Victorian Allied Health Workforce Research Program

Social Work Workforce Report

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Social Work Workforce Report

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Except where otherwise indicated, the images in this publication show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. Where the term ‘Aboriginal’ is used, it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

Contents

Abbreviations and acronyms

AASW	Australian Association of Social Workers
ABS	Australian Bureau of Statistics
AH	Allied health
AHA	Allied health assistant
AHWQ2	Allied Health Workforce Questionnaire 2
CPD	Continuing professional development
EBA	Enterprise bargaining agreement
NFP	Not for profit
PD	Professional development

Executive summary

Overview

This report provides an overview of the social work workforce in Victoria in 2016 - 2017. It is based on survey responses from 1,294 individual social workers (approximately 25% of the social worker workforce identified in the 2011 Australian Bureau of Statistics (ABS) census data or 15% of Australian Association of Social Workers (AASW) estimates of Victorian social worker numbers[1]). It also draws on focus groups and interviews involving 28 social workers, and surveys from 273 organisational respondents that provide social work services across in Victoria.

Public sector and older employees were over-represented in the survey sample. Seventy-three per cent (73%) of respondents stated that they were state public sector employees as compared with 25% in the 2011 ABS census data, and 28% were age 35 and under in the survey sample as compared with 34% in the 2011 census. Where appropriate, issues of representativeness have been addressed by performing subgroup analysis by sector of employment.

It is important to note that, although the 2011 Census is the most recent definitive data on social worker numbers in Victoria, it is understood that the workforce has increased significantly since then. More than 3,000 domestic students have graduated from Victorian universities since 2011 (Department of Education and Training, 2017).

Key findings

Social Workers	AHWQ2 survey	ABS, 2011[a]	AASW, 2017[c]
Victorian population	1,294	5,182	2,825
Female	86%	84%	
Aboriginal and / or Torres Strait Islander	1%		
Australian trained	92%		
Age 35 years and under 55 years and older	28% 25%	34% 18%	
Median age (years)	35	37 (nationally) [b]	
Median income / annum	$60,000 to $69,999		
Public sector	80%		
Not for profit sector	15%		
Private sector	2%		
Principal area of practice	Mental Health - 21%		
Reporting advanced practice role	16%		
Work with allied health assistants	52%		
Reported use of telehealth	5%		
First qualification to practise	Bachelor degree – 70%		
Hold PhD	2%		
Intention to stay in profession for more than 5 years	73%		
Work for two or more employers	14%		
Of those with a supervisor, social worker as supervisor	67%		
% of workforce in regional areas	36%		

[a]*Source: ABS Census, 2011*
[b]*Source: ABS Labour Force Survey, annual average, 2015.*
[c]*Source: AASW membership data, 2017*

[1] The AASW estimate they represent about a third of the social work workforce in Victoria

According to the workforce survey and qualitative research findings, social work services are currently under pressure in the public system in Victoria with social workers citing long waiting lists, large workloads and limited capacity. Demand is predicted to continue to rise with the ageing population, and increasing policy focus on family violence, disability and mental health support. Future areas of high demand include family violence, aged care, disability, mental health, child protection, and Indigenous mental health. There are existing service gaps in these areas and also in rural areas. There is also an important and growing role for social workers in emergency departments.

Social workers were generally satisfied in their careers and value the diversity their profession offers; however they felt they lacked professional recognition and standing. While there was a sense that social workers' status is improving in the state's hospitals, many still felt undervalued and in the community sector, there was a particular concern about non-degree qualified social workers using the social worker title and sometimes getting paid at a similar level.

Another key issue for social workers was that career structures currently do not reward clinical expertise or specialty and this contributes to dissatisfaction and attrition in the profession. Approximately one third of respondents (32%) were working at the grade 2 level, with a high proportion of social workers not able to progress beyond this level due to lack of available positions , particularly in regional and rural areas, and in the community sector.

Workforce burnout (compassion fatigue) can have a significant effect on this workforce, but this is substantially mitigated with effective supervision. Clinical supervision is a valued and integral element of the profession. Many social workers want more access to supervision or better quality supervision, provided by an experienced social worker, not someone from a different profession.

Social work is a naturally innovative profession and social workers use their understanding of systems to suggest creative approaches that may not necessarily emerge from others with a more 'medical mindset'. Social workers often use their advocacy skills internally to lobby for new ideas, but the profession is perceived to lack the necessary status within organisations, as well as the level of evidence or documentation needed, to effectively advocate for different approaches to practice. Building a stronger research culture within the profession would assist with this.

Considerations

Key areas of consideration for the social work workforce going forward include:

- Improving professional understanding and definition of the social worker role.
- Increasing research culture across the profession, and evidence and knowledge base of models of care delivery, to improve referrals and develop business cases for optimal staffing levels to improve patient outcomes.
- Review of pay across the public, community and not-for-profit (NFP) sectors.
- Developing career structures that recognise and encourage clinical expertise and experience.
- Improving access to high quality supervision across the workforce to reduce compassion fatigue and increase capacity.
- Investigate the need for increased social work services in rural areas.
- Embedding social workers where there are opportunities for prevention and early intervention by addressing psycho-social needs, such as in emergency departments and with ambulance teams.

Introduction

The Victorian Allied Health Workforce Research Program (the program) aims to contribute to the evidence base of 27 selected Victorian allied health (AH) professions in the public, private and not-for-profit (NFP) sectors in Victoria. The data will be used to inform the policies and programs of the Department of Health and Human Services, provide a platform of evidence on which to build further understanding and development of the AH workforce, as well as guide any improvements to the associated education and training system.

This report presents the data arising from research on the social work workforce in Victoria.

Please note: Terminology used in this report reflects that used in the survey process by Southern Cross University, rather than standard Department of Health and Human Services terminology.

The 11 profession specific reports which form the meso and micro levels of this research (as described in the methods section) are based on similar but not identical surveys varied to meet the individual requirements of each investigated profession. Comparative data reflecting the Victorian state context is included wherever possible. While significant effort has been made to make each of these reports as consistent as possible in its presentation of material, differences in available comparative data and other profession specific differences have resulted in some variations in the material included and its presentation.

Throughout these reports the terms *grade* (e.g. 1, 2, 3 etc.) or *level* (junior, intermediate, senior) are used in both the text and quotes from research participants. The term grade refers to the different employment classifications used in the enterprise bargaining agreements (EBA) that individuals may be employed under. These EBAs (awards) generally cover the public sector employees and larger private sector organisations. These grades determine pay rates and benefits, and in some cases job responsibilities and job titles. The exact description and meaning of each grade will vary with the different awards. For individuals who were not employed under these awards (e.g. private business owners, contractors etc.) the term level was used to try and equate their job responsibilities and pay to those employed under the formal EBA structure. These terms were also used to determine the breakdown and specific issues relating to junior, intermediate and more senior members of the specific professions in Victoria.

Background

Who are social workers?

Social workers work with individuals, families, groups and communities to address life challenges and enhance wellbeing.

Social workers have a dual focus centred on assisting with and improving human wellbeing, and identifying and addressing any system or structural issues that may impact on wellbeing or may create inequality, injustice and discrimination. Social workers undertake roles in casework, counselling, advocacy, community engagement and development and social action to address issues at both the personal and social level. They also work in areas such as policy development, education and research, with particular focus on issues of social justice, disadvantage and the marginalisation of people in their communities or in society.

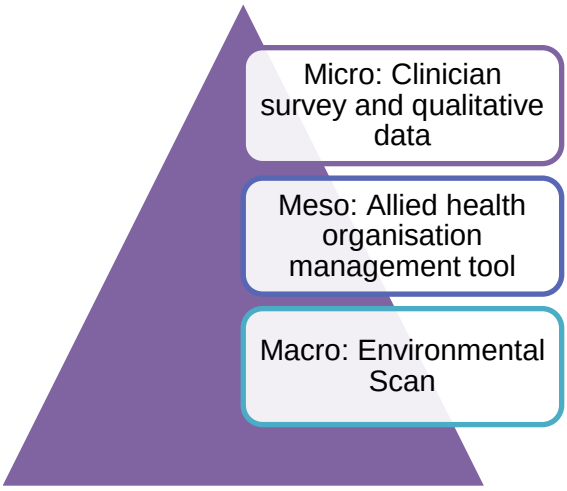
To qualify as a social worker completion of a Bachelor or Master of Social Work is normally expected.

Social work is not a registrable profession under the *National Registration and Accreditation Scheme / Australian Health Practitioner Regulation Agency* (AHPRA). Social work is effectively an unregistered profession. The peak professional body for social work is the *Australian Association of Social Workers* (AASW). AASW is not a member of the *National Alliance of Self Regulating Health Professions* and membership with AASW is voluntary. However many employer, including the Victorian public hospitals, required eligibility for membership with AASW. To qualify for AASW membership individuals must have undertaken an approved tertiary level course in social work.

Method

A three-tiered approach was used to capture workforce data at macro, meso and micro levels (Figure 1).

Figure 1: Three-tiered research approach



Macro

Environmental scan

The environmental scan examined 27 AH professions in Victoria during the first six months of the research program. The process involved engagement with each of the professional associations regarding workforce trends and issues alongside an analysis of a range of existing data sources. A 'snapshot' was generated for each profession which included key workforce statistics, workforce trends and issues presently affecting the profession, and those likely to affect the profession in the future. An environmental scan has been produced as a stand-alone document for each profession. Relevant findings from the social work environmental scan have been incorporated into this report.

Meso and micro level data

Subsequent to the environmental scan, four professions (physiotherapy, sonography, speech pathology and allied health assistance) were analysed in depth in 2015 – 16. A further three professions (occupational therapy, social work and psychology) were analysed during 2016 – 17. This analysis included organisational and individual level approaches as described below. These professions were selected by the Department of Health and Human Services for further study because they were either high priority professions or they were unregistered professions with limited existing data available. The in-depth analysis involved the use of a semi-standardised survey and focus groups with both standardised and profession specific questions.

In year one of the research program, three separate surveys were used to access data at an individual (Allied Health Workforce Questionnaire), team (Allied Health Organisation Mapping Tool) and organisation level (Allied Health Human Resources Tool). For this, second stage of the program, the questions from the three surveys were combined into a single tool (Allied Health Workforce Questionnaire 2 (AHWQ2)), and internal survey logic was used to direct respondents to the appropriate questions according to their role/s or perspective within an organisation.

The AHWQ2 collected the following information:

At the organisational level, team leaders, managers or directors of human resources were asked to provide information about the geographic location, numbers and grades of staff, skill set, recruitment and

retention issues, and organisational contexts of the profession. It was completed at a regional or organisational level, typically by a team leader or human resources department, to provide detailed information about the workforce structure and organisation.

Individual clinician data captured information about education and training, the nature of work, location of work, job satisfaction and career development opportunities, as well as open ended questions exploring issues that the profession specifically identified as being important.

Participants who completed the AHWQ2 were invited to provide their contact details for future follow-up.

Focus groups

Survey respondents who agreed to be followed-up via email were invited to participate in one of eight focus groups. Two groups were provided for early career professionals, while the remainder were heterogeneous, but designed to include a mixture of participants according to rurality and public / private sector. Three individual interviews were also conducted to accommodate participants who experienced difficulties joining the online conference, and one individual provided an emailed response to the focus group questions. The focus groups explored issues that were highlighted in the survey responses. The focus groups explored issues that were highlighted in the survey responses. The questions were developed in consultation with the reference groups and Department of Health and Human Services. Each focus group was held via teleconference using Zoom and was approximately 90 minutes. The focus groups were recorded and detailed contemporaneous notes were taken and used as the basis for analysis. Where necessary the recordings were accessed for clarity or confirmation.

Research governance

The research was overseen by an overarching research advisory group comprising experts from many health disciplines and sectors. In addition, each of the three professions had a discipline specific reference group comprising members of the profession who represented specific sectors or subgroups (such as new graduates, public, private and NFP sectors, and academics). The advisory group and the reference groups were consulted about the research approach, survey distribution methods and engagement strategies, as well as providing substantial input into the survey content and piloting. The discipline specific reference groups also advised on the content of the focus group questions, aided the interpretation and verification of the final reports, and provided feedback on the penultimate drafts of the discipline specific reports.

Distribution approaches

Surveys were initially distributed through the reference groups, the professional associations and Department of Health and Human Services contact lists. In addition, a communications database was developed comprising employers, professional networks and associations, individual professionals and relevant contacts for each profession. This database evolved during the project and continues to evolve.

The survey was circulated between 11 November 2016 and 7 April 2017.

Other methods of distribution and marketing included Department of Health and Human Services newsletters, marketing on social media (e.g. Facebook), a presentation at the Victorian Allied Health Research Conference, regional conference presentations, and presentations to individual professions.

Analyses

The Qualtrics survey tool generates descriptive statistics (frequencies, means, standard deviations, etc.) for all questions which are downloadable in Microsoft Word and Microsoft Excel formats. Further analyses were undertaken using cross tabulations of specific questions results, and comparisons with other available data from the Australian Bureau of Statistics (ABS) Census, Health Workforce Australia,

Australian Institute of Health and Welfare (AIHW), Department of Health and Human Services, and profession specific associations.

Data limitations

- The challenge of distributing and marketing a survey commissioned by a single government department to distributed health services, non-government services and private providers means that the data may not be representative of the profession.
- It was difficult to engage with the NFP and private social work providers. As a result, it is not possible to determine the representativeness of the data for these groups.
- The focus group participants were invited from the AHWQ2 respondents who agreed to be followed-up. This may have resulted in selection bias as only 35% of all survey respondents agreed to further follow-up.
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Results

The source of data in the tables and figures going forward is the AHWQ2 survey data unless otherwise stated.

Responses and respondents

Respondent numbers for each of the different data collection methods are presented in Table 1 below.

Table 1: Respondent numbers by data collection approach

AHWQ2 (individual respondents)	AHWQ2 (organisational respondents)	Focus groups and interviews
1,294	273	8 focus groups (25 participants) 3 individual interviews 1 email response

Allied health workforce questionnaire 2

The AHWQ2 survey was completed at both the organisational and individual practitioner level. The respondents to the managerial level questions were presented with seven questions, and the individual clinicians were presented with 53 questions. Completion of the survey was voluntary and respondents, both organisational and individual, had the opportunity to choose if they wished to answer a question or not. Some of the questions were conditional on the response to previous questions. Some questions allowed for multiple answers. As a result, the number of responses for each question varied and is included in the presentation of the data for each question.

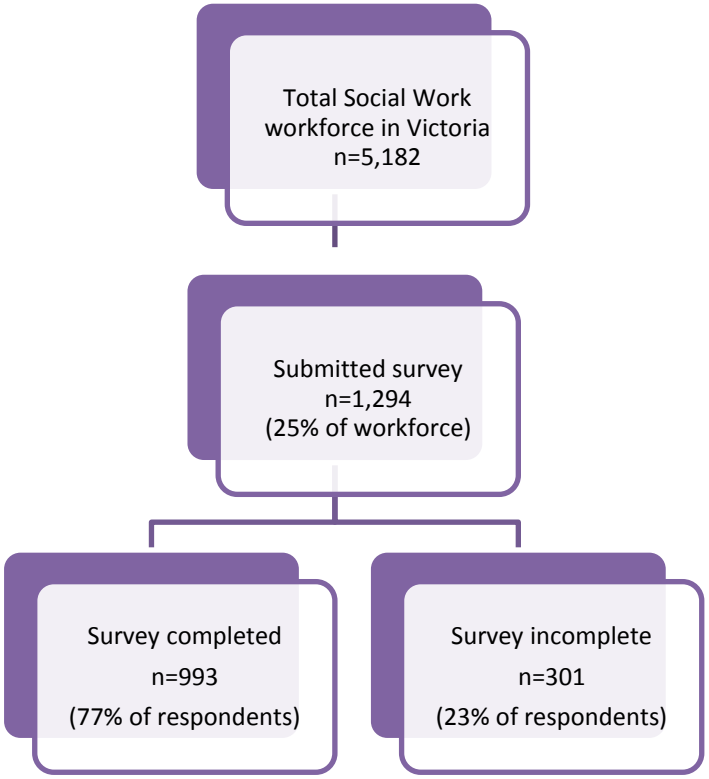
A total of 1,294 social workers completed at least one question on the survey and submitted their survey. This represents 25% of the social workers based in Victoria from the 2011 Census data. However, it is important to note that, although the 2011 Census is the most recent definitive data on social worker numbers in Victoria, it is understood that the workforce has increased significantly since then. More than 3,000 domestic students have graduated from Victorian universities since 2011 (Department of Education and Training, 2017). The survey was completed[2] by 993 individual social workers. The range of responses to an individual question was from 975 to 1562[3]. Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not (Figure 2).

A total of 273 employers or managers of social workers completed the AHWQ2. The organisations they represented employed a total of 1,751 full time equivalent social workers. Slightly more than half of these responses (54%) were from team leaders or managers of single social work teams.

[2] A survey was considered complete if the respondent answered the last survey question and submitted the survey, even if they did not provide answers to every survey question.

[3] Some questions allowed for multiple responses.

Figure 2: Survey responses



Capacity

Capacity refers to the ability of the profession to meet the needs of the community in terms of workforce numbers and allocation of staff, skill mix, ratios, geographic distribution, organisation of the workforce, and their ability to influence these factors at a political, professional and organisational level (Figure 3).

Figure 3: Workforce capacity framework

Key findings

- Twenty-eight percent (28%) of respondents were 35 years and under, with the age range being from 22 to 75 years.
- Two thirds of social worker respondents were metropolitan based. Few social workers worked in rural areas. The Grampians was the area with the least access to social workers.
- Grade 2 was the most common employment level accounting for about one third of respondents (32%).
- Mental health was the most common area of practice (21%), followed by general hospital / medical work (18%).
- Social workers worked across all age groups, with most working with adults (57%) or older adults (33%) and about a quarter working with adolescents or young adults.
- Over one third (35%) of respondents worked in hospital inpatient settings and a further 19% in hospital outpatient settings; 24% worked in the community.
- About half of respondents reported their main area of practice as mental health services (21%), general medical / hospital work (18%) and counselling (10%).
- There were no quantifiable measures of demand for social workers from the data collected. However, respondents pointed to a range of evidence indicating high and unmet demand for social work services.
- Nationally, very strong employment growth is forecast for social workers to 2020.
- Organisations surveyed had more difficulty recruiting social workers than occupational therapists or psychologists. The key reason for not being able to fill positions was a lack of applicants with appropriate skills and experience.
- Social workers at the intermediate grades were in most demand, particularly those with skills and experience in mental health or domestic and family violence.
- Twenty-nine per cent (29%) of social workers received funding via the Home and Community Care program to support social work services. Other common sources of funding included the Medical Benefits Scheme Accredited Mental Health Social Worker program (24%), Transport Accident Commission (24%), and the National Disability Insurance Scheme (19%).
- Sixteen percent (16%) of respondents reported that their work involved advanced scope of practice, however many of the roles described as advanced practice may well be considered within the normal scope of a social worker role. These included activities such as mental health assessments, grief counselling, crisis response, family therapy, family violence responses and supervision.
- Eighteen percent (18%) of respondents reported their work involved delegation to Allied Health Assistants. This arrangement appears to be an emerging feature in social work.
- Only 5% of respondents reported using telehealth. This was mostly to provide telephone, online chat or skype counselling; support to rural or geographically isolated patients; to videoconference with specialists; to provide or receive supervision via Skype; or to link into continuing professional development activities online or by videoconference.
- On the whole, social workers planned to be in the profession for the long-haul. Fifty-one per cent (51%) stated they intended to stay in the profession for more than 10 years and a further 22% said they intended to stay for six to 10 years. Only 2% indicated they looking to leave the profession in the next 12 months, and a further 25% were looking to leave in the one to five-year timeframe.
- Social workers have a key role in prevention and early intervention in relation to a range of areas

including mental health, child protection, financial counselling and domestic and family violence.

- Social workers tend to move towards working in the state public system and away from the NFP, Commonwealth and local government sectors as they progress through their careers.
- They also tend to move towards roles in hospital-based roles and away from community-based roles as they progress through their careers.

Workforce distribution

Demographics

As detailed in Table 2, the survey respondents were predominantly female (86%); this is consistent with the 2011 ABS data which showed 84% of the profession were female. One quarter of respondents were age 55 and older, and 28% were 35 and under. In contrast, the 2011 ABS data found that 34% of the social work workforce were age 35 and under. Thus, the AHWQ2 respondents were an older cohort.

Of the total cohort of survey respondents, 93% (n=1,149) were employed in the social work workforce at the time of completing the survey

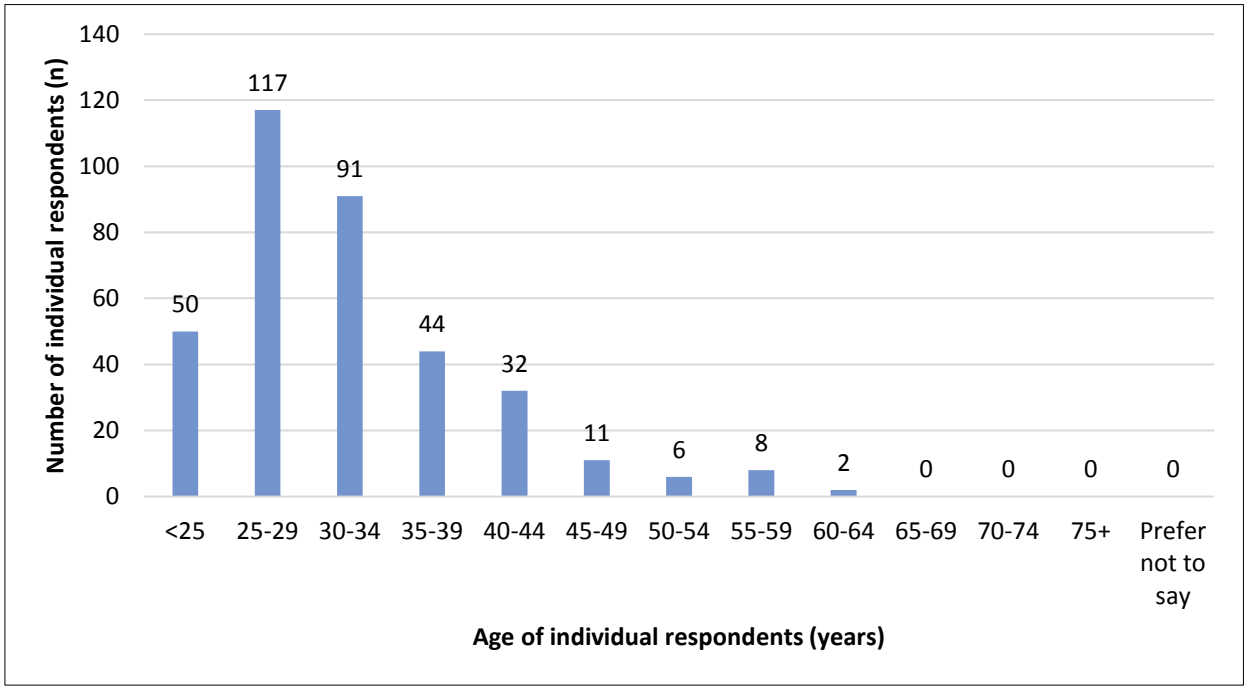
Twenty-five per cent (25%) of AHWQ2 respondents were age 55 years and older and 28% were 35 years and under (Table 2). The median age of social work respondents was 44 years (range 22 to >75) and the largest group of respondents was 45 to 49 years. (Figure 4)

Table 2: Demographics (n=1,217) compared with ABS 2011 data

Demographics	AHWQ2		ABS 2011[1]
	n	%	%
Female	797	86	84
Aboriginal and / or Torres Strait Islander	8	1	-
Australian citizen / permanent resident	1,121	99	-
Age 55 and older	279	25	18
Age 35 and under	307	28	34
Median age (years)	44.3	-	-

[1]*Source: ABS Census, 2011*

Figure 4: Age in 2016 / 2017 (n=1,118)



Geography

The AHWRP respondents were predominantly metro-centric with approximately 64% reporting they undertook their primary role in an inner or outer metropolitan area. Only 8% worked in rural areas (Table 3).

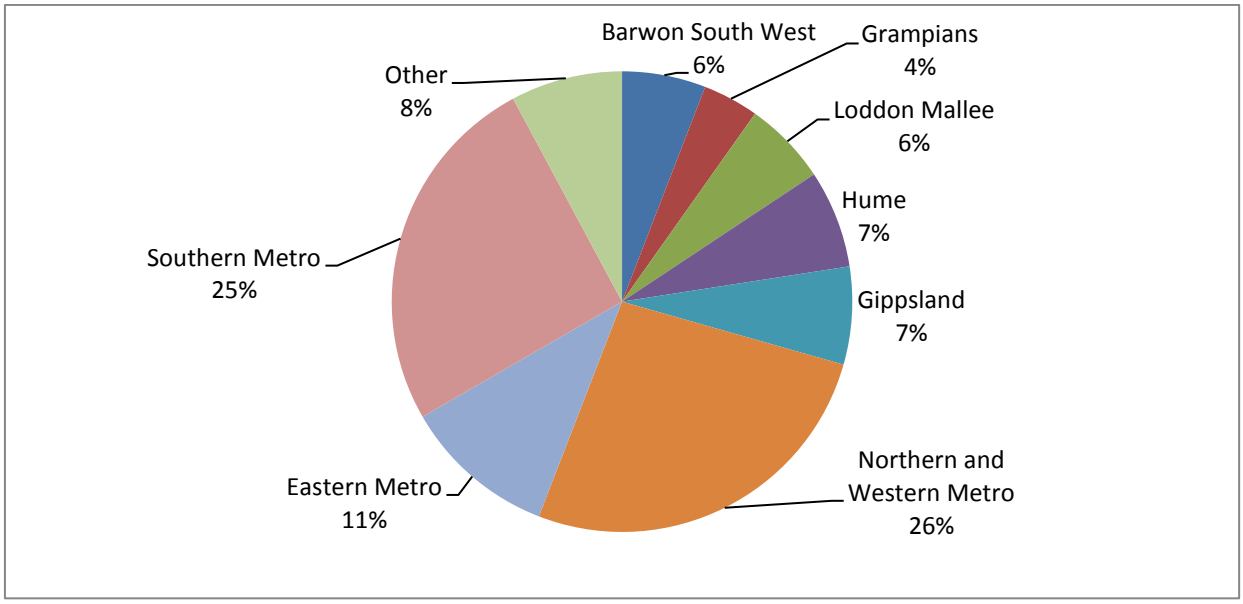
Table 3: Region of work (n=1,072)

AHWQ2		
Region	**%**	**Count**
Inner-metro	48	517
Outer-metro	16	171
Inner-regional	22	232
Outer-regional	6	60
Rural	8	90
Remote	<1	2
Total	**100**	**1,072**

The densest population of social workers was in the North and West Metropolitan region where 30% of respondents were based. Social workers were scarcest in the Grampians, with 4% working in this area (Figure 5).

The Australian Bureau of Statistics Census of Population and Dwellings 2011 (Australian Bureau of Statistics (ABS), 2011) indicated that the highest proportion of social workers were located in North and West Metro (1.16 per 1,000), Loddon Mallee (1.02 per 1,000) and Hume (0.84 per 1,000), while the lowest proportion of social workers were located in Eastern Metro (0.72 per 1,000) and Grampians (0.69 per 1,000)

Figure 5: Main place of work by Department of Health and Human Services' regions (n=1,089)

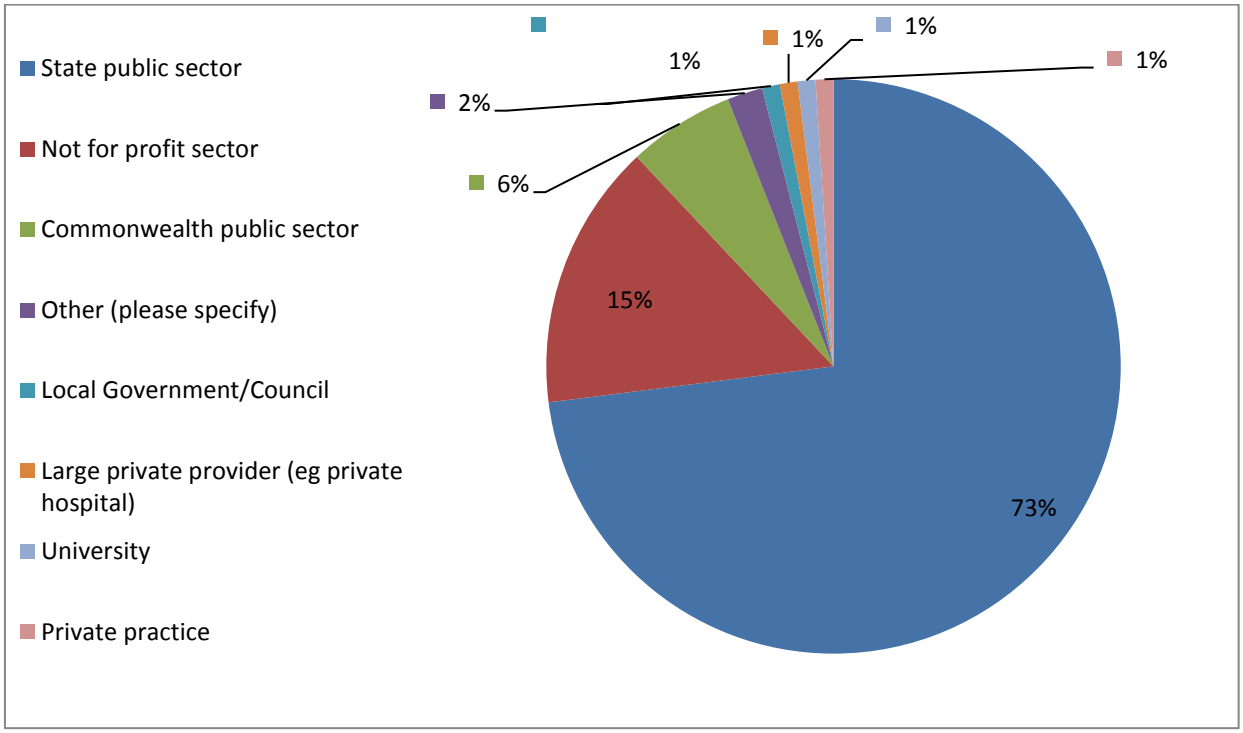


Sector

Almost three quarters of respondents (73%) worked in the state public sector, a further 6% in the Commonwealth public sector and 1% in local government, therefore public sector social workers made up 80% of all respondents.

Of those that worked in the Victorian public sector they primarily worked in public hospitals, with some working in schools and state government funded community services. The NFP sector was the next biggest employer of social workers at 15% of respondents. The 6% of respondents worked for the Commonwealth public sector included aged care, primary health networks and employment services. Small numbers of respondents worked in private practice, local government, Aboriginal and Torres Strait Islander Health services and universities (Figure 6).

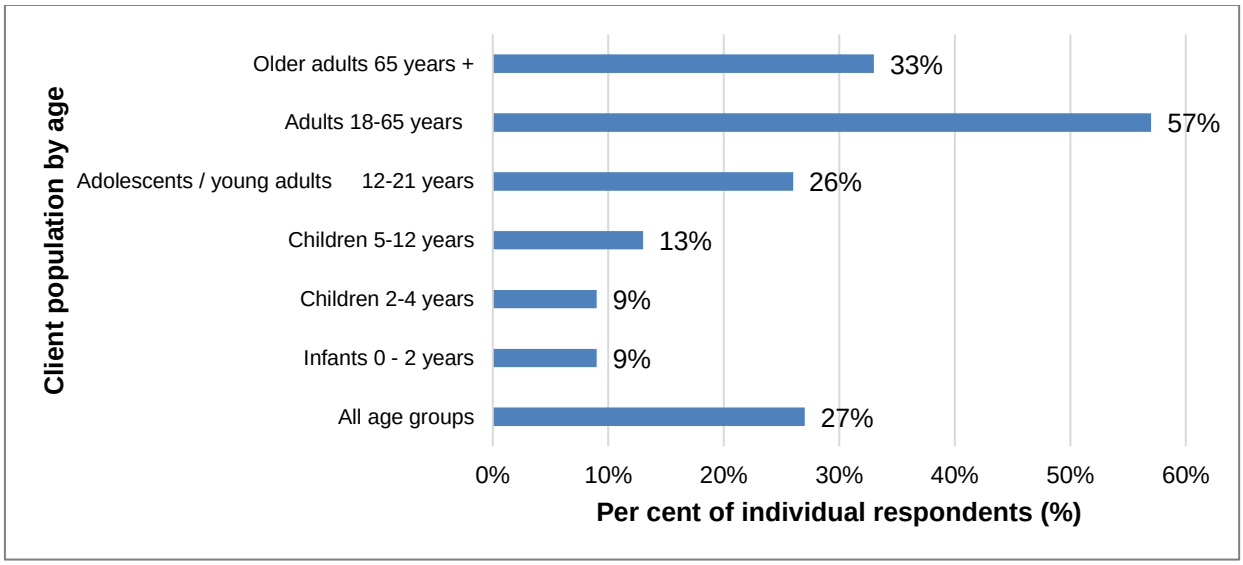
Figure 6: Employment sector of current main employer (n=1,077)



Clients

Social workers worked across all age groups. Most individuals worked with adults (57%) or older adults (33%). About a quarter of social workers worked with adolescents or young adults (Figure 7).

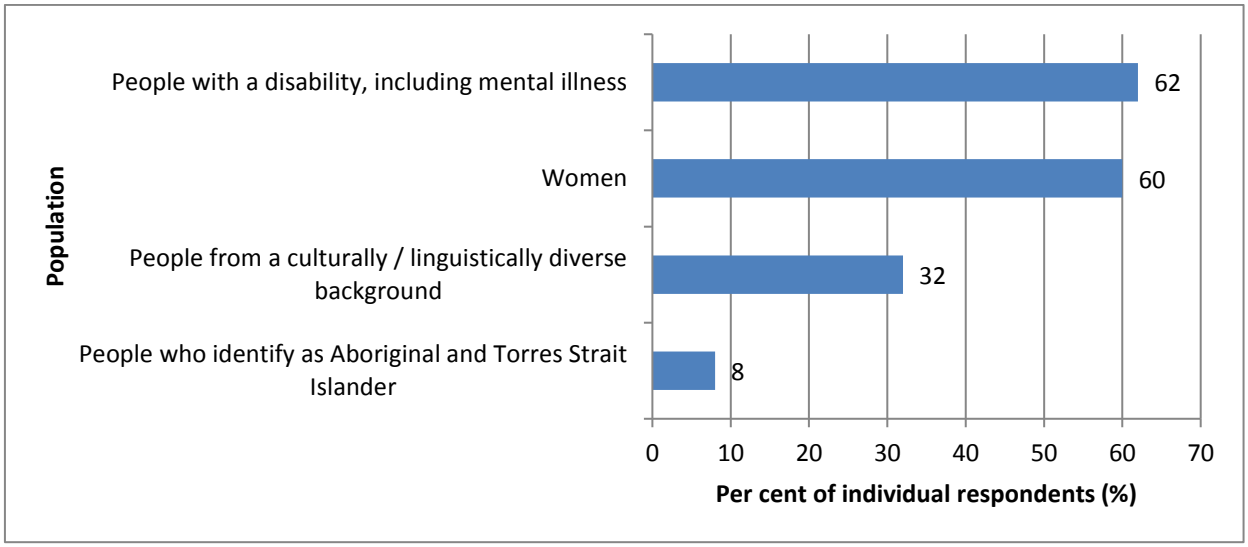
Figure 7: Clients by age (n=1,122) [a]



[a] *Respondents could select more than one response.*

Over half of the clients of social workers had a disability or mental illness and almost one third were from a culturally and linguistically diverse background. A high proportion of social work clients, relative to their numbers in the community, were Aboriginal and Torres Strait Islander people. Social work clients were also more likely to be women than men (Figure 8).

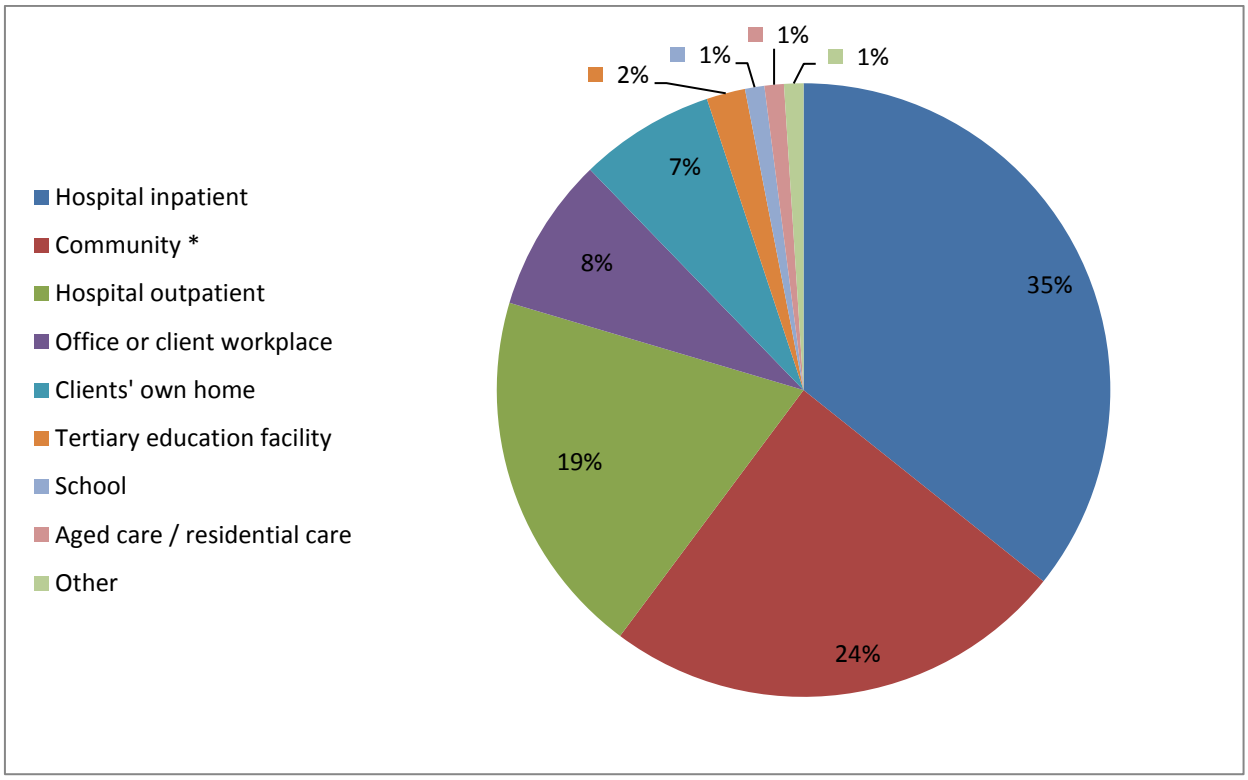
Figure 8: Average per cent of population groups within caseload (n=1,102)



Settings

Over one third (35%) of survey respondents worked in inpatient hospital settings and a further 19% worked in hospital outpatient settings. The next main setting where social workers performed their work was the community (24%). This included a range of sites such as private practice, mental health facilities and community rehabilitation centres. Eight per cent (8%) of responding social workers worked in offices such as government departments and peak bodies in policy or management roles (Figure 9).

Figure 9: Setting for service delivery of current main employer (n=1,103)



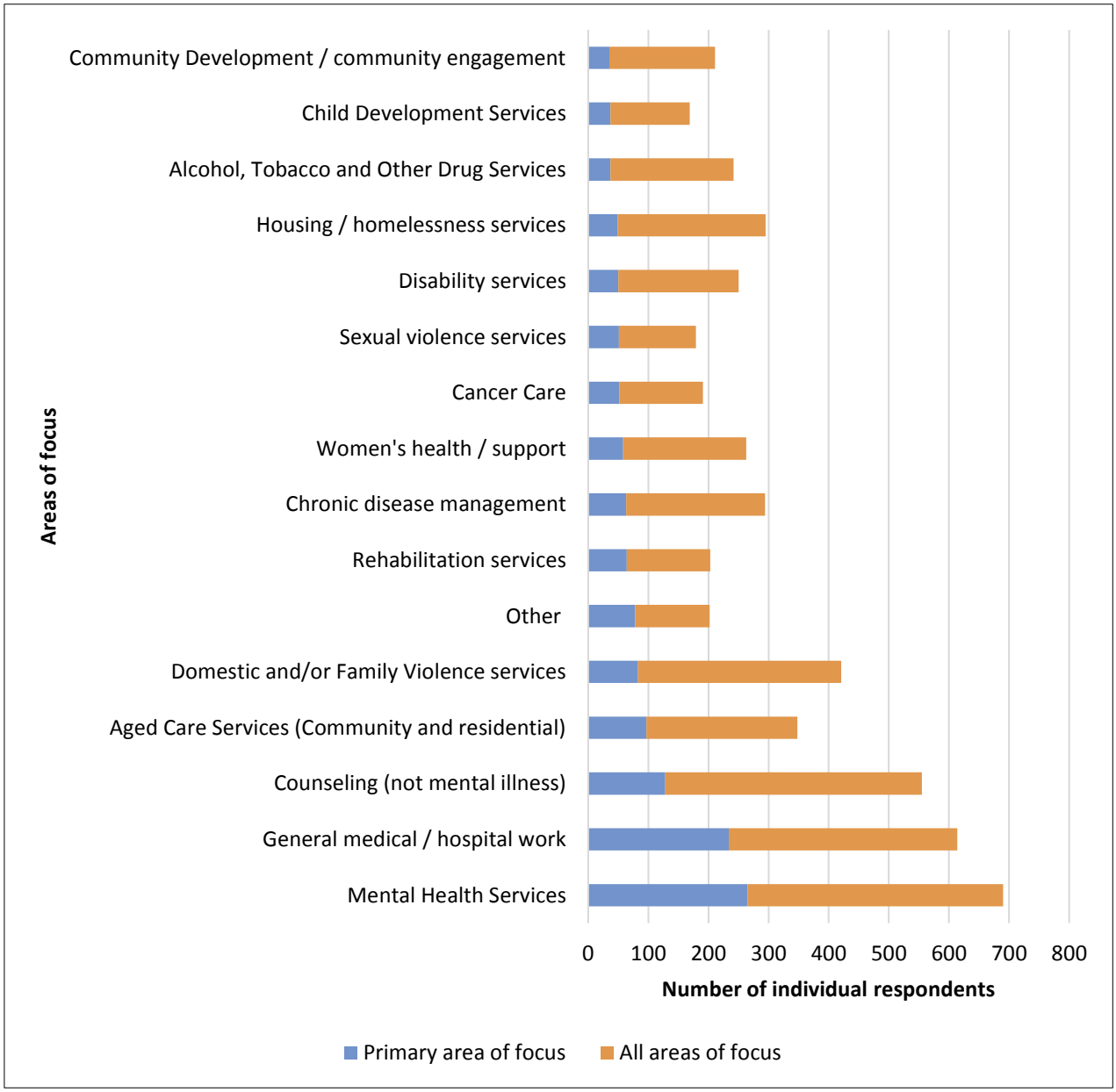
**Community included community-based clinics and services, private practice, refuges, community mental health services, street work, and child protection services.*

Area of practice

The largest number of respondents reported their main area of practice as mental health services, followed by general medical / hospital work and counselling. Other areas of practice included aged care, domestic and family violence, rehabilitation, women's health, chronic disease management, cancer care, sexual violence, housing and homelessness, alcohol, tobacco and other drugs, child development, community development, palliative care, health promotion, Aboriginal health and many others (Figure 10).

Most social workers were multi-focused in their areas of practice; however this was less prevalent amongst social workers who were focused on mental health and hospital work than those who were focussed in other practice areas. Please note per cent is not able to be provided in Figure 10 due respondents providing more than one answer to 'primary area of practice'.

Figure 10: Areas of practice [a] (n=1,544)



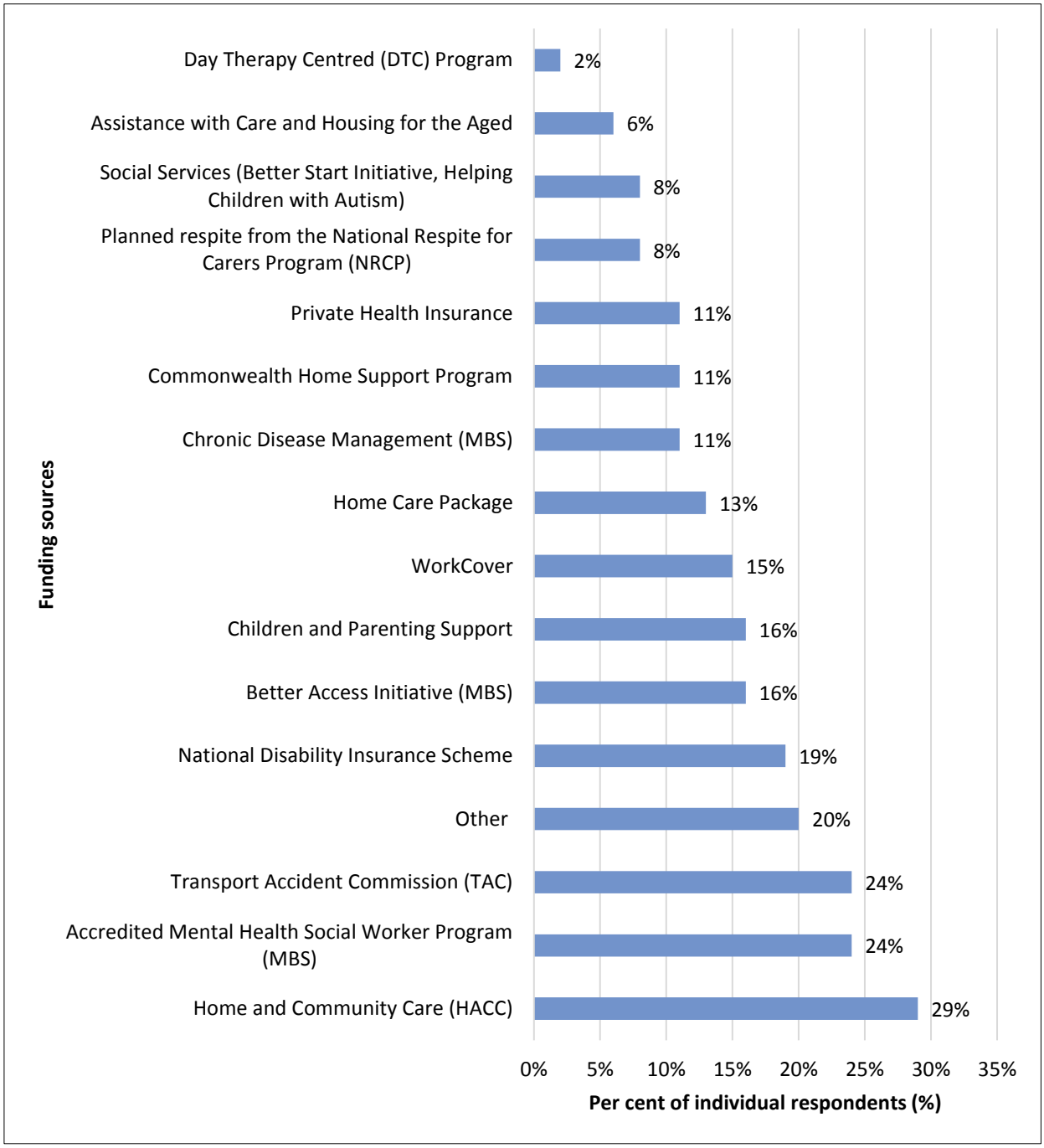
[a] *Respondents could select more than one response to signify 'all other areas of practice*

Funding sources

The most common program which provided funding to support social workers was Home and Community Care: Twenty-nine per cent (29%) of social workers received funding via this program. Other common sources of funding included the Medical Benefits Scheme Accredited Mental Health Social Worker program (24%), Transport Accident Commission (24%), and the National Disability Insurance Scheme (19%) (Figure 11).

There were a high number of responses in the 'other' category in relation to funding packages. These social workers were funded from a wide array of sources including Department of Veterans' Affairs, Employment Assistance Program, aged transitional care funding, and mental health community support service funding.

Figure 11: Per cent of respondents providing services funded by specific packages (n=323) [a]



Demand

There were no quantifiable measures of demand for social workers from the data collected. However, respondents pointed to a range of evidence indicating high and unmet demand for social work services, including:

- Unacceptably long wait list numbers and wait times
- Inpatients not getting social work services
- High workloads and increased stress leave and staff turnover
- Delayed discharges into the community
- Failed discharges, increased readmission rates due to lack of social support
- Numbers of people in the community in crisis, experiencing homelessness

The Australian Government, Department of Employment's *Job Outlook* initiative provides data on employment characteristics, trends and prospects for some occupations. Data from this initiative shows that social work is expected to experience very high employment growth in the years to 2020. It is rated in the 10 decile for future employment growth and the 8th decile for level of future job openings (Australian Government, 2017b) (Table 4).

The *Job Outlook* data provides an analysis of future job prospects using national statistics on job openings and employment. According to *Job Outlook*:

- Over the five years to November 2019, the number of job openings for social workers is expected to be above average nationally (between 25,001 and 50,000). Job openings count both employment growth and turnover (defined as workers leaving their occupation for other employment or leaving the workforce).
- Employment for social workers rose strongly (in per cent terms) in the past five years and very strongly in the long-term (ten years).
- Looking forward, employment for social workers to November 2020 is expected to grow very strongly compared to other occupations (Australian Government, 2017b).

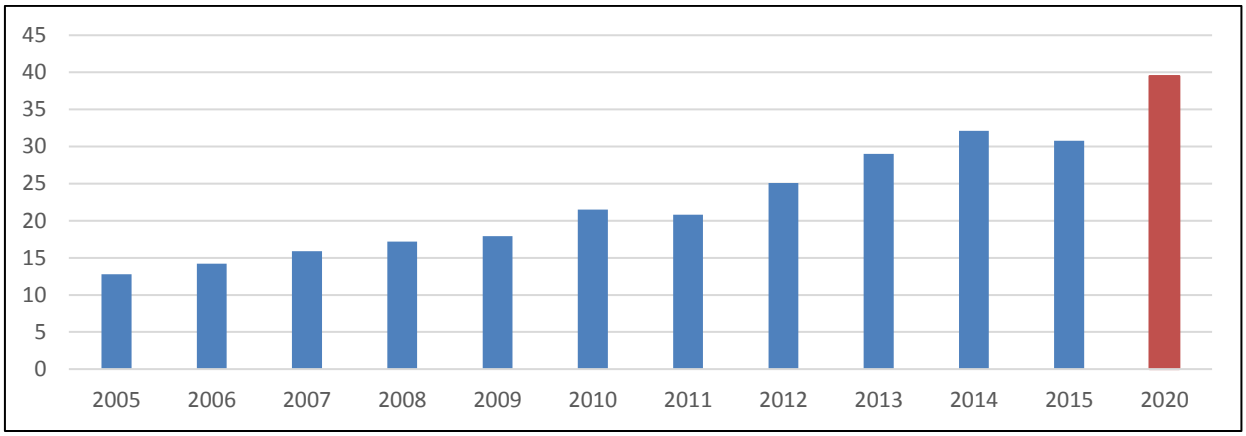
Table 4: Employment growth for social workers (nationally)

Key indicators	n	Decile
Workers employed as social workers	30,800	86
Unemployment compared to other occupations	Below average	2
Long term employment growth – 10 years (%)	141.5	10
Medium term employment growth – 5 years (%)	43.3	10
Likely future employment growth – 5 years	Very strong	10
Level of future job openings	Above average	8

Source: Australian Government, 2017, Job Outlook for social workers

Figure 12 shows the past, current and projected employment levels of social workers nationally. It indicates solid growth over 15 years, with a tripling of social work employment during that time.

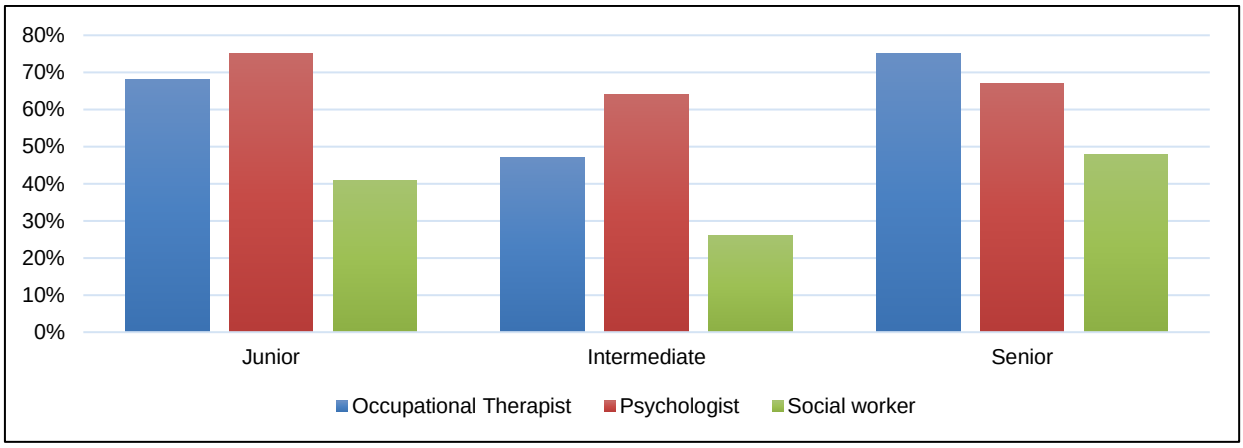
Figure 12: National social work employment levels 2005-2020 (thousands)



Source: ABS Labour Force Survey, Department of Employment trend data to November 2015 and Department of Employment projections to 2020.

The survey of organisations employing social workers indicated that there were more vacancies for social workers in employing organisations than there were for occupational therapists or psychologists (Figure 13). These vacancies were more likely to be at the intermediate grades (i.e. grades 2-5) than in senior and junior grades.

Figure 13: Organisations with no vacancies for occupational therapists, psychologists and social workers (n=169)



Department of Health and Human Services analysis of future need for social workers in the child protection space only, indicates that within a very short time they expect to have significant difficulties recruiting numbers to meet demand.

"Department of Health and Human Services has to recruit annually at least 175 new child protection practitioners a year just to keep pace. If all these individuals were social workers, Department of Health and Human Services child protection would therefore account for about 35% of new graduates each year, making it a major player in social worker employment.

Despite efforts to increase the proportion of social workers in the long term it is likely this will become difficult to sustain, as demand for social workers is likely to exceed supply by the mid-2020s. Thus, psychologists and others with similar degrees, and the VET diploma holders, are likely to gradually increase their penetration of the child protection workforce (Department of Health and Human Services, 2015)

Currently the demand appears to be for experienced social workers, rather than new graduates. Data collection through the *Graduate Careers: Australia's Annual Graduate Survey* indicates that the full-time employment rate for new social work graduates decreased from 82% in 2012 to 70% in 2013 and at the same time, the job-seeking rate (for full-time employment) increased, with the trend continuing in 2014 (30%). This growth in job seeking suggests that the labour market did not have sufficient demand for the number of new social work graduates in 2013 (Department of Health and Human Services, 2017).

Supply

There are a number of factors that interact with and influence the supply of social workers. These include the size of the social work workforce, the number of graduating social workers, the profession's age and gender profile, employment grades, remoteness, remuneration, and local approaches to recruitment.

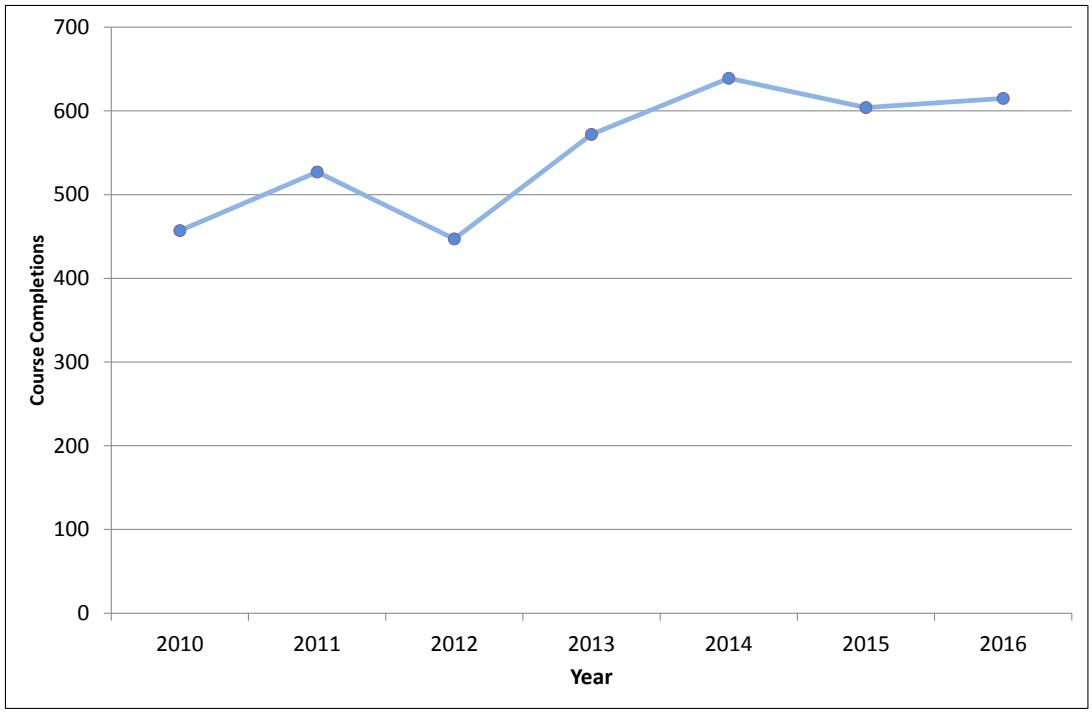
Social work workforce

According to the 2011 Census there were 5,182 social workers residing in Victoria at that time. However, when student completion data from 2011 onwards is included this number is more likely to be closer to 9,000 social workers currently working in Victoria. More than 3,000 domestic social work students have graduated from Victorian universities since 2011 (Australian Government, 2017a).

Student completions

Available data for graduate completions shows that 3,861 social workers graduated in Victoria between 2011 and 2015 (Department of Education and Training[4]) (Figure 14).

Figure 14: Victorian university domestic social work completions 2010-2016



[4] The Department of Education and Training (DET) conducts the Higher Education Statistics Collection which provides information on the number of student commencements and completions in higher education courses. While DET data does not identify those courses that lead to professional-entry for most disciplines, using information supplied by DET (in a particular field of education and course name), the Victorian Department of Health and Human Services has estimated the number of domestic students commencing and completing professional-entry courses for selected disciplines. Given this is an estimate; caution should be used in interpreting these data.

Source: Australian Department of Education and Training, Higher Education Student Data collection

Workforce supply / job shortages

Organisational respondents said that long waiting lists were an indicator of shortages in the profession as well as service limitations. In hospitals, failed and delayed discharges indicated that social work needs were not being met in a timely way. Unmet community needs in relation to housing, mental illness, family support and aged care transition were also indicators of shortages. There appeared to be particular issues with finding appropriately experienced and skilled professionals to work in the mental health area. Recent funding being made for family violence support means there is strong competition for skilled workers in this space.

"Waiting lists of over 100 children, with no capacity to allocate"

"We have a current waiting list for outpatient services with no plan for additional funding"

"Long stay patients in hospitals need complex discharge plans that a social worker could be involved in"

"30-60 antenatal patients on the waiting list as staff do not have capacity on their case loads

Large workload, limited capacity"

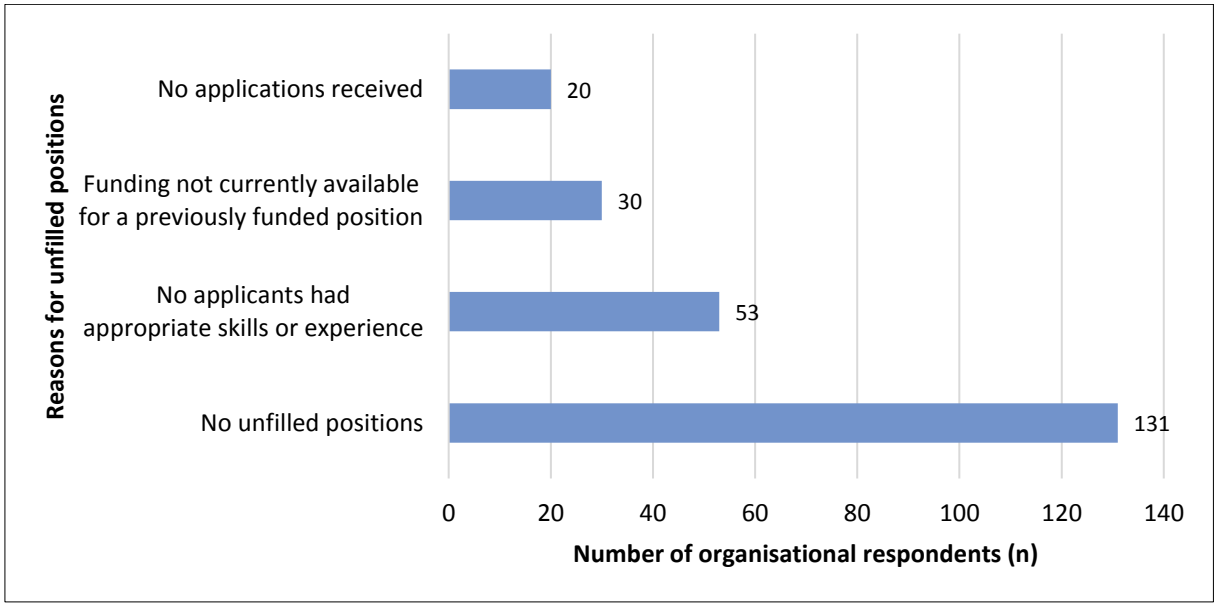
"Waitlists are in excess of three to four months"

"We could easily see double the number of clients we currently see if we had the funding to employ more clinicians"

Unfilled positions

Of the 222 organisational respondents to the AHWQ2 that employed social workers, 131 indicated currently having no unfilled positions. Of those that did report having unfilled positions, an inability to recruit due to lack of applicants with appropriate skills or experience was the predominant reason (n=53), followed by funding not currently being available for a previously funded position (n=30) and a lack of applicants (n=20) (Figure 15).

Figure 15: Reasons for unfilled positions (n=222) [a]



[a] *Respondents could select more than one response.*

Social workers at the intermediate grades were in most demand and the metropolitan areas had the highest number of unfilled positions. Shortages were due to both a lack of funding for sufficient positions to meet need and a lack of experienced social workers in particular niche areas of practice.

Recruitment

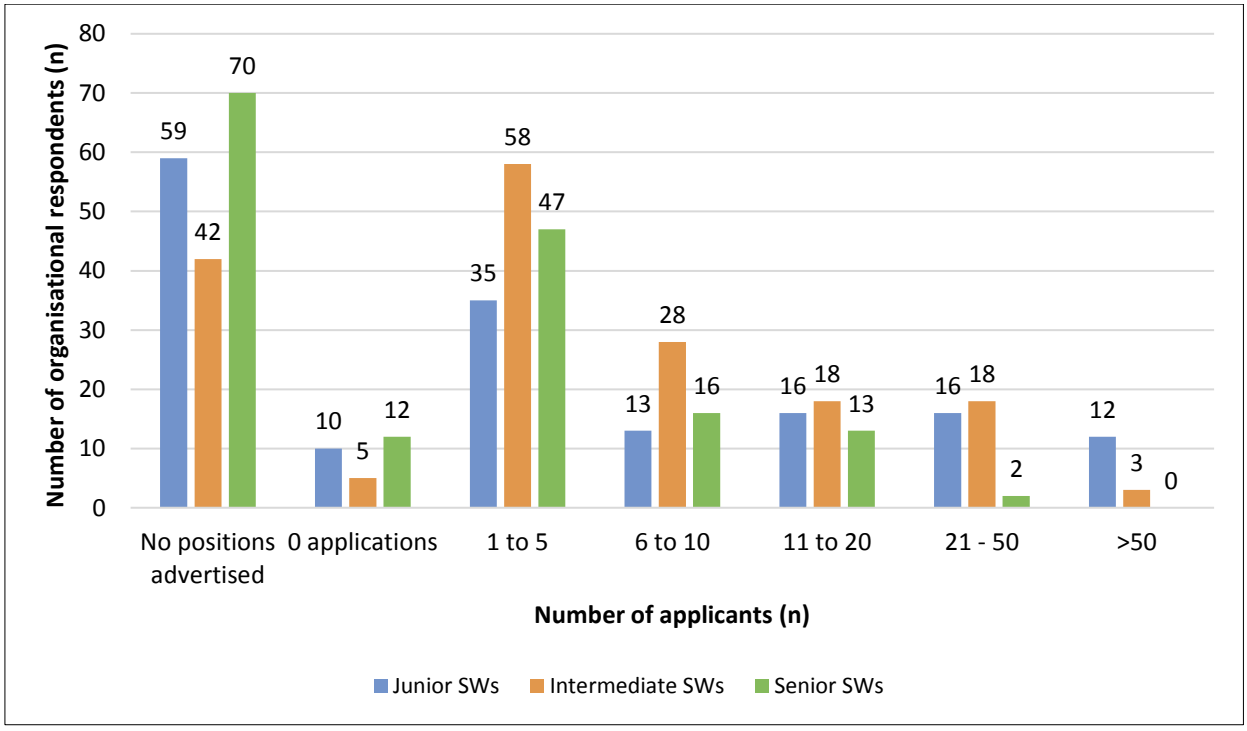
Number of applicants

Organisational respondents to the AHWQ2 were asked about the size of the applicant pool for positions advertised at different grades in the preceding year. A high proportion of responding organisations had not advertised any positions.

Of the 102 organisational respondents that reported having advertised junior positions, the largest number (n=35) received only one to five applications, and 10 reported receiving no applications for the junior positions they advertised.

In contrast to junior positions, greater difficulties were experienced filling intermediate and senior positions. Of the 130 organisational respondents that reported advertising intermediate grade positions, 47% (n=58) received between one and five applications. One hundred ten (110) organisational respondents advertised senior positions in the past year, almost half (n=47) of these reported having received only one to five applications (Figure 16).

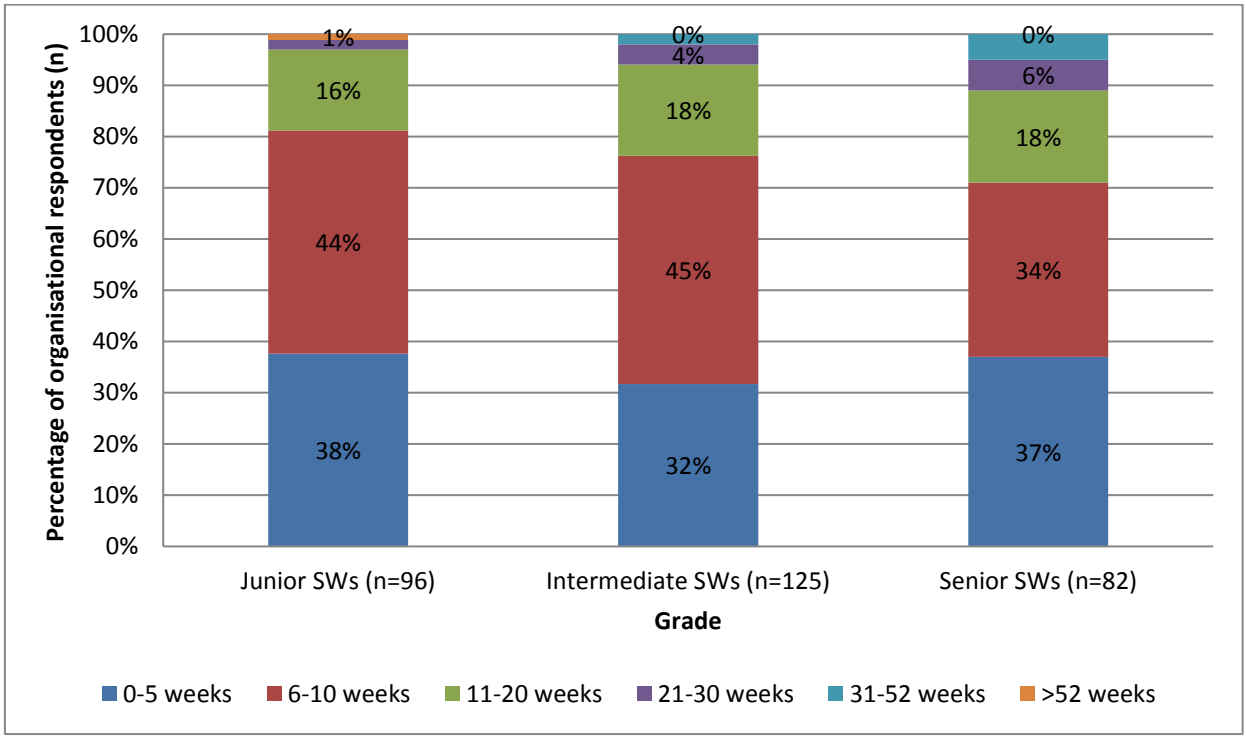
Figure 16: Number of applications for positions advertised in the past year by grade



Time to recruit

Organisational respondents indicated that while it takes longest to fill social work positions at the senior grades with 29% of these positions taking more than 11 weeks to fill, over one third of senior social work positions were filled quickly, in 0 to 5 weeks (37%). The vast majority of junior social work positions were filled within 10 weeks (82%) (Figure 17).

Figure 17: Time to fill vacancies (n=170) [a]



[a] *Although 170 organisational representatives responded to this question, data is only included for organisations that indicated they had vacancies in the prior 12 months.*

Recruitment strategies

Organisational respondents to the AHWQ2 reported using of a range of different recruitment strategies. The most successful strategies for recruiting social workers appeared to be through the online recruitment site, SEEK and by word of mouth. Employers were much more likely to use these methods, rather than recruitment consultants or social media, such as Linked-In. Only a small proportion of organisations reported use of international recruitment (n=6). Of the seven 'other' responses, the majority indicated use of recruitment processes internal to the organisation (Figure 18).

A mixture of barriers to recruitment were identified by respondents, including:

- lack of career pathways
- low pay levels in the community sector
- challenges finding experienced social workers in particular fields
- short-term contracts and funding constraints
- difficulties attracting staff to rural areas

"Lack of interest in short term contracts"

"[Barrier to recruitment is] the rates of pay offered by the community health service. SASS award is offered which rates of pay are low and therefore quality applicants are not recruited"

"Applicants wanting more pay than the agency will provide"

"Currently under-resourced system with a lot of pressure placed on clinicians resulting in limited capacity to fully support and nurture"

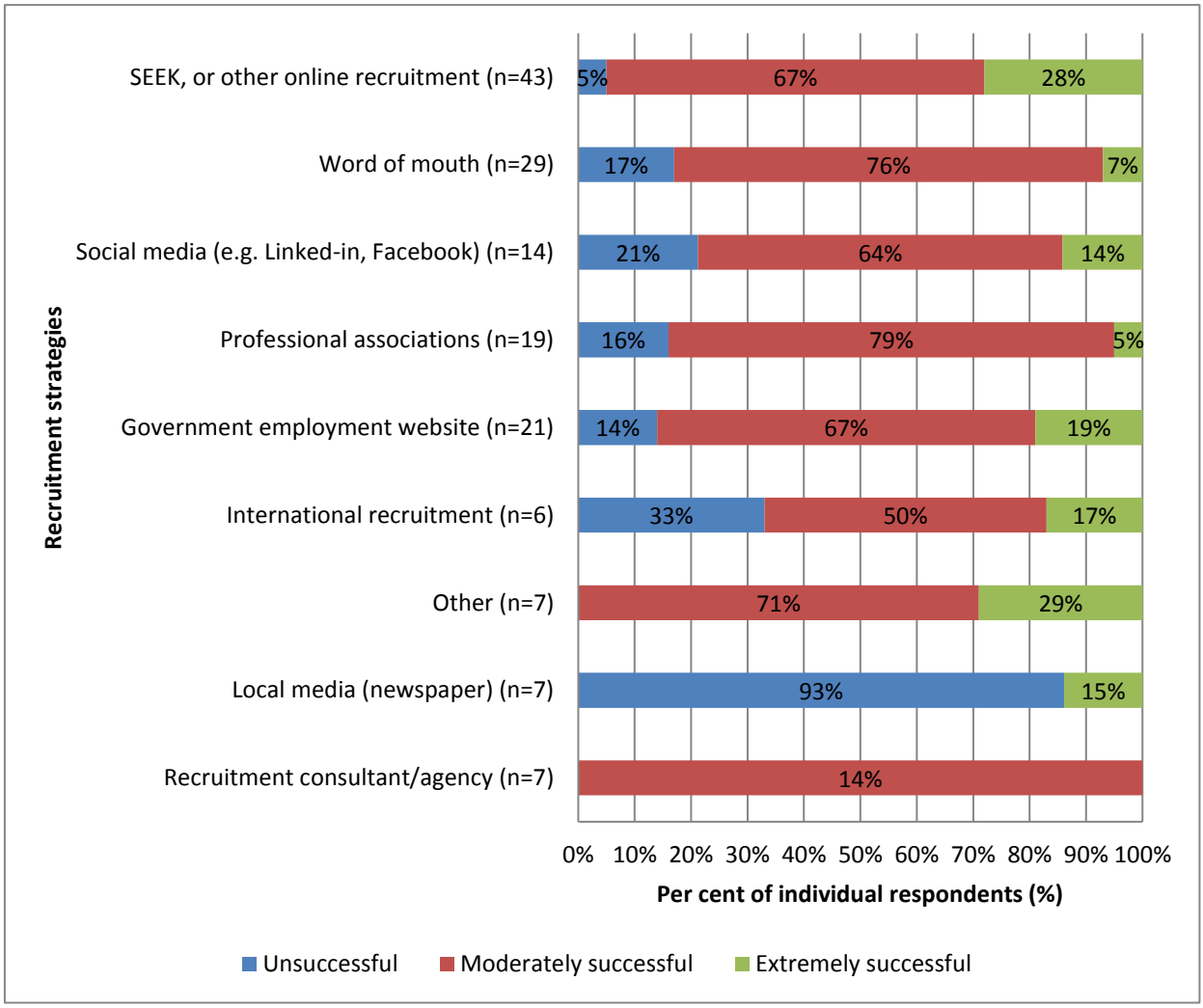
"It's difficult to attract qualified and experienced staff to rural areas"

"Working in a rural area, it is difficult to attract people to the profession"

"Getting experienced social workers, not the new batch of MSW(Q) graduates"

"There is a smaller number with the expertise required in the speciality area"

Figure 18: Relative success of strategies used to recruit social workers (n=50) [a]

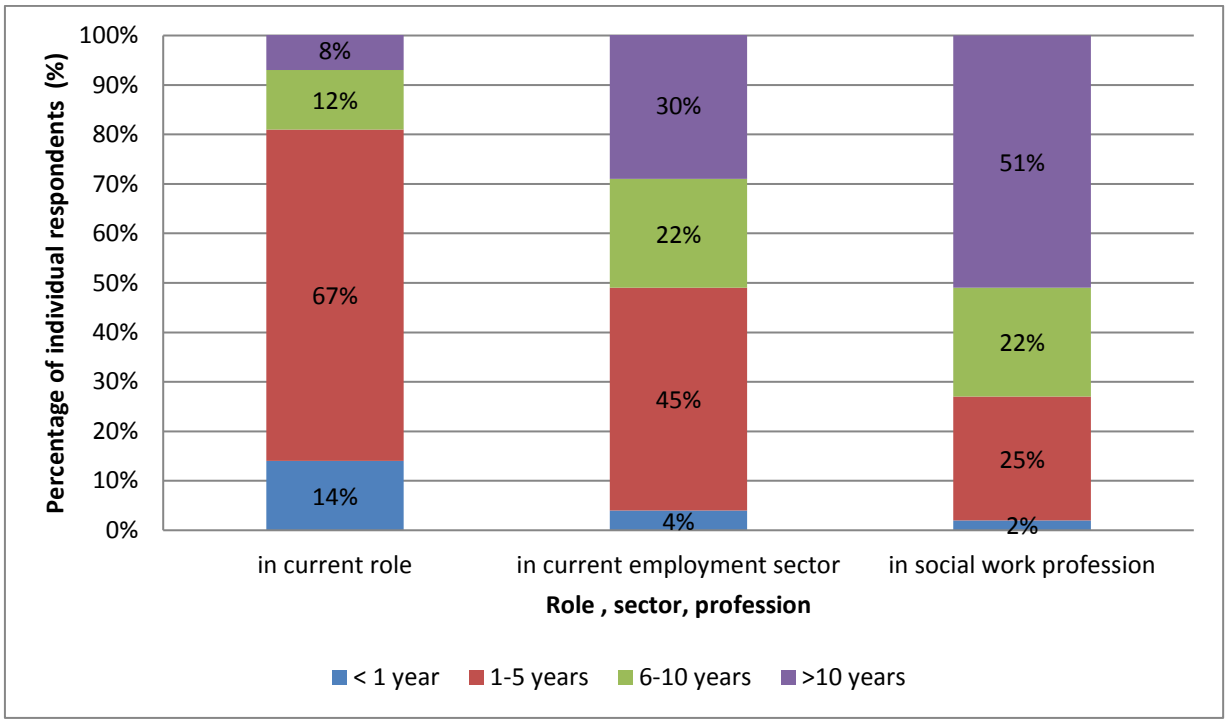


[a] *Although 50 organisational respondents responded to this question, for each recruitment strategy data is presented based on the number of organisations that reported that they used the strategy. For some strategies, such as international recruitment, a high proportion of respondents indicated they 'do not use' the strategy.*

Retention

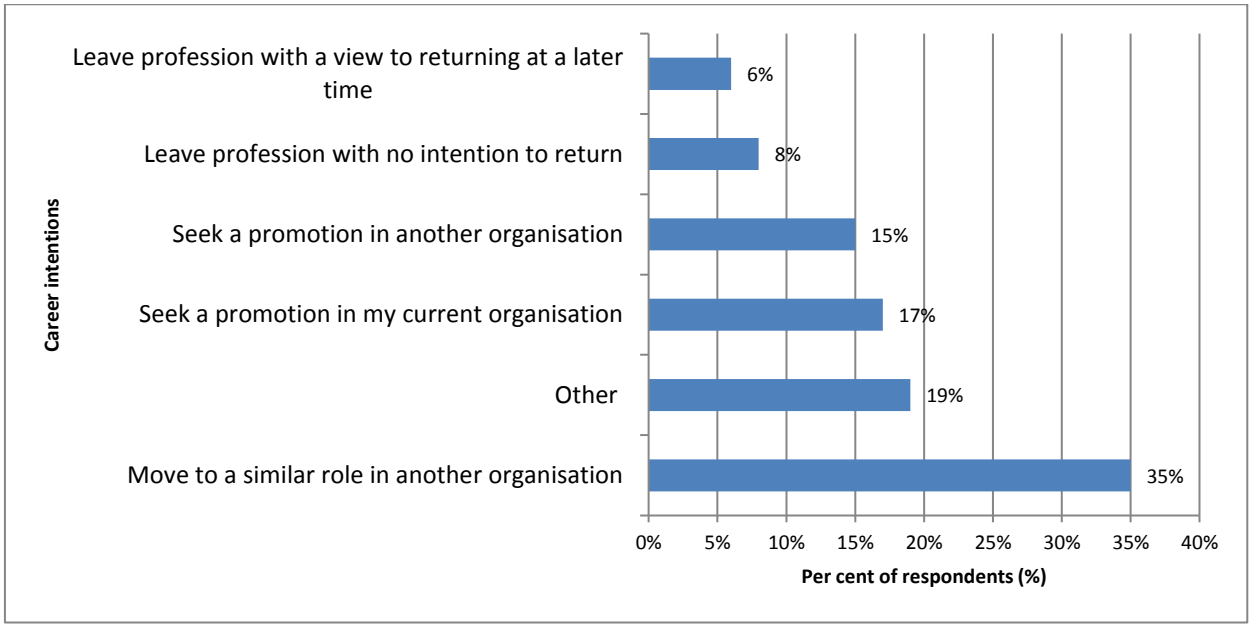
On the whole, social workers planned to be in the profession for the long-haul. Fifty-one per cent (51%) stated they intended to stay in the profession for more than 10 years and a further 22% said they intended to stay for six to 10 years. Only 2% indicated they were looking to leave the profession in the next 12 months, and a further 25% were looking to leave in the one to five-year timeframe. Fourteen per cent (14%) were hoping to change their role within the next twelve months, while only 4% wanted to change their employment sector (Figure 19).

Figure 19: Intention to stay in current role, profession and sector (n=1,053)



Of those who intended to change their career in the next 12 months (n=151), the majority intended to move into a similar role in another organisation (Figure 20).

Figure 20: Career intentions of respondents indicating an intention to stay in their current role for 12 months or less (n=151)



When asked about the reasons for changing roles, AHWQ2 respondents were offered the opportunity to select more than one possible reason. The main reason cited for changing roles was better job opportunity (n = 55), better working conditions (n=47), and better pay (n=45). Burn-out was also a common reason given by social workers for changing jobs (n=32) (Figure 21).

The barriers to retention cited by social worker employers were similar to the recruitment barriers. These included short-term contracts, high workloads and burn-out, lack of career progression opportunities, poor workplace culture or leadership and lack of adequate supervision and support.

"Increasingly, we're only able to offer short term contracts - funding is tied to specific time frames - lack of 'permanency' a factor"

"Difficulty maintaining staff due to lack of career opportunities at organisation"

"No career progression. Two wonderful & high qualified team members moved on due to no current positions relating to their growth"

"There has been no real career progression opportunities in my rural area"

"Our funding is on a two – three year cycle and can make retention of social workers difficult, especially if they are considering starting a family or seeking to purchase a home"

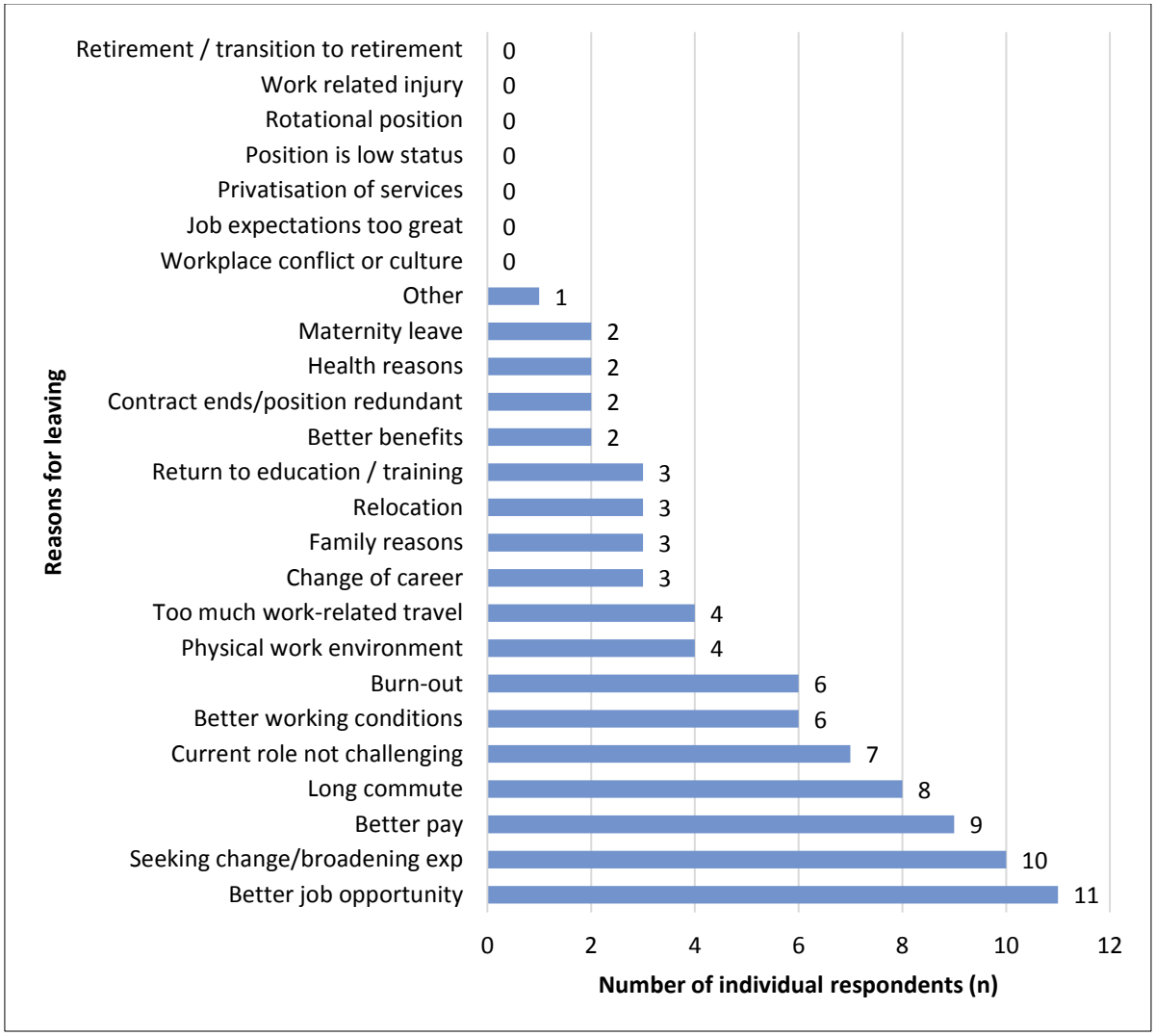
"Limited opportunities to have discipline specific roles and interventions"

"Work load has been a problem in the past in the retention of social workers at the hospital I am currently working at"

"Work place culture has an enormous impact in the retention of social workers"

"Lack of adequate supervision and supportive workplace is one big reason"

Figure 21: Reason for leaving (for respondents intending to change roles within 12 months) (n=151) [a]



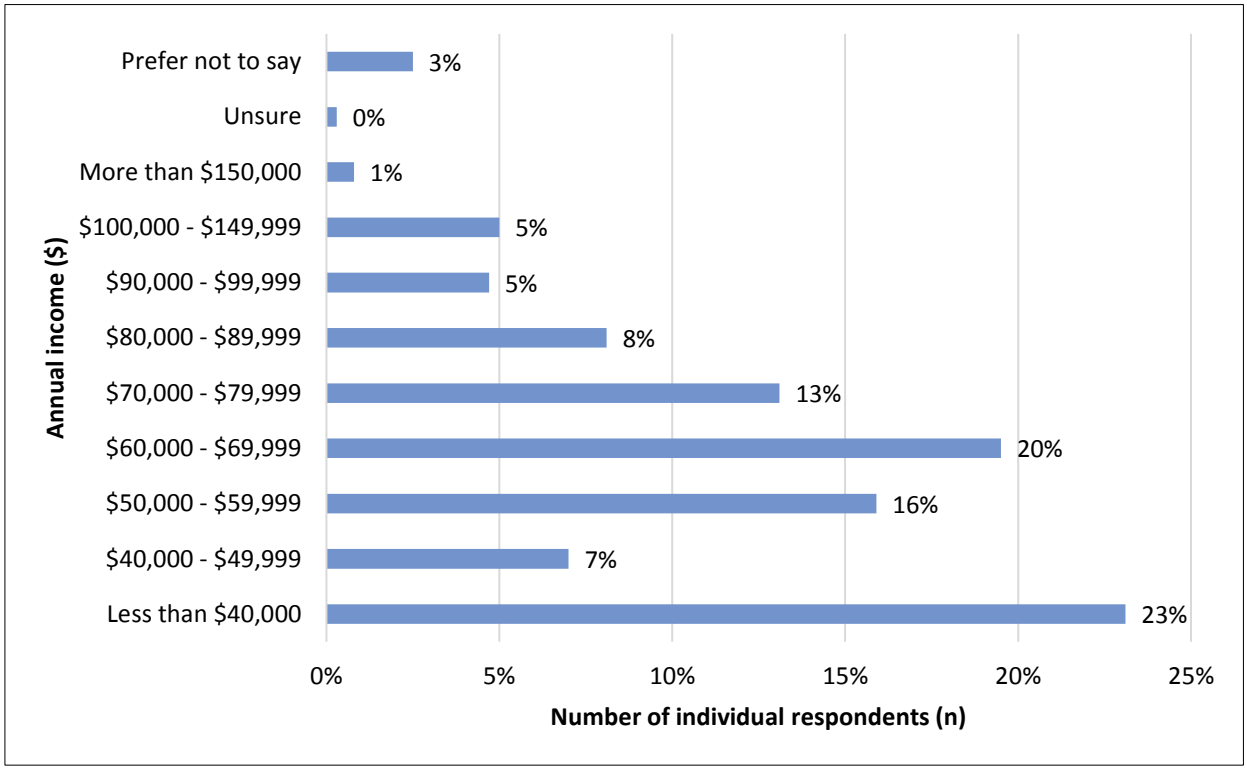
[a] *Respondents could select more than one response.*

Organisation of the workforce

Pay level

The median income category for social workers was $60,000 to $69,999 per year. Sixty-two per cent (62%) of social workers earn less than $80,000 per year and only 9% earn over $100,000 per year. This pattern of income corresponds with the fact that 57% of social workers who responded to the survey were employed at grade 3 or under, with the most common level being grade 2 (32%) (Figure 22).

Figure 22: Total annual income last year, before tax (n = 1098)

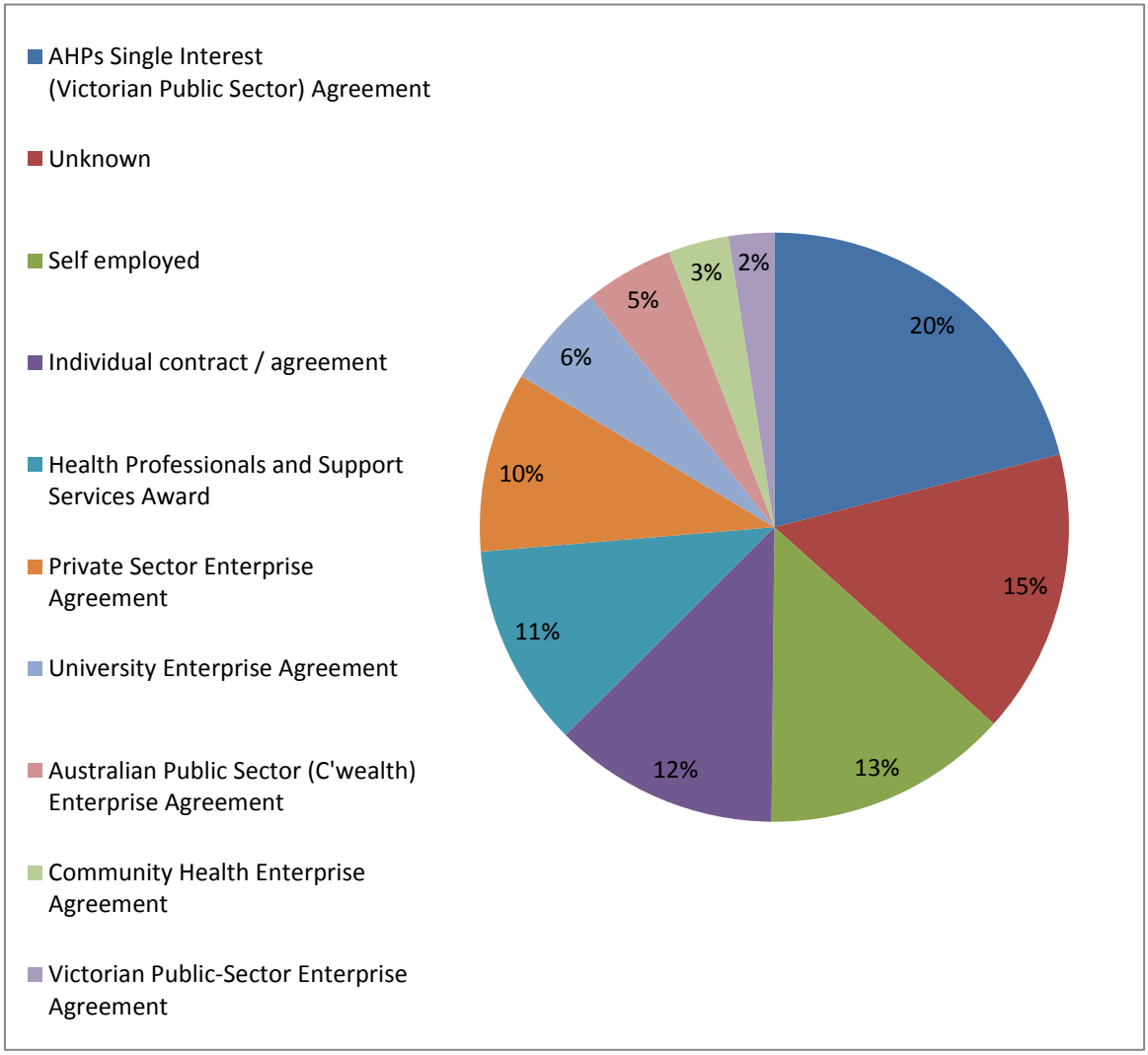


Awards

Social workers were employed under a range of awards and pay agreements. The Victorian Public Sector Enterprise Agreement was the employment award of 45% (n=445) of the respondents. Thirteen per cent (13%) were employed under the Australian Public Sector (Commonwealth) Enterprise Agreement and 11% were employed under the Social, Community, Home Care and Disability Services Industry Award. Other employment arrangements included the Community Health Enterprise Agreement (6%) and NFP Enterprise Agreement (5%) (Figure 23).

No respondents reported being employed under private sector enterprise agreements.

Figure 23: Current award or employment agreement (n=1,082)



Employment grade / level

About one third of survey respondents (32%) were working at the grade 2 level. Grade 3 was the next most common grade with 17% (Figure 24). Only a small number of respondents (15) were employed on an academic salary scale (Figure 25)

Figure 24: Current grade (non-academic) (n=995)

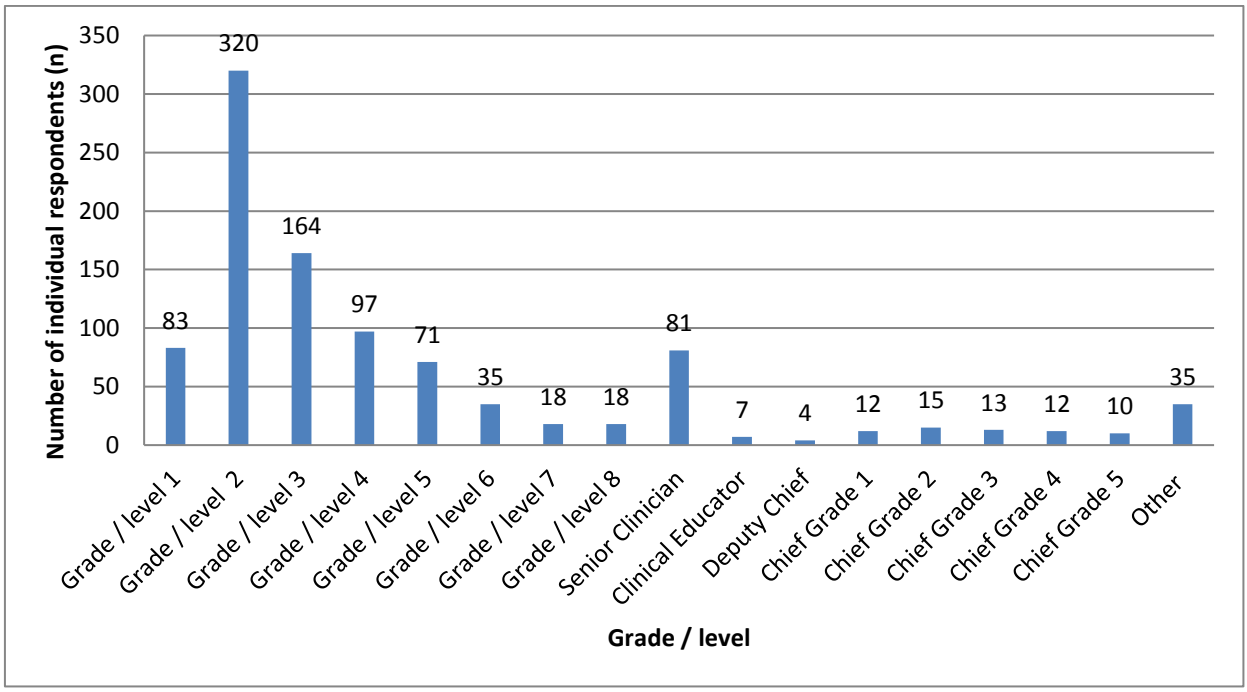
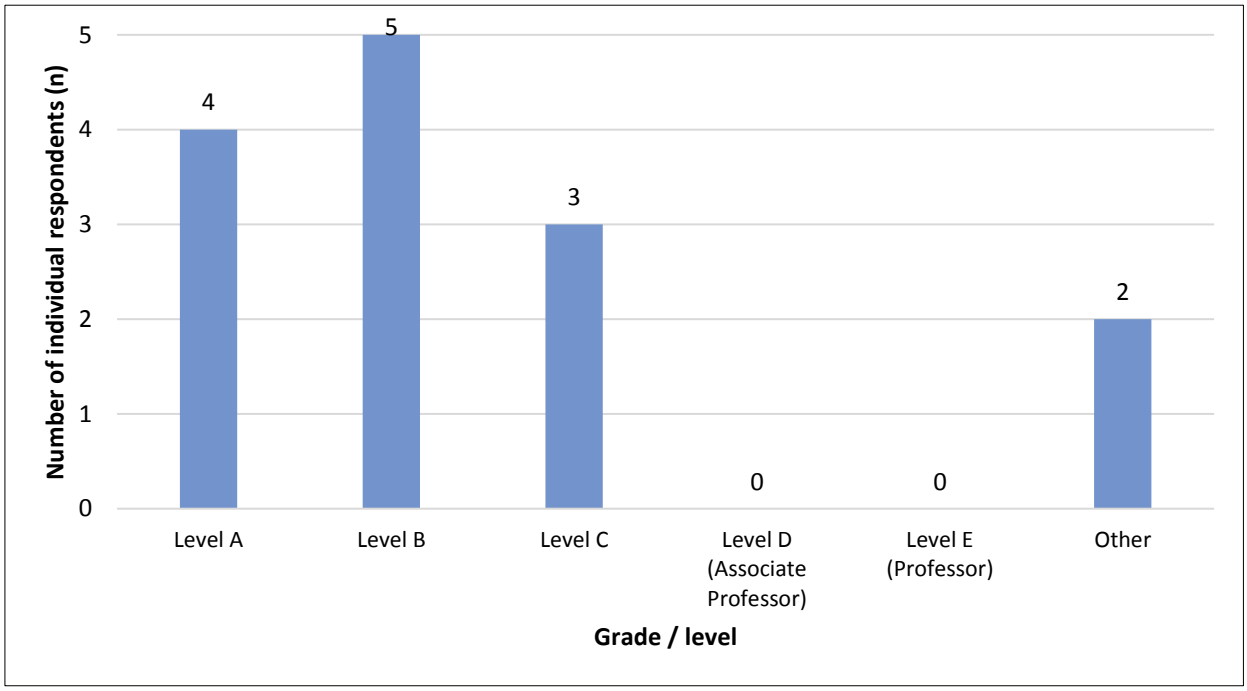


Figure 25: Current grade (academic) (n=15)



Employment status

The majority of social workers responding to the AHWQ2 indicated they were currently employed in permanent roles (88%, n=888) (Table 5).

Table 5: Nature of employment with current main employer (n= 1.077)

Nature of employment	n	%
Permanent	888	82%
Temporary	30	3%
Self-employed	5	0%
Contract	135	13%
Voluntary	0	0%
Casual	15	1%
Other	4	0%
Total	**1,077**	**100%**

Number of employers

Most social worker respondents (84%) worked for only one employer and 11% worked for two employers. There were very few self-employed respondents (2%) (Table 6).

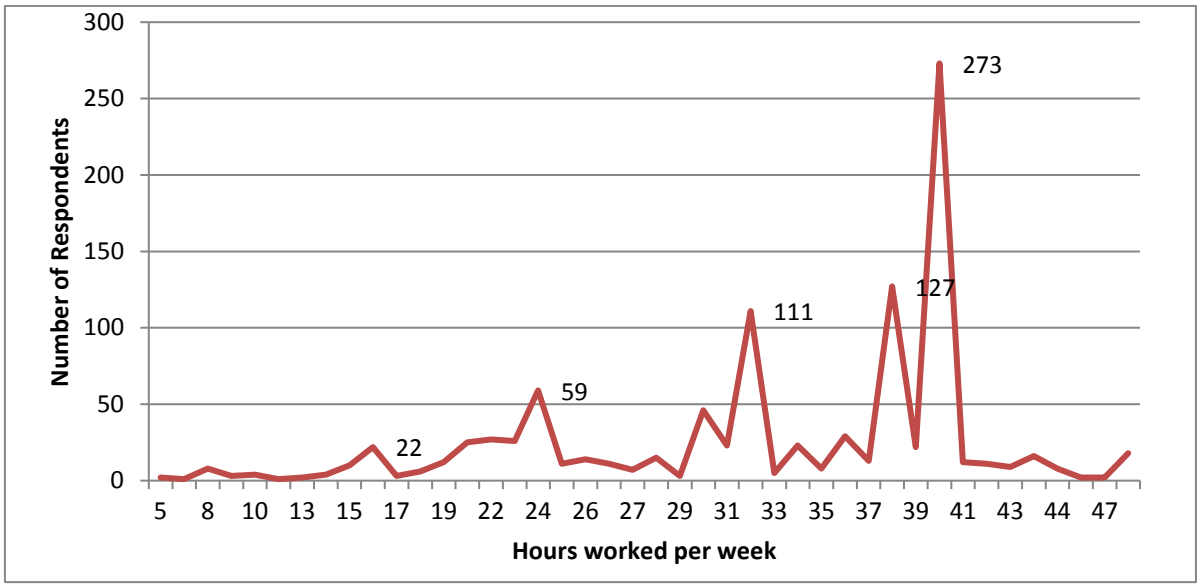
Table 6: Current number of employers (n=1,103)

Number of employers	%	Count
1	84	926
2	11	120
3	1	11
4	0	3
5 or more	2	21
I am fully self-employed	2	22
Total	**100**	**1,103**

Hours of work

On average, social work respondents to the AHWQ2 reported working 33 hours per week in their main role (n=1,034), with a range of 5 to 48 hours worked. The largest number of respondents (n=273) worked 40 hours per week, and 53% (n=550) worked more than 33 per week (Figure 26). The total average hours of paid work may be a little higher than 32 per week as 18% (n=186) of respondents reported being employed by more than one employer (Table 7).

Figure 26: Number of hours worked per week (n=1,034)



See Appendix Table 2 for hours of work per sector of employment

The vast majority of social workers (89%) worked Monday to Friday during the day. Only a few respondents stated they worked weekends, nights or shift work (Figure 25).

Table 7: Working pattern during a normal working week (n=1,065) [a]

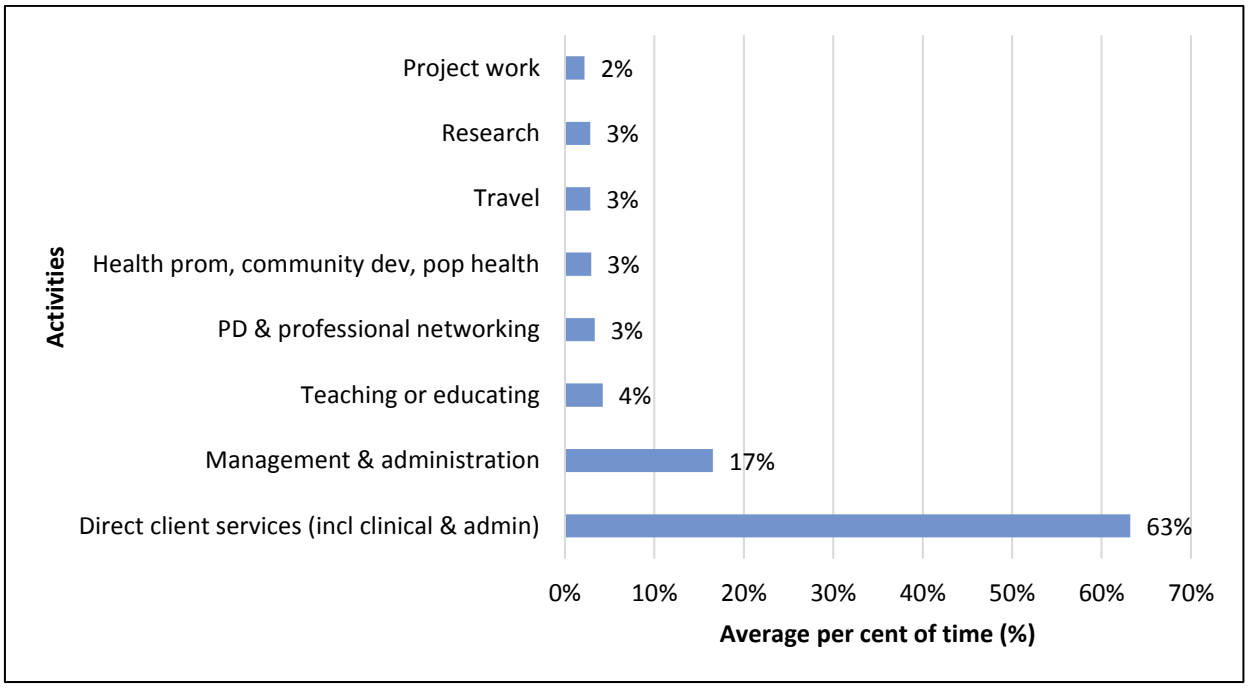
Working pattern	%	Count
Monday to Friday (mostly day time)	89	944
Monday to Friday (mostly night time)	<1	13
Saturday	2	25
Sunday	2	18
Shifts that change from day to day, or week to week	5	53
Other working pattern	8	88
Total	**100**	**1,065**

[a] *Respondents could select more than one response.*

Roles

In a typical week, social workers spent just over half their time providing direct services to their clients. They also spent a lot of their time performing management, supervision and administration tasks (Figure 27).

Figure 27: Average per cent of time spent on different work activities (n=1,060)



Scope of practice

Prevention and early intervention

Social workers have a key role in prevention and early intervention in relation to a range of areas including mental health, child protection, financial counselling and domestic and family violence. Social workers believe that more social work services need to be funded for this preventative work to save costly interventions, including regular hospital admissions, and painful experiences occurring down the track.

Increased use of social workers in areas such as emergency departments and outpatient areas should be investigated to prevent unnecessary admissions and re-admissions.

"Increased funding and resourcing for service provision, particularly early intervention approaches to prevent family and sexual violence."

"More focus on the role of early intervention and identification and increasing referral to social workers [in the area of family violence]"

"A better understanding in the public and among professionals of the importance of early intervention in addressing mental health issues."

"Improved child protection practice and early intervention support"

"Prevention services on a whole are underfunded and non-functioning"

"We're seeing less and less patients in outpatients – but maybe that's where social workers should be, in order to prevent admissions. But we can't be there because we're constantly needed to respond to the inpatient and acute end"

Generic roles

Social workers did not report being employed in generic mental health and care co-ordination roles similar to those found in occupational therapy and psychology.

Advanced practice

The following definition of advanced scope of practice was used and respondents were asked to describe their advanced scope of practice role.

> *Work that is currently within the scope of practice for your profession, but that through custom and practice has been performed by other professions. The advanced role requires additional training, competency development as well as significant clinical experience. Examples include non-medical prescribing (e.g. pharmacy, podiatry), physiotherapy led post-operative review clinics; physiotherapy and occupational therapy led spasticity and intervention clinics.*

Few respondents (16%) reported that their work involved advanced scope of practice and many of the roles described as advanced practice may well be considered within the normal scope of a social worker role. These included activities such as mental health assessments, grief counselling, crisis response, family therapy, family violence responses and supervision. Understanding of advanced practice in social work is slightly different to that described above, which may account for this response. In social work, "advanced practice is often recognised in terms of in-depth knowledge of a field or, perhaps less often, a method of social work" (Wilson, 2011 p.1). 'Advanced' is linked to understandings of expertise, experience or competence (Wilson, 2011).

In the focus groups, the social workers described advanced practice in the following ways:

"Advanced practice is advanced clinical therapeutic skills or demonstrated experience over a number of years in their particular field"

"My advanced skills are that I won't take no for an answer. I won't give up. I advocate"

"The advanced practice would be as you step higher into the grades there's higher expectations about what you would do and deliver"

"Advanced practitioner means they are more experienced than newer workers and their work level and pay reflects that"

"Currently in the world of 'Extended Scope of Practice' and 'Advanced Practitioner roles' within allied health, Social Work is struggling to find its own fit with these definitions"

Allied health assistants (AHA)

Only 18% of social workers reported their work involved delegation to an AHA. This arrangement appears to be only just emerging in social work. Those that had access to an AHA found it useful. There was some concern around ensuring the professional aspects of the job remained with professionally qualified social workers, that is, AHAs must never be used as a replacement for a professional social worker (AASW, 2016).

"I'm just beginning to use AHAs. I have one part time. She's really fantastic and useful. I use her for a lot of the practical stuff like Centrelink, finding accommodation, record keeping, computer work. We're also doing some research together. She's administering online cognitive testing and keeping records. It frees me up to be with the patients"

"In physiotherapy and occupational therapy, AHAs are very well embedded in carrying through treatment plans. In social work it is less common. They are treated with a bit of scepticism by social work. It's seen as devaluing the skills of the social worker"

"Maybe dedicated social work AHAs would assist with allowing more time to face to face clinical work and less time on administrative tasks"

Telehealth

Telehealth approaches were not commonly used by social workers. Only 5% of respondents (52 social workers) reported the use of telehealth. When it was used, it was mostly to provide telephone online chat or skype counselling and support to rural or geographically isolated patients, to videoconference with specialists, to provide or receive supervision via Skype, or to link into continuing professional development (CPD) activities online or by videoconference.

"To get access to a neuropsychologist for stroke patients"

"To provide supervision and counselling to rural and interstate social workers or clients"

"Telehealth to rural patients"

"Case conferencing with geographically isolated professionals"

See Appendix Table 1 for numbers of respondents to different scopes of practice questions.

Workforce movement

To identify patterns in the career pathway of social workers, participants were asked to provide details regarding their first position, their position prior to their current position, and their current position/s. Questions focussed on position locations, roles, settings and sectors. They were also asked about the number of years they had worked in each role. The results are presented as percentages as not all respondents had worked in three roles. The numbers of respondents for each position and each question are presented in the relevant figures, which illustrate the broad trends across respondents' careers to date.

Changes in location

The AHWQ2 data shows that the proportion of respondents working in metropolitan areas increased from 57% (468/820 respondents) to 64% (623/978 respondents) between an individual's first role and the role they were in immediately prior to their current role. This proportion remained stable between their immediately prior and current positions. Nearly one fifth of Victorian social workers started their careers overseas or interstate (Figure 28).

The number of respondents working in regional areas increased from 18% (150/820) to 28% (300/1,072) between respondents' first positions and their current position at the time of the survey (Figure 28). Despite this movement, social workers identified that there was still a significant unmet need for their services in rural and regional Victoria.

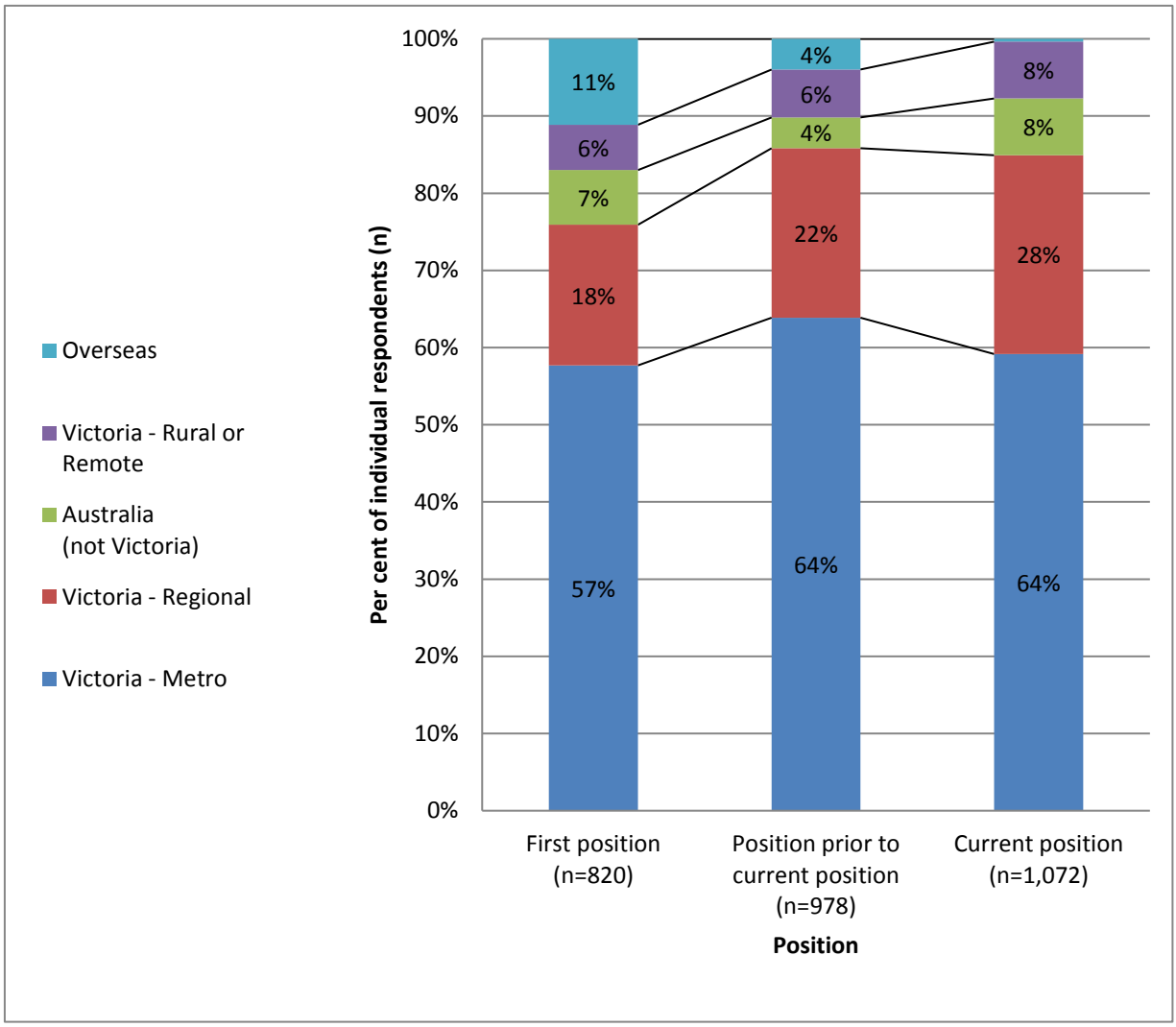
"Rural is a really serious issue. We need to be really encouraging people to move rurally. Access to services is a real problem"

"[single most important issue] is social and emotional wellbeing in rural areas"

"[in rural areas] people are tired, fatigued. It's a real challenge getting social workers. We are 1.4FTE down now. We're about to lose another SW: They are overcommitted to meet the demand"

"Rural is in crisis. People over age of 65 who have lived independently in remote and rural landscapes having to juggle new landscape in terms of assets, some have no family supports, no powers of attorney, high suicide, very complex mental health issues. There's a need for improved support for rural and ageing communities"

Figure 28: Changes in location across the career path (n=820 – 1,072)



Changes in role

When employed in their first role as a social worker, 88% (n=723) were employed as clinicians or indirect client services. This proportion shifted to 68% (n=668) for respondents' immediate prior position, with 16% (n=154) of respondents being employed in management positions and a very low number employed in a range of other role types such as researchers, project officers, and teachers / educators (Figure 29).

Social workers reported that in their current role, on average 52% of their time is spent in direct clinical care; 21% of their time is spent in management or administration; 5% of their time is spent teaching or educating and only 2% of their time is spent on research. Please note due to the wording of these questions relating to current role this data was not able to be included in the same manner as the prior roles in Figure 29.

It is not surprising that as social workers moved through their careers they also tended to move away from direct client services and towards management, administration, teaching and educating. However, this was an issue of some concern within the workforce, with many social worker participants in focus groups and interviews saying they would prefer to remain in direct care or clinical roles but the career structures did not allow it. If they wished to progress in their careers, there were little options for clinical

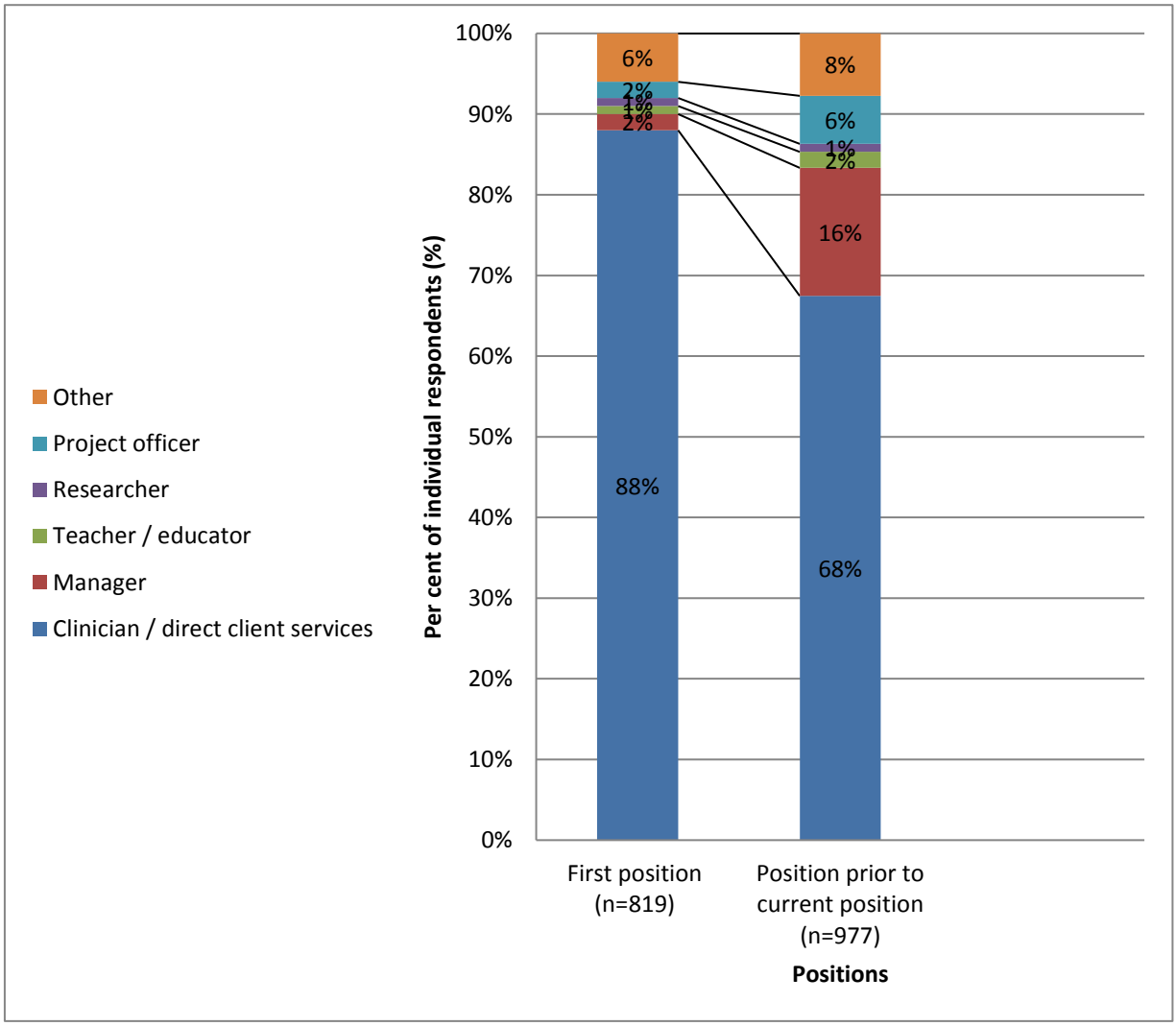
specialisation, instead they needed to take up management positions which required giving up some or all of their caseload.

"If you want to stay clinical you don't have a great career structure. You could be waiting a long while to progress."

"If you want to increase pay you have to start becoming a people manager at the same time. This is not true so much of other professions (except nursing). It's a real shame. There should be pathways for people who want to be pure clinical – extra duties might be teaching, clinical consultation. Some people love management and are good at that. But there's also a need to foster expert clinical practice."

"Progressing past grade 2 means making the decision to give up some case work. This is in contrast to physiotherapy that has full time grade 3 and grade 4 clinical experts."

Figure 29: Changes in role across career path (n=819 – 977)



Changes in setting

Figure 30 shows how the work setting for social workers changes across their career. The setting for a social workers' first role was more likely to be community-based, rather than hospital-based. However, there was a movement towards being hospital–based (inpatient and outpatient) as social workers progress through their career.

The qualitative data obtained through the survey, interviews and focus groups sheds some light on this movement. Social workers said that there were more career progression opportunities in hospitals and higher pay offered compared to positions in the community, therefore many aspire for jobs in hospitals. Also jobs in the community were easier to come by for less experienced social workers. Community jobs, such as in child protection, offer a good grounding in social work but people do tend to burn out or suffer from compassion fatigue and move on to other areas of work. Some social workers found they wanted to work in teams with other social workers. This structure is more common in large hospitals, than in community organisations where social workers are likely to be working in teams with people with a mix of education backgrounds.

"We have reasonably good perks as public servants. Good pay compared to community awards"

"There are more opportunities in the public system than the community sector to step up. There are opportunities for training in the community sector but not opportunities to step up and use those skills"

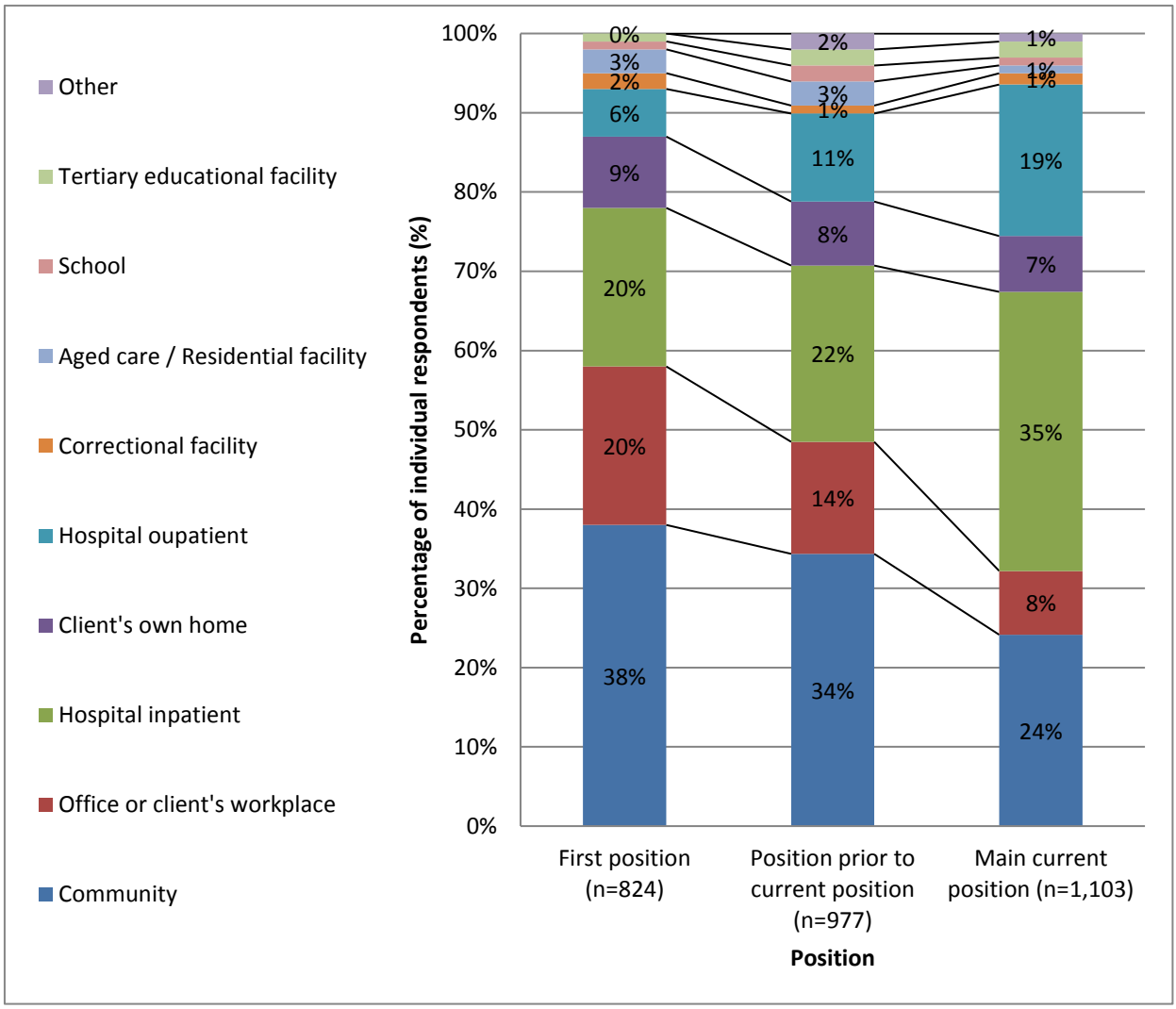
"I spent quite a few years in community organisations prior to current role. I didn't last long because I felt my social work degree went against me. My colleagues mostly had absolutely no education at all (not even basic courses at TAFE). I had been hired but felt very discriminated against."

"I'm attracted to hospitals and healthcare because we demand qualified social workers"

"When I was working in community there would be new graduates who were nursing or had psych degree. We all had the same titles – Case Manager. We were de-professionalised."

"In the community organisation, I don't know why new grads were coming in on the same pay band as me."

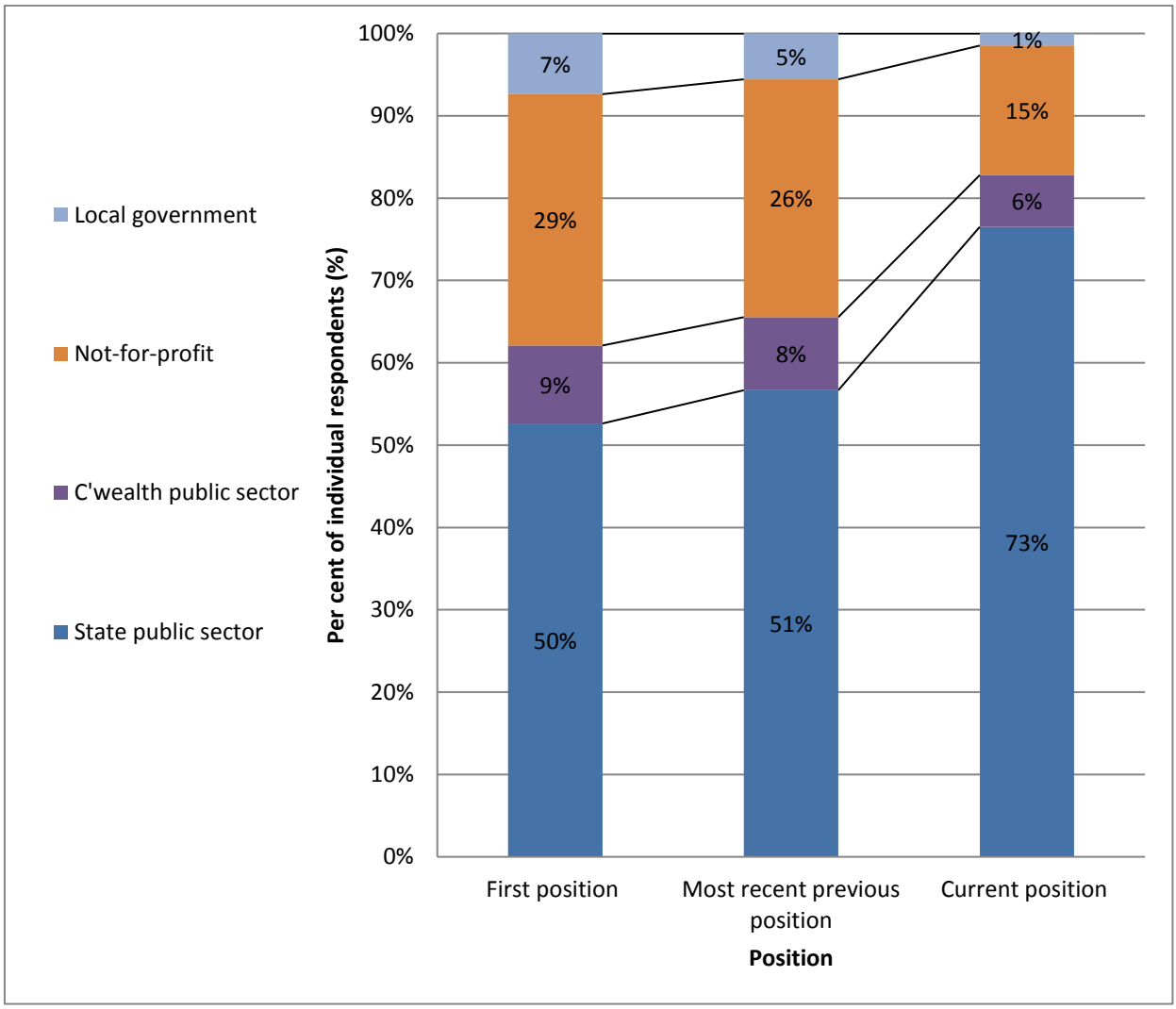
Figure 30: Changes in setting of care across career path (n=824 – 1,103)



Changes in sector

In the same way that the setting of work changed over a social worker's career, so too did the sector of care. Victorian social workers tended to move towards the state public sector and away from the NFP, Commonwealth and local government sectors. Just over one quarter (29%, n=243) of social workers were employed by the NFP sector in their first role, this dropped to 26% (n=258) in their prior role and 15% (n=163) in their current role. Half of the surveyed Victorian social workers (50%, n=409) were employed by the state government in their first role, this increased to 73% (n=784) in their current role. Almost none of the surveyed social workers were employed in the private sector, either in a hospital or in private practice (n=7 in first role, n= 38 in prior role, and n=19 in current role) (Figure 31).

Figure 31: Changes in sector over the career path (n=824 – 1,077)



Years in role

Over time, the number of years that respondents work in a role was shown to increase. The average time in first role was three years, while the average time respondents had worked in their current role was six years (Table 8).

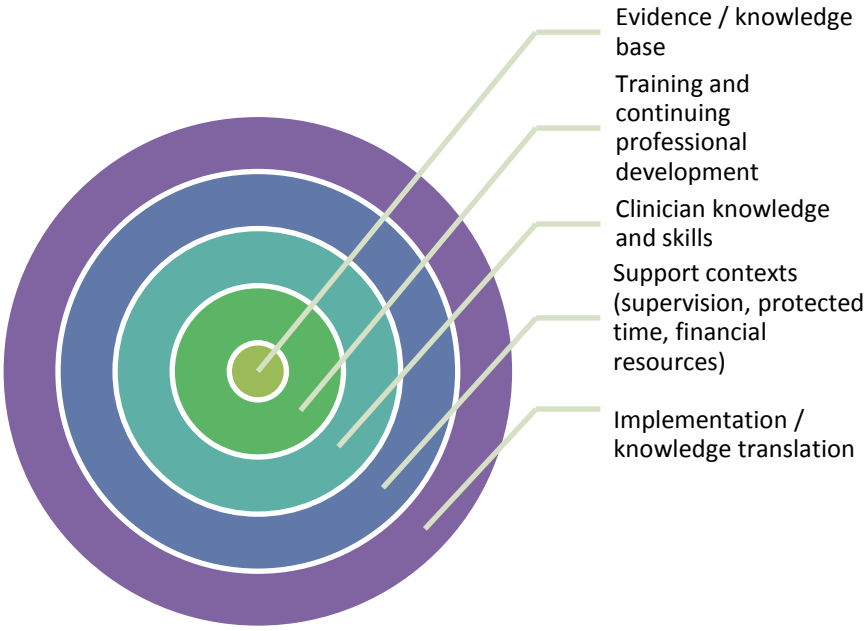
Table 8: Years in each role over the career path

	Mean	Range	Count
Years in current role	6	0<1 - 40	1,075
Years in previous role	5	<1 - 35	948
Years in first role	3	<1 - 35	787

Capability

Capability refers to the strength of the evidence underpinning relevant medical laboratory scientist professional activities, access to training and continuing professional development (CPD) to develop the appropriate skills, the standard of skills practitioners have to deliver evidence-based services, the contextual supports available (supervision, mentoring, dedicated time and appropriate funding models), and opportunities for change in practice to occur (i.e. knowledge translation and implementation) (Figure 32).

Figure 32: Workforce capability framework



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Key findings

- Social workers identified the need for a stronger research culture to build evidence to support different approaches to practice, care delivery models, and to increase understanding of the value and full scope of the profession.
- Most social workers entered the profession via completion of a bachelor's degree.
- Social workers held a vast array of qualifications. Of all qualifications held by social workers, 43% were bachelor degrees. Masters degrees, whether they were graduate entry, clinical, management or research masters degrees, made up 18% of qualifications. Fourteen per cent (14%) of qualifications were from the vocational education and training sector. Twenty-six respondents held a doctorate, making up 1% of qualifications held.
- About 14% of social workers are currently studying for another qualification, most commonly a clinical masters (a quarter of those studying), followed by a research masters or a PhD (both 11% of those studying).
- There was some concern reported amongst social workers about the new graduate entry or 'qualifying' master's degree, mostly because there appears to be a lack of understanding amongst employers and others about the difference between a 'qualifying masters' and an 'advanced masters'.
- The profession would benefit from increased career progression opportunities.
- Career progression pathways were not clear for social workers. There was a particular bottleneck at grade 2.
- Skill gaps included understanding the hospital/health environment, mental health knowledge and experience, family violence knowledge and experience, counselling skills, working with children and young people, understanding of alcohol and other drugs, research skills, and assessment skills.
- An emerging issue was the call for cultural supervision, both for Aboriginal and Torres Strait Islander social workers working with their own communities, or with other Indigenous communities, and for non-Indigenous social workers in building cultural understanding into their practice. This is an issue the AASW is currently investigating.
- Clinical supervision is a highly-valued part of social work practice and culture. Many social workers would like better access to clinical supervision and/or better quality supervision, preferably provided by an experienced social worker.
- Social workers' strongest concern about their support structures was that their salary does not commensurate with the work that they do.
- The majority of social workers (78%) worked in multidisciplinary teams.
- Social workers believed they bring a very important perspective to multi-disciplinary teams by viewing a patient's issues from a systemic standpoint, not a medical standpoint.

Evidence / knowledge base

Participants reported a need for a stronger research culture and increased valuing and greater investment in research. More research evidence would help social workers to argue their case with other professions for different approaches to practice. This would also help with the development of varied and model of care delivery. They believed this could lead to an improved understanding and valuing of the

profession and increase its potential scope of practice. Overall this would help develop the evidence-base of the profession.

"The social work profession requires more good quality research and evidence based practice.

Social work is pretty ordinary about putting it out there re what they've done and having researched based evidence."

Training and continuing professional development

Prior work experiences

More than half of the respondents (58%) reported that they had worked in a role or profession prior to entering social work. About a quarter of these (23%) had worked in multiple other professions or roles. For these individuals, the average number of years worked in their prior professions or roles was nine.

Social workers valued highly the experience they can bring from other parts of their lives, whether it be their personal life experience or previous work experience with vulnerable people.

"Beginning as a mature aged graduate I have had the benefit of having life experience to combine with the academic knowledge. There was also the benefit of having some knowledge of many of the clients as I had attended school and played sport with many of them."

"Experience in several social work fields and two interrelated professions has enhanced my career advancement"

"[career progression is enhanced by] previous skills in other sectors and maturity"

"Previous experience in the sector in a different role – welfare work"

Qualifications

Social workers held a vast array of qualifications. Of all qualifications held by social workers, 43% were bachelor degrees. Masters degrees, whether they were graduate entry, clinical, management or research masters degrees, made up 18% of qualifications. Fourteen per cent (14%) of qualifications were from the vocational education and training sector. Twenty-six respondents held a doctorate, making up 1% of qualifications held (Figure 33)

About 14% of social workers are currently studying for another qualification, most commonly a clinical masters (a quarter of those studying), followed by a research masters or a PhD (both 11% of those studying).

Seventy per cent (70%) of social workers stated that the first qualification that enabled them to work as a social worker was a bachelor degree and 12% indicated it was a graduate entry master's degree. Four per cent (4%) of respondents said they started working with as a social worker with a lower level qualification than a bachelor degree, primarily an associate or advanced diploma. See Appendix Table 3 for detailed breakdown by respondent numbers to different qualifications.

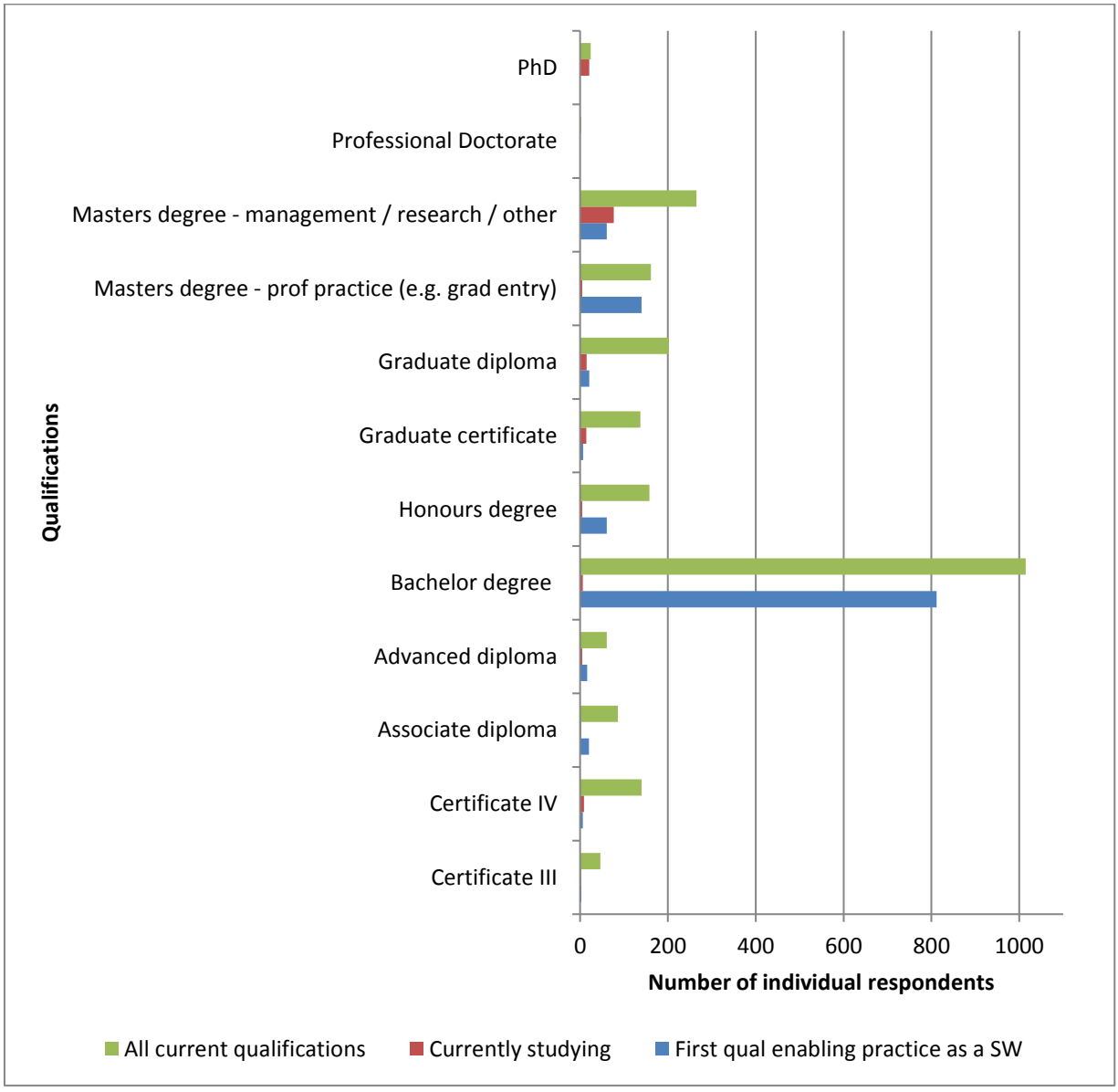
There was some concern reported amongst social workers about the new graduate entry or 'qualifying' master's degree, mostly because there appears to be a lack of understanding amongst employers and others about the difference between a 'qualifying masters' and an 'advanced masters'.

"The two year masters qualifying course is a problem. They say they now have a Master in Social Work. And people who don't know, who are employing, think it's post graduate social work training on top of an undergrad social work degree. But it's not."

"It's like there's no distinction between the qualifying masters and the advanced Master of Social Work. Some will write 'Qualifying Master of Social Work' on their CVs but others won't

Qualifying master is muddying the waters – it's really a glorified bachelor."

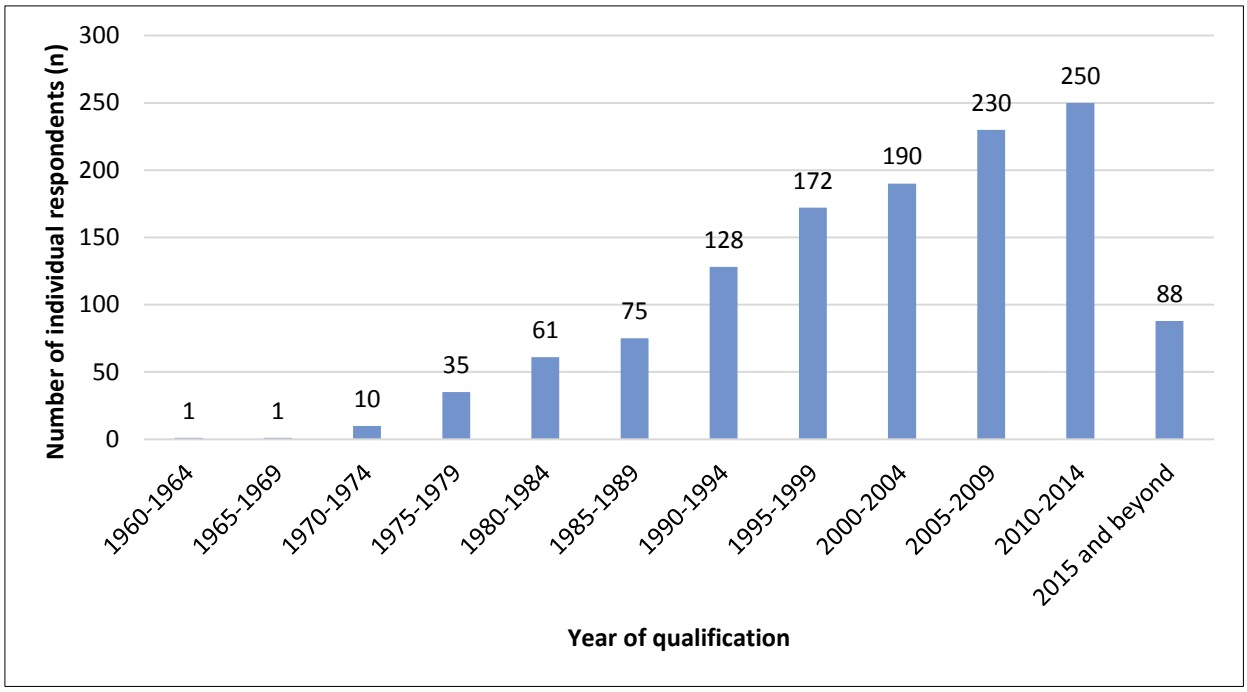
Figure 33: Qualifications held or currently studying (n=1,147) [a]



[a] *Respondents could select more than one response to 'all current qualifications' and 'currently studying'*

Many of the respondents to the survey were fairly recent graduates with 27% (n= 338) having graduated since 2010 and 61% (n=758) having graduated with a social work qualification since 2000. When considering the total respondent cohort, the mean length of time since completing their first qualification was 13 years (Figure 34).

Figure 34: Year of qualification (n=1,241)



Eighty-four per cent (84%) of social workers were educated in Victoria, with 8% educated overseas. The United Kingdom was the most common overseas location, followed by New Zealand and South Africa. The remaining social workers (8%) were educated in another Australian state or territory. One in five Victorian social workers gained their first qualification from a regional university or college.

Continuing professional development

The majority of respondents (54%) either disagreed or provided a neutral answer regarding their access to training to progress their careers. Only (46%, n=463) agreed they had access to adequate training to progress their career, and even less felt they had access to mentorship to support their career growth (43%, n=435) (Figure 35).

This response was consistent with the responses from the focus groups and interviews where respondents stated that the access to training opportunities was varied. Some felt they could access training opportunities while many others stated they had to instigating and paying for their own professional development.

"It's so different for PD [professional development] across locations. Almost all the PD I've done in my current role has been paid for by me and instigated by me."

"The organisation is unsupportive of PD and education"

However, even with appropriate professional development, social workers said that it was often difficult to move forward in their career due to bottlenecks at particular levels, particularly in rural areas.

Career development opportunities

A large proportion of respondents (72%) felt they did not have a clear pathway for career progression. Nevertheless, over half (56%) felt they had access to local career development opportunities (Figure 35).

This response again aligns with what social workers said in the interviews and focus groups. On the whole, they were able to access a diverse range of opportunities for working in different areas; however the experience varied across employers, with many social workers indicating they could not do this.

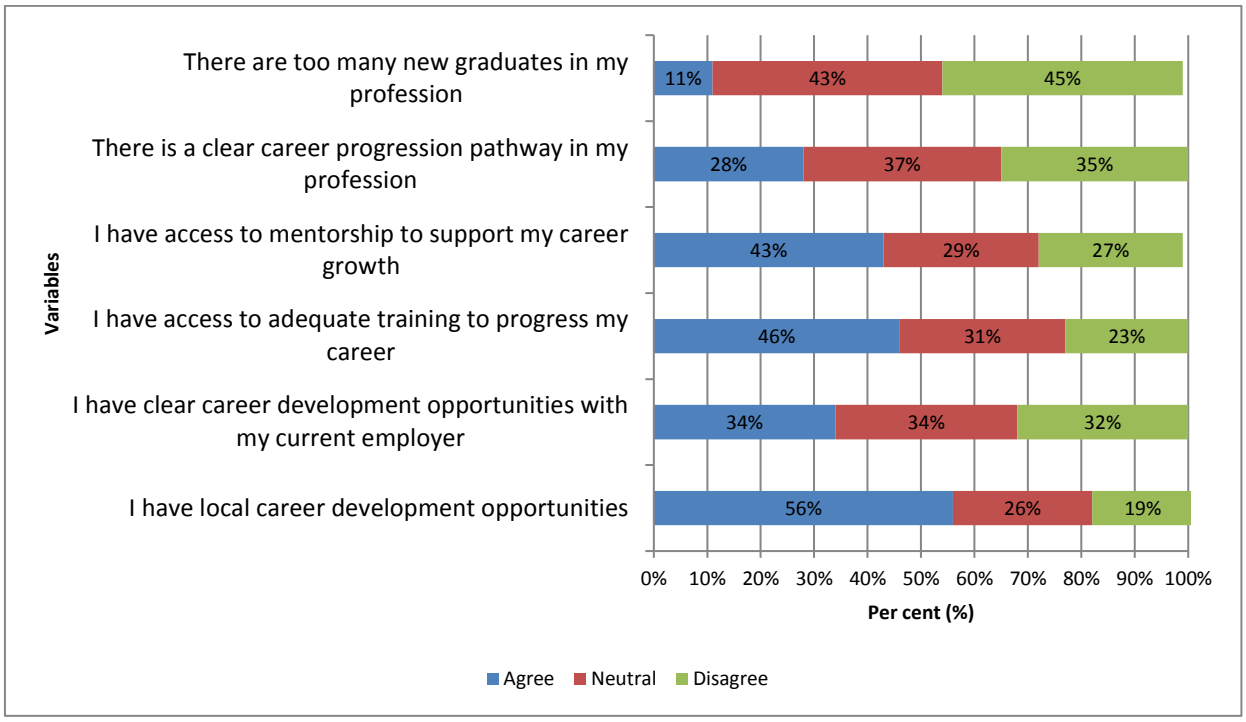
"There's a bottleneck for people at grade 2. There's significantly smaller number of grade 3s than 2. For some people it's frustrating, some are happy"

"There are no real options to progress to a manager because I'm in a rural area"

"There are all sorts of opportunities if people look out for them, for example secondments into private practice"

"Often the structures are quite flat. The challenge in my role is looking at how we have an effective career pathway for all the staff. The bulk of the workforce is grade 2 and they could stay there for 20 years."

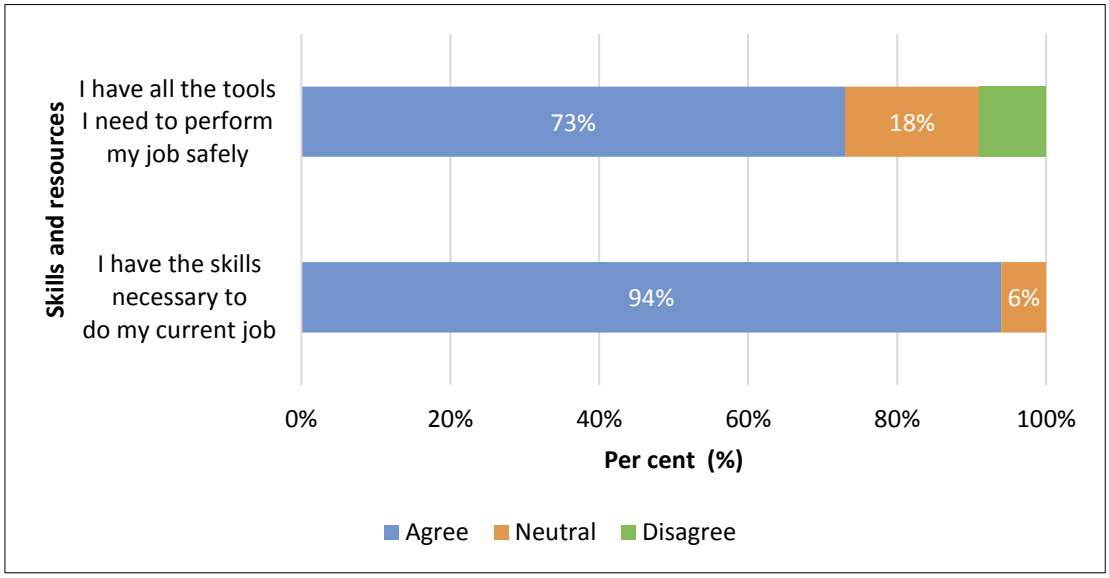
Figure 35: Career development opportunities (n=1,001)



Clinician knowledge and skills

On the whole, social workers felt they had the skills they needed and the tools to perform their jobs safely. Most had access to peer support and management support; however 19% felt they were professionally isolated (Figure 36).

Figure 36: Clinical skills and resources (n=996)



Skill gaps

When asked about skill gaps, 100 organisational respondents raised a range of different issues. The main gaps identified were:

- Understanding the hospital/health environment
- Mental health knowledge and experience
- Family violence knowledge and experience
- Counselling skills
- Working with children and young people
- Alcohol and other drugs
- Research skills
- Assessment skills

These were reiterated in the focus group responses:

"Lack of specialist skills, knowledge and/or experience in family violence - a huge gap and a risk in current workforce and the sector as generalist social workers are claiming themselves as specialists when they do not have sufficient knowledge/experience and the specialist skills / knowledge are undermined."

"Lack of specific/specialist training in mental health at university"

"I feel social work degrees do not provide enough education on case planning/management and counselling - particularly counselling as so much of a social work role is counselling"

"Each generation seems to have lesser counselling skills and overwhelmed by working in a complex hospital environment"

"AOD [alcohol and drug] treatment and interventions"

"Assessment skills are lacking, realistic expectations of work pressures are not present"

Support contexts to enhance capability

Supervision and support

Clinical supervision was a valued and integral element of the social work profession. When asked what was the single most important issue they would like to see addressed, high quality supervision was one of the most frequently cited points, referred to by 60 respondents. Supervision was also consistently referred to as a factor contributing to improved career progression. Social workers said that workforce burnout or compassion fatigue can be an issue in the workforce, but it is substantially mitigated with effective discipline-specific supervision.

An emerging issue was the call for cultural supervision, both for Aboriginal and Torres Strait Islander social workers working with their own communities, or with other Indigenous communities, and for non-Indigenous social workers in building cultural understanding into their practice. This is an issue the AASW is currently investigating.

"Social work has a culture of critical reflection and supervision. This is hugely important. We only see people who have a lot of challenges. It's not easy work and there's no glory in it."

"Good supervision helps you improve your practice. Gets you to reflect. Gives you time away from the treadmill. It's really important."

"Supervision has made a big difference for my capacity to retain resilience, energy, enthusiasm."

"If they don't have the supervision – they won't last. The work affects family life, personal life. People need support to work through complex situations. Unless they have that, young and older people will keep leaving."

"There are ethical issues when you think about kinship ties and putting the professional hat on and the cultural hat. Lots of colleagues say they feel uncomfortable when cultural stuff comes up. Non-Indigenous supervisors don't feel they can provide advice from a lived experience. Others might be Aboriginal but from a different country… these conversations have been happening for many years but we still haven't worked out what it looks like and how it varies from professional supervision."

According to the workforce survey, the majority of social workers had access to clinical supervision. Most social workers (68%) were supervised by other social workers, but it was not uncommon to be supervised by different AH professional or a nurse (Figure 37).

Figure 37: Professional background of clinical supervisor (n=1,048)

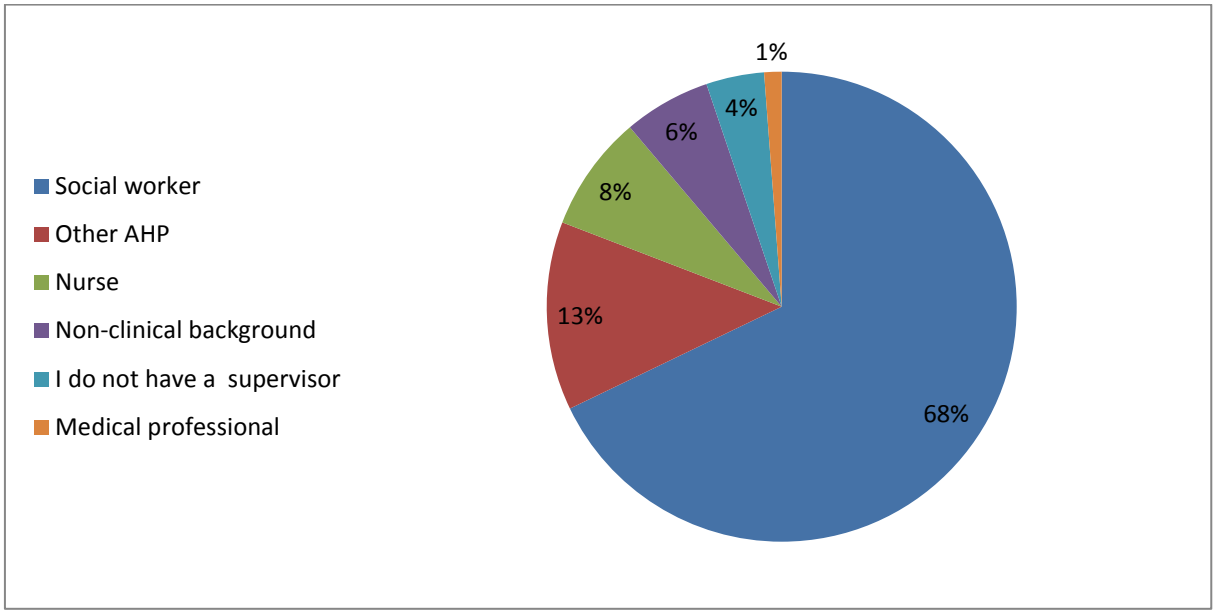


Figure 37 provides further information on the support experienced by social worker respondents. Most respondents reported that they had access to peer support within their profession, they had formal management support, they were not professionally isolated, they could access assistance if they were uncertain about their work, and they had access to clinical supervision. Even so, the context of those who indicated disagreement or a neutral perspective on these issues must not be disregarded. For example, over one quarter (29%, n=290) disagreed or were neutral regarding their access to formal management support from a member of their own team.

It is also of interest that although in Figure 36 (above) only 4% of respondents indicated they do not have a clinical supervisor, in Figure 37 (next page) 28% (n=280) disagreed or were neutral on the point of having access to clinical supervision. This suggests that although a professional may have an appointed clinical supervisor, this may not reflect the extent to which they receive clinical supervision.

The qualitative data corroborated this with many social workers stating they were not receiving as much clinical supervision as they believed they required or the supervision was pitched at an administrative level, rather than a clinical level. A number of social workers were accessing group supervision, in sessions with other professions. They found this useful, but it was not as good as one-on-one supervision by a skilled expert social worker. People working in rural areas and in the community sector had particular challenges in accessing the clinical supervision that they needed.

"Sometimes social workers are supervised by an OT [occupational therapist], rather than getting professional supervision from a social worker, but they become very disconnected to the profession."

"[We need] greater access to supervision by a qualified social worker; not a task-based managerial supervisor; if not within organisation, readily available externally.'

"Access to clinical supervision for sole practitioners in rural centres"

"Professional clinical supervision to be mandated"

"Lack of clinical supervision for social workers in the community because their job title may be 'key worker' or 'case worker' meaning that their employer does not have to follow AASW guidelines re conditions and development"

The key area for concern for social workers was their pay or salary level. Only 39% of respondents agreed that their pay or salary level was appropriate to the work they do (Figure 38). This was strongly backed up in qualitative responses.

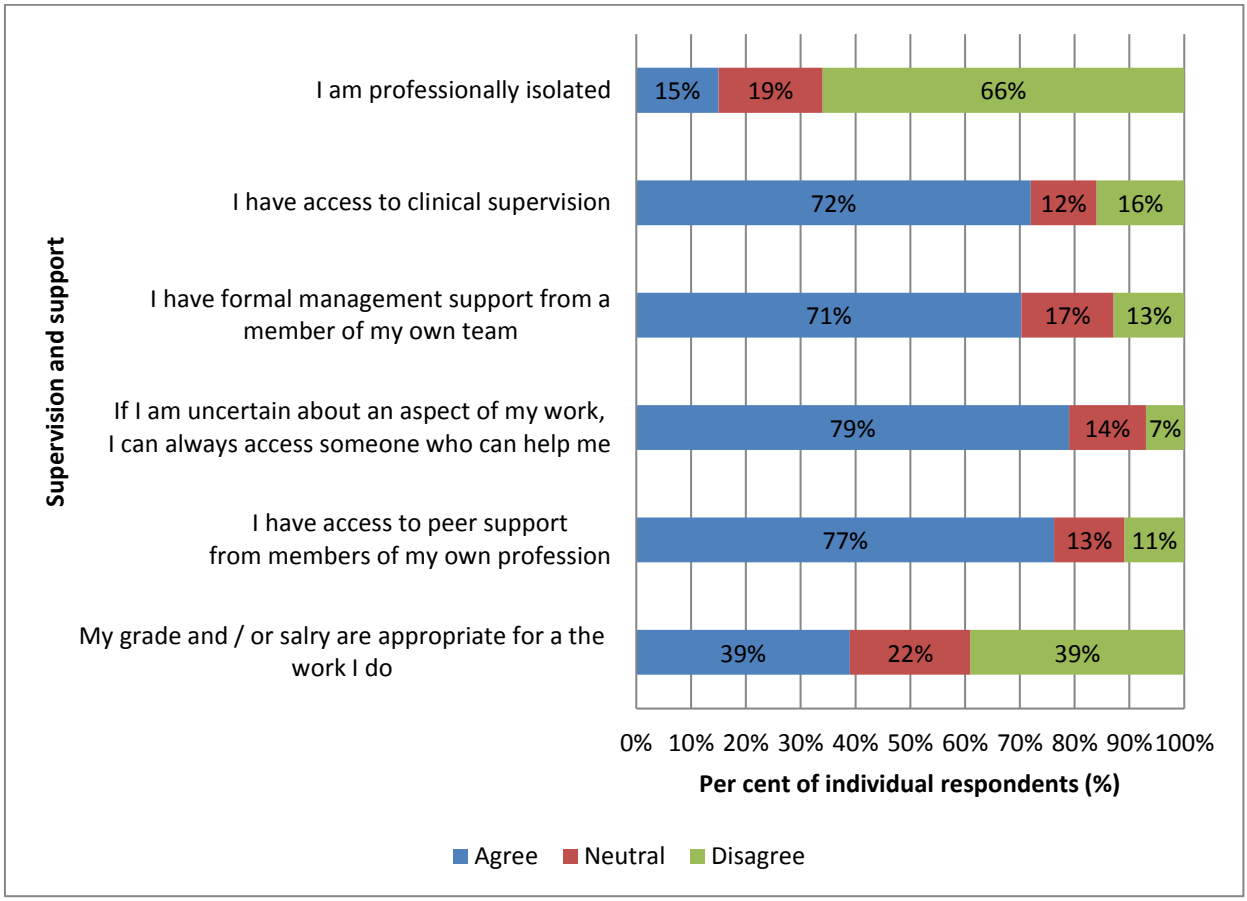
"Pay rates is a problem [for retention] – not enough push for better pay conditions"

"Staff are overworked and underpaid"

"A pay structure that reflects my professional status and clinical responsibilities"

"Pay rates for social workers versus other allied health professions is poor"

Figure 38: Access to supervision and support (n=1,001)



Team structure

It was uncommon for social workers not to work with other professions. The majority of social workers (76%) worked as part of a co-located multidisciplinary team within a formal team structure. No one who indicated that they worked in collaboration with other professionals was not co-located with their colleagues (Figure 39).

Social workers believed they bring a very important perspective to multi-disciplinary teams by viewing a patient's issues from a systemic standpoint, not a medical standpoint. However, some social workers felt that they were not given due respect for their skills and expertise in multidisciplinary teams.

"Social workers bring a particular perspective to the multidisciplinary team in mental health which is really important. The other disciplines are less likely to advocate for a client's rights in the way that social workers do. Social workers are concerned with more than just a person's mental state,

symptoms, diagnosis and medication. We view the person holistically and understand the importance of providing support to their families and carers."

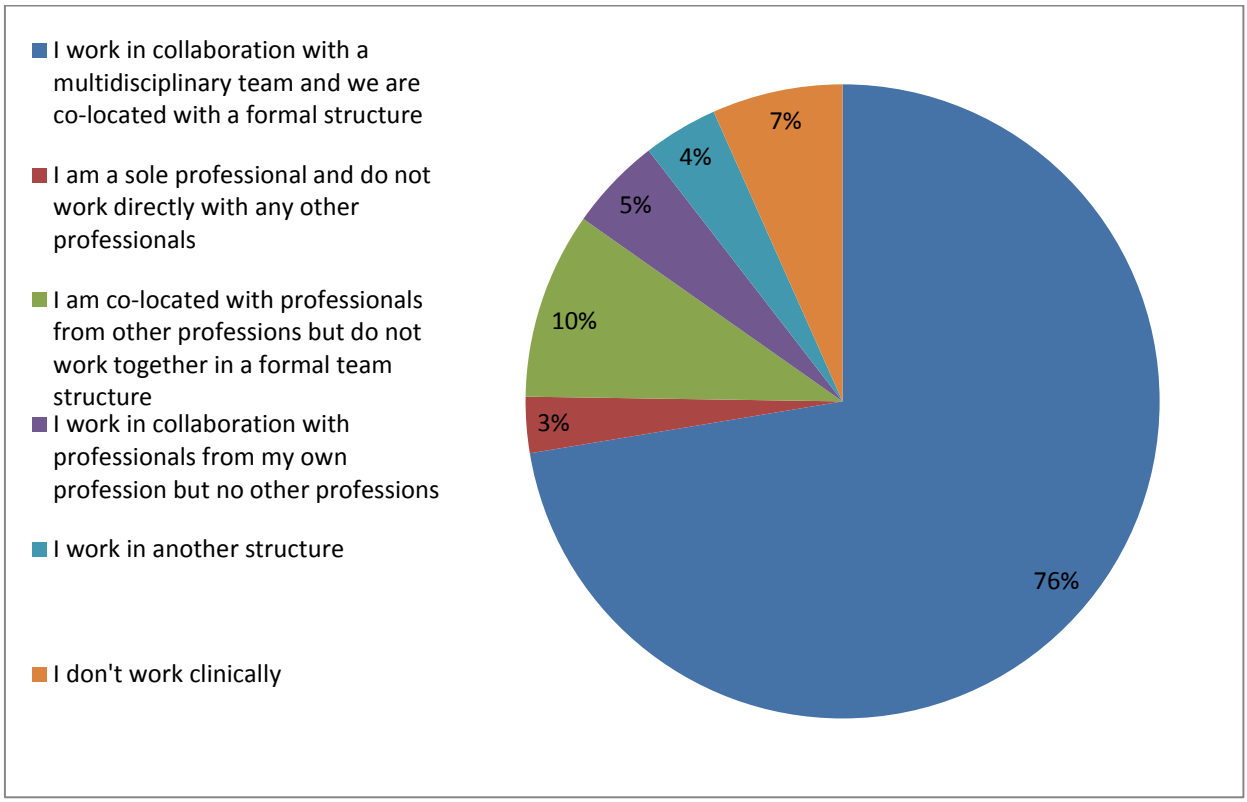
"[would like to see] respectful, professional working relationships within acute hospital settings.

Better communication between the multidisciplinary team and respect for the role of social work within the team"

"Social work is an outlier; you're in a medical setting, not the primary profession"

"You feel you have to explain yourself that you have good skills, good training, have the capacity to provide the service"

Figure 39: Practice structure (n=1,027)



Engagement

Engagement involves a continuum from the individual practitioner's engagement with their role to the wider engagement of the profession with society through regulatory mechanisms. Within this course there is engagement with the profession, engagement with other professions, and engagement with patients and the community (Figure 40).

Figure 40: Model of engagement

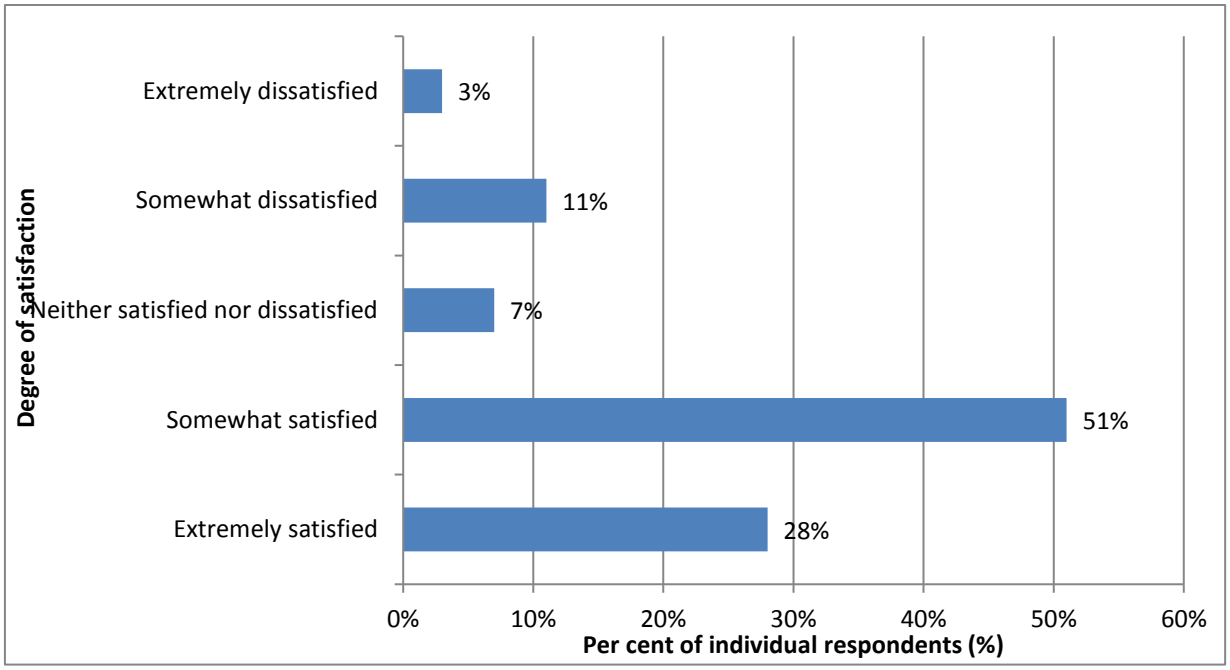
Key findings

- Overall social workers were satisfied with their careers, particularly the diversity available in the social work profession and the ability to make a difference to people's lives.
- Achieving an appropriate work-life balance was very important to social workers and 41% of social workers were happy with this aspect of their job.
- Social workers were generally happy with the type of work they do and their clients but would like to see more career advancement and professional development opportunities and better pay.
- Social workers would like to see increased professional status and recognition. There was a sense that this is improving in hospitals as social workers are employed under the same award as other AH professions and only employ AASW registered social workers.
- Respondents wanted the profession to have some form of registration, certification or accreditation.

Individual role engagement

Overall respondents were satisfied with their current work situation with 79% (n=828) stating that they were somewhat or extremely satisfied in their current work situation. Eighteen per cent (18%, n=194) of social workers were ambivalent regarding their satisfaction or stated being somewhat satisfied; 3% (n=33) were extremely dissatisfied (Figure 41).

Figure 41: Overall Satisfaction (n=1,055)



This aligns with the results of the qualitative data collection. Social workers said they enjoyed the diversity their career choice offered them and experienced satisfaction from providing direct support to people when they needed it most.

"I get joy from communicating with such a broad group of people. It's probably why I've survived as long as I have."

"Centrelink was very satisfying. Responding to policy change. Lots of opportunities. Supporting farmers during drought."

"I love this kind of work – with families and kids. I have a fantastic team to work as part of."

"I enjoy it immensely when I have been able to make a positive difference in people's lives. The most frustrating thing is the big picture stuff. Policies that penalise poor, disadvantaged, mental health."

Issues that lessened job satisfaction included:

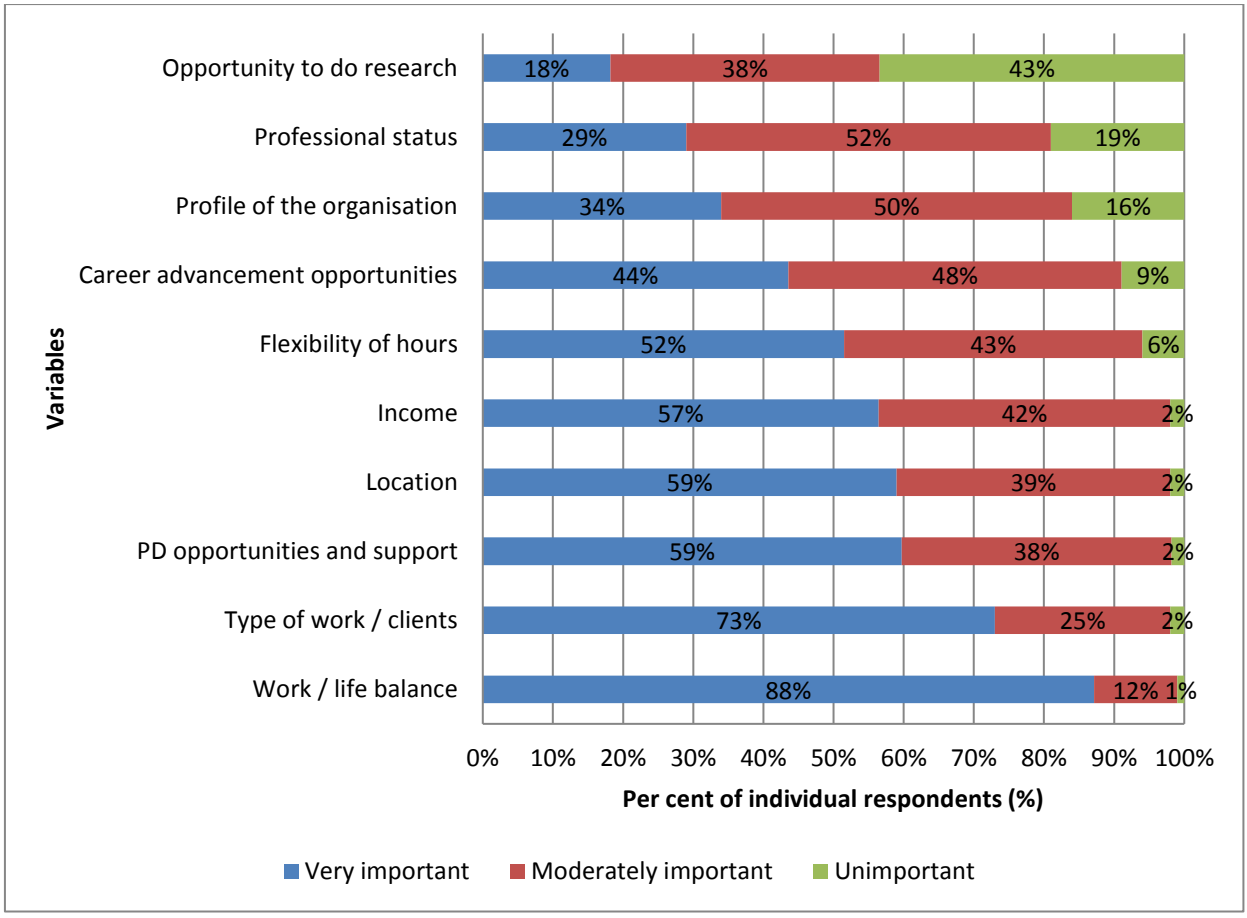
- Lack of professional recognition and respect
- Blockages to career progression
- Lack of social work influence in getting outcomes for patients
- Lack of support from management
- Lack of clinical supervision
- Large caseloads - lack of quality time with clients, rushed assessments and discharge plans.

The research participants were asked about the relative importance of different features of their employment. The four features identified as being very important to the greatest proportion of respondents were:

- work-life balance (88%, n=867),
- type of work / clients (73%, n=726),
- professional development opportunities and support (59%, n=585), and
- location (59%, n=581) (Figure 42).

Increased professional status was a strong theme throughout the survey and focus groups comments but most people rated this as moderately important as far as their employment choices go, rather than very important.

Figure 42: Importance of factors affecting employment choices (n=988)



When the level of satisfaction with these variables was assessed very satisfied was reported by 59% (n-580) for location and 60% for type of clients (n=596). Work-life balance had a 41% (n=403) level of very satisfied and professional development opportunities and support reported 29% (n=289) very satisfied (Figure 43).

In the qualitative data collection, social workers often spoke about ‘self-care’ and the need to take pro-active steps to avoid burnout and compassion fatigue. Part of this was ensuring an appropriate work-life balance. The majority respondents (87%) reported that they were either moderately or very satisfied with their current work-life balance. Only 13% of social workers were dissatisfied (Figure 43).

The major area of dissatisfaction for social workers was career advancement opportunities, with a third of respondents (32%, n=316) being dissatisfied with this aspect of their current roles. Income levels and

professional development opportunities were also areas of concern, with one in five respondents being unhappy with these aspects of their work.

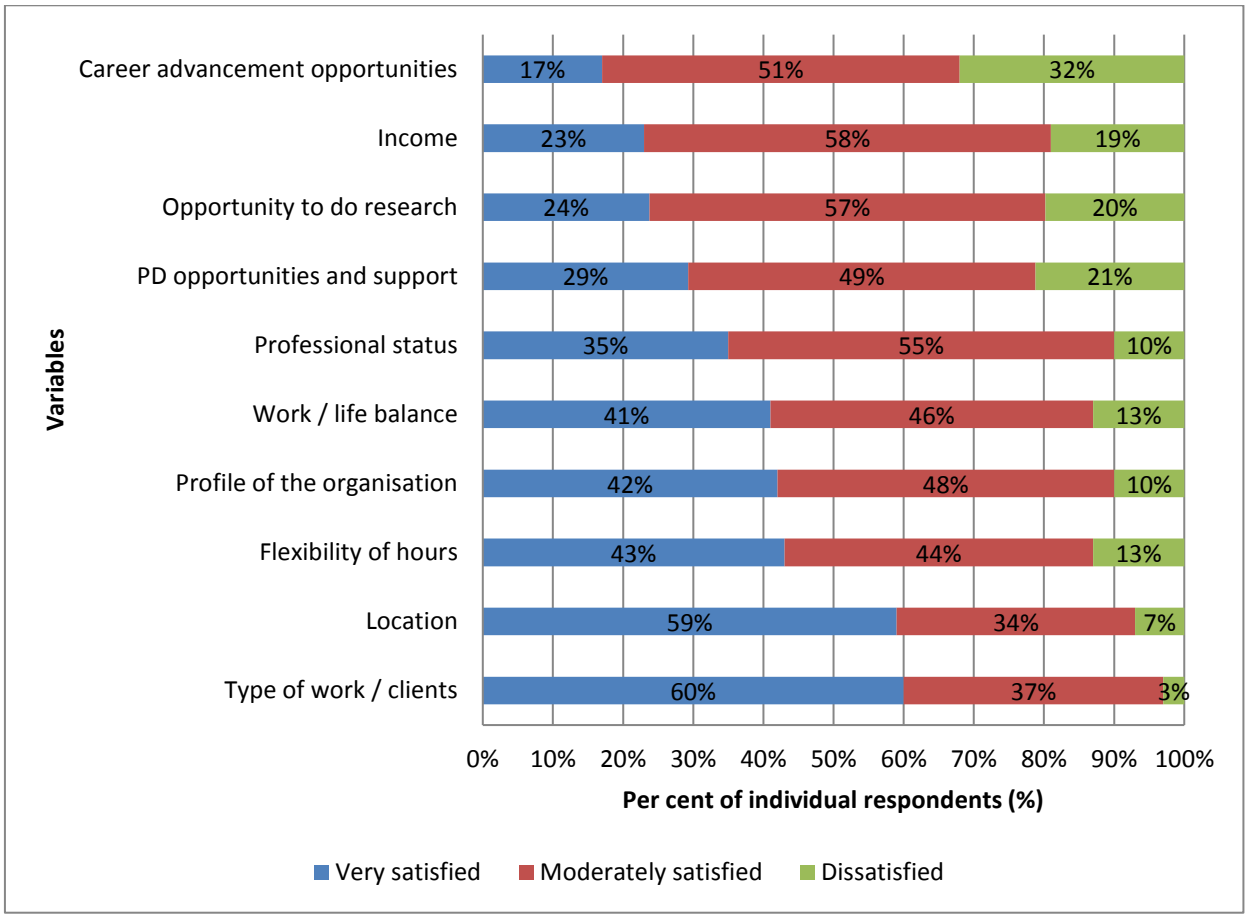
"Changing jobs can be a self-care thing and should be supported"

"Flexibility is important so people can work part time"

"'Self-care' is the buzzword but I think the onus needs to shift from workers to employers to create a safe, calm and healthy workplace."

"What I love is that you can actually influence policies and development of services. You can use advocacy skills for the profession and for the patient."

Figure 43: Current satisfaction with factors affecting employment choices (n=988)



Intra-professional engagement

Social workers generally identified strongly with their professional background. In the qualitative findings, many social workers indicated that they preferred working in teams with other social workers and being supervised by other social workers because of the unique perspective social workers have. However, there were some that said there were drawbacks to identifying as a social worker, in that they were not always respected for their professional background.

According to the AASW, about one third of Victorian social workers are members. While the research participants recognise that their professional association has been active in many important areas, they identified areas where they felt ongoing effort by the professional association could help to bring about

change. This included the development of clinical specialities. Social workers would like to see opportunities to undertake advanced practice in a wider range of specialities and have those specialities recognised or accredited in a way where it is possible to gain an accreditation in mental health social worker practice.

Inter-professional engagement

As noted above, professional recognition was a very strong theme for the social work profession. Social workers felt they lacked professional respect and standing and this was affecting their ability to implement good ideas in organisations. There was a sense that this was improving in the hospitals, partly because they were employed under the same award as other AH professions, and partly because hospitals only employ AASW registered social workers.

However, there was concern in the community sector about non-degree qualified social workers were using the social worker title and sometimes getting paid at a similar level. There was also a blurring of roles between psychologists and social workers, with some respondents saying that psychologists were taking over parts of the social work role in hospitals and getting paid more

"People [in the community sector] say they are a social worker, but they didn't study social work… they might be a volunteer at a local op shop."

"[In the community sector] you sit in with people who call themselves social workers who you know are not. It undermines our professionalism. It's like a deskilling of our profession."

"A psychologist will get paid more than a mental health social worker. We don't do anything less, we even actually have that extra lens. We're not just working with just with psychological and family issues but also working with society's view."

"Registration would help improve the professional status of social work. People couldn't go around saying they're a social worker."

"Social workers are very innovative and try out new things. But because of our lowly status in hierarchy we aren't able to pursue things. We suggest projects that are very valuable – but our status means the ideas don't get off the ground."

Community and society engagement

As was the case for many of their professional colleagues, many social workers felt it was important to improve community and the public understanding of the role of the profession. They wanted an increased understanding of what they do and how they work, increased recognition, and further work undertaken to ensure understanding of the social worker title, training and scope of practice.

There was also a strong push from the respondents for some form of registration, certification or accreditation. 'Registration' was felt to not only increase their professional recognition, but to also address concerns with less qualified people working in roles that should be filled by degree qualified social workers. . Most respondents believed some form of registration would bring more definition around the social work role, more understanding amongst other professions, and a higher status.

"There's a public perception that what social workers do is welfare, as opposed to working at a psychological level. Psychologists weren't a presence in hospitals when I started and now they want to take over that part of the job. Initially, psychologists only did neuropsychology but now they're infiltrating in more and more areas because social work has been dumbed down in terms of those skills."

"Lack of registration is a big problem for professional identity, and there are issues around status and misunderstanding about the role"

“More credentialing would be good – with that comes weight and definition”

“We hold the profession very close to our heart. We put a lot of years into developing our identity as social worker.”

Conclusion

To meet the increasing psycho-social needs in the community; respond to the needs of the ageing population; implement policy aspirations around domestic and family violence, disability and child protection; and to prevent failed discharges and regular readmissions social work services will need to grow.

Graduates are entering the profession in greater numbers, but it will take time for the new cohorts to develop the experience and skills needed to respond adequately to the complex needs in the community. The rural areas of Victoria have particular needs for social work services that are not currently being met.

As a profession, social work has a lot to offer. People can work in a diverse range of contexts and apply their skills and knowledge to make a difference at individual, family and structural level in the community. However, social workers lack career pathways that reward experience and clinical expertise. They also need to have greater professional recognition, definition and status.

There is a broad array of pay structures for social workers that do not necessarily reflect skills, experience or complexity of work. The lack of parity in terms of pay and status between social workers in the community sector and those in the public sector is an issue of particular concern.

References

Australian Association of Social Workers. (2016). *Position Statement: Allied Health Assistants*. Available from https://www.aasw.asn.au/document/item/9023

Australian Bureau of Statistics (ABS). (2011). *Census of Population and Dwellings 2011.* Provided to Southern Cross University by Department of Health and Human Services, Melbourne, Victoria.

Australian Government. (2017a). *ABS Labour force survey annual average, 2015*, as cited in Job Outlook: Social Workers, www.joboutlook.gov.au

Australian Government (2017b). *Job Outlook: Social Workers*. www.joboutlook.gov.au

Department of Health and Human Services (2015). *The Road Ahead: The Human Services Workforce in Victoria*: December 2015 – DRAFT. Melbourne: State of Victoria, Department of Health and Human Services.

Department of Health and Human Services. (2016). *Social Work Environmental Scan.* Melbourne: State of Victoria, Department of Health and Human Services.

Department of Health and Human Services. (2017). *The Victorian Social Work Training Pipeline: Analysis of data from the Commonwealth Department of Education & Training 2010 - 2015.* Melbourne: State of Victoria, Department of Health and Human Services.

Wilson, J. (2011). *Advanced Practice in Social Work*. The Australian College of Social Work. Available from https://www.aasw.asn.au/document/item/3363

Appendix

The following section contains additional data, figures and tables referred to in the main report relating to the data collected through the AHWQ2 social work survey.

Responses and respondents

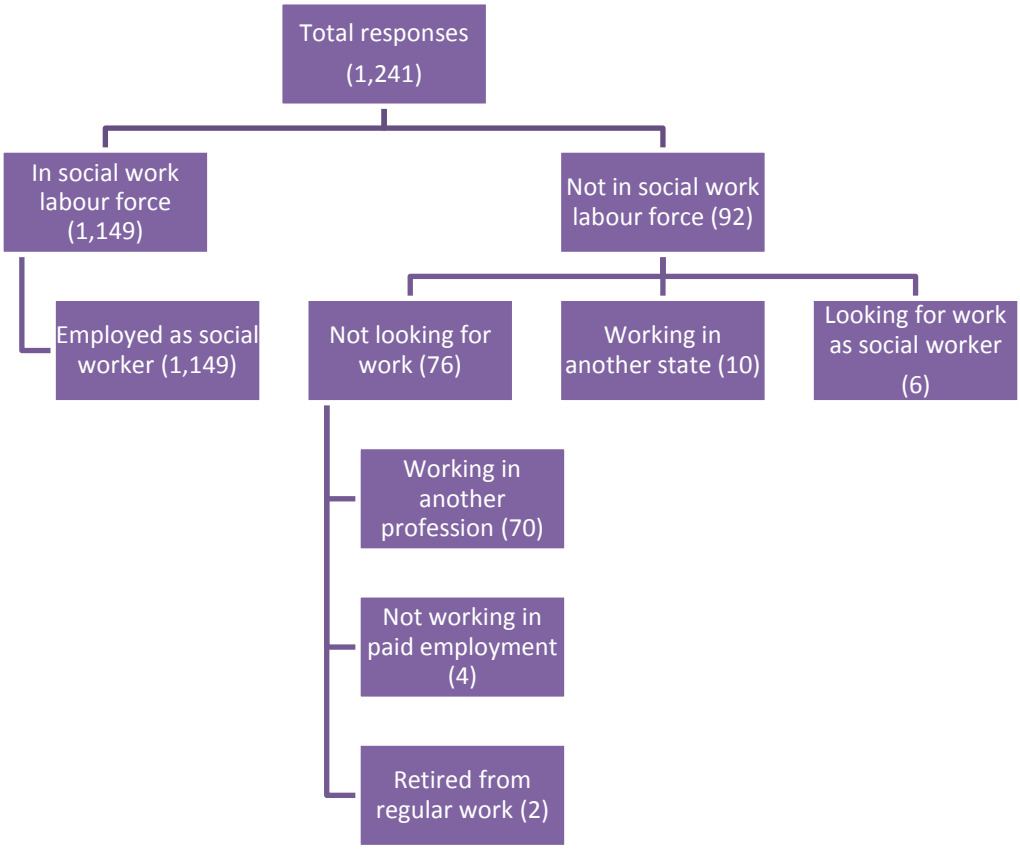
The AHWQ2 survey consisted of 53 questions or opportunities for the respondent to comment. Completion of the survey was voluntary and respondents had the opportunity to choose if they wished to answer a question or not. Some of the questions were conditional on the response to previous questions. Some questions allowed for multiple answers. As a result, the number of responses for each question varied and is included in the presentation of the data for each question.

A total of 1294 social workers completed at least one question on the survey and submitted their survey. The range of responses to an individual question was from 975 to 1562. Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not.

A total of 448 respondents (35%) provided their email address and agreed to be followed up for further research.

Most respondents (93%) were employed in the social work workforce in Victoria at the time of completing the survey.

Figure 1: Current Employment Status[5]



[5] All data in Figure 1 and Tables 1 – 6 comes from AHWQ2 survey

Table 1: Scope of practice

Scope of practice	n	%
Participants reporting their work includes an advanced practice role	164/1056	16%
Participants who delegate to allied health assistants	191/1060	18%
Participants who use telehealth (including video conferencing for supervision)	52/1060	5%

Table 2: Hours of paid work in each sector per week (main role)

Role	n	Min	Max	Average	Standard Deviation
State (Victorian) Public Sector, including health and school education (including TAFE but excluding universities)	726	8	48	33	8
Commonwealth Public Sector	62	10	43	33	9
Local Government / Council	11	31	40	37	3
Private practice (as an employee / subcontractor)	5	10	30	23	7
Private practice (I am the business owner)	5	8	30	19	7
Large private provider (e.g. private hospital)	9	20	40	34	7
Not for profit	157	8	44	33	7
University / higher education	15	5	45	27	13
Aboriginal Controlled Community Health Service	0	0	0	0	0
Other	16	19	48	35	8

Table 3: Qualifications held or currently studying (n=1,147)

Qualification	Current qualifications	Currently studying	First qualification to practise
Certificate III	46	2	3
Certificate IV	140	9	6
Associate diploma	86	2	20
Advanced diploma	61	5	16
Bachelor degree	1015	6	812
Honours degree	158	5	61
Graduate certificate	137	14	7
Graduate diploma	202	15	21
Master's degree - Graduate entry	161	5	140
Master's degree - Clinical	173	48	56
Master's degree - Management (e.g. MBA)	40	9	1
Master's degree - Research	52	20	4
Professional doctorate	2	1	0
PhD	24	21	0