found that GPs reported overwhelmingly positive feedback from patients regarding the SWiGP program and stressed the importance of having a service that can quickly and professionally provide practical support alongside mental healthcare:

> *GPs emphasised the benefits of having a specialised allied health professional, such as a social worker, to handle complex needs within the practice, leading to improved practice management and access to the right expertise. They also noted that the limited time of a typical 15-minute appointment hindered their ability to address the social issues underlying medical conditions. By including a social worker in their team, they could provide comprehensive health services, resulting in time savings for GPs and reduced mental strain* (University of Canberra 2024: 19)

Impacts on community development and cohesion

Social work practice impacts the health of communities by addressing health inequities and improving access to care for vulnerable populations. Social work practice can also have a significant impact on community development and cohesion through community-based interventions.

Studies show that through strategies such as community analysis, leadership development, and advocacy, social workers have helped mobilise community members to influence policies and practices.[61] The involvement of social workers in community settings has been shown to help address broader social issues, contributing to community wellbeing.[62]

Systemic societal change and policy reform

Social work practice impacts policy and practice through active engagement with end-users, highlighting social issues, and developing evidence-based policies to inform government and influence policy development.

Social work practice has demonstrated impacts on systemic and societal change, particularly in the context of climate change adaptation and community action. Studies highlight the role of social work in advocating for socially based adaptive measures for vulnerable groups such as older citizens, in response to climate

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[55] Lisa de Saxe Zerden MSW, PhD, Brianna M. Lombardi MSW, PhD & Anne Jones MSW, PhD (2019) Social workers in integrated health care: Improving care throughout the life course, Social Work in Health Care, 58:1, 142-149, DOI: 10.1080/00981389.2019.1553934

[56] Koenig T, Lee J, Fields N and Macmillan K (2011). "The Role of the Gerontological Social Worker in Assisted Living". Journal of Gerontological Social Work 54(5) pp 494-510. DOI: 10.1080/01634372.2011.576424

[57] Reese D and Raymer M (2004). "Relationships between Social Work Involvement and Hospice Outcomes: Results of the National Hospice Social Work Survey". National Association of Social Workers Inc. DOI: 10.1093/sw/49.3.415

[58] Tadic V, Ashcroft R, Brown J and Dahrouge S (2020). "The Role of Social Workers in Interprofessional Primary Healthcare Teams". Healthcare Policy 16(1) pp 27-42. DOI: 10.12927/hcpol.2020.2629

[59] Koenig T, Lee J, Fields N and Macmillan K (2011). "The Role of the Gerontological Social Worker in Assisted Living". Journal of Gerontological Social Work 54(5) pp 494-510. DOI: 10.1080/01634372.2011.576424

[60] Noel, L., Chen, Q., Petruzzi, L., Phillips, F., Garay, R., Valdez, C., Aranda, M., & Jones, B. (2022). Interprofessional collaboration between social workers and community health workers to address health and mental health in the United States: A systematised review. *Health & social care in the community*. https://doi.org/10.1111/hsc.14061.

[61] Ohmer M and Korr W (2006). "The Effectiveness of Community Practice Interventions: A Review of the Literature*". Research on Social Work Practice, 16(2)* p132-145. Sage Publications. DOI: 10.1177/1049731505282204

[62] Noel, L., Chen, Q., Petruzzi, L., Phillips, F., Garay, R., Valdez, C., Aranda, M., & Jones, B. (2022). Interprofessional collaboration between social workers and community health workers to address health and mental health in the United States: A systematised review. *Health & social care in the community*. https://doi.org/10.1111/hsc.14061.

change. This involves challenging existing discourses and influencing future policy development to better address social impacts.[63]

The history of Services Australia and its constituent programs (Medicare, Centrelink, Child Support, myGov etc) has been described as a testament to the role of social workers in achieving systemic changes to the health and social support systems (Australian Government Services Australia 2024).

[63] Appleby, K., Bell, K., & Boetto, H. (2017). Climate Change Adaptation: Community Action, Disadvantaged Groups and Practice Implications for Social Work. *Australian Social Work*, 70, 78–91. https://doi.org/10.1080/0312407X.2015.1088558.

3. STATUTORY REGISTRATION OF SOCIAL WORKERS IN OVERSEAS JURISDICTIONS

Many countries have enacted legislation to establish a registration or licensing scheme for social workers. Attachment 5 sets out the results of a desktop analysis that mapped the occupational regulation arrangements for social workers in a sample of countries.

Statutory registration for the social work profession has been enacted in many countries, including Canada, Ireland, New Zealand, the United Kingdom and the United States. Together these countries regulate an estimated workforce of more than 942,000 social workers.[64] The US alone accounts for nearly three-quarters of a million social workers and it was one of the fastest growing professions in the US in 2020.

The governance arrangements of regulators vary. In some jurisdictions, the licensing scheme operates under the health portfolio, reporting to the Health Minister, while in others, the regulator operates under a combined health and welfare portfolio and/or reports through multiple Ministers spanning both health and welfare.

Canada

In Canada, responsibility for regulating the professions is assigned to the provinces under section 92 of the *Constitution Act 1867* which grants provinces legislative authority over matters of a local or private nature, including the regulation of professions within their borders.

Each province has enacted legislation and established a social work regulatory body to govern the profession in accordance with the legislation, beginning with the *Act to Incorporate the Manitoba Institute of Registered Social Workers* in Manitoba in 1968. While most provinces legislated to regulate social workers in the 1990s, national coverage was achieved in 1998 with enactment in Ontario of the *Social Work and Social Work Service Act 1998*.

While social worker registration laws vary from province to province, individual social workers become registered by becoming a member of a provincial regulatory body.[65] Anyone using the title “Social Worker”, “Registered Social Worker” (RSW), or its French equivalent “Travailleur(se) Social(e)” must be registered with the responsible provincial or territorial social work regulatory body. However, registration is voluntary (Birnbaum & Lach, 2014) and while the social worker title is legally protected, it does not restrict who can provide clinical services (Newberry-Koroluk, 2014; Kourgiantakis et al. 2023: 17).

The Canadian Council of Social Work Regulators provides a national structure for provincial and territorial social work regulatory authorities to act together as the voice, both nationally and internationally, on social work regulatory matters in Canada.

Below is the list of provincial social work regulators:

- British Columbia
- Alberta

[64] United States (2023) 751,900 social workers – see: https://www.bls.gov/ooh/community-and-social-service/social-workers.htm;
Canada (2018) 52,823 social workers – see: https://www.casw-acts.ca/en/what-social-work;
United Kingdom (2024) 129,700 social workers – see: https://www.statista.com/statistics/319253/number-of-social-workers-in-the-uk/#:~:text=Number%20of%20social%20workers%20in%20the%20UK%202021%2D2024&text=There%20were%20estimated%20to%20be,122%2C200%20in%20the%20previous%20quarter;
New Zealand (2024) workforce report 2024 - 8354 social workers – see: https://swrb.govt.nz/about-us/news-and-publications/publications/#workforce-surveys;
TOTAL: 942,777 social workers. Note these figures do not distinguish between those registered, employed and practising.

[65] See the Canadian Council of Social Work Regulators website: https://www.casw-acts.ca/en/regulation-association-education/regulatory-bodies#canadian-council-of-social-work-regulators

- Saskatchewan
- Manitoba
- Ontario
- Quebec
- New Brunswick
- Nova Scotia
- Newfoundland and Labrador
- Prince Edward Island
- Northern Canada (Northwest Territories)
- Canadian Council of Social Work Regulators.

New Zealand

In New Zealand, the *Social Workers Registration Act* was passed in 2003, establishing the Social Workers Registration Board (SWRB) as a crown entity and the regulatory authority responsible for registration of social workers. The title "social worker" became a protected title at that time, although registration was voluntary until February 2021 when legislative changes made registration mandatory for all social workers. The duties and functions of the SWRB are set out in section 99 of the Act.

In championing the shift from voluntary to mandatory social worker registration, the New Zealand Social Workers Registration Board stated:

> *Voluntary registration does not meet the purposes of the Act; the public are at risk from poor social work practice by people using the title Social Worker outside the safety framework provided by the Act; and moving to mandatory registration is a fundamental step in reducing public risk from poor social work practice by improving the professionalism and accountability of social workers.* (SWRB 2011)

The experience of New Zealand suggests that a system of voluntary registration is insufficient, with the New Zealand government deciding to amend its legislation to make registration of social workers mandatory, commencing 2023.

United Kingdom

In England, social workers were first required to be registered in 2001 with the General Social Care Council, a statutory authority established under the *Care Standards Act 2000*. The title "social worker" became a protected title in 2005 (Manthorpe & Purcell 2023).

With enactment of the Children and Social Work Act 2017, social workers are now registered and regulated by Social Work England, a non-departmental public body that operates at arm's length from government. Social Work England registers and regulates the social work profession under the Social Workers Regulations 2018.

Prior to the establishment of Social Work England, between 2010 and 2019, social workers in England were registered and regulated by the Health and Care Professions Council (HCPC), a multi-profession health and social care regulator operating under the *Health Professions Order 2001*, made under section 60 of the *Health Act 1999*.

While the governance arrangements for regulation of social workers have changed several times since 2000, the UK experience is of interest because its multi-profession regulator (the HCPC) regulates professions whose members provide services across both the health and social care sectors. This model is evident in other jurisdictions in both the United States and Canada.

Social workers are also required to be registered in the other constituent countries of the United Kingdom:

- Scotland – the Scottish Social Services Council (SSSC)
- Northern Ireland – Northern Ireland Social Care Council (NISCC)
- Wales – Social Care Wales.

Ireland

In the Republic of Ireland, social workers are registered by the Social Workers Registration Board of CORU – the Health and Social Care Professionals Council.

CORU is Ireland's multi-profession regulator, responsible for regulating health and social care professionals in Ireland.

United States

In the United States, social work licence requirements are set by individual states and territories. All 50 US states have licensing requirements to work as a social worker. Most US jurisdictions have multi-tiered licensures with different practice scopes for each category that correspond to education and experience levels (ASWB 2021; Kourgiantakis et al. 2023: 19). Most schemes separately identify social workers with clinical training.

A "meta-regulator" is also in operation – the Association of Social Work Boards (ASWB) is the non-profit organisation composed of the social work regulatory boards and colleges of all 50 US states, the District of Columbia, the US Virgin Islands, Guam, the Northern Mariana Islands, and all 10 Canadian provinces.

The ASWB:

- maintains the Social Work Registry, which provides a repository for social workers' credential information while serving as a verification source for social work licensing boards – the Registry enables a social worker to establish a permanent file containing primary source records important to their social work career; at the social worker's request, this information can be transmitted to any regulatory board to which they may apply for licensure.
- owns and maintains the social work licensing examinations that are used to test a social worker's competence to practise ethically and safely; the Examination Committee meets up to four times a year to review questions for the exams; exams are administered throughout the year at secure test centres in North America and abroad.
- provides resource documents, regulatory research, and specialised training to help member boards carry out the mission of public protection.
- provides other services to member boards, including the "Approved Continuing Education program"; exam pre-approvals, licence application processing, and CE audits; the "Public Protection Database"; and "Look Up a License".

Comparative complaints data

The websites of other regulators provide a useful source of data on the nature of the risks associated with social work practice, compared with the practice of other related health professions, such as psychologists and occupational therapists.

Attachment 13 provides complaint-handling and disciplinary data from two regulators – the UK Health and Care Professions Council (HCPC) and the New York State Education Department's Office of the Professions (NYSED).

This data allows comparisons to be drawn between the complaint/notification rates of three professions: social workers, psychologists and occupational therapists. In each jurisdiction, both the rate of complaints and the rate of disciplinary actions are substantially higher for the social work profession than for psychology or occupational therapy.

4. SOME MYTHS ABOUT REGISTRATION OF SOCIAL WORKERS

This section sets out some of the myths about regulation of social workers that we have heard from time to time from government officials and politicians but less often from members of the community or social workers.

Myth 1: Social workers practise in many areas beyond health, which is sometimes used to argue that they should not be regulated by a health body such as the Australian Health Practitioner Regulation Agency.

In 2016, the AASW's submission requesting the inclusion of social work as a regulated health profession under the NRAS was subject to assessment by governments against the AHMAC criteria (2018). We received no formal advice on the outcome of this assessment or reasons for the decision taken – to refuse the AASW request. However, we understand that the application stumbled at the first hurdle – that Health Ministers accepted advice from their senior government officials (AHMAC), concluding that regulation of the social work profession was not the responsibility of Health Ministers.

However, this decision, and the advice on which it was based, was flawed.

Social work is defined as a health service under multiple federal, state and territory laws. Social workers are defined as health professionals under the *Occupation Standard Classification for Australia* (2024).

While it is true that social workers work in a variety of settings and sectors, not just in health, the largest proportion of the social work workforce does, in fact, work in healthcare. This is no different to the professions of psychology and occupational therapy, both of which are regulated health professions under the NRAS but whose members work in multiple sectors, including disability, community services and education.

Myth 2: Regulation isn't necessary because social work practice is low risk and self-regulation is already working just fine

Social work practice is not low risk. Social workers work with the most vulnerable and at-risk people in our communities. They often work alone and unsupervised. They deal with people who are often in crisis, suffering trauma, drug and alcohol addiction, family violence and/or mental health challenges.

We know from successive coronial inquiry reports, royal commissions, and parliamentary committee inquiries that repeated failures of social work practice have occurred, some of which are detailed in this submission. While the risk profile of the social work profession is far higher than most of the professions already regulated under the NRAS, many of the failures documented would be preventable with proper regulation of the education and practice of social workers.

Myth 3: Regulation isn't necessary because it's easy to identify who is a social worker, and there are nationally uniform standards already in place for social workers

We know from the findings of successive studies that it is not easy to identify whether a person using the title "social worker" or employed in a position under that title is, in fact, a qualified social worker. Service users often do not know whether their social worker is qualified.

We also know that some employers on occasion may employ workers without social work qualifications in positions with the job title of "social worker". While such employer actions may be in response to workforce shortages, they should be aware that their unqualified or underqualified employee may inadvertently be breaching a state or territory statutory Code of Conduct, all of which state:

A health care worker must not engage in any form of misinformation or misrepresentation in relation to the products or services he or she provides or the qualifications, training or professional affiliations he or she holds[66]

There are cases of social workers who have done things that should have disqualified them from practice; however, they continue to practise the profession and use the title.

The AASW has indeed worked hard over many decades to establish national standards for the training and practice of social workers. However, without the legal protections afforded by statutory registration (specifically title protection, monitoring powers and enforceable disciplinary sanctions), there is nothing to prevent an unqualified or underqualified person from calling themselves a social worker or from continuing to practise despite AASW disciplinary action.

While the AASW provides a publicly searchable register of social workers, less than 40% of the profession are members of the AASW, and many choose not to publish their details on the AASW register.

Myth 4: Regulation isn't necessary because social workers work primarily in public sector services where governance and standards are generally strong

While a large proportion of social workers work in government and government-funded not-for-profit services, the profile of the profession is changing. There are increasing numbers of social workers who are choosing to work in private practice, where clinical governance and oversight of practice standards may be limited or non-existent.

Also, despite the oversight and supervision of professional practice in public sector agencies, there are still social workers who do the wrong thing, and there is nothing to prevent a social worker from leaving one workplace to avoid disciplinary action and taking a job elsewhere, without sanction or scrutiny. This submission documents such cases.

We also know from parliamentary inquiries, royal commissions, and coronial inquiry reports that many publicly funded services are stretched, and the level of oversight and supervision provided to and by social workers is at times less than satisfactory. This has led to critical failures.

Myth 5: There aren't many complaints against social workers, so why is registration necessary? Isn't it overkill?

Complaints about health practitioners generate important information for the health services and the health system. Such complaints have been described as "the canary in the coal mine" – an early warning that all is not right. Sometimes a single complaint can reveal systemic problems and uncover broader clinical governance failures.

It is not possible to tell what the base rate of complaints about social workers is due to the fragmented arrangements for dealing with complaints, the multiple actors involved (HCEs, funders and insurers, employers, the police, the courts and the AASW) and the generally poor level of reporting by complaints bodies such as HCEs. If a service user is facing a crisis (such as homelessness, mental health, family violence, etc), they are unlikely to know or even ask whether their worker is a social worker, let alone know how to navigate the complex array of complaint-handling bodies to find the right place to complain. Highly vulnerable service users are always under-represented in complaints data.

What we do know from AASW complaints data is that although complaint numbers are rising, there is likely to be a significant level of under-reporting of social worker misconduct. This is because:

[66] See Clause 9 of the National Code of Conduct for health care workers; Clause 11 of the ACT Code of Conduct for Health Care Workers; Clause 10 of the NSW Code of Conduct for non-registered health practitioners; Clause 11 of the South Australian Code of Conduct for Certain Health Care Workers; Schedule 1 Clause 9 of the Tasmanian Health Complaints (Code of Conduct) Regulations 2024 (not yet commenced); Clause 9 of the Victorian General code of conduct in respect of general health services; Clause 9 of the Western Australian Code of Conduct for Certain Health Care Workers

- The majority of complaints received by the AASW relate to social workers who are not members, and therefore, there is no disciplinary action the AASW can take.
- Complaints data from HCEs in most cases does not identify, distinguish and report separately complaints data about those working as counsellors who are also social workers.
- Cases of serious misconduct have led to prohibition orders issued against social workers, but the published order and other information do not identify the fact that they are social workers (see section 5).
- For registered practitioners, research suggests the rate of complaints about practitioners who provide mental health services (as social workers do) is almost double the complaint rate for those who provide "physical services" (Veness et al., 2019; Hutchinson Mittendorf & Schroeder, 2004).
- While coronial inquiry reports and parliamentary inquiries have raised serious concerns about some social workers and social work practice more broadly, mostly the problems fly under the radar and do not come to public attention.

Myth 6: The AASW is only pushing statutory registration to increase the recognition and status of the profession, not to benefit service users

The assessment process established by governments to determine whether to expand the NRAS to include another profession is initiated by an application from a professional body external to government (see AHMAC, 2018).

The AASW has been asking governments to establish statutory registration for social workers since at least the 1960s, not because it is in the interests of the profession, but because we believe that it is in the broader public interest and that the benefits to our patients, service users and the community outweigh the costs. There is no other effective way of achieving these benefits.

The risk of harm associated with misconduct and poor practice by social workers is well documented in coronial inquiry reports, royal commissions and in complaints data held by the AASW and by HCEs. Statutory registration is a crucial and effective way of lifting standards of social work practice, dealing with misconduct and providing stronger powers and sanctions that are just not available to the AASW under the self-regulatory arrangements.

It is not necessarily in the interests of the AASW to push for statutory registration of the profession, because if social work becomes a registered health profession, some social workers may decide they can no longer afford to maintain their membership of the AASW while prioritising the payment of their registration fees.

If and when national registration is introduced for social workers, the AASW will have to work doubly hard to ensure that the benefits of membership are clear and that social workers choose to maintain both registration and membership of the AASW.

Myth 7: Registration will make things worse, not better, particularly with workforce shortages in rural and remote areas

It is true that there is a shortage of social workers, and not only in rural areas. However, we understand that there is no evidence to suggest that the introduction of registration for a profession adversely affects workforce supply. In fact, the opposite may be true – when governments are able to access more robust workforce data (such as that generated from the Ahpra registration system), they are in a better position to address workforce supply challenges.

Recent examples include the occupational therapy and medical radiation professions (where national registration commenced in 2012) and the paramedicine profession (where national registration commenced in 2018). Data published in the annual reports of Ahpra and the National Boards shows that these additional professions brought into the Scheme have experienced strong growth. National Boards are far better positioned than professional associations to support government workforce

strategies aimed at improving workforce supply and distribution, as well as enhancing service provision in rural and remote areas.

Myth 8: Registration won't solve the problem of lack of resources – it's not a magic bullet

It is true that statutory registration of the social work profession will not solve the resourcing and recruitment problems that many employers face. However, registration of social workers should improve the trust and confidence of the community and service users, provide more effective mechanisms for assuring the quality, safety, and effectiveness of social work services, and provide more effective levers to enable better workforce planning and development. It may also attract more students who are looking to choose a career in a well-respected and well-regulated profession.

Myth 9: Why register yet another profession with Ahpra? Won't this just add to the complexity of the scheme?

It is true that the National Scheme is large and, in some ways, complex and that a review of its complexity is currently underway.[67] However, it is less complex than the arrangements currently in place for assuring the quality and safety of the social work profession. Literally thousands of separate agencies and individuals – funders, employers, government departments, regulators and service users – are all individually responsible for checking the qualifications and probity of the social workers they engage, monitoring the adequacy of their practice and dealing with any complaints.

As a regulator, from the outside, the NRAS may look complex. However, prior to 2010, when the NRAS was established, there were over 90 separately constituted profession-specific regulators across the country under 38 separate administrations, and each was duplicating functions and reinventing the wheel. Consolidation of these arrangements in the form of the NRAS has:

- relieved the quality assurance burden on government agencies, funders, employers and service users
- improved the efficiency of registration functions and considerably increased the capability of the regulatory system
- provided the important consolidated data that governments and service providers need to enable effective workforce planning and health service improvement.

As we understand it, the governance arrangements for the National Scheme ensure the necessary profession-specific input into standard setting and administration of regulation. The NRAS regulators already report to multiple Ministers and Governments and have established streamlined arrangements for doing so.

Some members may be concerned that the NRAS has occasionally received negative press. While the media has a role to play in alerting us to potential regulatory failures, it is a tough job being a regulator and even in the best-run systems, things will go wrong occasionally. The evidence suggests the National Scheme has matured in recent years, and many of the early establishment and teething problems have been addressed.

We have considered the pros and cons of other models. For instance, one alternative would be to establish eight separate state/territory-based registration schemes, with arrangements for mutual recognition of standards and registration across state and territory borders. We consider this would be a backward step. It is an approach that history shows has failed to deliver, not least because those who wish to work across state borders would have to register multiple times, with multiple regulators and understand and meet their professional obligations under multiple registration laws.

[67] See the Independent Review of complexity in the National Registration and Accreditation Scheme: https://www.health.gov.au/our-work/independent-review-of-complexity-in-the-national-registration-and-accreditation-scheme

Another alternative would be to establish a separately constituted Social Worker Registration Board of Australia, operating under its own administration and reporting directly to multiple state, territory, and Australian government ministers (for health, mental health, family violence, disability, veterans' affairs, etc.). This is also a model that has failed to deliver the economies of scale necessary to support best practice regulation and perpetuates professional silos, doing little to facilitate interdisciplinary practice.

We believe the advantages of extending the scope of the existing national registration system (NRAS) to include social workers far outweigh those of alternative models.

Myth 10: Why pursue national registration now when South Australia can pilot and test the model?

The introduction of registration for social workers in South Australia (SA), while not yet commenced, raises many complexities and challenging issues that will take time to resolve. Implementing statutory registration in a single jurisdiction creates risks for the SA Government, the health and community services workforce and the community. While the SA Government is to be applauded for its decision to press ahead and regulate social workers, after being turned away by other jurisdictions, it is an unreasonable impost that sees other Health Ministers neglect their responsibilities.

The development and implementation of a registration scheme is a complex and expensive exercise. It is unfair for this burden to be borne by just one jurisdiction – South Australia. It is now urgent that Health Ministers revisit their 2016 decision and fix this problem.

The AASW also has some concerns that the model that has been legislated and is being implemented in South Australia may introduce unnecessary complexities and challenges, particularly around defining what is social work and social work practice, and the extent to which the broader social welfare workforce is to be caught up in efforts by the regulator to define and control social work scope of practice. In our view, it would be far better to apply the standard NRAS model and bring the social work profession into national registration rather than a piecemeal state-by-state approach. The latter approach has been shown to be flawed for other health professions (Australian Government Productivity Commission, 2005); therefore, it is unlikely to work well for the social work profession.

5. ASSESSMENT OF THE SOCIAL WORK PROFESSION AGAINST THE AUSTRALIAN HEALTH MINISTER'S ADVISORY COUNCIL (AHMAC) CRITERIA

This section presents an assessment of the social work profession against the nationally agreed government criteria for inclusion of additional professions in the NRAS (the AHMAC criteria).

Criterion 1 – Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation fall more appropriately within the domain of another Ministry?

Social work is the largest allied health profession in Australia (Australian Government Department of Health, 2022). While social workers work in multiple service sectors, responsibility for policy decisions concerning occupational regulation of the social work profession properly sits within the health portfolio, with State, Territory and Commonwealth Health Ministers. This is because, regardless of where social workers work or what their role is, social work is principally a health profession. Our reasons are set out below.

First, social workers are classified as "health professionals" under the Australian Bureau of Statistics (ABS) *Occupation Standard Classification for Australia* (OSCA) as follows:

Major group 2 – Professionals

> ***Sub-major group 26 –*** Health Professionals
>
> > ***Minor group 261 –*** Allied Health Counselling, Psychology, Social Work and other Creative Therapy Professionals
> >
> > > ***Occupation 2613 –*** Social Worker.

See Textbox 2.2 for further details of the definition of social worker.

Social workers are NOT categorised in *Sub-major group 41: Community and Personal Service Workers*, which includes the following minor groups:

41 Community and Welfare Support Workers

42 Aged Care and Disability Services and Support Workers

43 Early Childhood Educators, Child Carers and Education Assistants

44 Health Support Workers and Assistants.

Second, the services provided by social workers are defined as "health services" under various statutory definitions in key Australian laws.

For instance, the definition of "health service" contained in Section 5 of the *Health Practitioner Regulation National Law* (as applied in every Australian state and territory) lists the services provided by social workers – see paragraph (i) in Textbox 5.1.

Textbox 5.1: Health Practitioner Regulation National Law Act definition of "health service"

Section 5:

health service includes the following services, whether provided as public or private services:

a) services provided by registered health practitioners;
b) hospital services;
c) mental health services;
d) pharmaceutical services;
e) ambulance services;
f) community health services;
g) health education services;
h) welfare services necessary to implement any services referred to in paragraphs (a) to (g);
i) services provided by dietitians, masseurs, naturopaths, **social workers**, speech pathologists, audiologists or audiometrists;
j) pathology services.

Source: Health Practitioner Regulation National Law – see https://www.ahpra.gov.au/About-Ahpra/What-We-Do/National-Law.aspx

Similarly, the statutory definitions of "health service" that are contained in health complaints legislation in states and territories capture social work services, and HCEs routinely handle consumer complaints about social workers in each and every state and territory. For example, the Queensland Health Ombudsman has confirmed that:

- Social workers can be considered as providing a health service or support service to a health service as defined in section 7 of the *Health Ombudsman Act 2013* (Qld).
- In cases where a social worker is providing a health service, they must comply with the *National Code of Conduct for Health Care Workers (Queensland)*.
- The Health Ombudsman can receive and manage complaints about social workers and social work services in various ways, including assessment, investigation, local resolution and conciliation (Queensland Health Ombudsman 2024: 1-2).

Third, the Australian Government Department of Health classifies social work as an "allied health profession", with workforce estimates indicating social work is the largest of the allied health professions (Australian Government Department of Health 2022). While the available workforce data is limited (due to the lack of an effective mechanism for routine data collection), it does suggest that the largest proportion of the social worker workforce comprises those working in health and mental health (AASW membership data 2024).

Fourth, the fact that some social workers work in sectors other than health is no different to other regulated health professions. While many social workers work in disability services, child protection, and family support, they do so alongside other registered health practitioners, particularly psychologists, nurses, and occupational therapists (all registered under the NRAS), who work in the same range of sectors and settings as social workers.

For instance, workforce data supplied by the federal Department of Health estimates that 23% of occupational therapists and 27% of psychologists work in sectors other than health (Australian Government Department of Health 2022: 77)

Like psychologists and occupational therapists, social workers work with the same vulnerable service users, on the same multidisciplinary teams. They work as sole traders in private practice, providing the same types of Medicare-funded mental health services as psychologists. They work alongside occupational therapists in disability services.

Regardless of where registered health practitioners work, Health Ministers must exercise regulatory policy responsibility in conjunction with many other ministers who have overlapping portfolios. For example:

- Registered nurses who work in aged care facilities sit within the portfolio of the federal Minister for Aged Care.
- Registered occupational therapists who work in veteran services sit within the portfolio of the Minister for Veterans Affairs.
- Registered nurses, physiotherapists, and occupational therapists who work in disability services sit within the portfolios of multiple Ministers for Disability.
- Registered nurses, psychologists, and psychiatrists who work in Child and Adolescent Mental Health Services (CAMHS) sit within the portfolios of multiple Ministers for Mental Health.
- Registered psychologists who work in correctional services sit within the portfolios of multiple Ministers for Corrections.

As it is appropriate for Health Ministers to oversee occupational regulation of the professions of psychology and occupational therapy, so too is it appropriate for Health Ministers to oversee occupational regulation for the social work profession.

Fifth, internationally, there are many examples where the social worker profession is regulated under the health portfolio, including in the US, Canada and the United Kingdom.[68]

For example, the Alberta College of Social Workers (ACSW) serves as the regulatory College for the profession of social work in Alberta. ACSW's mandate and purpose are legislated by the *Health Professions Act* (HPA), which sets out the authority and regulatory duty of the College.

Similarly, the US State Texas State Board of Social Worker Examiners (TSBSWE) regulates social workers in Texas. The TSBSWE is a state agency that is part of the Texas Department of State Health Services.

In the UK, the question of whether a profession is or is not a health profession is irrelevant – the UK Health and Care Professions Council regulates 16 "health and care professions" under the *Health Professions Order* which, between 2010 and 2019, included social workers in England.

Sixth, regardless of where social workers work, what they do, or the tasks they perform every day, their goal is to intervene and improve the social determinants of health and wellbeing (SDH) to enhance the health of individuals and populations.

In defining "health" as "a state of complete physical, mental, and social well-being" (WHO 1946), the World Health Organization (WHO) recognises that health is broader than simply being free of disease. Instead, the WHO emphasises the importance of the social determinants of health – see Textbox 5.2.

We know that the rates of physical and mental ill-health are significantly higher for people who receive services from or interact with systems such as child protection, housing and homelessness, the justice system, drug and alcohol services etc – see Attachment 14.

It is unsustainable for Health Ministers to maintain the position that a profession whose principal service delivery role is to intervene to influence the social determinants of health is NOT a health profession.

Textbox 5.2: The social determinants of health – World Health Organization

The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

[68] See *Attachment 5: Occupational Regulation of Social Workers by jurisdiction*

The SDH have an important influence on health inequities – the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways:

- *Income and social protection*
- *Education*
- *Unemployment and job insecurity*
- *Working life conditions*
- *Food insecurity*
- *Housing, basic amenities and the environment*
- *Early childhood development*
- *Social inclusion and non-discrimination*
- *Structural conflict*
- *Access to affordable health services of decent quality.*

Research shows that the social determinants can be more important than health care or lifestyle choices in influencing health. For example, numerous studies suggest that SDH account for between 30–55% of health outcomes. In addition, estimates show that the contribution of sectors outside health to population health outcomes exceeds the contribution from the health sector. Addressing the SDH appropriately is fundamental for improving health and reducing longstanding inequities in health, which requires action by all sectors and civil society.

Source: World Health Organization website: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Finally, if governments are to make progress in addressing health inequalities, then a systems approach is required, one that:

- acknowledges the shared responsibilities that cross ministerial portfolios (health, community services, aged care, disability) and
- provides stronger regulatory stewardship and facilitates "joined up" government.

To date, Health Ministers and their departments have been able to ignore or shirk their responsibilities regarding decisions about the occupational regulation of the social work profession. However, shared responsibilities with other Ministerial portfolios should not prevent Health Ministers from taking the lead to ensure appropriate regulatory policy is in place.

It is no longer acceptable for governments to buck pass by claiming that the services provided by social workers are not "health services". Arbitrary divisions based on bureaucratic structures rather than community needs cannot be used as an excuse to do nothing.

Other jurisdictions have addressed these issues – see the UK Health and Care Professions Council and Ireland's Health and Care Professionals Council, both multi-profession regulators. While the name of the regulator is not important, public protection is critical.

Invariably, when asked about registration of social workers, members of the public know the right answer – surveys of public views and attitudes show that members of the public express surprise when they discover that social workers are not registered like other health professions (CHC 2011; University of Canberra 2024).[69]

[69] See for example The views of Australians regarding regulatory requirements of counsellors and qualified therapists: A summary paper of research conducted by Roy Morgan on behalf of the Australian Association of Social Workers. Craig Hodges Consulting (CHC) October 2011.

At a minimum, state, territory and federal ministers should agree on which portfolio has lead responsibility for the purposes of regulatory policy (and explain to the public and the profession that if social work is not about health, then why not?). To do nothing and continue to deny that social work is a health profession fails the "pub test".

To conclude, it is appropriate for Health Ministers to regulate the profession as the majority of social workers work in health and mental health related roles, social work is defined as a health profession under multiple government regulations and policies, and while social workers work across multiple portfolios, there is no other ministerial portfolio that is more appropriate to take primary responsibility for regulatory policy.

Conclusion regarding Criterion 1:

It is **appropriate for Health Ministers to exercise responsibility** for regulating the social work profession. Regulatory policy responsibility for social workers sits principally within the scope of the health portfolio. It does not more appropriately sit within the domain of any other Ministry.

Social work is first and foremost a health profession:

- A majority of members of the social work profession work in health settings, providing "health services" in hospitals and mental health services.
- Social work is classified as a health profession under the Australian Bureau of Statistics *Occupational Standard Classification for Australia* (OSCA) (formerly the ANZSCO).
- Social work is classified as a health profession under the International Labour Organization's *International Standard Classification of Occupations*.
- Social work is a regulated profession in every other country that has a similar regulatory system to Australia, including Canada, New Zealand, the United Kingdom and the USA.
- Regardless of where they work, what social workers do falls within the various statutory definitions of "health service" contained in Australian state and territory laws, including the *Health Practitioner Regulation National Law* and health complaint laws.
- The services provided by social workers are funded under Medicare and private health insurers.
- While social workers also work in disability and community services, they work in multidisciplinary teams, side by side with their colleagues from the registered health professions, such as psychology and occupational therapy.
- Social workers who are employed in sectors beyond health are, nevertheless, intervening principally to improve the social determinants of health for individuals and populations, that is, to reduce health inequalities and improve health and wellbeing.

Although Ministers from various portfolios have a role and an interest in the work of social workers, the majority of social workers are employed in the health sector or deliver health-related services in other settings. As such, Health Ministers hold primary responsibility for overseeing the occupational regulation of social workers. This responsibility obliges Ministers to adopt a system-wide perspective – one that recognises the social determinants of health and supports greater integration between health and social care systems.

Integrated occupational regulation is a key mechanism for achieving this goal. Occupational regulation under the NRAS will provide critical tools needed to facilitate collaborative team-based care and interprofessional practice, both within and between the health and community care sectors.

Criterion 2: Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?

Social workers work principally with vulnerable people, often in high-risk environments and during periods of crisis. It is demanding, morally complex and taxing work. There is little margin for error in settings in which violence, abuse and neglect are commonplace.

The vulnerability of service users is significant, and any malpractice or other practice failure can have profound and long-term impacts on the lives of children and young people, families and communities.

Unfortunately, there is considerable evidence of misconduct, ethical breaches and poor social work practice, from sources such as:

- complaints to state and territory HCEs
- coronial inquiries into deaths where there is social worker involvement
- Royal Commission reports examining systemic failures
- complaints dealt with under the AASW Ethics and Complaints Management Process
- evidence of harm from regulators of the social work profession in other countries.

Assessing the risk profile of the social work profession

Table 8 compares the risk profile of the social work profession with those of the 16 NRAS regulated health professions, using a tool that governments have used previously in assessing the risk profiles of professions for entry to the NRAS (COAG Health Council 2015; AHMAC 2015).[70] The tool lists 13 "high risk activities" and shows which professions carry out these activities as part of their usual scope of practice. This comparative assessment shows the following:

First, the scope of practice of social workers includes three out of the 13 high-risk activities identified in the tool – the same number as some of the NRAS-regulated health professions, notably psychologists, pharmacists and optometrists. They are:

> *High-risk activity 9:* Undertaking psychological interventions to treat serious disorders or with potential for harm
>
> *High-risk activity 11:* Primary care practitioners who see patients with or without a referral from a registered practitioner
>
> *High-risk activity 12:* Treatment commonly occurs without others present.

The same three high-risk activities listed above are part of the scope of practice of psychologists (a registered health profession).

Second, like psychologists, while the overall number of high-risk activities associated with social work practice is comparatively low, a simple rating scale such as this fails to capture the scale of the risks involved adequately. This is because the tool:

- does not include a rating of the extent to which these high-risk activities constitute part or all of the routine practice of members of a profession or occupation
- does not take account of the extent to which social workers engage with service users who are extremely vulnerable – this generally constitutes the entire practice of most social workers, not just a part of their practice as for other regulated health professions
- fails to include as "risky activities" the various statutory roles that social workers carry out, some of which involve the use of coercive powers (for example, in mental health and child protection), or take account of the verbal and physical abuse that social workers may face from time to time as they carry out their duties
- fails to factor in the impact of changes in the context of practice of social workers, particularly the growing private practice workforce, where the risks of professional misconduct are likely to be greater

[70] This assessment tool draws from the list of "controlled acts" that underpin regulation of the health professions under the Ontario Regulated Health Professions Act 1991.

- fails to take account of the extent to which many services and service sectors rely on the leadership and supervisory roles and skills of social workers, and how these roles have been implicated in some serious practice failures
- fails to give sufficient weight to the social determinants of health and therefore the role of professions such as social work in addressing these.

Table 8: Assessment of the NRAS professions and the social work profession against 13 high-risk activities or procedures

	REGULATED															UNREGULATED	
	ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONERS	CHINESE MEDICINE PRACTITIONERS	CHIROPRACTORS	DENTAL PRACTITIONERS	MEDICAL PRACTITIONERS	MEDICAL RADIATION PRACTITIONERS	NURSES AND MIDWIVES	OPTOMETRISTS	OCCUPATIONAL THERAPISTS	OSTEOPATHS	PARAMEDICS	PHARMACISTS [v]	PHYSIOTHERAPISTS	PODIATRISTS	PSYCHOLOGISTS	SOCIAL WORKERS
1. Putting an instrument, hand or finger into a body cavity[i]	X	X		X	X		X				X		X			
2. Manipulation of the spine[ii]		X	X		X					X			X			
3. Application of a hazardous form of energy[iii] radiation				X	X	X	X		X				X			
4. Procedures below dermis, mucous membrane, in or below surface of cornea or teeth	X	X		X	X	X	X				X			X		
5. Prescribing a scheduled drug (incl. compounding), supervising that part of a pharmacy that dispenses scheduled drugs	X	X		X	X		X	X			X	X		X		
6. Administering a scheduled drug or substance by injection	X	X		X	X	X	X				X			X		
7. Supplying substances for ingestion	X	X			X		X				X	X				
8. Managing labour or delivering a baby		X			X		X				X					

9. Undertaking psychological interventions to treat serious disorders or with potential for harm					X		X				X				X	X
10. Setting or casting a fracture of a bone or reducing dislocation of a joint					X											
11. Primary care practitioners who see patients with or without a referral from a registered practitioner	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
12. Treatment commonly occurs without others present[iv]	X	X	X		X	X	X	X	X	X	X		X	X	X	X
13. Patients commonly required to disrobe	X	X	X		X	X	X		X	X	X		X			
TOTAL risk factors per profession	**9**	**10**	**4**	**6**	**14**	**6**	**11**	**3**	**4**	**4**	**10**	**3**	**6**	**5**	**3**	**3**

Notes

i. Beyond the external ear canal, beyond the point in the nasal passages where they normally narrow, beyond the larynx, beyond the opening of the urethra, beyond the labia majora, beyond the anal verge, or into an artificial opening in the body

ii. Moving the joints of the cervical spine beyond the individual's usual physiological range of motion using a high velocity, low amplitude thrust

iii. Electricity for aversive conditioning, cardiac pacemaker therapy, cardioversion, defibrillation, electrocoagulation, electroconvulsive shock therapy, electromyography, fulguration, nerve conduction studies or transcutaneous cardiac pacing, low frequency electromagnetic waves/fields for magnetic resonance imaging and high frequency soundwaves for diagnostic ultrasound or lithotripsy

iv. Includes practitioners who practise solo or treat with no others present, such as medical specialists and practitioners who may be solely responsible for clinical care overnight or in a remote community

v. Paramedics included as per indicative assessment made in *Final report: Options for regulation of paramedics* (2016)

Source: Modified from AHMAC 2015: 110–1.

The literature provides extensive references on the risks associated with social work practice. An overview of these risks is set out in Table 9.

These are not just theoretical risks. Attachment 15 provides case examples of where these risks have been realised in practice in Australia.

Table 9: Overview of main risks to public health and safety associated with social work practice

Risks associated with the incompetence or ethical misconduct of the practitioner	
TYPE OF RISK	**DESCRIPTION/EXAMPLES**
Incompetent or inappropriate clinical treatment	Failure to provide competent clinical treatment or counselling services, such as failure to recognise the limits of one's skills and knowledge; failure to refer on appropriately or to seek assistance in setting professional therapeutic boundaries with clients
Inappropriate exercise of statutory powers	Failure to exercise powers of psychiatric assessment orders in state and territory mental health laws, protective orders under child protection laws, and restrictive practices under disability legislation in a competent or responsible manner
Lack of informed consent	Failure to obtain informed consent for the provision of services or treatment
Sexual misconduct	Inappropriate "consensual" sexual relationship with a service user and/or their carer; non-consensual sexual contact or harassment of a service user; inappropriate questioning, touching or relationships of a sexual nature with children or adults
Inappropriate relationship with service user	Poor understanding of professional boundaries; engaging in relationships that result in emotional, physical and fiscal harm to a service user; exploitation or manipulating power dynamics between worker and service user
Financial exploitation of service user	Taking advantage of a service user by overcharging services; providing services for financial gain rather than need; or otherwise financially exploiting or stealing from service users
Fraudulent billing of insurance provider	Submitting fraudulent bills to third party payer – public or private health insurance provider – Medicare, private health funds, traffic accident or workers compensation or NDIS
Holding out as qualified social worker	Use of the title "social worker" without holding a recognised or AASW-approved social work qualification; pretending or "holding out" to be qualified as a social worker when not; misrepresenting welfare or counselling qualifications as social work qualifications
Undermining public health messaging	Failure to follow public health guidelines in assessment and treatment of a service user; giving a service user advice that is contrary to or inconsistent with that provided by health officials; for instance, discouraging a service user from vaccinating themselves, their children and family members
Risks associated with the context of the practice of social workers	

Increased vulnerability of service users	Social workers spend most of their time working with the most marginalised, disadvantaged and vulnerable people in communities – those in crisis, those with mental health issues, suffering poor physical health and emotional trauma, family breakdown, domestic violence, homelessness, refugees, victims of crime, etc.
Exercise of statutory powers, including coercive powers	Social workers exercise powers of psychiatric assessment orders in state and territory mental health laws, protective orders under child protection laws, and restrictive practices under disability legislation.
Supervisory and management roles	Social workers in leadership or management positions are responsible for the supervision of staff working in direct service roles with vulnerable individuals, groups and communities.
Solo and self-employed practice	Solo practice increases the risk of all previously detailed risks – ineffective treatment, over/underservicing, financial or other exploitation, risk of not maintaining boundaries with service users; a provider who is a sole practitioner in private practice, with limited peer engagement or oversight with potentially no connection with a professional association through which their practice knowledge and skills is maintained and assured (NSW HCCC, 2019, 33); practitioners may work alone with few if any opportunities to discuss patient cases with peers, discuss difficult-to-treat cases or consider other modes of treatment or referral (ANC 2025: 42).

Source: Adapted from ANC 2025: 42

These risks are detailed further below.

Risks associated with the increased vulnerability of service users

As outlined earlier, social workers work with the most marginalised, disadvantaged and vulnerable people in our communities. Service users may be people and communities who are:

- in a crisis (such as experiencing abuse and violence within a family)
- experiencing trauma from previous events (such as sexual abuse, family violence) or intergenerational trauma (such as from dispossession)
- experiencing major life transitions and changes (such as a person who becomes profoundly disabled and is facing a substantial life change)
- not empowered to voice their rights (and therefore require support in advocacy), or
- not equipped to navigate overwhelmingly incapacitating systems, relationships and circumstances.

These are people who are often overwhelmed by the past experiences in their lives and current circumstances and events that they are powerless to control. The problems may be intractable because they are persistent and/or unexpected, and they severely impact the people involved. Recent traumas may exacerbate the impact of past experiences and intergenerational trauma. This combination of circumstances may increase susceptibility to abusive relationships and sexual or financial predators.

The proportion of time that social workers spend with vulnerable service users is substantial – see Textbox 5.3 and Figure 5.

Additionally, there is a significant power imbalance in the relationship between the social worker and the service user, as the social worker typically holds important knowledge and authority, acts as a gatekeeper to necessary resources, and possesses personal information about the service user that the service user does not have about the social worker.

Textbox 5.3: Data on time spent by social workers with vulnerable service users

Medicare – Social workers provided more than 400,000 occasions of Medicare-funded services each year for the years 2019/20 to 2023/24 (see Figure 6).[71] These services were under programs including Better Access to Mental Health Initiative; Mental health services under the Chronic Disease Management Program; Non-Directive Pregnancy Counselling Service; Allied Health Services to First Nations Australians; and Psychological treatment services under the Eating Disorders program.

Disability – For the period April to June 2024, more than 23,000 NDIS participants received services from a social worker.[72] The type of services supplied by social workers to participants include therapeutic supports (individual and group); early intervention supports for early childhood; behaviour support (including assessment and development of support plans); assistance in coordinating or managing life stages, transitions and supports; assistance to access and maintain employment or higher education; assistance with obtaining or retaining accommodation and tenancy; group and centre-based activities; and support coordination.

Community services – Social workers make up an unspecified but sizeable portion of Australia's welfare workforce (662,542 workers in 2022).[73] Specifically, social workers (with occupations including Counsellors, Enrolled and Mothercraft Nurses, Psychologists, Welfare, Recreation and Community Arts Workers, and Other Community Service Occupations) comprised 12% of the welfare workforce in 2022.[74] While it is not known the proportion of time a social worker spends on direct services in the welfare sector in Australia, in England, a survey found that 74% of social workers surveyed spent up to 25% of their time on frontline services, while a further 25% of respondents stated they spent between 26 and 75% of their time on frontline services.[75]

[71] Source: Data extracted from Services Australia Medicare Item Reports (Australian Government) on 28 August 2024 for the years 2019/20 to 2023/24 for the MBS Item Numbers listed below. Website: http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp
MBS item numbers: 10956, 10957, 80150, 80151, 80154, 80155, 80156, 80160, 80161, 80162, 80165, 80166, 80170, 80171, 80172, 80173, 80174, 80175, 80176, 80177, 80178, 81005, 81325, 82001, 82002, 82003, 82376, 82378, 82379, 82380, 82381, 82382, 82383, 91175, 91176, 91187, 91188, 91196, 91197, 91204, 91205, 93000, 93013, 93026, 93029, 93048, 93061, 93100, 93103, 93134, 93137
[72] Source: Data extracted from NDIS Average Support Line Payment data downloads on 16 September 2024 for the June 2024 quarter for the item numbers listed below. Website: https://dataresearch.ndis.gov.au/datasets/payments-datasets.
NDIS Item Number: 15_621_0128_1_3.
Note other applicable item numbers are: 15_005_0018_1_3 and 07_004_0132_8_3. However, these item numbers are used by allied health professionals (including social workers).
[73] Source: Australian Institute of Health and Welfare (2023). Welfare workforce. Australian Government (7 September 2023). https://www.aihw.gov.au/reports/australias-welfare/welfare-workforce (3 September 2024).
[74] Ibid.
[75] YouGov (2020). *A report on the social work profession: For Social Work England*. Pg 39. June 2020. https://www.socialworkengland.org.uk/media/3326/yougov-the-social-work-profession.pdf (5 September 2024)

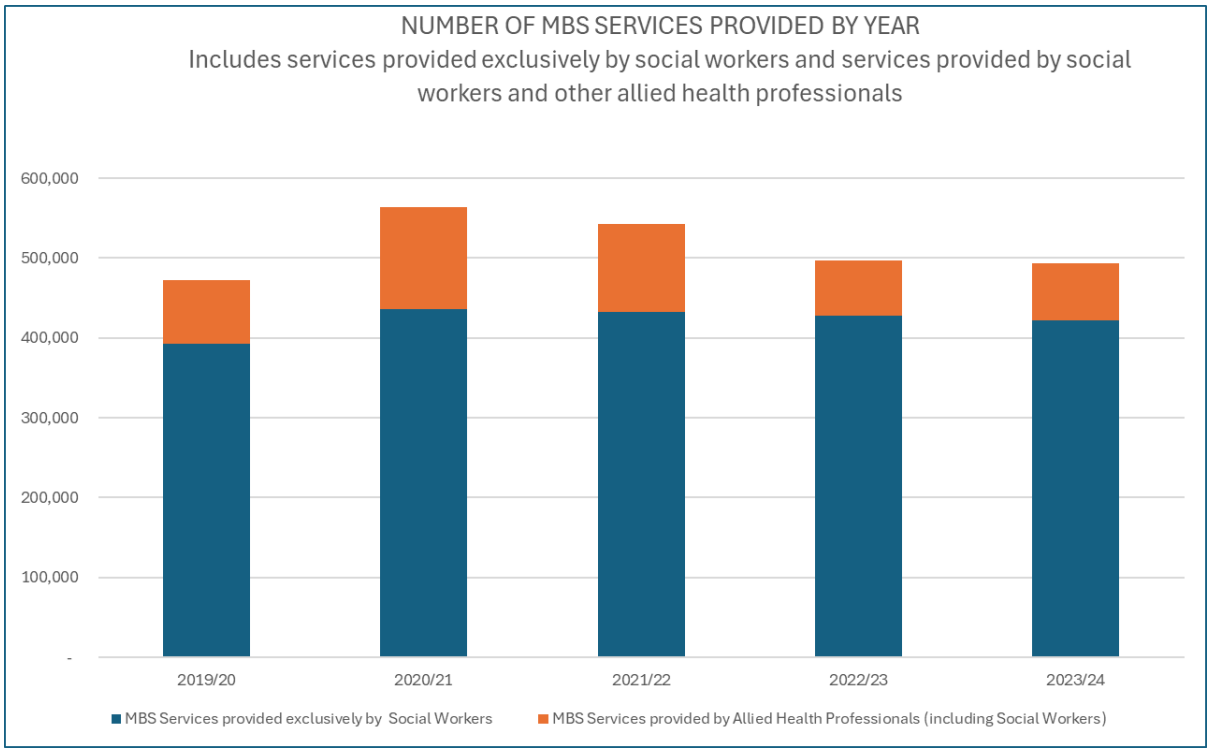

Figure 5: MBS services by year for MBS items that are used exclusively by social workers and MBS item numbers used by allied health professionals (including social workers)

Any harms inflicted through neglect, poor performance or wilful misconduct is abhorrent. In cases of misconduct by a social worker (particularly professional boundary violations), there may be misplaced trust and emotional dependency on the social worker, which can make a service user reluctant to say "no" and may raise experiences related to earlier traumas.[76]

The impact of social worker misconduct on a service user is likely to be serious, and may include:

- increased risk of suicide, self-harm or harm to others
- exacerbation of existing mental health issues
- ongoing emotional trauma and physical ill-health
- reluctance to seek help or engage with needed services or supports
- family breakdown
- homelessness
- financial impacts
- loss of education or career opportunities.

Matters reported to the AASW have included serious sexual boundary violations perpetrated against young vulnerable women with previous histories of sexual abuse. Such abuse by social workers has affected victims in many ways:

> *Mental health impacts* – Victims have reported suicidal thoughts and hospital admissions in response to misconduct by a social worker.
> *Health impacts* – One victim, after having exhausted all her paid sick leave, felt she had no choice but to resign from a senior position in order to take a less well-paid position with fewer responsibilities.

[76] Melville-Wiseman, J. (2016) The sexual abuse of vulnerable people by registered social workers in England: an analysis of the health and care professions council fitness to practise cases. The *British Journal of Social Work*, 46 (8). doi: http://dx.doi.org/10.1093/bjsw/bcw150

Financial impacts – Victims who have reported incidents have affected their ability to attend or perform at work, and in turn, to meet their financial commitments.

Recent cases of social worker misconduct in Australia illustrate these harms:

- A social worker has been charged with sexual penetration of a 24-year-old woman for whom he was providing face-to-face counselling at a sexual assault and family violence centre. The woman was receiving counselling for sexual abuse she was subjected to as a child (Case study 1).[77]

- An Accredited Mental Health Social Worker in solo practice in regional NSW entered into close personal and sexual relationships with two clients, where they lived at her house while she was providing mental health services, or shortly after the therapeutic relationship had formally ended. For one service user, the subsequent relationship breakdown led to a return to homelessness and an increase in the severity of her mental health symptoms, including suicidal ideation (Case study 2).[78]

Risks associated with the exercise of statutory powers

The statutory powers exercised by social workers under various state, territory and federal laws, in the areas of mental health, child protection, disability and family violence, carry significant responsibilities and heighten the risk of harm to service users if poorly exercised – see Attachment 6. Such powers are otherwise carried out only by registered practitioners (such as psychologists, nurses or medical practitioners).

For instance, while the arrangements differ depending on the jurisdiction (and the various laws use slightly different wording), the statutory roles may include:

Mental health powers – to act as an authorised person under state and territory mental health laws, with statutory powers to detain a person against their will and take them to an authorised treatment facility

Child protection powers – to act as an authorised person, to assess a child's protective needs and remove a child or young person from a place of risk, and to intervene in families to protect a child from abuse or neglect

Family law powers – to act as a family dispute resolution practitioner or counsellor under federal family law regulations; for instance, Court Child Experts are qualified psychologists or social workers with specialist knowledge in child and family issues after separation and divorce – they hold a statutory appointment as a family consultant and an authorisation as a family counsellor.[79]

Commentators have noted the importance of these statutory powers and the harms that may occur if these powers are misused or poorly performed:

> *When you consider the powers that a child-protection worker has in this province, power to walk into a home and remove a child, I think all of us should have the expectation that people with those powers in those roles should have the training of a social worker and should have the oversight and regulation...*[80]

77 [redacted]
78 [redacted]
79 [redacted]
80 [redacted]

Risks associated with referral arrangements

Risks are heightened in circumstances where patients may self-refer for services and there is no effective gatekeeping role exercised by another registered health practitioner, such as a GP.

Social workers who work in direct service roles with patients may see patients either with or without a referral from a registered practitioner. This depends on the arrangements for financing of the services – see Textbox 5.4.

With the expansion of private practice social work services, without the checks and balances afforded by the referral process, services may be poorly targeted to the needs of the service user and a social worker with a propensity for misconduct (particularly sexual predators) is able to "fly under the radar".

Textbox 5.4: Referral arrangements for services provided by social workers

Medicare – For services funded by Medicare or a private health fund, the social worker will mostly see patients who are referred to them by a registered practitioner or where their services are identified as part of a treatment plan developed by a registered practitioner. However, there are some exceptions. For example, for some services under the MBS Family and Carer Participation under the Better Access Initiative,[81] the referral for the social worker to provide consultations for focussed psychological strategies (FPS) can come from any eligible allied health practitioner – which may include unregistered practitioners such as a speech pathologist or another social worker.

Disability services – Social work services funded by the NDIS or other compensation schemes (e.g. TAC[82]) do not usually require a referral from a registered health practitioner, but instead are an approved set of services by the Scheme (e.g. set by a Local Area Coordinator[83]) that the Scheme participant may access as part of an approved set of supports.

Acute health, aged care, etc – Social workers working in acute health, aged care, welfare, NGO and school settings work directly with service users (e.g. to perform a psychosocial assessment) and will, in almost all cases, do so without a referral from a registered practitioner.

Private practice – Social workers working in private practice provide services funded by Medicare, private health insurers, compensation schemes (e.g. TAC) and NDIS, as well as primary care services paid by consumers themselves. The services funded by compensation schemes, NDIS and services paid by consumers themselves are, in most cases, provided without a referral from a registered practitioner.

Risks associated with the management and supervision roles of social workers

Many social workers in supervisory and management roles have responsibility for the management and/or supervision of staff who are carrying out direct service roles, generally with vulnerable service users, sometimes in high stress situations, such as in mental health and child protection.

Textbox 5.5 highlights the heavy responsibilities that some social work management roles carry (as reported by AASW members). Coronial inquiry reports have highlighted the lack of effective management and supervision of staff as a contributing factor to failures in social work practice.

[81] Specifically, MBS Item Numbers: 80154, 80156, 80162, 80166, 91196, 91197, 91204, 91205 (Source: Services Australia, as at 5 September 2024)
[82] For an example, see: https://www.tac.vic.gov.au/providers/working-with-tac-clients/guidelines/provider-guidelines/social-work-guidelines (6 September 2024)
[83] An NDIS Local Area Coordinator does not need to be a registered health practitioner. For an example, see: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwihlbL5w62IAxVeqFYBHdQAIakQFnoECBgQAQ&url=https%3A%2F%2Fsecure.dc2.pageuppeople.com%2Fapply%2FTransferRichTextFile.ashx%3FsData%3DUFUtVjMtlgBJtere2yqmEiClhTy_WVyl9pYBNOBgC4Fes3WBwEkcqN5r__7rFGauEuaZ7F9uRJTJ4uJ7zXeFo64Cz5p0KsIbQSSIgWf3vuIN5sDkYKoFeybEMp1n7NNnZK-PM1w42flsNROeDTw7WAhtm29iGg~~&usg=AOvVaw0URMRUixo6c6MxXLOP6anT&opi=89978449 (6 September 2024)

Textbox 5.5: Extracts from case studies of social workers as team leaders/managers

As a team leader of an out-of-home program for children at risk, I supervised 17 social workers, who placed up to 255 children aged 0–12 years in out-of-home care. They were the most vulnerable families in the service system. We were undertaking high-stakes risk assessment on a daily basis (AASW 2025).

As a manager responsible for a community health team, I directly supervised nurses, podiatrists, physiotherapists, psychologists, dietitians, speech pathologists – all allied health and medical professions. In addition, I managed five mental health services with 450 service users in mental health programs, the most intensive home-based outreach services with the most at-risk clients who had 15 hours of support services a week – with a ratio of one worker for only 2 x clients, all of this as a member of a self-regulated profession (AASW 2025).

As a social worker and manager of a home-based early intervention program for developmentally delayed babies and young children aged 0–6 years, I managed a transdisciplinary health team that comprised a physiotherapist, occupational therapist, speech pathologist, psychologist, community nurse and a special education teacher. We jointly assessed the babies and children in conjunction with specialist paediatricians, and then we designed, implemented and monitored developmental programs and supported the families to access necessary services (AASW 2025).

Formal professional supervision is concerned with a social worker's development of professional working methods and competency and linking their practice to the body of social work theory and knowledge, facilitating a practitioner's engagement in reflective practice, applying standards of ethical practice to their work, and in some cases developing their practical skills and insight for navigating a workplace and complex cases (AASW 2023).

There is some evidence that professional supervision of social workers:

- results in improvements in professional skill development and practice (Beddoe et al. 2020; Bradley & Hojer 2009; Davys et al. 2017; O'Donoghue & Tsui 2013; Revalier et al. 2023; Snowden et al. 2020) and improvements in care outcomes (O'Donoghue & Tsui 2013; Snowden et al. 2020)
- may lead to more productive relationships between social workers and service users (Davys et al. 2017; DHHS 2019; O'Donoghue & Tsui 2013; Revalier et al. 2023; Snowden et al. 2020)
- increases capability to work with cultural issues in practice (Beddoe et al. 2020), and
- has positive impacts on coping with stress (Beddoe et al. 2020: Bradley & Hojer 2009; Davys et al. 2017; DHHS 2019; O'Donoghue & Tsui 2013; Revalier et al. 2023) and increases job satisfaction (Davys et al. 2017; O'Donoghue & Tsui 2013).

Supervision is particularly important for new graduates and those in clinically demanding roles, such as mental health social workers. In New Zealand, for example, the Social Workers Registration Board sets standards for the provision of supervision of social workers in clinical roles, as well as standards and requirements for social workers who act as supervisors. The Board monitors compliance with these standards.

No such mechanism is available in Australia to ensure that social workers in high-risk clinical settings are providing and/or receiving adequate professional supervision. While the AASW accreditation standards and requirements for AMHSWs include supervision requirements, accreditation is not a mandatory requirement for practice.

Risks associated with the changing practice context

The risk profile of the social work profession is changing due to changes in the public/private mix of service delivery. Growth in private practice social work is expected to continue, in parallel with the development of market-based service systems such as the NDIS.

This change in style of practice, combined with the fact that accredited social work courses in Australia do not prepare new graduate social workers to operate in self-employed private practice, has implications not only for the risk profile of the profession but also for the mechanisms required to quality assure social work services.

While the AASW accredits social workers who can demonstrate additional mental health clinical competencies (the Accredited Mental Health Social Worker), this credential is not mandatory. Any newly graduated social worker may establish a private clinical practice without needing to demonstrate the necessary competencies in psychotherapeutic interventions.

Textbox 5.6 sets out some of the findings from a review of literature on risks associated with private practice social work, particularly in the provision of mental health clinical services. The evidence suggests the risks associated with private practice social work are generally higher than for social workers in the public sector (Veness et al. 2019; Hutchinson Mittendorf & Schroeder 2004; Kourgiantakis et al. 2023; Wang et al. 2024). There are also increased risks associated with practitioners in "dual practice", that is, practitioners who are employees while also maintaining a private practice (Ferrinho et al. 2004; Mohgri et al. 2017).

Factors referred to in the literature that may increase risk include:

- routine provision of services without any other person present
- lack of organisational practices and procedures to guide and assure the quality of service provision
- lack of formal or informal supervision
- reduced opportunities for peer engagement
- increased stress associated with isolation of practice
- practising from home, which increases the opportunity for, and likelihood of, relationship boundary issues and sexual misconduct.

In this changing context of practice, parallels can be drawn with the profession of paramedicine. One of the reasons for the 2015 Health Ministers' decision to introduce registration for that profession was the changing context of practice – the growth in non-government and private sector involvement in service delivery and therefore the need for stronger levers for governments to assure the quality and safety of this workforce (COAG Health Council, 2015).

Textbox 5.6: Findings from a literature review on the risks of private practice social work

The incidence of misconduct appears to be considerably higher for those working "mental health" professions compared to "physical health" professions – a study by Veness & colleagues (2019) compared the incidence of complaints against all psychiatrists and psychologists ("mental health practitioners") and all physicians, optometrists, physiotherapists, osteopaths and chiropractors ("physical health practitioners") registered to practise in Australia between 2011 and 2016. Mental health practitioners had a complaint rate that was more than twice that of physical health practitioners. Their risk of complaints was especially high in relation to reports, records, confidentiality, interpersonal behaviour, sexual boundary breaches and the mental health of the practitioner.

The rate of professional boundary violations by social workers is similar to that of other mental health providers – see Attachment 13.

The increased risks associated with private practice social work appear to relate to the environment and business practices, for example:

- social workers with insufficient expertise and experience to practise independently
- social workers who act unethically, for example, by soliciting their employer's clients for their own private practice, service users not supported when the social worker is absent, fees charged, handling of cancellations.

In some jurisdictions, occupational regulators have taken steps to address some of the risks associated with private practice. For example:

- The Nursing and Midwifery Board of Australia has issued specific guidelines for registrants in private practice, while other regulators have incorporated these requirements into general codes of practice (NMBA 2023).
- Some US regulators designate and distinguish "clinical" social workers from generalist social workers, with the former licensed to provide psychotherapeutic services to the public and requiring

a higher qualification and completion of a minimum number of hours of supervised clinical practice post qualifying as well as continuing education (Davis 2024).

- The Psychology Board of Australia uses the mechanism of an "area of practice endorsement" to certify and publish on the public register details of psychologists who have undertaken additional training and have skills and competence in areas such as clinical psychology and forensic psychology.[84]

Coronial inquiry reports

Failures of social work practice have been highlighted in coronial inquiry reports across multiple states and territories since at least 2016.

In 2023–24, the AASW undertook a review of coronial inquiry reports spanning a six-year period from 2018 to 2024. The report of this research is in Attachment 16.

71 coroner reports were identified and reviewed. The failures identified were classified according to the categories set out in Table 10.

Table 10: Social work practice issues identified in AASW analysis of coroner reports

Practice issue	Number of coronial inquiry reports	% of coronial inquiry reports
Risk assessments	65	92
Failure to act	57	80
Skills, competence and training	48	68
Inappropriate case closures	37	52
Inappropriate intervention	27	38
Failure to apply for protective orders	25	35
Inadequate supervision	20	28
Group think	7	10

Table 11 provides some details of a selection of these cases. Please note, the following contains discussion of sensitive and potentially distressing content.

[84] See the Psychology Board of Australia website for a description of the mechanism of an "area of practice endorsement": https://www.psychologyboard.gov.au/Endorsement.aspx

Table 11: Deaths subject to coronial inquiry where social workers and social work practice has been scrutinised

Name	State & year	Sector	Coronial inquiry finding re social worker practice	Cause of death
"WB"	Victoria (2025)	Mental Health	Clinical documentation was illegible (needed as communication tool, patient care and legal document).	Death at 59 years old from self-inflicted gunshot wound
Caleb Evans	South Australia (2024)	Child Protection	Incomplete safety assessment	Died just under 11 weeks old, living in squalor
Kobee Huddy	South Australia (2024)	Mental Health	Conduct of social worker during call was not satisfactory.	Death from police shooting in the context of mental health crisis
Emma Gertrude Weidemann	Victoria (2023)	Family violence, mental health	"Unclear" decision making regarding referrals and in-home support service assessments	Death from fire with head and neck injuries in the context of mental health, family violence and aged care services
Zhane Chilcott	South Australia (2023)	Mental health	Standard of performance of some social workers was "questionable".	Death by suicide at age 13 years
Amber Rose Rigney and Korey Lee Mitchell	South Australia (2022)	Child protection	Department officials, pursuant to statutory obligations, should have investigated and/or reported drug use to police for investigation.	Deaths at 6 years and 5 years, murdered with their mother by her partner
"PFS"	Victoria 2022	Mental health	Social worker failed to appropriately address disclosure of family violence.	Death by suicide in the context of family violence
Tara Matekino-Brown	Queensland (2021)	Hospital, family violence	Staff witnessed domestic family violence whilst Ms Brown was in labour but made arrangements for perpetrator to be present at the birth although it was	Died from head injuries inflicted from partner in context of Domestic Family Violence.

			known that his presence was a breach of a current DVPO and did not contact police.	
Brayden Stuart Dillon	Queensland (2021)	Child protection Family violence	Minimal application of risk assessment and a number of practice shortcomings identified	Death at nine years as a result of injuries and other abuse
"AP"	New South Wales (2020)	Mental health Family violence	Inexperienced social worker, poorly supervised and supported. Showed "concerning lack of insight".	Death of baby due to filicide
Mason Jet Lee	Queensland (2020)	Child protection Family violence	Numerous failures of social workers in child protection	Death of 21-month-old at hands of violent partner of mother
Child "AC"	Western Australia (2019)	Child protection	Inappropriate communication engagement with carer	Child died of renal failure
Heidi Eileen Roseanne Singh	South Australia (2019)	Child protection	Unable to deliver skilled care and therapeutic support required, with a lack of supervision and clinical oversight	Death at age 14 through electrocution
Mitchell Follent	Queensland (2019)	Hospital, mental health	Deficiencies in discharge planning and implementation, including lack of information gathering, risk assessment and management plan	Died from fall from balcony following discharge from hospital in absence of sufficient support
Aurora McPherson-Smith	South Australia (2018)	Mental health	Failure to put clear therapeutic boundaries in place with client, inadequate supervision	Death by suicide at aged 18 years
Ebony Simone Napier	South Australia (2016)	Child protection Family violence	Failure to investigate criminal background	Death of four-month old baby as a result of blunt head trauma

Chloe Valentine	South Australia (2015)	Child protection Family violence	Some social workers had poor quality of practice (poor assessments), lack of clinical supervision and lack of leadership.	Death at four years of age as a result of head injury and other abuse

Textbox 5.7 provides an extract from the AASW report of the analysis of these cases.

Textbox 5.7: Extract from AASW research report on coronial inquiry reports

21 coronial inquiry reports related to failures in mental health services. These reports included instances of filicide and suicide within the context of psychosis, family violence and alcohol and drug abuse.

Mental health stands out as a key feature across all of the cases, notwithstanding the different service systems. This review identified that over 30% of the coronial cases reviewed occurred directly in the mental health service system; however, it also identified professional practice issues in several related mental health roles, including employee assistance programs, family violence counselling, relationship counselling and dual diagnosis work.

Across many of the analysed coronial cases, there was an identified theme of mental ill-health, regardless of the service systems involved. Many people who were named in the coronial reports were living in circumstances of great stress, complexity, and disadvantage. Their experiences often involved poverty, homelessness, disability, family violence, child abuse and neglect, and trauma. It is widely known from research that these circumstances and experiences heighten vulnerability and increase the risk of further discrimination and violence. High standards of professional practice are required to appropriately assess the circumstances and provide the necessary intervention and support.

52 reports related to failures in child protection agencies. The reports included instances where practitioners and agencies may have prevented filicide, suicide, accidental overdose on prescription medication, accidental drownings, unsafe sleeping environments, medical conditions and other deaths resulting from abuse and neglect. Improvements in professional practice in mental health and family violence systems can reduce the flow-on demand to child protection systems and the increasing need for crisis responses.

13 cases involved family violence services. The reports included instances where practitioners and agencies may have prevented murders and suicides.

Source: AASW 2025: 5–6

The data suggests failures at multiple levels of the service system:

> *Failures of individual case workers* – These were failures of an individual case worker or a similar role to a social worker, since in many cases it is not possible to determine whether the case worker is a qualified social worker.
>
> *Departmental failures* – These include failures of standards, including in departments where the relevant staff are predominantly social workers, such as in the Department of Child Protection.
>
> *Systemic failures* – These include failures across multiple departments, such as Child Protection, Health and Police, and both failures of practice and failures in information sharing.

Seven coronial inquiry reports critically examined the role of social work practice in potentially avoidable deaths. These deaths show the tragic and fatal consequences of inadequate and/or inappropriate professional practice, attributed wholly or in part to social workers. The cases document the involvement of social workers in deaths in high-risk settings involving mental health, child protection and family violence, pointing to:

- poor social work practice
- inadequate training
- lack of professional accountability
- insufficient supervision and oversight.

These reports identify an ongoing pattern of social work practice that does not meet the needs of service users:

- poor case management
- failure to undertake risk assessment or appropriately act after disclosure of risks
- not addressing the needs of clients in a timely manner
- failure to follow departmental and agency policies and procedures
- lack of professional accountability for errors and adverse outcomes
- failure to maintain appropriate therapeutic professional boundaries
- failure to adhere to relevant procedures and frameworks, for example Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP).

Several themes emerge from the analysis of these reports:

- the high-risk nature of social work service users
- the need for graduates to have job-ready competencies
- the level of clinical skills and case management
- contemporary practice and family violence
- the importance of undertaking high-quality risk assessments and safety planning.

Many reports have highlighted concerns that point to an urgent need for the social work profession to be registered under the NRAS. At least five Australian coroners have specifically recommended that the profession of social work be registered or made findings that further support registration:

- Victorian Coroners Court Australia (2022). *PFS: Finding into death without inquest of PFS*[85]
- South Australian Coroners Court (2015). *Inquest into the death of Chloe Lee Valentine*[86]
- South Australian Coroners Court (2016). *Inquest into the death of Ebony Simone Napier*[87]
- South Australian Coroners Court (2022). *Inquest into the deaths of Amber Rigney and Korey Mitchell*[88]
- South Australian Coroners Court (2023). *Inquest into the death of Zhane Andrew Keith Chilcott*.[89]

Textbox 5.8 provides some extracts where coroners point to the need for stronger regulation of the social work profession – in Queensland, South Australia and Victoria. The critical message is that these deaths may have been prevented with:

- higher standards of practice
- stronger regulation
- better direct oversight, and
- more prepared, supported and practice-ready graduates.

Textbox 5.8: Extracts from coronial inquiry reports

Counsellors and social workers are often employed to work with vulnerable communities. The lack of accountability in this work raises concerning implications for their clients. The need for oversight demonstrated by PFS's social worker/counsellor in promoting the use of relationship counselling despite the presence of family violence, evidences the need for regulation of counsellors and social workers in Australia (Darren J. Bracken, Victorian State Coroner, 2022, in the case of "PFS").

Some social workers had poor quality of practice. Their assessments were not assessments, but storytelling. There was a lack of analysis, a lack of clinical supervision and a lack of leadership. In summary, it was broken and fundamentally flawed … I recommend that a measure be introduced which provides for registration of social workers (Mark Frederick Johns, South Australian State Coroner, 2015, in the case of Chloe Valentine).

[85] See https://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/vic/VicCorC/2022/27731.html
[86] See https://www.austlii.edu.au/au/cases/sa/SACorC/2015/6.pdf
[87] See https://www.austlii.edu.au/au/cases/sa/SACorC/2016/1.pdf
[88] See http://www.austlii.edu.au/cgi-bin/viewdoc/au/other/sa/SACorCResp/2022/3.html
[89] See https://www.austlii.edu.au/au/cases/sa/SACorC/2023/5.pdf

The standard of performance of some social workers involved with Zhane in 2015 and 2016 was questionable. The Social Worker Registration Act 2021 *was introduced following a recommendation made by former State Coroner Johns in the inquest into the death of Chloe Valentine* (David Whittle, South Australian State Coroner, 2023, in the case of Zhane Chilcott).

If [social worker] had acted on the significant information they received that afternoon and asked to see Mason, as was clearly their duty, they may have saved his life (Jane Bentley, Queensland Deputy State Coroner, 2020, in the case of Mason Jet Lee).

What this inquest has highlighted is the folly of governments ignoring coronial and other recommendations. I speak again of the course of the continuation of unlawful practices within the child protection authority despite coronial findings in the Valentine and Napier inquests that identified those practices (Anthony Schapel, South Australian Deputy State Coroner, 2022, in the case of Amber Rose Rigney).

Royal commissions, parliamentary committees and government inquiries

Successive royal commissions, parliamentary committee inquiries, and government-commissioned reports, as well as workforce policies and strategies, have documented concerns about the practice of social workers and the provision of social work services. Some have recommended stronger regulation of the profession, including statutory registration under the NRAS – see Attachment 17.

Textbox 5.9 provides excerpts from these reports, which identify calls made at the state and federal levels to introduce statutory registration for the social work profession and/or mandatory qualifications for social workers, dating back to 2016.

Textbox 5.9: Extracts from parliamentary committee and government reports and inquiries

Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings Report Volume 1 Summary, recommendations and findings (2023)

We also consider professional regulation of unregistered health workers a priority because they are a cohort that often provides services to children. (2023: 90)

Commonwealth of Australia, The Senate Community Affairs References Committee report – Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law (2022)

Recommendation 3.2.115

The Committee considers there is a substantial case for regulation of currently unregulated professions including social workers, aged care workers and personal care workers and recommends the Ministerial Council consider whether these professions should be included in the National Registration and Accreditation Scheme. (2022: xiii)

Commonwealth of Australia, Department of Social Services – Safe and Supported First Action Plan 2023–2026 (2022)

Action 3 – Workforce: Agree a national approach or strategy for a sustainable and skilled children and family services workforce. Activity – Scope national accreditation of the child protection and family support services workforce

Deliverable – Identify advantages and disadvantages of national accreditation for social workers and other child and family services workers to inform approaches for a national accreditation scheme. (2022: 30)

State of Victoria, Department of Health – Victoria's Mental Health and Wellbeing Workforce Strategy 2021–24 (2021)

Statutory registration scheme for social workers: In contrast to comparable jurisdictions, Australia does not currently have a statutory registration scheme for social workers. Absence of title protection and safeguards compromises quality and safety, and limits how this discipline functions within the mental health sector. The Victorian Government will advocate to Ahpra for a statutory registration scheme for social workers. (2021: 31)

Parliament of South Australia Report of the Joint Committee on the Social Workers Registration Bill 2018

While the Committee supports continued advocacy by the government for a national framework, it also recognises that the registration of social workers is long overdue. No state or territory in Australia has a registration scheme for social workers. For this reason, the Committee is of the strong view that it is time for South Australia to take the lead in putting in place a state-based legislative framework for the registration of the social work profession. (2020: 5)

Victorian Royal Commission into Family Violence (2016)

Recommendation 209

The Victorian Government to include in the 10-year industry plan for family violence prevention and response a staged process for the introduction of mandatory qualifications for specialist family violence practitioners, so that no later than 31 December 2020 all funded services must require family violence practitioners to hold a social work or equivalent degree.

Health Complaints Entity (HCE) complaints data

In June 2024, the AASW wrote to all state and territory HCEs to request data on complaints about social workers dealt with by HCEs under state and territory health complaints laws. In accordance with the AHMAC Guidance (2018), we consider this data essential to support evidence-informed policy making. We anticipated that non-identifying data on complaints about social workers would be readily available – we were wrong.

It is not possible to obtain reliable data on complaints and prohibition orders relating to social workers, from any state or territory HCE, with the possible exception of NSW.

All HCEs (except for WA) agreed to provide some basic complaints data on social workers to the AASW (such as number of complaints, type of complaint, number of prohibition orders issued). However, only NSW, Queensland and Victoria provided their data in time for the preparation of this submission. The findings of this data collection exercise are discussed under Criterion 3.

AASW complaints data

The AASW has a *Code of Ethics* (2020) that members are expected to comply with, and has in place an Ethics Complaints Management Process (ECMP) applicable to members. The purpose is to maintain minimum acceptable ethical practice standards for social workers and to take appropriate disciplinary action if these standards are not met.

Table 12 presents data on the volume of enquiries and complaints received by the AASW for the calendar years 2019 through to the end of the first quarter of 2025 (five and a quarter years).

During that period, 922 enquiries were received, and 120 complaint cases were handled. See Table 12.

Table 12: AASW Ethics and complaints data 2019–2025

	2019	2020*	2021	2022	2023	2024	2025#	Total
Complaint Enquiries	125	148	178	155	90	139	87	**922**
No. of Complaint Cases	15	12	2	18	24	34	23	**120**
Complaint Case – Closed by Ethics Office *(completed/finalised)*	0	2	0	0	9	9	8	**28**
Complaint Case – Dismissed *(Dismissed as determined by AASW Ethics Council)*	0	0	10	4	4	9	3	**30**
Complaint Case – Outside Jurisdiction *(E.g. the social worker is not a member, the alleged misconduct occurred more than 2 years ago, etc)*	0	4	36	50	17	8	14	**129**
Complaint Case – Withdrawn *(Withdrawn by complainant)*	0	0	0	3	3	4	3	**11**

First quarter only: Jan 1 – Mar 31 2025

Figure 6 presents the number of complaints dealt with by the AASW for the years 2019 through to 2025 (Quarter 1).

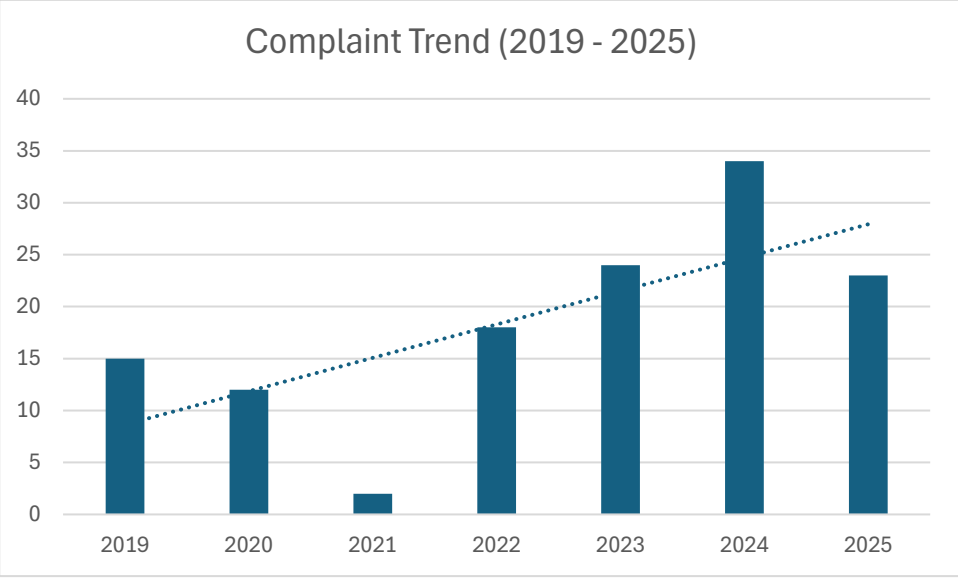

Figure 6: AASW number of complaints received 2019–2025

Analysis of this data shows:

- 14% of complaints were recorded as outside jurisdiction, i.e. AASW has no power to intervene; for example, the social worker is not a member.
- 40% of all complaint cases involved an AMHSW.
- 50% of all complaint cases involved a social worker in private practice.
- For recorded categorised complaints for the years 2021 to 2025 (Quarter 1):
    - 23% were about boundary violations.
    - 14% were about issues with clinical care.
    - 12% were about issues with communication.
    - 11% were about issues with confidentiality.
    - 17% were about issues with documentation.
    - 6% were about issues with informed consent.
- The number of complaint enquiries has grown compared to 2019 – the first quarter of 2025 saw a 150% increase in enquiries compared to the previous year's quarterly average – a threefold increase.
- The number of complaint cases doubled between 2019 and 2024.
- In 2023 and 2024, complaints and enquiries declined; the Ethics and Complaints team was unable to identify a clear reason, as there were no changes in reporting processes; the 40% decrease may be linked to external factors, including the lingering effects of the COVID-19 pandemic.
- However, the first quarter of 2025 saw a 170% increase in complaints compared to the previous year's quarterly average – a more than threefold increase.

Despite the best efforts of the AASW to operate a robust and effective complaint handling and disciplinary process, there are serious limitations with the AASW ECMP.

First, the AASW may only investigate complaints concerning AASW members. When we receive a complaint about a social worker who is not a member, we have no jurisdiction to deal with it and refer the complainant to the relevant authority. We have no data about how many of these complainants lodge their complaint with an HCE or other regulator.

We have found that approximately two-thirds of complaints received under the AASW ECMP related to matters beyond the jurisdiction of the AASW.

Second, in any disciplinary case concerning an AASW member, the most severe sanction that the AASW can impose is to find the member ineligible for membership and to withdraw their membership. In practice, this has little effect since there is nothing to prevent the lapsed member from continuing to practise, and there is little transparency for the public since none of the information is on the public record about why their membership was withdrawn, apart from their name being published on the AASW website.[90]

Additionally, we are aware that some social workers have allowed their membership to lapse in order to avoid disciplinary action for breaches of the AASW *Code of Ethics* and *By-laws on Ethics*.

Third, the AASW has no statutory powers to publish information arising from a complaint investigation and disciplinary process, and no statutory protection from liability should it do so in good faith.

For example, unlike in a statutory scheme where there are regulatory powers and protections, the AASW is unable to publish any identifying details of cases of professional misconduct. The only power the AASW has is that when a decision is made to cancel membership, the name of the member is published on the AASW website. This means there are no public statements or other information available in the public domain to warn

[90] See https://www.aasw.asn.au/find-a-social-worker/

prospective service users or employers about a social worker's disciplinary history or to act as a deterrent for members of the profession who might be tempted to go down a similar path.

Conclusion regarding Criterion 2:

The activities of the social work profession carry a significant risk of harm to the health and safety of the public.

A range of factors are contributing to **a risk profile** that is **unacceptably high** and on a par with or greater than many of the health professions that are subject to statutory registration under the NRAS.

Factors exacerbating the risks include the nature of social work practice, particularly the vulnerabilities and challenges of the service users that social workers predominantly work with; the changing context of practice, particularly due to changes in the public/private mix of social work services; and the substantial evidence that existing regulatory measures are failing to contain and mitigate the risk.

These risks are not just theoretical – the data from coronial inquiry reports, royal commissions, parliamentary committee and government inquiries, and AASW's own complaint handling data show there is a pattern of harm, with repeated cases demonstrating a pattern of harm, over two decades. The case studies documented present stark examples of regulatory failure.

Criterion 3: Do existing regulatory or other mechanisms fail to address health and safety issues?

The four main types of occupational regulation that apply to the health professions in Australia are described in Attachment 1. They are voluntary certification, co-regulation, negative licensing and statutory registration. All of these already apply to the profession of social work, except that statutory registration is pending implementation in South Australia, subject to government proclamation (no fixed date has been set).

It seems the main options available to Health Ministers (in addition to the option of no change – maintaining the status quo) are to:

- Strengthen voluntary certification – such as via the AASW's existing certification scheme.
- Strengthen co-regulation – such as via an accredited voluntary registers program.
- Strengthen negative licensing – such as improving the way HCEs administer the Codes of Conduct and prohibition order powers.
- Introduce statutory registration nationally, for all social workers, via an expansion of the NRAS.

The evidence amassed in this submission shows that:

- Poor practice and misconduct by social workers has had adverse psychosocial and health impacts on those affected.
- Existing regulatory and other quality assurance mechanisms are failing to deal with the failures associated with poor social work practice and professional misconduct.
- Multiple reports of coronial inquiries have made recommendations concerning the need to strengthen the regulation of social workers and introduce statutory registration, to:
    - Establish minimum national standards for entry to practice.
    - Provide more effective mechanisms to monitor compliance with professional ethics and practice standards and improve supervision and management arrangements.
    - Deal more effectively with departures from professional standards.

The following sections describe why the existing regulatory arrangements are failing to provide adequate protection for service users.

The failures of self-regulation

Self-regulation or voluntary certification schemes generally combine the elements set out in Textbox 5.10.

Textbox 5.10: Key elements of self-regulation schemes for health professions

- a professional association with a constitution and/or bylaws that set out the rules of the association
- a board of directors constituted with persons elected by members of the association
- published membership requirements that include:
  - a recognised minimum qualification or qualifications for practising membership
  - a requirement that members agree to comply with a Code of Conduct and standards of practice set by the association
- a process for assessing and approving qualifying education programs for membership eligibility purposes
- operation of a publicly accessible, web-based, searchable register enabling the public to locate qualified practising members who are in good standing with the association
- policies and procedures for receiving and investigating complaints about members and dealing with any misconduct
- rules that enable removal of membership from those who breach the Code of Conduct.

As the peak body for the social work profession, the AASW carries out all of these self-regulation functions – we set standards for entry to and practice in the profession, we monitor compliance of members (and education providers) with these standards, and we deal with departures by members from accepted professional practice – see Textbox 5.11.

We are proud of what we do as regulators for the social work profession, and we are committed to doing it to the very best of our abilities. We are, however, painfully aware of the shortcomings of our powers and how these shortcomings compromise our efforts to protect vulnerable service users and ensure effective social work practice.

Textbox 5.11: Self-regulation functions carried out by the AASW

Setting education standards – the Australian Social Work Education and Accreditation Standards (ASWEAS)[91] sets the standards that underpin the AASW system for accreditation of Higher Education Provider Bachelor and Masters Social Work courses, for entry to practise as a social worker.

International recognition of overseas qualified social workers – AASW is the Authority for International Qualifying Assessments for migration and/or employment purposes.[92]

Ethics – the AASW publishes a *Code of Ethics* (2020)[93] to which all members commit to comply with when they join the association. There is also an AASW Ethics Consultation service.[94]

Practice standards – the AASW has published the AASW *Practice Standards* (2023)[95], which sets out the minimum requirements for effective, professional and accountable social work practice.

Credentialing – the AASW credentials the social work qualifications in a range of fields of practice, including Clinical, Disability, Child Protection and Family Violence[96].

Mental health social worker accreditation[97] – the AASW carries out accreditation of social workers who are considered qualified to provide mental health services. There are over 3,000 Accredited Mental Health

[91] See https://www.aasw.asn.au/education-employment/higher-education-providers/asweas-2024/
[92] See https://www.aasw.asn.au/education-employment/migration-eligibility-assessment/
[93] See https://www.aasw.asn.au/about-aasw/ethics-standards/code-of-ethics/
[94] See https://www.aasw.asn.au/about-aasw/ethics-standards/ethics-consultation-service/
[95] See https://www.aasw.asn.au/practice-standards-2023/
[96] See https://www.aasw.asn.au/overview/
[97] See https://www.aasw.asn.au/credentials/aasw-accredited-mental-health-social-worker-application-criteria/

Social Workers (AMHSWs) who provide psychological services through public and private initiatives, such as Better Access, DVA, Bupa Health and Medibank.

AASW Logo and Digital badges[98] – the AASW logo is a legally protected Collective Trademark that is available for use only by accredited members; the social worker member and credential badges display the AASW's legally protected Collective Trade Mark, which enables eligible social workers to distinguish themselves to clients, employers and the general public as professionals with legitimate credentials; as well as providing a mark of quality, the trade mark also provides increased protection and safety for clients accessing social work services; they can be used in email signatures, digital resumes, personal websites and social media platforms, and are a great way to increase opportunities in the workforce and beyond.

Continuing professional development[99] – the AASW CPD Policy sets out the requirements for membership, which can be met through participation in CPD activities provided by the AASW and/or external providers.

Complaints – the AASW receives complaints about social workers and operates an investigation and disciplinary process[100].

As of 23 June 2025, AASW membership stands at 17,627.[101] This leaves approximately 30,000 people employed as social workers who are operating out of reach of these self-regulatory arrangements.

Additionally, despite its well-established system of self-regulation, the AASW is not a statutory authority; hence, its powers are limited. We do everything we can, within our powers and capacity; however, we know from first-hand experience that it is not enough. The reasons are set out below.

First, membership of the AASW is voluntary – if we receive a complaint about a non-member, we have no jurisdiction to deal with it. We have no power to prevent a social worker expelled from the AASW for professional misconduct from continuing to practise.

While eligibility for membership of the AASW is a requirement specified by many employers, including some public sector employers, this simply means the applicant must demonstrate that they hold an approved qualification and have met the membership standards of the AASW. However, it does not require them to hold and maintain AASW membership. This means there is no mechanism for monitoring their compliance with AASW membership standards, and when the AASW receives a complaint about a non-member, we have no powers to take disciplinary action.

Second, in cases of misconduct by a social worker, the most severe sanction the AASW has available is to withdraw or refuse membership or refuse to renew membership. This does nothing to prevent a poorly performing social worker from continuing to practise.

We have cases of social workers known to have breached the AASW's professional standards, including for serious boundary violations involving sexual assault, who are continuing to practise and are protected from public scrutiny. When a decision is made to cancel membership, the name of the member is published on the AASW website. However, the details of any professional misconduct cannot be published; thus, there is often little information in the public domain about such cases. Unlike the HCEs, Ahpra and the National Boards, we have no statutory powers to issue public statements identifying a practitioner and warning the public.

Third, where concerns are raised with us about the conduct, competence or health of a social worker, the AASW has no powers to determine whether a social worker is fit and competent to practise. Unlike a statutory regulator, we cannot require a social worker to undergo a performance assessment or health assessment, even where we have a well-founded concern that their continued practice may be placing service users at risk.

[98] See https://www.aasw.asn.au/membership/digital-badges/
[99] See https://www.aasw.asn.au/professional/cpd/cpd-overview/
[100] See https://www.aasw.asn.au/about-aasw/ethics-standards/making-a-complaint/
[101] Internal AASW membership data

Fourth, without statutory title protection, the AASW has no power to prevent use or misuse of the title "social worker" by those who are unqualified or underqualified. Employers have been known to employ people without social work qualifications in positions that are earmarked, titled or described as a "social worker". This raises many issues, not least the implications for the employer and the worker's professional indemnity insurance (PII) cover, any funding provided for the services, and whether the worker, by misleading the public about their qualifications, may be in breach of the applicable HCE statutory Code of Conduct.

Fifth, without statutory registration, CPD is not mandatory. While AASW members are expected to meet our CPD standards, two-thirds of the profession (non-members) are under no such obligation, and there may be no alternative systems in place to monitor compliance.

To summarise, the key concerns of the AASW about the current self-regulatory arrangements are set out in Textbox 5.12.

Textbox 5.12: Key concerns of the AASW with association-led self-regulation

- Under association-led self-regulation, it is not mandatory for social workers to be registered and to submit themselves and their credentials for external validation.
- Self-regulation does not "cover the field", that is, the entire social worker workforce, and does not deliver the buy-in needed from employers and industry to recognise the certification program.
- Self-regulation cannot restrict use of the title "social worker" only to qualified persons (title protection); hence, the public and employers are unable to distinguish qualified social workers from other social care, community or welfare workers or those who use the title without an accredited social work qualification.
- Self-regulation cannot provide a mechanism to ensure that every practising social worker is fit for practice and is meeting their professional obligations – to maintain their skills and competence up to date, through participation in CPD.
- Self-regulation does not provide statutory powers to investigate complaints about social workers and conduct a disciplinary process.
- Self-regulation does not provide a mechanism to permanently ban from practice those who are not of "good character" or "suitable" persons, or those who have engaged in professional misconduct, and prevent them from providing any healthcare or social care services. Nor does it protect the regulators from lawsuits should they issue public statements identifying an individual practitioner about whom disciplinary findings and orders have been made.
- A growing proportion of the social work workforce is operating in independent private practice, either as sole practitioners or in small practice settings. Private practice carries an increased risk of professional misconduct, particularly of professional boundary violations.
- The experience of social worker registration in New Zealand is instructive – a system of voluntary registration was found to be insufficient to protect the public, and the New Zealand Government proceeded to amend legislation to make registration of social workers mandatory, commencing in 2023.

The limits of co-regulation

The criticisms directed at self-regulation apply equally to existing co-regulatory arrangements.

First, there is already a patchwork of co-regulation arrangements that apply to the social work workforce under federal, state and territory funding programs. However, even major program funders such as NDIS, DVA, aged care, health and mental health services (Department of Health, Disability and Ageing) have limited powers under their respective co-regulatory arrangements to regulate the social worker workforce effectively.

Second, the AASW already operates a co-regulatory scheme with the credentialing (accreditation) for Accredited Mental Health Social Workers (amongst others) – we have worked hard to build strong partnerships with government in programs such as Medicare and with non-government private health insurers – see Textbox 5.13. However, we still have insufficient powers to adequately monitor the social worker workforce and to deal with those AMHSWs we accredit when they fail to meet professional standards of practice, continue

to practise with impairments that may compromise the safety and well-being of service users, or are otherwise performing poorly. Such powers are only available under a statutory registration scheme such as the NRAS.

Third, the National Alliance of Self-Regulating Health Professions (NASRHP) already operates a program of certification of association-led voluntary registers, similar to that run by the UK Professional Standards Authority for Health and Social Care (PSA). The main difference is that the NASRHP does not have statutory powers, functions or accountabilities. The AASW is not currently a member of NASRHP and would have to change its constitution in order to meet the NASRHP standards.

This fragmented co-regulatory system, where regulatory powers and functions are distributed amongst a large number of players, is a highly inefficient way to manage finite regulatory resources. As such, it cannot effectively assure the safety, quality and professional accountability of social workers, or counter the risks and opportunities for misuse of government funds. The risks of regulatory failure are much higher with such fragmented and distributed regulatory arrangements.

Textbox 5.13: AASW co-regulatory arrangements with private health insurers

Private Health Insurance Funds that ***recognise*** AASW Accredited Mental Health Social Workers (AMHSWs) as ancillary providers under the Private Health Insurance Rules include:

- Medibank Private
- Bupa
- HCF
- Doctors' Health
- St Lukes Health
- Phoenix Health Fund
- Teachers Health (including Nurses and Midwives Health and UniHealth)

Three providers that ***recognise*** AMHSWs account for over half the market:

- Medibank Private (including AHM) – 27.1%
- Bupa – 24.9%
- HCF – 12.5%.

Sources:

AASW website https://www.aasw.asn.au/about-aasw/social-policy-and-advocacy/private-health-funds/

CHOICE website https://www.choice.com.au/money/insurance/health/articles/private-health-insurance-statistics-in-australia

Several recent government reports and consultation papers (Cormack 2024; Dawson 2024) have identified problems with the current arrangements and have proposed reforms to strengthen co-regulation, specifically through the introduction of a quality assured, voluntary, registers program, similar to that operated by the UK Government's PSA. See Textbox 5.14 for a description of how this scheme operates.

Textbox 5.14: Key features of the United Kingdom Professional Standards Authority's Accredited Registers Program

- Under the UK Accredited Registers program, the PSA has published minimum standards for the operation of public registers of "unregulated" health and social care practitioners and healthcare workers.

- An organisation that operates a public register for unregulated health practitioners, healthcare workers or social care workers may apply to the PSA for accreditation of its register.
- The organisation pays a fee to the PSA for the assessment.
- An unregulated practitioner or healthcare worker who has met the qualification and other requirements and whose name appears on an "Accredited Register" may advertise that fact to the public.
- The PSA publishes a list of Accredited Registers and allows these registers and their registrants to use the PSA's "Accredited Registers Quality Mark" on their literature and websites.
- Accreditation is intended to provide assurance to the public and others that a register is well run and requires its registrants to meet high standards of personal behaviour, technical competence and, where relevant, business practice.
- When choosing a health service, consumers are encouraged to choose a practitioner who is a member of a PSA Accredited Register.
- The PSA has statutory powers to suspend the accreditation of a register, apply conditions or remove a register's accreditation.

Source: Professional Standards Authority;[102] adapted from ANC 2022: 43.

To be clear, the AASW has no objection to governments exploring more efficient ways of conducting the current highly fragmented co-regulatory arrangements that apply to the non-registered professions across both the health and social care sectors. However, for the social work profession, a PSA-style, quality assured, voluntary, registers program will not provide any greater protections for the public nor be any more effective or efficient than the existing AASW scheme that already operates in partnership with the federal Department of Health and Aged Care (the Accredited Mental Health Social Worker program) – a regulatory scheme already relied upon by a range of government and non-government funding programs. The reasons include:

First, lack of centralisation and integration of key regulatory functions in a single regulator leads to gaps, inefficiencies and duplication of effort. The barriers to information sharing and efficient management of complaints are placing the public at risk and compromising the capacity of governments to ensure the social work workforce meets population health needs.

Despite over 10 years of operation, we understand that the UK PSA program has not yet achieved extensive buy-in from government and non-government funders and regulators – to recognise practitioners credentialled under the scheme for access to funding and other privileges (PSA 2021: 3–6). Ten years is a long time to wait for a program to reach maturity and become self-sustaining, particularly in the case of social work, where the vulnerability of service users is so great.

Second, the PSA program accredits multiple voluntary registers, sometimes more than one for a single profession.

Without a single national trusted source of information about who is a qualified social worker, funding bodies, insurers and employers are obliged to do their own qualifications and probity checking, but sometimes without sufficient skills, knowledge and administrative resources. Not only is this a highly inefficient way to assure the quality and safety of an essential workforce, but it also increases the risk of regulatory failure. For instance, it is likely that funds are being claimed under various government and non-government programs by individuals who are not appropriately qualified and/or of good character, potentially compromising the services and supports for vulnerable participants. If governments are serious about removing rorts in the NDIS and other programs, then only statutory registration is likely to be effective in regulating this workforce and providing the necessary tools to tighten up these systems.

Third, like the self-regulation schemes, even if the register has been accredited by a statutory body, any disciplinary information generated from the operation of a voluntary register disciplinary process is unlikely to

[102] See Professional Standards Authority website: https://www.professionalstandards.org.uk/organisations-we-oversee/our-work-accredited-registers

be in the public domain, unless the practitioner has been prosecuted for a criminal offence or has a prohibition order issued against them by an HCE. Hence, it is questionable what added value this type of program adds, at least for the social work profession, beyond the existing arrangements.

Fourth, these co-regulatory schemes remain voluntary, allowing social workers to continue practising outside the scheme's scope. Furthermore, even for participating members, there are no effective mechanisms to enforce compliance with practice standards. For instance, even a quality assured registers program that has a statutory base will not provide sufficient powers for an accredited register to deal proactively with competence, health and conduct issues before they escalate, and initiate preventative measures to avoid negative impacts on service users – for an entire profession and across the entire health and social care system.

Fifth, the fragmented nature of these multiple co-regulatory schemes means there is no single source that can generate and supply to governments a comprehensive workforce data set to support workforce planning and service improvement. Also, without statutory registration, the avenues and tools available for governments to shape the workforce reform agenda for these professions are far more limited.

The limitations of HCE complaint management and code regulation (negative licensing)

Governments may point to state and territory health complaints commissioners (HCEs) as a suitable avenue of complaint for health service users when things go wrong. Most, if not all, HCEs have general powers to conciliate complaints, conduct health system inquiries, and, more recently (except in Tasmania and Northern Territory), investigate breaches of a statutory Code of Conduct and issue a prohibition order to remove an unfit person from the health workforce.

About the National Code of conduct for healthcare workers

A national agreement signed by all state, territory and Commonwealth governments in 2015 committed every state and territory to strengthen the powers of their respective HCEs, to implement a "negative licensing" or "code regulation" scheme in accordance with a nationally agreed policy framework.[103] Ten years on, these extended powers are in force in only six out of eight Australian states and territories – NSW (2008), QLD (2014), SA (2013), VIC (2017), ACT (2023) and WA (2023).

While amendments were made to Tasmanian health complaints legislation in 2018, at the time of writing, 10 years after the national agreement was signed, the National Code of Conduct is yet to be made and the powers are yet to commence in that state.[104] There is no publicly available information to indicate whether the NT Government has progressed the development of legislative amendments to give effect to the Ministerial Council agreement of 2015.[105]

In 2020, amendments to NSW legislation extended the Code of Conduct and prohibition order powers of the NSW Health Care Complaints Commission (HCCC) to cover health organisations, as well as individual practitioners,[106] and in September 2022, the NSW *Public Health Regulation 2022* was amended to introduce the *Code of Conduct for health organisations*.[107]

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[103] See: COAG Health Council (2015). *Final Report. A National Code of Conduct for health care workers*. https://content.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/f/final-report---a-national-code-of-conduct-for-health-care-workers.pdf

[104] Tasmania has enacted legislation but it has not yet commenced. See the *Health Complaints Amendment (Code of Conduct) Act 2018* (Tas): https://www.healthcomplaints.tas.gov.au/national-code-of-conduct#:~:text=The%20Code%20of%20Conduct%20outlines,to%20protect%20you%20from%20infection and https://www.justice.tas.gov.au/community-consultation/consultations/2025/health-complaints-code-of-conduct-regulations-2024

[105] In 2017, the Northern Territory Department of Health published an Information Paper on proposed changes to give effect to the National Code of Conduct and prohibition order powers, but there is no indication since then of any progress in framing the necessary legislative changes. See: http://www.hcscc.nt.gov.au/wp-content/uploads/2017/11/National_Code_of_Conduct_NT_Information_Paper.pdf

[106] See Health Legislation (Miscellaneous Amendments) Act 2020 (NSW)

[107] See https://www.hccc.nsw.gov.au/about-us/about-the-commission/legislation

Apart from these extended powers in NSW, the six schemes operate in broadly the same way – see Textbox 5.15.

Textbox 5.15: Key features of code regulation (negative licensing) schemes in six jurisdictions

- A health complaints law is enacted (or amended) that contains definitions of "health service" and "health care worker" (or equivalent term such as "non-registered health practitioner"). These definitions determine the scope of the negative licensing powers and to whom these powers apply.
- A statutory code of conduct is made by regulation. The Code of Conduct sets minimum standards of practice for all non-registered healthcare workers who provide a health service regardless of their discipline or occupation; the nature of their practice; the titles they use; or how they badge, describe or advertise the services they provide. See, for example, the regime in Queensland, Australia.[108]
- The regulator (a complaints commissioner supported by an administrative office) has statutory powers to receive and investigate complaints from health service users or other interested parties and has the power, if warranted, to issue a "prohibition order", to attach conditions to a worker that limit their scope of practice, or to ban them from practice altogether.
- If a healthcare worker who is subject to a prohibition order breaches the order, they may be prosecuted through the courts. Offences are punishable by fines or up to two years' imprisonment.
- HCE websites provide online searchable public registers of prohibition orders that provide information to the public on the prohibition orders issued and other warning statements and press releases. There are links to, and mutual recognition of, orders published in other states, to prevent those who are subject to a prohibition order from skipping across borders to continue practising.

Source: Carlton et al. 2024: 40–41

Under these schemes, there is no legal barrier to entry to an unregistered health profession – anyone can set out their shingle and practise, no matter what their level of training or skill. However, the law provides a mechanism for a regulator (usually an HCC or health ombudsman) to receive and investigate complaints about a practitioner. The regulator (an HCE or tribunal) may then issue a prohibition or banning order to remove a practitioner from practice if it finds that the practitioner has either committed a serious offence or breached minimum standards of practice set out in the statutory Code of Conduct (or both), AND their continued practice presents a serious risk to the public.

An online register of prohibition orders is intended to inform the public of the identity of prohibited or banned workers and provide details of the misconduct. See, for example, the register of prohibition orders published by the NSW HCCC.[109]

There are, however, some deficiencies in how these arrangements have been implemented. When considered in the light of the risk profile of the social work profession and the absence of other controls over professional practice of social workers, these deficiencies translate into inadequate protection for service users. These deficiencies are outlined below.

ISSUE 1 – Unacceptable delays in implementation of the Code of Conduct across the country

It is now over 10 years since Health Ministers agreed to implement the National Code of Conduct, and as outlined above, implementation was staggered over 10 years, and it is yet to be implemented in every state and territory. At the time of writing, the HCEs in two jurisdictions (NT and TAS) still have no Code of Conduct,

[108] Queensland Health. *The National Code of Conduct for Health Care Workers (Queensland)*. 2015; Available from: https://www.health.qld.gov.au/system-governance/policies-standards/national-code-of-conduct.
[109] NSW Health Care Complaints Commission. *Prohibition Orders*. 2021; Available from: https://www.hccc.nsw.gov.au/Decisions-Orders/Register-of-Prohibition-Orders-in-Force

no strengthened complaint investigation powers, and no powers to issue prohibition orders to remove unfit persons from practice, even in the most egregious cases such as those set out in this report (see Criterion 3).

The ACT and WA Codes only came into effect in 2023, eight years after the Ministerial Council agreement and more than 15 years after the powers were first implemented in NSW. History shows that delays of this nature are not unusual with state-by-state implementation of a national agreement. However, given the risks associated with social work practice, such delays are unacceptable.

ISSUE 2 – Serious under-resourcing, lack of transparency and lack of standardisation

Delayed implementation of these extended HCE powers is not the only concern. Given the harms that have been reported, even more concerning is the general lack of transparency in the application of these powers by most HCEs and evidence of serious under-resourcing (AASW 2024; Doolan 2025; Dawson 2025).

For instance, the level of information available to the public concerning prohibition orders issued under the six schemes is highly variable. In Victoria, for instance, virtually no information is published on the website of the HCE when a prohibition order or interim prohibition order is published.

The single national register of prohibition orders that Health Ministers agreed to in 2015 is yet to be implemented. The intention was that consumers could go to one place to find persons banned or prohibited from practice in any state or territory. It appears this has fallen off the agenda altogether.

We question how members of the public are supposed to know and understand the seriousness of the matters dealt with by HCEs and take steps to avoid or protect themselves from practitioners who are unfit to practise, if the most basic information about the nature of the misconduct that led to the prohibition order remains confidential and there are eight different places to go to find out whether a practitioner has a prohibition order. Add to this the banning orders now being issued in other sectors, such as under the NDIS[110] and by the Aged Care Quality and Safety Commission.[111]

A recent study of the operation of several of these HCE negative licensing schemes has found a range of other anomalies, inconsistencies and gaps in the way the schemes operate, all of which reduce efficiency and increase the risk of regulatory failure – see Textbox 5.16.

Textbox 5.16: Findings from a study of HCE prohibition order powers in Queensland and NSW

- In NSW, prohibition orders may be removed once they have expired, whereas in Queensland, prohibition orders may be removed if the Health Ombudsman (HO) or the Queensland Civil and Administrative Tribunal (QCAT) revokes the prohibition order. This means the number of prohibition orders reported in the NSW HCCC and Qld Office of the HO (OHO) Annual Reports does not accord with those available on their websites.
- Unlike under the NRAS, there is no link or permanent record of disciplinary decisions provided to the public for unregistered health practitioners.
- Unlike under the NRAS, there is no national register of prohibition orders available for the public to easily search to check unregistered practitioner qualifications or details.
- Information available on the type of practitioner issued with prohibition orders is variable, with a lack of adequate description on some HCE websites, and in most cases, details or reasons for issuing a prohibition order are not provided.
- Many of the prohibition orders provide no detail or reasons for why a prohibition order was made.
- There is no standardisation in the reporting of complaints data across the jurisdictions, so it is difficult to compare the schemes against the most basic of performance indicators. For example, while NSW

[110] See: NDIS Quality and Safeguards Commission website: https://www.ndiscommission.gov.au/about-us/compliance-and-enforcement/compliance-actions
[111] See: Aged Care Quality and Safety Commission website: https://www.agedcarequality.gov.au/providers/non-compliance/banning-orders

provides an annual breakdown of complaints against types of unregistered health practitioners, Queensland does not.

Source: Doolan 2025.

In the AASW's own investigations, we found worrying deficiencies in relation to how HCEs deal with complaints about social workers. We found that HCEs:

- cannot identify which practitioners are social workers in their complaints data
- cannot report on how many prohibition orders have been issued in relation to social workers
- are unable to report on the scale and scope of social worker misconduct across Australia
- have provided no guidance to the public about how they may lodge a complaint about a social worker
- have failed to attach relevant practice conditions when issuing prohibition orders about social workers
- do not coordinate with the AASW when issuing a prohibition order about a social worker, to ensure suitable practice conditions are put in place and practice is monitored to identify any breaches.

We understand that Ahpra from time to time works with professional associations to share complaints data and to help associations develop preventative strategies for their members (such as case noting, supervision, what constitutes a boundary violation etc). To our knowledge, HCEs do not provide similar support. Instead, it seems the HCEs are under-resourced, operate in silos, do not share information, and it appears they have no obligation or resources to work with professional associations on prevention and risk mitigation strategies.

ISSUE 3 – The threshold for regulatory action is too high, given the risks

The threshold for regulatory action by an HCE is generally "serious risk to public health or safety" or commission of a serious criminal offence, that is, an offence punishable by imprisonment. This is a very high threshold for regulatory action. As a consequence, only the most egregious cases result in regulatory action and a prohibition order (Lloyd et al. 2021: 51).

Presumably where a complaint does not meet the threshold for a prohibition order and is not suitable for conciliation (for example, where the practitioner refuses to come to the conciliation table), the matter is closed without further action. It is no surprise then that service users are reluctant to complain and lack trust in the system.

Complaints about social workers could be referred by the HCEs to the AASW for necessary action, but this is not happening.

ISSUE 4 – Failure to consider impacts of prohibition orders on non-health service sectors

To issue an order that prohibits a practitioner from providing health services, without considering the broader context of practice, in many cases simply pushes the problem into another sector, generally the social care (community services or disability) sector.

Ministers and their departmental officers talk to us from time to time about the importance of "joined up government" and about the need for greater focus on the social determinants of health. However, the way these separate schemes are designed, there are missed opportunities to achieve better system-wide integration of complaint management across states and territories and across healthcare and social care.

We have provided case studies of social worker misconduct as examples of the insufficient protections for the public – see Case studies 1, 2, and 3.

In Case study 1, for instance, the service user (the victim) had multiple vulnerabilities, was a victim/survivor of child abuse and sexual assault and was experiencing suicidal ideation. While a prohibition order was issued, its focus was on preventing the practitioner from continuing to provide counselling and psychotherapy services,

overlooking or unaware of the fact that the practitioner was a social worker. The order failed to identify the practitioner as a social worker and failed to prohibit them from working in settings outside of health.

We are alarmed that this scenario has been presented to demonstrate that the public is being protected from social worker misconduct when the social worker concerned is continuing to work in the community sector without sanction or restriction.

This is an extremely serious failure, one that has placed other vulnerable service users at risk. Sadly, this is not the only example.

If HCEs continue to work in isolation like this, they are simply shifting the problems, not solving them. Unless Health Ministers address this issue by taking a systems view, and design better regulation that satisfactorily addresses the interdependencies between health, community services and disability sectors, we will see many more of these types of cases.

ISSUE 5 – The system is complex and largely reactive, responding generally only after harm has already occurred

With multiple separate state and territory complaint management systems, the system is complex and fragmented – see Figure 7.

Also, application of the prohibition order powers is largely reactive, with regulatory action triggered usually once harm has already occurred (Lloyd et al. 2021: 51).

Such schemes do not provide the infrastructure to enable proactive and non-punitive quality assurance measures to be applied. Minimum levels of practitioner training and probity checks are not enforceable, nor are education programs to assist practitioners to identify and prevent inappropriate practice behaviours – measures that would be expected to prevent recidivism and reduce the risk of breaches by other practitioners (Lloyd et al. 2021: 51).

The AASW experience with the HCEs and their administration of the National Code of Conduct for healthcare workers highlights some of the flaws in these arrangements. In our view, HCEs are not resourced or equipped to deal with complaints about social workers and social work practice. To say we were surprised by the results of the survey of HCEs is an understatement:

- Only one out of eight HCEs (the NSW HCCC) was able to provide data on complaints received and dealt with relating to social workers, and to identify the prohibition orders that have been issued against social workers.
- No HCE or government department has approached the AASW about the rate of complaints made about social workers or the data the AASW collects through its Ethics and Complaint Management Process (ECMP).

At least one HCE has reported on some of the deficiencies:

> *In the absence of the ability to identify all classes of unregistered practitioners or to know how many are in each class, communicating clearly to consumers and providers about who is regulated and who is not is difficult. Planning and effective regulation is also a significant challenge … defined and consistent treatment standards or protocols are often not in place … evidence gathering throughout investigations may be more difficult and resource intensive.* (NSW HCCC 2019: 33)

As the NSW HCCC statement on unregistered practitioners observes:

> *…these investigations tend to raise serious concerns of public health and safety and generate intensive and complex investigations.* (NSW HCCC 2020: 55)

These findings, when considered alongside the data presented under Criterion 2 and the case studies described below, suggest that while the prohibition order powers may be serving an important public protection function, given the risks, stronger regulation with a preventive focus is warranted.

ISSUE 6 – Lack of transparency in reporting and no composite data to support and inform risk-based regulation

The HCE powers and functions, the scope of their jurisdiction and the reporting arrangements are different in each state and territory. The system is complex, and no government has a national overview of misconduct in the social work profession or the risks this presents to the public. There is no nationally reported data available.

As outlined earlier, the AASW made efforts to gather data from HCEs about the number and type of complaints received and dealt with about social workers, what prohibition orders had been issued and the details of these. Table 13 summarises the results of this data collection exercise. It reveals the following limitations with HCE data collection and reporting:

- Only three jurisdictions (NSW, QLD and VIC) reported that they had dealt with one or more complaints about social workers.
- Only two of the forms published by HCEs for lodging complaints (in NSW and SA) provide the option of, or guidance about, identifying the practitioner as a social worker.
- It seems that when a complaint is received about a counsellor, only two HCEs take the time to query whether the practitioner is also a qualified social worker.
- In the six jurisdictions where code of conduct and prohibition order powers apply, the data about how many prohibition orders have been issued against social workers is unavailable and/or unreliable.
- No HCE routinely contacts the AASW when a complaint about a social worker is or has been dealt with, or even when a prohibition order is issued.
- Only NSW HCCC reported that prohibition orders issued about social workers make reference to their qualifications and include conditions relevant to social worker ethics and practice standards.
- No HCE reported that they liaise with the AASW to monitor whether conditions placed on the practice of a social worker are complied with.

Most HCEs have been operating for at least 30 years, and while they meet on a regular basis to discuss issues of common concern, it is an indictment of the system that there is still no agreement on a common data set for reporting HCE data nationally.

Table 13: Health Complaints Entity reporting and management of complaints about social workers

Jurisdiction	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
HCE agreed to assist AASW	✓	✓	✓	✓	✓	✓	✓	X
Produced a report for AASW in the time requested	X	X	X	✓	X	X	✓	X
Reported complaints about social workers	N/A	✓	N/A	✓	N/A	N/A	✓	N/A
Public complaint form provides guidance/option to identify practitioner as social worker	X	X	✓	X	X	X	X	✓
HCE is able to identify whether a complaint is against a qualified social worker (rather than related professions such as counsellor, psychotherapist, youth worker etc)	X	✓	X	X	✓	X	X	X

HCE routinely contacts AASW when a complaint against a social worker is received	X	X	X	X	X	X	X	X
HCE routinely notifies AASW when prohibition order against a social worker is issued	X	X	X	X	X	X	X	X
HCE includes identification of social worker qualifications in prohibition orders	N/A	✓	N/A	X	X	N/A	X	N/A
Prohibition orders issued by HCE include conditions relevant to social worker ethics and practice standards	N/A	✓	N/A	X	X	N/A	X	N/A
HCE routinely liaises with AASW to monitor compliance with members' conditions as a result of complaints	X	X	X	X	X	X	X	X

The response from the Victorian Health Complaints Commissioner illustrates some of these shortcomings – see Textbox 5.17.

Textbox 5.17: Extract from the Victorian Health Complaints Commissioner (HCC) on difficulties generating data on complaints about social workers

Between 1 July 2016 and 30 June 2024, the Health Complaints Commissioner (HCC) received 69 complaints that could be attributed to social workers.

Direct classification of Social Workers within our case management system was difficult due to the various terms used (as per definitions provided in the letter from AASW).

A keyword search was conducted across all complaints between 1 July 2016 and 30 June 2024, focusing on the keywords of "social", "counsellor", "psychotherapist", "youth worker" and associated terms.

Additionally, many social workers operate within the Public Hospital system, and complaints are generally classified against those agencies rather than against an individual social worker.

The data illustrates that a significant proportion of complaints received by the HCC about social workers in the specified period related to health services in the public hospital system. Early data searches indicated a relatively low volume of complaints directly attributed to social workers.

Source: Victorian Health Complaints Commissioner correspondence to AASW dated 9 September 2024

Consultation Papers 1 and 2 of the *Review of the Complexity of the NRAS* do not report national figures on complaints made against social workers or provide any breakdown of the types of prohibition orders issued across the country, in relation to any health profession. This means governments are unable to establish and compare with other professions the level and nature of social worker misconduct. In response, we ask:

> *How are Health Ministers (and the public) to assess the effectiveness of the regulatory arrangements for the non-registered health professions when the data collection and reporting is in such a parlous state?*

How are Health Ministers to assess which professions warrant stronger regulation when their own regulatory systems cannot tell them (or anyone else) what is happening?

Without aggregated national complaints/prohibition order data that can be broken down by profession, how is risk-based regulation to be effective?

Failure to report basic HCE performance data at a national level lulls Health Ministers into a false sense of security – that these arrangements are working well to protect the public. While this may be true (although it is certainly not our experience), it is not good enough that these systems cannot answer basic questions about their performance, let alone report on:

- where the "hot spots" of risk are and how these are being addressed, and
- whether Ministers need to consider stronger protections for some professions or occupational groups.

To summarise, HCEs have varying powers, disclosure obligations and resourcing. The specific limitations in relation to complaints to HCEs about social workers include:

- There are no information sharing and coordination arrangements between the AASW and complaint handling bodies to track and address professional misconduct by social workers.
- The HCEs are not set up to oversee the social work profession.
- Complaint handling bodies do not always report the practitioner's role or qualifications; for example, a social worker may be identified and reported as a "counsellor" or "psychotherapist".
- Social workers can deliver a broad range of health and psychological services; hence, they can continue to work in other fields of practice outside the jurisdiction of the complaint handling bodies, even when a prohibition order is in place.
- The primary concern of complaint handling bodies is safety after harm occurs, not quality.
- HCEs and other complaint handling bodies often respond to matters after professional practice standards and conduct have seriously deteriorated – the "ambulance at the bottom of the cliff" instead of the "fence at the top".
- Registration of social workers delivers a preventive approach to reduce instances of poor practice and misconduct before they occur.

Case studies of regulatory failure

We have selected three case studies that show how the system is failing to protect the public and why urgent action is needed to strengthen regulation of the profession.

Case study 1: [redacted] – dual qualified social worker and psychologist

[redacted] is a social worker who provided counselling services at [redacted] A total of six interim prohibition orders (IPOs) were issued by the Victorian Health Complaints Commissioner (HCC) covering the period July 2021 through to September 2022. An ongoing or permanent prohibition order (PO) was issued in August 2022, but it provides no detail as to the conduct that led to the PO.

A check of the Ahpra Register shows that [redacted] registration as a psychologist was cancelled effective 24 January 2025. A search of the AustLii website located the order, dated 11 February 2025. [redacted] was found to have failed to recognise and maintain appropriate boundaries, engaging in sexual activity with his client, before and within two years after terminating the professional relationship, sexualising the professional relationship, and causing severe harm to his service user.

He was reprimanded, disqualified from applying for registration as a psychologist until April 2026 and prohibited from providing counselling or other mental health services or providing services of a similar nature to those provided by registered psychologists until April 2026.

According to media reporting, when [redacted] relinquished his psychology registration in 2021, he was reported to be continuing to practise in other social work roles, including in an NDIS support service and an Aboriginal Support Service.

None of the eight orders issued (seven from the HCC and one from VCAT) identifies [redacted] as a social worker, and the HCC did not notify the AASW about any of the orders. None of the orders appear to have prevented [redacted] from continuing to practise as a social worker.

The AASW has no disciplinary powers because [redacted] is not a member. According to AASW records, [redacted] did not renew his membership after June 2021.

Sources: Victorian HCC website: [redacted]

Media report: [redacted]

Ahpra Cancelled Registrants Register: [redacted]

Australian Legal Institution (AustLii) website: [redacted]

Case study 2: [redacted] ***– Accredited Mental Health Social Worker***

[redacted], a NSW-based social worker accredited by the AASW as a Mental Health Social Worker was working in private practice at [redacted]

An investigation by the AASW found that [redacted] had engaged in inappropriate relations with vulnerable mental health clients. The investigation found that [redacted] commenced and maintained an inappropriate close personal and sexual relationship with two of her clients, Client A and Client B, in 2018 and 2019, respectively. The Commission found that both clients were highly vulnerable at the time of their counselling, and at the commencement of their close personal and sexual relationships with [redacted], with both having significant mental health issues and a history of drug abuse.

The investigation found that for both Clients A and B, [redacted] did not ensure a suitable period of time had elapsed before commencing a close personal and sexual relationship with them.

In September 2020, the NSW Health Care Complaints Commission (HCCC) issued a prohibition order, permanently prohibiting [redacted] from providing health services, either paid or voluntarily to any person.

A notification of the prohibition order was sent by the NSW HCCC to the AASW. However, [redacted] continues to be able to practise with vulnerable clients in other social work services and settings, beyond the jurisdiction of the HCCC's prohibition order.

Source: NSW HCCC website: [redacted]

Case study 3: [redacted]

[redacted] was working in independent private practice as a psychotherapist and counsellor at two Gold Coast medical centres. An interim prohibition order was issued by Queensland office of the Acting Health Ombudsman in 25th January 2018 prohibiting [redacted] from having contact with female patients. On the 6th of July this Order was varied with later charges being dismissed, resulting

in the Order being revoked on the 16th January 2019. The later prohibition order (issued May 2019) was based on further investigations of the allegations. (Allen QC, 2021, para. 15).

[redacted] applied to the Queensland Civil and Administrative Tribunal (QCAT) to review the decision of the Queensland Health Ombudsman. The case was heard by Judge Allen, QC, Deputy President, in November 2020, and the decision was delivered in March 2021. Judge Allen found:

- [redacted] had, at the very least, acquiesced to sexual activity with patient P.
- [redacted] committed gross boundary violations in his treatment of P. He failed to maintain anything close to the proper professional boundary required between counsellor/therapist and patient. He invited, permitted and encouraged an improper personal relationship with P. He engaged in physical intimacy with P, exploiting their relationship for his own sexual and emotional gratification.
- [redacted] then continued the boundary violation by seeking to continue his relationship with P.
- [redacted] behaviour was particularly disgraceful in deliberately seeking to exploit the knowledge he had gained of P's particular vulnerabilities during his treatment of her.

However, Judge Allen decided that [redacted] did not pose a serious risk to persons and set aside the Queensland Health Ombudsman's prohibition order. In making this decision, Judge Allen referred, amongst other things, to the "personal deterrence" of [redacted] membership with the AASW as a "protective factor against future misconduct". However, no input was sought from the AASW, and no reference was made to the AASW *Code of Ethics* or AASW *Practice Standards*. If the Director of Proceedings from the Health Ombudsman's Office or the Judge had checked with the AASW, they would have found that [redacted] membership of the AASW lapsed on 30 June 2022.

No record or reference could be found on the website of the Queensland Health Ombudsman to indicate that an interim prohibition order was ever issued concerning [redacted] or the results of the appeal to the QCAT.

In relation to QCAT appeals, the OHO website states, "*We report on the number of QCAT decisions in our performance reports. To view QCAT decisions, go to the Supreme Court Library Queensland website"*. However, the link to the performance reports is broken. Reviewing performance reports for the period when this case was determined, AASW had difficulties tracking cases to direct outcomes and finding any reference to data relating to cases heard by QCAT.

In contrast, Ahpra provides extensive information and links to any tribunal decisions and appeals arising from its regulatory activity – see https://www.ahpra.gov.au/Resources/Tribunal-decisions.aspx

Source: [redacted]

The Parliament of South Australia's Joint Committee Report on the Social Workers Registration Bill 2018 (2020) presented additional case studies of regulatory failure involving misconduct by social workers (2020: 14–15).

These cases demonstrate why existing arrangements are not working to protect the public.

First, all cases demonstrate multiple failures in the system.

In the case of [redacted]:

- None of the seven prohibition orders issued identify [redacted] as a social worker.
- [redacted] is identified as a counsellor and former registered psychologist, but not as a social worker.
- Neither the case records nor the prohibition orders reference AASW *Social Work Practice Standards* or *Code of Ethics*.

- At no time was the AASW contacted to verify [redacted] qualifications or to seek information about his membership status.
- In the Victorian HCC orders, [redacted] is prohibited from providing "general health services" involving counselling or psychotherapy, but there is no mention of other components of the social work scope of practice.
- None of the seven prohibition orders issued by the Victorian HCC identified the conduct or reasons for which the orders were issued.
- [redacted] misconduct had a significant adverse impact on a vulnerable service user who was at risk and reportedly continues to feel unsafe.
- The case of [redacted] was not included in the Victorian HCE's reporting to the AASW, presumably because the HCC did not identify him as a social worker.

These processes have had the unintended consequence of shifting the problem from the health sector to the social care system. For the victim, the involvement of multiple regulators and successive disciplinary processes has resulted in repeated trauma, only to see [redacted] able to continue to practise as a social worker.

In the case **of** [redacted]:

- While she was permanently prohibited from providing health services, and the AASW was notified of the prohibition order by the NSW HCCC, there is nothing to prevent [redacted] from continuing to practise with vulnerable clients in other services and settings, beyond the jurisdiction of the HCCC's order.
- A Google search conducted on 14 March 2025 generated data that suggests [redacted] may still be practising in [redacted] and advertising her qualifications as an Accredited Mental Health Social Worker.

In the case of [redacted]:

- The QCAT order pointed to his membership of the AASW as a factor in the decision to set aside the OHO prohibition order. [redacted] last renewed his membership in June 2021 and then let his membership lapse the following year.
- A Google search of [redacted] conducted on 14 March 2025 reveals nothing of his disciplinary history.
- No record was found on the OHO website of any prohibition order being issued in relation to [redacted].

Second, in all three cases, only a determined researcher with knowledge of these systems is likely to track down relevant information. In all three cases:

- The information on the websites of HCEs is difficult to find.
- In some cases, the search functions do not work reliably, even when using the correct name of the practitioner.
- The prohibition orders generally do not provide details as to the reasons for the decisions.
- In some jurisdictions, such as Victoria, even the nature of the misconduct that led to the order is not published.

While the public statements issued by the NSW HCCC usually provide more detailed information, they do not appear to be issued routinely in every case.

Given these deficiencies, how are service users or employers supposed to navigate such a system?

Third, there is insufficient guidance for service users about how to make a complaint about a social worker. Most people are unaware of their workers' qualifications, particularly when social workers typically hold or carry out many different roles within a service, with job titles that may give no indication they are a social worker.

We know from the experience of the Chinese medicine profession in Victoria, when a profession-specific complaint handling body was established, complaints escalated significantly – when people knew where to complain, they did (Lin & Gillick 2011).

Fourth, HCEs may well believe they are adequately dealing with complaints about social workers and that such workers do not pose risks to the public that require government attention. Without accurate data, HCEs are likely to mislead government bureaucrats and Ministers about the scale and nature of the problem.

To try to solve these problems state by state will take many years and considerable duplication of resources. Efforts to coordinate across jurisdictions are hampered by the fact that the Health Ministers' decision of 2015 to establish a single national register of prohibition orders has not been implemented, and there appears to be no timetable for doing so.

The lack of transparency and lack of data is stark when compared to the information available on the Ahpra website. Textbox 5.18 provides an extract from the Ahpra website, showing explanatory information and links to court and tribunal decisions, and the ability to search the "Cancelled health practitioners" register. While the tribunals have the power to issue a prohibition order at the time they cancel the registration of a practitioner, these orders only relate to health services.

What protection does this afford the service users when it simply shifts the problem to another service sector?

Textbox 5.18: Extract from the Ahpra website information on Court and tribunal decisions

Court and tribunal outcomes are independent and public.

Tribunal decisions relate to complaints or concerns about the conduct, performance or behaviour of a health practitioner.

Court decisions can sometimes refer to an appeal of a tribunal decision or more commonly the outcome in court of a criminal offence matter.

We publish summaries of these outcomes on the Ahpra and National Board websites. For decisions about practitioners in New South Wales, please refer to the Health Care Complaints Commission website.

We also publish a link to tribunal or court decisions on each practitioner's record on the Public register , which involve adverse findings and which were delivered after the start of the National Registration and Accreditation Scheme.

Publishing outcomes can help the person we receive the complaint or concern about see through the eyes of the person who raised it with us.

They also help practitioners understand how the National Law helps them to practise safely or ethically.

Importantly, they show members of the public what is an acceptable and unacceptable level of care and behaviour.

A full record of decisions made by adjudication bodies (other than panels) relating to complaints made about health practitioners or students is published in the Australian Health Practitioner Law Library published on the Australian Legal Information Institute's (AustLII) website.

Source: Ahpra website - https://www.ahpra.gov.au/Resources/Tribunal-decisions.aspx

https://www.ahpra.gov.au/Registration/Registers-of-Practitioners/Cancelled-Health-Practitioners.aspx

Conclusion regarding Criterion 3:

The **risk profile of the social work profession is substantial**; the risks are increasing, and the pattern of harm to service users is not being adequately addressed under the current fragmented regulatory arrangements.

The existing mix of self-regulatory, co-regulatory, negative licensing and other mechanisms are failing to adequately address the risks of harm associated with the under-regulated practice of social work.

Criterion 4: Is regulation possible to implement for the occupation in question?

It is possible to implement statutory registration for the social work profession.

First, social work qualification, accreditation, and practice standards are well established and can be readily adapted and adopted by a statutory regulator:

- Social work has an established body of knowledge and well-established and accepted national standards of practice that include requirements for CPD. It is therefore possible to define the profession and its body of knowledge sufficiently for the purposes of regulation.
- Qualifying programs for entry to practise as a social worker have been offered at university level for over six decades in Australia and are available in every state and territory.
- There is a well-established system of accreditation of education providers and programs, with national accreditation standards and social worker competencies.
- There are already established standards for certifying social workers to meet requirements for the delivery of Medicare-rebated clinical mental health services.

Second, there is a proven process and ample precedents for extending the NRAS to include an additional profession – undertaken in 2018–19 for the paramedicine profession and in 2012 for medical radiation practitioners, Chinese medicine practitioners, Aboriginal and Torres Strait Islander health practitioners and occupational therapists.

Third, our knowledge of the profession suggests that social workers generally support statutory registration for the profession, would welcome inclusion of the profession within the NRAS, and will accept the self-funding mechanism where the registration fees they pay are set at a level to cover the costs of regulation.[112]

Fourth, while it is true that the National Scheme is large and somewhat complex, it:

- provides a national legislative and governance arrangement that effectively navigates the complexities of our federal system of government
- provides the economies of scale necessary to support a national regulator with enormous capacity to deliver government workforce objectives, all at no cost to governments
- is far less complex than the regulatory arrangements that applied prior to its establishment, when there were over 90 separately constituted regulators across the country under 38 separate administrations under multiple pieces of legislation
- is far less complex than the current fragmented and under-resourced, complaint-handling arrangements that apply under state and territory HCEs and a variety of other federal and state complaint-handling bodies
- offers significant efficiencies over the existing arrangements where hundreds of government and non-government agencies and individuals (public and private employers, health insurance providers and self-managed service users) must separately undertake their own credentialing and probity checking of social workers, rather than accessing a single trusted source – the Ahpra register.

Given the status quo is unacceptable, and South Australia has already commenced implementation of statutory registration, we have given some consideration to various alternative governance models, including:

- eight separate state/territory-based social worker registration schemes, relying on arrangements for mutual recognition of standards and registration across state and territory borders

[112] See also surveys conducted by the Social Workers Registration Board of South Australia – Wendt et al. 2024

- a separately constituted Social Work Board of Australia under its own administration, reporting directly to multiple state, territory and Australian government ministers (for health, mental health, community services, disability, veterans' affairs, etc).

Each of these options brings its own set of complexities and is likely far more difficult to implement than expanding the NRAS.

While we support the path the South Australian Government has taken to break the deadlock and legislate to establish the SWRB in that state, we are opposed in principle to separate state-based social worker registration schemes. Reverting to a jurisdiction-by-jurisdiction regulatory system is a backward step – a model that history shows has failed to deliver (Productivity Commission 2005; 2012; OECD 2015: 61).

Similarly, to establish a single profession regulator under its own national administration:

- is not best practice regulation
- would not provide the economies of scale needed to support a best practice regulator, and
- would not facilitate the interprofessional collaboration, education and standard setting that our healthcare and social care systems need.

Instead, we support an integrated solution – an extension of the NRAS, with a Social Work Board of Australia, with administrative support provided by Ahpra. We believe the advantages of extending the NRAS to include social workers far outweigh those of alternative models, given the risks and costs. We are confident that an NRAS regulator would manage the complexities of dealing with Ministers in multiple portfolios.

Conclusion regarding Criterion 4:

Regulation is possible to implement for the social work profession – it **is a well-defined and well-established health profession in Australia**. It has an established body of knowledge, modalities, principles and philosophies; education programs at the university level accessible across the country; and established education and practice standards.

The profession is generally supportive of statutory registration and able to finance via registration fees the operation of a self-funded National Board and associated administrative infrastructure.

Criterion 5: Is regulation practical to implement for the occupation in question?

Mandatory registration for social workers has been introduced in many countries, including Brazil, Canada, Finland, France, Hong Kong, Iceland, Ireland, Israel, Japan, Lithuania, New Zealand, Russia, Romania, Slovakia, South Africa, United Kingdom (England, Scotland, Northern Ireland and Wales), United States, Nigeria and Zimbabwe.

Australia is lagging in ensuring a fit-for-purpose regulatory framework for the profession.

Other countries also have been far more effective at managing the systems interface between healthcare and social care. For instance, the UK HCPC is a multi-profession regulator that is responsible for regulating both the psychology and occupational therapy professions, and up until 2018 also regulated social workers (prior to the establishment of a separate regulator in Social Work England). The HCPC's responsibilities span both health and social care professions, as does the UK meta regulator, the Professional Standards Authority for Health and Social Care.

There are multiple examples that demonstrate the practicality of implementing statutory registration for the social work profession.

There is nothing new or different required. The same "protection of title" model of regulation that applies to the 16 health professions regulated under the NRAS may be applied to the social work profession. No adaptations or modifications to the basic NRAS regulatory model are necessary. Unlike provisions

contained in the *Social Workers Registration Act* of South Australia, we are not seeking a scope of practice definition or any practice protections.

For some years now, the AASW has been benchmarking against, and aligning its practice standards, guidelines and complaint management and disciplinary processes with those of the National Boards and Ahpra.

Social work is no different to psychology in that a proportion of registrants would be working in sectors associated with health, such as disability etc. Like psychology, one or more area of practice endorsements may be required, for example, to ensure that Medicare can continue to identify those social workers with the additional credentials that qualify them to deliver Medicare-rebatable mental health and other clinical services.

Conclusion regarding Criterion 5:

Regulation is practical to implement for the social work profession. There are ample precedents both in Australia and internationally. The standard model that applies to the 16 NRAS-regulated health professions is appropriate for the social work profession. No specific modifications would be required.

Criterion 6: Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

The current regulatory arrangements are not providing sufficient protection for the public from misconduct by social workers and poor social work practice – see Figure 8.

Policy Problem: Overview

Social work requires high standards of practice.
• Vulnerable service users and high-risk environments.
• Demanding and morally complex work.
• Requires clinical skills in many settings.
	Poor social work practice and ethical misconduct is occurring.
	• Evidence of misconduct and poor social work practice includes:
	  • Complaints to health bodies.
	  • Coronial investigations of deaths and social work involvement.
	  • Complaints made through AASW Ethics and Complaints Management Process.
	  • Evidence of harm from occurring in other countries.

Self-regulation model is limited and insufficient to protect the public.
• AASW as the peak body and holds key self-regulation functions.
• Membership with the AASW is voluntary.
• Large part of the workforce are not members of AASW.
• Refusal of membership is the strongest penalty available to the Association (for those members with credentials, this also includes removal of their AASW credential)
	There is no national mechanism to regulate professional conduct of social workers in Australia.
	• Regulatory and complaints authorities across Australia are not designed to address social work conduct and practice.
	• Health complaints commissions:
	  • Cannot prohibit social workers from delivering services in all fields of practice.
	  • Focus on response to practitioners after severe transgressions – once harm has been done.
	  • Do not coordinate with AASW.

Figure 8: The policy problem

The options

We assume the range of feasible options that may be assessed under a Regulation Impact Analysis (RIA) process are the same range of options assessed in the RIS on the National Code of Conduct for healthcare workers and the COAG Health Council RIS on paramedics, that is:

- maintain the status quo (no change)
- strengthen co-regulation – a quality assured, voluntary, registers scheme
- strengthen HCE complaint-management systems (negative licensing)
- introduce statutory registration (extend the NRAS).

As things stand, the patchwork of arrangements that apply under separate HCE legislation in each state and territory provides a regulatory regime that is unable to protect the public from social worker misconduct. Our concerns include:

- lack of appropriate resourcing of the investigation of the complaint management functions
- lack of suitable arrangements to manage complaints about social workers or to provide guidance to the public about how to complain about a social worker
- inability to report on the risks associated with social work practice
- lack of suitable arrangements for identifying and distinguishing social workers from other counsellors, and to apply appropriate conditions on practice when a prohibition order is issued (e.g., lack of reference to the AASW Code of Ethics and Practice Standards)
- lack of understanding of social work professional expectations
- lack of coordination and cooperation with the AASW and our complaints management process
- lack of capacity to identify "hot spots" of risk and take preventive action to mitigate the risks associated with social work practice.

Our view is that while HCEs have an important public protection role to play, the powers and functions they exercise are insufficient to protect the public, given the extent and seriousness of the risks and harms associated with social workers and social work practice.

Anticipated costs of statutory registration

Registration fees vary with the size of the profession – smaller professions have higher fees because there are less economies of scale, and some professions are more expensive to regulate than others, due to the nature of their practice.

Assuming a registrant base of approximately 48,000 social workers, we estimate that the fee for general registration as a social worker under the National Scheme would be in the order of $400 per annum per registrant (although we understand based on the experience of other professions, this figure may reduce after the first few years, once the financial reserves of the new National Board are built up to cover contingencies).

This figure of $400 has been arrived at, taking into account the following factors:

- The registrant base is likely to be relatively large, equivalent to that of psychologists and physiotherapists, the third and fourth largest registered professions in the National Scheme.
- The fee charged for renewal of general registration in 2024–25 for other similar-sized professions (pharmacists, physiotherapists, psychologists, occupational therapists) is comparable with what we are suggesting – see Table 14.
- The risk profile of the social work profession may mean lower costs – there may be fewer complexities in the regulatory task (and therefore lower costs) than for psychologists (where there are nine area of practice endorsements available and disciplinary matters are often complex) or pharmacists (where factors such as internships, and the interface with medicines regulation and pharmacy premises regulation adds complexity and cost).

Table 14: General registration renewal fees by profession

Profession	Registrant base (31 Mar 2025)	General registration renewal fee (2024–25)
Occupational therapy	34,143[113]	$127
Pharmacy	40,516[114]	$470
Physiotherapy	47,519[115]	$202
Psychology	50,066[116]	$454

Source: Ahpra/National Boards data and statistics

Anticipated benefits of statutory registration

There are considerable benefits likely to flow from statutory registration of social workers. Figure 9 sets out some of the anticipated benefits. These benefits are likely to be broadly distributed across:

- service users
- governments – at all levels
- non-government organisations – employers, health insurers
- the profession
- the community more broadly.

In addition, under statutory registration, the regulatory and representative functions of professional associations would be separated, thereby reducing the possibility of conflicts of interest. Professional associations would be able to focus their resources on supporting their members and professional development. Statutory registration would provide more robust and effective complaints and disciplinary processes. Every government requires the levers to control its workforce, particularly where substantial budgets are directed to pay for services. However, best practice regulation today is not only about better managing risks and harms.

Regulation is increasingly being used to facilitate the achievement of broader health system, population health and societal goals (Carlton et al. 2024 p. 18; 72). Modern multi-profession regulators are increasingly expected to assist governments in this endeavour. This is not possible without the necessary tools. Statutory registration of a profession provides these tools.

[113] See https://www.occupationaltherapyboard.gov.au/About/Statistics.aspx
[114] See https://www.pharmacyboard.gov.au/About/Statistics.aspx
[115] See https://www.physiotherapyboard.gov.au/About/Statistics.aspx
[116] See https://www.psychologyboard.gov.au/About/Statistics.aspx

Benefits to the public of national regulation of social workers through NRAS

Professional quality	Public safety
• All professionals registered against consistent high -quality, national professional standards. • Recency of practice requirements. • Registered professionals required to maintain a program of continuing professional development • All practitioners have been trained by an accredited social work education provider.	• Title protection means the public are assured their practitioner has completed the approved training to be called a Social worker. • Public register that includes names of all registered practitioners and outlines any conditions placed on a practitioner's registration. • National and consistent disciplinary framework to undertake disciplinary action in response to the conduct or performance of a social worker.
Professional accountability and recognition	**Workforce mobility**
• Mechanisms for sanctions and investigation of professional misconduct. • Registration and title protection supports public recognition of social work scope of practice.	• Enables practitioners to work across Australia, instead of different registration requirements between South Australia and other states and territories.

Figure 9: Anticipated benefits of statutory registration of social workers

Cost/benefit analysis

In 2016, AASW commissioned Deloitte Access Economics to report on the costs and benefits of the registration of social workers under the NRAS. This report has been updated in 2025 to reflect contemporary costings. Key findings from the 2025 report are summarised in Textbox 5.19.

Textbox 5.19: Extract - Deloitte's Estimates and Calculations Updated for 2025

The size of the social worker workforce is difficult to estimate, with a wide range of estimates depending on sources and methods.

"Break-even" analysis was used to determine the number of adverse incidents of social worker misconduct that would need to be averted for the benefits of registration to outweigh the costs.

Costs:

- *The variable costs were estimated by using the registration fee for psychologists, as a comparable profession, which was $454 in 2025. This will be fully recovered through practitioner fees.*
- *The fixed cost of establishing a board was estimated to be $2 million, based on data from Ahpra annual reports.*
- *Overall, it is estimated that the total cost between 2025 and 2029 of registration of professional social workers is estimated to be $97.8 million, in net present value terms (2025-26 dollars). Based on AHPRA's current practice of fully recovering all costs through registration fees, it is expected that registration would not be a net cost to government. Hence, all costs of registration would be passed on to and borne by social workers registering every year.*
- *The costs were estimated of child abuse, deaths, and admitted patient mental health care.*

Benefits:

- *While occupational regulation in general is seen as creating more costs than benefits, the main class of exceptions is where consumers are ill-equipped to judge the quality of a professional's services. That is arguably the case with the clients of social workers, who are often vulnerable or experiencing distress.*
- *Registration of social workers can drive broader benefits for the profession, service users and the broader community, including:*
    - *improved public safety and confidence in the profession*
    - *higher standards of conduct and accountability, and*
    - *professional development and mobility opportunities for workers.*

Conclusion:

Overall, it is estimated that 2 incidents of child abuse and 1 child death would need to be averted in the first year of social worker registration for the benefits to outweigh the cost of establishing the registration of the social workers.

Source: Deloitte's Estimates and Calculations Updated for 2025.

While the size of the social worker workforce has tripled since 2016, to an estimated 49,500, the methodology and findings of this study remain relevant. In fact, the break-even point would be expected to be lower because, in estimating the benefits of national registration, the study did not take account of the administrative savings that would be expected to flow to a broad range of bodies that under current arrangements are obliged to individually undertake credentialing of social workers (state, territory and federal governments, public and private health insurers, employers, and self-managed service users).

Conclusion regarding Criterion 6:

This assessment provides prima facie evidence of the need for statutory registration of the social work profession and that the substantial benefits of regulation are expected to outweigh the costs. This assessment demonstrates that existing mechanisms for protecting the public are inadequate and that statutory registration is the only option that will provide sufficient protection from harm, given the risk profile of the profession.

Australia is an outlier in its failure to implement a regulatory framework for the social work profession to better protect vulnerable people and communities.

6. CONCLUSIONS

Social work fulfils the six criteria for inclusion in the NRAS.

Criterion 1: Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?

YES.

- Social work is the largest allied health profession in Australia.
    - https://www.health.gov.au/topics/allied-health/about
    - https://www.health.nsw.gov.au/workforce/alliedhealth/Documents/social-work-workforce-horizons-scanning-report.pdf
    - https://www.health.vic.gov.au/allied-health-workforce/allied-health-research
- The two largest fields of practice of AASW members are mental health and health.

Criterion 2: Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?

YES.

- Social work has the same risk profile as psychology, which is a registered health profession.
- Coronial inquests have determined that improved performance and oversight through regulation of social workers may have prevented loss of lives.

Criterion 3: Do existing regulatory or other mechanisms fail to address health and safety issues?

YES.

- Complaints processes are insufficient and not coordinated to regulate social workers.
- State Codes of Conduct are not enough to prevent social workers from working in another field of social work practice.
- If governments want the levers to assure the safety and quality of social work services and, at the same time, drive workforce reform, then the tools afforded by statutory registration provide those levers.
- Implementing national registration for the social work profession would bring Australia into line with other comparable countries, including the UK, US, Canada and New Zealand, where mandatory statutory registration is required for social workers.

Criterion 4: Is regulation possible to implement for the occupation in question?

YES.

- The occupation has a well-defined body of knowledge, with functional competencies defined, including accreditation standards and contemporary practice standards.
- The occupation has accreditation standards with higher education providers.

Criterion 5: Is regulation practical to implement for the occupation in question?

YES.

- Self-regulation is insufficient.
- AASW leadership favours the public interest over the self-interest of the profession.
- AASW will seek compliance from members.
- There are sufficient numbers of social workers to contribute to the cost. There is no issue with cost recovery.

Criterion 6: Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

YES.

- Other comparable countries have all made this determination. Australia is lagging.

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ATTACHMENT 1: BACKGROUND TO THE AHMAC REGULATORY ASSESSMENT CRITERIA AND PROCESS AND TYPES OF OCCUPATIONAL REGULATION

The regulatory assessment policy framework

The policy framework governing joint government (national) assessments of the need for statutory registration of the non-registered health professions is set out in three key documents.

First, the *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the health professions* (the NRAS IGA), signed in 2008 by Australian state, territory and Commonwealth Governments committed all governments to the establishment of NRAS. The NRAS was established for 14 professions in 2010–12 and the scheme was expanded in 2016 to include the profession of paramedicine and regulate midwifery as a separate profession (making 16 regulated health professions encompassing 24 health occupations, regulated by 15 National Boards).

Attachment B of the NRAS IGA sets out the arrangements for inclusion of other health professions in the National Scheme and adopts the AHMAC criteria for regulatory assessment that were first agreed upon in 1995 – see Textbox 1.1.

The NRAS IGA references two "guiding principles in developing these criteria":

> (a) the sole purpose of registration is to protect the public interest; and
>
> (b) the purpose of registration is not to protect the interests of health occupations.

Second, in 2018 AHMAC published a document titled *AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions* (the AHMAC Guidance).

The AHMAC Guidance outlines the process to be followed by the NRAS Ministerial Council (comprising all state, territory and Commonwealth Health Ministers) when deciding whether to extend the scope of the NRAS to include a non-registered health profession. The document sets out:

- how the NRAS Ministerial Council (formerly known as the COAG Health Council or CHC) considers submissions
- details of the six "threshold criteria" from the NRAS IGA that a profession must meet in order to be considered for regulation under the NRAS, and
- a two-stage assessment process which includes assessment against the six AHMAC criteria as well as a regulatory impact assessment (RIA).

The AHMAC Guidance notes that statutory registration is one of a number of types of regulation governing health workers in Australia and can be restrictive and costly compared with other forms of regulation that may provide similar benefits at lower cost to the community (AHMAC, 2018: 5). These other forms of regulation include:

- self-regulation
- negative licensing
- protection of title
- credentialing
- various forms of co-regulation. (AHMAC, 2018: 5)

Third, in 2021, an updated guidance on the Regulatory Impact Assessment (RIA) process was published on the website of the Australian Government Department of Prime Minister and Cabinet's Office of Impact Analysis (formerly the OBPR) in a document titled *Regulatory impact analysis guide for Ministers' meetings and national standard setting bodies* (2021).

The regulatory assessment process

The AHMAC criteria have not changed since they were first agreed upon in 1995 by state, territory and federal governments (AHMAC, 1995; COAG, 2008; AHMAC, 2018). However, the assessment process has been revised to include a further hurdle – that an RIA be done that complies with the requirements set out in the OIA publication outlined above (OIA, 2021).

While decisions to extend statutory registration to a non-registered health profession are subject to national agreement, there are circumstances where a state or territory government may choose to "go it alone" and regulate a health profession outside of the NRAS, with or without securing the prior agreement or blessing of the NRAS Ministerial Council. This has occurred recently with the passage through the South Australian Parliament of legislation to establish a registration scheme in that state for the profession of social work.[117]

Types of occupational regulation

Four main types of occupational regulation are outlined below. These have been adapted from various sources (AHMAC 2018; Carlton 2017; WHO WPR 2016). They are:

- voluntary certification
- co-regulation
- negative licensing
- occupational licensing or statutory registration.

Voluntary certification (also known as self-regulation)

Under voluntary certification there is no underpinning statute enacted by government that confers powers on a regulator to license members of the profession or occupation. Rather, professionals join and establish an association with a constitution, bylaws and rules for its members. The association may be registered as a body corporate under the relevant law of a country.

On joining the association, professional members agree to abide by the rules of the association and its code of ethics. The association may operate a consumer complaints mechanism and the rules may provide for members to be expelled for serious breaches of the code of ethics. However, the system is entirely voluntary – practitioners can choose not to join an association and still practise and can continue to practise if expelled from an association for misconduct.

A variation on this type of occupational regulation is where a legal entity is established specifically to carry out regulatory functions on behalf of a profession separately from the professional association/s. While there is organisational separation of the regulatory functions from the membership representation and advocacy functions, the system continues to be entirely voluntary. While consumers, insurers and health service providers may rely on the professional association for trusted advice about who is qualified to practise the profession, there is no direct involvement or recognition from government.

Co-regulation

Co-regulation is similar to voluntary certification. The key difference is that some of the functions of the self-regulating professional association may be either delegated from or recognised by government. This government recognition or delegation may be conditional on the certification body meeting specified standards in relation to governance and its certification standards and processes. This recognition process establishes, in effect, a partnership between government and the certifying body, and the benefits that flow to practitioners from certification create incentives for practitioners to comply with the professional association's standards.

Code regulation (also known as negative licensing)

[117] See the *Social Workers Registration Act 2021 (SA)* at: https://www.legislation.sa.gov.au/__legislation/lz/v/a/2021/social%20workers%20registration%20act%202021_56/2021.56.un.pdf

Under a negative licensing system, there is no legal barrier to entry to an unregistered profession – anyone can set out their shingle and practice, no matter what their level of training or skill. However, a law is enacted that provides a mechanism for a statutory regulator to receive and investigate complaints about a practitioner. The regulator may issue a prohibition or banning order to remove a practitioner from practice when the regulator finds that a practitioner has committed an offence or a breach of minimum standards of practice and their continued practice presents a serious risk to the public. There may be offences for a breach of a prohibition order and an online searchable public register of prohibition orders.

Occupational licensing (also known as statutory registration)

Under an occupational licensing system, the purpose and functions of the system are not determined by the profession alone (as in the case of voluntary certification) but are generally set out in legislation or other instrument of authority and are subject to public scrutiny (through the responsible parliament and minister). The legislation establishes a regulatory body with powers to register/license and regulate practitioners. Entry to a regulated profession is limited only to those the regulatory body considers to be properly qualified and of good character. This gate-keeping role is underpinned by statute, with powers for the regulatory body to prosecute unregistered persons who "hold themselves out" as qualified to practise the profession when they are not. The statute provides an effective mechanism for restricting entry to the profession, and disciplinary powers to deal with practitioners whose practice falls below an acceptable standard.

There are two distinct models of occupational licensing: reservation of title and reservation of practice. While registration/licensing laws generally prohibit unregistered/unlicensed persons from using restricted professional titles or pretending to be qualified and registered when they are not (reservation of title), some laws go further, prohibiting unregistered persons from providing certain types of clinical services (reservation of practice). Such laws create an exclusive scope of practice, in effect a monopoly, for the profession or occupation concerned.

Comparison of occupational regulation types

The Table 18 compares each main type of occupational regulation against a list of key features and capabilities.

The AASW's membership arrangements and certification program fits within the first model of "self-regulation" and for mental health certified social workers, it also meets the definition of "co-regulation".

Table 18: Types of occupational regulation and key features/capabilities

Key feature/capability	Type of occupational regulation			
	Self-regulation	Co-regulation	Negative licensing	Statutory registration
Statutory basis	NO	NO	YES	YES
Enforceable minimum qualifications for entry to practise	NO	NO	NO	YES
Probity checking of persons prior to entry to practise	NO	NO	NO	YES
Accreditation of qualifying programs for entry to practise	YES	YES	NO	YES
Enforceable minimum standards of practice	NO	NO	YES (on complaint)	YES

Mandatory continuing professional development (CPD)	YES (for members only)	YES (for members only)	NO	YES
Obligation to report professional misconduct by fellow practitioners	NO	NO	YES	YES
Powers to monitor practitioner compliance with practice standards	NO	NO	NO	YES
Powers to impose conditions or limitations on a practitioner's practice	NO	NO	YES	YES
Power to issue practice guidelines/codes	YES	NO	NO	YES
Complaints and disciplinary powers	YES (for members only)	YES (for members only)	YES	YES
Powers to remove unfit practitioners from practice	NO	NO	YES	YES
Offences and penalties for unauthorised use of professional titles	NO	NO	NO	YES
A publicly accessible register of qualified practitioners	YES (for members only)	YES (for members only)	NO	YES
A publicly accessible register of disqualified or barred practitioners	NO	NO	YES	YES
Publication of disciplinary decisions	NO	NO	YES	YES
Protection from civil liability for board members discharging regulatory functions	NO	NO	YES	YES

Source: Adapted from Carlton et al., 2024

ATTACHMENT 2: KEY EVENTS AND ACTIONS RELEVANT TO REGULATION OF SOCIAL WORKERS

Date	Event /action
1968	Hospital Commission of NSW issues General Instruction No 1715 (dated 29.7.68) that only professionally qualified persons be given the title "social worker" and that the test of qualification be eligibility for membership of the AASW.
1985	Northern Territory passes the *Health Practitioners and Allied Health Professionals Registration Act.* Statutory regulation for social workers in the Northern Territory is based on their eligibility for membership of the AASW.
1986	In South Australia a Working Party is established by the Minister of Health the Honourable John Cornwall M.L.C. to report and make recommendations on the appropriateness or otherwise of the statutory regulation of social workers in South Australia. The working party was unable to reach agreement on the need for the introduction of statutory regulation. There was fairly unanimous support for statutory regulation by title from those who would be able to use the title "social worker", but opposition from those who would be excluded from its use under any changes.
Dec 2004	The Commonwealth Government asks the Productivity Commission to undertake a research study to examine issues impacting on the health workforce including the supply of, and demand for, health workforce professionals and propose solutions to ensure the continued delivery of quality healthcare over the next 10 years.
July 2005	The AASW provided a submission to this inquiry, advocating for statutory registration. See https://www.pc.gov.au/inquiries/completed/health-workforce/submissions/sub116/sub116.pdf The AASW also provided a second submission to the position paper. The final report recommended that there should be a single national registration board for health professionals, but failed to include social work in its recommendations for the scope of the scheme.
Dec 2005	Report of Productivity Commission *Australia's Health Workforce* publicly released January 2026 recommends establishment of a National Registration and Accreditation scheme for the health professions (Productivity Commission 2005: 127).
Mar 2008	Intergovernmental Agreement was signed by the Council of Australian Governments, setting out the criteria that are to be applied to assess submissions for expansion of the NRAS to include additional health professions (COAG, 2008, 22).
July 2010	NRAS commences with national registration for 10 health professions.
Nov 2010	Australian Health Ministers, sitting as the Australian Health Workforce Ministerial Council (AHWMC) agree to proceed with a national consultation to consider whether there is a need for strengthened regulatory protections for consumers who use the services of unregistered health practitioners.
Feb 2011	AHMAC releases a consultation paper titled *Options for regulation of unregistered health practitioners*. AASW makes a submission.
Oct 2011	The AASW develops a submission to Health Ministers on the national regulation of the social work profession.

July 2012	Registration commences under the NRAS for four additional professions.
Nov 2012	Following lobbying by the AASW, the Western Australian Minister for Health Kim Hames agrees to put the inclusion of social workers in the NRAS on the agenda of the Health Minister's Meeting of November 2012. State, territory and federal Health Ministers agree to refer the proposal for advice and further consideration by the Australian Health Minister's Advisory Council (AHMAC).
Mar 2013	AASW is advised that AHMAC met and discussed the proposal for registration of social workers and requested that its Health Workforce Principal Committee (HWPC) include in its work plan the progressing of a management process for the inclusion of unregistered professions in the NRAS.
April 2013	*Final Report on Options for the Regulation of Unregistered Health Practitioners* released; it concludes "a single National Code of Conduct with enforcement powers for breach of the Code is considered likely to deliver the greatest net public benefit to the community" (AHMAC, 2013: 7).
July 2013	The first review of the NRAS commences (the Snowball Review). The AASW makes a submission to the review strongly advocating for the inclusion of social work in the National Registration and Accreditation Scheme.
Aug 2013	Australian Health Ministers announce that a National Code of Conduct for unregistered health practitioners will be made by regulation in each state and territory. Ministers asked AHMAC to undertake a public consultation on the terms of the first National Code of Conduct and proposed policy parameters to underpin nationally consistent implementation of the Code, for consideration by Ministers.
Mar 2014	National Code of Conduct Consultation paper is released publicly and submissions invited. The AASW makes a submission continuing to advocate for statutory registration for social workers, as the only pathway for achieving adequate professional standards and public safety.
April 2015	Health ministers agreed to the terms of the first national code of conduct for healthcare workers and a policy framework to underpin nationally consistent implementation of the national code and code-regulation regime. Ministers also agree to establish a single national publicly accessible register of prohibition orders (COAG Health Council, *Communique 17* April 2015, 1).
Aug 2015	Australian Health Ministers met to consider the Final Report on the Independent Review of the National Registration and Accreditation Scheme for health professions (the Snowball Review). The AASW's submission to the Review advocates for the formal regulation of the social work profession in Australia. However, this recommendation is not accepted by the Australian Health Ministers. Health Ministers note that the NRAS Review identified a lack of clarity with regard to the purpose and scope of the National Scheme and agreed to issue a communique to clarify the intent of the National Scheme and propose a process for unregistered professions to raise concerns regarding government policy, funding and programs where absence of registration is the sole factor for exclusion.
Nov 2015	Australian Health Ministers, sitting as the COAG Health Council agree to amend the *Health Practitioner Regulation National Law* to include the profession of paramedicine in the NRAS (COAG Health Council, 2015).

April 2016	South Australia Health Minister Jack Snelling puts social worker registration on the Health Ministers' Meeting agenda for discussion. Health Ministers discuss the proposal and decide to refer the matter to AHMAC for further work and advice back to Ministers at a future meeting.
Oct 2016	After considering further advice, Health Ministers decided not to include the social work profession in the NRAS.
2017	AASW refocuses its advocacy efforts, to lobby states/territories for local registration legislation. Throughout the year, the AASW strongly advocated to relevant Ministers in all states/territories for the development of local registration legislation, focusing primarily on South Australia due to the coronial inquiry reports.
Mar 2018	The South Australian Liberal Party includes social work registration as part of their policy platform, in response to coronial recommendations and advocacy by the AASW.
Sept 2018	AHMAC publishes guidance on the regulatory assessment criteria and process for adding new professions to the NRAS (AHMAC 2018).
	Greens member Tammy Franks introduced the Social Workers Registration Bill 2018 to South Australian Parliament.
Dec 2018	A Joint Committee of the South Australian Parliament was established to inquire into and report on the Social Workers Registration Bill 2018.
2019	The Social Workers Registration Bill is subject to a parliamentary committee inquiry. The AASW attends every hearing and provides oral evidence and two written submissions.
2020	The final report for the inquiry into the Social Workers Registration Bill is released along with the amended legislation.
Oct/Nov 2021	Greens member Tammy Franks introduces the Social Workers Registration Bill, and it is passed with 17 amendments.
Dec 2021	The Victorian government releases *Victoria's mental health and wellbeing workforce strategy 2021–2024,* which states that "The Victorian Government will advocate to Ahpra for a statutory registration scheme for social workers".
April 2022	The Australian Parliament Senate Standing Committee conducts an inquiry into the administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law. The final report – Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law (aph.gov.au) – includes a recommendation that *"...there is a substantial case for regulation of currently unregulated professions including social workers, aged care workers and personal care workers and recommends the Ministerial Council consider whether these professions should be included in the National Regulation and Accreditation Scheme".*
Jan 2023	The AASW develops a renewed focus on advancing national registration of social workers through the NRAS, administered by Ahpra, as the model regulatory solution.

	This involves developing a strategy, building the evidence base, and identifying and engaging key stakeholders.
Sept 2023	The South Australian government introduces into Parliament the Social Workers Registration (Commencement) Amendment Bill 2023, setting the commencement date for the scheme as 1 July 2025. Professor Sarah Wendt is appointed as the inaugural Director for the Social Worker Registration Scheme in South Australia.
May 2024	The AASW commissions research and preparation of a submission to update the 2016 submission.
June 2025	The South Australian Parliament passes the Social Workers Registration (Commencement) Amendment Act 2025, which amends the commencement of the Social Workers Registration Act to a date by proclamation rather than on 1 July 2025.

ATTACHMENT 3: SOCIAL WORKER REGISTRATION – MEDIA COVERAGE 2014–2025

Date	Media	Headline	Link
2 Sept 2025	News.com.au	[redacted]	[redacted]
4 Mar 2025	ABC News	SA's Department for Child Protection did not remove children from mother despite being in "urine-soaked" clothes	https://www.abc.net.au/news/2025-03-04/department-failed-to-remove-urine-soaked-child-from-mother/105000710
18 July 2024	National Indigenous Times	Social workers urge national reform to child protection after damning NSW report	https://nit.com.au/18-07-2024/12604/social-workers-urge-reforms-to-child-protection-system
7 April 2024	Limestone Coast	Social Worker's Registration Scheme established	https://borderwatch.com.au/news/2024/04/07/social-workers-registration-scheme-established/
3 April 2024	The Advertiser	SA social worker registration board revealed	https://www.indaily.com.au/business/appointments/2024/04/03/sa-social-worker-registration-board-revealed
25 Mar 2024	The Advertiser	Building a new workforce by degrees	https://www.adelaidenow.com.au/news/south-australia/south-australian-universities-offering-new-degrees-to-build-education-workforce/news-story/0e9292bc85121ff335c36921c4620739
2 Feb 2024	Mirage News	Enhanced Aid for Social Workers Unveiled	https://www.miragenews.com/enhanced-aid-for-social-workers-unveiled-1177202/#google_vignette
27 Jan 2024	ABC Radio Melbourne	Social Work Registration and Mental Health	https://fb.watch/tuNqaGQFMO/
25 Nov 2023	CityMag	Advocating for a better life for one and all	https://citymag.indaily.com.au/partnership/advocating-for-a-better-life-for-one-and-all/
23 Nov 2023	National Indigenous Times	Australia's peak social workers' association appoints first Aboriginal president	https://nit.com.au/15-11-2023/8633/linda-ford-aasw
1 Sept 2023	Social Work Focus	Make National Social Work Registration a Reality	https://socialworkfocus.partica.online/social-work-focus/spring-2023/flipbook/8/

22 April 2022	The Advertiser	A national child protection database would allow authorities to instantly access crucial information — but Australia still doesn't have one	https://www.adelaidenow.com.au/news/south-australia/a-national-child-protection-database-would-allow-authorities-to-instantly-access-crucial-information-but-australia-still-doesnt-have-one/news-story/c3a05927d46073a4e925e00c4158967a
19 Mar 2019	Limestone Coast	City social workers celebrated	https://borderwatch.com.au/local-news/2019/03/19/city-social-workers-celebrated/
01 Mar 2018	ABC News	SA election: What have the major parties been promising ahead of the March 17 vote?	https://www.abc.net.au/news/2018-03-03/sa-election-what-major-parties-are-promising-ahead-of-march-17/9460654
1 April 2018	Australian Journal of Social Work	Is there a case for the registration of social workers in Australia?	https://journals.sagepub.com/doi/abs/10.1177/0020872818767496?download=true&journalCode=iswb
13 March 2026	ABC News	National social workers' registration scheme urged by South Australia ahead of COAG health meeting	https://www.abc.net.au/news/2016-03-13/sa-pushes-for-national-social-worker-registration/7241018
15 April 2015	SBS.com.au	Coroner slams Families SA over Chloe Valentine death	https://www.sbs.com.au/news/article/coroner-slams-families-sa-over-chloe-valentine-death/opissjiue
10 April 2015	ABC News	Coroner praised over "shocking" findings on how authorities failed 4yo Adelaide girl	https://www.abc.net.au/news/2015-04-10/chloe-valentine-coroner-findings-shocking-freda-briggs-child/6381638
9 April 2015	Nine.com.au	Grandmother of four-year-old Chloe Valentine calls for urgent action on state welfare overhaul	https://www.9news.com.au/national/coroner-calls-for-massive-overhaul-of-families-sa-after-chloe-valentine-death/b173df8a-9780-4728-9354-08dbc5510a43
4 Oct 2014	News.com.au	Chloe Valentine inquest: What could have Families SA done differently?	https://www.news.com.au/national/south-australia/chloe-valentine-inquest-what-could-have-families-sa-done-differently/news-story/7e8292661768e640cb08fff84f409302

ATTACHMENT 5: OCCUPATIONAL REGULATION OF SOCIAL WORKERS BY JURISDICTION – RESULTS OF MAPPING

COUNTRY / STATE	LEGISLATION	REGULATORY AGENCY	PROFESSIONS REGULATED	PORTFOLIO
Alberta **(Canada)**	https://www.acsw.ab.ca/site/about?nav=sidebar#:~:text=The%20HPA%20provides%20for%20protection,by%20the%20Government%20of%20Alberta. *Health Professions Act* https://kings-printer.alberta.ca/documents/Acts/H07.pdf	Alberta College of Social Workers (ACSW) https://www.acsw.ab.ca/	Social workers	Health
Florida **(United States)**	*The 2023 Florida Statutes* *Regulation of Professions and Occupations Clinical, Counseling and Psychotherapy Services* http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0491/Sections/0491.016.html	Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling Florida Department of Health https://floridasmentalhealthprofessions.gov/licensing/licensed-clinical-social-worker/		Health (including Mental Health)
Texas **(United States)**	*Occupations Code.* *Title 3 Health Professions* https://statutes.capitol.texas.gov/Docs/OC/htm/OC.505.htm	Texas Behavioural Health Executive Council www.bhec.texas.gov/texas-state-board-of-social-worker-examiners/index.html	Social workers Psychologists Counsellors	Health (Behavioural Health)
Michigan **(United States)**	Public Health Code, Public Act 61 of 2004 www.legislature.mi.gov/mileg.aspx?page=PABillSearch&paYear=2004&paNumber=61	Michigan Board of Social Work (Health Professional Licensing) www.michigan.gov/whitmer/appointments/oma/all/2/michigan-board-of-social-work		Health

Ireland	https://data.oireachtas.ie/ie/oireachtas/act/2023/14/eng/enacted/a1423.pdf	CORU www.coru.ie/		Health and Social Care
Japan	https://www.japaneselawtranslation.go.jp/en/laws/view/2693/en	Ministry of Health, Labour and Welfare		Health and Welfare
South Korea	*Social Welfare Service Act* https://elaw.klri.re.kr/eng_service/lawView.do?hseq=40193&lang=ENG	Minister of Health and Welfare		Health and Welfare
China	*Social Worker Act* https://law.moj.gov.tw/ENG/LawClass/LawAll.aspx?pcode=D0050125	Ministry of Health and Welfare		Health and Welfare
British Colombia (Canada)	*Social Workers Act* www.bclaws.gov.bc.ca/civix/content/complete/statreg/1527898742/08031/?xsl=/templates/browse.xsl	https://bccsw.ca/		Social Workers (standalone)
Saskatchewan (Canada)	www.sasw.ca/document/4751/S52-1(1).pdf	www.sasw.ca/site/socialworktitle		Social work (standalone)
Manitoba **(Canada)**	https://web2.gov.mb.ca/laws/statutes/ccsm/s169.php	https://mcsw.ca/about-the-college/		Social work (standalone)
Ontario **(Canada)**	*Social Work and Social Service Work Act, 1998* www.ontario.ca/laws/statute/98s31	www.ocswssw.org		Social work and social services

Newfoundland and Labrador **(Canada)**	www.assembly.nl.ca/Legislation/sr/statutes/s17-2.htm	https://nlcsw.ca/Minister for Health and Community Services www.gov.nl.ca/dgsnl/files/NLG20200501.pdf		Social work (standalone)
England	*Children and Social Work Act 2017* www.socialworkengland.org.uk/media/1501/cswa-2017.pdf	Professional Standards Authority for Health and Social Care		Social work and children
Scotland	*Regulation of Care (Scotland) Act 2001* www.legislation.gov.uk/asp/2001/8/contents	The Scottish Social Services Council www.sssc.uk.com/		Social services
Wales	https://socialcare.wales/cms-assets/documents/Social-Care-Wales-Registration-Rules-2022-ENG.pdf	Social Care Wales		
New Zealand	*Social Workers Registration Act* https://www.legislation.govt.nz/act/public/2003/0017/latest/whole.html#DLM189915	Social Workers Registration Board https://swrb.govt.nz/ Ministry of Social Development		Social Worker (standalone)
California **(USA)**	*Business and Professions Code of California* https://www.bbs.ca.gov/pdf/publications/lawsregs.pdf	Board of Behavioural Sciences www.bbs.ca.gov/about/board_info.html	• Licensed Clinical Social Workers (LCSW) Associates (ASW) • Licensed Marriage and Family Therapists (LMFT) and	Department of Consumer Affairs (California state regulatory agency)

			Associates (AMFT) • Licensed Professional Clinical Counselors (LPCC) and Associates (APCC) • Licensed Educational Psychologists (LEP)	
South Africa	*Social Service Professions Act* www.sacssp.co.za/documents/Social%20Service%20Professions%20Act%20110%20of%201978%20(2019).pdf	Professional Board for Social Work www.sacssp.co.za/#:~:text=The%20South%20African%20Council%20for%20Social%20Service%20Professions%20(SACSSP%2FCouncil,of%201978%20(the%20Act		Welfare
Nigeria	*Chartered Institute of Social Work Practitioners of Nigeria (Established by Act No.25 of 2022)* *https://www.c-isown.org/about/enabling-law/*	Charted Institute of Social Work Practitioners of Nigeria *https://www.c-isown.org/#:~:text=The%20Chartered%20Institute%20of%20Social,of%20Social%20Work%20in%20Nigeria*.	Licensed "Sw" prefix	Health and social welfare
Malaysia	*Social Work Profession (PKS) Bill* [PENDING] https://themalaysianreserve.com/2023/04/29/recognise-the-role-of-social-workers-in-nation-building-fostering-unity-among-malaysians/	Social Work Profession Council		

Indonesia	*Law No. 14 of 2019 concerning Social Workers* (Unavailable in English)	Ministry of Social Affairs		*Law No. 14 of 2019 concerning Social Workers* (Unavailable in English)
Thailand	Social Work Profession Act B.E. 2556 (2013) www.krisdika.go.th/data/document/ext838/838221_0001.pdf	The Social Work Professions Council		Social Work Profession Act B.E. 2556 (2013) www.krisdika.go.th/data/document/ext838/838221_0001.pdf
Singapore		Social Work Accreditation and Advisory Board (SWAAB) https://accreditation.sasw.org.sg/		
Philippines	*Board of Social Workers Republic Act No. 4373* www.prc.gov.ph/sites/default/files/Social%20Workers%20Law%20-%20RA%20No.%204373_0.PDF	Professional Regulation Commission www.prc.gov.ph/social-workers		*Board of Social Workers Republic Act No. 4373* www.prc.gov.ph/sites/default/files/Social%20Workers%20Law%20-%20RA%20No.%204373_0.PDF

Hong Kong	*Social Workers Registration Ordinance* https://www.elegislation.gov.hk/hk/cap505	Social Workers Registration Board		*Social Workers Registration Ordinance* https://www.elegislation.gov.hk/hk/cap505
India	*National Council of Professional Social Work Practitioners Bill* http://164.100.47.4/billstexts/lsbilltexts/asintroduced/814%20as.pdf	National Council of Professional Social Work Practitioners		*National Council of Professional Social Work Practitioners Bill* http://164.100.47.4/billstexts/lsbilltexts/asintroduced/814%20as.pdf

ATTACHMENT 6: STATUTORY POWERS EXERCISED BY SOCIAL WORKERS UNDER VARIOUS STATE, TERRITORY AND FEDERAL LEGISLATION

State	Legislation	Powers
		MENTAL HEALTH
ACT	*Mental Health Act 2015* About the Mental Health Act - ACT Government	Mental health officer (MHO) – A person is not eligible for appointment as a mental health officer unless the person is a nurse, nurse practitioner, psychologist, occupational therapist or **social worker**. If an MHO believes you have a mental illness or mental disorder and determines that you need immediate assessment or treatment, they are authorised to take you to an approved mental health facility. It is important to note that those responsible possess a high level of clinical experience and a thorough understanding of the legal requirements that regulate their role. An MHO has the power to enter a property, apprehend a person or search the person and seize items when doing the following: - executing a removal order - apprehending and taking to an approved facility. In carrying out the power of entry and apprehension, the MHO may use necessary and reasonable assistance and minimum force.
New South Wales	*Mental Health Act 2007* *Mental Health Regulation 2013*	A **social worker** may be appointed as an "accredited person"; however, they must be a suitably qualified senior mental health practitioner. Accredited persons are senior mental health practitioners with a minimum of five years of clinical experience in direct mental health consumer care. An accredited person is empowered to write Schedule 1 Certificates and Form 1s. The Schedule 1 Certificate, completed by either a medical practitioner or an accredited person, enables an individual to be taken to a declared mental health facility, against their will if necessary, for the purpose of an assessment. In 2015, accredited persons were given additional powers, in particular circumstances, to conduct an assessment of a person detained in a declared mental health facility (section 27A). Form 1 in the *Mental Health Regulation 2013* has been amended to incorporate this change. As such, accredited persons should document the results of this assessment on Form 1.

Northern Territory	*Mental Health and Related Services Act 1998*	A **social worker** may be appointed as a designated mental health practitioner (all other professions named are regulated under Ahpra). They must have at least 2 years clinical experience and have successfully completed a training course. A designated mental health practitioner must assess a person and determine whether the person is in need of treatment under the Act. A designated mental health practitioner must make a recommendation for psychiatric examination of a person if, after assessing the person, the practitioner is satisfied that the person fulfils the criteria for involuntary admission on the grounds of mental illness or mental disturbance. This recommendation authorises the practitioner to do any of the following: - Control the person and bring the person to an approved treatment facility for psychiatric examination of the person. - If this cannot happen, they can hold them at a hospital or other place a person can be safely held at without the approval of the Tribunal (c) to administer treatment immediately necessary: (i) to prevent the person causing serious harm to the person or to someone else; or (ii) to prevent behaviour of the person likely to cause serious harm to the person or to someone else; or (iii) to prevent further physical or mental deterioration of the person; or (iv) to relieve acute symptomatology; (d) to detain the person at an approved treatment facility for up to 24 hours. The recommendation may authorise a police officer to exercise, or to assist someone else exercising, the powers under subsection (3)(a) if the practitioner considers there is no other alternative in the circumstances. The practitioner may use reasonable force and assistance. A practitioner may apply to the Tribunal for a warrant to apprehend a person. The warrant authorises a practitioner to apprehend and control the person, and to conduct an assessment of the person. A designated mental health practitioner may also be appointed as psychiatric case managers. A psychiatric case manager must: (a) monitor the progress of the treatment, care and rehabilitation of the person for whom the order is made; and

		(b) provide a report, orally or in writing, on the progress of the person to the authorised psychiatric practitioner at least once every 6 weeks.
Queensland	*Mental Health Act 2016*	A **social worker** may be appointed as an *authorised mental health practitioner*; however, they must have a number of competencies as outlined in the document, Appointment of authorised doctors and authorised mental health practitioners. As an *authorised mental health practitioner,* a **social worker** may examine a person to decide whether to make a recommendation for assessment for the person. An examination may be undertaken in any way, for example, with a person's consent or under a provision of the Act. An examination authority authorises an authorised mental health practitioner to enter a place, such as a person's home, to examine the person without the person's consent. The person may be detained for the examination, in a public sector health services facility or authorised mental health service for up to 6 hours, which may be extended up to 12 hours, or in any other place up to 1 hour. The authorised mental health practitioner may exercise these powers with the help and using the force that is necessary and reasonable in the circumstances. In performing these functions, the authorised mental health practitioner is a public official for the purposes of the *Police Powers and Responsibilities Act 2000*. This means that a police officer may be asked to assist the doctor or health practitioner in the exercise of these powers. An authorised mental health practitioner may, within 7 days of examining a person, make a recommendation for assessment for person. A recommendation for assessment authorises an authorised doctor to detain and involuntarily assess a person to decide if a treatment authority should be made for the person. A transfer recommendation may be made by an authorised mental health practitioner if they are satisfied it is clinically appropriate for the person to receive treatment and care for the person's mental illness in an authorised mental health service. Authorised mental health practitioners also complete statements on whether the behaviour of the person, or other relevant factors, could reasonably be considered to satisfy the requirements for making an examination authority for the person.

South Australia	*Mental Health Act 2009*	Authorised mental health professional = An experienced mental health nurse, psychologist, occupational therapist or **social worker** who has been approved by the Chief Psychiatrist to be able to make level 1 community treatment orders and level 1 inpatient treatment orders. Mental health clinicians can also be authorised officers. Social workers who are employed by a public/private mental health service and are eligible for membership of the AASW can be gazetted by the Chief Psychiatrist as authorised officers. Section 56 or "care and control" powers give authorised officers the ability to help people who are mentally unwell and at risk of harm get assessment and treatment. Chief-Psychiatrist-Determination-Mental-Health-Clinicians.pdf Mental Health Act 2009 - Plain Language Guide
Tasmania	*Mental Health Act 2013*	No named powers. Social worker not specifically named as a profession able to be a named Mental Health Officer but may be possible depending on their role.
Victoria	*Mental Health and Wellbeing Act 2022*	**Social workers** are listed as an *authorised mental health practitioner.* As such, they have responsibilities such as ensuring a patient receives a statement of rights and examining a person. As an *authorised mental health practitioner*, a **social worker** may: • make an assessment order in respect of a person if the social worker has examined the person within the previous 24 hours and is satisfied that the compulsory assessment criteria applies to the person • determine whether the order is a community assessment order or an inpatient assessment order. Social workers are also responsible for ensuring transport is arranged for a patient to the responsible designated mental health service after the inpatient assessment order is made • vary the inpatient assessment order at any time before the patient is assessed by the psychiatrist.
Western Australia	*Mental Health Act 2014* Clinicians-Practice-Guide-to-the-Mental-Health-Act-	A **social worker** may be an Authorised Mental Health Practitioner (AMHP). AMHPs are mental health practitioners who are authorised by the Chief Psychiatrist if they are satisfied that the mental health practitioner has the qualifications, training and experience appropriate for performing the functions of an AMHP in the MHA2014. All other professions named under AMHPs are Ahpra-registered health professionals (nurse, psychologist, and OT). The role of the AMHP includes facilitating the referral process to a psychiatrist when a person is suspected of having a mental illness for which the person needs treatment.

	2014-Edition-3.3-June-2024.pdf	AMHPs can, following an assessment, refer a person they reasonably suspect is in need of an involuntary treatment order or is on a CTO, and is in need of an inpatient order, to be examined by a psychiatrist. AMHPs are required to make judgements as to whether to refer a person for examination by a psychiatrist and whether to use transport officers of the police in the process. Consequently, there is an expectation that AMHPs work to an acceptable standard and make responsible informed decisions. AMHPs may make an order authorising the person's detention for up to 24 hours from the time when the order is made if satisfied that the person needs to be detained to enable the person to be taken to the authorised hospital or other place (s. 28). Other functions include: • detention order to enable a person to be taken to an authorised hospital or other place • extension of a detention order • transport order • extension and revocation of a referral order • changing the place of the examination • extension and revocation of transport order.
CHILD PROTECTION		
NSW	*Children and Young Person's (Care and Protection) Act 1998* Children and Young Persons (Care and Protection) Act 1998 No 157 - NSW Legislation	**Taking of action by Secretary** (1) If the Secretary forms the opinion, on reasonable grounds, that a child or young person is in need of care and protection, the Secretary is to take whatever action is necessary to safeguard or promote the safety, welfare and wellbeing of the child or young person. (2) Without limiting subsection (1), the action that the Secretary might take in response to a report includes the following— (a) providing, or arranging for the provision of, support services for the child or young person and his or her family, (a1) offering alternative dispute resolution processes to the family of the child or young person as referred to in section 37. **Removal of children and young persons without warrant**

	Roles and responsibilities | Communities and Justice	(1) If the Secretary or a police officer is satisfied, on reasonable grounds— (a) that a child or young person is at immediate risk of serious harm, and (b) that the making of an apprehended violence order would not be sufficient to protect the child or young person from that risk, the Secretary or police officer may (without the need for any authority other than that conferred by this subsection) remove the child or young person from the place of risk in accordance with this section. (4) For the purposes of this section, the Secretary or a police officer may (without the need for any authority other than that conferred by this subsection)— (a) enter any premises or place in which the Secretary or police officer suspects the child or young person (or the person suspected on reasonable grounds of being a child or young person) may be, and (b) enter the premises or place (and any adjacent place, if the Secretary or police officer suspects on reasonable grounds that the person, having just left the premises or place, is in the adjacent place), and (c) search for the person in the premises or place and in any such adjacent place. DCJ can also— Apply for certain orders (exclusively), Make application for warrants, parent capacity orders (PCOs), emergency care and protection orders (ECPOs), supervision orders, guardianship orders and care orders. The Secretary may delegate to any person any of the Secretary's functions. Delegated officers typically include: - Child protection caseworkers - Team leaders and managers - Specialist practitioners. The Minister delegates particular functions of parental responsibility to the Secretary of the department (section 249 and section 250). In turn, the Secretary delegates particular functions to various positions in the Department via an internal delegations schedule.

Northern Territory	*Care and Protection of Children Act 2007* Northern Territory Legislation	**Delegation** The CEO may, in writing, delegate any of the CEO's powers and functions to a person* who is: (a) an authorised officer; or (b) a public sector employee. **32. The CEO may make inquiries about a child** if the CEO receives information that raises concerns about the child's wellbeing. **35. The CEO may initiate an investigation to determine whether a child is in need of protection.** (2) The CEO may do so only if the CEO believes on reasonable grounds the child might be in need of protection (whether or not inquiries about the child have been made under section 32 or 33). (3) The investigation must be conducted by an authorised officer. **37. Access to child** (1) For an investigation about a child under section 35 or 36, the officer conducting the investigation may request a person mentioned in section 34(2)(b) to (j) (child-related authority) to allow the officer: (a) to have contact with the child; and (b) to do so without informing the parents of the child. *this includes a **social worker** as they fall under the definition of “health practitioner”.
Queensland	*Child Protection Act 1999* Child Protection Act 1999 - Queensland	The definition of a “health practitioner” includes – "a person who is eligible for membership of the AASW'. The Act confers powers on the chief executive. The chief executive then has the ability to delegate statutory powers to officers or categories of officers. This occurs formally through an “instrument of delegation” signed by the chief executive. It gives relevant staff the legal authority to perform the relevant actions.

	Legislation - Queensland Government Roles, responsibilities and delegations | Child Safety Practice Manual	The chief executive may appoint any of the following persons: (a) an officer or employee of the department; (b) a person included in a class of persons declared by regulation to be eligible for appointment as an authorised officer. (1) If the chief executive becomes aware (whether because of a notification given to the chief executive or otherwise) of alleged harm or alleged risk of harm to a child and reasonably suspects the child is in need of protection, the chief executive must immediately— (a) have an authorised officer investigate the allegation, assess whether the alleged harm or risk of harm can be substantiated and, if it can, assess the child's protective needs; or (b) take other action the chief executive considers appropriate. **Contact with child at immediate risk of harm** (1) This section applies if— (a) an authorised officer or police officer is investigating an allegation of harm, or risk of harm, to a child; and (b) the officer has been denied contact with the child or cannot reasonably gain entry to the place where the officer reasonably believes the child is; and (c)the officer reasonably suspects the child— (i) is at immediate risk of harm; or (ii) is likely to leave or be taken from a place and suffer harm if the officer does not take immediate action. (2) The officer may exercise the following powers— (a) enter the place; (b) search the place to find the child;

		(c) remain in the place, and have contact with the child for as long as the officer reasonably considers necessary for investigating the allegation. **Child at immediate risk may be taken into custody** (1) This section applies if an authorised officer or police officer reasonably believes a child is at risk of harm and the child is likely to suffer harm if the officer does not immediately take the child into custody. (2) The officer may take the child into the chief executive's custody. (3) For subsection (2), the officer may— (a) enter the place where the officer reasonably believes the child is; and (b) search the place to find the child; and (c) remain in the place for as long as the officer reasonably considers is necessary to find the child. (4) The officer may exercise a power under subsection (2) or (3) with the help, and using the force, that is reasonable in the circumstances.
Victoria	*Children, Youth and Families Act 2005* Powers of the Secretary when the Secretary has parental responsibility | Child Protection Manual | CP Manual Victoria	**Social workers** are listed as mandatory reporters. **Social workers** may be appointed to the Suitability Panel. Functions include: (a) to hear any matter referred to it by the Secretary under this Part; and (b) to determine whether or not a person should be disqualified from being placed on the register of out-of-home carers; and (c) to hear and determine any application by a person for the removal of a disqualification under this Part. Multiple functions/powers can be delegated by the Secretary to any employee or class of employee. **Child protection practitioners and managers can have authority conferred on them as delegates of the Secretary.** The legislation gives the Secretary powers to intervene in families to protect children from abuse and neglect, and balances these powers with procedures to protect the rights of children and parents. **In relation to a child for whom the Secretary has parental responsibility, the Secretary**:

		• has the sole right to care for the child, and thus the power to decide where a child resides (s. 172(2)(a)) • the power to order that a child be examined to determine their medical, physical, intellectual or mental condition (s. 597(1)) • the power to give consent to the medical treatment, surgical or other operation or admission to hospital, on the advice of a registered medical practitioner that such treatment, operation or admission is necessary (s. 597(3)) • the capacity to demand, sue for and recover any money due to a child (s. 172(2)(b)), and • in the name and on behalf of the child, may commence and prosecute any proceeding relating to any property or rights of the child (s. 172(2)(c)) • the power to detain the child without a warrant (s. 172(3)) • in some circumstances, the power to enrol a child in an educational institution • the power to authorise a carer to make certain decisions on behalf of a child in their care (ss. 175A – 175C).
Federal	*Family Law Amendment Act 2023* *Family Law Regulations 1984* *Federal Circuit and Family Court of Australia (Family Law) Rules 2021*	No powers listed. NOTE With the exception of Western Australia, all states referred state powers with the effect that the Australian Parliament has jurisdiction over marriage, divorce, parenting and family property on separation. All states and territories retain jurisdiction over adoption and child welfare. Rather than referring its powers to the Commonwealth, Western Australia established a state family court, the Family Court of Western Australia, which exercises both federal and state jurisdiction.
	Family Law (Family Dispute Resolution Practitioners) Regulations 2008	appropriate qualification means: (a) a higher education award in: (i) law; or (ii) psychology or **social work** (however described); or (iii) conflict management, mediation or dispute resolution (however described); or

		(b) a higher education award in a field or discipline that, in the opinion of the Secretary, is relevant to the provision of family dispute resolution services; or (c) a vocational graduate diploma (however described) in a field or discipline that, in the opinion of the Secretary, is relevant to the provision of family dispute resolution services.
	Family Law Amendment Regulations 2007 (No. 1) (no longer in force)	Accreditation rules, appropriate degree, diploma or other qualification means: Examples of social sciences relevant to the provision of family dispute resolution: • psychology (including behavioural science) • sociology (including **social work**).
	Family Law Amendment (Recognition of Surrogacy Parentage Orders) Regulations 2022 (no longer in force)	47. Accreditation of counsellors The Secretary of the Department may, by notice in writing, accredit as a counsellor for the purposes of this Act a person who— (a) has a tertiary qualification or its equivalent in **social work**, psychology, counselling or another relevant field; and (b) in the opinion of the Secretary, has appropriate experience.

ATTACHMENT 7: SUMMARY OF AASW ATTEMPTS TO OBTAIN WORKFORCE DATA ON SOCIAL WORKERS EMPLOYED IN PUBLIC HEALTH SERVICES

Jurisdiction	Publicly information available	CAHO* role in holding data?	FOI required	Held within Human Resources	Number of govt units consulted	Time taken to obtain data	Summary
CWTH	No	Did not liaise	Did not liaise	No	3	N/A	• Health Workforce Data Intelligence team do not have the data. • The HR Department advised that this information is not readily available from a system perspective. Key barrier is a lack of social work specific job titles. • Referred to enquiries team.
ACT	No	No	Not required	Did not liaise	4	N/A	• Approached the Health Workforce Analytics team who manage health workforce data at the territory level. • Advised that a formal FOI is not required; however, a Data Request Form is required to be completed. • Senior Analyst from the Heath Workforce Strategy team met with the AASW to discuss the data request. • Advised that the ACT Public Sector employs social workers in health settings across multiple directorates and areas, including education and housing. That means AASW request also covers social workers whom the ACT Health Directorate does not employ. Since ACT Health Directorate is not the data custodian for workforce data in other directorates, ACT is not in a position to respond to this data request. • Advised that there are complexities around data custodianship.

							• Advised that social workers are employed by both the ACT Health Directorate and the Canberra Health Services, which are two separate directorates. To make things more complex, the Canberra Hospital and North Canberra Hospital use different HR systems. There are also ANZSCO code classification issues. • Request sent to 2 directorates above. • Response from Canberra Health Services. • ACT Health Directorate advised they do not have social workers employed in their department.
NT	No	Yes	Not required	Did not liaise	4	20 days	• Sent to data release requests team – advised they are the wrong team as they are data governance. Suggested HR Department or ABF. • Clinical Innovation and Research Unit referred AASW to CAHO office. • CAHO Office has data and can provide it.
NSW	Yes – most recent data is for 2021	Yes, but not provided	Yes, at cost of $840	Did not liaise	2	N/A	• Publicly available information is not up to date. Most recent data is from 2021. • Commenced as an informal data request. Initially advised that the “Ministry of Health” does not employ social workers (appears to be confusion about the request and bureaucratic divisions). • Advised that the data request will require a formal FOI request at a cost of $840 for file searches, locating and retrieving documents/info, assessing and reviewing and analysis of info, third-party consultations (15 LHDs). • Liaised with CAHO office – advised that they tend not to release this information. Advised that the 2021 data that is publicly available is close to the current total figure.

QLD	No	No	Application made	Unsure – sent to HR Branch, response TBC	4	122 days	• Contacted RTI team. • Contacted Public Sector Commission. Told they would follow up as they do not have authority to release info. • Sent email to CAHO office – they do not hold the data. Sent request to HR branch. • PSC advised AASW to persist with QLD Health. • Received another email from RTI advising that the request has come around to them again. Unclear if it has actually reached HR branch as yet. • Likely require an RTI application. • RTI application completed on 13th March. Data received 16th May 2025.
SA	No	No, do not hold data	Yes, for each individual LHN	Did not liaise	3	N/A	• CAHO advised no data held. • Nil advice regarding whether FOI request is required. • Nil response from emails to other sections of Department of Health. • Department of Health FOI team advised via email that the Department for Health and Wellbeing Workforce branch advised that the data would need to be requested from each individual Local Health Network using the FOI process. • Decision was made not to pursue as it was too time-intensive.
TAS	No	No	Not required	Yes	4	8 days	• Request sent to FOI team at legal services. Advised to contact CAHO. • Request sent to CAHO – sent through to HWPU for response. • Informed that as it is a specific request on DoH Social Workers, rather than the Social Worker workforce across the state, it will be information that can be obtained from People and Culture.

							• Data obtained from HR.
VIC	No	No	No	No	4	36 days	• Commenced an FOI request. • Was advised that "after a thorough and diligent search no documents could be found responsive to the terms of your request". • The issue was that employee data was not held by the Department of Health's People and Culture Branch for social workers employed in acute and community health and mental health services. • Emailed the CAHO office and was advised that they do not hold "this level of workforce data" • Emailed the Allied Health Workforce team and they advised that as Victorian Health services operate in a devolved governance structure, social workers are employed by the health service, not the Department of Health. Advised that the Workforce data team should be able to help. • Allied Health Workforce team provided data on social workers employed by Victorian Public Hospitals, not including 3 public hospitals.
WA	No	Yes	Not required	Did not liaise but data did come from HR database	2	13 days	• Emailed the FOI department with request. Sent to the Data Department. • Response from the Office of the Assistant Director General. Provided data from the whole WA health system, where position title includes social work. Provided with the following disclaimer for data: ○ *Source: HR Data Warehouse* ○ *Extraction Date: 05-February-2025* ○ *Excludes Mental Health Commission* ○ *Headcount includes only staff directly employed by the WA Health system and excludes agency workers.*

							○ *Headcount reflects the number of WA Health employees who received payment in the last pay period before the extraction date.* ○ *Social Worker headcount identified based on the "Position Name" field in the HR Data Warehouse, where the title includes Social.*

*CAHO – Chief Allied Health Officer

ATTACHMENT 8: SAMPLE OF WORKFORCE DATA SUPPLIED BY STATE AND TERRITORY HEALTH DEPARTMENTS

According to the *Victorian Mental Health Workforce Strategy* (2021), the number of social workers in Victorian mental health services is greater than all other mental health clinicians apart from medical practitioners and nurses – see Table 8.1a and Figure 8.1a.[118]

Table 8.1a: Victorian public hospital allied health workforce

Discipline	2023	2024	% change 2021–2024
Social Work	924	955	33%
Psychology	606	624	25%
OT	488	437	10%

Source: Victorian Mental Health Workforce Strategy (2021)

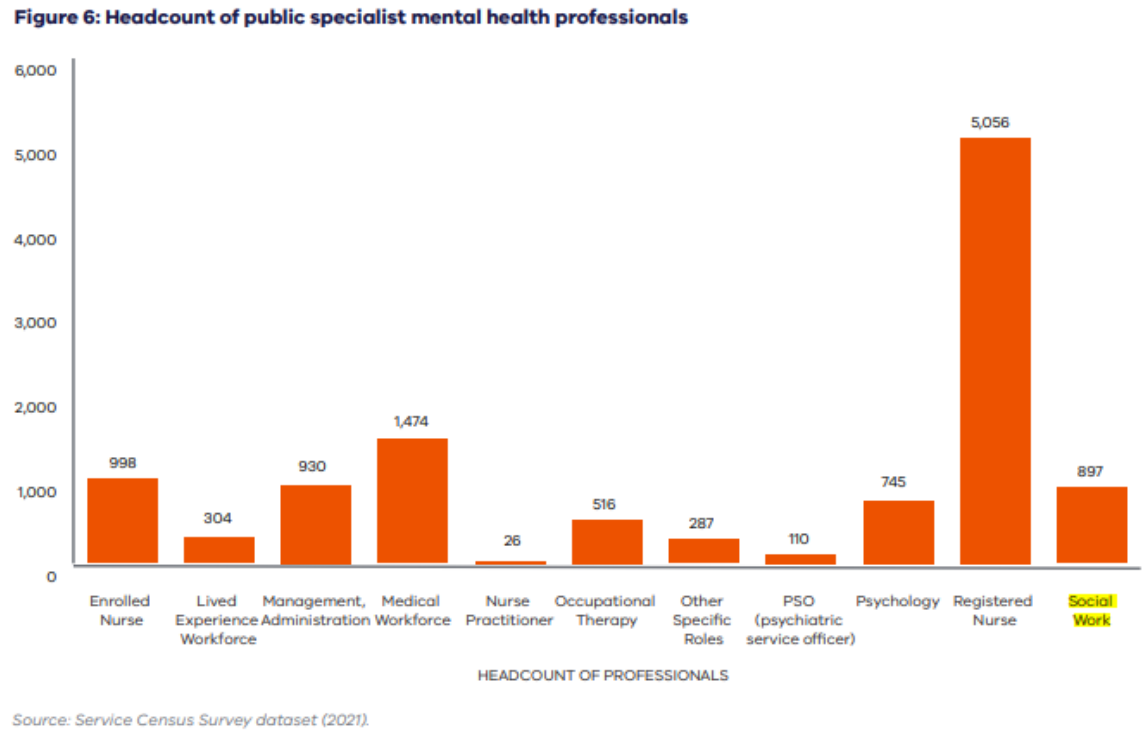

Figure 8.1a: Headcount of Victorian public specialist mental health professionals

In 2019, the South Australian Department of Health and Wellbeing (covering the health and mental health portfolios) was the largest direct employer of social workers, with a substantially greater number of social workers employed than in the Department of Child Protection – see Table 8.2a.[119]

[118] See https://www.health.vic.gov.au/sites/default/files/2022-04/victorias-mh-wellbeing-workforce-strategy-2021-24-140422-pdf.pdf.pdf

[119] See: https://www.parliament.sa.gov.au/api/sitecore/search/GetCommitteeFileDownload?id=363&fileId=0c93c859-8fcc-463b-bdbf-bec1c960e0d5

Table 8.2a: Social workers employed by state government agencies – South Australia

Position Name	FTE	Headcount/positions
Department of Health and Wellbeing	667	827 (headcount)
Department for Child Protection	586.3	622 (headcount)
Department for Education	182	159 (headcount)
Department of Human Services	N/A	100 (positions)
Attorney General's Department	N/A	39 (positions)
Department of Corrections	N/A	27 (positions)
SA Police	N/A	3 (headcount)

Source: Joint Committee on the Social Workers Registration Bill 2018 – Question on Notice 370 – Department for Child Protection 2019

In Western Australia, 916 social workers were employed in the public health system – see Table 8.3.

Table 8.3a: Social workers employed in the Western Australian public health system

Position Name	Headcount
Senior Social Worker	512
Social Worker	331
Manager Social Work	40
Coordinator Social Work	14
Head Of Department Social Work	10
Deputy Head of Department Social Work	5
Prof Lead Social Work	2
Allied Health Assistant Social Work	2
Coord Complex Care Social Work	1
Professional Lead Social Work	1
Total	**918**

Source: WA Health (2024)

ATTACHMENT 9: TYPES OF ROLES SOCIAL WORKERS OCCUPY IN HEALTH SERVICES

Area	Role	Tasks
Intensive Care Units (ICU)	The ICU social worker is an active member of the multidisciplinary team, with the primary focus of supporting both practical and emotional needs of patients and their families during their critical illness experience.	• **Comprehensive assessments** – individual support needs and concerns including family or home-related issues that can impact treatment or ability to return home • **Service and discharge planning** – including planning and family meetings • **Counselling and support for patients** and family/ carers in relation to issues associated to illness, accidents, disability and hospital care. Where necessary and appropriate, referrals for ongoing counselling are made to community agencies • **Coordination and facilitation of meetings** that provide an opportunity for patient/family/carer participation in the treatment and care planning process • **Information provision and referrals** to support services including housing/accommodation, legal and income support/financial services • **Information and education** to patients, their family/carers and community service providers regarding the effects of illness, treatments, hospitalisation and services (one-to-one and group services) • **Support accommodation and transport needs of r**ural and interstate patients/carers and their families
Burns units	In the context of burn injury, the social worker conducts initial and ongoing psychosocial assessment to ensure that appropriate and effective interventions are put in place to meet the needs of the patient, family and carers, in relation to the psychological and practical impacts of the burn injury.	• **Counselling and support** people during periods of crisis, including for children, teenagers and young adult patients, parents, couples and families • **Assisting communication** with healthcare providers • **Representing patients and families** within the hospital to outside agencies • **Providing relevant information and education** about family issues and child health • **Locating** community resources and support groups See https://aci.health.nsw.gov.au/__data/assets/pdf_file/0007/162637/ACI-Clinical-practice-guidelines-social-work-adults-burn-patient-management.pdf

Acute geriatrics	Social workers provide clinical services to complex geriatric patients and support interdisciplinary collaboration.	• **Providing psychosocial interventions**, crisis intervention, and patient advocacy • **Coordinating care** with medical, nursing, and allied health staff • **Contributing to case conferences**, and departmental activities • **Counselling including** general counselling and relationship counselling • **Advocacy and referral** to appropriate community resources
Oncology	Oncology social workers provide support and resources to cancer patients and their families. Oncology social workers serve as a bridge between patients, families, and medical teams, ensuring that emotional, social, and practical needs are met throughout the cancer treatment journey.	• **Psychosocial assessment** and risk-based screening • **Clinical services and social work interventions** for patients and their families/carers • **Case management**, crisis management, referrals and care coordination with multidisciplinary staff. • **Complex discharge planning/**transition to other services/providers • **Psycho-oncology** including assessment, counselling and complex psychological services to patients and families • **Support of oncology in the home**
Renal unit **(Nephrology)**	Social workers provide practical and emotional support for patients with kidney failure and how various treatments may impact on their lifestyle.	• **Provide specialist services** to transplant medical services, both inpatient and outpatient Liver and Renal transplant patients • **Provide patient/family-centred clinical advice** to clients, carers, families, and other healthcare professionals to ensure delivery of innovative clinical practice models and therapeutic techniques for patients to access transplant medical services • **Provide a consultative service** in area/s of clinical expertise to clinicians, promote the consistent provision of safe high-quality client/patient/consumer-centred care, related to transplantation
Acute services	Care and support to patients and families across critical and acute inpatient areas and specialised outpatient settings, including medical and surgical wards, intensive care unit, the emergency department, maternity and paediatrics.	• **Assessments and interventions** to address complex psychosocial needs. This may include working with traumatic injury, psychological trauma, family violence, new diagnosis, adjustment to health condition, management of chronic health conditions, loss and grief, safety concerns, mental health and alcohol and other drug issues • **Referral and liaison** with health and other service providers • **Advocacy** to promote and address patients' needs • **Counselling** and emotional support

Paediatric children, maternity	Comprehensive social work services to children, young people and their families referred from the relative clinical area.	• **Clinical work for complex issues** including domestic violence, unexpected patient outcomes (including psychological first aid), bereavement services, child protection issues, and families in need of support • **Psychosocial assessments**, counselling and advocacy • **Crisis intervention** • **Individual, family and group work and program development** • **Referral to community support services** for children and families confronted with illness and disability
Discharge planning and support	Social workers work closely with other hospital staff to plan and arrange any support which may be required during or after hospital.	• **Conduct comprehensive psychosocial assessments** for patients and their family/carers • **Case conferences, goal setting meetings and family conferences** • **Counselling** to assist patients and their families/carers to deal with the emotional impact of injury, illness and disability, and undertaking discharge planning, liaison, advocacy and referrals to maximise access to appropriate community services • **Client rehabilitation and discharge plan** in consultation with patients, their family/carers and the multidisciplinary team • **Refer patient and family/carers** to appropriate community support services such as financial, health, housing, legal and personal care services • **Risk assessment and safety planning** • **Crisis management** including bereavement and trauma, social crisis issues and de-escalation of conflict
Acquired brain injury and traumatic injuries	Social workers provide clinical services to patients after an acquired brain injury or other neurological condition.	• **Clinical care,** assessment and therapy/intervention • **Discharge planning** for a complex patient cohort • **Additional services** such as transfer and mobility assistance, behavioural support and emergency management • **Treatments** in both individual and group sessions • **Family liaison** and discharge planning See https://jobs.smartrecruiters.com/Epworth/744000045814425-social-worker-grade-2 https://c.smartrecruiters.com/sr-company-attachments-prod-aws-dc5/628da3b877ce4f07a431c451/7bd1dda8-93c1-4c40-b672-7df076d8aa93?r=s3-eu-central-1

Termination of pregnancy	Social workers may be involved in the care of a woman requesting termination of pregnancy (other healthcare professionals include counsellor, Aboriginal and Torres Strait Islander health worker, medical practitioner, obstetrician, nurse or midwife).	• **Social work support for special circumstances** including:
		  ○ young person less than 14 years
		  ○ pregnancy resulting from forced sexual activity
		  ○ woman disclosing domestic violence (or fear of violence)
		• **Referral** where the woman considers but does not proceed to termination, provide information and access to appropriate referral pathways (e.g. access to a social worker, referral for antenatal care)
		• **Supports and discussions** of costs, funeral arrangements, individual preferences, cultural or religious beliefs
		
		See https://www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf

Voluntary Assisted Dying (VAD)	The role of social work role in VAD is one of offering counselling and practical support to a person with a terminal disease, illness, or medical condition choosing to end their life.	• **Involvement in assessing** a person's eligibility and capacity for informed consent to access voluntary assisted dying after a referral for determination from a coordinating or consulting practitioner • **Conduct a biopsychosocial-spiritual assessment** • **Bereavement counselling** for the spouse of a person who has died by voluntary assisted dying but who chose to not be directly involved in the voluntary assisted dying process • **Help clients distinguish** between care options and make decisions based on their values • **Advocate** for clients' rights • **Explore impact of decision** on clients' family and community • **Provide support on day of death** to the person and their loved ones See https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/voluntary-assisted-dying/information-for-healthcare-workers/scope-of-practice
Centre Against Sexual Assault in hospitals and health services	Confidential counselling and advocacy to adult victim/survivors.	• **Counselling, support and advocacy** – short- to medium-term counselling service includes support, information and advocacy which aims to provide assistance in recovery, clarification of rights and identification of choices • **Support groups** – opportunity for victim/survivor to provide mutual support to one another within a group setting • **Support for families and friends** – information, support and referral is offered to non-offending friends, partners and family members

		• **Professional consultation** – CASA House provides information, debriefing and consultation to other professionals • **Therapeutic treatments** – provide therapeutic treatment to young people under 18 years of age exhibiting harmful sexual behaviours and children with problem sexual behaviours. This role also includes provision of advocacy, secondary consultation, report writing, intake and wait list management work • **Immediate crisis care** (e.g. 24-hour crisis care following a recent assault) • **Liaison and consultation with other professionals**, including protective services, police, mental health services, courts and medical services • **Preparation of reports** for the victims of crime assistance, tribunals and other relevant bodies

ATTACHMENT 10: DETAILS OF THE AASW COURSE ACCREDITATION STANDARDS AND PROCESSES

Australian Social Work Education and Accreditation Standards (ASWEAS) 2024

In Australia social work is a self-regulating profession and the AASW is trusted by the profession, by governments and other stakeholders to maintain the standards and ensure high standards in social work education, practice and ethics.

The *Australian Social Work Education and Accreditation Standards* (ASWEAS) set out the AASW's principles and criteria for accrediting social work education courses in Australia, ensuring graduates meet professional standards.

The AASW accredits Bachelor of Social Work and Master of Social Work degrees, with graduates of such accredited courses eligible for AASW membership – a benchmark for professional practice in Australia.

Accreditation process

The requirements for education providers are set out in the ASWEAS. These accreditation standards are, in turn, informed by the principles, values and professional competencies outlined in the AASW Code of Ethics (2020) and the AASW Practice Standards (2023).

Meeting ASWEAS standards ensures education providers design and deliver social work programs that clearly equip entry-level social workers to practise safely and effectively, thus making them eligible for membership of the AASW.

Types of accreditation outcomes

Full Accreditation – Approval by AASW following a recommendation of the Accreditation Assessment Panel for a period of five years, following the latest assessment of the education provider's submission, site visit and annual reports received over the assessment period

Conditional accreditation – Approval by AASW following a recommendation of the Accreditation Assessment Panel when a program substantially meets the requirements for accreditation

Provisional Accreditation – Approval following a recommendation of the Accreditation Assessment Panel for a new education provider offering a program for the first time, or an existing education provider adding a new social work course that has not yet delivered its first graduates.

Accredited courses

The list of education providers and courses accredited through the AASW process is available at the following website: https://www.aasw.asn.au/education-employment/higher-education-providers/accredited-courses/

ATTACHMENT 11: EXTRACTS ON LIVED EXPERIENCES FROM THE SOCIAL WORK SERVICES & SCOPE OF PRACTICE CONSULTATION REPORT

Social Workers Registration Board South Australia – *Social Work Services & Scope of Practice Consultation Report (2024), pp 27–30*

Focus group participants discussed the role of a social worker.

The main themes that arose from the group were advocacy and navigating the human services sector to help families and individuals. *"...And making sure process are in place to keep people safe."* (2024: 28)

Groups recognised and described the high level of power a social worker holds, with one participant saying that social workers:

> *…need to ethically represent information … because there's a lot of power in that information.* (2024: 28)

With such power, participants also identified that social workers need high levels of skill and knowledge to be able to work amongst trauma, complexity, and advocacy. They described, first, the power social workers held, but also, second, for social workers to understand dynamics of power particularly in domestic and family violence, child protection and other trauma-related experiences such as:

> *There is power imbalance in removal of children and assessment, and you need greater skill, accuracy and professionalism for people doing this role.* (2024: 28)

> *You need a good skill set around trauma, and social workers need to understand the dynamics of power in domestic violence with the life of control, including the trauma to a child of being removed from a family.* (2024: 28)

Across all focus groups, participants emphasised the need for social workers to be highly skilled and trained so they could liaise with other professions, navigate complex systems, and understand and respond to complexity and trauma.

Furthermore, they identified the need to be educated and because the role of a social worker is "demanding", they identified that social workers need "a lot of skill and sector knowledge" and to "continue to learn to remain current".

They thought it was important for a social worker to have a very nuanced understanding of power, coercion, and control, and bring this to all complex issues. Many expressed social workers need to have a good understanding of themselves and their own biases.

The groups identified the importance of a degree-level qualification, explaining that social workers are required to have advanced interpersonal skills as they work in areas of high complexity. Continuing professional development was also recognised as important because people need to stay skilled throughout their career.

The groups recognised that the skills of social workers need to be at a very high level, and they need to know how to adapt to the multiple roles they perform in multiple systems:

> *Have advanced skills because they have extremely difficult conversations with people who are experiencing significant life events that can cause lifelong trauma.* (2024: 29)

The groups generally thought that having a complaints and disciplinary process/procedure was important, and they felt that it would give them "peace of mind" that a social worker was "board certified" noting that registration will:

> *Hold them accountable as well, like if they do the wrong thing, obviously they'll have a process that they need to go through to then be able to stay in their profession.* (2024: 30)

The groups also identified that there will be a level of "choice and control" of who is providing the services to them, and knowing if they are a social worker or not, or whether they have the qualifications.

> *Currently there is an assumption that people calling themselves social workers will have a high degree of education, ethical practice, and skill set. That is not always the case, especially in the community. People with no training who have social connection with community-based clients have been called social workers and very likely cannot provide the quality of care that family expect.* (2024: 30)

> *I just find that absolutely baffling that someone can go and work at one hospital, have a complaint made against them, and that doesn't travel with them.* (2024: 30)

Lived experience survey results

1. 4/5 respondents indicated that before the survey, they were not aware that social work is not a registered health profession in Australia.

2. 5/5 respondents indicated that if they had concerns about poor social work practice, they would not know where to go for support or to make a complaint.

   > *…and there would be no point anyway.*

3. 5/5 respondents indicated that they think social workers should be held to national high professional standards of practice, such as those required by other health professions.

   > *Absolutely. I am shocked to hear that they aren't already.*
   >
   > *Because what they say and do can be life changing and must be done with the utmost integrity and they should be held accountable.*

4. 5/5 respondents indicated that they think social workers should have to do ongoing training and supervision to keep their skills up to date and be allowed to practise.

   > *Yes for sure. Things are constantly evolving and changing and I feel the best practitioners are the ones who are keeping up to date with new information and new evidenced-based ways of working.*
   >
   > *They can read all the textbooks in the world whilst at Uni but things change and I suspect that given their stretched workload, they wouldn't have time to stay on top of advance[ments] in their field.*

5. 4/4 respondents think that social workers should be registered under NRAS.

ATTACHMENT 12: FINDINGS FROM ANALYSIS OF COMPLAINT HANDLING AND DISCIPLINARY DATA ON THREE PROFESSIONS, FROM THE UK HEALTH AND CARE PROFESSIONS COUNCIL AND THE NEW YORK STATE OFFICE OF THE PROFESSIONS.

RATES OF NOTIFICATION AND SERIOUS MISCONDUCT BY JURISDICTION: Summary

21-Jun-24

The median rates of notification and serious misconduct for Social Workers, Psychologists and Occupational Therapists for 2 jurisdictions for a given year range are shown below. The comments provide an indication of the extent to which the rate of notification and serious misconduct is comparable for the professions WITHIN the jurisdiction. However, this information cannot be used to show how the rate of notification and serious misconduct for a profession compares BETWEEN jurisdictions, as there is variation about the make up of a particular measure in different jurisdictions (please refer to the jurisdiction specific tables).

Jurisdiction	Year Range	Median Proportion of Registrants with *Notifications*			Median Proportion of Registrants with Referral/Hearing/Finding of *Serious Misconduct*			Number of Registrants (for the most recent year in the "Year Range")		
		Social Workers	Psychologists	Occupational Therapists	Social Workers	Psychologists	Occupational Therapists	Social Workers	Psychologists	Occupational Therapists
UK / England*	2013 - 2019	1.26%	0.72%	0.27%	0.07%	0.03%	0.04%	94,453	24,290	39,925
US - New York State#	2017 - 2023	na	na	na	0.04%	0.02%	0.01%	68,015	15,645	17,117

*Rates of *Notification* and *Serious Misconduct* are comparable for the professions in this jurisdiction.

#Rates of *Serious Misconduct* are comparable for the professions in this jurisdiction. No information about Notifications by profession by year.

UK/England: Social Workers/Psychologists/Occupational Therapists

Years: 2013 - 2019. Regulator: UK Health & Care Professions (HCPC)

From 2012 to 2019, Social Workers (in England) registered with the UK Health & Care Professions Council (HCPC). Psychologists (in the UK) and Occupational Therapists (in the UK) are also registered with the HCPC. As of December 2019, the regulation of Social Workers transferred to Social Work England. From this time, HCPC provided less granular reporting on fitness to practice (particularly hearing of outcomes), and most data was reported across all professions. Social Work England reports on fitness to practice for the last 12 months only.

The table below includes historical data (mid-2012 to mid-2019) for Social Workers, Psychologists and Occupational Therapists for notifications (complaint, fitness to practice, and fraudulent registration activity) and hearing outcomes (found to be misconduct where the practitioner was struck off/suspended/removed [as registration is fraudulent], including those by consent).

The proportion of registrants (for both notifications and hearing outcomes) should be comparable between professions for this jurisdiction.

YEAR *(FinYr)*	NOTIFICATIONS					
	Number			Proportion of Registrants		
	Social Workers (England only)	**Practitioner Psychologists** (UK)	**Occupational Therapists** (UK)	**Social Workers** (England only)	**Practitioner Psychologists** (UK)	**Occupational Therapists** (UK)
2019	1,345	175	107	1.42%	0.72%	0.27%
2018	1,174	160	120	1.22%	0.69%	0.31%
2017	1,226	143	84	1.33%	0.63%	0.22%
2016	1,174	146	93	1.26%	0.68%	0.26%
2015	1,251	157	97	1.42%	0.75%	0.27%
2014	1,085	157	105	1.22%	0.79%	0.31%
2013	733	179	76	0.88%	0.93%	0.23%
MEDIAN RATE				1.26%	0.72%	0.27%

YEAR *(FinYr)*	HEARING OUTCOMES - STRUCK OFF/SUSPENDED/REMOVED (incl by Consent)					
	Number			Proportion of Registrants		
	Social Workers (England only)	**Practitioner Psychologists** (UK)	**Occupational Therapists** (UK)	**Social Workers** (England only)	**Practitioner Psychologists** (UK)	**Occupational Therapists** (UK)
2019	75	8	14	0.08%	0.03%	0.04%
2018	113	5	10	0.12%	0.02%	0.03%
2017	102	6	11	0.11%	0.03%	0.03%
2016	60	7	14	0.06%	0.03%	0.04%
2015	66	5	9	0.07%	0.02%	0.03%
2014	21	5	17	0.02%	0.03%	0.05%
2013	11	6	16	0.01%	0.03%	0.05%
MEDIAN RATE				0.07%	0.03%	0.04%

YEAR *(FinYr)*	NUMBER OF REGISTERED PRACTITIONERS		
	Social Workers (England only)	**Practitioner Psychologists** (UK)	**Occupational Therapists** (UK)
2019	94,453	24,290	39,925
2018	96,497	23,104	38,183
2017	92,180	22,698	38,182
2016	93,175	21,471	35,769
2015	88,099	20,933	35,926
2014	88,934	19,873	33,871
2013	83,295	19,247	33,043
MEDIAN RATE			

New York State (US): Social Workers/Psychologists/Occupational Therapists

Years: 2017 - 2023. Regulator: New York State Education Department - Office of the Professions (NYSED)

In New York State, Social Workers, Psychologists and Occupational Therapists cannot practice without a licence. Licensees can include practitioners who reside outside NYS, but are practising within NYS for that year. There are two different licences for Social Workers - Licensed Master Social Worker (LMSW) and Licensed Clinical Social Worker (LCSW). The LCSW has had more hours of supervised practice, and has a broader scope of practice. Unable to find statistics on notifications, therefore, these are stated as " na " in the table. However, the NYSED does list enforcement actions by year and profession. These were counted. "Enforcement Actions - Proportion of Registrants" is comparable across professions.

Note that The Number of Enforcement Actions for social workers may sometimes refer to 2 cases for one social worker. This is because some social workers have dual licences (ie for LMSW and LCSW), so when their registration is suspended or cancelled, it affects both of their licenses. This way of reporting the number of enforcement actions for social workers has been included in the table below, as it enables comparison of the proportion of registrants with enforcement actions across the three professions to be performed.

YEAR *(FinYr)*	NOTIFICATIONS					
	Number			Proportion of Registrants		
	Social Workers	Psychologists	Occupational Therapists	Social Workers	Psychologists	Occupational Therapists
2023	na	na	na	na	na	na
2022	na	na	na	na	na	na
2021	na	na	na	na	na	na
2020	na	na	na	na	na	na
2019	na	na	na	na	na	na
2018	na	na	na	na	na	na
2017	na	na	na	na	na	na
MEDIAN RATE				na	na	na

YEAR *(FinYr)*	ENFORCEMENT ACTIONS					
	Number			Proportion of Registrants		
	Social Workers	Psychologists	Occupational Therapists	Social Workers	Psychologists	Occupational Therapists
2023	18	3	1	0.03%	0.02%	0.01%
2022	36	3	2	0.06%	0.02%	0.01%
2021	20	2	2	0.03%	0.01%	0.01%
2020	35	6	0	0.06%	0.04%	0.00%
2019	23	2	2	0.04%	0.01%	0.01%
2018	18	6	2	0.03%	0.04%	0.01%
2017	24	4	3	0.04%	0.03%	0.02%
MEDIAN RATE				0.04%	0.02%	0.01%

YEAR *(FinYr)*	NUMBER OF REGISTERED PRACTITIONERS (all registrants, incl active, inactive, provisional, temporary)		
	Social Workers	Psychologists	Occupational Therapists
2023	68,015	15,645	17,117
2022	64,525	15,415	16,551
2021	61,679	15,430	15,819
2020	60,135	14,906	15,398
2019	58,658	14,650	14,584
2018	57,525	14,352	14,010
2017	57,544	13,926	13,401
MEDIAN RATE			

ATTACHMENT 13: FINDINGS FROM LITERATURE REVIEW ON RATES OF ILL-HEALTH CHILD PROTECTION, HOUSING AND HOMELESSNESS, AND CORRECTIONS/JUSTICE SYSTEM SERVICE USERS

1. CHILD PROTECTION

Key findings

Research indicates that children involved with child protection services in Australia experience higher rates of physical and mental ill-health compared to their peers.

Prevalence of contact: In 2022–23, approximately 1 in 32 Australian children (over 180,000) had contact with the child protection system. AIHW

Mental health hospitalisations: A study of South Australian adolescents found that 44.9% of mental health-related hospitalisations involved individuals with prior child protection contact before age 11, despite only 15.5% of all adolescents having such contact. MJA

Self-reported mental health issues: Research indicates that any level of child protection involvement is associated with increased odds of mental health difficulties across various domains. PubMed

Emotional abuse: In 2022–23, 57% of children with substantiated maltreatment cases were primarily victims of emotional abuse. AIHW

Out-of-home care (OOHC) and mental health: Children entering OOHC at an older age (average 7.5 years) often exhibit poorer mental health upon entry but may show improvement over time.[120]

Evidence of higher rates of ill-health and mental ill-health for people accessing Child Protection services in Australia

Mental health outcomes

Research consistently shows that individuals who have had contact with child protection services in Australia experience higher rates of mental ill-health. A study focusing on adolescents in South Australia found that 45% of mental health–related hospitalisations were among those with a history of child protection contact, despite this group comprising only 15.5% of the population studied. The likelihood of hospitalisation increased with the level of child protection involvement, with those in out-of-home care showing the highest rates of mental health hospitalisations (Judd et al., 2024; Judd et al., 2023).

Self-reported mental health difficulties

Children with varying levels of child protection contact report higher odds of mental health difficulties. A study from New South Wales indicated that children placed in out-of-home care or with substantiated reports of maltreatment had the highest odds of reporting clinical levels of mental health difficulties. Even children with unsubstantiated reports were at increased risk, highlighting the pervasive impact of child protection involvement on mental health (O'Hare et al., 2021).

Hospitalisation and health costs

Children involved with child protection services also face higher rates of hospitalisation for both physical and mental health issues. A study found that by age 16.5, children with child protection involvement had significantly higher cumulative incidences of hospitalisation compared to those without such involvement. Mental health and injury-related hospitalisations were particularly prevalent among this group (Gnanamanickam et al., 2020). Additionally, the costs associated with these hospitalisations were significantly higher for children with child protection contact, especially those in out-of-home care (Neil et al., 2019).

[120] Predicting long-term mental health for children in care - Emerging Minds

Long-term mental health outcomes

The long-term mental health outcomes for individuals with a history of child protection involvement are concerning. A scoping review highlighted that both out-of-home care and in-home care are associated with an increased risk of adult mental ill-health, including higher rates of suicide attempts and completed suicides. This underscores the lasting impact of child protection involvement on mental health into adulthood (McKenna et al., 2020).

2. HOUSING AND HOMELESSNESS

Australian Evidence

AIHW (Australian Institute of Health and Welfare) – Specialist Homelessness Services Annual Report

- The 2022–23 report found that **people accessing homelessness services** experience **higher rates of chronic health conditions, disability, and mental illness** than the general population.
- Approximately **30% of clients reported a mental health issue**, a rate significantly higher than the general population.
- People experiencing homelessness also have **higher rates of substance use disorders and trauma-related conditions**.

Australian Bureau of Statistics (ABS) – National Health Survey

People who have experienced homelessness report **significantly worse health outcomes**, including chronic illnesses such as diabetes, respiratory diseases, and cardiovascular conditions.

Kirby Institute – Surveillance Reports on Bloodborne Viruses and STIs

Homeless populations are disproportionately affected by **infectious diseases** (e.g. hepatitis C and HIV) due to limited access to healthcare and harm reduction services.

Mental Health and Homelessness

Mission Australia and University of Western Australia – "Mental Health and Homelessness in Australia" (2018)

- **Severe mental illness is both a cause and consequence of homelessness**.
- People experiencing homelessness are significantly more likely to have diagnoses of schizophrenia, bipolar disorder, and major depression.
- 60% of young people experiencing homelessness reported **high psychological distress**.

The Lancet Psychiatry (2020) – Global Review on Homelessness and Mental Health

- Found that rates of **psychotic disorders were 10 times higher** among people experiencing homelessness compared to the general population.
- Depression and PTSD are also highly prevalent.

Physical health and multimorbidity

The physical health of people experiencing homelessness is also notably poorer. In the same Perth study, 67.8% of patients had at least one chronic physical health condition, and 74.9% were multimorbid, having at least two long-term conditions.[121] This aligns with findings from a systematic

[121] Vallesi, S., Tuson, M., Davies, A., & Wood, L. (2021). Multimorbidity among People Experiencing Homelessness—Insights from Primary Care Data. *International Journal of Environmental Research and Public Health*, 18. https://doi.org/10.3390/ijerph18126498.

review that identified a high prevalence of chronic diseases and comorbidities among homeless populations, exacerbating their vulnerability to health issues.[122]

3. CORRECTIONS/JUSTICE SYSTEM

Research indicates that individuals involved with the Australian corrections and justice system experience significantly higher rates of physical and mental ill-health compared to the general population. Key findings include:

- **Mental health conditions**

  Prevalence in prisons: A 2022 report by the Australian Institute of Health and Welfare (AIHW) highlights that mental health conditions are over-represented in the prison population. Studies have found that the prevalence of psychosis in prison populations is more than 20 times that of the general community, with almost 70% of incarcerated individuals having more than one mental health disorder. AIHW

  Youth in the justice system: Justice-involved youth have higher rates of psychiatric admissions after criminal justice supervision, indicating a critical need for mental health services during and after incarceration. PubMed Central

- **Cognitive disabilities**

  Over-representation: Individuals with mental health disorders and cognitive impairments are significantly over-represented in the criminal justice system. In New South Wales, such individuals are three to nine times more likely to be in prison than the general population. Australian Human Rights Commission

- **Substance use disorders**

  Contributing factor: Alcohol and substance abuse are major contributors to poor physical and mental health, family violence, and antisocial behavior, which can lead to increased contact with the criminal justice system. Australian Parliament House

Evidence of higher rates of ill-health and mental ill-health in the Australian corrections system

Mental illness prevalence

Research consistently shows that individuals in the Australian corrections system experience significantly higher rates of mental illness compared to the general population. A systematic review and meta-analysis found that the lifetime prevalence of any mental illness among prisoners in Australia and New Zealand is 69%, with current mental illness affecting 54% of the prison population (Yee et al., 2024). This is substantially higher than the prevalence rates in the general community.

Cross-cultural mental health factors

A study focusing on cross-cultural prison populations in Australia highlighted that mental health issues such as anxiety, depression, and PTSD are prevalent among prisoners, regardless of cultural background. These mental health factors are significant predictors of psychological distress, indicating that justice involvement is a critical factor in mental health outcomes (Rose et al., 2020).

Gender differences

Women involved in the criminal justice system face a higher burden of morbidity compared to their male counterparts and women in the general population. They are more likely to experience poor social and health circumstances, which contributes to elevated risks of preventable mortality (Janca, 2020).

[122] Onapa, H., Sharpley, C., Bitsika, V., McMillan, M., Maclure, K., Smith, L., & Agnew, L. (2021). The physical and mental health effects of housing homeless people: A systematic review. *Health & social care in the community*. https://doi.org/10.1111/hsc.13486.

Health outcomes post-release

Individuals released from prison, particularly those with dual diagnoses of mental illness and substance use disorder, face increased risks of injury and psychiatric hospitalisations. This highlights the need for integrated mental health and addiction treatment during the transition from prison to community life (Young et al., 2018; Akpanekpo et al., 2024).

Trends over time

The prevalence of self-reported mental illness among prisoners in New South Wales has increased over time, with a significant rise in mental health diagnoses from 2001 to 2015. This trend suggests a growing mental health burden within the prison system, with women experiencing a higher prevalence of psychiatric disorders than men (Browne et al., 2022).

4. CONCLUSIONS

The evidence from multiple studies indicates that individuals who have accessed child protection services in Australia are at a significantly higher risk of experiencing mental ill-health. This risk is evident in both the short-term, with increased rates of hospitalisation and self-reported mental health difficulties, and the long-term, with adverse adult mental health outcomes. These findings highlight the critical need for targeted mental health support and early intervention for this vulnerable population.

The evidence indicates that people involved with the Australian corrections system experience significantly higher rates of mental ill-health compared to the general population. This is compounded by factors such as gender, cultural background, and dual diagnoses, which further exacerbate health disparities. Addressing these issues requires targeted interventions and improved healthcare access both during incarceration and post-release.

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ATTACHMENT 14: CASES OF HARM ASSOCIATED WITH SOCIAL WORKERS OR SOCIAL WORK PRACTICE

Practitioner	Nature of conduct	Selection of media coverage
[redacted], **Social worker** (New South Wales, 2015)	[redacted] was a 51-year-old social worker working in community mental health. [redacted] had an inappropriate sexual relationship with a 17-year-old client in her final year of school who was particularly vulnerable and had a complex mental health history. [redacted] was emotionally and physically abusive to the client. He was issued with an apprehended domestic violence order and he was found guilty of assaulting and stalking/intimidating the client, in addition to breaching the AVO on a number of occasions. He was sentenced to an eight-month suspended sentence. [redacted] was issued a five-year prohibition order on 22 June 2015, which has now expired. [redacted]. Otherwise, he has no conditions on his practice.	[redacted]
[redacted] (Victoria, 2019)	[redacted] was a 52-year-old social worker, who groomed and sexually assaulted a 15-year-old boy. She worked for [redacted] for Women in [redacted], Victoria. She also had her own life-coaching business, which she started in 2011. She did not meet the boy through her job, and her former employer released a statement confirming she had no contact with children through her social work. [redacted] was sentenced to a maximum three-and-a-half years sentence in 2019. There are no records in relation to [redacted] with the Victorian Health Complaints Commissioner.	[redacted]

Unnamed social worker (Queensland, 2022) A Queensland-based social worker, who claimed to be a psychologist and treated a patient was fined $7,000 by the Sandgate Magistrates' Court following prosecution by the Australian Health Practitioner Regulation Agency (Ahpra). A patient attended five treatment sessions with the person, during which the patient believed they were seeing a registered psychologist. Believing them to be a psychologist, the patient received treatment over five sessions between February and March 2021. During those sessions, the patient disclosed personal and sensitive information to the person, who diagnosed the patient with a disorder. The sessions only ceased when the patient discovered they were receiving treatment from a person who was not a registered psychologist. Despite being confronted by the patient, the person continued to claim they were registered. Even when being investigated and required by Ahpra to stop making false claims, the person told the Ahpra investigator they were a provisional psychologist and held registration. The name of the social worker was not made public or provided to the AASW.	https://www.psychologyboard.gov.au/News/2022-06-14-social-worked-fined.aspx
Unnamed social worker (Victoria, 2016) The Australian Health Practitioner Regulation Agency (Ahpra), on behalf of the Psychology Board of Australia (the Board), prosecuted the defendant, a qualified social worker, who at the time of the allegations was based in Victoria. The defendant has never held registration as a psychologist; however, it was alleged that she purported to use the title "psychologist" at two medical clinics in Victoria between May 2015 and June 2015 by accepting referrals under mental health plans. The social worker pleaded guilty to 14 charges and was ordered to pay a fine of $12,000 and costs of $20,200 to Ahpra, with no conviction recorded. The name of the social worker was not made public or provided to the AASW.	https://www.psychologyboard.gov.au/News/2016-11-30-media-release.aspx?_gl=1*4elv7f*_ga*MTEyNDg5MjE1NS4xNzA3NzEwODEx*_ga_F1G6LRCHZB*MTcxMzQwMDAwOS44LjEuMTcxMzQwMDMxMS4wLjAuMA..

[redacted] **(Victoria, 2020)** [redacted] has a Masters in Social Work from Canada and practised in Australia. [redacted] traded as [redacted]. [redacted], had 5 Interim Prohibition Orders issued against her by the Victorian Health Complaints Commissioner on 22 December 2020, 15 March 2021, 15 June 2021, 8 September 2021 and 3 November 2021. The Commissioner found that [redacted] had contravened a code of conduct and that she posed a serious risk to the health, safety or welfare of the public. No details were made available to the public and it is unclear what the status of her ability to practise in Australia is in 2025.	[redacted]
[redacted] (Victoria, 2021) [redacted] was a youth worker who sexually assaulted a child "Zack". In February 2021 he was convicted of this sexual assault. [redacted] deceived his employer [redacted] about his employment history and qualifications. [redacted] falsely claimed to have obtained a Social Work degree from Queensland University while employed at [redacted]. [redacted] was never qualified to work with children. Social workers registered with Ahpra would not be able to subvert these screening processes in this way. Furthermore, title protection of the title "social worker" would prohibit someone from falsely claiming to be a social worker to be able to work with vulnerable people.	[redacted]

[redacted] (South Australia, 2022) The Health and Community Services Complaints Commissioner (HCSCC) issued a prohibition order against [redacted], a social worker. The Commissioner found she did not act in a safe and ethical manner and that she breached the Code of Conduct by providing manifestly false and misleading claims about COVID-19 and COVID-19 vaccines. The prohibition order allowed [redacted] to continue to offer social work services so long as she did not breach the terms of her Prohibition Order. She was not ordered to undertake supervision regarding ethical conduct, standards of practice or her scope of practice.	[redacted]
[redacted] (NSW, 2020) [redacted] was working as an Accredited Mental Health Social Worker (AMHSW) at her solo private-practice, "[redacted]". An investigation found that [redacted] breached the Code of Conduct for Unregistered Health Practitioners. [redacted] was not open and honest during the investigation. [redacted] took advantage of two clients, both highly vulnerable individuals, for the primary purpose of commencing a close personal and sexual relationship with them. The investigation found that [redacted] did not refer either client to another health service following the end of their therapeutic relationship, despite their long-standing and current mental health issues. The investigation found [redacted] placed her own needs and desires above those of her clients and as a result, significant harm was caused, in particular to "Client A", who returned to being homeless and without a support network after the acrimonious breakdown of the relationship. The Commission determined that [redacted] poses a risk to public health or safety and has ordered that she is prohibited from providing any health service, either in paid employment or voluntarily, to any person.	[redacted] [redacted]
[redacted] (Victoria, 2022 & 2024) A prohibition order was made on 2 August 2022 by the Health Complaints Commission for contravening the code of conduct for a general health service. The order prohibited him from providing a "general health service" defined in the *Health Complaints Act 2016*. [redacted] was required to undertake training in relation to professional boundaries, ethics and record-keeping. The prohibition order was in place until its conditions were met. No further details about his misconduct were provided. On 3 June 2024 a banning order was made under the *National Disability Insurance Scheme Act 2013*. [redacted] was permanently prohibited	[redacted] [redacted]

from providing disability supports and services, directly or indirectly, to National Disability Insurance Scheme (NDIS) participants. No details about his misconduct were provided.	
[redacted] Interim Prohibition Order – no details published	[redacted]
[redacted] Interim Prohibition Order – no details published	[redacted]

ATTACHMENT 15: EXTRACTS FROM ROYAL COMMISSIONS, PARLIAMENTARY COMMITTEE INQUIRIES AND GOVERNMENT REPORTS

Govt	Year	Name of inquiry	Key findings
TAS	2023	*Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings Report Volume 1 Summary, recommendations and findings*[123]	*The need for ongoing CPD* *For all staff, in all the institutions we considered— including teachers, social workers, health workers, youth workers, police, lawyers and judicial officers—we recommend tailored minimum and continuing professional development on child sexual abuse that aligns with their specific work context.* (p 19) *We make a number of recommendations to ensure institutions provide training and ongoing professional development to their staff so they are equipped to respond to child sexual abuse and harmful sexual behaviours…* (p 19) *In some areas, we have identified the need for more advanced knowledge and skills for staff in specialist roles. This may be because they are directly involved in responding to child sexual abuse or they work with high-risk groups. For example, we consider child safety officers should have access to continuing professional development, so they clearly understand their ethical and professional obligations and meet mandatory minimum knowledge requirements to investigate and respond to sexual abuse and trauma.* (p 19) *Implementation of the Code of Conduct for unregistered health care workers* *The Tasmanian Parliament passed amendments to the Health Complaints Act to implement the Code in 2018, but no date has been set for them to begin. The Health Complaints Commissioner will be responsible for administering the Code in Tasmania ... In his 2021–22 annual report, Mr Connock observed that any complaints related to the Code "would mean an added strain on resources that are already stretched" and require "extensive modifications to our case management system to accommodate workflows related to the administration of the Code".* (pp 87–88) *We also consider professional regulation of unregistered health workers a priority because they are a cohort that often provides services to children.* (p 90)
CWTH	2022	*The Senate Community Affairs References*	*Unregulated professions*

[123] See https://www.commissionofinquiry.tas.gov.au/__data/assets/file/0011/724439/COI_Full-Report.pdf

		Committee Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law, *Australian Parliament*[124]	*2.94 There are several professions not regulated by AHPRA, such as social work, audiology, and aged care and personal care work. As practitioners in these fields are unregulated, there is no standard or code to hold them to account, and no requirement for a minimum level of qualifications.* *2.95 For a new profession to be included in the National Registration and Accreditation Scheme (NRAS), approval is required by the Ministerial Council and is subject to a formal regulatory impact assessment.* *2.96 The committee received evidence, particularly from those in the social work and aged care sectors, that these unregulated professions require oversight and should be regulated.* *2.97 The Australian Association of Social Workers told the committee that anyone can call themselves a social worker regardless of whether they have any training or qualifications. It said this poses a significant public risk as social workers "support people across a range of issues including mental health, family violence, child abuse, elder abuse, disability, housing, poverty, alcohol and other drugs".* *2.100 Ahpra noted that approval for new professions to be considered in the NRAS is a matter for health ministers, not Ahpra or the national boards.* (pp 29–30) *Recommendation 3* *2.115 The committee considers there is a substantial case for regulation of currently unregulated professions including social workers, aged care workers and personal care workers and recommends the Ministerial Council consider whether these professions should be included in the National Regulation and Accreditation Scheme.* (p 32)
VIC	2021	*Victoria's Mental Health and Wellbeing Workforce Strategy 2021–24*	*Statutory registration scheme for social workers: In contrast to comparable jurisdictions, Australia does not currently have a statutory registration scheme for social workers. Absence of title protection and safeguards compromises quality and safety, and limits how this discipline functions within the mental health sector. The Victorian Government will advocate to Ahpra for a statutory registration scheme for social workers.* (p 31)
CWTH	2021	*Safe and Supported: the National Framework for Protecting Australia's*	*d.i. Identify advantages and disadvantages of national accreditation for social workers and other child and family services workers to inform approaches for a national accreditation scheme. Timing: One year, 2023.*

[124] See https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024690/toc_pdf/AdministrationofregistrationandnotificationsbytheAustralianHealthPractitionerRegulationAgencyandrelatedentitiesundertheHealthPractitionerRegulationNationalLaw.pdf;fileType=application%2Fpdf

		Children 2021–2031S[125]	
SA	2016	*The life they deserve. Child protection systems Royal Commission Report Volume 1: Summary and Report*[126]	*The Commission believes that at this stage the emphasis should be on effecting improvements with respect to the education, training and professional development of child protection practitioners. However the efforts of AASW to achieve national registration are encouraged and, the Commission would support South Australia's participation in a scheme which may eventually be established*. (p 98)
VIC	2016	*Royal Commission into Family Violence Summary and recommendations*[127]	*Recommendation 209* *The Victorian Government include in the 10-year industry plan for family violence prevention and response a staged process for the introduction of mandatory qualifications for specialist family violence practitioners, so that no later than 31 December 2020 all funded services must require family violence practitioners to hold a social work or equivalent degree [within five years].* (p 102)

SA	2008	*Children in State Care Commission of Inquiry*[128]	*Recommendation 14*
			
			That the following be formalised in, and implemented as part of, the Keeping them safe reform agenda:
			
			• *Every child and young person in care has an allocated social worker.*
			• *Every child and young person in care has regular face-to-face contact with their allocated social worker, the minimum being once a month, regardless of the stability or nature of the placement.*
			• *The primary guiding principle in determining the workload of each social worker is quality contact between each child and young person in care and their social worker, which includes face-to-face contact at least once a month and the ability to respond within 24 hours if contact is initiated by the child or young person. As part of implementing the above, it is recommended that:*
			• *Sufficient resources are allocated to recruit and retain qualified social workers.*
			• *Emphasis is placed on the professional development and support of social workers including:*
			  ○ *The reduction of team sizes to a maximum of seven or eight, to increase the capacity for better supervision of social workers and their own professional development*
			  ○ *Mandatory training in supervision for all social workers employed in supervisory roles*

[125] See https://www.health.vic.gov.au/publications/mental-health-workforce-strategy
[126] See https://www.childprotection.sa.gov.au/research-and-publications/publications/child-protection-systems-royal-commission/child-protection-systems-royal-commission-report.pdf
[127] See https://www.childprotection.sa.gov.au/research-and-publications/publications/child-protection-systems-royal-commission/child-protection-systems-royal-commission-report.pdf
[128] See https://www.childabuseroyalcommission.gov.au/sites/default/files/WEB.0198.001.0001.pdf

			○ *The introduction of a system of registration or accreditation for social workers, which requires ongoing professional development and training*. (p XXIV)

ATTACHMENT 16: DELOITTE ACCESS ECONOMICS REPORT 2016 (PROVIDED AS SEPARATE PDF DOCUMENT)

ATTACHMENT 17: DELOITTE'S ESTIMATES AND CALCULATIONS UPDATED FOR 2025 (PROVIDED AS SEPARATE PDF DOCUMENT)

ATTACHMENT 18: REPORT OF AASW ANALYSIS OF CORONERS' INQUIRY REPORTS 2018–2024 (PROVIDED AS SEPARATE PDF DOCUMENT)

Deloitte Access Economics

The registration of social workers in Australia

Australian Association of Social Workers Limited

10 June 2016

Deloitte.

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10 June 2016

Dear Glenys

The registration of social workers in Australia

Our final report is attached. It outlines the cost of registering social workers with the Australian Health Practitioner Regulation Agency (AHPRA). The results show an upfront investment is required to establish a national board for professional social workers ($1.4 million in 2016), with ongoing registration costs of $6.9 million in 2016, rising to $8.6 million in 2019. The potential benefits, while not quantified in this report, may be large. Break-even analysis suggested that if approximately 1.5 child deaths were averted from registration, as one of a number of possible benefits, annual costs would be recovered.

Please contact me if you would like to discuss any aspect of the report – we would be happy to answer any of your questions.

Yours sincerely,

Lynne Pezzullo
Lead Partner, Health Economics and Social Policy, Deloitte Access Economics Pty Ltd
Office Managing Partner, Canberra, Deloitte Touche Tohmatsu

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Glossary

AASW	Australian Association of Social Workers
ABS	Australian Bureau of Statistics
AHPRA	Australian Health Practitioner Regulation Agency
CBA	Cost benefit analysis
CPD	Continuing Professional Development
CPI	Consumer Price Index (the Australian measure of consumer price inflation)
OBPR	Office for Best Practice Regulation
NRAS	National Registration and Accreditation Scheme
VSLY	Value of a statistical life year

Executive summary

Social workers help deal with a range of complex issues in Australia by providing psychological, psychosocial, and other interventions to vulnerable people across a range of different settings, including in health care. Currently, people working in social work are not required by law to hold registration in Australia, which may lead to some clients being unaware of the workers' qualifications, skills and ethical obligations (AASW, 2014). In some cases, sub-standard, unethical or unqualified practice has caused substantial harm to clients.

The National Registration and Accreditation Scheme (NRAS) regulates the practice of some health professions in Australia. It is administered by the Australian Health Practitioner Regulation Agency (AHPRA).

This report outlines the costs of registration of social workers under the NRAS, and highlights some of the broad benefits of registration that could flow to Australian society.

> Overall, it is estimated that **registration of professional social workers would cost $8.2 million in 2016**, including the cost of establishing a national board and registering an estimated 15,730 professional social workers. Based on AHPRA's current practice of recovering costs through registration fees**, it is expected that registration would not be a net cost to government.**

Social worker workforce and costs of registration

The size of the social worker workforce is difficult to estimate, with a wide range of estimates depending on sources and methods. **ABS data indicate that there were approximately 23,166 professional social workers in 2016**. Our estimate of 15,730 professionals who would be required to register with AHPRA in 2016 comprises social workers working in the health care and social assistance sector with an accredited qualification in social work.

Using this definition, the number of professional social workers is expected to grow to 18,261 by 2019.

The total cost of registering social workers with AHPRA comprises both fixed costs (related to establishing a new national board) and variable costs (associated with ongoing registrations):

- The variable costs were estimated by using the registration fee for psychologists, as a comparable profession, which was $436 in 2016.
- The fixed cost of establishing a board was estimated to be $1.4 million, based on data from AHPRA annual reports.
- The total cost between 2016 and 2019 was estimated to be $29.2 million in net present value terms (2015-16 dollars). The costs in each year are shown in Table i.

Table i: Total costs, 2016 to 2019

Year	2016	2017	2018	2019
Registrants	15,730	16,532	17,375	18,261
Total costs ($m)	8.2*	7.4	8.0	8.6

Source: Deloitte Access Economics calculations.
* Includes the establishment cost of a national board.

Using data from AHPRA annual reports, it was estimated that AHPRA fully recovers all expenses. Hence, all costs of registration would be passed on to and hence borne by social workers registering in each year.

Benefits of registration

Registration of social workers in Australia could result in a broad range of benefits, including improved public safety, higher standards of conduct and accountability, and improved professional development and mobility opportunities for workers.

A detailed, quantitative analysis of benefits is beyond the scope of this report. However:

- While occupational licensing in general is seen as creating more costs than benefits, the main class of exceptions is where consumers are ill-equipped to judge the quality of a professional's services. That is arguably the case with the clients of social workers, who are often vulnerable or experiencing distress.
- 'Break-even' analysis was used to determine the number of adverse incidents of social worker misconduct that would need to be averted for the benefits of registration to outweigh the costs.

> Overall, it is estimated that if social worker registration could prevent approximately 0.05% of incidents of child abuse, 0.6% of child deaths from such abuse, or 0.5% of public hospital separations for mental and behavioural conditions, the benefits could outweigh the costs.

Future research activities could be directed towards developing robust parameter values for quantifying the benefits of social worker registration in Australia. These could be used to inform a detailed cost benefit analysis and consider a more extensive range of potential benefits to build the case for achieving mandatory registration for social workers.

Deloitte Access Economics

1 Background

Social workers help deal with a range of complex issues in Australia by providing casework, counselling and psychological interventions to vulnerable people across a range of different settings. Social workers also provide psychosocial assessments, which involve using particular skills and knowledge to assess a person's physical, psychological and social context. This includes identifying issues and strengths in (AASW, 2015):

- social role functioning;
- meeting financial and other basic needs;
- family interactions;
- social supports; and
- cultural factors.

Social workers provide services across a range of different settings, including community health, acute inpatient, rehabilitation, health promotion, mental health, and other health services. Social workers also practise in services such as asylum seeker and refugee centres, domestic and family violence services, youth services, disability services, homelessness services, and child protection agencies. Social workers aim to improve health and wellbeing outcomes for individuals, their families and the community.

Currently, people working in social services are not required by law to hold registration in Australia, which may lead to some clients being unaware of the workers' qualifications, skills and ethical obligations (AASW, 2014). The AASW has argued that, in some cases, sub-standard, unethical or unqualified practice can cause substantial harm to clients, for example, abuse or even death. Social workers often provide their services without another person present, and are increasingly providing services as a sole proprietor or small practice (AASW, 2014). These settings can increase the risk for professional boundary violations and harm being inflicted on the community.

The inclusion of social workers under the National Registration Accreditation Scheme (NRAS) may potentially avert sub-standard, unethical, or unqualified practice in Australia. The NRAS was established in 2010, and is the only government scheme overseeing the regulation of qualifications, standards and practices for health practitioners in Australia.

The Australian Health Practitioner Regulation Agency (AHPRA) is the registration body with responsibility for implementing the NRAS across Australia. Each profession that is part of the NRAS is represented by a national board under AHPRA. While the primary role of the boards is to protect the public, the boards are also responsible for registering practitioners and students, as well as performing other functions for their professions. There are currently 14 National Boards, including for professions (such as psychologists) that often deal with a similar client base to social workers.

The Australian Association of Social Workers (AASW) is the peak body representing approximately 10,000 members who are professional social workers in Australia. AASW represents social workers and aims to ensure the sustainable development of the

profession, the maintenance of accountability and compliance with benchmark standards, and the promotion of professional indemnity.

AASW aims to keep the public safe from harm – the same core objectives as the NRAS. As social workers regularly work with vulnerable people, AASW continues to actively campaign for the inclusion of the social work profession under the NRAS. If this were to occur, the social work profession would also be regulated by AHPRA. Throughout this report, social workers are defined as those who have completed a four year AASW accredited Bachelor of Social Work, Master of Social Work, or an international social work qualification which has been assessed by the AASW as comparable to an AASW accredited qualification. In 2010, 29 of 39 universities in Australia offered a social work degree accredited by AASW (Healy and Lonne, 2010).

2 Costs of registration

The total cost of registering social workers with AHPRA comprises both fixed costs (related to establishing a new national board) and variable costs (associated with ongoing registrations). In turn, variable costs depend on the number of professional social workers expected to register with AHPRA. Accordingly, two components were required to estimate the cost of registration:

- **Workforce –** the total number of professional social workers in Australia (those that hold a four year degree in social work) and, of those, the number who are expected to register with AHPRA; and
- **Variable and fixed costs –** the initial establishment fees, and ongoing expenses to manage a national board for professional social workers under the NRAS.

The data sources and estimates used for estimating costs are outlined in the following sections. Having estimated costs, it was necessary to identify the extent to which costs are expected to be borne by government. As described in the following sections, it is expected that AHPRA would fully recover its costs, and hence registration would not be a net cost to government.

2.1 Social worker workforce

The Australian Bureau of Statistics' (ABS) Labour Force Survey was used to estimate the total number of people identifying as social workers in Australia (ABS, 2016a). Overall, there were more than 34,800 people who self-reported as social workers in Australia in 2015.[1] However, not all people identifying as social workers have the necessary qualifications or intention to register as a social worker. In particular, to meet the AASW's current requirements for membership, a professional social worker is required to hold a four year AASW accredited Bachelor of Social Work, an AASW accredited Master of Social Work, or an international social work qualification which has been assessed by the AASW as comparable to an AASW accredited qualification.

Data from the ABS 2011 Census of Population and Housing were used to estimate the number of social workers who meet these requirements in Australia. In the 2011 Census, there were 16,916 people who identified as a social worker and were currently employed. Of these, only 63%, or 10,699, had a bachelor or postgraduate qualification in social work (ABS, 2011). This ratio was applied to the total number of people identifying as social workers in 2016 reported above. **It was estimated that there were around 23,166 professionally qualified social workers in Australia in 2016**.

The number of professional social workers in Australia may be higher or lower for two reasons. First, ABS data report the qualification type (social work) and level, but there is no way to identify whether the qualification has been accredited by AASW. Second, it is possible that social workers may identify their occupation differently – for example, they

[1] This was calculated as the average of the quarterly Labour Force Survey results in 2015, the latest complete year for which data were available.

may report that they are a welfare support worker. These caveats may mean that the total number of professional social workers is slightly higher or lower than the number reported. Consequently, sensitivity analysis is conducted on the number of social workers who would register under the NRAS in section 2.3.

Finally, to assess the costs to government of registration, it was necessary to make an assumption of the proportion of professionally qualified social workers who would register under the NRAS. For the baseline estimate, it was assumed that social workers who would register under the NRAS are those who hold an accredited qualification in social work **and** are employed in the health care and social assistance sector. The health care and social assistance sector represents the broad range of work undertaken by social workers. For example, this includes social workers operating in hospitals, medical and other primary care services; residential care services (including aged care services); and social assistance services (including child care services) (ABS, 2013).

Recognising that social workers also work in family violence, sensitivity analysis was conducted by including social workers in the public administration and safety sector, which comprises public administration (including justice); defence; and public order, safety and regulatory services (ABS, 2013). As there was no way to identify if social workers in this industry provide services directly to clients (and hence would require registration), they were not included in the base case.

The number of professional social workers who would register in 2016 was adjusted by the ratios of those who hold a relevant qualification and work within the health care and social assistance sector, which was estimated to be 68% of all professional social workers from the 2011 census (ABS, 2011). The ratio is relatively stable over time.[2] Consequently, it was assumed that these ratios still hold in 2016.

The number of social workers in 2016 to 2019 was estimated using employment growth projections for social workers from the Department of Employment (2016), which forecast an average workforce growth of 5.1% per year.

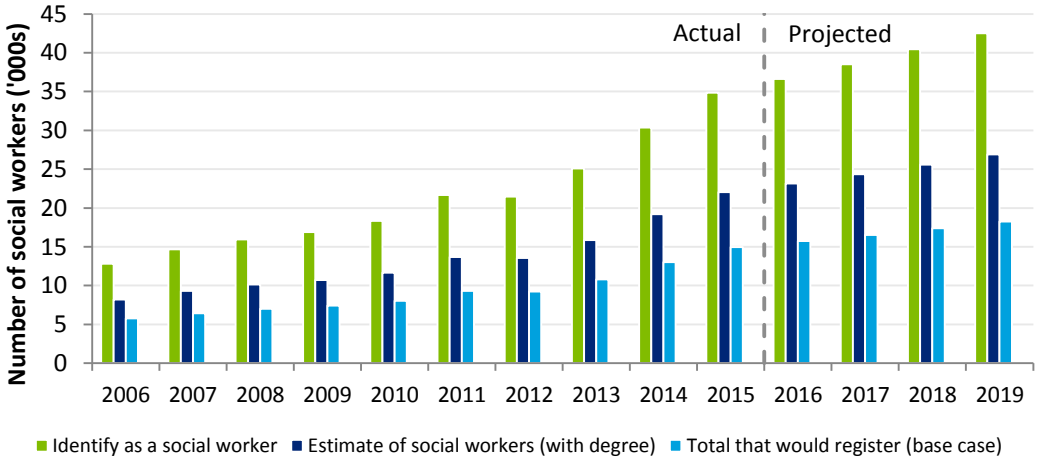
Overall, it was estimated that there were approximately 15,730 professional social workers who would register under the NRAS in Australia in 2016. By 2019, the number of registered social workers is expected to grow to approximately 18,260 (see Chart 2.1). This represents approximately 68% of the total workforce in each year.

The modelling in this report calculates costs of registration between 2016 and 2019, and hence it was assumed that an NRAS national board for social workers would be established in 2016.[3] Chart 2.1 also provides estimates for the number of social workers who would have registered in the years 2006 to 2015 if registration were available.

[2] In 2006, these ratios were 64% and 70%, respectively (ABS, 2006).

[3] To illustrate the costs of registering the workforce, it was assumed that all social workers employed in the health care and social assistance sector, and holding a qualifying degree, would be registered in each year commencing 2016. However, in practice, there may be a ramp-up period following implementation, with target levels of registration only achieved after a number of years.

Chart 2.1: Estimates of social worker workforce, and number of expected registrants



Source: Deloitte Access Economics analysis based on ABS (2016; 2011).

2.2 Variable and fixed costs

Costs of registering professional social workers include establishing a new professional board with AHPRA (a one-off, fixed cost), and the ongoing costs of registrations (variable costs). These costs are outlined further in the following sections.

2.2.1 New board establishment fees – fixed cost

To estimate the costs of establishing a board under the NRAS it was assumed that the costs would be similar to the change in costs observed when four new boards joined the NRAS in 2012.[4] Data were collected from the 2012-13 AHPRA annual report to estimate these costs (AHPRA, 2013).

Total AHPRA expenditure increased between the 2012 and 2013 financial years, following the establishment of the four new boards. AHPRA notes that the addition of the four new boards resulted in additional expenditure, including for the following reasons (AHPRA, 2013):

- an additional $4.8 million in board expenditure for sitting fees and meetings;
- an additional $2.6 million in accreditation expenditure.

However, not all of AHPRA's additional expenditure over this period is directly attributable to the establishment of the new boards. For example, it is plausible that there would be other, unrelated changes in fixed costs including systems and communications costs, and other property expenses. These costs actually declined in the 2013 financial year. It was considered unlikely that the establishment of the four additional boards contributed to the decline, so these costs were removed from the analysis.

[4] The four new boards were the Aboriginal and Torres Strait Island Practice Board; the Medical Radiation Practice Board; the Occupational Therapy Board; and the Chinese Medicine Board.

Further, there was an increase in accreditation expenditure associated with the four additional boards during the 2013 financial year. This coincided with a change in the scope of accreditation for the existing boards. Accreditation expenses increased by $1.1 million on average in the financial years either side of the 2012 financial year (AHPRA, 2012; 2014). Similarly, board sitting fees and other expenses increased by $0.8 million on average. Consequently, these average increases in expenditure were removed from the change in 2013 to estimate the costs directly associated with the implementation of the four additional boards.

This means that the additional costs associated with the establishment of the four new boards were estimated to be $5.6 million in 2013, comprising:

- $4.0 million for board sitting fees and direct board costs; and
- $1.6 million for accreditation expenses.

These costs were assumed to be shared equally by all boards – meaning that **the costs of establishing a new board were approximately $1.4 million**. It was assumed that the fixed costs of establishing a new board for social workers would be similar to this average cost.

2.2.2 Ongoing costs of registration – variable costs

Variable costs are those that would vary according to the number of social workers registered under the NRAS. For example, variable costs include staff costs, legal and notification costs, and other costs associated with maintaining registrations and handling complaints. Variable costs are likely to increase with an increase in workload associated with a greater number of registrations. This was illustrated by an increase in AHPRA's variable costs associated with staffing when the four new boards were established in 2012.

Data from AHPRA's annual reports between 2011 and 2015 indicates that registration income between 2011 and 2015 covers 98% of all AHPRA expenses, on average. Further, AHPRA appears to receive registration fees upfront, which means they earn interest on registration income throughout the year. Including interest payments, total income is slightly higher than total expenses, on average. Consequently, it was assumed that **AHPRA operates on a full cost recovery model**. This means that if social workers were registered under the NRAS, all costs would likely be recovered through fees charged to social workers, and the interest on those up-front fees.

The variable costs from professional social workers were estimated by assuming an average cost per registrant that is equivalent to the Psychology Board of Australia fee – which was set at $436 per applicant in 2016 (AHPRA, 2016).[5] To derive total variable costs, this fee was multiplied by the expected number of registrants in 2016, and in each subsequent year (see section 2.1). The fee was assumed to grow in line with past trends in the consumer price index (CPI) – an average of 2.5% per annum between 2017 and 2019 (ABS, 2016b).

The variable costs of registration for each year between 2016 and 2019 are shown in Table 2.1.

[5] Across all professions, annual registration fees in 2016 ranged from $100 per applicant for the Aboriginal and Torres Strait Island Health Practice Board, to $724 for the Medical Board of Australia.

Table 2.1: Variable costs of registration, 2016 to 2019

Year	2016	2017	2018	2019
Registrants (people)	15,730	16,532	17,375	18,261
Registration fee ($)	436	450	460	470
Variable costs ($m)	6.9	7.4	8.0	8.6

Source: Deloitte Access Economics' calculations.

The variable costs were estimated to be $6.9 million in 2016, increasing to $8.6 million in 2019. The net present value of this stream was estimated to be $27.8 million (in 2015-16 dollars) between 2016 and 2019.[6]

2.2.3 Summary of costs

The total cost of registration was estimated to be $8.2 million (in 2015-16 dollars) in the first year social workers are registered under the NRAS. This cost comprises:

- $1.4 million in fixed establishment costs (including accreditation expenses); and
- $6.9 million in variable costs including staffing, travel and accommodation, and legal and notification costs.

The total cost between 2016 and 2019 was estimated to be $29.2 million in net present value terms (2015-16 dollars). The costs in each year are shown in Table 2.2.

Table 2.2: Total costs, 2016 to 2019

Year	2016	2017	2018	2019
Total costs ($m)	8.2*	7.4	8.0	8.6

Source: Deloitte Access Economics' calculations.
* Includes $1.4 million of fixed costs associated with the establishment of a national board.

Since AHPRA fully recovers all expenses, costs of registration would likely be covered by fees paid by social workers. **Registration of social workers is not expected to be a net cost to government.**

2.3 Sensitivity analysis

Sensitivity analysis was undertaken to develop a range of cost estimates, reflecting the uncertainty surrounding key parameters in the modelling.

The sensitivity analysis included:

- a 20% increase in the number of social workers who would register under the NRAS, which represents registrations by social workers who work in the public

[6] A discount rate of 7% was used to calculate net present value, as recommended by the Australian Office of Best Practice Regulation for regulatory impact analysis (Australian Government, 2007).

administration and safety sector,[7] in addition to those in the health care and social assistance sector;

- a 35% decrease in the number of social workers who would register, which approximates a scenario where only existing members of AASW register under the NRAS; and
- registration fees for social workers are set to the average fee across all AHPRA national boards ($356), and registration fees are set to be higher by the same difference ($516).

The results of the sensitivity analysis suggest that the total cost would range between $5.8 million and $9.6 million in the first year. In net present value terms, the total cost between 2016 and 2019 would range between $19.5 million and $34.8 million (in 2015-16 dollars). The number of registrants, fees and costs for each scenario are presented in Table 2.3.

Table 2.3: Total costs– sensitivity scenarios, 2016 to 2019

Scenario	2016	2017	2018	2019	Net present value
Base case					
Registrants (people)	15,730	16,532	17,375	18,261	
Fee ($)	436	450	460	470	
Total cost ($m)	8.2	7.4	8.0	8.6	**29.2**
Social workers increase by 20%					
Registrants (people)	18,876	19,839	20,850	21,913	
Fee ($)	436	450	460	470	
Total cost ($m)	9.6	8.9	9.6	10.3	**34.8**
Social workers decrease by 35%					
Registrants (people)	10,225	10,746	11,294	11,870	
Fee ($)	436	450	460	470	
Total cost ($m)	5.8	4.8	5.2	5.6	**19.5**
Fee lower by $80					
Registrants (people)	15,730	16,532	17,375	18,261	
Fee ($)	356	368	376	384	
Total cost ($m)	7.0	6.1	6.5	7.0	**24.1**
Fee higher by $80					
Registrants (people)	15,730	16,532	17,375	18,261	
Fee ($)	516	533	544	556	
Total cost ($m)	9.5	8.8	9.5	10.1	**34.3**

Source: Deloitte Access Economics' calculations.

[7] The public administration and safety sector comprises public administration (including justice); defence; and public order, safety and regulatory services (ABS, 2013).

3 Benefits of registration

This section provides a discussion of the potential benefits from registration of professional social workers in Australia. The discussion considers some of the main benefit categories and case studies from other countries that have successfully implemented registration schemes.

That said, a comprehensive benefits analysis was outside the scope of this report, and additional research is needed to develop robust parameters for quantifying the benefits of registration in Australia.

3.1 The licensing of occupations

The general view among economists is that licensing:

- can often create more costs than benefits, but that
- the main exceptions are where consumers aren't well placed to judge the quality of services.

For example, Kleiner (2006) provides a broad review of occupational licensing and finds that, while licensing can impose costs on society, it can be justified where it helps to minimise consumer uncertainty over the quality of services.[8] This is particularly important where poor quality can have large social implications (for example, in the case of a doctor who makes incorrect diagnoses). In such cases, regulation requiring practitioners to meet minimum professional standards can have positive social payoffs. These payoffs will often outweigh the burdens of licensing, which can include occupational barriers to entry, higher prices for service delivery, and reduced access to services.

In relation to registration of health practitioners under the NRAS, the Victorian Department of Health (2013) found that registration can be an appropriate regulatory option when the risks of harm associated with a profession are high, and there are no less restrictive means for addressing these risks.

It is arguable that social work falls under the general exception here. As social workers often work with vulnerable populations, clients are often ill-equipped to properly judge quality, and the costs of misconduct can be high. Indeed, the client base of social workers is, in some cases, similar to that of professions currently regulated under the NRAS (including, for example, psychologists).

This section concludes with a 'break-even' analysis which identifies how many incidents of child abuse, child death, or hospital separations for mental and behavioural conditions would need to be averted for the benefits of registration to exceed the costs.

[8] Another useful overview is found in Cox and Foster (1990), *The Costs and Benefits of Occupational Regulation* (See https://www.ftc.gov/system/files/documents/reports/costs-benefits-occupational-regulation/cox_foster_-_occupational_licensing.pdf)

3.2 Benefits

Social workers are deeply embedded in Australian communities, and have a direct influence on the health and wellbeing of some of Australia's most vulnerable people. In particular, the nature of social work requires the establishment of long-term relationships based on trust, and the human costs of unsafe or unethical practice can be high. This means that high standards of professionalism, safety, and accountability must be ensured to protect Australian communities and uphold the integrity of the social work profession.

The risks of harmful practice can be mitigated through registration schemes which set and maintain standards of professionalism, and introduce formal mechanisms for oversight and accountability (Beddoe & Duke, 2009). Registration of social workers can drive broad benefits for the profession, service users, and the broader community, including

- improved public safety and confidence in the profession;
- higher standards of conduct and accountability; and
- professional development and mobility opportunities for workers.

These benefits are discussed below.

3.2.1 Improved public safety and confidence in the profession

The major objective of professional registration is to ensure that service users are protected from socially unacceptable or harmful practices (Kirwan & Melaugh, 2015).

Social workers work closely with vulnerable people and often in intimate therapeutic relationships based on trust and authority. Further, social workers typically provide services without supervision, and in the absence of another person besides the client. Such settings can heighten the risk of serious professional boundary violations and incidents of illegal or unethical conduct. Furthermore, the absence of a legally enforced code of conduct and complaints mechanism means that misconduct can continue for some time before action is taken.

Professional registration of social workers sets and maintains standards of professionalism and provides service users with formal channels for complaints and reviews (Beddoe & Duke, 2009). Registration can protect public safety by prescribing competency requirements for social workers and accountability for how they practice (Orme & Rennie, 2006). Mandatory registration also provides the opportunity to conduct checks on qualifications, practice currency, probity and criminal history as a condition of practice.

The recent Australian case of the tragic death of Adelaide girl Chloe Valentine has resulted in the recommendation from the South Australian coroner for formal registration of social workers in Australia. This recommendation recognises the importance that professional registration of social workers plays in the protection of service users.

Registration of social workers provides the public with assurance that social workers are appropriately qualified, fit to practice, and have the capability to deliver expected levels of service. Introducing minimum professional standards also ensures that the workforce is

well-educated and better equipped to meet the diverse needs of its service users, including children and other vulnerable people (Beddoe & Duke, 2009).

3.2.2 Higher standards of conduct and accountability

In 2004, both New Zealand and the United Kingdom (UK) introduced procedures for the registration of the social worker workforce.[9] To become registered in the UK, social workers need to demonstrate achievement of relevant qualifications, mental and physical fitness-to-practice and evidence of good moral character (Orme & Rennie, 2006). In New Zealand, where registration is voluntary, registered practitioners demonstrate a minimum three years of study, that they have undertaken supervised practice, that they are professionally competent (including cultural competency), and that they are 'fit and proper' to perform the job (Orme & Rennie, 2006). Registered practitioners also undergo police checks.

Despite the voluntary nature of the registration system in New Zealand, more than 4,000 social workers have chosen to meet the professional standards for registration, and the number of social workers becoming registered has increased by, on average, 38% per year over the four years prior to 2013 (Gilray 2013). These figures highlight the high standing that professional registration has in New Zealand's social work sector.

In the UK, since 2012, the UK-wide Health and Care Professions Council has reported annual rises in Fitness-to-Practice cases[10] that correlated with increases in the number of registrants, although this still represents only a very small proportion of those on the register (Furness, 2015). This has demonstrated that formal registration of social workers can result in higher levels of accountability by providing accessible mechanisms for complaints and review.

In New Zealand, 46 complaints were received in 2011-2012 in relation to registered social workers, primarily associated with poor social work practice (Gilray 2013). Further, in 2013, 35 social workers had compliance conditions attached to their annual practising certification and a number have had their registration suspended as a result of not maintaining recertification requirements (Gilray 2013). The restriction or removal of these individuals from social work practice may have averted incidents of professional misconduct, leading to improved public wellbeing in the community.

3.2.3 Ongoing professional development opportunities for workers

Health professionals regulated under the NRAS are required to continue their education to ensure the currency of their qualifications and knowledge of new developments in their field. However, there are currently no requirements for continuing professional

[9] Other countries that require licensing or registration to work as a social worker include Spain, South Africa, and all but seven states of the USA (Weiss-Gal & Welbourne, 2008). Codes of ethical conduct for the social worker profession exist in each of these countries; however their enforceability varies substantially from sanctions-based codes (e.g. South Africa and the USA) to those more of moral value.

[10] Fitness-to-practice cases include referrals for investigation by the regulator of potential contraventions of codes of practice/ standard operating procedures, including behaviours associated with professional practice and those outside of work that could affect the reputation of the profession and public safety. Referrals can come from employers, self-reporting, service users, members of the public and the police.

development or education for social workers in Australia. Professional development opportunities for social workers can not only benefit clients through improved service provision, but also provide the social worker with a rewarding and fulfilling career path.

A national registration scheme would also have the benefit of transferability, allowing workers to move between states with full recognition of qualifications and fitness-to-practice. This could also benefit employers who would avoid costs associated with assessing the suitability of applicants for social work positions.

In both the UK and New Zealand, maintaining registration is dependent upon demonstration of continued professional development. In the UK, re-registration is required every three years with a minimum of 15 days of continuing professional development (CPD) achieved in that time. In New Zealand, social workers must demonstrate that they have undertaken 150 hours of CPD in a three year period (Orme & Rennie, 2006).

3.3 Break-even analysis

Social workers regularly work with vulnerable people, and hence the costs of unsafe or harmful conduct can be high. The consequences can be especially extreme when children are involved, as was illustrated in the recent case where a four-year-old child died in 2012 while under the care of *Families SA*. This section provides estimates for the costs of child abuse, child death and public hospital separations for mental and behavioural conditions, based on existing research and literature. These estimates are used to derive the number of adverse incidents that would need to be averted in order for the benefits of social worker registration to outweigh the costs.

Note, this section only provides a 'break-even' analysis and does not estimate the number of adverse incidents that would actually be averted. Further research and analysis is required to develop robust and defensible parameter values for quantifying the benefits of registering social workers.

> Overall, it is estimated that 60.6 incidents of child abuse, 1.5 child deaths or 903.7 public hospital separations for mental and behavioural conditions would need to be averted in the first year of social worker registration for the benefits to outweigh the costs.

3.3.1 Costs of child abuse

As part of their professional responsibilities, social workers often work with government and non-government providers to deliver services to children involved with the child protection system, including responding to incidents of child abuse. Raising professional standards of social workers may contribute to more effectively identifying and responding to child abuse incidents.

In our 2008 Report, *The Cost of Child Abuse in Australia*, we estimated that the lifetime costs of child abuse and neglect in 2007 was $14.4 million (Access Economics, 2008). This includes the net burden of disease, estimated to be $7.7 million, and other costs, including

health system expenditure, productivity losses, crime, government expenditure and deadweight losses of $6.7 million. We also estimated that, in 2007, there were 130,237 children who were abused or neglected for the first time in Australia.

Overall, it was estimated that the average lifetime cost of child abuse in 2007 was $110,253 per abuse victim. Inflating this to 2016 dollars (ABS, 2016b), we estimate the lifetime cost per abused child to be $136,025 in 2016.

In Section 2 it was estimated that the total cost of registration of social workers in the first year would be $8.2 million. This implies that if 60.6 incidents of child abuse (less than 0.05% of annual cases in 2007) were averted in the first year of registration, the benefits of registration of social workers would outweigh the costs.

The number of incidents needed to be avoided has been estimated for each year from 2016-2019 based on the total costs of registration estimated in Section 2.2.3, and applying trend growth in CPI (ABS, 2016b) to estimate costs of child abuse in forward years. This is shown in Table 3.1.

Table 3.1: Child abuse incidents needed to be averted, 2016 to 2019

Year	2016	2017	2018	2019	Total
Abuse incidents needed to be averted	60.6	53.0	55.7	58.5	227.8

Source: Deloitte Access Economics' calculations.

3.3.2 Costs of death

Recognised by the South Australian Coroner's recommendation in its investigation into the tragic death of Adelaide girl, Chloe Valentine, a national registration system for social workers could help ensure the protection of service users, including in the avoidance of preventable death.

Life and health can be valued using the concepts of disability adjusted life years, expected years of life lost, and the value of a statistical life. These concepts are used to establish the value of life lost associated with premature death. This methodology has been adopted and applied in Australia by the Australian Institute of Health and Welfare (AIHW) in its burden of disease studies (for example, see Begg et al, 2007).

The Department of Prime Minister and Cabinet (2014) provided an estimate of the value of a statistical life year (VSLY). The value of a statistical life year was estimated to be $182,000 in 2014, which inflated by CPI (ABS, 2016b) is approximately $187,328 in 2016 dollars. This was applied to the number of years of life lost due to a premature death which, based on ABS standard life tables for Australia, was estimated to be 72.2 years of life lost for a child who dies at age ten (ABS, 2014).[11] Each year of life was multiplied by the VSLY, and this was

[11] The estimate for years of life lost is based on an average life expectancy of 82.2 years (ABS, 2014).

then discounted back to current dollars at 3%[12] (as benefits are preferred now, rather than in the future). If a ten year old child were to die in 2016, society would value the loss of life at around $5.5 million (in 2016 dollars).

Hence, it was estimated that if 1.5 childhood deaths were averted in the first year of registration, the benefits of registration would exceed the costs, or 5.8 deaths over the period 2016 to 2019. Table 3.2 shows the number of child deaths averted in each year to break-even on this criterion alone. In reality, death is an extreme outcome, although in Australia there were an estimated 240 deaths from child abuse in the year 2007 (Access Economics, 2008), suggesting the break-even point is reducing deaths by around 0.6%.

Table 3.2: Child deaths needed to be averted, 2016 to 2019

Year	2016	2017	2018	2019	Total
Child deaths needed to be averted	1.5	1.3	1.4	1.5	5.8

Source: Deloitte Access Economics' calculations.

3.3.3 Costs of admitted patient mental health care

Social workers, and particularly mental health social workers, often provide skilled counselling and advocacy for people with cognitive and psychiatric impairment. Effective performance of this role by qualified practitioners can reduce the burden on other areas of the health system, such as admitted patient mental health care in hospitals.

In 2013-14, there were approximately 381,718 hospital separations for which the primary diagnosis was a mental or behavioural condition, of which approximately 198,556 were in public hospitals.[13] It has been estimated that the average cost of a public hospital separation for mental and behavioural conditions was $9,128 in 2013-14 (AIHW 2015).[14]

Therefore, it is estimated that registration of social workers would break-even if 903.7 public hospital separations for mental and behavioural conditions were avoided in 2016. This is equivalent to approximately 0.5% of all public hospital separations for mental and behavioural conditions in 2013-14.

Table 3.3 : Public hospital separations needed to be averted, 2016 to 2019

Year	2016	2017	2018	2019	Total
Public hospital mental and behavioural condition separations needed to be averted	903.7	789.6	829.4	871.9	3,394.6

Source: Deloitte Access Economics' calculations

[12] This is lower than the 7% discount rate used in the cost modelling, since it only includes positive time preference, not inflation or productivity gains included in that former rate.

[13] 'Separation' is the term used to refer to the process by which an admitted patient completes an episode of care by being discharged, dying, transferring to another hospital, or changing type of care.

[14] AIHW advises that caution should be used in interpreting these data as the costs are based on estimates for the 2011–12 reference period.

4 Next steps

This report has estimated the costs of registration of social workers in Australia. **While a detailed, quantitative analysis of benefits is beyond the scope of this report**, the potential benefits of registration were also considered, including through break-even analysis showing the number of adverse impacts of non-registration that would need to be averted for the benefits of registration to outweigh the costs.

While this analysis has provided some useful parameters around the costs and benefits of registration, further research is needed to develop a robust cost benefit analysis (CBA) that could be used to present the economic case for registration of social workers. In particular, a robust cost benefit analysis is necessary to meet the requirements of the Office of Best Practice Regulation (OBPR) to establish new policy. To do this, the expected costs and benefits need to be established for a range of options, including the status quo (the scenario of no change to current non-regulated practice).

Based on the qualitative benefits and break-even analysis in Section 3, there is the potential for substantial benefits to be realised. Future research to quantify these benefits could include establishing robust parameters around the impacts expected from registration of social workers in Australia. This could be based on data analysis from other countries where social workers are required to be registered. Ultimately the benefits may be reflected in reduced hospital admissions for mental health conditions, reduced cases of child abuse, and in some cases, reduced deaths. However, further analysis is required to estimate the actual size of expected reductions, and whether there are broader impacts not considered in this break-even analysis.

In addition to the benefits considered in the break-even analysis, there are likely to be other benefits from the registration of social workers. For example, it is likely that registered social workers equipped with the correct skills and knowledge will be better able to help support their clients, and provide improved health outcomes in situations of vulnerability (for example, for elderly Australians). Again, these benefits would need to be established relative to the status quo (no change), by considering differences in impacts evident in literature from other countries where mandatory registration has been implemented.

Future work to establish the costs and benefits of registering social workers, and who bears the costs, for each regulated and un-regulated option (in line with OBPR guidelines) could also include stakeholder consultations. Potential stakeholders include AHPRA, existing national boards and other stakeholders which could provide more detailed information on the components of the fixed and variable costs, and extent of benefits associated with registrations. This may allow a more detailed CBA to be developed.

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AASW
Australian Association of Social Workers

The registration of social workers in Australia

Australian Association of Social Workers Limited

Deloitte's Estimates and Calculations Updated for 2025 by the Australian Association of Social Workers.

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Glossary

AASW	Australian Association of Social Workers
ABS	Australian Bureau of Statistics
AHPRA	Australian Health Practitioner Regulation Agency
CBA	Cost-benefit analysis
CPD	Continuing Professional Development
CPI	Consumer Price Index (the Australian measure of consumer price inflation)
OBPR	Office for Best Practice Regulation
NRAS	National Registration and Accreditation Scheme
VSLY	Value of a statistical life year
JSA	Jobs and Skills Australia
ACMS	Australian Child Maltreatment Study
SWRB	Social Workers Registration Board New Zealand
GSCC	General Social Care Council

Executive Summary

Social workers help deal with a range of complex issues in Australia by providing psychosocial and other interventions to vulnerable people across a range of different settings, including in health care. Currently, people working in social work are not required by law to hold registration in Australia, which may lead to some clients being unaware of the workers' qualifications, skills, and ethical obligations (Australian Association of Social Workers (AASW), 2014). In some cases, sub-standard, unethical, or unqualified practice has caused substantial harm to clients.

If a ten-year-old child were to die in 2025, society would value the loss of life at around **$7.4 million** (in 2025 dollars). The **prevention of one child's death in the first year alone** would justify the establishment costs. With **two cases of abuse averted**, registration demonstrates a full return on investment.

The National Registration and Accreditation Scheme (NRAS) regulate the practice of some health professions in Australia. It is administered by the Australian Health Practitioner Regulation Agency (AHPRA).

This report outlines the costs of registration of social workers under the NRAS, and highlights some of the broad benefits of registration that could flow to Australian society.

Introducing national registration for social workers in 2025 is estimated to cost $20 million. Of this, **$18 million will be fully recovered through registration fees** in line with AHPRA's cost-recovery model, meaning the implementation will **not create an ongoing cost to government**. Only the **$2 million** establishment expense will require government funding.

Social worker workforce and costs of registration

The size of the social worker workforce is difficult to estimate, with a wide range of estimates depending on sources and methods. **Jobs and Skills Australia data show 49,500 professional social workers in 2025** (Jobs and Skills Australia, May 2025)**.** Based on New Zealand's 75-85% mandatory registration compliance[1], we estimate 80% of Australia's workforce would register, approximately 39,600 professionals.

Using this calculation, the number of professional social workers is expected to grow to 53,300 by 2029.

The total cost of registering social workers with AHPRA comprises fixed costs (for establishing a new national board) and variable costs (for ongoing registrations, **which will be fully recovered through practitioner fees**):

- The variable costs were estimated by using the registration fee for psychologists, as a comparable profession, which was $454 in 2025.
- The fixed cost of establishing a board was estimated to be $2 million, based on data from AHPRA annual reports.
- The total cost between 2025 and 2029 was estimated to be $97.8 million in net present value terms (2025-26 dollars). The costs in each year are shown in Table 0.1.

[1] The 75-85% compliance rate estimate is derived from available workforce data and registration statistics. The 2018 Census recorded 8,019 social workers in New Zealand, while registered social workers grew from 7,800 in 2018/19 (pre-mandatory registration) to over 10,000 by 2021 (Social Workers Registration Board New Zealand, 2022). Accounting for natural workforce growth over the three-year period and assuming a total workforce of approximately 11,000-13,000 in 2021, the registration of 10,000 social workers represents an estimated compliance rate of 75-90%. This range accounts for uncertainties in total workforce size and variations in workforce growth rates during the transition period.

Table 0.1: Total costs, 2025 to 2029

Year	2025	2026	2027	2028	2029
Registrants	39,600	42,646	45,937	49,482	53,300
Total cost ($ m)	20*	19.8	21.9	24.2	26.7

Source: AASW calculations.

*Includes the establishment cost of a national board and $18m recoverable through fees.

Using data from AHPRA annual reports, it was estimated that AHPRA fully recovers all expenses. Hence, all costs of registration would be passed on to and hence borne by social workers registering in each year.

Benefits of registration

Registration of social workers in Australia could result in a broad range of benefits, including improved public safety, higher standards of conduct and accountability, and improved professional development and mobility opportunities for workers.

A detailed, quantitative analysis of benefits is beyond the scope of this report. However:

- While occupational licensing in general is seen as creating more costs than benefits, the main class of exceptions is where consumers are ill-equipped to judge the quality of a professional's services. That is arguably the case with the clients of social workers, who are often vulnerable or experiencing distress.
- 'Break-even' analysis was used to determine the number of adverse incidents of social worker misconduct that would need to be averted for the benefits of registration to outweigh the costs.

> Overall, it is estimated that if social worker registration could avert approximately **0.01%** of child abuse incidents or **1.5%** of child deaths from abuse, this would justify the establishment costs.

1 Background

Social workers help deal with a range of complex issues in Australia by providing casework, counselling, and psychological interventions to vulnerable people across a range of different settings. Social workers also provide psychosocial assessments, which involve using particular skills and knowledge to assess a person's physical, psychological and social context. This includes identifying issues and strengths in (Australian Association Of Social Workers (AASW), 2015):

- social role functioning
- meeting financial and other basic needs
- family interactions
- social supports, and
- cultural factors.

Social workers provide services across a range of different settings, including community health, acute inpatient, rehabilitation, health promotion, mental health, and other health services. Social workers also practise in services such as asylum seeker and refugee centres, domestic and family violence services, youth services, disability services, homelessness services, and child protection agencies. Social workers aim to improve health and well-being outcomes for individuals, their families, and the community.

Currently, people working in social services are not required by law to hold registration in Australia, which may lead to some clients being unaware of the workers' qualifications, skills and ethical obligations (Australian Association of Social Workers (AASW), 2014). The AASW has argued that, in some cases, sub-standard, unethical or unqualified practice can cause substantial harm to clients, for example, abuse or even death. Social workers often provide their services without another person present and are increasingly providing services as a sole proprietor or small practice (Australian Association of Social Workers (AASW), 2014). These settings can increase the risk for professional boundary violations and harm being inflicted on the community.

The inclusion of social workers under the National Registration Accreditation Scheme (NRAS) may potentially avert sub-standard, unethical, or unqualified practice in Australia. The NRAS was established in 2010 and is the only government scheme overseeing the regulation of qualifications, standards and practices for health practitioners in Australia.

The Australian Health Practitioner Regulation Agency (Ahpra) is the registration body with responsibility for implementing the NRAS across Australia. Each profession that is part of the NRAS is represented by a national board under AHPRA. While the primary role of the boards is to protect the public, the boards are also responsible for registering practitioners and students, as well as performing other functions for their professions. There are currently 15 National Boards, including for professions (such as psychologists) that often deal with a similar client base to social workers.

The Australian Association of Social Workers (AASW) is the peak body representing approximately 17,700 members in Australia. The AASW represents social workers and aims to ensure the sustainable development of the profession, the maintenance of accountability and compliance with benchmark standards, and the promotion of professional indemnity.

AASW aims to keep the public safe from harm – the same core objectives as the NRAS. As social workers regularly work with vulnerable people, AASW continues to actively campaign for the inclusion of the social work profession under the NRAS. If this were to occur, the social work profession would also be regulated by AHPRA. Throughout this report, social workers are defined as those who have completed a four-year AASW accredited Bachelor of Social Work, Master of Social Work (qualifying), or an international social work qualification which has been assessed by the AASW as comparable to an AASW accredited qualification. Currently, 41 higher education institutions across Australia provide social work programs accredited by the AASW (Australian Association of Social Workers (AASW), 2025).

2 Costs of registration

The total cost of registering social workers with Ahpra comprises both fixed costs (related to establishing a new national board) and variable costs (associated with ongoing registrations). In turn, variable costs depend on the number of professional social workers expected to register with Ahpra. Accordingly, two components were required to estimate the cost of registration:

- **Workforce –** the total number of professional social workers in Australia (those that hold a four-year degree in social work) and, of those, the number who are expected to register with Ahpra; and
- **Variable and fixed costs –** the initial establishment fees, and ongoing expenses to manage a national board for professional social workers under the NRAS.

The data sources and estimates used for estimating costs are outlined in the following sections. Having estimated costs, it was necessary to identify the extent to which costs are expected to be borne by government. As described in the following sections, it is expected that Ahpra would fully recover its costs, and hence registration would not be a net cost to government.

2.1 Social worker workforce

The Jobs and Skills Australia National Occupation Trend Series was used to estimate the total number of people identifying as social workers in Australia (Jobs and Skills Australia, May 2025). Overall, there were approximately 49,500 people who self-reported as social workers in Australia in 2025[2].

The number of professional social workers in Australia may be higher or lower, as it is possible that social workers may identify their occupation differently – for example, they may report that they are a welfare support worker. These caveats may mean that the total number of professional social workers is slightly higher or lower than the number reported. Consequently, sensitivity analysis is conducted on the number of social workers who would register under the NRAS in section 2.3.

To assess government registration costs, we applied New Zealand's mandatory registration experience, where 75-85% of social workers complied with requirements. New Zealand implemented mandatory social worker registration on February 27, 2021, following amendments to the Social Workers Registration Act 2003. The transition demonstrated strong professional compliance, with registered social workers growing from 7,800 in 2018/19 to over 10,000 by 2021 and reaching 11,000 by 2022 (Social Workers Registration Board New Zealand, 2022). Based on 2018 Census data showing 8,019 social workers worked in New Zealand (careers.govt.nz, 2024), and accounting for natural workforce growth, this represents an estimated 75-90% compliance rate with the mandatory registration requirement. The NZ Social Workers Registration Board's two-year preparation campaign and strong professional support contributed to this successful implementation, establishing social work as a regulated profession alongside teaching, law, and health.

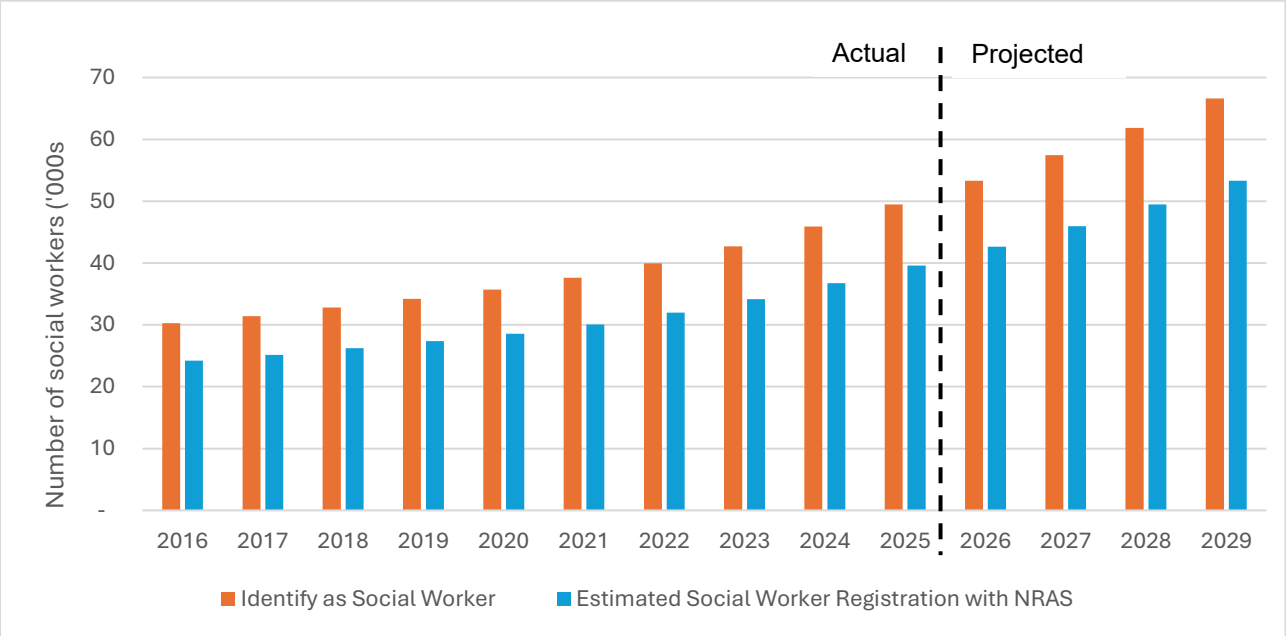
Using an 80% registration rate assumption, our baseline estimate captures professionally qualified social workers across health care and social assistance sectors, including hospitals, primary care, residential care, and social assistance services (Australian Bureau of Statistics (ABS), 2022).

The number of social workers from 2025 to 2029 was estimated using employment growth projections for social workers from the Jobs and Skills Australia (Jobs and Skills Australia, May 2025), which forecast an average workforce growth of 7.7% per year.

[2] This was calculated as the average of the quarterly Detailed Labour Force Survey results in 2025 (May 2025), the latest complete year for which data were available, and the data trended by Jobs and Skills Australia.

Overall, it was estimated that there were approximately 39,600 professional social workers who would register under the NRAS in Australia in 2025. By 2029, the number of registered social workers is expected to grow to approximately 53,300 (see Chart 2.1). This represents approximately 80% of the total professional social work workforce in each year.

The modelling in this report calculates costs of registration between 2025 and 2029, and hence it was assumed that an NRAS national board for social workers would be established in 2025. Chart 2.1 also provides estimates for the number of social workers who would have registered in the years 2016 to 2025 if registration were available.



Source: AASW calculations.

2.2 Variable and fixed costs

Costs of registering professional social workers include establishing a new professional board with Ahpra (a one-off, fixed cost), and the ongoing costs of registrations (variable costs). These costs are outlined further in the following sections.

2.2.1 New board establishment fees – fixed cost

To estimate the costs of establishing a board under the NRAS it was assumed that the costs would be similar to those observed for the Paramedicine Board of Australia, which joined the National Scheme in December 2018 as the most recent profession addition. Data were collected from the 2016 -17 (Australian Health Practitioner Regulation Agency (AHPRA), 2017), 2017-18 (Australian Health Practitioner Regulation Agency (AHPRA), 2018) and 2018-19 (Australian Health Practitioner Regulation Agency (Ahpra), 2019) AHPRA annual reports to estimate these costs.

The Australian Health Ministers' Advisory Council (AHMAC) provided direct funding for the establishment of the Paramedicine Board over two financial years. AHPRA received $211,874 in 2016-17 and an additional $1.4 million in 2017-18, totalling $1,611,874 specifically for "the costs of establishing the regulation of paramedics and the new Paramedicine Board of Australia" (Australian Health Practitioner Regulation Agency (AHPRA), 2018).

The Paramedicine Board implementation demonstrates a more reliable cost estimation methodology as it represents actual establishment expenditure for a single new profession rather than proportional calculations from multiple board changes. The Board achieved **full cost recovery within the first operational year**,

validating the adequacy of the establishment investment. By 29 March 2019, over 17,900 applications for registration had been received and over 16,200 practitioners were granted first registration, demonstrating successful implementation within the budgeted establishment costs (Australian Health Practitioner Regulation Agency (Ahpra), 2019).

The Paramedicine Board provides a comparable case study for social work board establishment, as both professions were previously unregulated at the national level. As noted in the 2017–18 annual report, "the paramedicine profession was not previously regulated in any jurisdiction, significant work was required to develop and implement the necessary regulatory infrastructure" (Australian Health Practitioner Regulation Agency (Ahpra), 2018). The 24-month preparation period (from February 2017 establishment to December 2018 participation day) and systematic approach to stakeholder engagement provide a proven implementation model. **For social work, implementation would be comparatively simpler, given that the profession has long abided by a single National Code of Ethics (developed by the AASW since the late 1960s) and one set of National Practice Standards.**

However, establishment costs require adjustment for current economic conditions. The original Paramedicine Board establishment costs occurred during 2016-2018, and significant inflation has occurred since implementation. **Applying the cumulative Consumer Price Index (CPI) inflation of 23.17% from 2019 to 2025** (Australian Bureau of Statistics (ABSb), 2025) **to account for increased costs in technology infrastructure, staffing, consultation processes, and general operational expenses, the adjusted establishment cost estimate becomes $2 million.**

2.2.2 Ongoing costs of registration – variable costs

Variable costs are those that would vary according to the number of social workers registered under the NRAS. For example, variable costs include staff costs, legal and notification costs, and other costs associated with maintaining registrations and handling complaints. Variable costs are likely to increase with an increase in workload associated with a greater number of registrations. This was illustrated by an increase in AHPRA's variable costs associated with staffing when the four new boards were established in 2012[3] and when the paramedics joined in 2018.

Data from AHPRA's annual reports between 2011 and 2024 indicates that registration income between 2011 and 2024 covers 95% of all AHPRA expenses[4], on average. Further, AHPRA appears to receive registration fees upfront, which means they earn interest on registration income throughout the year. Consequently, it was assumed that **AHPRA operates on a full cost recovery model**. This means that if social workers were registered under the NRAS, all costs would likely be recovered through fees charged to social workers, and the interest on those up-front fees.

The variable costs from professional social workers were estimated by assuming an average cost per registrant that is equivalent to the Psychology Board of Australia fee – which was set at $454 per applicant in 2025 (Australian Health Practitioner Regulation Agency (AHPRA), 2024)[5]. To derive total variable costs, this fee was multiplied by the expected number of registrants in 2025, and in each subsequent year (see section 2.1). The fee was assumed to grow in line with past trends in the consumer price index (CPI) – an average of 2.5% (Australian Bureau of Statistics (ABSb), 2025) per annum between 2026 and 2029.

[3] The four new boards were the Aboriginal and Torres Strait Island Practice Board; the Medical Radiation Practice Board; the Occupational Therapy Board; and the Chinese Medicine Board.

[4] Data from AHPRA's annual reports between 2011/12 and 2023/24 indicates that registration fee income typically covers approximately 95% of total expenses. Coverage varied significantly, ranging from 88.7% to 110.0% depending on operational cycles and major investments. Source: AHPRA Annual Reports 2011/12 to 2023/24, Statement of Comprehensive Income.

[5] Across all professions, annual registration fees in 2025 ranged from $154 per applicant for the Aboriginal and Torres Strait Island Health Practice Board, to $1,027 for the Medical Board of Australia.

The variable costs of registration for each year between 2025 and 2029 are shown in Table 2.1.

Table 2.1: Variable costs of registration, 2025 to 2029

Year	2025	2026	2027	2028	2029
Registrants (people)	39,600	42,646	45,937	49,482	53,300
Registration fee ($)	454	465	477	489	501
Variable costs ($m)	*18.0	19.8	21.9	24.2	2.7

*Recoverable Source: AASW calculations.

The variable costs were estimated to be $18 million in 2025, increasing to $26.7 million in 2029. The net present value of this stream was estimated to be $95.8 million (in 2025-26 dollars) between 2025 and 2029[6].

2.7.1 Summary of costs

The total cost of registration was estimated to be $20 million (in 2025-26 dollars) in the first-year social workers are registered under the NRAS. This cost comprises:

- $ 2 million in fixed establishment costs; and
- $ 18 million in variable costs (recovered), including staffing, travel and accommodation, and legal and notification costs.

The total cost between 2025 and 2029 was estimated to be $97.8 million in net present value terms (2025-29 dollars). The costs in each year are shown in Table 2.2.

Table 2.2 Total costs, 2025 to 2029

Year	2025	2026	2027	2028	2029
Registrants	39,600	42,646	45,937	49,482	53,300
Total cost ($ m)	20.0*	19.8	21.9	24.2	26.7

Source: AASW calculation.

* Includes $2 million of fixed costs associated with the establishment of a national board.

> Since AHPRA fully recovers all expenses, costs of registration would likely be covered by fees paid by social workers. **Registration of social workers is not expected to be a net cost to government.**

2.8 Sensitivity analysis

Sensitivity analysis was undertaken to develop a range of cost estimates, reflecting the uncertainty surrounding key parameters in the modelling.

The sensitivity analysis included:

- a 25% increase in the number of social workers who would register under the NRAS, which represents the total number of Social Worker employed in May 2025 reported by Jobs and Skills Australia (Jobs and Skills Australia, May 2025), and
- registration fees for social workers are set to the average fee across all AHPRA national boards ($385), and registration fees are set to be higher by the same difference ($523).

[6] A discount rate of 7% was used to calculate net present value, as recommended by the Australian Office of Best Practice Regulation for regulatory impact analysis (Australian Government, 2007).

The results of the sensitivity analysis suggest that the total cost would range between $17.2 million and $24.5 million in the first year. In net present value terms, the total cost between 2025 and 2029 would range between $83.5 million and $121.7 million (in 2025-26 dollars). The number of registrants, fees and costs for each scenario are presented in Table 2.3.

Table 2.3 Total costs– sensitivity scenarios, 2025 to 2029

Year	2025	2026	2027	2028	2029	Net Present Values
Base case						
Registrants (people)	39,600	42,646	45,937	49,482	53,300	
Fee ($)	454	465	477	489	501	
Total cost ($m)	20.0	19.8	21.9	24.2	26.7	$97.8
Social Worker employed in May 2025 (JSA, 2025)						
Registrants (people)	49,500	53,307	57,421	61,852	66,625	
Fee ($)	454	465	477	489	501	
Total cost ($m)	24.5	24.8	27.4	30.2	33.4	$121.7
Fee Lowered by $ 69						
Registrants (people)	39,600	42,646	45,937	49,482	53,300	
Fee ($)	385	398	407	415	424	
Total cost ($m)	17.2	17.0	18.7	20.6	22.6	$83.5
Fee is Higher by $ 69						
Registrants (people)	39,600	42,646	45,937	49,482	53,300	
Fee ($)	523	539	551	563	576	
Total cost ($m)	22.7	23.0	25.3	27.9	30.7	$112.5

Source: AASW calculations.

The only cost to government for introducing national registration of social workers in 2025 is the $2 million establishment expense, with the remaining $18 million and all ongoing year-on-year expenses fully recovered through registration fees – and this applies for all scenarios.

2.9 Data Limitations and Workforce Estimation Methodology

This analysis acknowledges the limitations inherent in occupational self-identification within census and survey data for the social work profession. The Jobs and Skills Australia National Occupation Trend Series remains the most comprehensive source available for workforce estimation and cost analysis.

To address this uncertainty, we implemented several safeguards: conservative registration assumptions (80% participation based on New Zealand's experience), comprehensive sensitivity analysis (testing scenarios from 39,600 to 49,500 registrants), and explicit recognition that **workforce numbers may vary due to occupational self-identification differences**.

The sensitivity analysis demonstrates that cost estimates remain robust across plausible workforce scenarios. While mandatory registration would provide more precise workforce data, this analysis is based on the best available evidence for informing future policy considerations.

3 Benefits of registration

This section provides a discussion of the potential benefits from registration of professional social workers in Australia. The discussion considers some of the main benefit categories and case studies from other countries that have successfully implemented registration schemes.

3.1 The licensing of occupations

The general view among economists is that licensing:

- can often create more costs than benefits, but that
- the main exceptions are where consumers aren't well placed to judge the quality of services.

For example, (Kleiner, 2006) provides a broad review of occupational licensing and finds that, while licensing can impose costs on society, it can be justified where it helps to minimise consumer uncertainty over the quality of services[7]. This is particularly important where poor quality can have large social implications (for example, in the case of a doctor who makes incorrect diagnoses). In such cases, regulation requiring practitioners to meet minimum professional standards can have positive social payoffs. These payoffs will often outweigh the burdens of licensing, which can include occupational barriers to entry, higher prices for service delivery, and reduced access to services.

In relation to registration of health practitioners under the NRAS, the Victorian Department of Health (2013) found that registration can be an appropriate regulatory option when the risks of harm associated with a profession are high, and there are no less restrictive means for addressing these risks.

It is arguable that social work falls under the general exception here. As social workers often work with vulnerable populations, clients are often ill-equipped to properly judge quality, and the costs of misconduct can be high. Indeed, the client base of social workers is, in some cases, similar to that of professions currently regulated under the NRAS (including, for example, psychologists).

This section concludes with a 'break-even' analysis, which identifies how many incidents of child abuse and child death need to be averted for the benefits of registration to exceed the costs.

3.2 Benefits

Social workers are deeply embedded in Australian communities and have a direct influence on the health and well-being of some of Australia's most vulnerable people. In particular, the nature of social work requires the establishment of long-term relationships based on trust, and the human costs of unsafe or unethical practice can be high. This means that high standards of professionalism, safety, and accountability must be ensured to protect Australian communities and uphold the integrity of the social work profession.

The risks of harmful practice can be mitigated through registration schemes which set and maintain standards of professionalism and introduce formal mechanisms for oversight and accountability (Beddoe & Duke, 2009). Registration of social workers can drive broad benefits for the profession, service users, and the broader community, including

- improved public safety and confidence in the profession
- higher standards of conduct and accountability, and
- professional development and mobility opportunities for workers.

[7] Another useful overview is found in Cox and Foster (1990), *The Costs and Benefits of Occupational Regulation* (See https://www.ftc.gov/system/files/documents/reports/costs-benefits-occupational-regulation/cox_foster_-_occupational_licensing.pdf).

These benefits are discussed below.

3.2.1 Improved public safety and confidence in the profession

The major objective of professional registration is to ensure that service users are protected from socially unacceptable or harmful practices (Kirwan & Melaugh, 2015).

Social workers work closely with vulnerable people and often in intimate therapeutic relationships based on trust and authority. Further, social workers typically provide services without supervision and in the absence of another person besides the client. Such settings can heighten the risk of serious professional boundary violations and incidents of illegal or unethical conduct. Furthermore, the absence of a legally enforced code of conduct and a complaints mechanism means that misconduct can continue for some time before action is taken.

Professional registration of social workers sets and maintains standards of professionalism and provides service users with formal channels for complaints and reviews (Beddoe & Duke, 2009). Registration can protect public safety by prescribing competency requirements for social workers and accountability for how they practice (Orme & Rennie, 2006). Mandatory registration also provides the opportunity to conduct checks on qualifications, practice currency, probity, and criminal history as a condition of practice. The recent Australian case of the tragic death in Adelaide of Chloe Valentine has resulted in the recommendation from the South Australian coroner for the formal registration of social workers in Australia. This recommendation recognises the importance that professional registration of social workers plays in the protection of service users.

Registration of social workers provides the public with assurance that social workers are appropriately qualified, fit to practice, and have the capability to deliver expected levels of service. Introducing minimum professional standards also ensures that the workforce is well-educated and better equipped to meet the diverse needs of its service users, including children and other vulnerable people (Beddoe & Duke, 2009).

3.2.2 Higher standards of conduct and accountability

In 2004, both New Zealand and the United Kingdom (UK) introduced procedures for the registration of the social work workforce. To become registered in the UK, social workers are required to demonstrate relevant qualifications, mental and physical fitness-to-practice, and evidence of good character (Orme & Rennie, 2006).

In New Zealand, registration has since become mandatory under the Social Workers Registration Act 2003 (amended in 2019, with full effect from February 2021). Registered practitioners must hold a recognised qualification in social work, undertake at least 2,000 hours of supervised practice, demonstrate competence (including cultural competence), and meet the statutory requirement of being a “fit and proper person” to practise. Police checks and ongoing professional development are also required, with practitioners needing to renew their annual practising certificate.

As of 30 June 2024, there were 12,449 registered social workers in New Zealand, of whom 9,135 held a current practising certificate (SWRB New Zealand, 2024). This demonstrates not only the substantial growth of the register since the introduction of mandatory registration, but also the profession’s commitment to accountability and public protection.

Regulatory oversight remains an important function of the Social Workers Registration Board. In 2023–24, the Board received 194 regulatory concerns, including 156 complaints and notifications relating to social workers, the majority of which concerned professional conduct and competence (SWRB New Zealand, 2024). Outcomes included conditions on practice, suspensions, and, in some cases, removal from the register, ensuring that only those who maintain the required standards continue to practise. These regulatory actions highlight the protective role of registration in safeguarding public well-being and strengthening confidence in the social work profession.

Social workers in England were first brought into statutory professional regulation in 2001, when the General Social Care Council (GSCC) was established (Social Work England, 2020). The CCETSW remained in place

until the passing of the Care Standards Act 2000, that required for the first time, that all social workers in England be registered, and thus obligated them to abide by the standards and rules of the new regulator, the General Social Care Council (GSCC) (Social Work England , 2023).

Those who supported the innovation aimed to set out the principles and values of social work to inform the public and against which social workers could be held to account. Establishing a regulatory body also put social work on an equal footing with many other professional groups.

The GSCC's key functions included:

- Setting and promoting standards of conduct and practice
- Maintaining a register of qualified professionals
- Holding practitioners accountable for standards
- Ensuring high standards of social work education

Since December 2019, Social Work England has been responsible for regulating social workers in England. This requires all practising social workers to be formally registered. A central part of its regulatory role is managing fitness-to-practice (FtP) concerns, providing transparent mechanisms for public complaints and professional accountability.

In 2023–24, Social Work England reported:

- 1,617 new referrals about social workers' fitness to practise.
- Of these, 641 concerns came from members of the public (representing 55% of referrals with a known source), while 337 came from employers of social workers, with the remainder from other sources (Social Work England, 2024).
- 1,613 cases reached a final outcome during the year, with the vast majority (73% or 1,179 cases) closed with no further action at the initial triage stage, meaning they did not meet the threshold for full investigation (Social Work England, 2024).

While only a small proportion of the over 100,000 registered social workers are ever subject to such proceedings, the fitness to practise process plays an important role in ensuring accountability and protecting public confidence in the profession. Social Work England's regulatory approach continues to emphasise fairness, transparency, and public protection through its established framework.

This shows that formal registration of social workers in England not only safeguards professional standards but also provides a visible and accessible route for addressing concerns. However, the data also highlight operational challenges, with a high volume of referrals requiring careful triage and increasing demand on regulatory capacity.

3.2.3 Ongoing professional development opportunities for workers

Health professionals regulated under the NRAS are required to continue their education to ensure the currency of their qualifications and knowledge of new developments in their field. However, there are currently no requirements for continuing professional development or education for social workers in Australia. Professional development opportunities for social workers can not only benefit clients through improved service provision but also provide the social worker with a rewarding and fulfilling career path.

A national registration scheme would also have the benefit of transferability, allowing workers to move between states with full recognition of qualifications and fitness-to-practice. This could also benefit employers who would avoid costs associated with assessing the suitability of applicants for social work positions.

In England, all social workers must renew their registration annually with Social Work England. As part of the renewal process, they are required to record and submit evidence of continuing professional development

(CPD) each year, though the specific requirements for CPD are not detailed in terms of minimum pieces or mandatory peer reflection components.

By the end of the 2023 registration renewal period, 101,052 social workers (98%) had successfully renewed their registration by meeting the required standards (Social Work England, 2024). The compliance rate and lower volume of enquiries indicated that social workers were increasingly familiar with the registration renewal requirements.

CPD Quality Assurance: As with previous years, Social Work England randomly selected 2.5% of social workers for a CPD review. A team of 9 independent CPD assessors completed this review between January and March 2024. They accepted 2,406 (97.7%) social workers' CPD and gave 57 (2.3%) advice on how to improve their recording of CPD (Social Work England, 2024). The assessors noted that the quality of CPD recording had improved. Social workers showed better understanding when describing the impact of their learning on their practice.

Failure to meet CPD requirements or renew registration results in removal from the public register, and the social worker is no longer legally able to practise. CPD was identified as a key element of Social Work England's growing relationship with social workers, with plans to continue strengthening this relationship by promoting further adoption of learning, development and reflection as a routine and valued part of professional life.

The Social Workers Registration Board (SWRB New Zealand requires all registered social workers to hold a current practising certificate, which must be renewed annually. As part of this renewal, practitioners are required to demonstrate engagement in ongoing Continuing Professional Development (CPD) and professional supervision (SWRB New Zealand, 2024). Specifically, the NZ SWRB mandates that each social worker completes a minimum of 20 hours of CPD per practising year, with at least one activity addressing practice that supports competence to work with Māori, and logs these activities in their MySWRB CPD log, which is subject to annual audit.

3.3 Break-even analysis

Social workers regularly work with vulnerable people, and hence, the costs of unsafe or harmful conduct can be high. The consequences can be especially extreme when children are involved, as was illustrated in the recent case where a four-year-old child died in 2012 while under the care of *Families SA*. This section provides estimates for the costs of child abuse and child death based on existing research and literature. These estimates are used to derive the number of adverse incidents that would need to be averted for the benefits of social worker registration to outweigh the costs.

Note, this section only provides a ‘break-even’ analysis and does not estimate the number of adverse incidents that would actually be averted. Further research and analysis is required to develop robust and defensible parameter values for quantifying the benefits of registering social workers.

Overall, it is estimated that 2 incidents of child abuse and 1 child death would need to be averted in the first year of social worker registration for the benefits to outweigh the cost of establishing the registration of the social workers.

3.3.1 Costs of child abuse

As part of their professional responsibilities, social workers often work with government and non-government providers to deliver services to children involved with the child protection system, including responding to incidents of child abuse. Raising professional standards of social workers may contribute to more effectively identifying and responding to child abuse incidents.

The evolution of Australian child maltreatment research demonstrates dramatic methodological and scope advances reflected in escalating lifetime cost estimates. The foundational 2008 Taylor et al. study established $6.0 billion lifetime costs for children first abused in 2007, plus $7.7 billion burden of disease, using narrow medical-model approaches focused on children aged 0-17 (Taylor, et al., 2008). The 2016 McCarthy et al. study refined methodology to estimate $9.3 billion lifetime financial costs plus $17.4 billion

non-financial costs (totalling approximately $26.7 billion) with more sophisticated population attributable fractions but maintained the traditional child-focused scope (McCarthy, et al., 2016). The 2019 Deloitte study recorded an estimate of $78.4 billion lifetime costs through comprehensive whole-of-life analysis, expanded age ranges (0-24 years), and sophisticated co-occurrence modelling (Deloitte Access Economics, 2019). Earlier studies relied on Moore et al. (2015) prevalence estimates of 13% males and 22% females experiencing maltreatment (Moore, et al., 2015) or similar prevalence rates. In contrast, the 2023 Australian Child Maltreatment Study (ACMS) explores the prevalence understanding through direct measurement of 8,503 nationally representative participants, revealing that **62.2% of Australians experienced childhood maltreatment** (The Australian Child Maltreatment Study, 2023) - nearly **3 - 4 times higher than previous estimates used in economic studies**. The ACMS findings suggest that even the Deloitte study's advanced $78.4 billion lifetime cost estimate may represent substantial underestimation.

In its 2019 report, the economic cost of violence against children and young people, Deloitte Access Economics estimated that the lifetime financial cost of child and young people abuse and neglect in 2016–17 was $16.0 billion. When the non-financial costs associated with the burden of disease and premature mortality are also considered, the total estimated lifetime cost rises markedly to $78.4 billion. During this period, there were an estimated 489,194 total cases of violence against children and young people, of which 15.8% (approximately 86,200) were first-time cases of abuse or neglect (Deloitte Access Economics, 2019).

Based on these data, the average lifetime cost per victim was estimated to be $910,000 in 2017. Inflated to 2025 dollars (Australian Bureau of Statistics (ABSb), 2025), this equates to approximately $1.16 million per victim. By comparison, the estimated cost of establishing registration of social workers in the first year is **$2 million**. This implies that the registration scheme would achieve a positive net benefit if as few as **2 incidents of child and young people abuse were averted in the first year** (less than 0.01% of annual cases in 2017). If consideration is limited to the financial costs alone, the break-even point would be 9 averted incidents (less than 0.06% of annual cases in 2017).

Registration pays for itself by preventing just **2 incidents** of child abuse in year one.

3.3.2 Costs of death

Recognised by the South Australian Coroner's recommendation in its investigation into the tragic death of Adelaide girl, Chloe Valentine, a national registration system for social workers could help ensure the protection of service users, including in the avoidance of preventable death.

Life and health can be valued using the concepts of disability adjusted life years, expected years of life lost, and the value of a statistical life. These concepts are used to establish the value of life lost associated with premature death. This methodology has been adopted and applied in Australia by the Australian Institute of Health and Welfare (AIHW) in its burden of disease studies (Begg, et al., 2007).

The Department of Prime Minister and Cabinet (The Office of Impact Analysis (OIA), 2024) provided an estimate of the value of a statistical life year (VSLY). The value of a statistical life year was estimated to be $245,000 in 2024, which inflated by CPI (Australian Bureau of Statistics (ABSb), 2025) is approximately $250,119 in 2025 dollars. This was applied to the number of years of life lost due to a premature death, which, based on ABS standard life tables for Australia, was estimated to be 73.1 years of life lost for a child who dies at age ten (Australian Bureau of Statistics (ABSc), 2024)[8]. Each year of life was multiplied by the VSLY, and this was then discounted back to current dollars at 3%[9] (as benefits are preferred now, rather than in the future). If a ten-year-old child were to die in 2025, society would value the loss of life at around $7.4 million (in 2025 dollars).

[8] The estimate for years of life lost is based on an average life expectancy of 83.1 years (Australian Bureau of Statistics (ABSc), 2024)

[9] This is lower than the 7% discount rate used in the cost modelling, since it only includes positive time preference, not inflation or productivity gains included in that former rate.

Given the **$2 million** establishment cost for social worker registration, it is estimated that **preventing just one childhood death** in the first year would justify the investment. While death represents an extreme outcome, Australia recorded an estimated 66 child abuse deaths in 2016-17 (Deloitte Access Economics, 2019). This suggests the program would break even by preventing approximately 1.5% of such deaths.

Saving just **one child's life** would justify the entire investment.

4 Next Steps

This report has estimated the costs of registration of social workers in Australia. While a detailed, quantitative analysis of benefits is beyond the scope of this report, the potential benefits of registration were also considered, including through break-even analysis showing the number of adverse impacts of non-registration that would need to be averted for the benefits of registration to outweigh the costs.

While this analysis has provided some useful parameters around the costs and benefits of registration, further research is needed to develop a robust cost benefit analysis (CBA) that could be used to present the economic case for registration of social workers. In particular, a robust cost benefit analysis is necessary to meet the requirements of the Office of Best Practice Regulation (OBPR) to establish new policy. To do this, the expected costs and benefits need to be established for a range of options, including the status quo (the scenario of no change to current non-regulated practice).

Based on the qualitative benefits and break-even analysis in Section 3, there is the potential for substantial benefits to be realised. Future research to quantify these benefits could include establishing robust parameters around the impacts expected from registration of social workers in Australia. This could be based on data analysis from other countries where social workers are required to be registered. Ultimately the benefits may be reflected in reduced cases of child abuse, and in some cases, reduced deaths. However, further analysis is required to estimate the actual size of expected reductions and whether there are broader impacts not considered in this break-even analysis.

In addition to the benefits considered in the break-even analysis, there are likely to be other benefits from the registration of social workers. For example, it is likely that registered social workers equipped with the correct skills and knowledge will be better able to help support their clients and provide improved health outcomes in situations of vulnerability (for example, for elderly Australians). Again, these benefits would need to be established relative to the status quo (no change), by considering differences in impacts evident in the literature from other countries where mandatory registration has been implemented.

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AASW
Australian Association of Social Workers

Social work and professional practice in coroner reports 2018 – 2024

Report summary

May 2025

Executive Summary

This report provides summary analysis undertaken by the Australian Association of Social Workers (AASW) to document instances where coroners have raised concerns about the standards of practice of practitioners in their reports reviewing sudden or unexplained deaths.

The AASW identified 71 coroner reports in the period between 2018 – 2024 in which coroners highlighted the professional practice of practitioners and agencies providing services.

Coroners undertake their work to improve public health and safety. Coroners have documented numerous occasions where practice was not safe and fell short of the expected standards. Most jurisdictions in Australia have either mandatory requirements or policies that encourage government to respond to coronial recommendations. Government must be held accountable to these recommendations.

Three Australian coroners have recommended the profession of social work be registered and many others have highlighted concerns that point to an urgent need for the social work profession to be registered under the National Registration and Accreditation Scheme (NRAS).

National registration of social workers goes to the heart of these concerns by establishing nationally consistent standards of practice, and ensuring recency of practice, underpinned by a program of Continuous Professional Development of training and supervision.

Coronial findings have a pivotal role in shaping legislation and government reform. The recommendations of coroners led to the passage of the *Social Worker Registration Act 2021* (SA) and the establishment of the South Australian Social Worker Registration Scheme in South Australia. This report builds on the evidence base demonstrating the need for the national registration of social workers in Australia.

Mental health stands out as a key feature across all of the cases notwithstanding the different service systems. Whilst over 30% of the coronial cases reviewed occurred directly in the mental health service system there was a recurring theme of people experiencing mental health issues in the other coronial cases.

Coroner recommendations for social worker registration

1. Darren Bracken in death of 'PFS' (Victoria, 2022)
2. Anthony Schapel in death of Ebony Napier (South Australia, 2016)
3. Mark Johns in death of Chloe Valentine (South Australia, 2015)

Findings that support social worker registration

4. Coroner Schapel in deaths of Amber Rigney and Korey Mitchell (South Australia, 2022).[1]
5. David Whittle in death of Zhane Chilcott (South Australia, 2023).[2]

1. Coroner Schapel recommended review and implementation of all coronial recommendations relating to child protection.
2. Coroner Whittle made adverse findings about social worker competence but concluded it would be premature to recommend additional amendments to the *Social Workers Registration Act 2021* before its implementation.

Coroner recommendations for social worker registration

There have been numerous calls for social worker registration in Australia yet still with no national coordinated action from government. This analysis builds on the evidence for the need for national registration of social workers.

Mandatory registration of social workers in Australia would mean that all social workers are working to established standards of effective and ethical practice. Of the 47,700 social workers in Australia, only approximately 17,000 are members of the AASW agreeing to abide by a national *Code of Ethics* and *Practice Standards*.

The recommendations of coroners in South Australia led to the passage of the *Social Worker Registration Act 2021* (SA) and the establishment of the South Australian Social Worker Registration Scheme in South Australia.

In 2022 Victorian Coroner Darren Bracken has also recommended that the Australian Government consider including social workers in the NRAS.

"Social workers are often employed to work with vulnerable communities. The lack of accountability in this work raises concerning implications for their clients.

National registration and accreditation of social workers would, assist in defining and protecting professional educational and practice standards; defining safe and competent scopes of practice for social works; requiring mandatory hours of annual continuing professional development in order to ensure skills and knowledge remain up to date.

One of the key benefits of registration and accreditation is an ongoing obligation to maintain and update their knowledge in their field of practice. Without these obligations social workers and counsellors are not currently required to undertake professional development or engage in education outside of the requirements placed on them by their employers resulting in social workers and counsellors being at risk of not being aware of innovations in their respective fields of work to the detriment of their clients.

The need for oversight demonstrated by PFS' social worker/counsellor in promoting the use of relationships counselling despite the presence of family violence, evidences the need for regulation of counsellors and social workers in Australia." (Darren J. Bracken, VIC Coroner, 2022 Case of 'PFS').

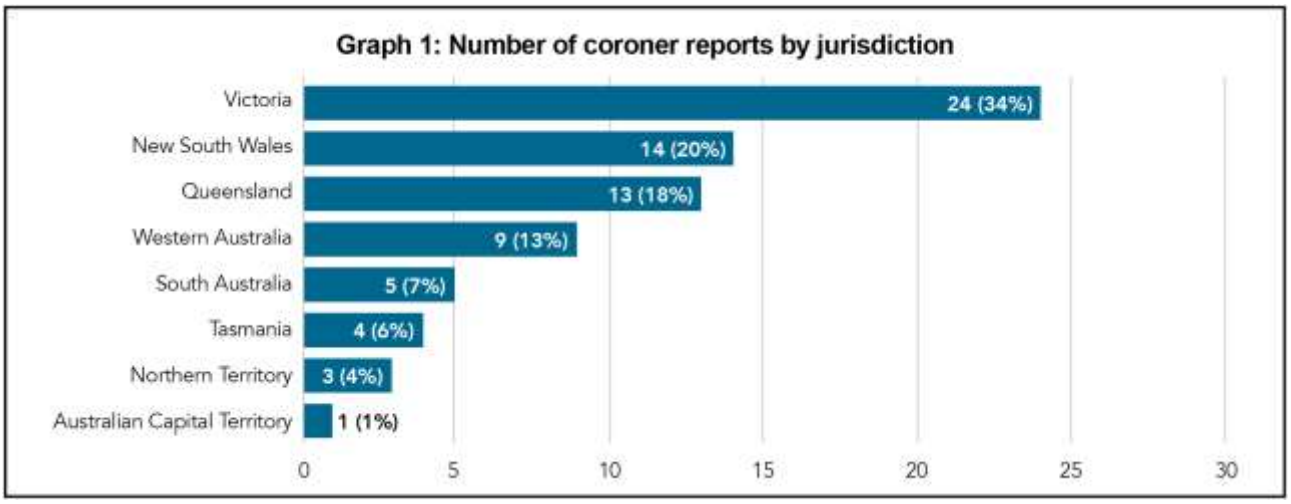
The coroner noted that registration of social workers through the National Registration and Accreditation Scheme (NRAS) would ensure that their practices are regulated and underpinned by standards, guidelines and an educational framework facilitating best practice, as it develops over time.

Report findings

The AASW reviewed coroner reports in all states and territories from 2018 to mid-2024. 71 reports were identified in scope for inclusion in this analysis. The deaths in these reports occurred due to child abuse (including filicide) and neglect, mental illness, domestic and family violence and alcohol, drug and substance abuse.

Coroner reports by jurisdiction

Coroner reports were identified in every state and territory. Some coroner reports were the subject of considerable media attention, government investigations and systemic reforms.



Practice issues identified in coroner reports

The coroner reports were reviewed to analyse practice issues as identified by coroners.

Table 1: practice issues identified in coroner reports

Issue	Number of coroner reports	% of coroner reports
Risk assessments	65	92
Failure to act	57	80
Skills, competence and training	48	68
Inappropriate case closures	37	52
Inappropriate intervention	27	38
Failure to apply for protective orders	25	35
Inadequate supervision	20	28
Group think	7	10

The majority of coroner reports reviewed included deficiencies in risk assessments. 65 cases relating to inadequate assessments were identified. If risks are not identified or correctly identified, and/or managed correctly, then the appropriate safety considerations and or necessary interventions are not taken.

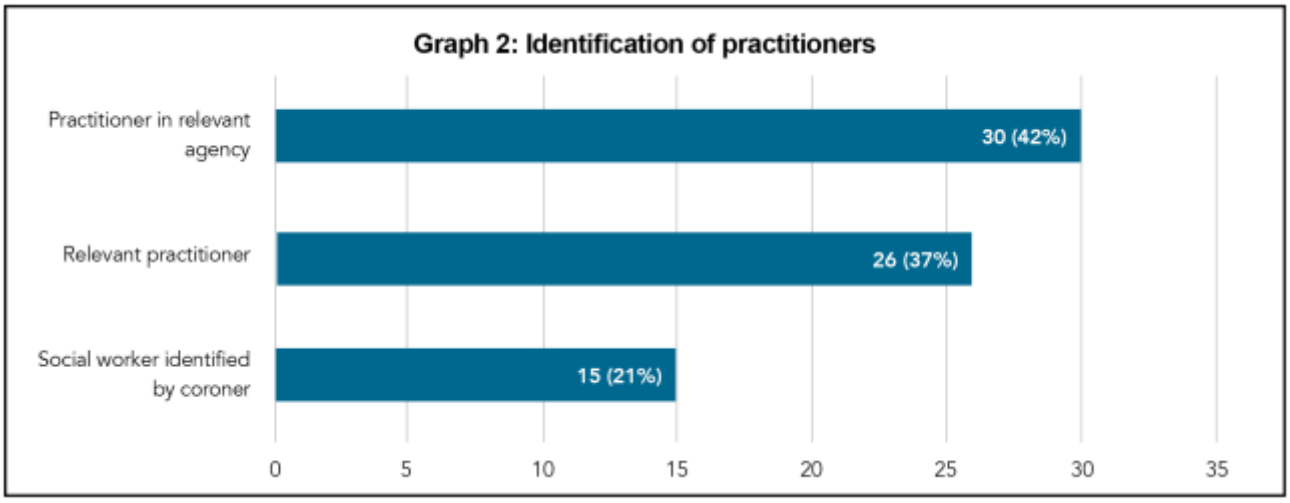
57 reports relate to scenarios in which a practitioner or agency learns information and does not take appropriate actions to intervene or reduce risks. In many cases this is around safety planning or the need to connect service users with relevant services and supports.

48 reports identified issues in skills, competence and training and 20 reports identified issues around appropriate supervision arrangements.

In 28 out of the 71 reports, the coroners noted that events occurred in the context of staff and resource shortages.

Identification of practitioners

In 15 reports, the coroner clearly identified the practice of a social worker to be at issue, and 26 reports identified issues around the practice of relevant practitioners who may be social workers.



Practitioners are not always clearly identified by coroners. Social workers were specifically referenced in 15 reports including in mental health, hospital, child and mental health and child protection roles. This analysis only included these reports where the coroner commented on inadequate standards of practice.

Identification of service systems

21 reports related to failures in mental health services. The coroner reports included instances of filicide and suicide within the context of psychosis, family violence and alcohol and drug abuse.

Mental health stands out as a key feature across all of the cases notwithstanding the different service systems. This review identified that over 30% of the coronial cases reviewed occurred directly in the mental health service system, however it also identified professional practice issues in a number of related mental health roles including employee assistance programs, family violence counselling, relationship counselling and dual diagnosis work.

Across many of the analysed coronial cases, there was an identified theme of mental ill-health, regardless of the service systems involved. Many people who were named in the coronial reports were living in

circumstances of great stress, complexity, and disadvantage. Their experiences often involved poverty, homelessness, disability, family violence, child abuse and neglect, and trauma. It is widely known from research that these circumstances and experiences increase the likelihood of vulnerability, risks of further discrimination and violence. High standards of professional practice are required to appropriately assess the circumstances and provide the necessary intervention and support.

52 reports related to failures in child protection agencies. The reports included instances where practitioners and agencies may have prevented filicide, suicide, accidental overdose on prescription medication, accidental drownings, unsafe sleeping environments, medical conditions and other deaths resulting from abuse and neglect. Improvements in professional practice in mental health and family violence systems can reduce the flow on demand to child protection systems and the increasing need for crisis responses.

13 cases involved family violence services. The reports included instances where practitioners and agencies may have prevented murders and suicides.

Table 2: identification of service systems

Issue	Number of coroner reports	% of coroner reports*
Child protection	52	73
Mental health	21	30
Family violence	13	18
Health	3	4
AOD	3	4
Corrections	2	3
Disability	1	1
Foster care	1	1

** Adds to more than total as multiple agencies involved.*

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