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BUILDING ON WHAT WORKS:

CHILD DEVELOPMENT CENTRES AND THE FUTURE OF CYSN SERVICES

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The Health Sciences Association of BC (HSA) is a democratic union that represents more than 20,000 health science and social service professionals in over 250 acute and community settings across BC including hospitals, long-term care homes, child development centres, mental health programs, and community social service agencies.

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HSA would like to acknowledge that our office is located on the unceded homelands of the Qayqayt First Nation (pronounced keekite) on whose territories we live and thrive on. Our union works and has members in unceded territories across the province. Unceded means that Aboriginal title to this land has never been surrendered or relinquished.

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Early child development strongly influences well-being, obesity/stunting, mental health, heart disease, literacy and numeracy skills, criminality, and economic participation throughout life—all issues that have profound implications for economic burden on countries.

If the window of opportunity presented by the early years is missed, it becomes increasingly difficult, in terms of both time and resources, to create a successful lifecourse. Governments must recognize that effective investments in the early years are a cornerstone of human development and central to the successfulness of societies.[1]

Introduction

Early child development is one of the most important foundations in society, but one of the most neglected. It is widely recognized that strong and well-funded early child development (ECD) benefits population health and economies.[2] Investment in ECD is the most powerful investments a country can make, which yields benefits across the lifecourse many times over the initial investment.[3] Early childhood development itself is a social determinant of health.

Despite the foundational role of early child development, publicly funded child development services in BC have suffered decades of underinvestment, long waits, and system fragmentation. The deteriorating situation, especially for children and youth with support needs (CYSN), has been extensively documented by the Representative for Children and Youth (RCY), the Select Standing Committee on Children and Youth, community agencies, unions, researchers, and advocates.[4]

Children, youth, and their families are not able to access the services and supports they need in BC. The RCY estimates that there are 114,297 children and youth in BC, ages birth to 18, who have a disability, and that the BC Ministry of Children and Family Development (MCFD) underestimates the number of children and youth with disabilities by a factor of ten. The current system, serving approximately 35,000 children and youth, is serving fewer

1 L. G. Irwin, A. Siddiqi, C. Hertzman, Early child development: a powerful equalizer, Final report for the World Health Organization's Commission on the Social Determinants of Health, Vancouver, BC: University of British Columbia, Human Early Learning Partnership, 2007.

2 L. G. Irwin et al., 2007.

3 Ibid., p. 5.

4 Kids Can't Wait: The Case for Investing in Early Childhood Intervention Programs in British Columbia, Report of the November 2016 Summit on Early Childhood Intervention; Select Standing Committee on Children and Youth, Children and Youth with Neuro-Diverse Special Needs, Legislative Assembly of BC, 2019.

than one-third of those who need supports and services.[5] This leaves an estimated 80,000 children and youth with disabilities who are not currently receiving support in the province.

The effects of this underinvestment in early child development and lack of access to therapy and supports, specifically for CYSN, can be measured by children's vulnerability by the time they reach kindergarten. The UBC Human Early Learning Partnership's Early Development Instrument (EDI) is one of the most important measures available in monitoring the state of early child development in BC. The most recent wave of data collection (2019-2022) found that one in three kindergarten children were vulnerable in one or more areas critical to their healthy development – the fifth wave of data collection where more than 30 per cent of children were vulnerable.[6] And, for a third wave in a row, the two EDI scales with the highest vulnerable rates remain social and emotional development, followed by communication and physical vulnerabilities.

In response to these and other concerns, MCFD engaged in consultations beginning in 2018 to develop a new framework for CYSN. After pandemic and election-related delays, in October 2021, that framework, *CYSN Service Framework and Service Descriptions* (hereafter, CYSN Framework), was released. In the new framework, MCFD committed to the following service approaches: relationship-based, family-centred, holistic, and based on person-centred planning.[7] The CYSN Framework acknowledged the significant barriers to families accessing timely diagnosis, services, and supports, noting that "many children lose precious time for early intervention services and support." The most significant part of the new framework was the restructuring of services for CYSN, and the creation of 40 to 45 service hubs across the province to be called Family Connection Centres (FCC).

MCFD's proposed restructuring of services for CYSN through the creation of FCCs has been influenced by the lack of timely access to services and internal MCFD pressures to reform procurement practices and contract management. Following a competitive RFP process, in January 2023, one of the FCC contracts was awarded to ARC Programs Ltd. – a for-profit, non-union employer with no experience delivering child development and early intervention services,[8] over Starbright Children's Development Centre, which was the established community-based non-profit provider for the past 50 years. Contracts were also awarded to service providers for FCCs in Haida Gwaii/Prince Rupert, Terrace/Kitimat, and Bulkley Valley/Smithers. Following Starbright and the community's advocacy against the planned closure due to the loss of funding, the provincial government paused further FCC implementation beyond the four pilots, provided Starbright a two-year contract

5 Representative for Children and Youth (RCY), Still Left Out: Children and Youth with Disabilities in BC, 2023, p. 12.

6 UBC HELP, EDI Wave 8: Provincial Summary, n.d.

7 Ministry of Child and Family Development, Children and Youth with Support Needs: Service Framework and Service Descriptions, 2021, p. 23.

8 Government of BC, Operators announced for pilot family connection centres, news release (January 5, 2023).

extension, and initiated a year-long public consultation. In its consultation, the MCFD has asked, "what is your vision for an effective system of services for CYSN?" and "what model or approach do you favour and why?"[9]

In response to MCFD's consultation on the future services for CYSN, HSA initiated a large research project to provide government with the perspectives of frontline professionals in the child development sector. HSA is the lead union in the child development sector, representing over 1,000 frontline professionals, including, but not limited to, speech-language pathologists, occupational therapists, physiotherapists, supported child development and infant development consultants, family support consultants, early childhood educators, behaviour interventionists, social workers, and administrative support staff. Over the course of 2024, HSA conducted 17 focus groups (13 in-person and four virtual) involving over 100 frontline staff working in CDCs and non-profit agencies across the province (see Appendix A for research methods and focus group locations). To our knowledge, this is the most extensive effort to understand challenges and opportunities in the child development sector from the perspective of those professionals who work most closely with CYSN and their families. This research spotlights the frontline voices from approximately two-thirds of CDCs and non-profit child development agencies in the province.

What are Child Development Centres and how are they funded?

Child Development Centres (CDCs) provide services to children with a wide range of physical, neurological, and developmental disabilities (such as cerebral palsy, Down syndrome, autism, and fetal alcohol spectrum disorder), as well as mental health and behavioural issues. Approximately 30 CDCs in BC provide interprofessional therapy and integrated services to more than 20,000 CYSN and their families throughout the province. CDCs fall under the "community subsector" of the Health Authorities Act, which reflects the historical placement of CDCs under the Ministry of Health prior to the creation of the Ministry of Children and Family Development in 2001. Since the creation of MCFD, this ministry oversees funding levels, contract language, service planning, and policy development.

CDCs specialize in providing services to children from birth to school entry (usually age five). CDC services are essential to enable children with special needs to participate in child care programs, as well as to make a successful transition into the K-12 school system. Unfortunately, there are too many children that never make it off the waitlist before they have aged out of this critical phase of support services, making the transition to school more challenging. Traditionally, most CDCs have focused on addressing the physical and

9 MCFD, Written submission guidelines - Children and Youth with Support Needs.

behavioural needs of children with disabilities, but the need to provide emotional, social, and psychological supports for these children and their families is growing.
CYSN who do not receive necessary services are less likely to succeed in school, and more likely to require additional ongoing services from MCFD, and the health care and education systems. Beyond the clear benefits of health equity and addressing the cognitive, social-emotional, and functional needs of young children, early childhood development makes economic sense. The research also indicates a higher return on investment when comprehensive programs begin at birth.

Historical and current funding context

The vast majority of funding for CDCs comes from MCFD contracts for "foundational programs" to support caregivers in their child's early years (infant development program and Indigenous development program) and to support children to participate in child care settings (supported child development and Indigenous supported child development), and rehabilitation therapies (occupational therapy, physiotherapy, and speech-language therapy) to support health and developmental outcomes and quality of life for children and youth.[10]

Foundational program contracts fall under the Services for CYSN envelope within MCFD. However, this funding envelope also includes services that are not delivered by CDCs, including MCFD CYSN social workers. Therefore, the CYSN funding envelope does not provide the most accurate picture of funding for the CDC sector because it includes other expenditures. From fiscal year 2012/13 and 2023/24, provincial spending on services for CYSN only increased an average of 3 per cent per year in real terms (inflation-adjusted) (Table 1). The most significant funding increase came in 2017/18 – the first year of the BCNDP government. Since that year, annual spending increases on services for CYSN have been modest. Total MCFD spending increased an average of 1 per cent from 2012/13 and 2023/24 in real terms.

While there have been modest increases to CYSN service spending over the last decade, the funding baseline beginning from 2012/13 was widely recognized then to be severely inadequate – which is to say, much more significant investment in the child development sector is required. More specifically, the BC Association for Child Development and Intervention (BCACDI) notes that while there have been occasional contract increases for CDCs following the freeze to base contracts that occurred in 2008/09, little funding has been provided for service development and expansion.[11] The first significant increase to CDC early intervention therapies (OT, PT, SLP) was announced in February 2023. Budget 2023 committed to increase funding by $95 million over three years for CDCs, including $35 million over three years to hire up to 90 new pediatric therapists, including

10 For a helpful overview of all publicly funded CYSN services, see BC Association for Child Development and Intervention, BC's CYSN Service Delivery Transformation, 2024, p. 5.

11 BCACDI, BC's CYSN Service Delivery Transformation, 2024, p. 7.

physiotherapists, occupational therapists, and speech-language pathologists.

Currently, CDCs are not directly funded to provide some services for CYSN, including autism diagnosis and services. For example, the PHSA BC Autism Assessment Network is a network of clinicians who provide publicly funded diagnostic assessments, but inadequate funding and long wait times mean that many families are forced to seek private-pay diagnostic assessment in order to obtain publicly funded services (via individualized funding). Concerns about the current inequities and fragmentation of funding and service delivery for CYSN are discussed in subsequent sections.

In addition, some CDCs hold contracts with school districts for school age therapy and others hold funding from the Ministry of Mental Health and Addictions for early years mental health services. A minority of CDCs offer fee-for-service autism services whereby families can use their individualized autism funding at the CDC. The majority of CDCs are non-profit charitable organizations and fundraise to supplement provincial funding.

Table 1: Services for CYSN and total MCFD expenditures in BC ($000), 2012/2013 to 2023/2024

Current expenditures (not inflation-adjusted)				
	Services for CYSN	Annual change (%)	MCFD total	Annual change (%)
2012/13	286,596		1,333,067	
2013/14	301,428	5%	1,344,816	1%
2014/15	284,294	-6%	1,339,206	0%
2015/16	285,460	0%	1,378,927	3%
2016/17	303,568	6%	1,451,160	5%
2017/18	349,335	15%	1,595,020	10%
2018/19	361,468	3%	1,792,455	12%
2019/20	390,669	8%	2,067,946	15%
2020/21	410,091	5%	2,223,356	8%
2021/22	441,091	8%	1,661,408	-25%
2022/23	480,381	9%	1,740,645	5%
2023/24	528,889	10%	1,912,095	10%
Avg. annual change, 2012/13 to 2023/24		**6%**		**4%**

Real expenditures (2015 constant dollars)				
	Services for CYSN	Annual change (%)	MCFD total	Annual change (%)
2012/13	305,449		1,420,761	
2013/14	312,135	2%	1,392,583	-2%
2014/15	286,124	-8%	1,347,824	-3%
2015/16	285,460	0%	1,378,927	2%
2016/17	301,373	6%	1,440,668	4%
2017/18	339,271	13%	1,549,069	8%
2018/19	345,277	2%	1,712,168	11%
2019/20	360,564	4%	1,908,590	11%
2020/21	364,394	1%	1,975,604	4%
2021/22	377,397	4%	1,421,498	-28%
2022/23	388,884	3%	1,409,109	-1%
2023/24	411,300	6%	1,486,973	6%
Avg. annual change, 2012/13 to 2023/24		**3%**		**1%**

Sources: MCFD Annual Service Plans; CIHI NHEX government current implicit price index.

Effective services for CYSN: what the research literature says

In response to concerns within the disability sector about the FCC model and the government's subsequent decision to pause further FCC roll-out beyond the four pilots and engage in deeper consultation, the Representative for Children and Youth (RCY) commissioned Pat Mirenda, UBC education professor emeritus, to conduct a literature review of the key components of effective service delivery for CYSN and their families.[12] The main impetus for the RCY commissioning Pat Mirenda was the need to help address ongoing concerns within the disability sector and Indigenous leadership about whether a transformed system of services for CYSN would be based on research about effective service delivery models. The RCY intended for Mirenda's literature review to help inform MCFD's consultation process and changes to CYSN service delivery. The "Mirenda report" identified six key components common across 20 or more of the 50 peer-reviewed research studies reviewed:

- Provision of family-centred care;
- Cross-sector collaboration and connections to community networks and resources;
- Coordination of services across therapies;
- Sufficient, accountable funding, equitable funding allocation, and sufficient resources;
- Services customized to meet individual needs (intensity, quality); and,
- Staff training related to the service delivery model.

Mirenda's literature review provides evidence-based direction to government in relation to the FCC pilots. Her review also identifies where the pilot FCC contract language is inconsistent with the research evidence, and offers recommendations to remedy these concerns.

The Mirenda report alludes to, but does not directly address, the importance of organizational factors, including service delivery/organizational ownership and governance in the delivery of effective services for CYSN. A large and growing body of academic and policy research over the last 20 years identifies the role of organizational ownership and governance as structural determinants of high-quality health and social

12 Pat Mirenda, *Key Components of Effective Service Delivery for Children and Youth with Support Needs and Their Families: A Research Review and Analysis*, Representative for Children and Youth, 2023.

services provision.[13] This body of research finds a strong association between staffing levels, staffing mix, and workforce stability and superior patient and client outcomes. Staffing levels, staffing mix, and workforce stability enable relational continuity of care to patients and clients, and these characteristics tend to benefit from non-profit and public ownership and governance.

One of the foremost scholars of care organization and delivery is Pat Armstrong, distinguished professor of sociology at York University. In over two decades of research, she concludes that there is an important positive relationship between the conditions of work and the conditions of care.[14] Research by Armstrong and colleagues in the health care, social services, and public administration fields find outcomes are generally inferior in for-profit service delivery due to the tendency to cut labour costs – a structural determinant of care quality. Furthermore, there is wide recognition in the research literature that organizational factors strongly influence the ability to provide effective interprofessional, team-based care.[15] These organizational factors include co-location of services/providers, funding approaches that enable collaboration rather than professional and business autonomy, and community responsiveness and cross-sector collaboration through non-profit or co-operative board governance.

13 K. Vrangbæk, O. Petersen, and U. Hjelmar, Is contracting out good or bad for employees? A review of international experience, *Review of Public Personnel Administration*, 35(1), 2015, 3-23; L. Ronald, M. McGregor, C. Harrington et al., Observational evidence of for-profit delivery and inferior nursing home care: When is there enough evidence for policy change? *PLoS Medicine 13*(4), 2016, e1001995; C. A. Estabrooks, S. Straus, C. Flood, et al., *Restoring Trust: COVID-19 and the Future of Long-Term Care*, Royal Society of Canada, 2020; A. Banerjee et al., Long-term care facility workers' perceptions of the impact of subcontracting on their conditions of work and the quality of care: A qualitative study in British Columbia, *Canadian Journal on Aging 41*(2), 2021, 264-272; B. Goodair and A. Reeves, The effect of health-care privatisation on the quality of care, *Lancet Public Health 9*(3), 2024, e199-e206.

14 CBC News, Canada's for-profit model of long-term care has failed the elderly, says leading expert, *The Sunday Edition*, April 24, 2020.

15 Conference Board of Canada, *Improving Primary Health Care Through Collaboration: Briefing 2—Barriers to Successful Interprofessional Teams*, 2012; M. Cohen, *How Can we Create a Cost-Effective System of Primary and Community Care Built Around Interdisciplinary Teams?* Canadian Centre for Policy Alternatives, BC Office, 2014; A. Longhurst, *The Importance of Community Health Centres in BC's Primary Care Reforms: What the Research Tells Us*, Canadian Centre for Policy Alternatives, BC Office, 2019.

Table 2: Summary of focus group themes from frontline professionals

	Current state of CYSN services, specifically CDCs	What is working?	What is not working?	What is the ideal future state?
Access and wait times	Constrained access & long wait times at CDCs due to high service demand & understaffing, especially for early intervention therapies.	CDCs provide single point of contact, centralized intake for CYSN. CDCs prioritize access based on urgency & need.	High service demand & inadequate funding to increase staffing levels leaves many CYSN with mild to moderate complexity without timely access.	CYSN have access to properly funded non-profit CDCs across the province that are funded to meet all attributes as identified by the Mirenda report.
Physical location	Many CDCs own their land/building and some lease. Building offers "one-stop" access for CYSN. Non-centre-based services are spread across communities.	Co-location of team members allows for teamwork, collaboration, and communication.	Many CDCs have outgrown their existing, older building, and organizations don't receive capital funding to grow. Building improvements largely dependent on fundraising within the community.	Government capital funding to support expansion and building modernization, with the potential for satellite locations in new & growing communities.
Staffing and team-based care delivery	CDCs exemplify multidisciplinary, interprofessional care delivery.	Recruitment & retention efforts benefit from the model of multidisciplinary, interprofessional care delivery under one roof which provides high level of professional satisfaction.	Understaffing & vacancies cause large caseloads and moral distress. Many individualized-funded private practice professionals, including behaviour interventionists & analysts, are unregulated, without education & practice standards. No quality assurance or complaint process for unregulated private practitioners.	Significantly increased CDC staffing levels across foundational programs & funding for CDC-provided autism services. All staffing employed by non-profit organizations & a prohibition on contracted for-profit provision.
Relationships with CYSN and families	CDCs embody the six components of effective services identified in the Mirenda report, although underfunding & understaffing create long waits that frustrate families.	Families express high satisfaction *when* they get service, due to long waits. CYSN & families establish trust with care providers & CDC.	Underfunding & understaffing create long waits for CYSN & families. This creates frustration/ desperation for families & moral distress for staff. Staff are not always able to provide the intensity of individual & family intervention they know would benefit CYSN.	Significantly increased funding & staffing levels allow CDCs to fully realize the CYSN Framework & components of effective service delivery identified in the Mirenda report.

Cross-sector collaboration, including other organizations and service providers	CDCs are recognized as leaders & experts in their community for CYSN. School districts, pediatricians, health authorities, & community organizations depend on CDCs for their services & expertise.	Cross-sector collaboration is a consistent & core feature of CDCs provincewide. As accredited organizations, CDCs are committed to continuous service improvement, decolonization, & relationship-building.	Some private-practice providers misunderstand CDC model. Despite potential benefits to CYSN, many private practitioners do not collaborate with CDCs because there is a financial disincentive & business autonomy for private practitioners. SCD consultants are spending significant time with new ECEs in the child care sector due to inadequate ECE training & lack of inclusive child care. Demand on CDCs to support community partners (school districts, medical providers, child care) with inclusion & diverse needs is significant.	CDCs are properly funded, staffed, & recognized by government for their expertise so they may become lead CYSN agencies provincially, & help realize the positive goals the CYSN Framework & FCC model.
Funding level and funding approach	CDCs often hold multiple contracts, which vary between CDCs. MCFD contracts for foundational programs do not reflect the current funding level required for services to meet growing demand.	Indefinite-term contracts have prevented the workforce instability that became common in the long-term care sector due to RFPs & contract flipping.	Lack of consistent, population-based funding formula informed by service demand, & population needs & complexity. CDCs' reliance on donations to fund core services creates inequities between communities.	Transparent, data-informed, & population-based core funding model for centre-based care that better aligns staffing levels with provincial wait time standards.
MCFD understanding of sector		CYSN Framework recognizes lack of timely access & equity.	Lack of understanding of what CDCs do, how they operate, funding and staffing constraints & the value of CDCs to communities made evident by RFP process.	MCFD demonstrates understanding of CDCs, strengths, challenges, & need for funding improvement, rather than competition & restructuring based on privatization & lowest-cost bid.

What is working with BC's system of services for CYSN, and specifically in CDCs?

Focus groups generated extensive and rich insight from frontline professionals. Key themes from the focus groups are summarized in Table 2 and discussed below.

Coordinated, family-centred, interprofessional team approach under one roof

The coordinated, interprofessional team approach of CDCs is identified as a core strength of services for CYSN in BC. Focus group participants overwhelmingly spoke to this approach benefiting children and families:

> *What is working? It's one location. Children have access to all the services if they're getting more than one. (Focus group 2)*

> *Children have a difficult time with transitions. Going here, going there […] like that's draining. What we do is to reduce the transitions. We want to keep it simple and make sure those children are getting the support they need so if we can have it all at one centre, if the people can come in, the children do well with routine. Minimizing all this going here, going there, going to the doctor, the pediatrician. (Focus group 2)*

> *Well [we're] physically co-located in the same shared space, which is very conducive to planning, collaboration, just checking in with each other about family priorities. […] [We learn] so much from the other disciplines. You know, some of us are generalists, but learning from OTs, speech paths, physios has been where I've gotten my best learning. It didn't come from my schooling. It came from the fact that we're together in a shared space with the same families, with the same commitment. (Focus group 4)*

A consistent theme from all focus groups was that CDCs are focused on providing care that is based on family goals and providing individualized care that responds to the different needs of CYSN and their families. However, staffing levels, waitlists, and organizational resources were often viewed as a tension that constrained many frontline professionals. For many, this caused moral distress for frontline providers and frustration for families – issues discussed in subsequent sections.

Evidence-based service delivery

Occupational therapists, speech-language pathologists, and physiotherapists as well as SCD and infant development consultants, commonly spoke of the importance of evidence-

based practice provided by CDCs. As accredited, expert organizations in the field, CDCs are committed to continuous learning, the use of evidence, and supporting the professional development of their staff.

There is sometimes a misconception that "direct" therapy is the most important intervention, and because CDCs are not exclusively offering direct therapy, this leads some to believe the services are inferior to private sector services. One therapist noted that evidence-based interventions are not limited to direct therapy:

> *Everything we do is intervention, but not everything we do is direct therapy, so the direct therapy is, I am sitting at a table with you and I'm going to fix something about you like your body structure or function. Those therapies happen, and they're needed for lots of people, especially in acute periods after surgery. But intervention can be all kinds of things. Intervention can be getting equipment intervention, can be consultation, intervention can be doing a little bit of that to model to the family. Another one could be a home assessment. (Focus group 5)*

Many frontline professionals spoke to the rigorous accreditation process that is conducted every few years with Accreditation Canada. Private sector providers, whose services are obtained through individualized funding or private-pay, are generally not working within accredited organizations, and these individual professionals may be entirely unregulated if they are not a provincially regulated profession.

Cross-sector collaboration

Cross-sector collaboration is a consistent and core feature of CDCs provincewide. As non-profit organizations, their governance structure enables CDCs to foster relationships with the broader sector and community. Within a context of limited staffing and resources for CYSN, frontline professionals are adept at working closely with other non-profit organizations to maximize the services and resources for the families that they serve.

Cross-sector collaboration is understood by frontline staff as a necessary and important part of their work. It is also where CDCs have demonstrated leadership. Participants consistently spoke about how cross-sector collaboration was difficult, if not impossible, with private practice providers, and sometimes constrained with individuals located within larger bureaucratic organizations like MCFD, health authorities, and school districts.

The following exchange is reflective of the general experience of frontline staff:

> *Speaker 1: We speak, meet regularly with the early learning team at the school district and coordinate our efforts in kindergarten transition planning. It's not just for our kids that have support needs, but for all the children.*
>
> *Speaker 2: There are committees that we collaborate on.*

Speaker 3: Yeah. There's something called the early years collaborative [in our community] that a lot of agencies sit on. The school districts are a big part of that, and we kind of host it.

What is not working with BC's system of services for CYSN, and specifically in CDCs?

Competitive tendering and request for proposals for awarding FCC contracts

Following a request for proposal (RFP) competition, in January 2023, one of the FCC contracts was awarded to ARC Programs Ltd. – a for-profit, non-union employer with no experience delivering child development and early intervention services,[16] over Starbright Children's Development Centre, which was the established community-based non-profit provider for the past 50 years.

This experience is symptomatic of the provincial government's problematic approach to using market-based procurement processes for contracting health and social services. In the late 1990s, the BC provincial government – embracing neoliberal changes in public administration that were taking hold across high-income countries – began moving to competitive tendering for contracted health and social services, namely in the long-term care sector.[17]

As part of this shift, governments moved away from direct service delivery of health and social services and began contracting out service delivery to non-profit organizations and for-profit businesses. Even as non-profit organizations may have historically received core operational funding, renewed on an indefinite basis, Canadian provinces have moved away from core funding models that provide sustainable year-over-year funding in favour of time-limited, project- and contract-based procurement involving competitive tendering (i.e., RFP competitions) where organizations must compete for funding.[18] This has led to growing instability within the non-profit sector and the growth of for-profit service delivery.

16 Government of BC, Operators announced for pilot family connection centres, news release, January 5, 2023.

17 Andrew Longhurst, Sage Ponder, and Margaret McGregor, "Labour restructuring and nursing home privatization in British Columbia, Canada," in Pat Armstrong and Hugh Armstrong (eds.), *The Privatization of Care: The Case of Nursing Homes*, 2019.

18 Katherine Scott, *Funding Matters: The Impact of Canada's New Funding Regime on Non-profit and Voluntary Organizations*, Canadian Council on Social Development, 2004.

As researchers and the province's Seniors Advocate have noted, the dominant use since the late 1990s of competitive RFPs – and the lack of public capital funding – in long-term care and assisted living has encouraged the growth of for-profit ownership and provision.[19] Importantly, legislation and policy have not been updated since the early 2000s, which continue to bias competitive tendering and does not differentiate between procurement/funding for health and social services and other goods and services like highways.

Competitive tendering/RFP rests on the assumption that public costs can be contained or reduced through competitive (re)tendering and contract consolidation – the same misguided beliefs that led to much more for-profit involvement in seniors' care, contract flipping, and poor working/caring conditions. It is important to remember that under these policies, for-profit long-term care operators cheated taxpayers on half a million care hours they were funded to deliver in one year alone.[20] Further, the idea is that RFP processes generate more cost-effective service delivery as providers compete for contracts, and that contract consolidation can reduce, in the case of CYSN services, MCFD's administrative burden, thereby reducing overall costs to government.

These assumptions have not been borne out by experience. Competitive RFP competitions place significant financial and administrative strain on non-profit organizations, which comes at the expense of frontline care. The Family Connection Centre RFP competition added significant internal and external costs for non-profit organizations to prepare complex and lengthy proposals and to incur additional costs for legal support on contract language. Corporations and large organizations are inherently advantaged by a process in which they can more readily call upon these resources.

RFP competitions especially put smaller Indigenous organizations and service providers at a disadvantage, even as these organizations may have the necessary expertise and culturally appropriate approaches to the provision of health and social services. Competitive RFP risks undermining BC's commitment to truth and reconciliation enshrined under the *Declaration on the Rights of Indigenous Peoples Act* and Action Plan, under Goal 4 (Social, Cultural, and Economic Well-being), as Indigenous organizations—typically smaller and with potentially limited expertise with Eurocentric procurement approaches—often do not have resources to make successful bids. Previous and ongoing procurement reform initiatives have somewhat touched on this issue, but the existing Procurement

19 C.S. Ponder, Andrew Longhurst, Margaret McGregor, "Contracting-out care: The socio-spatial politics of nursing home care at the intersection of British Columbia's labour, land, and capital markets," *Environment and Planning C: Politics and Space 39*(4): 800-817, 2020.

Office of the Seniors Advocate, *A Billion Reasons to Care: A Funding Review of Contracted Long-Term Care in BC*, 2020, p. 16.

Andrew Longhurst, *Assisted Living in British Columbia: Trends in access, affordability and ownership*, Canadian Centre for Policy Alternatives, 2019.

20 Office of the Seniors Advocate, *Billions More Reasons to Care: Contracted Long-Term Care Funding Review Update*, p. 26.

Services Act and Core Policies and Procedures Manual remain barriers. Policy options for procurement and funding reform for health and social services are discussed in a previous HSA policy brief submitted to government.[21]

Long waits and inadequate provincial funding

Long wait times for CYSN and their families to access publicly funded services have been a significant concern for many years in BC. A recent survey conducted by the Representative for Children and Youth found that "[a]lmost three-quarters of the more than 1,000 parents and caregivers of children and youth with disabilities who responded to RCY's survey – from every region in B.C. – reported feeling 'no confidence' or 'minimal confidence' that their child would receive the services they need, whether in or out of school, within the next one to three years."[22]

Timely access was the most significant concern expressed by focus group participants for early intervention therapies, supported child development, and infant and child development:

> *So right now OT (occupational therapy) is running at 14 months for active service, three to four months for an initial consult, and then speech-language, two years, yeah. And again, she's doing additional consults as well. Two years. […] She just goes right in to see families right away and she was prioritizing all babies before, but now she she's had to tighten up her criteria, and she's running a four-month wait list and that's never happened before. (Focus group 6)*
>
> *So what's our wait list right now? For speech, two years to two and half years. (Focus group 9)*
>
> *Our "Priority 2" kids are the kids that maybe have Down syndrome without feeding issues, hemiplegia something where the delays are moderate. They and the "Priority 3" kids, which tend to be kids with undiagnosed autism or autism. Because those kids, compared to a kid who's trached and vented their needs are lower. So our Priority 2 and 3 kids now don't go on case load.*
>
> *What we've done is we've implemented a clinic system. So what happens is the parents get invited to clinic, and then they can come see either an OT, PT or speech. And then they get recommendations and resources and then they can come back in three to six or nine months depending on need. Or once they've reached those goals. So that is a profound change in service delivery. It's not a satisfying change in service delivery. But it's what we've had to do to cope. (Focus group 2)*

21 HSABC, Procurement and Non-Profit Funding Reform Options for Health and Social Services in BC, April 2024.

22 RCY, 2023, p. 4.

[There is] 0.5 FTE for physiotherapy and 98 kids. 68 of those were in the schools, which I covered one day a week, and then I tried to fit in the others. (Focus group 3)

There's not enough staff, there's not enough funding and recruiting and retaining are a real challenge, and that is the case more than ever in northern communities and same thing [in this northern community]. They're doing virtual SLP consults. Most of the therapists don't have time to do direct therapy because they only have time to do consultations and the staffing levels are just so, so minimal. So and even on the SCD and IDP side as well as respite and all of the other family support services. There's only so much you can do with the resources, and you know it comes at a cost. It's like if you can't provide the early intervention before kindergarten, you've missed this big window. (Focus group 11)

Another physiotherapist noted that the CDC held the contract for school age physiotherapy, but her caseload only permitted her one day a week to see all the students on her caseload in [this Lower Mainland] school district (Focus group 3).

Mostly physio vacancies right now. We just hired a new speech path finally […] but in physio we are quite short. I think we have probably like 3.4 FTE funded, and right now we only have about 1.2 of that filled. (Focus group 13)

0.7 FTE of OT to provide therapy for 120 children, and 1.0 FTE of SLP to provide therapy for 140 children. (Focus group 3)

I'm not going to pretend people don't have complaints, but the complaints aren't about the CDC. It's about that there's not enough and there's waitlists. (Focus group 5)

And there's no, like, there's no way if we kept all the kids on the spectrum and the early intervention programs, there's no way. There's no way we could have manageable workload and get the kids the evidence-based service that they should get. (Focus group 4)

Yeah, there's a physio position [that] has been open for on and off for like 5 years, and there's kids that have never received service there or have been on the wait list for over a year. (Focus group 17)

The long waits for CYSN are the result of decades of underfunding the child development sector, which has prevented CDCs from increasing staffing levels. As BCACDI notes, "austerity measures put into place during the 2008/09 financial crisis resulted in a freeze on base contract funding for many years. Over the past decade there have been occasional contract increases related to collective bargaining agreements, but little to no increases for service development and expansion."[23]

23 BCACDI, 2024, p. 7.

MCFD intended to repurpose existing CYSN funding streams and redirect these dollars to the FCCs. These funding streams include the Autism Funding Program (individualized funding), At Home Program, funds assigned to a key worker program for children with diagnosed or suspected FASD, and CDC contract funding.[24] However, Pat Mirenda notes that while Budget 2022 intended to facilitate the FCC transformation, it did not account for the 8,300 additional children who were not currently receiving MCFD-funded services, but were anticipated to be eligible through FCCs. Furthermore, Pat Mirenda has been clear about the completely insufficient funding for CYSN:

> *It is important to emphasize that the current CYSN budget does not take into account either existing Autism Funding Program and At Home Program funding shortfalls, existing service wait lists at the current CDCs or the lengthy wait lists for diagnostic services available through the health authorities (which have the effect of avoiding or delaying service costs). […] The bottom line is that funding for the current system is grossly inadequate and will be even more so when an additional 8,300-plus children are eligible for CYSN services. […] Without a substantial infusion of new funding, wait lists will be even longer, service quality will be even more compromised, and CYSN and their families will suffer as a result.*[25]

In its CYSN position paper, BCACDI, which represents CDCs and non-profit agencies, notes that "wait times are a significant challenge, both for diagnosis and for service access. The province and service providers should collaborate to publicly set benchmarks for reducing assessment and service wait times, and publicly report on outcomes on an annual basis."[26] It is abundantly clear from frontline HSA professionals and many other expert voices that long waits for publicly funded services are the product of inadequate funding.

Burnout and moral distress

In focus groups, frontline CDC professionals routinely spoke about the moral distress and burnout from exceptionally long and growing case loads and wait lists. Heavy workload arising from grossly inadequate provincial funding is causing moral distress, burnout, mental health crises, and ultimately, loss of staff in the child development sector.

> *We're truly in it because we care about publicly funded services for children and their families and. That's a huge reason that a lot of us stay, but it's a huge reason that a lot of us get burnt out because of being like, "Oh my god, wait list is huge. I'm going to try and do more. I'm going to try and do more and I'm working 10 hours every week off the side of my desk in nonpaid hours." (Focus group 3)*

24 Mirenda, 2023, p. 14.

25 Mirenda, 2023, p. 14-15.

26 BCACDI, 2024.

Widespread shortages and recruitment and retention

Shortages and recruitment and retention challenges are widespread in the non-profit child development sector. Although geographically varied, unfilled vacancies and shortages were reported to be most severe and widespread for speech-language pathologists, followed by occupational therapists and physiotherapists. Recruitment and retention of social workers and qualified supported child development, infant and child development, and Indigenous supported child development consultants were also challenges in some communities, especially northern and rural.

> *Support roles need to have compensation levelled up with the school district. [CDCs] can't hold on to them. (Focus group 2)*

> *Right now in our centre, it's SLPs that are hardest hit by filling positions. All disciplines need more funding for more FTE, but at the moment SLPs are hit hardest for having vacant positions. (Focus group 3)*

> *If you ask me the hardest job to fill right now when we have a vacancy, it's SLP and social work. And for SLPs, and certainly social workers, there's just not very many who can do the work that [our existing SLPs and social workers do]. But for SLPs it's they make a lot of money when they're [working] privately." (Focus group 4)*

> *I think we've only ever in 20 years we've had a full team for, I don't know, maybe three or four years out of that whole time, yeah. But yeah, there has not been a full team with early intervention therapies and IDP. (Focus group 12)*

> *Currently the biggest vacancies are in our speech department. We have shortages in the infant development and support child development. […] Everything is backlogged and I know the [community A] office has about a hundred children on waitlist and [community B] office I think has around 60 or 70. We are trying in the physiotherapy department, we are trying to triage and try to see the children who come with the motor delays because of the limited window that we have. (Focus group 14)*

Autism services and private sector provision

Concerns were widespread among focus group participants about the availability and quality of autism services in the province. Beginning in 2002, BC established the Autism Funding Program (AFP) for children and youth with an autism diagnosis. Currently, families with eligible children under the age of six may receive up to $22,000 of funding annually, and families with eligible children aged six to 18 may receive up to $6,000 per year. Aside from the At Home Program, which provides individualized funding for equipment needs, autism is the only neurodevelopmental or physical disability diagnosis for which caregivers can receive individualized funding.

Frontline professionals noted that this approach may work well for some families, but it does not meet the needs of lower-income and marginalized families. It burdens families with unnecessary stress, paperwork, and workload to find appropriate and affordable professional autism services, especially when behaviour interventionists and behaviour analysts remain unregulated professions in BC. This approach is even more problematic in smaller rural and remote communities where there may be few, or no, professionals who can provide these services on a privately delivered basis. The other deeply problematic outcome is that this funding model has constrained the ability of non-profit agencies, such as CDCs, to offer financially sustainable autism programs.

> *One of my big concerns is behavioural intervention. Well, this is one of a few but, and this isn't necessarily in order of importance […] but it's an unregulated health profession. So that for me is a huge concern. There's no way for parents to really make any complaints. There's no resolution for any ethical concerns or anything that happens in their interactions with behavioural consultants or behavioural analysts in the province. (Focus group 5)*

> *Autism intervention is very segmented and operates in isolation from early intervention therapies provided by CDCs. (Focus group 1)*

> *There's so much funding just for that diagnostic group that, I think you used the words perverse incentive. We've accidentally incentivized identifying people with having autism and some people do have autism. But I think we all know there's a lot of false positives. And there's this push no matter what your diagnosis is, no matter what we know about you, if you have any autistic features, you better go get labeled with that, too. (Focus group 5)*

> *And in the end, our kid's grandma did the math and she paid for his assessment. Because he's going to give himself a head injury. But then he went to a preschool that took all his money, all his [individualized] autism funding money and didn't help him with the fact that he was headbanging. And so, what is not working honestly in the autism funding land is there's no oversight on the services that they're getting, the quality, the approaches they're using. (Focus group 4)*

> *I think what you said before about, it's affluent families who benefit from this funding not the families who can't get groceries. Or have low literacy or have trauma. They can't even go out and find the private provider. They're more likely to get taken advantage of. They're more likely not to be able to make it to the appointments. People who live rurally or remotely: there's no service providers up there, so it's all well and good to have your autism assessment. You have money you can't spend. (Focus group 5)*

> *OK. So the private sector, it's just too expensive that the parents can't afford it. So here we go. If you have autism diagnosis, we know it's $22,000 a year. That's $423 a week. So some behaviour consultants charge $250 an hour. (Focus group 2)*

Many focus group participants expressed concerns about how the autism individualized funding perpetuates inequities in access and a two-tier system since autism-diagnosed children and youth may still access services provided by publicly funded CDCs.

> *So that's a strong word, but […] we have a two-tiered system. We have kids with autism who get two funding sources, and we have kids with cerebral palsy, Down syndrome, genetic disorders, significant prematurity, who have significant delays and they do not get the second [individualized funding]. So they get public [CDC] service and the way that that has rolled out is we're able to provide therapy based on need. We cannot exclude based on diagnosis. So if somebody has a behaviour team in place, I have moms phone me and say where's my kid on the OT waiting list because once they're picked up by you guys, I'm going to cancel my private OT and put that money into speech therapy and there's no reason why they can't do that. Because that's their money and they can choose how to spend it. So they're accessing the public and the private services. What then happens is that we have horrendous waitlists because we have to take all these kids. (Focus group 2)*

> *The people who it's not working for don't have the time or the energy to be complaining. The people who stand to lose are not the squeaky wheels. (Focus group 1)*

What are the potential challenges and benefits of the Family Connection Centre model?

MCFD's proposed restructuring of services for CYSN through the creation of FCCs has been influenced in part by long wait times and inequitable access in services. Focus group participants appreciated the provincial government's attempt to address these challenges. However, there were many concerns about the implementation of the FCC pilots, and the potential privatization of non-profit services. As well, challenges and concerns were raised about specific elements of the FCC model based on the RFP documents, FCC staffing model, and the contract language.

Concerns about privatization of non-profit CYSN services

As discussed previously, frontline professionals were very upset over MCFD awarding the Central Okanagan FCC to a private, for-profit company. Focus group participants worried about the potential for the privatization of the non-profit child development sector, and the loss of expertise and workforce instability that would result, similar to the experience in the long-term care sector. A consistent theme was the belief that for-profit service delivery has fundamentally different values and aims compared to non-profit service delivery. Frontline professionals were concerned about how the profit motive structures

how services are provided:

> *I know a lot about the Kelowna piece with physio, and I think there was this 'great idea' [from MCFD] that like, "Oh, these private therapists are used to seeing 8 to 10 patients a day and you're going to get so many more kids in, and it's going to be cheaper because we're going to just, like, turn them out. (Focus group 4)*

Another common theme was concern and confusion that the FCC approach ignores the strengths of the current system, and through the RFP process could dismantle the non-profit child development sector.

> *I feel confused that it seems like the approach to rolling it out is like burn it all down versus build on what's working. (Focus group 4)*

Concerns about the FCC contract language and opportunities to build on the CDC model

Focus group participants and others have commented on the admirable goal of the FCC approach, which is in part a response to long wait times and inequities in services access. However, focus group participants consistently expressed concern that the FCC contracts are reinventing, duplicating, and complicating already existing systems and tools:

> *They're building new systems that don't need to be built. They don't talk to any of the other ministries so as far as I'm concerned MCFD is not competent to carry this out. They can't do it and I sit in meetings with the MCFD reps and someone says something that should be common knowledge and they will just look blank. (Focus group 4)*

> *And like the people making all of these decisions about essentially health care are not just well-versed in healthcare, but like completely unaware. And so it seems, sometimes like bizarre, that we're under this umbrella of MCFD when we are providing health care services. (Focus group 4)*

While supportive of many of the high-level goals of the FCC vision, frontline professionals expressed concern that the FCC contract language and staffing model demonstrated a lack of awareness of how child development services are actually provided, where there are gaps and silos, and the importance of cross-sector collaboration. This is also echoed in the Mirenda report: "Altogether, it appears that there is no coherent plan between MCFD, MMHA or any other ministry of the delivery of coordinated, integrated, wraparound mental health services for CYSN across the province."[27]

Furthermore, as Pat Mirenda notes, there was little attention in the FCC RFP and contract language to whether proponents (bidding on the RFP) could demonstrate cross-sector

27 Mirenda, 2023, p. 24.

collaboration and community relationships:

> *In fact, there was no specific mention of either community networking or cross-sector collaboration with other ministries in the development or execution of the support plan. In the weighted criteria for adjudication of the RFPs that were issued in May 2022 for the four pilot FCCs, applicants' approach to "Connection to and understanding of community" accounted for 6.5 per cent of the total points assigned (p. 22). However, aside from "connection" and "understanding," there was no requirement in the RFP that the FCCs demonstrate a plan for cross-ministry or community partnerships, collaboration, or service delivery. There was also no indication that provisions were made for cross-ministry resource-sharing, information-sharing or funding allocation.*[28]

The FCC outcome in the Central Okanagan reinforces Mirenda's concern that cross-sector collaboration and community relationships were not priorities for MCFD, and by extension, they were given little weight in the RFP.

Focus group participants were hopeful that MCFD would learn from the FCC pilots and recognize the urgency of developing a much deeper understanding of, and better relationships with, the child development sector. Focus group participants consistently expressed a desire for MCFD staff and other government officials to visit their CDC and learn about the strengths and challenges of the CDC model.

Funding a consistent suite of publicly funded, not-for-profit services in every community

While focus group participants recognized the need for services for CYSN to reflect local community needs, a constant theme was the need for the provincial government to fund a consistent suite of publicly funded, not-for-profit services in every community. Participants recognized that the FCC approach was an attempt to address service gaps and availability and moving away from diagnosis-based eligibility. However, participants discussed how this vision was not operationalized effectively through a competitive RFP process which is undermining the very foundations that exist in many communities: CDCs.

Focus group participants wanted to see the provincial government build from, and expand, CDCs, and plan a non-profit system with a consistent suite of services for ages 0-19 in every community. This would require addressing the historical hodgepodge of different publicly funded services and funding models while explicitly building from the CDCs and non-profit agencies currently contracted to deliver services:

> *And I think too, to expand on what you said, and also expand on what you said like not reinventing the wheel, but also allow for that individual community feel while maintaining some of that consistency because you shouldn't receive separate, like*

28 Mirenda, 2023, p. 11.

different care because you live in Victoria, and you shouldn't receive different care because you live in Oak Bay, versus Sooke, versus Surrey. Like nurse-to-patient ratios. You can set therapist ratios, too, right? (Focus group 4)

We don't have all the resources in our team. We have been floating the idea of a behaviour consultant for years and that was one thing about the FCCs that really made me excited is that holistic look at a child. Both from a developmental lens but also in terms of their behaviour and how that behaviour shows up because the behaviour is what is a barrier for their school, for access to camps. And the fact that we don't have someone on our team who can really focus on that. (Focus group 4)

And we're noticing a lot of families moving to Chilliwack because there is this idea that they're going to get better services because they've got that connection there. But what that does is it places more demand on the public system now that they're living in that catchment area, our referrals have gone way up with requests for service and especially requests for support in child care, and we don't get any increases. So we have a huge wait list now. (Focus group 1)

One-third to double what [staffing] we have […] and we could do a lot better. (Focus group 6)

And the reason that the school therapists have a really limited scope is because of caseload. In addition to that, though, the school district always says, "Oh yeah, and there's probably four or five kids more coming into kindergarten that we don't know about. (Focus group 2)

Conclusion and recommendations

Frontline pediatric therapists and child development professionals, working in child development centres and non-profit agencies across the province, are deeply concerned about the state of services for CYSN and their families. The publicly funded service landscape is underfunded, understaffed, and fragmented. And yet, the proposed restructuring of services for CYSN through competitive tendering that risks privatization of publicly funded, non-profit services sent shock waves through the child development sector. There is grave concern about potential for an already-fragile CYSN service landscape to experience greater fragmentation, privatization, and staffing shortages if the provincial government does not dramatically rethink its policy direction by strengthening the existing community-based non-profit sector.

Despite the current situation, there are many positive elements to services for CYSN and their families based on the existing child development centre model of service delivery. The CDC model is an existing and well-established network of experienced and reputable organizations and professionals, which exemplifies the six key elements of effective services for CYSN and their families identified by Pat Mirenda and the Representative for Children and Youth. However, the ability of existing CDCs and non-profit agencies to realize the vision of MCFD's CYSN Framework – including timely, coordinated, one-stop access to an interprofessional team of therapists and supports – is dependent on what only the provincial government has control: funding, staffing levels, and policy.

Regardless of the label used, CDCs are, in many ways, an existing "family connection centre" that provide coordinated, interdisciplinary access to publicly funded services and supports under one roof. CDCs and other non-profit agencies should be supported through a community development approach to significantly expand and enhance their services. A community development approach means supporting the expansion of the existing non-profit sector, rather than creating a competitive landscape of winners and losers that may ultimately undermine the strengths of the current system.

Based on the research findings, HSA recommends that the provincial government expand services for CYSN and their families based on existing CDC and non-profit agencies who are experienced and respected service providers. Specifically, HSA makes the following recommendations:

1. Stop further implementation of Family Connection Centres based on competitive tendering and request for proposal (RFP).

2. Immediately provide Starbright Children's Development Centre with an indefinite-term funding contract extension similar to what existed prior to the FCC pilot implementation in order to maintain workforce stability and service continuity for CYSN and families.

3. Immediately increase CDC funding by at least 50% to allow organizations to increase staffing levels, expand programs, and reduce wait times for CYSN. The existing and expanded CDC sector can realize the vision of the CYSN Framework and FCC approach, but need dramatically increased funding to do so.

   In addition to increased funding for existing CDC-delivered foundational programs, HSA recommends that government provide new and ongoing funding to CDCs to provide autism services and school age therapy to age 19. Frontline professionals noted that the current autism individualized funding approach may work for some families, but it does not meet the needs of lower-income and marginalized families. It burdens families with unnecessary stress and work to find appropriate and affordable professional autism services, especially within an environment where there is highly varied quality and lack of professional regulation. Individualized funding is even more problematic in smaller rural and remote communities where there may be few, or no, private practice professionals. This funding approach has constrained the ability of non-profit agencies, such as CDCs, to offer financially sustainable autism programs.

   In order to rationalize funding and ensure equitable access, families would be required to choose individualized funding or centre-based autism services.

4. Modernize the Procurement Services Act, the Core Policies and Procedures Manual, and Capital Asset Management Framework, so that alternatives to competitive tendering and RFP are the preferred methods for funding health and social services that are not delivered directly by government or health authorities. Current legislation and policies bias competitive tendering even when it is widely recognized to destabilize the workforce and service quality. In April 2024, HSA published a detailed policy brief on non-profit funding reform options for health and social services in BC.[29]

5. Enshrine not-for-profit delivery of services for CYSN through provincial funding/contracting in legislation or regulation. While it is assumed that some private sector service delivery will continue through autism individualized funding and private-pay services, HSA recommends that government ensure that provincial funding for contracted services delivered by organizations remain in the non-profit sector based on the research literature and the deleterious consequences of privatization in seniors' home support and long-term care.

6. Explore moving Child Development Centres, currently under MCFD, to a dedicated team in the Ministry of Health, and establish a partnership table that brings together senior cross-ministerial leadership, the Representative, unions, and community-based, non-profit child development organizations. CDCs are defined services under the Health Authorities Act and would benefit from greater integration with primary

29 HSABC, Procurement and Non-Profit Funding Reform Options for Health and Social Services in BC, April 2024.

and community health care services, acute care, specialized outpatient services, and health workforce planning.

7. Extend Ministry of Health recruitment and retention incentives for allied health professionals, including physiotherapists, occupational therapists, and speech-language therapists, to these same professionals working in MCFD-funded organizations. Pediatric therapists in the child development sector have been excluded from recruitment and retention incentives offered to the same professions working in Ministry of Health-funded services, despite the widespread recruitment and retention challenges of pediatric therapists.

8. Ensure ongoing seat expansion for physiotherapy, occupational therapy, and speech-language pathology programs, including expansion of programs beyond UBC Vancouver, UBC-Island, and UBC-UNBC cohorts, so that more individuals can train in communities across the province. Public practice streams with tuition bursaries for return-of-service to encourage PT, OT, and SLP recruitment into the child development should be implemented. Through a health equity lens, review current post-secondary curriculum and program design so that it can better showcase and encourage practice in the public health care system and child development sector.

9. Immediately extend the Early Childhood Educator (ECE) Wage Enhancement to any ECE who works in the child development sector, often as a supported child development/aboriginal supported child development consultant. SCD/ASCD consultants are currently ineligible for the wage enhancement, despite having the same or greater qualifications.[30]

   Additionally, review the need for recruitment and retention incentives, similar to those in the health sector, for other specialized child development roles, including but not limited to, SCD consultants, infant and child development consultants, Aboriginal/ Indigenous supported child development consultants, family support consultants, psychologists, behaviour interventionists, and behaviour analysts.

10. Re-establish the Provincial Advisor for Supported Child Development, which was discontinued in 2009. The role can provide program coordination to foster integration and promote consistency of services to families provincewide. With the expansion of child care spaces, there has not been commensurate focus on supported child development to ensure access to inclusive child care.

11. With the involvement of researchers, the Representative, HSA, and the non-profit sector, develop a transparent, data-informed, and population-based core funding model for centre-based services that better aligns funding allocation with provincial wait-time access standards. In April 2024, HSA published a detailed policy brief on

30 Ministry of Education and Child Care, 2024-25 ECE-WE Funding Guidelines, November 2023.

non-profit funding reform options for health and social services in BC.[31]

12. In collaboration with BCACDI and the sector, the Ministry should establish consistent definitions and provincial wait-time access standards, beginning with foundational programs, and monitor and publicly report wait times.

13. With the input of researchers, the RCY, HSA, and the non-profit sector, review school district, public health unit, and MCFD CYSN social worker funding and service delivery models in order to create a more consistent and family-centred provincial service delivery approach where Child Development Centres are the lead organizations in their communities for CYSN.

    Focus group participants consistently raised concerns that MCFD CYSN social workers are distant for many families, and do not provide the necessary care coordination and system navigation supports that are required. This role should be formalized with CDCs and sufficient funding provided within any new funding model or existing contracts that enable CDCs to hire a sufficient number of social workers.

14. Implement recommendations contained in the First Call Child Poverty Report Card, with the aim to address the root causes of child, youth, and family poverty, and a focus on increasing income supports for families with children with disabilities.

    The broader socioeconomic context greatly influences early childhood development and the increasing complexity and workload of frontline professionals. Child and family poverty, as well as growing income inequality, contribute to poor health and greater vulnerability for children and families. Although the BC child poverty rate declined from 23.9 per cent in 2014 to 14.3 per cent in 2021, the rate has increased following the end of temporary pandemic supports.[32] This translates to one in seven children in BC living in poverty in 2021—the most recent year available.

31 HSABC, 2024.

32 First Call: Child and Youth Advocacy Society, BC Child Poverty Report Card 2023, February 2024, p. 9

Appendix A: Research methods and focus group locations

Over the course of 2024, HSA conducted 17 semi-structured focus groups (13 in-person and four virtual) involving over 100 frontline staff working in CDCs and non-profit agencies across the province. Participants were recruited through email to HSA members working in CDCs and non-profit agencies serving CYSN. This research spotlights the frontline voices from approximately two-thirds of CDCs and non-profit child development agencies in the province. To our knowledge, this is the most extensive effort to understand challenges and opportunities in the child development sector from the perspective of those professionals who work most closely with CYSN and their families. Focus groups were semi-structured with three main questions:

1. What is working/not working with BC's system of services for CYSN, and specifically those services provided by CDCs?

2. Based on the pilot Family Connection Centres, what are the potential benefits and limitations of this service delivery model?

3. What are the top 2-3 recommendations that you have to improve services for CYSN?

Focus groups were recorded, transcribed, and analyzed for recurrent and emergent themes. Focus group participants also provided written comments that were transcribed and analyzed for recurrent and emergent themes. Key themes were coded, organized, and form the basis of this report.

Focus group locations:

- Quesnel (Quesnel and District CDC)
- Dawson Creek (South Peace CDC)
- Fort St. John (Fort St. John CDC)
- Prince George (CDC of Prince George)
- Abbotsford (Fraser Valley CDC, Ridge Meadows CDC, Inclusion Langley)
- Surrey (Centre for Child Development, Sources)
- Burnaby (BC Centre for Ability, Deaf Children's Society of BC)
- Victoria (Queen Alexandra Centre for Children's Health)

- Nanaimo (Nanaimo CDC, Port Alberni Association for Children with Development Disabilities)
- Courtenay (Comox Valley CDC)
- Penticton (Okanagan Similkameen Neurological Society)
- Kelowna (Starbright CDC, North Okanagan Neurological Association)
- Kamloops (Thompson Nicola Family Resource Society/Children's Therapy and Resource Society)
- Virtual focus group 1 (frontline HSA CDC professionals from any community)
- Virtual focus group 2 (frontline HSA CDC professionals from any community)
- Virtual focus group 3 (frontline HSA CDC professionals from any community)
- Virtual focus group 4 (SHARE)

In addition, a review of the academic and grey literatures was conducted. Public expenditure data from MCFD Service Plans from 2012/13 to 2024/25 were extracted and analyzed.

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