LOCAL 006 A.U.P.E.

CASELOAD ISSUES

THIRTY YEARS OF STRUGGLE WITHOUT RESOLUTION

1981-2011

NOVEMBER 2011

WORKLOAD/CASELOAD ISSUES

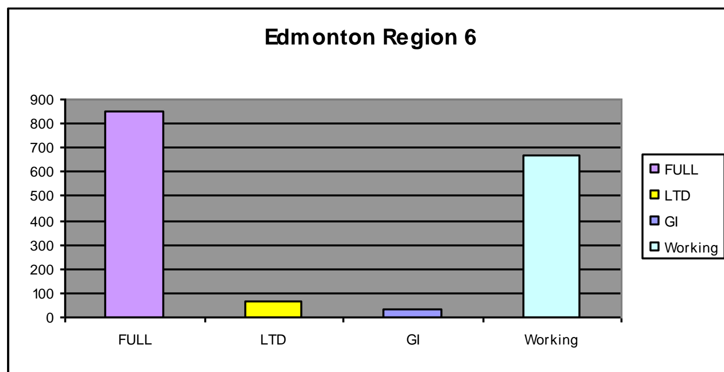
The new Human Services Ministry, area of Child and Family Services and the Seniors Ministry, area of PDD and AISH workers have been working short staffed for many years. In fact, it is a rare occasion when these areas have been fully staffed. Not only do employer expectations remain at a fully staffed level; but constant changes to the standardizations, data collection, and reporting have created organizational chaos that includes additional new forms and in-depth reports. Many of these new tasks are too cumbersome and labor intensive to adequately manage with the number of employees on the worksite. Any efficiency created by a seasoned worker now has to be re-established.

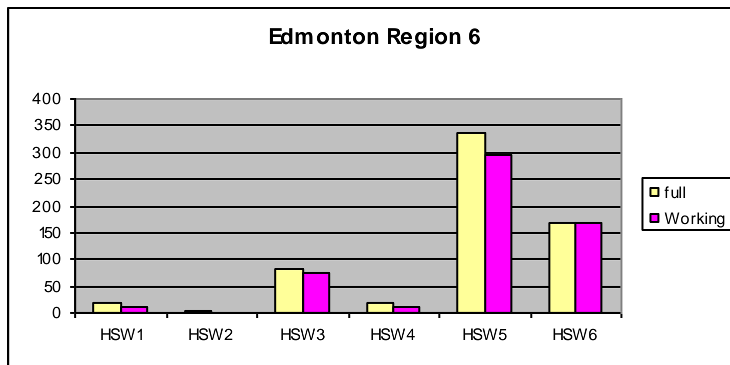
This paper contains details that effect staffing levels and makes recommendations to resolve the 30-year problem of caseload tragedies, issues and ethical dilemmas.

GENERAL ILLNESS/LTDI AND THE EFFECT ON WORKLOAD

Caseloads and the number of staff required to provide quality care is complicated by the number of staff that are employed compared to the number actually working. The exact number of staff working is difficult to determine because different information is calculated differently. General illness is collected by Region and it does not differentiate between classifications; thus all 26 in Calgary could be staff that does not maintain a caseload, however, unlikely. Long-term disability differentiates by classification and areas within Regions. To create a chart for comparison, the data displayed is for one month. Full indicates the number of full time positions, LTD indicates the number of workers on long-term disability, GI indicates general illness and working indicates the difference between the number of positions minus the number of members on disability. The 63 members on LTD maybe covered off by a temporary salaried person, a wage staff or the position may have been hired to permanent status. The general illness positions will not be covered. In some cases LTDI is not covered, as the Employer does not know when the worker is to return, therefore it is left vacant.

		FULL	LTD	GI	Working
Edmonton	HSW1	19	7		12
	HSW2	5	5		0
	HSW3	83	5		76
	HSW4	18	5		11
	HSW5	336	29		295
	HSW6	170			170
	HSW7	220	12		102
	TOTAL	851	63	34	666

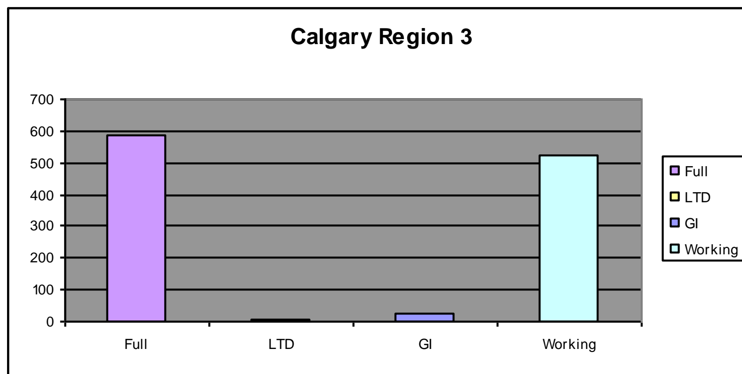


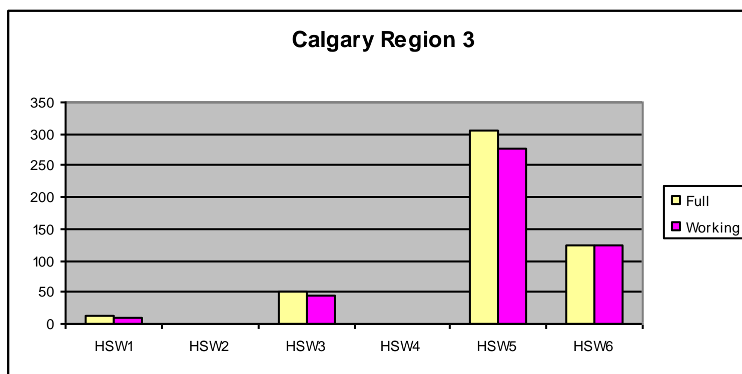


This graph indicates the comparison of positions, and the number of members off on LTD by classification in the Edmonton Region; the greatest difference is noted in the HSW5 classification.

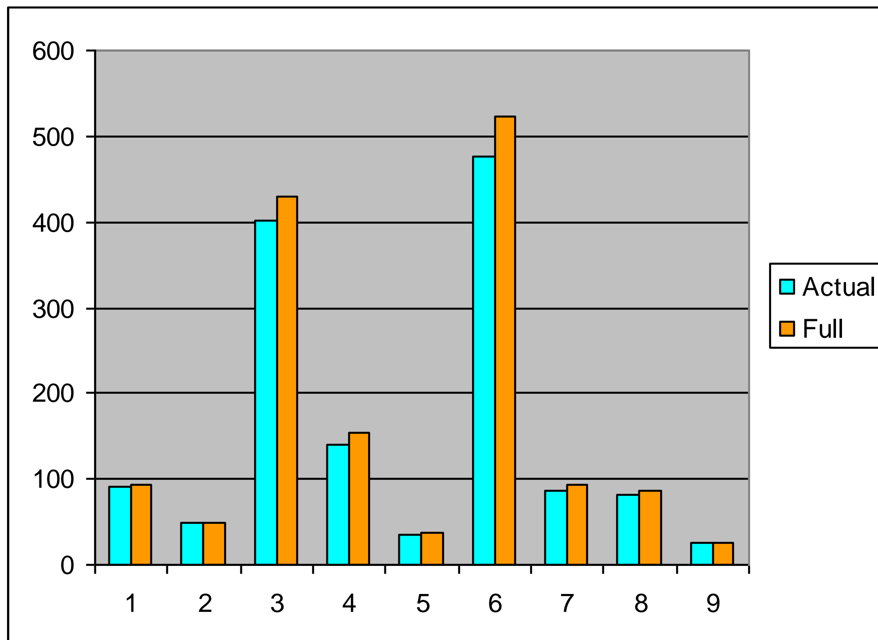
Workers on LTD are replaced; however, the 34 on general illness will not be covered, so 34 caseloads will be distributed among the remaining workers, who are probably over caseload already.

		Full	LTD	GI	Working
Calgary	HSW1	12			11
	HSW2				
	HSW3	51	1		45
	HSW4				
	HSW5	304	6		277
	HSW6	125			125
	HSW7	97	1		91
	Total	589	8	26	523





Long-term disability does provide for the position being hired to on a temporary basis so it would be reasonable to assume that there may be as many as 105 temporary workers covering long-term disability absences for the HSW 4, 5 and 6 classifications. General illness information is provided by Region not by classification; thus the HSW 4, 5, and 6 classifications represent approximately 2/3 of the series. 2/3 of the reported general illness for 1 month would be 64 employees; this brings the total to 1387 workers. The number of children in care for the month of May was 12,502.



This chart shows the difference between the number of full time positions compared to the number of workers actually working.

When workers resign there is a delay of at least 30 days before the position can be advertised. When there is difficulty hiring, then the position remains open for as long as it takes to find a suitable candidate. Even when a worker is hired there are training considerations and a lack of experience to be compensated for by senior workers; thus the office does not have a worker that can carry full responsibilities for the first several months. The turnover rate exceeds the hiring rate by 20 positions province wide. Thus,

between LTD, general illness and turn over, there are approximately between 50 and 100 positions at issue.

WORKLOAD/CASELOAD ISSUES

The issue of excessive workload has been an ongoing problem for Local 006 since the early1980s and much discussion and actions have occurred to attempt to remedy this situation, including the province-wide strike of 1990. In 1991, there was an agreement between Local 006 and the employer to the Workload Standard of 101 hours per worker per month. There was also a three-step appeal process when the standard was exceeded for 60 days. The caseload sizes have continued to increase and there has only been some very temporary relief from the Appeal process. There has never been a solid standard for foster care, adoptions, Family Support for Children with Disabilities, AISH (Assured Income for the Severely Handicapped) and PDD (Persons with Developmental Disabilities).

Now the caseloads are as follows:

Child Intervention/Child Protection

Such caseloads exceed the provincial standard of 101 hours with 135 hours to 146 hours per worker per month. The aboriginal caseloads can start a relatively new worker with a caseload count of 119.5 hours and he/she will get more cases as the caseload is “just getting started”. With such caseloads, the expectations of band consultations, religious and cultural requirements, we should really be adding 1/3 more hours to the caseload, which at this time are not taken into consideration. In this case, a caseload, which is already at 146 hours would have a count of 194 hours, almost double the 101-hour standard. Such numbers are now the rule, and not the exception.

Assessors (Investigators) are under a tremendous burden to do as many investigations per month as possible. The workload standard was 11 investigations per month, but has been informally decreased to 6 to 8 per month due to paperwork requirements and complexity of cases. However, the cases keep coming in and they are assigned to the existing

workers, even though they cannot see them in a timely manner; giving rise to a "hidden waitlist" of cases. This establishes liability at the worker level, when the issue is a systematic one — too many cases and not enough staff. Sometimes the additional cases are assigned to staff that are not trained to do investigations, thereby increasing staff and system stress, and liability. With the additional stresses and delays, the children requiring services are left at risk.

The toll it takes on workers is extreme, increasing general illness and sometimes LTDI; health issues (especially high blood pressure and heart ailments) are a major concern. Workers are also leaving our employment disillusioned and depressed. It is common that those who manage to survive will stay for their probationary period, then move on. Retention continues to be a problem for our Employer. For example, 470 workers were recruited in 2009/2010 and 450 workers left for various reasons. In 2010/2011, 319 workers were recruited but only 200 remain. New employees attending delegation training are overwhelmed and need to be supported prior to taking on larger caseloads, so the constant need to replace trained workers creates further caseload risks. As union stewards, we spend considerable time with many of these individuals to try and solve the issues; however, dealing with the stresses of their own caseload plus the stress of the workers is proving to be difficult for the stewards.

AISH (Assured Income for the Severely Handicapped)

The AISH Generalist position (only a HSW 3 classification) is the key contact for new AISH applicants and persons starting to receive benefits, provision of financial benefits with continual review of income the clients may receive. They do ongoing file reviews and management of financial information to assess income changes for all clients annually, discussions with clients re: medical and living needs as they arise, inform clients of community resources to better help them meet their needs, assist with the completion of requests, and confer with the Director and Senior Health Managers to determine eligibility for additional personal benefits. They also assess a client's capability to administer funds, meet with the appropriate agencies and/or people to assist client arranging a financial administer or other Guardian/Trustee.

Note: In order to qualify for AISH and receive supports, clients have been evaluated by a doctor, and have to meet a certain standard of need.

AISH workers do all of the tasks from intake to caseload maintenance and these clients have difficulty understanding the processes. If the processes are unable to be communicated to the clientele as slowly and often as needed; this results in more calls to workers, fixing mistakes, and/or increasing the approval time for benefits.

This is not the type of clientele that workers see only once a year for a review—they are needy and often require constant communication.

The AISH workers' caseloads exceed what they can be expected to do in a 7.25 hour day; subsequently clients are at risk. Example: problems with budgeting issues can result in clients being evicted; a worker may discuss immediate help with paying rental arrears, but unable to explore the problem to learn what other issues are involved (family abuse, budget issues); thus difficult to ensure this does not happen again. A band-aid approach often has to be used, which causes greater costs to be incurred in government issued benefits and greater ongoing crises in client's lives.

Due to high caseloads and huge volumes of paperwork and calls, it takes more time for health requests and urgent matters to be resolved. The clients also get less personal help as workers do not have the time to assess their complex needs.

At any given time there are 500-1000 applications waiting for AISH approval. The average time it takes to assess assets, income and medical information leading to possible approval for AISH is six (6) months and up.

Clients suffer as a result. The ideal caseload would be 250 clients but often the caseloads are now 355 up to 370 and there are other duties such as completing up to four (4) assessment interviews and up to six (6) commencements/reinstatements to perform each month.

Due to lack of support staff some workers are reduced to doing their own filing or it does not get done in a timely and correct manner. Some existing staff are expected to train new staff, when it should properly be a supervisory role. One AISH Generalist was informed through e-mail that if the team members were not prepared to train new staff the new staff members would be assigned to another team. This was seen as a threat and to encourage staff to train even though it is not their job.

When staff is away on illness or vacation, files continue to be assigned to the worker even though they are not there, and are held accountable for anything that happens on that file, increasing liability.

Some clients are at risk such as when a client submits a request for additional services or coverage; it is not unheard of for an answer from the Health Benefits Review to take anywhere from 3 to 8 weeks for a response to came back from the AISH Generalist to the client.

Staff turnover is a major problem, for example, for the summer of 2011 AISH Calgary had 18 staff leave, most of them experienced and senior staff that left for other government positions or for retirement. With new staff coming in, they look at the situation and quickly look for other options within government or in the private sector.

The cycle prevalent now is: caseloads increase, responsibilities increase, illness increases, co-workers et al relationships decrease, clientele services decrease, staff self-satisfaction decreases.

PDD (Persons with Developmental Disabilities)

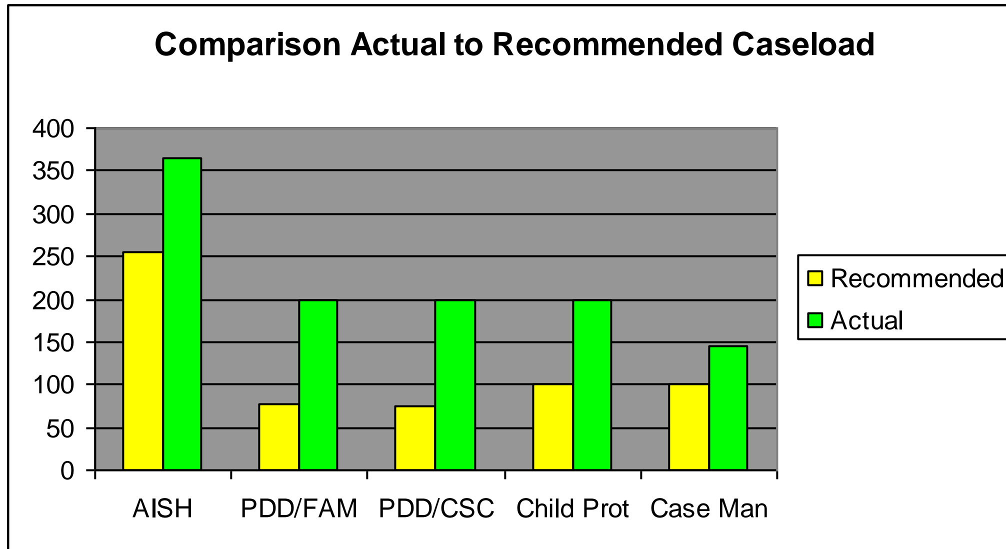
This program is for adults with special needs of all sorts and many clients arrive in the program via the Child Intervention and Management Program and can be seen as a continuation of the Child Welfare and FSCD programs. This program is comprised of Client Service Coordination (dealing with clients and agencies) and Family Managed Services (working directly with clients and families). The clients tend to have very special intellectual needs as one of the entrance criteria is an IQ of 70 or less.

In order to do meaningful client work, the Family Managed caseloads should be no more than 78 and they are often anywhere from 79 to 200; where as the Client Service Coordination caseload should be no more that 75 to maximum 150, they are now anywhere from 180 and rising to 300 in some areas. The highest caseloads are in the larger urban areas. The clerical work done by both programs should be reduced significantly with additional administrative support staff.

The program strives for consistency across the province but this has not been achieved as of yet. This program has a waiting list of clients who need services.

The caseload problem can be summarized in the table and graph below:

	AISH	PDD/FAM	PDD/CSC	Child Prot	Case Man
Recommended	255	78	75	101	101
Actual	364	200	200	199.5	146



(NOTE: If any employee is away on Annual Vacation, General Illness, ongoing training, etc, then the caseload numbers go up and the difference is more pronounced.)

(Child Protection numbers include both Assessor (Investigation) and Child Management workloads. The last column highlights Case Management workload only).

CCC (Child and Youth Care Counselors)

The workload here is very tenuous due to the volatile nature of the young clientele; therefore child and youth care counsellors should never have to work alone, this would be an addition of 3 positions province wide.

RECOMMENDATIONS

1. Ensure all program areas, for example-Day Care Licensing, Adoptions, Foster Care, Supports for Permanency, Family Support for Children with Disabilities, as well as those listed above, have meaningful and realistic workload standards with an appeal process; and that employees and the employer participate in that process.
2. Ensure enough staff are hired to manage the clients and programs with all their demands, as cutting back on tasks is shortsighted and could mean that volatile situations end up in the media for attention/resolve.
3. Employees receive proper training and treatment on the worksite, and that they are allowed to participate in provincial and Regional workload meetings to resolve issues in a timely manner.
4. Public services continue to be offered by government employees under the government mandate, as to privatize/contract out means poor quality of services with greater costs. This often means more work for employees in the long run to ensure good service, for example, adoptions.
5. When an employee is on General Illness for more than two (2) continuous weeks, additional staff be hired to cover such caseloads, perhaps to have permanent "floater" positions available. (ex: mobile unit)
6. There is enough relief staff available for Child and Youth Care Counselors to ensure proper shift coverage, and rely on overtime staff only when necessary.
7. There be a public awareness campaign funded by the employer to ensure that the citizens of the province know of the valuable services that we provide, similar to the ones presently done by AUPE.

8. The staff hiring-freeze for administrative support personnel be lifted immediately as some of our workers now have to do filing to ensure adequate file preparation.
9. Implement whistle blower policy/legislation to provide front line workers the opportunity to identify personnel issues, and program challenges and inefficiencies. (Example: the training budget for home study writers has increased exponentially since the commencement of contracting out).

As professional social workers (equivalencies included), child and youth care counsellors and psychologists, we are responsible for the resolution of the problems that prevent families and individuals from functioning at their optimum level, yet our problems with caseload persists. Let us move forward to find a permanent resolution to the caseload problem today. Reasonable caseloads and associated processes would likely lead to increased morale and increased staff retention, staff engagement and ultimately increased productivity—thus lessoning Ministry costs. Certainly, this would be a win-win situation for clients, workers and the employer.