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To:	CYAA Review
Cc:	Guy Smith; Carl Soderstrom
Subject:	AUPE Submission to the Committee
Date:	Thursday, October 13, 2016 6:15:43 PM
Attachments:	16301ChildYouthAdvocateSubmission.pdf

Dear Sirs and Mesdames,

Please find attached the submission on behalf of the Alberta Union of Provincial Employees to the Standing Committee on Legislative Offices with regard to the review of the *Child and Youth Advocate Act*. Thank you for the opportunity to present our thoughts.

If you have further questions, please do not hesitate to contact the undersigned.

Sincerely,

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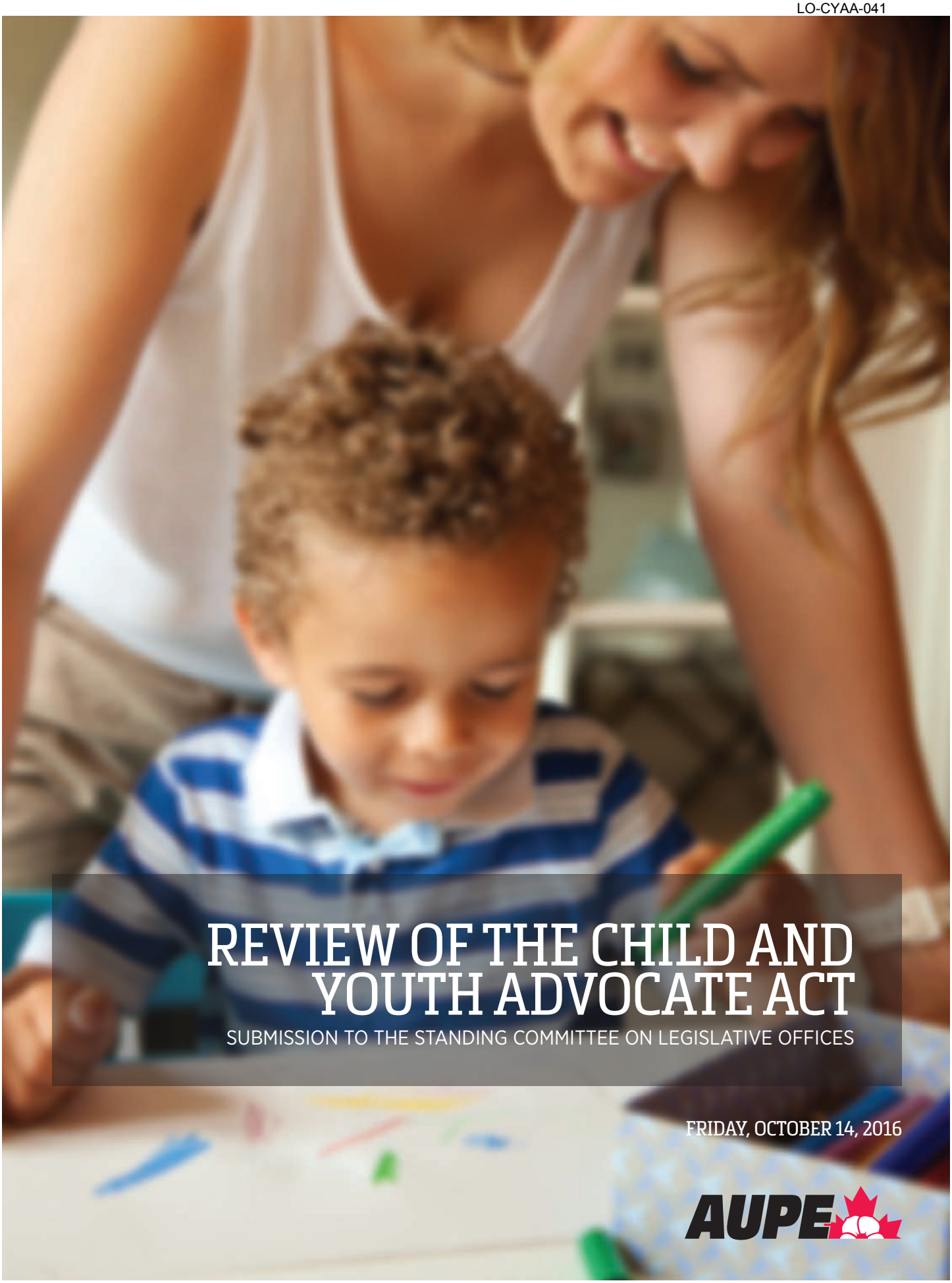

REVIEW OF THE CHILD AND YOUTH ADVOCATE ACT

SUBMISSION TO THE STANDING COMMITTEE ON LEGISLATIVE OFFICES

FRIDAY, OCTOBER 14, 2016

AUPE

The Alberta Union of Provincial Employees represents more than 3,000 social service workers across the province, including the dedicated child intervention staff. Though AUPE members do not work directly under the *Child and Youth Advocate Act*, the role of the Advocate's office is intimately tied to the work that AUPE social service members do and to many of the challenges they face.

As such, our comments in this review process are narrowly confined to those areas of interaction between social work and the Office of the Child and Youth Advocate. We acknowledge the importance of the review and thank the Standing Committee on Legislative Offices for their work and for the opportunity to present our thoughts.

Of primary concern is reiterating and reminding the Committee of the importance of systems-based death reviews, which consider respectfully the role and needs of the staff who cared for the deceased child. Modern day social work is a stressful and high-pressure work environment. Burnout, high turnover, low morale, post-traumatic stress disorder and other psychological injuries are increasingly common. Workers are even more vulnerable to these effects after a crisis occurs with one of their cases – especially if that event is the death of a child. Indeed, of all the stressors that social workers face in their jobs, one of the most distressing is the death of a child – above even assault or threats of assault to the worker themselves.[1]

Experiencing the death of a child client is difficult enough, but media and public scrutiny and fatality inquiry or review processes can substantially worsen the stress. Workers experience self-blame and doubt, vicarious trauma and increased anxiety in both their professional and personal lives. When one of their cases is investigated, these effects are heightened. Workers must re-live the trauma and be re-exposed to the event. Many co-workers feel secondary stress and scrutiny.[2] The loss of confidence can lead to job performance difficulties and to personal distress. These effects are felt long-term[3] and sometimes result in workers leaving the profession entirely.

In fact, studies also show that intensive and complex death review processes, while well intentioned, can lead to increased risk aversive practice modifications and anxiety born largely by social workers.[4] In turn, the quality of the services provided, the integrity of the relationship with the client and the eventual outcome may also suffer from constrained decision making on the part of the social worker. Often, rather than tackling the systemic issues they strive to address, modern child fatality reviews lead to defensive practice by social work professionals[5] – defeating the very purpose of improving upon child intervention services.

Social work, like all professions involving human interaction, requires professional judgment based on available information at the time. Just as with doctors, nurses or lawyers, social workers are humans and are not infallible. A common result of invasive fatality reviews is the formalization of processes with a reduced role for human reasoning and increased compliance monitoring and paperwork.[6] Creating rigid practices does not result in enhanced quality of care for the most vulnerable and at-risk youth, takes valuable time and attention away from direct client service and only leads to disengagement and dissatisfaction on the part of the workers.

Repetitive public and high profile death review processes can also cause severe deterioration in morale and heightened risk of burnout, stress, anxiety, depression and other psychological conditions in social workers.

Nonetheless, the role of an external investigator has considerable potential to address and improve many of the systemic factors that put vulnerable children at risk of death or serious injury. While the Advocate has made recommendations relating to factors outside of the particular worker's control – like workload issues and specified training, support and mentorship improvements – rather than easing the appearance of blame on a social worker, these findings can reinforce perceptions that the primary factors in a vulnerable child's death is the work and decisions made by the child intervention workers.[7]

The preferred lens of investigative reviews, therefore, should be a systems-based framework. A systems framework considers the family system, worker system, organization system (statutory frameworks, government funding and policy decisions, workplace structures) and the wider system (political and community environment and pressures) to better identify and explore the many facets and interactions of complex casework. A systems framework sees human errors or judgments as arising from the interactions of all those factors.[8] Similar frameworks are often used in medicine and engineering, where safety is also a high priority.[9]

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[1] Regehr C., Chau S., Leslie B., Howe P. (2002) "Inquiries into Deaths of Children in Care: The Impact on Child Welfare Workers and their Organization" Child and Youth Services Vol. 24 No. 11 p. 641-644.
[2] Ibid.
[3] Ibid.
[4] Ferguson H. (2004) Protecting Children in Time: Child Abuse, Child Protection and the Consequences of Modernity. Palgrave, New York.
5 Connolly M and Doolan M. (2007) "Responding to the Deaths of Children Known to Child Protection Agencies" Social Policy Journal of New Zealand Issue 30.
[6] Munro E. (2005) "Improving practice: Child protection as a systems problem" Children and Youth Services Review, 27375-391.
[7] Connolly 2007.
[8] Munro 2005.
[9] Munro 2005.

For example, rather than making findings solely based on an apparent gap in a specific skill training or inappropriate use of a tool or assessment, a systems investigation considers how the existing documentation and training requirements, workload, resource constraints, apparent public or political priorities, unique characteristics of the family or child, and other factors might interact to affect behaviours or decisions across all the players involved.

In addition, all staff and officials involved in the death review process should be made familiar with the stressors and challenges of child intervention social work from the workers' perspectives. These perspectives should form an integral part of the systems-based framework used for investigations and file reviews, but also for all the work of those involved in the child intervention system.

An enhanced sensitivity to the experiences and needs of social workers and a focus on building processes, reports and findings that are supportive of social workers and their professional and personal needs can only help to serve the ultimate goal of continual improvements to child intervention programs and better outcomes for all vulnerable youth.

Similarly, the Advocate should be encouraged to conduct broader research and advocacy work with regard to the realities and challenges of social work today. While social work has always been a challenging profession, working conditions today make it difficult for staff to practice at their best, resulting in reduced job satisfaction and morale and higher burnout and turnover. Caseloads are well above recommended maximum levels and the associated workload only climbs also as complexity of files and additional paperwork, compliance and administrative tasks increase. As reliance on contracted agencies proliferates and those relationships become more complicated, added stress and accountability is placed on social workers who no longer have full control over their cases. Lack of supports and proper equipment and tools and ever-changing policies, procedures and organizational matters compound these difficulties. Few of these issues are new and little progress has been made to date in addressing them.

Though the office is specifically the advocate for vulnerable youth and children, assisting in workplace and practice challenges for the service providers will have immense and direct impact on the wellbeing of children in contact with the intervention system. While these powers exist under a broad interpretation of section 9 (2), a clear mandate to address these sorts of systemic issues and to work alongside social work practitioners in addressing their challenges will improve the efficacy of the Advocate's work.

AUPE thanks the Committee for the opportunity to provide our input to the review of the Child and Youth Advocate Act and we look forward to ongoing work to develop an effective and respectful process for investigative reviews.

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