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Institute of Child Protection Studies

Authors:

Erica Russ
Louise Morley
Mark Driver
Bob Lonne
Maria Harries
Daryl Higgins

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AUTHORS

Dr Erica Russ, Senior Lecturer & Director of Field Education, Social Work and Community Welfare, Faculty of Health, Southern Cross University

Dr Louise Morley, Lecturer in Social Work, School of Health, University of New England

Mark Driver, Research Assistant, School of Health, University of New England

Adjunct Professor Bob Lonne, School of Public Health and Social Work, Queensland University of Technology

Associate Professor Maria Harries, Population and Public Health, The University of Western Australia; Adjunct Professor, Curtin University

Professor Daryl Higgins, Director, Institute of Child Protection Studies, Australian Catholic University

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The Institute of Child Protection Studies (ICPS) at the Australian Catholic University aims to enhance outcomes for children, young people and families through quality research, evaluation, training and community education. ICPS research strengths include promoting children's participation, strengthening service systems and informing practice, and supporting child-safe communities.

Email: icps@acu.edu.au
Web: www.acu.edu.au/icps
Phone: (02) 6209 1228
Twitter: @ACU_ICPS
LinkedIn: https://www.linkedin.com/company/institute-of-child-protection-studies/

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Foreword

This report presents findings from an exploratory study that examined broad-ranging, publicly available data to investigate emerging trends, issues and needs in the child welfare workforce and the educational profile of this workforce. The research project itself stemmed from an awareness of the multifaceted changes required for implementing a public health approach to child protection in Australian jurisdictions alongside the escalating demands for new policies, practices and approaches to address the untenable number of children and young people, particularly Aboriginal and Torres Strait Islander children, in Australia's statutory care system (AIHW, 2021a).

The results from our study are sobering. They demonstrate the significant hurdles that need to be overcome before change can happen. That change encompasses a well-prepared, educated and supported child welfare workforce that can effectively deliver the preventative strategies and support programs necessary to reduce the prevalence of child abuse and neglect in Australia.

The public health framework outlined in the *National Framework for Protecting Australia's Children 2009-2020* (hereafter *National Framework*) (Council of Australian Governments [COAG], 2009) presented a long-term plan based on public health principles, to improve the safety and wellbeing of Australia's children and young people. The *National Framework* highlighted the significance of developing primary universal services, and secondary services with early intervention capacity aimed at child safety and wellbeing. It also highlighted prevention strategies to support families and communities. These services could reduce the over-reliance on existing tertiary tier interventions offered to children, young people and their families experiencing adversity, disadvantage and lacking in skills to promote safety and wellbeing of their children.

The *National Framework* plan provides an exemplary model for framing work that ensures the safety and wellbeing of children and young people in the context of a whole-of-community and government responsibility. The plan positions tertiary tier protective intervention as an important but last resort. This analysis uses data that correlates to the period 2009-2020, but we acknowledge that actions to be agreed under the *National Framework for Protecting Australia's Children 2021-2031* might go part of the way to address some of these issues.

People working with a focus on child safety and wellbeing deal with some of the most complex issues within the community service sector. Embedded within this complex

landscape are the highly sensitive and emotional worlds of families, their cultures and their communities. These contexts all influence very personal approaches and abilities of families concerning the care and wellbeing of their children and young people.

Many of the decisions that workers need to make involving vulnerable children, young people and their families can comprise extremely complex situations involving multiple stakeholders. The decisions can be ethically fraught and emotionally challenging, demanding a high level of knowledge and skill. To support workers in ensuring the safety and wellbeing of children and young people, all organisations that offer services to vulnerable children and families, directly or indirectly, need to be able to attract, recruit and sustain a reliable and appropriately qualified and skilled workforce. Such a workforce needs broad-ranging community support networks, formal and informal, with capacity to introduce efficacious prevention strategies and interventions.

Staff already engaged in tertiary tier formal child protection interventions also need skills development to ensure children's personal security, safety and wellbeing. An effective system of evidence-based supports for families and earlier interventions requires an integration of programs and services across the primary, secondary and tertiary tiers.

Terms used in this report

Child welfare

Consistent with the spirit of the public health approach outlined in the *National Framework*, the term ‘child welfare’ is used in this report to refer to practices at all points of the child safety and wellbeing continuum, including:

- the practice of preventing child abuse and neglect, which occurs within any organisation that delivers services to children, young people and their families, either directly or indirectly
- early intervention services that aim to reduce the risk of harm occurring
- the statutory services that are needed for investigating and responding to concerns about the abuse and neglect of children and young people.

Child welfare workforce

Similar to the use of the term child welfare, the term ‘child welfare workforce’ is used to relate to all the professional and support roles, including helpers, carers and administrators, within government and non-government organisations (NGOs). From a public health perspective, all are involved in ensuring the safety and wellbeing of children and young people. From this perspective, the child welfare workforce includes:

- primary care workers who have a shared responsibility in preventing the occurrence of child abuse and neglect
- early intervention workers, family support workers and youth workers who may be employed by NGOs
- a range of workers with different qualifications employed by statutory departments.

We see all those people on this workforce continuum as having equally important roles to play in ensuring the safety and wellbeing of children and young people. Those carrying out primary or prevention work need to be skilled in identifying the signs and risk factors of child abuse and neglect, and those working in statutory departments need to be able to investigate and respond to concerns reliably and effectively. All workers need to be able to engage with families in non-stigmatising ways and to work collaboratively with other members of the workforce as well as families and communities (Higgins et al., 2021).

It is important to note that because child welfare in Australia falls within the jurisdictional responsibility of the states or territories, technically there are many separate workforces that

will need to engage in this work. Within the spirit of the *National Framework* however, we use the term workforce to refer to all community or human service workers who have responsibility for ensuring the safety and wellbeing of children and young people in Australia.

Government departments

The term 'government department' is used to refer to any government agency that has responsibility for the safety and wellbeing of children and young people. This includes:

- statutory departments that are responsible for investigating and responding to concerns about child abuse and neglect
- other departments that may not play a statutory role, but are nevertheless responsible for the safety and wellbeing of children and young people from a public health perspective, including health, education, law enforcement and housing.

Statutory child protection systems

Statutory child protection systems incorporate the state/territory statutory departments and services responsible for assessing and responding to notifications and reports of harm/risk of harm, and the agencies to which families, children and young people are referred for services. They provide involuntary services to children, young people and families, as well as voluntary services and assistance as guided by the legislation in each jurisdiction.

Industry

This term is used where it relates to Australian Bureau of Statistics (ABS) data consistent with their terminology which is predominately linked to the broader category of health, care and social care.

Non-government organisations

The term non-government organisation (NGO) is also used broadly to refer to organisations within the non-government sector which, for the most part, provide voluntary, non-statutory services to vulnerable children, young people, and their families. They may also provide statutory services, particularly therapeutic and out-of-home care services. These include for-profit organisations, not-for-profit organisations, as well as community cooperatives, and social enterprise organisations.

Executive summary

Until recently, there has been limited focus on the nature and readiness of the broader child welfare workforce for stronger engagement in child abuse intervention and prevention, particularly the universal workforce. There is a concentration of effort and funding in the tertiary sector but there are now increasing calls to prioritise public health prevention.

An effective system of family supports, and early interventions entails an integration of programs and services across the three tiers of a public health system: primary, secondary and tertiary.

To support workers in ensuring the safety and wellbeing of children and young people, all organisations that offer services to vulnerable children, young people and families—directly or indirectly—need to be able to attract, recruit and sustain a reliable and appropriately qualified and skilled workforce.

This report presents findings from an exploratory study that examined broad-ranging, publicly available data to investigate emerging trends, issues and needs in the child welfare workforce and the educational profile of the workforce.

We investigated emerging workforce trends, issues and needs stemming from multifaceted changes. We also scoped the contemporary and future workforces needed to implement efficacious prevention strategies and interventions that can ensure children's and young people's personal security, safety and wellbeing, and facilitate the development of family and community formal and informal support networks. In addition, we examined the enrolment and graduation rates of higher education programs in relevant qualifications such as social work, psychology, and community services, and their capacity to prepare the workforce with the skills, knowledge and values required for the future. In the analysis, we considered the societal and institutional orientations, processes and outcomes that affect workforce capabilities, development needs and capacity.

In concluding, we evaluated the readiness of the workforce in child welfare to implement the core public health principles of the *National Framework for Protecting Australia's Children 2009-2020* (Council of Australian Governments, 2009). We identified numerous impediments to re-tooling the workforce to be capable of implementing the required early intervention and family support programs, and community development strategies, within an integrated system of prevention.

Methods

Conducting our evaluation was challenging because there is no clear-cut state or federal workforce data category that defines the child welfare workforce. This was especially problematic for this project because we conceptualised the workforce to include all three tiers of the public health model: primary, secondary and tertiary. For this reason, the methods we adopted were multi-tiered.

To understand the primary tier workforce, we looked at growth in numbers of appropriately skilled and/or qualified people employed in the broader health and social care sector.

For the secondary service tier, we looked at NGO expenditure and activity data, captured either from the Australian Charities and Not-for-Profits Commission (ACNC) database or the Office of the Registrar of Indigenous Corporations (ORIC) database, as national data bases, supplemented by data from self-service employment websites (i.e., SEEK and Ethical Jobs) that advertise child welfare positions.

The tertiary tier was evaluated mostly from Australian Bureau of Statistics (ABS) data and from data obtained from state and territory statutory child protection agencies, law enforcement agencies, and health and education departments—most of which have designated child welfare staff.

These were supplemented with data and information from the following sources:

- workforce surveys
- profiles
- targeted studies
- media articles that reported on staff experiences
- the experiences of the project team members
- parliamentary documents
- studies examining the effectiveness of collaboration and information sharing between agencies
- the Productivity Commission's annual Report on Government Services and associated data on worker ratios and spending.

Results

Our findings suggest that the tertiary component of the child welfare workforce within jurisdictional statutory welfare agencies are predominantly tertiary-qualified. However, there was limited opportunity for more extensive and detailed workforce analysis, including the tertiary tier, for the following reasons:

- absence of coherent and relevant workforce databases
- overlapping of roles within organisations and government departments
- absence of specific required qualifications for staff holding dedicated child welfare roles within statutory welfare departments and for those roles that have a child welfare focus in other primary and secondary tier services such as education, health and NGOs.

These limitations demonstrate that further research is necessary to gain a more detailed analysis of Australia's workforce readiness for fully implementing a public health approach to protecting Australia's children and young people. However, from our analysis we were able to determine the following staffing challenges:

- The workforce in the primary tier is very broad and there is limited data on child welfare responsibilities and roles, so it is difficult to precisely determine the capacity and capability to transition to public health approaches in this tier.

- The trends suggest that the number of frontline child welfare workers in the child welfare sector statutory child protection system has steadily increased; this is likely to continue to grow to meet the increasing demand, along with demand in other sectors defined by the ABS category of Heath Care and Social Assistance.

- The tertiary workforce continues to dominate the child welfare landscape with little attention offered to the important role that the primary and secondary tiers have in ensuring the safety and wellbeing of children and young people.

- The workforce in the tertiary tier is relatively younger than the workforce in the primary and secondary tiers.

- The workforce within the primary and secondary tiers is ageing. This is problematic for many reasons but, from a best practice perspective, it means without an adequately qualified or skilled replacement of this workforce, in the future less

experienced workers will be providing direct services to families with complex issues without the guidance and direction of a more experienced staff member.

- The diversity of the workforce is not consistent with the population trends. Given disproportionate representation of some population groups such as Aboriginal and Torres Strait Islander children and children with a disability subject to tertiary child protection intervention, this poses a challenge in providing services responsive to diverse populations.

- Workforce turnover and retention has been a longstanding issue in child welfare, particularly the statutory context. High proportions of the tertiary tier workforce leave these positions within the first few years, many transitioning to find employment in related non-statutory child welfare jobs in the secondary and primary tier services.

- There is a high level of casualisation in some of the categories that make up the child welfare workforce.

- Many staff working in the primary, secondary and tertiary services are inadequately prepared for the complex and skilled work required to recognise and assess risk of harm of child abuse and neglect, notwithstanding that the tertiary workforce has high levels of bachelor-qualified staff.

- The workforce across all three tiers is overrepresented by female workers.

Overall, we conclude that the child welfare workforce in Australia cannot be easily defined or quantified owing to significant gaps in data and the lack of consistent data sets across jurisdictions, especially for the secondary and primary tiers.

Implications

These results point to some serious issues in relation to the preparedness for the child welfare workforce into the future, especially in the context of implementing a public health approach.

- Without a clearly defined and quantified workforce grounded in consistent reporting regimes in and across all jurisdictions for primary, secondary and tertiary tiers of the child welfare sector, it is not possible to plan and develop a workforce that will be effective in meeting the growing demand for prevention services and programs, and upholding best practice principles.

- A tertiary approach to child welfare alone is not currently sustainable in terms of preventing child abuse and neglect or minimising its occurrence. A continued focus on resourcing the tertiary tier at the expense of the secondary and primary tiers, will undoubtedly undermine the efforts already made to honour and implement a public health approach to child welfare in Australia.

- It is not sustainable to maintain high numbers of unsuitably qualified staff who are unable to recognise and respond to the complex nature of child abuse and neglect, especially in the primary and secondary tiers. Not only does this deficit have serious implications for vulnerable children, young people and their families, it also contributes to staff burnout and, thus, workforce retention.

- The under-representation of men in the child welfare workforce has the potential to perpetuate the gendered perception that child welfare work is ‘women’s work’ and, hence, perhaps less worthy of research and development and resources. This has the potential to further jeopardise the implementation of the public health approach.

- The lack of diversity in the workforce has implications for the provision of services that are appropriate and responsive to the needs of diverse populations of children and families that are disproportionately represented in child welfare systems

- Insufficient focus on skill development of the workforce in all tiers jeopardises the consistent provision of high-quality professional supports. Staff who work in primary tier services and who hold child welfare roles and responsibilities require greater direction and support to develop their skills for prevention strategies with vulnerable children, young people, families and communities. Developing a suitably qualified workforce across statutory organisations as well as a range of other organisations within the health and community service sector remains a significant issue.

- The high levels of staff turnover have a negative impact on the quality and consistency of prevention and support services.

- The higher levels of casualisation in some categories has the potential to create instability and thereby impact negatively on the overall workforce development and service quality and consistency, especially in the primary and secondary tiers.

This report draws attention to the significant workforce issues that impede the successful transition to a public health model in child welfare in Australia. It also reveals the paucity of comprehensive data about the contemporary Australian child welfare workforce, as well as the continuing stressor of worker turnover in a system that continues to focus on the tertiary tier of services. Children who are or risk becoming vulnerable, and parents who deserve better support and prevention/early intervention services, will miss out unless we resolve these data gaps and address the staffing challenges.

Background

Child welfare systems are in various states of crisis worldwide (Herrenkohl et al., 2019). Scandals, tragedies, formal inquiries and sensationalised media scrutiny draw attention to failings. Such negative attention influences policy (Lonne & Parton, 2014). This situation is coupled with a loss of public and political faith in the ability of child welfare systems to meet the social goals of preventing child abuse and neglect, and providing timely, accessible support to vulnerable children and young people and struggling families (Higgins et al., 2019; Lonne et al., 2021; Parton, 2020).

Statutory child protection systems are the state agencies responsible for assessing and responding to reports of children harmed or at risk of harm. These agencies are the main point of referral for concerns regarding families, children and young people. State departments and their budgets have grown substantially due to rising demand for services (Productivity Commission, 2019), and growing numbers of children entering into—and remaining in—out-of-home care (Australian Institute of Health and Welfare [AIHW], 2021a). Statutory departments are continually changing on many fronts including organisational structure, legislation and policy (Lonne & Parton, 2014). They are also constantly evolving in professional practice to accommodate the concepts of risk management and increased legalism and proceduralism (Higgins et al., 2019).

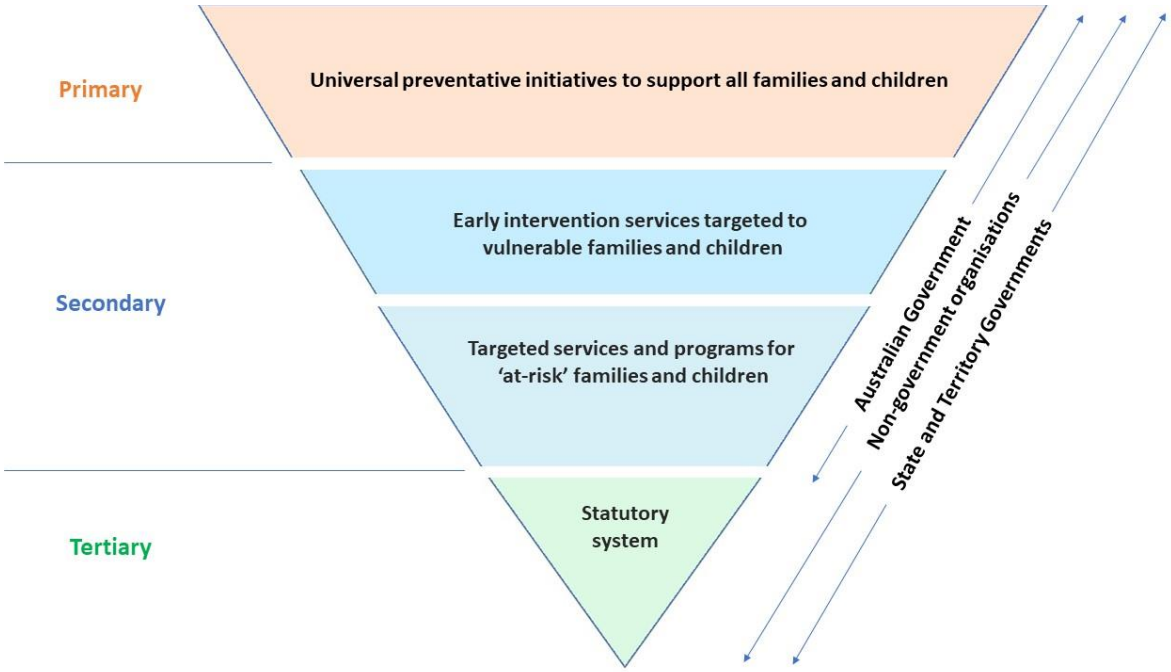
A premise of the *National Framework,* endorsed by COAG in 2009, was that the statutory child protection systems should move towards a public health approach focused on prevention and early intervention. This system reform aimed to incorporate a shared responsibility across the whole community service sector and across the broad community, and to be applied consistently across state borders. The model proposed by the *National Framework* (COAG, 2009) had three tiers:

- Primary: focused on preventing child abuse and neglect within the broader community
- Secondary: focused on targeted programs that aim to prevent child abuse and neglect in matters where there is an identified increased risk of child abuse and neglect
- Tertiary: focused on investigating and responding to notified cases of suspected child abuse and neglect.

Such an approach promoted a shared responsibility where government and NGOs work together to ensure the safety and wellbeing of children and young people. In the *National Framework*, this shared responsibility was represented with a pyramid that outlined each sector and the roles in relation to the state and federal governments and the NGO sector. Primary services, being universal and broad in scope, were represented at the bottom of the pyramid, with secondary being more targeted and in the middle, and tertiary services, which have a narrower remit, were represented at the top.

However, from a public health perspective, the investment and responsibilities should ideally be the reverse, as illustrated in Figure 1 below.

Figure 1: A public health approach to protecting children and young people



Source: Adapted from the National Framework (COAG, 2009, p. 8)

Despite this ideal, the reality in Australia continues the original trend of stronger investment in child safety and wellbeing through the statutory (tertiary) systems with less focus on developing a population-level (primary) prevention investment approach. Much of the investment in child safety and protection of children and young people is at the level of tertiary responses—where risk of harm has escalated to significant levels, or where harm has occurred. There is much smaller investment in intensive secondary services to reduce risks, or primary prevention strategies at the whole-of-population level as is suggested under a public health approach. Yet ARACY/Allen Consulting (2008) demonstrated through their national consultations with key stakeholders that this pyramid with tertiary services as the apex and focus of the child welfare system was the reality then. According to the evaluation

of the *National Framework* by PricewaterhouseCoopers [PwC] (2020), this remains the case 12 years later.

The *National Framework* was aspirational in that it endorsed a best-practice approach to ensuring the safety and wellbeing of all Australian children and young people. In this context, best practice means responding to concerns about child welfare in ways that are appropriate to vulnerable children's individual circumstances and that are also sensitive to family, community and cultural context. It moves away from a 'one-size-fits-all' approach to protecting children and young people, towards a differential response (Waldfogel, 1998). Agencies that apply a differential response in the triaging process recognises variation and diversity among families, children and young people. To achieve the stated aim of ensuring the safety and wellbeing of all Australian children and young people would require deep and fundamental change within the whole community service sector. It demands a move away from siloed thinking within government departments and organisations towards a more collaborative and holistic way of working at all levels within government hierarchies and all NGOs that provide services, either directly or indirectly, to vulnerable children, young people, their families and communities.

This planned transition towards prioritising public health prevention approaches to ensuring the safety and wellbeing of children and young people is consistent with proposed changes in many other Organisation for Economic Co-operation and Development (OECD) jurisdictions internationally (Herrenkohl et al., 2019; SPERU, 2016). It is also mirrored in increased focus in health systems on the social determinants of health. Health systems that are based on public health approaches provide a potential allied approach to children's and young people's safety and wellbeing (Chung et al., 2016). In addition, the United Nations Sustainable Development Goals also draw on social determinants of health through engagement with public health approaches to addressing community disadvantage and enhancing child wellbeing (UNICEF, 2021).

Despite a comprehensive plan, which was to be staged over a 12-year period, the aim of the *National Framework* in Australia has not yet been achieved. This systemic failure through inaction has led to stakeholders expressing ongoing concerns about the narrowing focus on tertiary, statutory-based systems over the life of the plan (PwC, 2020). One of the contributing factors was the limited consideration given to the nature and readiness of the broader child welfare workforce for stronger engagement in child abuse and neglect intervention and prevention, particularly the universal workforce. Instead, as with many other elements of *National Framework*, there continued to be a concentration of effort and funding in the tertiary sector. Recent evaluation reports (Families Australia, 2020; PwC, 2020) draw

attention to this workforce issue, suggesting the successor plan needs to "further develop the capability of the cross-sectoral workforce to strengthen protective factors and address adverse childhood experiences" (Families Australia, 2020, p. 20).

The successor strategy to the *National Framework* was launched in late 2021, titled *Safe & Supported: The National Framework for Protecting Australia's Children 2021 - 2031* (Commonwealth of Australia, 2021). Although this new framework acknowledges the need to "prioritise prevention and early intervention, with child protection services as a last resort" (p. 31), it no longer claims to be based on a public health approach, and instead is focused on targeted services and strategies for higher-risk priority groups, not population-wide public health strategies.

Other studies into the child welfare workforce (admittedly only relatively few have been conducted) further support this report by suggesting that while the number of statutory workers engaged in the front line of child welfare has increased (Bromfield & Ryan, 2007; McArthur & Thompson, 2012), a suitably qualified workforce across a range of organisations within the health and community service sector remains a significant issue (Lonne et al., 2020). Several commentators have suggested that those with social work qualifications are well suited to fulfilling these varying roles (Healy & Lonne, 2010). However, owing to funding constraints and the casualisation of the workforce more generally (AIHW, 2021b), many of the positions relevant to child welfare work are not remunerated in a way that would attract qualified social workers or those with a Bachelor level qualification in a similar field (Lonne et al., 2020).

In addition, there are significant workforce issues concerning staff recruitment, professional development, supervision, and retention (Healy & Lonne, 2010) with workplace stress figuring prominently amongst staff in these statutory systems (Russ et al., 2009; Russ et al., 2020), many of whom are social and community services workers with varying levels of skills and training (Lonne et al., 2012). Trends of an ageing workforce are likely to further exacerbate these pressures (Howard & Williams, 2017).

Another issue that has received little attention is diversity within the child welfare workforce. This is significant given that Aboriginal and Torres Strait Islander Peoples comprise approximately 3.3% of the overall population (AIHW, 2020a) and are disproportionally represented in the child welfare statistics (AIHW, 2021a). Similarly, people with disabilities comprise approximately 18% of the population (AIHW, 2020b), and children with a disability and children of parents with a disability are also disproportionally represented (see for example Ziviani, Darlington, Feeney, Meredith and Head, 2013; Lima, 2022). In addition,

approximately 20% of Australia's population are from non-English speaking backgrounds and speak a language other than English in the home (AIHW, 2018).

Given these shortfalls in the potential staff pool, as well as ongoing high growth in health and welfare employment, there is an urgent need to better understand these workforce issues. Understanding these issues can help us prepare for the successful implementation of a public health approach to prevention and early intervention and to promote the safety and wellbeing of all children and young people.

This study builds on prior Australian human services workforce and education research and analysis (e.g., Healy & Lonne, 2010; Lonne, 2016; Martin & Healy, 2010), by investigating emerging workforce trends, issues and needs stemming from these multifaceted changes. It also scopes the contemporary workforce and considers the future workforce needed to implement efficacious prevention strategies and interventions, ensure children's personal security, safety and wellbeing, and facilitate the development of family and community formal and informal support networks. Additionally, it examines the enrolment and graduation rates of higher education programs relevant to child welfare work, such as social work and psychology, and their capability to prepare the workforce with the skills, knowledge and values required for the future. Our analysis and results considered the societal and institutional orientations, processes and outcomes that affect workforce capabilities, development needs and capacity.

Aims

We used an exploratory approach to scope the Australian child welfare workforce in statutory child protection, child/family welfare, and broader education, health and community sectors. These research questions guided our study:

1. What are the characteristics and trends within the Australian child welfare workforce in statutory and community-based agencies, and the broader workforce in universal services?
2. Focusing on the overall capability of child welfare systems to meet their social aims to prevent child abuse and neglect and provide timely interventions and accessible supports to prevent and respond to emerging vulnerability in children, young people families and communities, what issues are evident:
    a) in the identified contemporary workforce trends?
    b) in the education of and preparation for the emerging workforce?
3. What are the emerging needs regarding changing child welfare program workforce requirements with particular focus upon public health approaches to prevention of child abuse and neglect?

This report uses publicly available data to provide an overview of the existing workforces, and their capacity to respond to a shifting focus towards public health approaches and challenges, including identifying and building capacity in preventative responses.

Methodology

In this section we outline the framework used for identifying and analysing the data we collected, as well as the methodologies used in the different public health tiers for data collection.

Our framework

To meet the requirements of a scoping study, we used a quantitative archival approach (Das et al., 2018) to examine and analyse various large publicly available data sets. This approach allowed us to provide a detailed description of the current formal child welfare workforces and the related vocational and professional education programs relevant to these workforces. The research team collected workforce data that addressed the research questions about the three-tiered public health approach, and then examined aspects of the workforce in each of the tiers.

We did not use sector-based surveys, which have been a feature of scoping studies in the past (see for example, Martin & Healy, 2010). Such surveys typically have relatively low response rates and lack of comparability between service providers. Instead, we used a substantial body of information that is now publicly available in document form and through self-serve data portals.

Once we identified relevant data sets consistent with archival methods (e.g., Das et al., 2018; Lucko & Mitchell, 2010), we gathered quantitative data about the size and nature of workforces and trends compared to earlier analyses (particularly by Healy & Lonne, 2010). From here, we undertook a secondary analysis of the data (Cheng & Phillips, 2014) that enabled us to provide a detailed description of the current child welfare workforces and their related vocational and professional education programs. This analysis was undertaken in three phases, each phase reflecting the three-tiered public health approach (primary, secondary, tertiary (see Figure 1) and aspects of the workforce in each of the tiers. To a large extent, the use of existing datasets meant that large-scale industry consultations were unnecessary (McArthur & Thompson, 2012).

This analysis was supported by data mining methods (Lucko & Mitchell, 2010) to enable a greater depth of analysis and identify patterns and trends. Data mining was guided by a matrix that was adopted and developed on what appeared to be ‘standard’ and ‘recommended’ service models within the statutory system as a consistent starting point. This informed the identification and analysis of relevant data and allowed us to complete estimates for workforce numbers across Australia. Such a matrix is reflective of the

structures and approaches within tertiary service agencies in response to the recommendations made in many of the formal and judicial inquiries that have been conducted in relation to child protection systems.

This project required the grouping of occupations to reflect the various roles of workers associated with child welfare service delivery (see Table 1 below). The process involved grouping occupations described under the Australian and New Zealand Standard Classification of Occupations (ANZSCO).

Table 1: Occupation groups

Project grouping	Services provided to clients	Examples
Helpers	Therapeutic, advisory, advocacy, counselling	Social Worker, Welfare Worker, Psychologist
Carers	Assist in meeting day to day needs of clients	Special Carer, Child Carer
Nurses	Nursing related	Nurse, Midwife
Administrators	A stable and efficient client focussed service	Manager, Receptionist, Clerk
Supporters	Physical infrastructure maintained and usable, provision on food and basic assistance	Cook, Cleaner, Repair person Bus Driver
Specialist helpers	Addressing clients' special needs, includes allied health workers and other professionals	Physiologist, Occupational Therapist, Dentist, Financial Advisor, Education Specialists

In addition, we created a matrix informed by the Victorian State Government's (2022) model that exemplifies such a structure (see Table 2 below). Essentially, this matrix model ends with front-line 'Caseworkers', whose undergraduate degrees offer entry into the statutory system. These caseworkers hold the primary responsibility for direct intervention with children, young people and families. Promotion to the immediate higher levels of responsibility is often dependant on experience and agency demand. Further promotion can be to either managerial or specialist practice support roles. The model also recognises that 'Caseworker Support' roles commonly exist below the 'Caseworker' level in these structures, often staffed by people holding vocational qualifications. These support workers may also undertake direct work with children, young people and families under the guidance of a caseworker. Many secondary services have a similar structure, with less qualified and experienced staff responsible for providing direct services to vulnerable and at-risk families.

Table 2: Victorian Statutory Child Protection Workforce structure and roles

Victorian Public Service	Job title	Organisational role
CPP-6.2	Operations manager	Responsible for management and oversight of all aspects of divisional child protection operations-including strategic directions, workforce, operational decision making and review, quality assurance and performance monitoring.
CPP-6.1	Area manager/Area manager (regional services)	Provide strategic leadership across the area-including local service planning, ministerial briefings, stakeholder engagement, and operational management across the local child protection catchment (financial, some budget, HR and performance management). Responsible for supervising area team managers, practice leaders and deputy area managers
CPP-6.1	Deputy area manager	Responsible for assisting the area manager in regional operational management. Provides leadership in local service planning and stakeholder engagement. Directly supervises the team managers and practice leaders in the local area.
CPP-6	Principal practitioner	Provide peer support and practice guidance resources for divisions. Carry a case load commensurate with their other duties.
CPP-5.2	Practice leader	Report to area managers and undertake co-work, mentoring, live supervision of CPP-3, -4 and -5 staff and supervision of community-based advanced CPPs. Carry a case load commensurate with their other duties, and are responsible for quality auditing, capability development, case practice and case planning guidance.
CPP-5.1	Senior child protection practitioner (court officer)	Assist CPPs at court with legal advice and facilitate court skills training. The role does not involve formal supervisory responsibility, but does provide live supervision, mentoring and support to CPPs at court.
CPP-5	Team manager	Reports to the area manager or deputy area manager and is responsible for leading a team of staff, comprising child protection practitioners. Has a broad range of delegations, including some budgetary and formal HR responsibilities, and endorsing statutory case planning decisions.
CPP-4	Advanced practitioner	Perform case management and other functions at an advanced level.
CPP-3	Practitioner	Entry level for child protection CPPs, with case management responsibilities.
CPP-2	Case support worker	Tasks include facilitating contact visits, transporting children and other case support duties.

Source: Victorian State Government: Health and Human Services (2022)

Data sources and sampling approaches

Across the three tiers, this study examined the emerging workforce through an analysis of enrolments, graduations and graduate destinations in university and VET system social welfare and related courses. The data sources, and therefore the analysis methods used, varied for each tier of the child welfare system. Consequently, this report discusses each tier separately. We examined the following data sets:

- ABS Census Data: 2006, 2011 and 2016 supplemented by quarterly Labour Force Survey estimates
- Child Protection Australia: national child protection annual data reports up to 2020
- State and Territory statutory child protection reporting data for 2019/2020
- Job Outlook and recruitment data
- Annual Australian University Enrolment and Graduation Statistics
- Graduate Outcomes Survey
- National Centre for Vocational Education Research (NCVER): Student Outcomes Survey
- Government department budget data.

As with the study undertaken by Healy and Lonne (2010), there were challenges in identifying and collecting relevant data to develop a coherent overview of the national child welfare workforce. A particular challenge is related to the lack of a central data set adequately describing the size, demographic profile, and dynamics of the statutory child protection workforce nationally. Although there is national reporting on statutory child protection services, there no single source of workforce data for the tertiary child protection system; each state captures their own data and reports on this differently.

To meet our aim of considering the workforce through a public health perspective, this study also sought data across:

- primary prevention universal services such as health, early childhood and school education delivered by related government departments that do not necessarily view the services as universal primary services
- secondary prevention, early intervention services, or intensive supports such as family support service agencies working with individuals or families at risk
- tertiary services that respond to suspected cases of abuse and neglect.

Similar constraints were faced associated with limited availability of data on the size of the NGO sector. Very few universal services report on their role and workforce as it relates

specifically to child welfare. Additionally, we found a lack of consistency across the various data sets in relation to the type of data collected, data reporting, data reliability, data gaps and definitions. For example, while the ABS provide useful insights generally, the data sets use generic categories such as ‘Other Social Assistance Services’ which include child welfare workers alongside multiple other types of human services work (aged care, disability, and general welfare). Another important point is that alongside the formal workforce is an informal or voluntary workforce (e.g., sporting clubs). We were unable to account for this informal workforce in this study due to the lack of a single source of child welfare sector-wide national volunteer data.

Primary tier: universal initiatives to support all families and children

We found the data for the primary tier (population-level services) significantly more difficult to identify, gather, and analyse due to the limited focus on child welfare in this tier. We were able to source some data from publicly available data collections and surveys. These focused on growth in numbers of trained people employed in the broader health and social care sector. In addition, we investigated the number of people with social welfare training who worked in occupations that deal with children, young people and families: nursing, childcare, teaching, medical practitioners. Further investigations are required to better explore this system and overcome these data challenges.

Secondary tier: targeted or early intervention services for vulnerable families and children

Secondary services are primarily provided by the non-government sector under funding arrangements with relevant state/territory government departments. NGOs are recognised as making the largest contribution (in terms of expenditure, personnel, and clients). Most funding arrangements are local to the state or territory jurisdiction. Therefore, the data sources were more varied and less comprehensive, particularly workforce data that is found in the national data sources such as the ABS and NCVER. This required a greater level of extrapolation and estimation of workforce data.

The primary source of data for this tier of the child welfare system was from the NGO expenditure and activity data, captured either from the Australian Charities and Not-for-Profits Commission (ACNC) database or the Office of the Registrar of Indigenous Corporations (ORIC) database, as national data bases. The ACNC data is reported and published annually on their website, and provides a good avenue to gauge not-for-profit (NFP) employment in the secondary child welfare sector. This database provides data for each NGO on the following factors:

- amount of income
- destination of income and amount of expenditure (including employee expenditure)
- number of full-time, part-time and casual employees
- number of full-time employee equivalents and volunteer numbers from over 46,000 registered charities.

One of the challenges involved in using this data source is that it only provides consolidated data. It does not adequately identify secondary child welfare sector entities, especially with large NFPs that provide a range of services besides welfare such as general education, general childcare, and aged care. To address this challenge, we examined self-service employment websites (i.e., SEEK and Ethical Jobs) that advertise child welfare positions. A benefit of SEEK is that it attaches various economic descriptor categories to the jobs advertised. Those categories describe general community service positions that align to a large extent with secondary child welfare sector sub-categories:

- child welfare
- youth and family services
- community development
- employment services
- housing and homeless services
- Indigenous and multicultural services.

SEEK job advertisement data were extracted periodically over several months in 2020 to form a sample that reflected the workforce in the NGO sector containing a child welfare function.

Aboriginal and Torres Strait Islander children, young people and families are overrepresented in the child welfare system, particularly the tertiary system (AIHW, 2021a). As targeted secondary services aim to prevent entry to the tertiary system, we sought data specific to this population from ORIC. This was the most appropriate data source because it identifies 3308 corporations as potential secondary tier child welfare service providers that are required to report to the ORIC annually. For the year 2020, we took a structured sample of annual reports from 167 corporations) and analysed them. One disadvantage of ORIC reporting is that it gives only a basic indication of areas in which employees are engaged (i.e., construction, health and health, arts and crafts etc.), so we estimated the persons engaged in child welfare activities through a similar process used with the ACNC data.

To supplement the above data, we examined media articles and published surveys to capture attitudes of the secondary workforce. This process included an analysis of job seeker feedback on various NFPs captured on self-service employment websites (SEEK, Indeed, Glassdoor); this feedback centred around qualified workers dropping out of tertiary tier employment to work in the secondary tier seeking a less stressful environment.

Tertiary tier: Statutory child protection systems

The current and continuing reliance on statutory child protection services allows for more accessible data within the tertiary tier. However, there were still considerable gaps and inconsistencies because reporting is focused on services delivered and outcomes for children and young people, rather than provision of accessible workforce data.

We sourced data from the ABS and from state and territory statutory child protection agencies. We also sourced data from law enforcement agencies, and health and education departments which have designated child welfare staff. This was supplemented with data from parliamentary documents (budget statements, submissions and findings of parliamentary inquiries and Royal Commissions, Statutory Departmental Reporting), media reports (where workforce data was quoted, for example, reports on inquiries or child deaths), as well as studies examining the effectiveness of collaboration and information sharing between agencies.

In Australia, out-of-home care is considered part of the statutory child protection systems, but depending on the jurisdiction, can be provided through either government statutory services or through non-government agencies under funding agreements, or both. To make up for this inconsistency, we sourced additional data sets that capture the non-government sector workforce from the section on child protection in the Productivity Commission's annual Report on Government Services and associated data on worker ratios and spending.

We overlaid tertiary child welfare data with contextual information including remuneration and qualification profiles estimated from job advertisement data. Sector workforce issues (i.e., age profile, workload, worker resilience) were identified through collating information obtained from workforce surveys, profiles, targeted studies, media articles and experiences of the project team members.

Statutory child welfare responses, particularly responses to investigations and potential criminal acts, include statements from police personnel who prosecute various child protection offenders under each jurisdiction's Criminal Code. An internet search (through an inquiry submission) yielded a description of the role and staffing of the various squads

that deal with child welfare for only one jurisdiction (Queensland Commission of Inquiry, 2013). We proceeded with the assumption that staff in equivalent roles in other jurisdictions may be deployed differently based upon the structure of their jurisdiction's police organisation. In this case, a straightforward population-based extrapolation was used to estimate national figures.

The health and education workforce also include dedicated medical and allied health department personnel attached to state health service facilities (including community health organisations) and designated education officers. We were not able to find any data sources specific to child welfare staff numbers. In cases where programs with a child welfare focus were identified, particularly in health, we estimated staffing levels based on the available data.

Analysis process

The framework for analysis was based on the purpose of the study: to scope the nature of, and trends in, the current child welfare workforce, with a view towards the implementation of a public health model. Conceptualising the workforce across the three tiers of the child welfare system had implications for collection and analysis of data. The data captured were very broad and complex to analyse so our results are primarily descriptive.

We began the scoping element of this study by examining broad workforce categories from ABS census data over the last decade (2006-2016). Child welfare sits within the ABS Health Care and Social Assistance Industry category. We acknowledge that the self-reporting nature of any census is a weakness since stated occupations do not necessarily align with the ABS definitions. However, self-identification may be a positive as it reflects how respondents saw themselves and how they aligned with specific industries and categories within these industries. In addition, we noted that the relative position of an occupation relative to other occupations seems to be fairly fixed over the time period, reflecting the general structure of welfare service delivery organisations. Due to the substantial size of the data set, nuances in individual reporting were likely to be minimal. Therefore, we concluded that census data were appropriate as an accessible and reliable time series data source. As the census data uses a 4-digit level, we developed a profile of workers using the health and social care workforce data with an analysis of the occupations by industry group from the subsets 'Other Social Assistance' and 'Other Residential Care Sectors' which are most likely to involve child welfare workers.

In line with our matrix model of staffing structures (Table 2), initial analysis of the tertiary tier workforce numbers was based on caseworker numbers and deployments posted publicly on several state/territory government websites as a performance measure. We determined qualifications and experience required for each level of the matrix from job descriptions in online recruitment processes. Where specific caseworker data were not available, we extrapolated from reported staffing numbers based on the matrix. This approach allowed comparisons between jurisdictions.

We developed our analysis of data relevant to the secondary system staffing numbers using a sample of job advertisements to profile the workforce through job-specific data (position, hours, location, and pay). The number of job advertisements in each sample that relate to child welfare was calculated as a percentage of overall jobs contained in the sample. This indicated comparability to the tertiary system matrix. The percentage of child safety workers in each NGO's sample was then applied to the corresponding ACNC data to estimate employment related numbers. An estimated allowance was made for this small, but important, NGO component.

Alongside ABS census data, we used data from health and education agencies and non-government agencies for the primary tier of the child welfare workforce. The breadth and variety of the workforce is vast and requires complex analysis. As a scoping study there was limited capacity to undertake the depth of analysis required to achieve definitive results for this section of the child welfare workforce in this study. Further work is required to better understand this section of the workforce.

Results: Understanding child welfare workforce

Disaggregated data available posed a challenge for scoping the child welfare workforce. To understand the whole child welfare workforce, we needed to take account of the broad range of contributing sectors, to make sense of the workforce across all three tiers that are made up of different categories. As already stated, many of the key positions for the safety and wellbeing of children and young people across the tiers, particularly the primary tier, are drawn from sectors not specifically identified as child welfare, such as education, and are not defined specifically as child welfare. Regardless, informed estimates can provide useful insights.

We made a broad estimate of the potential child welfare workforce and the key characteristics based on the available data (see Table 3 below). We explore these data in more detail in the following sections.

Table 3: Broad estimate of the potential child welfare workforces, by public health tier

	Primary+	Secondary^	Tertiary#	All tiers+
Number of workers	1,136,100	78,200	17,700##	1,213,900
Average age	42	43	40	42
Percentage female	76%	83%	87%	76%

+ includes practitioners only
^ includes 14,500 administration workers
 # includes 3,600 administration workers
See Table 9 for details
Sources: Australian Charities and Not for Profits Commission, Office of the Registrar of Indigenous Corporations, JobOutlook, SEEK, Ethical Jobs

The current and emerging workforce

In 2009, the national statutory child welfare workforce within the tertiary tier, including government and non-government workers, was estimated to be 10,000 (Martin and Healy, 2010). However, it has been more difficult to estimate workforce numbers across the other tiers because similar historical estimates are not available. There has been ongoing growth in demand for all three tiers of services (AIHW, 2021a), and the statutory workforce has grown in response over the past decade. There are approximately 18,000 government statutory workers in the current child welfare workforce. This excludes the non-government workers. Very strong growth is predicted across a range of child welfare related occupational groups in the next five years (Job Outlook, 2021). This may reflect the growth in the ‘Health Care and Social Assistance’ industry and workforce categories within this industry from

which the child welfare workforce is predominantly drawn, including the 'Other Social Assistance' and 'Other Residential Care' categories.

Government initiatives under the *National Framework* have also seen growth in secondary services adding to the growth in the child welfare workforce overall, with an estimated 3,400 family support workers alongside other workers in this tier (Job Outlook, 2021). To understand the broader child welfare workforce, we must look beyond statutory services to include other elements of the tertiary tier, as well as the secondary and primary tiers.

The ABS breaks down the Health Care and Social Assistance industry further into four main industry groups:

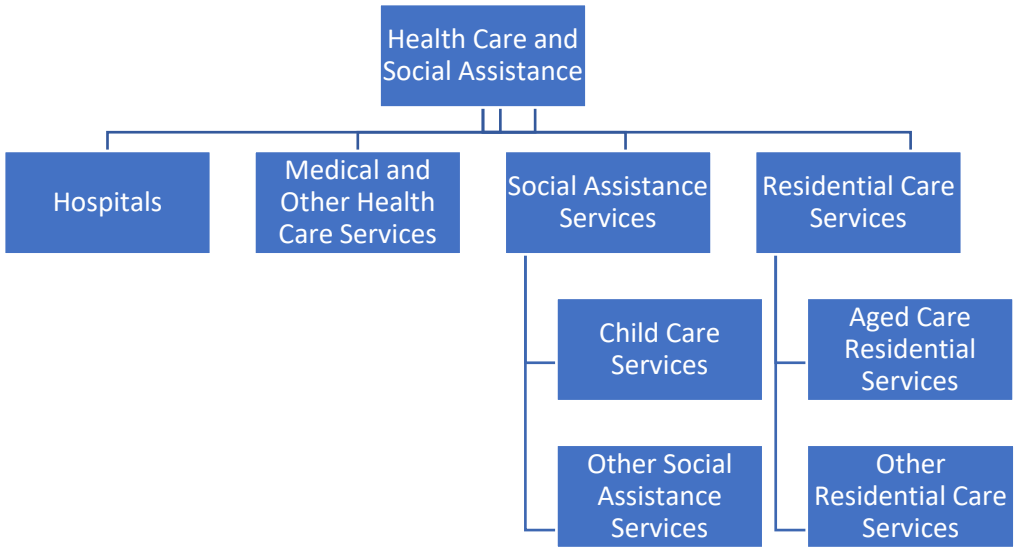
- Residential Care Services
- Social Assistance Services
- Hospitals
- Medical and Other Health Care Services.

The tertiary and secondary child welfare workforce is primarily captured in the two classes:

- Other Social Assistance Services Class (within Social Assistance Services Group)
- Other Residential Services Class located Residential Services Group.

It is also important to note a small number of tertiary child welfare workers are also captured within the Hospitals and Medical and Other Health Care Services groups. These groups include workers in the primary tier (see Figure 2 below).

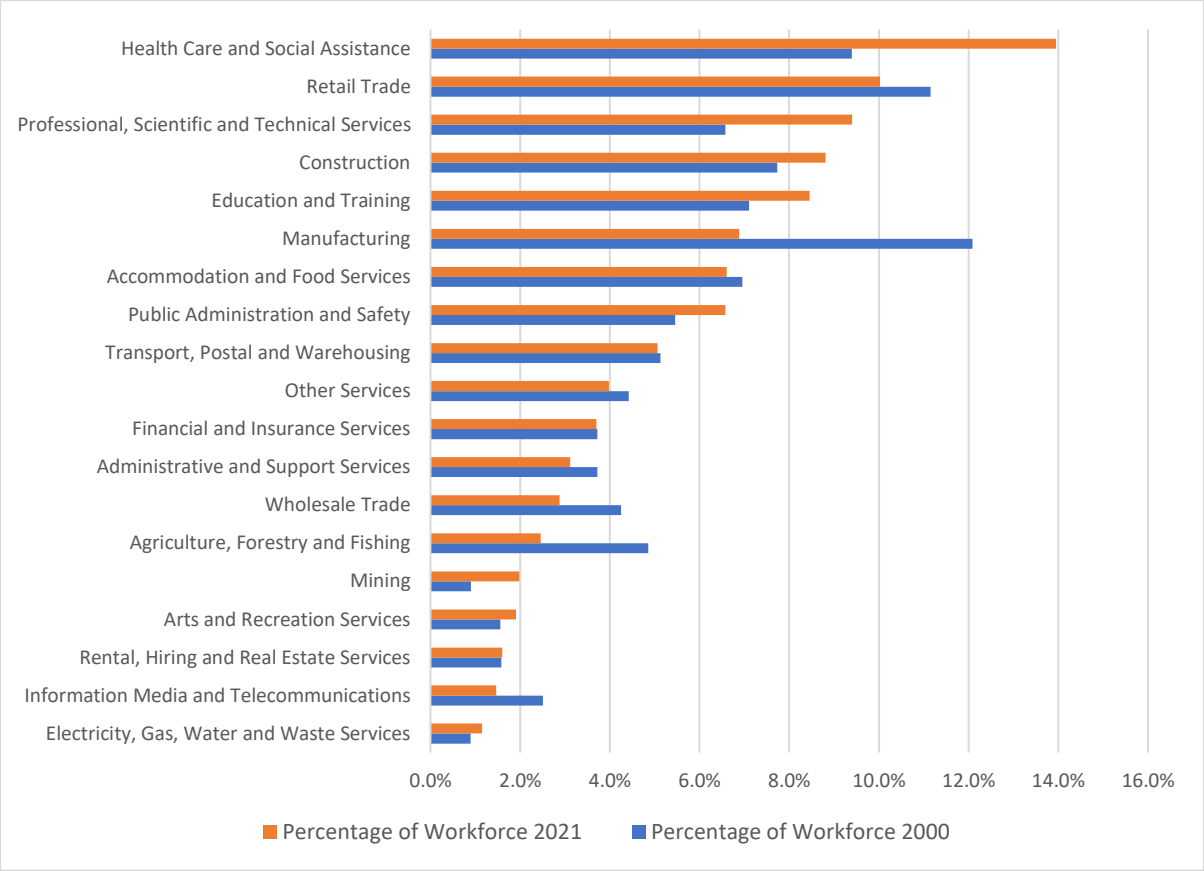
Figure 2: Health Care and Social Assistance industry sub-categories



Source: Australian Bureau of Statistics Workforce Survey (2021)

Data from the ABS Workforce Survey (2021) demonstrates that the Health Care and Social Assistance industry, that contains the child welfare workforce, had the most rapid growth over the past 20 years. It has grown from 10% of the whole Australian workforce in 2000 to over 14% of the workforce in 2021 (ABS, 2021), becoming the largest industry workforce nationally (see Figure 3 below).

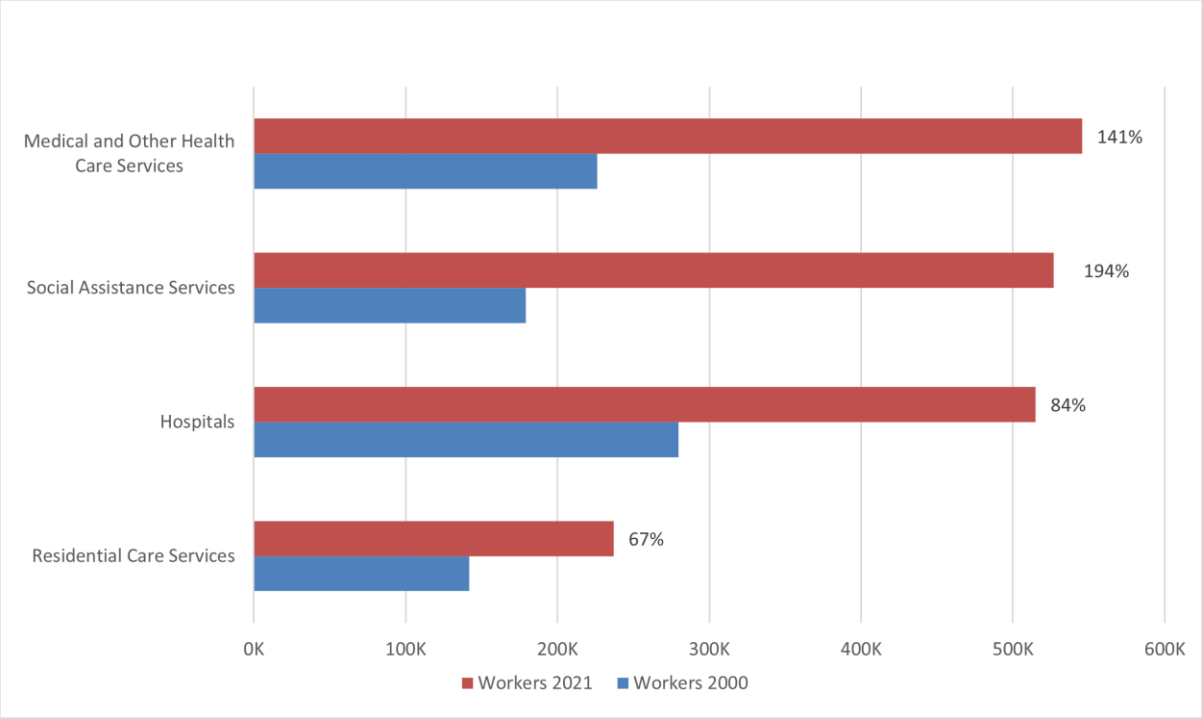
Figure 3: Workforce numbers, selected industry groups 2000-2021



Source: Australian Bureau of Statistics (2021) Labour Force

There has been strong growth across the sub-categories in the Health and Social Assistance industry over the past 20 years. The workforce in the Residential Care category has grown by 67%, from 141,800 in 2000 to 237,100 in 2021 (ABS, 2021). The Social Assistance Services category workforce has seen a greater increase of over 194% growing from 179,200 to 526,700 (ABS, 2021), outstripping the growth rate in Hospitals (84%) and in Medical and Other Health Care Services (141%) (ABS, 2021). See Figure 4 below.

Figure 4: Number of workers and percentage change in Health and Social Assistance Workforce (2000 -2021)



Source: Australian Bureau of Statistics (2021) Labour Force

This trend has led to worker numbers in the Hospital and Medical and Other Health Care Services sub-categories declining as a percentage of all workers in the Health and Social Assistance industry workforce from 61% in 2000 to 58% in 2021.

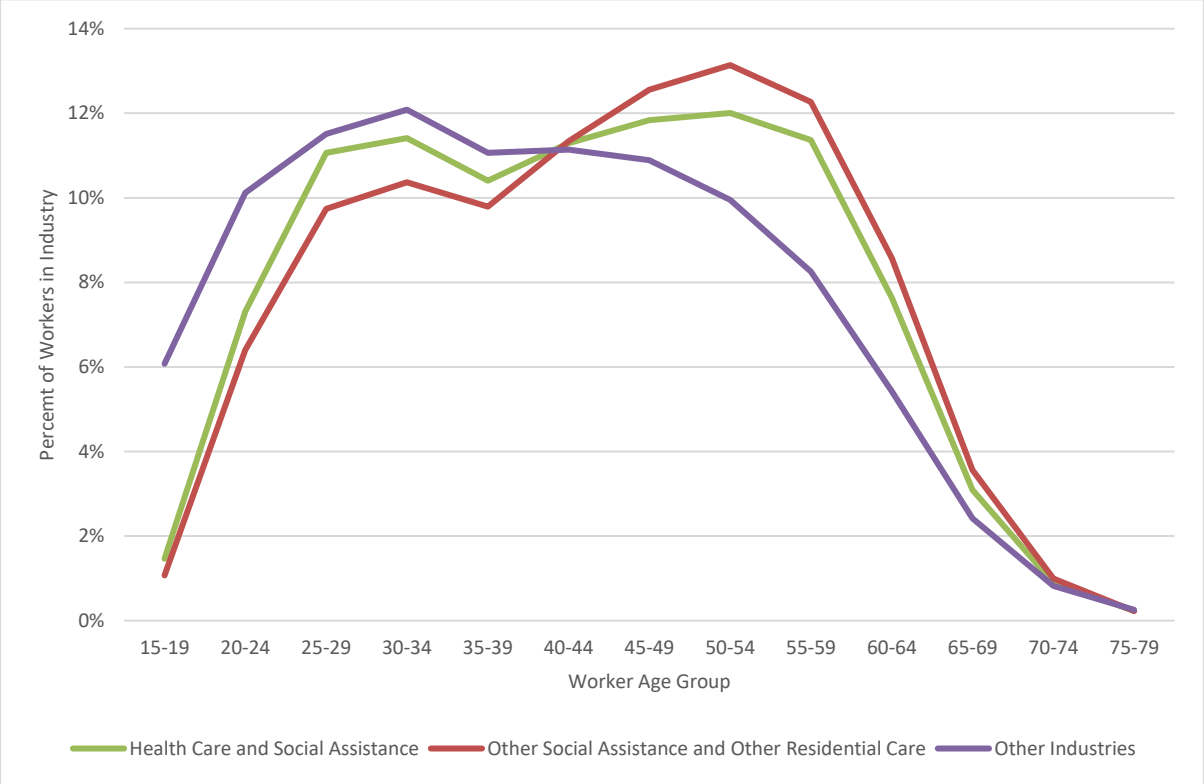
Age and gender profiles

Our analysis identified some important issues regarding the age and gender within the workforce categories, namely:

- The tertiary tier workforce was relatively younger compared to the primary and secondary tier workforces.
- We found very high proportions of women (80% and more).
- The workforce in some categories has high levels of casualisation; this has the potential to render these categories unstable and vulnerable to not providing consistent high standards and outcomes for their work with vulnerable children, young people and families.

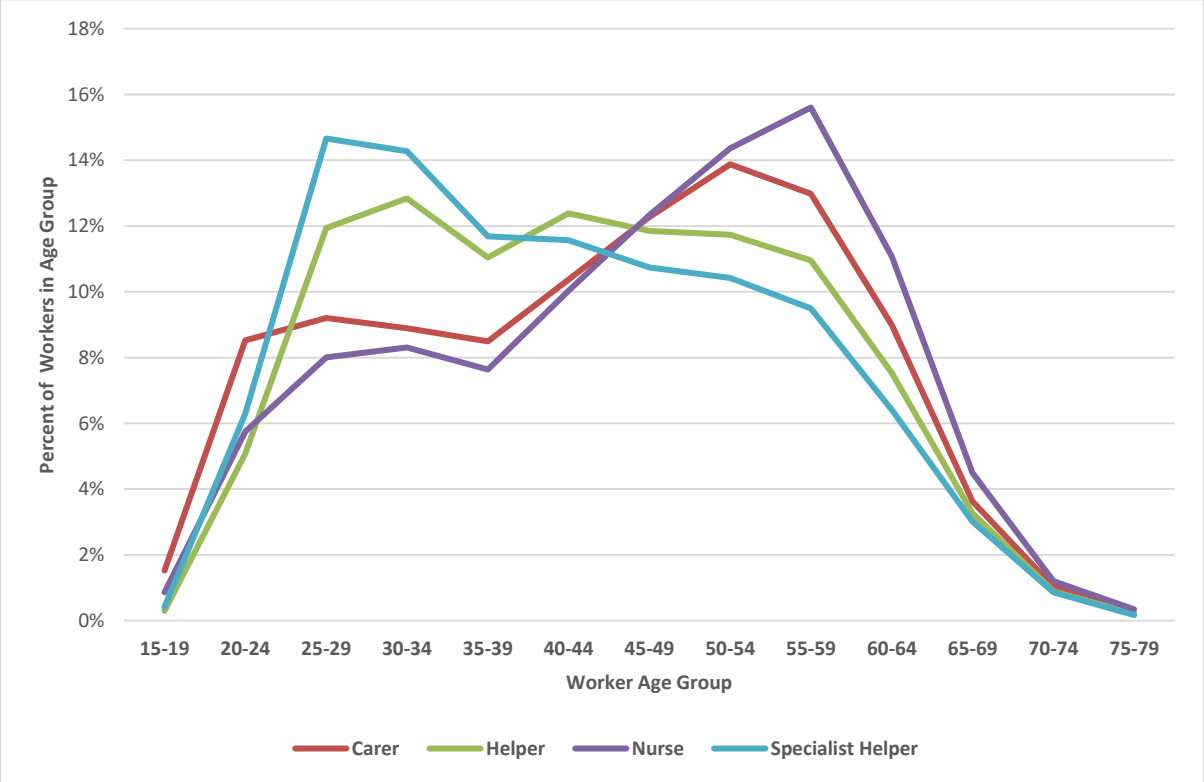
An examination of industry age profiles suggests that the child welfare workforce is ageing. The age profile of the child welfare workforce is like the ABS Census (2016) profile for All Industries. See Figure 5 and Figure 6 below.

Figure 5: Age profile for selected industries and industry groups where child welfare workers are employed



Source: Australian Bureau of Statistics (2018) Census of Population and Housing, 2016

Figure 6: Age profile of selected occupational groupings (in Other Social Assistance Services or Other Residential Services Groups)



Source: Australian Bureau of Statistics (2018) Census of Population and Housing, 2016

As would be expected with an ageing population, there is a higher proportion of older workers for the Healthcare and Social Assistance industry, particularly in the Other Social Assistance and Other Residential Care industry classes. This trend is quite evident when compared with the age profile of the remainder of the workforce.

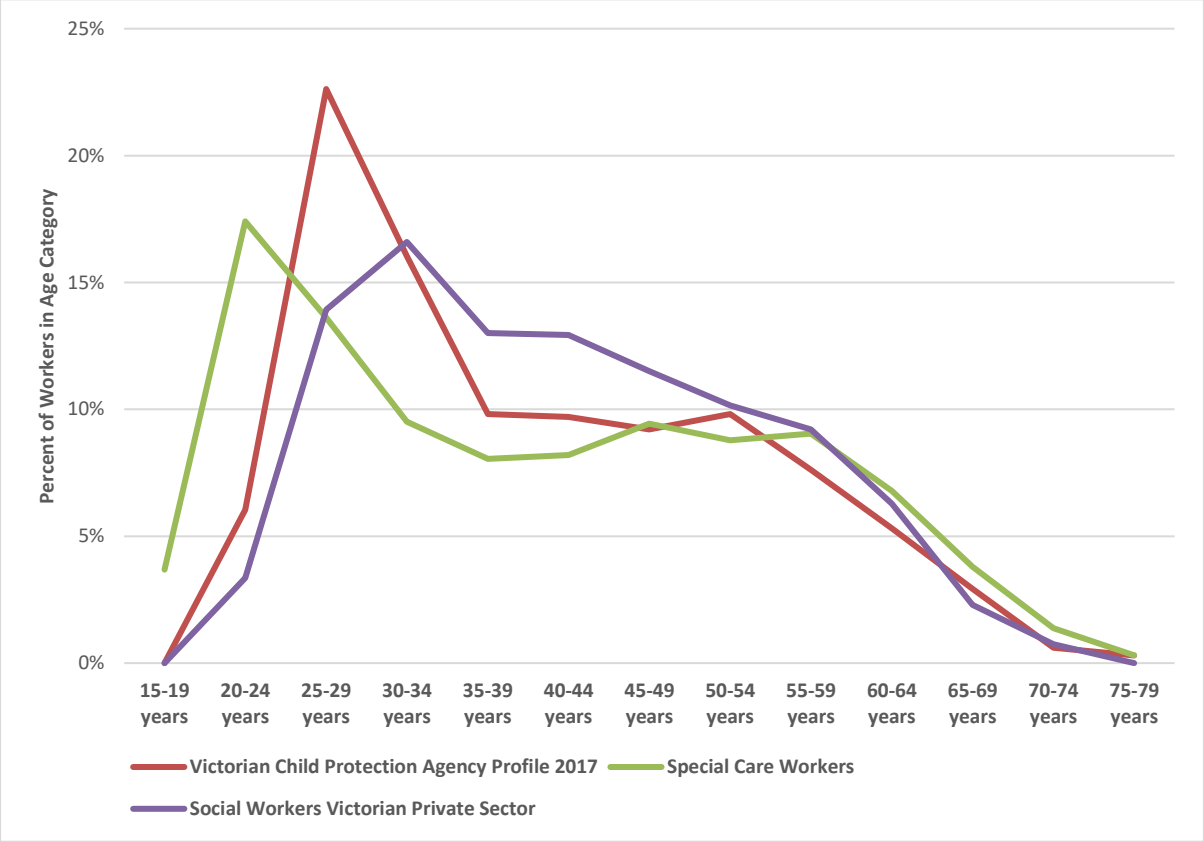
Within these industry categories, workers can be identified as administrators, helpers, carers, specialist helpers, supporters and nurses. These terms make it possible to see the type of work likely to be undertaken.

As with the general sector data, the workforce in the non-government sector (the predominant provider of secondary services) also trends towards an ageing workforce. This trend (see Figure 6) is reflected in the Nurse and Carer occupational grouping as well as Administrator and Supporter groups (not displayed). The Helper and Specialist Helper groups, however, display a much younger profile.

This trend may be an advantage since helpers are likely to be providing direct services to children, young people and families. However, it also highlights that less experienced workers are providing direct services to families with complex issues.

Workers in statutory level workplaces are more likely to hold higher level qualifications and are significantly younger than the overall child welfare workforce (see Figure 7 below). In contrast, the Health Care and Social Assistance workforce and the non-government workforce (i.e., those who can be specifically identified as tertiary tier workforces) are older. This contrast may be beneficial for the long-term prospects of the workforce but it highlights the limited experience of some workers undertaking the highly complex work of statutory service provision. It also suggests that many of these workers leave the sector early rather than continuing. This turnover can have serious consequences by reducing the number of workers with accumulated expertise thereby impacting the overall workforce performance and service delivery.

Figure 7: Comparative age profiles of selected child welfare worker groups



Sources: Victorian State Government: Health and Human Services (2018); Australian Bureau of Statistics (2018) Census of Population and Housing, 2016

From a national perspective, the tertiary tier workforce is generally well qualified and performs the complex work that statutory interventions entail. But their work roles are highly demanding and stressful. High proportions of the tertiary tier workforce leave these positions within the first few years, many transitioning to find employment in related non-statutory child welfare jobs in the secondary and primary tier services. Workforce turnover and retention has been a longstanding issue in the child welfare workforce, particularly the statutory one. Similar situations and employment transitions have been previously identified (see for example, Russ et al., 2009, Russ et al., 2020; Pennsylvania Council of Children, Youth and Family Services, 2021; Scourfield et al., 2021). It is an issue of real significance and ought to be part of a national strategy to build the child welfare workforce. The quality of supervision by staff who oversee child protection programs can vary because of these disruptions, and there is clear evidence from many formal inquiries examining system failures that higher levels of skills and training are needed.

Gender is another important consideration when profiling the child welfare workforce. Consistent with the welfare workforce more generally, and with many of the roles designated

as caring roles, there continues to be a predominance of women (Healy & Lonne, 2010). For example, the ABS data for Health and Welfare Services lists 79% of the welfare workforce as female. In social work, 84% of workers are female (AIHW, 2021b; National Skills Commission [Job Outlook], 2021a, 2021b). These predominantly female workforces are also largely made up of part-time workers (AIHW, 2021b). Casualisation is also another factor. Cortis and Blaxland (2017) calculated that approximately 22% of the NSW workforce in child, youth and family services were employed on casual contacts. This issue of casualisation is also associated with gendered caring roles, which are paid less than other roles (AIHW, 2021b; Cortis & Blaxland, 2017).

Diversity

Our examination of the child welfare workforce from the perspective of diversity found a distinct lack of data regarding workforce diversity including Aboriginal and Torres Strait Islander peoples, people from non-English speaking backgrounds and people with disabilities. However, from the limited data available, we found that people from these population groups continue to be under-represented in the workforce. This was not only in relation to the population, but particularly given the disproportional representation of these groups as children and families subject to child welfare intervention. For example, in 2020, Aboriginal and Torres Strait Islander children represented more than 40% of children in care (9 times more likely than the general population) and children with a disability represented 30% of children in care (AIHW, 2021).

Despite the disproportional representation of children from diverse population groups in the child welfare system, there is low representation of these populations in the workforce. Table 4 below demonstrates the low representation of these groups in the workforce profile.

The data presented is drawn primarily from the ABS ‘Other residential’ and ‘Social Assistance’ category data with supplementary data from State and Territory government reporting and a review of sector job advertisements.

Table 4: Shares of roles undertaken by Worker Groups Other Residential and Other Social Assistance Industry Classes Combined

Role	Aboriginal and Torres Strait Islander	Non-English Speaking Background	Disability	All workers
Administrator	17.4%	18.8%	11.3%	23.2%
Carer	33.4%	42.9%	12.1%	36.5%
Helper	35.5%	20.4%	6.9%	23.2%
Nurse	3.9%	9.2%	1.1%	5.5%
Supporter	7.4%	6.0%	67.4%	8.2%
Special helper	2.4%	2.6%	1.1%	3.4%
Approximate Number of Workers	5 720	27,830	7 380	174,000
Share of all Workers in Other Social Assistance and Other Residential Care	3.3%	16.2%	4.2%	100.0%

Source: Australian Bureau of Statistics Census 2016

In relation to the roles people from these specific population groups are employed in, it is evident that people predominately fill the Helpers (mainly as Welfare Support Workers) and Carers roles. In contrast to those from Aboriginal and Torres Strait Islander and non-English speaking background populations, workers that identify as having a disability are mostly employed as Supporters providing accommodation and facility maintenance services. People who identify as having a disability also appear to be employed in activities related to institutionalised fundraising in the secondary child protection sector. This pattern of roles suggests that they mainly carry out jobs at lower skill levels in the industry and therefore potentially have less influence in the direction of their organisations and policy.

Occupational activities

We built a profile of the occupational activities for the tertiary, secondary and primary tiers by examining Other Residential Care Services and Other Social Assistance categories, which are both categories of the ABS (2020) industry category Health Care and Social Assistance. Our analysis showed that the patterns of employment within these categories were very similar. This is demonstrated in Table 5 below:

Table 5: Patterns of employment in Other Social Assistance Services and Other Residential Care Services 2016

Worker grouping	Other social assistance services	Other residential care services
Helpers	23%	30%
Carers	37%	33%
Administrators	24%	20%
Specialist helpers	4%	3%
Other	12%	14%

Source: Australian Bureau of Statistics (2018) Census of Population and Housing, 2016

Given the similarity of these role breakdowns, analysis was then extended to occupational groups. This was based on the premise that the Other Residential Care Services category would be generally indicative of others and thus the broader child welfare workforce.

In 2019, the estimated total workforce in the Other Residential Care category was 19,000. The Level 4 breakdown of this 2016 Census data provided further information on relevant occupational groups relevant to the child welfare sector. From a public health perspective, it is arguable that all those employed under this category have a responsibility for child welfare. However, the ones considered most relevant to the tertiary and secondary tiers are those in helping roles where they were engaged in short- and long-term solutions to client issues. These make up 30% of this workforce and include welfare workers, social workers, special care workers, counsellors and psychologists as indicated in Table 6 below.

Table 6: Child welfare relevant positions from ABS Census Exemplar - Other Residential Services

Occupational data Level 4	2006	2011	2016	% increase 2006-2016
Welfare workers	**3873**	**4743**	**3893**	**1**
Social workers	**475**	**644**	**636**	**34**
Special Care worker	**335**	**467**	**451**	**35**
Counsellors	**146**	**172**	**98**	**33**
Psychologists	**87**	**161**	**92**	**6**

Source: Australian Bureau of Statistics (2018) Census of Population and Housing: 2006, 2010, 2016

Vocational and educational pathways and capacity to meet shifting demands

As demonstrated above, the child welfare workforce is made up of people holding varying qualifications from across a range of disciplines and/or occupational groups. Table 7 below outlines the qualifications and employment rankings in the Other Residential Care Services category. Social work, psychology and welfare studies feature strongly. This was similar in the Other Social Services category with social work, psychology, counselling, welfare and youth work most common, and other groups such as nursing not included. Whilst nurses play an essential role in many child welfare contexts, they feature less than those professions that traditionally work in the community services sector.

Table 7: Ranking of qualification levels by discipline area for workers engaged in Other Residential Care category

Ranking	Certificate	Advanced Diploma and Diploma	Bachelor	Post-graduate
1	Care for the Disabled	Society and Culture/Human Welfare Studies	Social Work	Psychology
2	Society and Culture/Human Welfare Studies	General Nursing	General Nursing	Social Work
3	Care for the Aged	Care for the Disabled	Society and Culture/Human Welfare Studies	Administration Related
4	Administration Related	Administration Related	Psychology	Education
5	General Nursing	Youth Work	Administration Related	Society and Culture/Human Welfare Studies
6	Youth Work	Social Work	Education	Counselling
7	Community Health	Children's Services	Occupational Therapy	General Nursing
8	Children's Services	Counselling	Care for the Disabled	Public Health
Percentage of workers with qualifications at each level				
	28%	21%	23%	9%

Source: Australian Bureau of Statistics (2018) Census of Population and Housing, 2016

The majority of workers (49%) in the Other Residential Care Services category had Certificate or Diploma level qualifications across these groups. Only 32% had a Bachelor degree or Postgraduate level qualification. In the Other Social Assistance category there were similar levels of qualified staff.

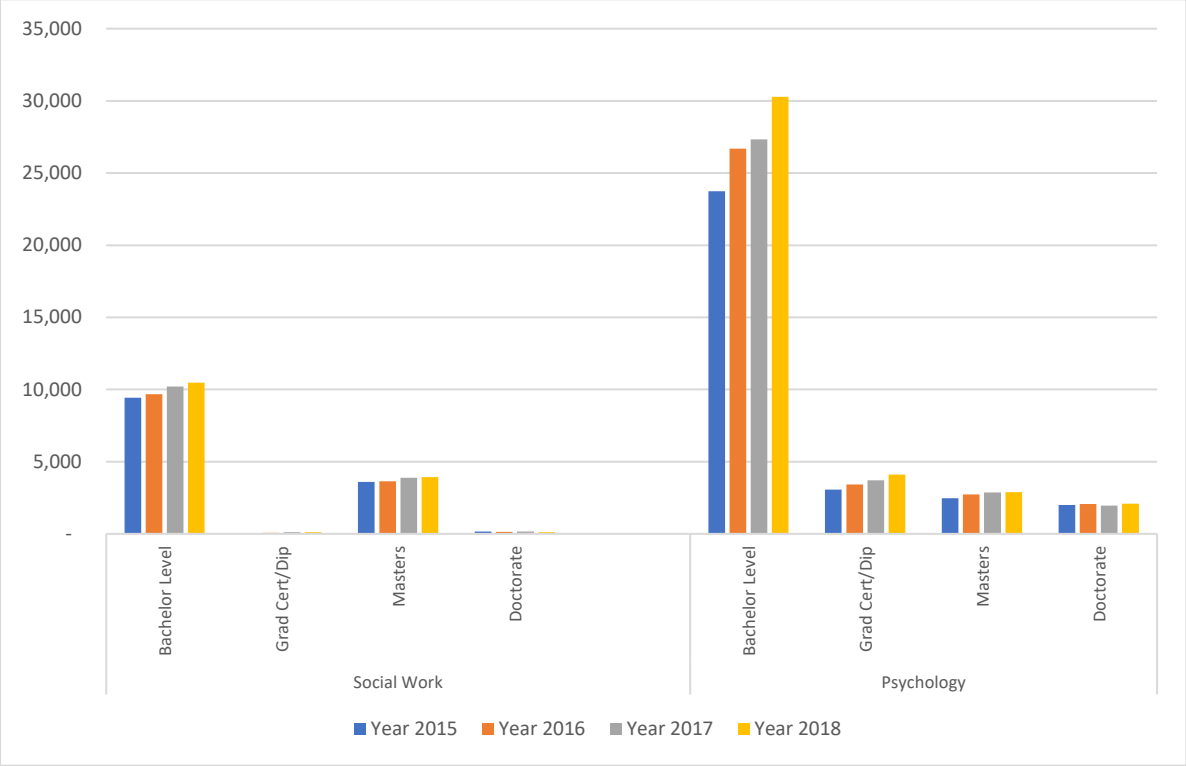
Preferred professions

Evidence suggests that the child welfare sector has sought to increase the level of qualified staff in the industry with social work and welfare studies being considered as key qualifications (Healy & Meagher, 2007: Healy, 2004). Position descriptions for statutory child protection agencies indicate a preference for applicants to hold qualifications in social work or similar such as human services and psychology. We identified these requirements in job descriptions for statutory child protection agencies caseworker/manager roles across Australian states, (for example, NSW Caseworker and QLD Child Safety Officer roles). Similarly, consistent with moves in the sector to increase staff qualification levels, many secondary services seek workers with social work, human services or similar qualifications. In addition, some child welfare non-government peak bodies provide vocational training in community welfare and/or youth and family services (Association of Children's Welfare Agencies, 2021).

This study examined social work and psychology as exemplars of the preferred qualifications with the skills to meet the needs of children, young people and families. These exemplars were examined with a view to assessing the profession's ability to meet future workforce needs where a move to public health models is likely to increase the need for qualified workers across the service tiers in a sector already experiencing substantial growth.

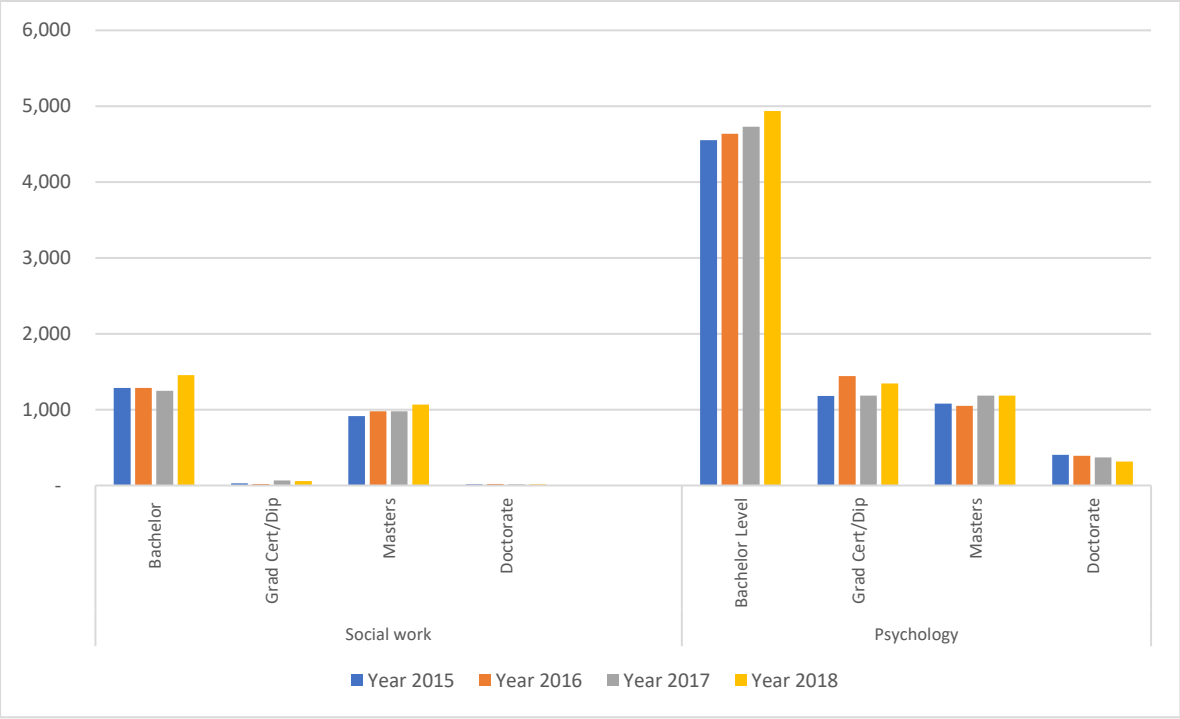
There has been identifiable growth in enrolments and graduates for both psychology and social work at the undergraduate level. However, the graduate numbers have remained significantly lower than enrolment would suggest. This mismatch between enrolment and graduate numbers is clearly visible in Figure 8 and Figure 9 below. Social work and psychology have seen growth in graduates qualified at Masters level. Nonetheless, based on the growth across the Health Care and Social Assistance industry, this growth of Masters-level graduates is insufficient to fill workforce demand in an individual sector such as child welfare.

Figure 8: University social work and psychology enrolments 2015-18



Source: Universities Australia data base

Figure 9: University social work and psychology graduates 2015-18



Source: Universities Australia data base

Social work

Consistent with the growth in the Health Care and Social Assistance industry workforce (see Figure 3 and Figure 4) and the Job Outlook data (National Skills Commission, 2021a and 2021b), there has been a rapid expansion of students completing social work and community welfare qualifications in the last decade. Related courses in the vocational sector have expanded and accredited Master of Social Work courses have been introduced across numerous Australian universities since 2009. This expansion is represented by the growth in social work enrolments and graduates over the 4 years from 2015 to 2018 (see Figure 8 and Figure 9). While there has been significant enrolment growth, particularly in the Master of Social Work qualification, the undergraduate growth has been more limited, and is unlikely to meet the current growth in demand.

Psychology

The psychology profession has also experienced growth. According to the Australian Government Department of Health (2017) the number of registered psychologists increased by an average of 3.3% annually for the period 2014-2017. In December 2021, there were 34,417 general registered practising psychologists in Australia, according to the Psychology Board of Australia (the registration body, under the Australian Health Practitioner Regulation Agency, responsible for regulating Australia's registered health practitioners). Like social work, psychology is a predominantly female profession, with four out of five (80.3%) or 27,653 of the pool of fully registered practising psychologists being female. Of the 15,151 registered psychologists with one or more areas of practice endorsement, 13,438 were practice endorsements that strongly correlates to child- or family-focused welfare-related work. These areas of endorsement are outlined in Table 8 below.

Table 8: Number of psychologists working in specific areas of practice

Practice endorsement type	Number of psychologists
Clinical psychology	10,716
Counselling psychology	1054
Clinical neuropsychology	805
Educational & developmental psychology	810
Community psychology	53
Total (child/family-related endorsements)	13,438

Source: Psychology Board of Australia, 2021 (December)

Developmental and educational psychology graduates are probably more suited to take up positions in sectors that can more easily become part of the child welfare prevention workforce. However, recent media commentary has highlighted the fact that demand for courses specialising in this area of practice is low. The low demand may be linked with a significantly lower Medicare rebate ($88.25 for a 50-minute session) for practice in these areas compared with the rate for clinical psychology ($129.55) (Daniel, 2021).

Human services

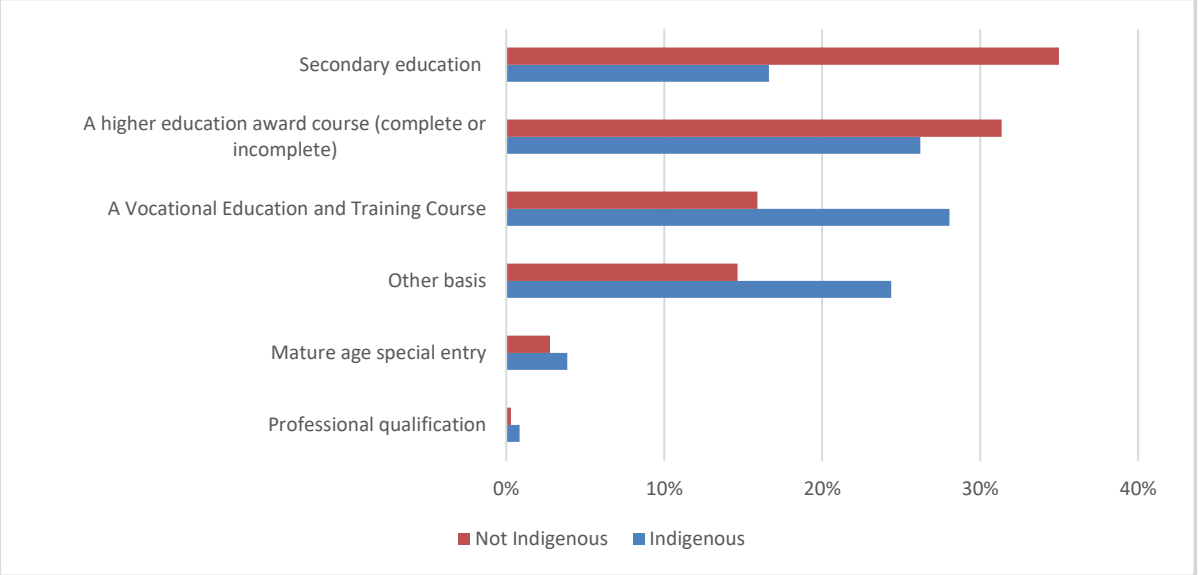
The other preferred degree qualification in child welfare is human services (sometimes referred to as community welfare). Fewer universities offer human services degrees than either social work or psychology degrees. Only eight universities list this degree, whereas at least 20 universities offer social work (Australian Government, 2021). As a result, there are fewer graduates with a degree in human services. Similarly, while social work and clinical psychology are offered as qualifying Master degrees, human services is only offered as an undergraduate degree. While there are fewer graduates with a degree in human services, there is a range of human services/community welfare related vocational courses at Certificate, Associate Diploma and Diploma levels which may be employed in secondary and primary tier services.

Graduate diversity

A major issue with increasing the numbers of Aboriginal and Torres Strait Islander people in child welfare worker roles lies in the supply of suitably qualified workers. Given the preference for specific tertiary qualifications and only small numbers of Aboriginal and Torres Strait Islander students graduating with these qualifications, the current supply is unable to meet the proposed growth nationally. Current data indicates approximately 150 (approximately 2%) out of the 7900 graduating from these courses each year identify as Aboriginal and Torres Strait Islander people (Universities Australia, 2018).

In response, jurisdictions have been active in increasing the number of Aboriginal and Torres Strait Islander graduates through incentives such as cadetships and partnering with universities. This approach is having the effect of attracting more students identifying as Aboriginal and/or Torres Strait Islander People to university through methods other than the traditional secondary school pathway (see Figure 10 below). Alternative pathways to university level education is through the articulation from the vocational education and training sector, where students may have completed higher level studies in the Community Services training package.

Figure 10: Means of university entry



Note: Chart indicates percentage of commencing students enrolling in Bachelor level in Social Work, Psychology and Other Humanities University Studies (Indigenous and Non-Indigenous Students)

Source: Universities Australia 2018

Understanding the workforce within the primary, secondary and tertiary tiers

The current status of the child welfare workforce in relation to the three tiers of the child welfare system has grave implications for the implementation of a public health model. The effect on the workforce is similar to the effect of growth in services and workforce numbers across the broader workforce categories and graduate numbers: there is a struggle to keep pace with demand in the health care and social assistance sectors. This poses challenges for building a workforce equipped to enable a transition to a public health model of child welfare.

Primary tier

The primary tier is the most significant tier within a public health framework because of the potential role of the workers in preventing child abuse and neglect. It is also the largest sector in terms of workforce numbers. Workers in this tier are truly on the front line of the child welfare workforce. They need to feel confident about responding to the complex needs of vulnerable children, young people, their families and communities effectively. If workers are equipped to identify the broad range of issues that have the potential to impact the safety and wellbeing of children and young people, the demand on the secondary and tertiary tier services could potentially decrease.

Despite this pivotal role, the primary tier is the least well defined of the three tiers. It is constituted from a broad range of services, many of which do not have child welfare as the sole or primary focus. Most health workers or police officers, for example, do not have child-focused roles, yet, according to the *National Framework* still have an obligation to a shared responsibility for the safety and wellbeing of children and young people, as do other occupational groups such as educators or carers. Overall, an estimated 1.14 million practitioners work in this tier. These workers comprise a large subset of the total number of workers engaged in the occupational groups listed in Table 9 below. This information reflects their relative numbers and their gender and age profiles.

Table 9: Occupational groups operating in the Primary Child Protection Sector (Numbers of Workers and Profile)

Groups of workers	Total numbers	Average age	Percentage female
Educators	515,400	43	79%
Police	68,800	40	27%
Helpers	226,600	44	74%
Medical Professionals and Specialists	88,700	41	55%
Nurses	163,700	45	85%
Carers	150,700	34	94%
All	1,213,900	42	76%

Source: JobOutlook, 2021

Although the different roles and professions that make up the primary tier have different percentages of female workers, most workers in this sector are female, thus further confirming the gender bias towards female workers in the child welfare workforce. In relation to the age range, the lower age for carers in this sector could be explained by the perception that this caring work is unskilled work and so, across the board, is occupied by a younger cohort, which pulls the average age down. As previously indicated, the workforce across the ABS industry Health and Social Assistance is ageing, as many workers in this tier are more widely drawn from this sector. This may have implications for the capacity of the workforce to support and sustain the development of public health approaches.

We acknowledge that this breakdown is limited because it has not included the voluntary sector workforce (including sporting, arts and/or community groups). Voluntary workers also have responsibility for ensuring the safety and wellbeing of children and young people and play a significant role in the lives of many children.

We also recognise that workers drawn from other sectors, for example teachers, early childhood educators and health workers, may not see child welfare as their primary role. And only a portion of the budgets which fund these roles may include child welfare. However, these roles are part of the broader public health system that can address the social determinants of health (Lonne et al., 2019). Determinants of disadvantage are known to contribute to family stressors. They also have the potential to have a negative impact on the life course of children and young people, and to contribute to child abuse and neglect. As such, the workforce across this tier can significantly contribute to the early identification and prevention of child welfare issues, supporting children, young people and families in the early phases of stress and adversity, thereby enhancing the safety and wellbeing of children.

It is commonly understood that health inequalities have significant impact on children's and young people's welfare, wellbeing and future opportunities (Lonne et al., 2019). But there is less clarity regarding the specific roles of the services which respond to these health inequalities (e.g., health, education, and early childhood services) in addressing and reducing risk to children and young people, and enhancing their safety and wellbeing. Similarly, given the focus of each service area is targeted on particular needs, the ability to identify specific roles, workforce capacity and supports that respond to child wellbeing is very limited and there is little publicly available reporting on this.

Secondary tier

The secondary child welfare workforce involves a variety of services targeted at children and young people in at-risk circumstances and their families and communities. It also involves early intervention for families who are identified as highly vulnerable. Many of the organisations that deliver these services are NGOs. In addition, this sector has seen an increasing interest in recent years in peer support and advocacy for children and families. These peers do not have formal qualifications but bring lived experience to support roles either as employees or volunteers (Cocks, 2019). The voluntary nature of these roles made it more difficult to capture data because it is not centralised within either state or national jurisdictions, and there is more variability in the nature of services offered and the data collection formats. Generally, the range of organisational types providing these services included:

- state government (often by other sections of the department containing the child protection entity)
- local government
- community health organisations
- community-controlled Indigenous services

- for-profit social welfare organisations
- NFP social welfare organisations.

Across this tier, direct child welfare services include family support, parenting support and counselling services, children's and young people's counselling, child and adolescent mental health services, youth support services, and community development programs. The indirect services include housing support, alcohol and drugs, and educational as well as health and community development services.

To account for the diversity of services, this study examined resources devoted to secondary child protection activities, particularly family support and early intervention. A sample of NGOs and an examination of expenditure and service types of the secondary workforce led us to conclude that approximately 29,000 full-time employees were involved. After including part-time and casual employees, this figure came to some 73,000 workers (see Table 10, column 3 below). This indicates a high level of part-time and casual employees in the secondary sector.

Table 10: Estimated expenditure and number of employees from sample of 233 NGO providers

Item (2019/20)	Selected organisations with secondary child protection activities in their service portfolio	Selected organisations' estimated employee resources devoted to secondary child protection activities
Total expenditure (millions)	$ 11,830	$ -
Employee expenditure (millions)	$ 7 462	$ 4 842
Full-time employees	41,554	29,106
Part-time employees	55,061	28,967
Casual employees	24,354	14,659
All employees	120,969	72,732
Full-time equivalent employees	79,474	50,668
Volunteers	110,771	-

Sources: Australian Charities and Not for Profits Commission, Office of the Registrar of Indigenous Corporations, JobOutlook, SEEK, Ethical Jobs

When assembling data for workforce diversity in the secondary tier, we encountered similar issues to those encountered when assembling data for the overall workforce in this tier: lack of data, consistency and comparability. Those issues were also apparent when examining diversity in other tiers. We addressed this by sampling the annual reports of 223 NGOs for

workforce profile information; of those annual reports, only 25 had relevant data. This data was supplemented with a sample of job advertisements. Overall workforce numbers were calculated using a weighted average percentage for each criteria (see Table 11 below).

Table 11: Calculated human resource profile of secondary child safety tier

Identity	Female	CALD*	LOTE**	Indigenous	Disability	LGBTIQA+#
Estimated percentage of workforce	82.6%	35.0%	18.0%	4.0%	6.9%	9.1%

**Culturally and linguistically diverse*

*** Languages other than English*

 # Identifying as lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual

Of note was the trend in a sample of advertisements for secondary tier child welfare jobs. These fell into one of three categories:

- No diversity requirement indicated (approximately 3% of sample).
- Very role specific (approximately 5% of sample). Descriptions in these advertisements indicated that an applicant would only be considered if they met certain stated or implied gender and /or cultural criteria (e.g., be a woman and have Indigenous heritage).
- Inclusive (over 90% of sample). These advertisements welcomed anyone to apply and contained phrases such as the following:
    - understand the importance of diversity and inclusion
    - We recognise that everyone has the right to an equitable, safe and productive environment and to be treated with dignity and respect
    - We welcome applications from all people regardless of age, gender, ethnicity, cultural background, disability or sexual orientation
    - Aboriginal and Torres Strait Islander people are encouraged to apply.

Aboriginal and Torres Strait Islander children and young people

Aboriginal and Torres Strait Islander children and young people are significantly over-represented in the child welfare system. There has been increasing recognition of the need to increase the capacity of the secondary system to provide targeted and early intervention responses to help address this issue. In response to this need, we examined the workforce in Aboriginal and Torres Strait Islander targeted agencies by looking at Aboriginal Corporations that provide child and family specific services.

Analysis of the ORIC data indicated a total annual Corporation expenditure of approximately $3 billion across 3336 registered corporations. Expenditure is funded by grants including the following sources:

- Community Development Program (CDP) initiatives
- sale of individual corporation goods and services
- royalties.

Around 25,000 people are estimated to be employed through this expenditure. Through this data a subset of data specific to services targeted towards children, young people and families was captured using a structured sample of 166 corporations.

This sample data indicated that Health and Community Services was the major area for employment within Aboriginal Corporations, with 72 organisations providing these services. The second largest category was Employment and Training, with 36 organisations providing these services. A total of 51 organisations provide either Housing and/or Education Services. While acknowledging that the estimation of numbers engaged in these employment areas is limited by the method of data capture, we attribute some 5500 workers to the Health and Community Services component of Aboriginal Corporations.

Growth in the secondary tier

The secondary child welfare tier has seen significant growth. An example of this growth is the expansion of Intensive Family Support Services. These provide targeted services to children, young people and families with a focus on preventing at-risk children entering the tertiary tier (AIHW, 2021a). Over the past 10 years, there has been a rapid increase of funded intensive family support services (from 207 to 461), with an increase of children being supported (from 15,432 to 40,200) (AIHW, 2011, 2021a). While growth has occurred in other areas of the secondary tier, funding arrangements suggested this is less pronounced and more variable depending on the service type and jurisdiction.

Some specific initiatives targeting a broader range of families facing difficulties existed across jurisdictions. Even where initiatives were focused on a broader approach to supporting families, programs in high-risk categories continued to predominate, requiring highly skilled workers. For example, in the NSW *Their Futures Matter* initiative, only 3 of the 11 programs supported children and families who have not been in either the secondary or tertiary tier (Department of Communities and Justice, 2021). This rapid expansion of programs including specialist programs for high-risk families has required significant growth

in skilled workers to work with complex family situations. The quality and performance frameworks implemented for funded services also suggested a need for more highly skilled and qualified workers in this sector.

Tertiary tier

In the tertiary child welfare system, workers are drawn from across the Other Social Assistance workforce category (ABS 2016) or from out-of-home care services within the Other Residential Care category. Some workers may come from other categories such as Health (including Hospitals or Medical and Other Health Care Services categories) or Public Administration and Safety (e.g., police).

Roles and responsibilities

Across jurisdictions, we identified a common structure within the statutory child welfare departments: most of the caseworkers providing direct interventions with children, young people and families met the entry level requirement for degree-qualified workers. Those with a high-level qualification or who had experience tend to be employed as senior caseworkers. Workers could then progress to supervisor or practice consultant positions. Statutory departments also employ family and youth support workers with Certificate or Diploma level qualifications.

Workforce data related to the tertiary tier of the child welfare workforce exists within the statutory state and territory governments and relevant sub-departments. It is estimated that, across Australia, these departments employ approximately 18,000 staff in various roles, from front-line worker to management positions. Table 12 below outlines staff numbers across these different positions.

Workforce growth

Consistent with previous studies, our analysis identified that the child welfare workforce in statutory services has continued to increase significantly with departmental staffing levels indicated in Table 12 below. In comparison to the study by Martin and Healy, (2010, p. 23) which used industry surveys to estimate the sector workforce, our study identified that the frontline child welfare workforce in the statutory agencies increased from approximately 10,000 to approximately 18,000 over the past decade. This is astonishing growth.

The table below shows a dramatic drop in the estimate of the size of the statutory workforce from 2010 to 2012. This could be explained by various jurisdictions responding to the survey

differently without consistent criteria (e.g., whether they should be responding about the whole of the department or just case workers working in the field). We draw attention to the overall highest numbers quoted in the 2010/2012 period compared with current data as an indication that the system overall has expanded over the last ten years.

Table 12: Estimate of staff numbers in dedicated child welfare entities – Australian States & Territories 2020

	Past studies			Current study		
	2007*	**2010****	**2012*****	**2019a+**	**2019b+**	**2019c+**
NSW	1479	3342	3576	2253	2429	4682
VIC	937	1749	1232	2107	2242	4349
QLD	1432	2725	1689	1528	1768	3296
WA	1198	790	883	1016	1176	2192
SA	600	853	-	1236	859	2095
TAS	220	365	-	175	175	350
ACT	120	130	81	145	145	290
NT	115	-	-	332	110	442
National	6101	9954	7461	8792	8904	17,696

Sources:
Bromfield & Ryan (2006); **Martin & Healy (2010); * McArthur & Thomson (2012); +NSW: New South Wales Family and Community Services Annual Report, New South Wales Department of Communities and Justice Caseworker Dashboard; VIC: Victorian Department of Health and Human Services Annual Report 2018/19; QLD: Queensland Service Delivery Statement 2019/2020, The New Daily (2018), Queensland Department of Child Safety, Youth and Women Annual Report 2018-19; WA: Western Australia State Budget 2019-20; SA: South Australia Report of the Auditor General; TAS: The New Daily (2018), Tasmania State Government Department of Communities Tasmania Annual Report 2019; ACT: Community Services Directorate Annual Report 2018/19; NT: Northern Territory Families Annual Report 2018-19*

Note: 2019a includes Caseworkers; 2019b includes Other workers and frontline support; 2019c includes all frontline workers

Caseworkers

Of the total number of workers within statutory systems (see Table 12, 2019c), we identified approximately 8800 workers who could be identified as caseworkers responsible for direct intervention with children, young people and families. This included workers with roles in investigation, family intervention, and working with children and young people in the care of the department on statutory child protection orders (including supervisory and custodial orders). Entry-level employment as a caseworker requires successful completion of a Bachelor degree in social work, psychology or related fields across the various statutory child protection agencies in Australia.

Other frontline workers

We identified a further group of frontline workers who held some direct service delivery responsibilities (approximately 3200). This group was made up of case support workers, supervisory and practice support roles. The Caseworker Support role exists below the Caseworker level and is often staffed by those holding higher level certificates/diplomas, or students in the human services field. We estimated that there are about 2000 of these positions nationally. Those in supervisory or practice support roles, the immediate higher levels to caseworker roles, are expected to build their experience to a certain level of satisfaction.

Staff turnover rates

Another aspect of the tertiary workforce employed by statutory departments was the rate of staff turnover and acknowledged vacancy rates. Previous Australian studies have reported turnover rates as high as 40% (Russ et al., 2020). The data we accessed indicated up to one-third leave each year. This was reflected in high vacancy rates being reported in some jurisdictions for entry-level employees who had an average tenure of between 1.1 to 1.5 years (Cortis & Blaxland, 2017, Victorian State Government, 2018). This is similar to some states in the USA (Pennsylvania Council of Children, Youth and Family Services, 2021).

Police, health, allied health workers and educators

Police, health and education departments also have identified child protection workers who they considered to be part of the tertiary tier response. In some cases, police are required to attend where possible criminal acts need to be investigated or where offenders are prosecuted under the relevant jurisdiction’s Criminal Code. Based on this data, we estimated that police officers with a specific child welfare role occupied approximately 1700 full time positions nationally.

Health and allied health workers are required in cases where physical or sexual trauma has occurred or was suspected and/or substantiated and medical assessment or treatment is required. Similarly, health workers may be involved in mental health responses and counselling for children and young people under statutory intervention or orders. The number of health workers reported as part of the tertiary child welfare specific workforce able to be identified was limited, with only NSW data available indicating 53 positions. Similarly, although policy indicates that education staff do play a role in tertiary child welfare responses, for example Suspected Child Abuse and Neglect Teams in Queensland, data on this dedicated education child welfare workforce was not able to be located in this study.

In some jurisdictions children and young people on child protection orders were supported by NGOs funded by state governments to provide targeted intervention, particularly out-of-home care. However, workforce numbers were not directly reported. In residential and home-based care, we were able to calculate workforce numbers using staff-to-child ratios. Using Productivity Commission's Report on Government Services (ROGS, 2019) data on children and young people in residential and home-based out-of-home care and recognising shift work in a proportion of these settings, we estimated the direct care workforce (excluding volunteers such as foster and kinship carers) to be approximately 3500. When this approximation included other support workers and administrators in this context, this increased to around 4600 workers. We were unable to determine turnover rates for this workforce.

Workforce diversity

In general, the profile of the tertiary tier workforce diversity was similar that of the secondary tier, with data drawn from the human resources profile of several statutory child protection agencies (see Table 13 below). This is similar to the overall workforce profile. In some areas the proportion of people from specific population groups is similar to the general population. However, in other areas, it does not reflect either the general population or the proportions of children and families from these population group in the child welfare system. The variations in the diversity of the workforce profiles across jurisdictions reflect the history of the State or Territory and the organisations within each jurisdiction. Most jurisdictions cite a plan to actively lift the percentages of these population groups to more acceptable levels.

In terms of the proportion of Aboriginal and Torres Strait Islander People in the child welfare workforce, jurisdictions generally aim to raise it to 3% to 5% of total workers. There are arguments for this component to take a significantly greater share of the profile given the

significant disproportion of Aboriginal and Torres Strait Islander children within the statutory system. This is currently limited by graduate numbers.

Table 13: Share of workforce profile by worker groups in Statutory Authority and Public Service

Jurisdiction	Indigenous	Disability	CALD	Non-English Speaking Background
Statutory authority level				
Victoria	1.9%	-	-	-
South Australia)	5.3%	1.6%		-
Northern Territory	17.0%	2.4%		22.1%
Australian Capital Territory	4.5%	5.7%	17.1%	
Public service level				
New South Wales	3.5%	2.5%		18.0%
Queensland	2.5%	3.3%		6.5%
Western Australia	2.7%	1.6%	14.0%	-
Tasmania	3.0%	6.0%		-

Note: Profile information for South Australia and Victoria is listed at a statutory authority unit level. The Northern Territory and the Australian Capital Territory have their statutory agencies co-located in host departments which undertake other non-child protection functions. Queensland, New South Wales and Western Australia report their staff profiles at a whole of public service level. While Tasmania does not have a history of reporting its profile, the findings of a recent independent inquiry (Watt, 2021, p. 173) supplements the departmental level data.

Discussion: Capability of the child welfare system

Perhaps the most significant finding from this study is that the child welfare workforce in Australia cannot be easily defined or quantified owing to significant gaps in data and the lack of consistent data sets across jurisdictions, especially for the secondary and primary tiers. This is a significant issue for estimating a public health approach workforce because the successful implementation of such an approach relies on the knowledge and skills of the whole workforce, including those on the preventative end of the workforce continuum, all of whom need to be able to engage with families in non-stigmatising ways (Higgins et al., 2021).

In this section we address the implications of the persistent focus on the tertiary tier of the child welfare system and ongoing staffing challenges. We also discuss how this contradicts the aims of the *National Framework* and hinders a general transition to a public health approach to responding to child welfare.

Data gaps

Our findings drew on data from a variety of data sets that could relate to child welfare in different ways. Similarly, the preferred occupational groups relevant to child welfare that were able to be identified also relate to other health care and social assistance sub-categories. This complexity created challenges in understanding the trends and needs in this workforce research. Child welfare, for example, does not have its own category within the ABS workforce data but sits within broader social care categories Welfare or Health, which can mean a number of different things. When conceptualised from a public health perspective, many important child welfare positions seemed to overlap, making it difficult to determine the full constitution of the workforce. For this reason, data comparison and extrapolation from multiple data sets was necessary to develop an understanding of this workforce.

Another challenge was the evident focus on the tertiary tier as having responsibility for fulfilling the service needs of vulnerable children, young people and their families, and communities. This focus meant that data for examining the primary and secondary tiers were harder to identify and source. Available data required significant extrapolations in order to examine the trends and issues.

Fixation on the tertiary tier

The *National Framework* was developed over a decade ago. One of the aims was to establish a public health model of child welfare in Australia that prioritises a universal preventative approach to supporting children, young people and their families, and communities. The data gathered in this research demonstrates there is a continuing systemic and cultural prioritising of a tertiary/statutory and forensic approach to child welfare. This is reflected in the limitations of workforce data collection and reporting, alongside continuing rises in numbers of children, young people and families in contact with the statutory system (AIHW, 2021a). Additionally, the staffing levels, qualification requirements, and the types of positions available indicate a clear bias towards the tertiary tier. Hence, the workforce that is needed to achieve the principles embedded within the *National Framework*, appears to have had its development hindered—this runs contrary to its ambitions to prioritise the safety and wellbeing of children and young people with a more preventative stance.

Despite this dominance, the tertiary workforce itself appears to be ill-defined internally with little or no consistent requirement for knowledge, skills or qualifications across jurisdictions. Nor is there any consistent national workforce reporting protocol. Ironically, the increasing size of the tertiary workforce is accompanied with high turnover and vacancy rates and difficulty attracting and retaining experienced staff. This state of affairs indicates that the tertiary workforce does not have enough relevant skills and that not enough is known about the knowledge and skills needed for this workforce.

Without a highly skilled workforce across all three tiers, it would have been difficult to prepare for the implementation of the *National Framework (*2009-2020), or any subsequent framework. There needs to be consistency in the understanding of the workforce and monitoring of the trends. Without this, there are likely to be ongoing challenges in addressing the national and state jurisdiction's policy intent for child safety and wellbeing and reducing the number of children, young people and families in the tertiary tier of the child welfare system.

Tertiary services are essential—this cannot be disputed—but their continued prioritisation, in conjunction with workforce shortages in this sector, hampers a transition to a broader service system and targeting earlier intervention that responds to the needs of children and families. This is evident in the secondary sector where there are also staff shortages, and staff with less qualifications and experience. The very complex nature of the direct client work with

vulnerable children, young people and families, many of whom have complex needs (Price-Robertson & Schuurman, 2019) requires staff with adequate qualifications and experience. In addition, high workloads and individual pressures, such as vicarious trauma, can exacerbate staffing shortages (Russ et al., 2020) similar to those in the tertiary tier and across the broader Health Care and Social Assistance industry. These issues pose further challenges to establishing the additional qualified workforce needed to enable a transition towards public health models. This is consistent with the limited recognition and consideration of the nature and needs of the broader workforce, suggested above, and runs counter to the position embodied in the initial *National Framework*. The publication *Safe & Supported: The National Framework for Protecting Australia's Children 2021–2031* illustrates that this is an ongoing issue.

Based on the trends identified in this study, we believe that the tertiary workforce will face challenges that will further impede the development of the child welfare system across the three tiers. However, the large 'invisibility' of child welfare workforces outside of the tertiary child protection system makes workforce planning and pre-service training and in-service professional development difficult to understand, conceptualise and address. This invisibility is compounded by the cross-sectoral nature of what such planning and skill development would require. It needs to cover different levels of government (national, state/territory and local) as well as cross-portfolio (early childhood, health, education, community services, etc.).

Shortages of staff and limited graduates

Workforce shortages were evident in the tertiary and secondary tiers of the sector with strong future job growth predicted not only in the child welfare sector but in the Health Care and Social Assistance industries generally. These indicate continuing challenges in provision of current and future services. Additionally, in a context of very high demands in the health sector in response to the pandemic, and ongoing growth in the tertiary sector, this is likely to be exacerbated. Against this backdrop, it will be difficult to promote growth in the secondary and primary tiers to enable a transition to public health approaches.

Consistent with previous research (Healy & Lonne, 2010; McArthur & Thompson, 2012), it is apparent there are staff shortages across all child welfare system tiers. Factors influencing these shortages include high turnover and high vacancy rates in the tertiary system. Staff shortages were also evident in the secondary system, as well as broader features of high industry growth and limited graduates in the preferred professions. The ongoing impacts of

the pandemic may well exacerbate this situation (Herrenkohl et al., 2021; Pennsylvania Council of Children, Youth and Family Services, 2021).

Another relevant factor to workforce shortages is the graduate numbers relative to the industry growth within health and community services generally and the child welfare system overall. In relation to those preferred qualifications for child welfare practice in both tertiary and secondary tiers, such as social work and psychology, this problem is particularly pertinent for workforce preparedness for implementing the public health model. The social work sector has insufficient workers to meet demand across the broader workforce; it is listed as a skilled occupation for immigration (Australian Government, 2021). While social work and psychology courses and enrolments have increased over the past 10 years, the annual graduate numbers continued to fall well short of enrolments and remain insufficient to meet industry growth and associated demands for qualified staff.

The available data also indicated that there are additional challenges posed by an ageing workforce in the Health Care and Social Assistance workforce flowing into the tertiary tier of the child welfare system. This has significant implications because age is associated with experience and expertise. As individuals move into retirement, there is a loss of valuable experience across the sector. In an industry with high turnover and high vacancy rates there is a reliance on those with a depth of experience. Without substantial and sustained efforts to inject suitably qualified staff at entry level, and develop and grow their experience and expertise, the system is unable to replace these ongoing losses, which in turn will impact service delivery, especially services modelled on best practice principles. This issue is also likely to have implications for the system's ability to guide and support workers during periods of change such as a transition towards a public health approach, and ongoing systemic and organisational reforms.

The growth and workforce demand of the Health Care and Social Assistance industry and the existing trends in the tertiary and secondary child welfare systems suggest multiple challenges to developing a strong, well-qualified and equipped primary tier to respond to child welfare needs. Specific data were limited but this position is consistent with the trends identified across the other tiers and the broader Health Care and Social Assistance industry.

The growing secondary tier

In line with the staged rollout of the *National Framework*, the secondary tier has seen significant growth over the past decade, with an increase in the number and range of services. This is indicated by the growth in Intensive Family Support Services and grant

funding increased in some jurisdictions (AIHW, 2011, 2021b). The nature of services required in this sector include programs for families at risk of meeting the statutory threshold for intervention, which for the most part is provided by the non-government sector. This significant growth has resulted in high workforce demand.

The increased funding and growth in this tier may appear to align with the *National Framework* intent, but the actual practice continues to be focused on high-risk families who may not have reached the statutory threshold but are at high-risk of doing so without intensive supports (AIHW, 2021a). While secondary interventions that reduce risk of harm occurring may slow down the entry of high-risk families into tertiary services, secondary interventions do not provide targeted services through a broader support response to families facing difficulties. Across jurisdictions, statutory department annual reports suggest there has been growth in funding to other services such as the *Their Futures Matter* initiative in NSW (NSW Government: *Their Futures Matter*, 2018). The growth in targeted services for struggling families not deemed high-risk is less well reported, indicating a lower priority. The successor strategy to the *National Framework* is more narrowly focused on higher risk target groups rather than continuing to prioritise a transition towards a public health approach (see for example, Ministers for the Department of Social Services, 2021).

The secondary tier is particularly interesting because while it appears to cover a broader range of services for family needs, the efforts and funding tend more towards the high-risk end of the continuum of risk. Part of the reason for this could be explained by staff shortages within the tertiary sector, with a resulting reliance on the secondary sector to respond to these families' and community needs. The non-government sector successfully provides many support programs to vulnerable communities and populations across a range of service types. However, the complex nature of child welfare work, combined with fewer statutory protections and legal mechanisms to protect children and young people in services operating in the secondary tier, creates complex service delivery practice issues.

These high-risk populations serviced by the secondary sector are likely to be impacted by complex social systems and require specialist services. This approach requires adequate resourcing to employ skilled staff. However, our research suggests that many staff are often underqualified for this complex work. The data on the secondary system workforce indicated a lower level of qualified staff than found for the tertiary system.

In some jurisdictions, agencies are pursuing increased skill and qualification requirements for staff. Given the existing shortages, progress is likely to be slow. Training unqualified staff takes significant time, particularly when those workers are part-time or casual, and/or study

part-time. It is also likely that workforce shortages and vacancies also place pressures on staff, further limiting their capacity to undertake relevant training.

The secondary tier has a high rate of casual employees, so it is likely that, as with the tertiary sector, there is a high rate of staff turnover. However, it is unclear if this also applies to the permanent workforce in this tier. Workforce stability might also be affected by the lower qualification levels of staff. Job vacancy levels are also high for this sector which may be indicative of sector growth and/or turnover issues. Given the growth in the overall sector, it is likely there are similar workforce pressures and staff shortages in this tier, particularly where more skilled or highly qualified workers are required.

Generally, the workforce issues in the secondary tier are similar to those in the tertiary tier in terms of sector growth, retention of workers, numbers, recruitment of suitably qualified staff. These issues are especially relevant in rural areas.

The elusive primary tier

We were unable to identify the child welfare workforce within the primary tier in any definitive way because there are no clearly defined child welfare datasets where they can be easily identified. For example, guidance officers, psychologists or social workers all play an essential role in ensuring the safety and wellbeing of children and young people, but their roles are not defined specifically in terms of child welfare. These roles are considered part of community, health, and education more generally, despite the policy intent of the *National Framework*, which sees this tier as an integral part of effective responses to the safety and wellbeing needs of vulnerable children, young people and their families, and communities. In Australia, these services have priorities specific to the services delivered and therefore commonly see their central child welfare role as one of referral. Without positions that have a child welfare focus in these contexts, it may be difficult to promote a responsibility for workers for supporting vulnerable children, young people and families in this tier. This is especially likely in services which may not work directly with children, such as adult mental health or drug and alcohol services.

Diversity

The issues outlined above are further exacerbated by the issues surrounding diversity within the child welfare workforce. This is a serious problem given the continued disproportionate representation of Aboriginal and Torres Strait Islander children in the system (AIHW. 2021), as well as the increased rates of children with a disability or born to parents with an intellectual disability (Ziviani et al., 2013; Lima et al., 2022). For these families, best practice

for primary, secondary and tertiary intervention requires not just that practice be deemed culturally safe and/or sensitive to the specific needs of children and their families by institutions or organisations, but this be experienced as such by the children and families themselves. To achieve this end, diversity in all levels of the workforce needs to match the diversity that exists within the population that has contact with child welfare systems. This is necessary across all roles, from support roles to senior practitioner roles and above. Without the means to fully profile the diversity that already exists within the workforce or to obtain a coherent picture of the recruitment ambitions across jurisdictions, it would be difficult to know where to start preparing a workforce that is able to meet the needs of some of Australia's most vulnerable children and their families.

Issues and implications

There are many issues related to a poorly defined and ill-prepared workforce and these are influenced by a high variance in skills and qualifications, high turnover of staff, and high rates of casual workers, especially in some services embedded in the primary and secondary tiers. When considered in the context of the relationship between the three tiers of public health, the issues are exacerbated. High turnover in the tertiary workforce, for example, and the higher rates of casual staff in the secondary tier workforce, limits the development pathways of skilled workers generally, which in turn hinders the collaborative practices that are so crucial to the successful implementation of the National Framework. Without stable and skilled workers, the ability to manage in a context of change and transition is likely to be reduced, and may possibly preclude the required transition.

Another pertinent issue to consider are the cultures within which child welfare agencies exist. It is commonly understood that the tertiary tier is perceived as solely responsible for responding to child welfare issues. In contrast, many of those in the primary tier perceive their major child welfare role as centred around referral. When the tertiary agencies are not able to effectively respond, this encourages a culture of blame (Higgins et al., 2019).

This issue is exacerbated by competitive funding structures that compel many NGOs to continually compete with other NGOs to secure their funding. Funding cycles not only encourage competition, but also impact agency stability, which in turn, hinders long-term planning, agency relationships and workforce capability in an extremely complex practice field (Carey, 2015). These factors are highly problematic in a context where collaboration is essential to achieve a stronger public health approach and integrated system. For collaboration to be successful, it is critical to have equal 'buy-in' from agencies within, and across, the tiers of the whole sector to achieve effective coordinated responses to the

various safety and wellbeing needs of vulnerable children, young people and families, and their communities (Winkworth & White, 2010).

There is a need to upskill workers across all three tiers of child welfare service provision in order to meet the shifting needs for a transition to a public health approach. We reach this conclusion based on data about the low qualification levels of the broader child welfare workforce, sector growth and shortages of workers with preferred qualifications such as social work or psychology. This so-called ‘up-skilling’ is not straightforward because not only does it relate to the types and levels of qualifications required for effective child welfare practice, but it also requires a fundamental shift in thinking about practitioner roles and responsibilities within a public health approach (Lonne et al., 2020). This sets a significant challenge, not only for organisations, but also for vocational and tertiary education systems to grow the workforce to meet demand, and to better prepare workers for providing best practice in child welfare across the tiers.

Conclusion

This report draws attention to the significant workforce issues that will impede the successful transition to a public health model in child welfare in Australia. It also reveals the paucity of comprehensive data about the contemporary Australian child welfare workforce, as well as the continuing stressor of worker turnover in a system that continues to focus on the tertiary tier of services.

Key findings

- There has been sustained high growth in the demand for services across the three tiers of the child welfare sector as well as a continued disproportionate number of Aboriginal and Torres Strait Islander and children with a disability or born to parents who have an intellectual disability in the system.
- There has been corresponding growth in the size of workforces, particularly in the tertiary child protection statutory services.
- A higher number of workers from Aboriginal and Torres Strait Islander or other CALD backgrounds, or workers with a disability occupy lower skilled positions.
- Most of the significant resources provided for protective interventions and prevention services has remained narrowly focused on the tertiary tier, namely, statutory agencies.
- Many staff working in the primary, secondary and tertiary services are underqualified for the complex and skilled work required to recognise and assess risk of harm of child abuse and neglect.
- Skill development of the workforce in all tiers is inadequate to ensure the consistent provision of high-quality professional supports.
- High levels of staff turnover have a negative impact on the quality and consistency of prevention and support services.
- Casualisation of the workforce, particularly for the tertiary and secondary tier services, is impacting negatively on overall workforce development and service quality and consistency.

- Staff who work in primary tier services and who hold child welfare roles and responsibilities require greater direction and support to develop their skills for prevention strategies with vulnerable children, young people, families and communities.

- Educational programs that provide core parts of the child welfare workforce such as social work, psychology and human services graduates cannot currently meet the industry and child welfare sector workforce needs, and the ageing nature of the workforce is exacerbating this shortfall.

The *National Framework* (2009-2020) was presciently aspirational in endorsing and promoting a public health approach to ensuring the safety and wellbeing of Australia's children and young people. The model it proposed was grounded in a wellspring of data and ideas, was thoughtfully developed in consultation with a wide-ranging collection of professionals, academics, and government policy makers, and systematically refined during four sequentially produced Action Plans. It articulated the ambition and logical policy drive to shift the focus from reactive child welfare systems to that of promoting child wellbeing and preventing harm to children and young people by intervening early with families and communities who experience the adversities that threaten the wellbeing of their children.

What our research highlights is that in pursuing its laudatory agenda, the *National Framework* rollout did not include sufficient strategic acknowledgment of the significance of workforce matters and the requirement for formal mechanisms for addressing these matters. Workforce planning still remains within the remit of the statutory agencies, and their community services ministers; yet lack of integrated and coordinated responses to workforce issues across the nation requires their combined attention.

For any national level strategy of such magnitude, its success has to be contingent in some large part on developing an associated workforce strategy, as has been exemplified by the National Health Medical Workforce Strategy (Australian Government: Department of Health, 2021). A key priority for the child welfare sector embarking on transforming its approach to the care, wellbeing and safety of children and young people, must be that of careful planning and integrating strategies for a unified commitment to workforce matters. This is especially necessary given that the sector remains within the jurisdictions of legislation by states and territories.

It is important to point out that the *National Framework* noted at a very early stage:

> The attraction and retention of an appropriately skilled and qualified workforce – including statutory and non-government service workers, as well as voluntary carers – is a high priority (p. 25).

In relation to qualifications and skills, we found that the higher education sector is not able to meet the anticipated demand for graduates with Bachelor or Master level degrees who can undertake prevention and intervention strategies at services/programs at the primary, secondary and tertiary tiers.

The lack of available or accessible workforce data provides the unequivocal evidence that child welfare has not been given priority across Australian jurisdictions. This has been noted in a number of consultations conducted by Families Australia (2020) and it is evident in our research that the employment focus of most jurisdictions appears to remain on those workers engaged in the tertiary (statutory) rather than the primary (prevention) and secondary (early intervention) tiers. Until there is a more comprehensive mapping and understanding of the needs of a child welfare workforce that can span across the three tiers of the ecosystem of services in child welfare, the ability to plan for enhanced capability and preparedness for transition to a public health approach is not achievable.

This will leave the overall prevention and protection system with a workforce that is not fit for the purpose of implementing the *National Framework;* this task requires integrated practice frameworks and response capability. This study of the workforce has identified that the present system is narrowly focused on the individual children, young people and families who are assessed as being at significant risk of harm.

The system relies on statutory interventions at the tertiary tier rather than addressing the underlying social determinants of child abuse and neglect. Despite the policy frameworks, significant investments and resources devoted to the prevention of child abuse and neglect in Australia since the advent of the *National Framework*, the numbers of children and young people in out-of-home care. In particular, the numbers of Indigenous children and young people within the protective system have steadily increased (AIHW, 2011, 2021a; PwC, 2020).

The inadequacy of these endeavours is borne out by the international research undertaken by Professor Ruth Gilbert and her colleagues (2009, 2012) of child abuse and neglect across the developed world. This research identified that tertiary tier responses addressed only one-

tenth of the actual harm experienced by children. Reviewing their work, Professor Nigel Parton concluded:

> The researchers were clearly highly sceptical of the ability of existing child protection systems to overcome child maltreatment, reinforced by the fact that there was absolutely no evidence that existing child protection systems made any impact on any of the child maltreatment indicators in six jurisdictions over a thirty-year period. (Parton, 2019, p. 477).

A public health approach to child welfare offers promise and hope in the context of many years of Australian systems that are failing to prevent child abuse and neglect and its devastating impacts. It is particularly important to skilfully pursue this approach if we are as serious as we must be in dramatically reducing the number of children and young people, particularly Aboriginal and Torres Strait Islander children, in Australia's statutory care system (AIHW, 2021a). Therefore, adopting public health approaches to child welfare is imperative. To achieve this, better workforce planning is critical.

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