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Being a Self-regulating Profession in the 21st Century: Problems and Prospects

In August 2015 the Council of Health Ministers announced the outcome of an independent review of the National Registration and Accreditation Scheme (NRAS) and their response to the review (COAG Health Council, 2015). After many years of lobbying for the inclusion of social workers in NRAS, the Australian Association of Social Workers (AASW) was again disappointed on two counts. The first disappointment was that the independent reviewer did not recommend the extension of NRAS to include currently self-regulating health professions (Snowball, 2014). This was despite strong representations from the AASW about the continuing risks to public safety and the unintended consequences for service delivery flowing from the exclusion of social work as one of the largest allied health professions in the country (AASW, 2011). The second disappointment was that the Health Ministers rejected the independent reviewer's recommendation that governments "establish a system of quality assurance for voluntary registers of self-regulated professions" (Snowball, 2014, p. 6). The Australian Health Workforce Ministerial Council did not view government support for self-regulating professions as necessary to protecting the public, to promoting a level playing field among the allied health professions, or to supporting quality services (COAG Health Council, 2015). The Australian Governments' resolution not to extend the scheme to social work remains despite recent calls by the South Australian Coroner and the South Australian Parliament for our inclusion in NRAS (see Johns, 2015; Parliament of South Australia, 2015).

So for the time being the Australian social work profession remains a self-regulating profession in an environment of mixed regulation where some professions are regulated by national law while others are not. To acknowledge our current situation as a self-regulating profession is not to retreat from our continued and strong advocacy for national regulation. For reasons that will become apparent in this address, I consider that national regulation is essential for enhancing public confidence in social work services. In this address I will focus

on the situation we are currently in as a self-regulating profession in Australia. The key questions I focus on in this address are:

1. What is a self-regulating profession?
2. What are the problems and prospects for achieving public confidence in self-regulating professions?
3. What can the AASW do to further promote confidence in social work as a self-regulating profession?

What is a Self-regulating Profession?

A self-regulating profession is one that undertakes to be a "reliable guarantor for the competence and conduct of its members" (Dixon-Woods, Yeung, & Bosk, 2011, p. 1452). A self-regulating profession involves professional peers in establishing and monitoring professional standards at both the collective level, through setting entry and ongoing education standards, and the individual level, such as through monitoring standards of ethical conduct. A profession can be self-regulating through delegated government authority. For example, in England the Medical Act, first established in 1858, empowered the British medical profession to found the British Medical Council, which was a self-regulating body for a period of 150 years to 2009 (Dixon-Woods et al., 2011). Or a profession can be self-regulating without legislative support. In this circumstance members of the profession organise themselves to establish and monitor education, ethical, and practice standards for the profession, as is the case for several allied health professions in Australia, including social workers, speech therapists, and dieticians.

There are reasons why governments may prefer professions to be self-regulating. These reasons include that self-regulating bodies monitor professional standards "with a minimum of regulatory overheads and low transaction costs" (Dixon-Woods et al., 2011, p. 1458). In addition, professionals may trust and comply with directives from others within their profession who understand the scope of their work. In essence, self-regulation costs government less and may be preferable in professions where the majority of professionals are members of the relevant self-regulating body and where the risks to public safety are low.

In recent years in Australia and in many comparable countries there has been an increase in government regulation of health and human service professions and a decline in professional

self-regulation. For example, in England in 2003 the Council for Health Care Regulatory Excellence was established and "the long tradition of doctors occupying majority on the GMC [General Medical Council] ended in 2009" (Dixon-Woods et al., 2011, p. 1453). In Australia the advent of the NRAS has extended the reach of national registration to some health occupations that were previously registered in only some States or Territories and to some previously unregistered health occupations. For instance, the extension of the National Regulation Scheme in 2012 saw the inclusion of the previously unregistered professions of Chinese Medicine practitioners—a diverse group including Chinese herbal dispensers and acupuncturists—and Aboriginal and Torres Strait Islander Health Workers. Of course it is true also that speech therapists became unregistered largely as a consequence of only being registered in one State (Queensland) prior to the advent of NRAS. The net sum increase in the number and range of health occupations registered under NRAS may perhaps be seen as ironic given that a key objective of the scheme to reduce the amount of government red-tape by replacing the numerous State and Territory based health boards with 10 health boards, which after 2012 expanded to 14 health boards.

Internationally social work has been affected by this trend toward increased government regulation of health and human service professions. Indeed, Australia now stands alone among comparable countries in its lack of government regulation of the social work profession. The number of countries where social work is regulated through a form of government regulation or licensing is on the rise and includes: England, Wales, Scotland, Northern Ireland, the Republic of Ireland, Canada, the USA and New Zealand (Kirwan & Melaugh, 2015).

The extension of regulation schemes in the health and human service professions has many critics. At the heart of these criticisms lies a concern with the loss of professional autonomy and increased managerial control of professional standards without clear evidence of improved public safety (Dixon-Woods et al., 2011; Van Heugten, 2011). In Australia the medical profession opposed the introduction of NRAS. The Australian Medical Association asserted that NRAS could lead to the employment of nonmedically trained people in positions currently held by doctors and it "would strip medical colleges of their control in setting educational and training standards for doctors, and put in the hands of politicians and people without expertise" (Carrigan, 2008, p. 25). While the Australian Psychological Society did not oppose the Scheme, it raised concerns about the costs to registrants and also

the recognition of psychologists working outside health services (Littlefield, Giese, Stokes, & Voudouris, 2009).

Despite strong support for registration among AASW members (AASW, 2011), across the profession the push for registration is debated. For many social workers registration is seen to promote professional recognition and public safety through monitoring professional standards and ongoing professional development (AASW, 2011; Beddoe & Duke, 2009). A recent New Zealand study found that social workers reported that registration had enhanced their access to continuing professional development and thus enabled them to keep up-to-date professionally (Beddoe, 2015). Yet others view the goal of professional registration as "elitist and antithetical to the social justice and social activist foundations of social workers" (Lonne & Duke, 2009, p. 386; McDonald, 2006; Van Heugten, 2011). The highly diverse nature of the Australian human services workforce raises some concern about the implications of registration of social workers for the many social welfare practitioners without social work qualifications (Chenoweth & McAuliffe, 2011).

Social workers, alongside other professions, raise concerns about the impact of government regulation on the profession's autonomy in setting its own standards drawing on its own traditions and knowledge base (see also Legal and Social Issues Committee, 2014). Reflecting on the extension of regulation schemes to social workers in the Republic of Ireland, Kirwan and Melaugh (2015, p. 1051) observed:

the primary purpose of professional registration is to ensure that the public is protected from harmful or socially unacceptable practices on the part of service providers, in this instance, social workers. Additional drivers underpinning social regulation include public expectations of quality service provision, the growing focus on risk avoidance within society and the increasingly embedded political expectations regarding service provider accountability and clinical governance.

Kirwan and Melaugh raised concerns that regulatory regimes lead to increased focus on the conduct of the individual practitioner and less on the systems in which the practitioner is embedded. In their review of the professional misconduct hearings in England, Kirwan and Melaugh concluded that responsibility for poor practice was located with the practitioner but that the hearings seemed to lack information about the organisational context that may have contributed to poor practice.

Any form of government-supported national regulation of social work in Australia would reshape the profession. For example, a professional board constituted under NRAS would necessarily involve community members who would have a say in the education and practice standards of the profession. Similarly disciplinary misconduct hearings would necessarily involve a panel with a majority of nonsocial workers. This would involve some diminution of the profession's control over its standards but this may also increase public confidence in those standards. From the viewpoint of the AASW, the argument for government-endorsed regulation of social work remains one of promoting public safety by ensuring that practitioners are appropriately qualified, retain currency of practice, and are accountable for providing quality professional services to vulnerable individuals.

The Prospects and Problems of Self-regulation

To an extent, the benefits and costs of national regulation are a moot point. For here we are in 2015 and the profession remains self-regulating despite our many attempts to achieve national regulation. It is probably worth noting that some professions would give their collective eye-teeth to be self-regulating. Though few would opt to be in our situation where we lack formal legislation or other government backing to support our self-regulating efforts.

Before turning to the problems of being a self-regulating profession, we should remind ourselves of some benefits of self-regulation. These benefits include that the profession keeps control of its standards including determining the nature and scope of professional knowledge and skills as well as professional conduct standards. There is scope for self-regulating professions to take a developmental role in matters of minor professional misconduct rather than dealing with this in a more formalised manner that may occur within an external regulatory regime

But what are the challenges of being a self-regulating profession? To answer this we need to look no further than to the reasons why governments in Australia and many comparable countries have found self-regulatory models untenable for the majority of health and human service professions and have shifted towards increased government regulation of them.

The first issue is a crisis of trust in health and human service professions. In their analysis of the demise of self-regulation of the British medical profession, Dixon-Woods et al. (2011) pointed to the failures of the British General Medical Council in preventing or adequately

addressing the medical scandals that resulted in abuse, serious injury, or death of patients. Indeed the litany of failures by the General Medical Council led doctors to pass a motion of no confidence in their own council (GMC loses doctors' backing, 2000). Dixon-Woods et al. (2011, p. 1455) concluded that within the self-regulatory model the "system imperative to engage in monitoring and correction of deviant behaviour was in conflict with the social imperatives for collegial cooperation" (Dixon-Woods et al., 2011, p. 1455).

Similar institutional and professional failings have been exposed in a myriad of inquiries such as those into forced adoptions, children in institutional care and more recently, the Royal Commission into the Institutional Abuse of Children (Community Affairs References Committee, 2004, 2012; Forde, 1999; Royal Commission into Institutional Responses to Child Sexual Abuse, 2014; Wilson, 1997). Time after time, those before these inquiries have highlighted the tendency of powerful groups, whether in the clergy or in the human service professions including nursing, midwifery, medicine, and social welfare occupations to serve their own interests rather than those of the most vulnerable with whom they are practicing (Healy, 2015). In the context of these multiple failings, public confidence in the capacity of health and human service professions to effectively regulate themselves is low. In essence, it would seem that government, the general public, and sometimes members of the professions themselves don't trust health and human service professions to self-regulate.

The second challenge to professional self-regulation is the growing recognition of the rights of consumers in shaping health and human services. In many fields of practice—particularly in health, disability, mental health and-increasingly in child welfare services—service users are demanding that service providers are accountable to them and not only, or even primarily, to their own professional bodies (Healy, 2014). Consumer involvement in setting professional standards is an important step towards enhancing confidence in all professions, including self-regulating professions.

A third challenge pertains to the nature of the professional contract between practitioners and those whom we serve. In the absence of formal regulation, people using services of self-regulating professions necessarily rely on trust in service providers, namely that a practitioner will act in the best interests of those using their services. But are relations of trust appropriate, or tenable, as a basis for professional practice relationships? Tonkiss and Passey (1999, p. 258) differentiated between trust and confidence in the following way:

> trust – as pertaining to ethical relations which are not conditioned by an external framework of controls – and confidence – [as] referring to relation which are secured by contract or by other regulatory forms, and which proceed on the basis of rational expectation.

From this perspective, trust can be seen as a reliable basis for exchange in informal relationships but is less reliable as a basis for professional relationships. For example, one might trust one's friends with confidences knowing that the relationship, rather than a system of legally binding controls, is the basis of one's trust. By contrast, the confidence one has in the confidentiality of the midwife–patient relationship pertains to the regulatory system that shapes that relationship. Moreover, the service user needs to be confident not only in the professional integrity of the service provider, but also in their professional competence which is reliant on the professional's achievement of foundational educational requirements and ongoing engagement with professional learning. Without a system of formal regulation, people's confidence in services offered by a self-regulating profession may be compromised.

Challenges to Achieving Public Confidence in a Self-regulated Profession

The nature of self-regulation of social work poses many challenges to achieving public confidence in our services. These challenges persist despite the considerable success of the AASW, as a voluntary body, in establishing robust ethical, education, and professional standards. A key barrier to achieving public confidence in social work services is that the standards set by the AASW are voluntary. Imagine if the other service providers with whom social workers practice or from whom the general public seek advice for health and personal problems—such as psychologists, doctors, nurses, midwives—could opt out of professional regulation. Yet government has refused to support our own attempts to self-regulate, despite the recommendation of the independent review to NRAS that such protections should be provided for “voluntary registers of self-regulated professions” (Snowball, 2014, p. 6).

Achieving public confidence in AASW standards is challenged also by the fact that only a minority of social workers choose to join the AASW and thereby participate in its model of professional self-regulation. This fact remains despite the substantial membership growth in recent years. The relatively low uptake of membership of the professional association is an

important way in which the AASW differs from some other self-regulating professions. For example, the workforce data on dieticians indicate that more than 90% of qualified dieticians in Australia are members of their professional association (Dieticians Association Australia, 2015; Health Workforce Australia, 2014). This relatively high rate of association membership may be due to the large proportion of dieticians with private practices that require Medicare accreditation via their professional association. In other words, for dieticians, membership of their professional association is mandatory should the practitioner wish to access funding via the Medicare schedule.

In contrast to dieticians, the majority of social workers work for public or not-for-profit organisations where employers are unable to require social workers to be accredited with the AASW. Were the AASW to be supported by national law to operate a voluntary register of professional social workers it may be lawful to require registration as a condition of employment or funding in areas where the register was relevant. However, in the absence of government regulation, neither employers nor the general public can have confidence that a social worker is obliged to meet the robust standards applied to registered professions in Australia. Furthermore, the voluntary nature of our self-regulation model means that the AASW has no jurisdiction to monitor or address professional misconduct for those who choose not to join the Association.

Strengthening Public Confidence in Social Work

While the AASW will continue to strive for national regulation of the social work profession and also for State and Territory based legislation, we are also seeking to strengthen our capacity for self-regulation so as to provide the framework needed to enhance public confidence in our profession. First, we are working alongside similar allied health and human service professions to develop a model of self-regulation that mirrors many of the features of the national regulation and accreditation scheme (see AHPA, 2012). We are founding members alongside other self-regulating professions such as speech therapists and dieticians of the National Alliance of Self-Regulating Health Professions (NASRHP). Our Association will have a seat on the Board of NASRHP and the Alliance will support the monitoring of professional standards including fitness to practice and continuing profession educational standards for members of self-regulating health professions. As a member of NASRHP we will continue to advocate for government to provide legislative support for voluntary registers

within self-regulating professions. Legislative support may increase public confidence and safety by obliging social workers on the voluntary register to participate in a system of professional self-regulation.

Second, we must continue to build the membership of the Association. The AASW has had considerable achievements in building its membership base, growing by around 50% from mid-2011 to mid-2015. However, the AASW system of professional self-regulation cannot reach the majority of social workers who continue to opt not to be members of the professional association. Without the participation of the vast majority of social workers in a robust system of professional regulation, those who use our services cannot be confident that practitioners will be supported to achieve high ethical and practice standards and to be held accountable where they do not.

Linked to the growth of membership, we also need an engaged, active and, dare I say it, a sceptical membership. We need a membership that holds the AASW to account in upholding high education, ethical, and practice standards and to ensure that the AASW remains a viable association. Our capacity for effective self-regulation will be enhanced by members holding the leadership accountable for ensuring the financial viability of the AASW, and to protecting the Association's responsibility to support social work education, practice, and ethical standards.

Third, we need to increase our accountability to those who use our services. An important lesson of the failure of the British General Medical Council as a self-regulating body is that it reminds us “of the practical problem of confronting deviance, and [that] the tolerance and protection of the inept, are pervasive features of all organised groups” (Dixon-Woods et al., 2011, p. 1458). This flaw of organised groups becomes magnified in the context of self-regulating professions when the profession loses sight of the interests of outsiders, particularly service users and those who care for them. Notably NRAS requires the mandatory inclusion of community members on each of its 14 professional boards. Further, the national law for disciplinary hearings within NRAS requires a three member panel that involves at least one and usually two members who are not from the same profession or specialty as the person being investigated (Commonwealth of Australia, 2009). The involvement of outsiders to the profession in determining standards and in monitoring conduct is recognised under national law and protects those standards from collusion or misuse within the profession. As NASRHP develops it will be important to include the voices

outside our profession, particularly those who use our services and those who care for them, in assisting us to improve our standards. For public safety, it seems important that this is the case.

Building Public Confidence in the Social Work Profession

I began this address by acknowledging the disappointment of many within the AASW arising from our continued exclusion from NRAS and the refusal of government to provide legislative support to enhance our capacity to self-regulate. The absence of government regulation creates challenges in building public confidence in social work professionals as without regulation we have no protection of our title and limited jurisdiction to monitor standards across the profession. Yet we remain for the time being a self-regulating profession, which has the advantage of maintaining the profession's autonomy in setting its standards in accordance with our values and norms. The major weaknesses of this model include its potential closure to the views of those who use our services and to tensions within the capacity of self-regulating professions to manage deviant behaviour within the profession.

In this address I have outlined practical actions the AASW can take to strengthen our capacity to be a self-regulating profession and to reduce the inherent flaws of self-regulation. I am optimistic about the opportunities for promoting high professional standards provided by our membership of the alliance of self-regulating health professions. Ultimately the success of the self-regulating model depends on the quality of the AASW leadership, the alliances we form, and the active involvement of AASW members in monitoring the AASW at every level. Our capacity to build public confidence in our profession depends on each of us being engaged with our professional association. This involves being an active member who takes notice of how the Association is faring at every level including: financially; in representing our profession to stakeholders; and in fulfilling its obligation for maintaining high standards in social work education, ethics, and practice. Every member has a role to play in supporting and, where necessary, constructively challenging the AASW to achieve the high professional standards. I hope you will all play your part.

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