

Children & Youth with Support Needs
Ministry of Children and Family Development
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Re: MCFD Children and Youth with Support Needs Engagement Project

On behalf of the Physiotherapy Association of BC (PABC) we are pleased to submit our recommendations regarding the Ministry of Children and Family Development's (MCFD) Children and Youth with Support Needs (CYSN) engagement project.

Since the initiation of the pilot Family Connection Centres (FCCs) PABC has received considerable feedback on the new delivery model and its impact on families and allied health practitioners. Although the intention of the pilot sites was to address longstanding community pediatric service issues such as lengthy waitlists, most of our members and colleagues felt there was minimal meaningful consultation prior to the implementation of these pilot sites, which led to confusion and conflict for families and providers.

In addition to PABC member engagement, we consulted with numerous organizations and other allied health professionals, as well as various CYSN engagement reports.

Based on these consultations, the following are our recommendations to provide families who access CYSN services with culturally safe, family-centred, evidence-based physiotherapy.



Recommendations:

1. Set-up a CYSN Allied Health Task Force

- In the medical community, it is well-accepted that Occupational Therapists, Speech Language Pathologists and Physiotherapists are similar allied health professionals. Emerging research has shown that the engagement of the allied health sector can improve both processes of care as well as healthcare outcomes.¹ Setting up a task force with these voices will ensure that appropriate services are co-designed with other stakeholders in a real time setting. Within this task force it is suggested that Indigenous health and rural and remote initiatives be prioritized as key service delivery components.
- The lack of allied health representation to date is evident in the new proposed framework. For example:
 - The Family Connections Centre: Service Expectations & Description document² cites that there will be “a shift away from the concept of 1:1 intervention with therapists as the primary option.” It mentions that a transdisciplinary model and group programs “allows for a higher number of children to be served while meeting the needs of families with an amount of service that supports ongoing developmental needs.” This statement is contraindicatory to the tenets of family-centered care.³ Families need choice, and for many group therapy is not effective nor safe.
 - Several assessment tools have been suggested to determine Disability Service eligibility. For example, the Gross Motor Function Classification System (GMFCS) has been suggested to determine if a child requires assistive technology or wheeled mobility.⁴ This is inappropriate as the GMFCS has only been validated as an outcome measure for children with cerebral palsy.⁵



2. Maintain Continuity of Care

- Respect the existing infrastructure and past service provider relationships. Creating an entirely new system seems counterproductive and can be particularly distressing for patients and families with support needs.
- The First Nations Leadership Council (FNLC) best summarized this opinion recommending an “expansion of existing services rather than replacing existing services”. The FNLC went on to elaborate that Hub models have failed and traumatized our people [and] are not rights compliant.”⁴
- Other engagement reports and organizations have also shared similar opinions:
 - The BC Disability Collaborative recommends, “Various infrastructures and programs are already working in individual communities (e.g., child development centres, and, for some families, direct/individualized funding). Our goal is to build upon these existing programs across the province, to create a hybrid model rather than replacing them.”⁶
 - The BC Association for Child Development and Intervention recommends “procuring services in a manner that acknowledges and values the experience and expertise of existing service providers, and doesn’t significantly disrupt services to children, youth and families.”⁷
 - The Community-Led Collaboration Project⁸ has found similar opinions in some communities. For example, the Campbell River and Gold River Community Report noted, “local organizations are doing good work and there is a strong inter-agency community.”⁹
 - During one of the MCFD’s First Nation Rights and Titleholders engagement sessions the suggestion was to focus on “building from what’s already working”.



- In summary, when considering these opinions as well as other themes mentioned below (i.e., recruitment and retention), a hybrid service model is suggested. This would entail the continuation and expansion of private and public partnerships. For example, a family could still access physiotherapy through a Child Development Centre or school district as well as having supplemental extended therapies based on their needs.

3. Continue to Promote Family Centered Care

3.1. Individualized funding and treatment

- Offer families the choice/flexibility of how they access services. Both service provider and families^{11,12} alike have been clear that the continuation of individualized funding is desired. Streamlining the application for these services is recommended, notably decreasing the approval time and removing the need for constant medical justification. Notably in Reciprocal Consulting’s community engagement with underrepresented populations, one participant noted: “It’s very frustrating to have to have a doctor justify everything you do.”¹²
- In regard to individualized service needs, the Representative for Children and Youth’s report on key components of effective service delivery for CYSN and their families found that numerous research studies have reported a general trend that higher intensity intervention equals better child outcomes.⁴ Independent of the service delivery model, quality services with adequate intensity will equate to not only better child outcomes, but also probable favorable performance indicators.
- One concerning theme emerged regarding inequitable CYSN services for children in foster compared to children not in foster care.^{11,12} Specifically, “families and service providers describe that children in care have greater access to CYSN services compared to children

with their families.”¹¹ Equitable care for children should be provided independent of family structure.

- Service providers should consider more flexible service delivery such as offering drop-in appointments and not having punitive cancellation policies.¹¹ Furthermore, offering early morning and evening appointments as well as weekend appointments should be considered to facilitate working parents’ work schedules.¹²

3.2. Wrap-around services

- Provide wrap-around services to support the entire family. We defer to several of the referenced engagement projects and organizations for specific wrap around service recommendations.^{4, 6, 7, 12}

4. Funding

4.1 Needs based not diagnosis-based funding

- Although the majority of funding is needs based, there is still an inequality of individualized services. Other engagement projects as well as our consultations have identified that funding should be needs-based, not diagnosis-based.^{4,6,11} Focusing on a “child’s deficits in order to convince decision-makers that they are “disabled enough” to “deserve” support” is trauma-inducing.⁶ The following are specific recommendations for needs-based funding:
 - The threshold for services needs to be lowered, so that more families have access to care. Many children have the clear need for physiotherapy services but do not qualify for public programs nor individualized funding. This creates an inequitable system where “disability services and supports are entirely dependent on a child or youth



having the “right” diagnosis. ⁶ There are massive waitlists for families to get a diagnosis. Multi-year waitlists have been widely reported.

- Families should be able to start services without a confirmed diagnosis. During one of the MCFD’s First Nations Rights and Titleholder engagement sessions it was identified that “often a diagnosis is not received early enough to see a difference.”¹⁰

4.2 Transparent Funding

- Transparent funding was a consistent theme addressed by several organizations.^{4, 6, 7} It is recommended that there is a public central location that lists all contracted services providers with explicit reporting of the funding formula as well as the allocated funding amounts. Most families and allied health practitioners are confused about who provides what service in what region.
- Some standardization of this reporting is required so that funding is easily comparable. For example, the BC Association for Child Development and Intervention suggests that “standards need to be set in terms of FTE allocation and expected wait time for service to assist with equitable funding distribution.”⁷

4.3. Adequate Funding

- Adequate funding with sufficient resources was a universal theme consistently mentioned by all parties consulted as well as posted engagement reports. Insufficient funding was one of the main reasons noted for the shortcomings (i.e., waitlists) of the current system. To completely revamp the service delivery model without allocation of inflation adjusted funding will result in similar short comings.

5. Program Accountability

- Evidence-based, accountable and transparent accreditation is recommended. The BC Disability Collaborative notes that failure to implement an accountable framework has the “potential to lead paediatric therapy services into a two-tiered system of care.”⁶ As mentioned above, with meaningful consultations there is a potential for effective private and public partnerships; however, a formalized accreditation process is needed beforehand.
- Co-creation of an accreditation process is recommended to determine key performance indicators as the current publicly available performance indicators are inadequate.¹³ The Canadian Institute for Health Information Performance Measurement Framework can be used as a starting framework.¹⁴
- It should be noted that there was no transparent evaluation plan prior to the implementation of the pilot FCCs. More specifically, there was not a complete evaluation of existing service providers prior to the pilot FCCs. Thus, no meaningful pre- or post-implementation analysis can be conducted of this pilot program.

6. Workforce Planning

6.1 Address chronic allied health recruitment and retention issues

- Recruitment and retention of qualified allied health practitioners to provide CYSN services has been a chronic well-established issue and was mentioned in all consultations and engagement reports. This issue is especially dire in rural and remote communities.¹⁵ Specific strategies have been recommended in the past¹⁶ and concrete changes such as expansion of a distributed Master of Physical Therapy program have been enacted.¹⁷



That said, recruitment and retention continue to be chronic problems identified by all parties consulted.

- Overall recruitment and retention issues may become a much larger problem if there is a net loss of practitioners. For example, the FCCs resulted in the closure of some existing services, with several practitioners leaving pediatrics and pursuing hospital work instead. Several people consulted noted that they would do the same and cited a possible “brain drain” if the proposed FCC model was expanded. These opinions are supported by a Simon Fraser University/Autism Community Training collaboration which surveyed 485 Registered Autism Service Provider professionals.⁴ Notably, the study identified that 37% of respondents were unlikely or very unlikely to work for an FCC.⁴
- The above suggested Allied Health Task Force would help to co-develop a robust recruitment and retention strategy. The following are two recruitment and retention issues that the Task Force can help address:
 - Although allied health service providers can qualify for the *BC Loan Forgiveness Program* if they work in underserved communities, they are not being offered the same substantial hiring incentives that many health authorities are providing at this time. For example, Island Health is currently offering competitive recruitment bonuses up to \$20,000 for eligible allied health roles.¹⁸ Similar incentives should be offered to CYSN service providers.
 - Furthermore, there are significant public and private practice wage discrepancies that need to be addressed.

6.2 Increased Utilization of Rehabilitation Assistants

- To help address the noted recruitment and retention issues it is recommended that there is increased utilization of rehabilitation assistants in CYSN services. In support of this recommendation, several Indigenous CYSN engagements have identified the need to



train local peoples who are connected to their lands and will likely work in their communities longitudinally.^{11, 12} The following barriers will need to be addressed for the successful increased utilization of Rehabilitation Assistants in CYSN services:

- Although the UBC Physical Therapy Program offers some education around the delegation and supervision of Rehabilitation Assistants, a recurring theme was that more training is needed. For example, the Representative for Children and Youth’s report on key components of effective service delivery for CYSN and their families suggested, “therapists who are expected to work with therapy assistants and have no experience doing so will need to familiarize themselves with strategies to train, mentor, supervise and evaluate their performance.”⁴
- The wage differential between acute care Rehabilitation Assistants and community Rehabilitation Assistants needs to be addressed.

7. Improved Communication

7.1 Cross-sector collaboration

- Independent of the proposed service delivery model a strong theme emerged for improved cross-sector collaboration and connections to community networks and resources. This recommendation was shared by all parties consulted as well as in past engagement reports.^{4,7,9, 12}
- Specifically, the Community-Led Collaboration Project (Campbell River and Gold River) noted that “service providers and families want greater collaboration and coordination between MCFD, healthcare, education, and community agencies”.⁹
- At this time PABC cannot recommend a mechanism to improve cross-sector collaboration; however, suggest that this be addressed by the above noted Task Force.



7.2 Coordination of therapies

- Continued and improved communication across therapies is recommended to ensure effective transdisciplinary care. This coordination of therapies is especially important in circumstances where therapists are working in different locations and/or organizations.
- One tangible recommendation to improve communication is to conduct inclusive team meetings with families and all service providers. This would entail Child Development Centre therapists meeting collaboratively with therapists hired by families for extended therapies. Alternatively, the Community-Led Collaboration Project (Campbell River and Gold River) noted that “inter-agency meet and greets” would facilitate connection and collaboration.⁹ To date, neither of these practices are commonplace. Unfortunately, there are even case reports of no communication occurring at all. For example, in one consultation with a service provider it was noted that despite numerous attempts to connect with a pilot FCC site, no communication was received.

8. System Navigation: Make the system less confusing for families

8.1 Create a centralized resource

- Families and service providers are confused about how to navigate the current system and access available resources. Specifically, during one of the MCFD’s engagement sessions with First Nation Rights and Titleholders, it was noted that “eligibility requirements are often poorly communicated to families and are difficult to understand.”¹¹
- A family-friendly online centralized resource that families can search for services is recommended. For example, during the Campbell River and Gold River Community-Led

Collaboration Project⁹ “a centralized and current database and/or an app where they could easily access information about local supports, services, and family groups” was suggested.

8.2 Create a new family navigator position

- A universal theme that was suggested by all parties consulted was the need to create a position to navigate the system. The following job titles were suggested in our consultations other engagement projects: care coordinator, case manager, CYSN services system navigator, family support worker, navigator, primary support coordinator, program navigator and system navigator.

8.2 Streamline the intake process

- The assessment process should be related to the needs, not diagnoses.
- It was identified that further consultation is needed around what disciplines should be involved in the intake process.
- From point of referral, there should be a first point of contact early in the process especially when waitlists are in place. For example, there could be a benchmark for the above noted family navigator to connect with families within 30 days of referral. The navigator could help identify resources and be a point of contact for any family queries. This “ongoing support while awaiting assessment or diagnosis” was identified in the MCFD’s engagement sessions with First Nation Rights and Titleholders.¹¹
- Alternative forms of assessment processes should be explored and evaluated. One organization noted success with a rostering system to streamline the intake process.



15. Pursue Indigenous Health Initiatives

- PABC has a strong commitment to Indigenous health and reconciliation. It should be noted that we have not yet consulted extensively with Indigenous families or nations for this project. Moving forward, we anticipate this consultation process being a priority for the ministry prior to any decisions being made that would impact Indigenous patients. The below recommendations have emerged as universal themes and key recommendations from other posted engagement projects which PABC supports through a physiotherapy lens.
 - Embed Indigenous culture, values, and practice into the CYSN service delivery.^{11, 12}
 - Provide trauma informed and culturally safe services as well as educate service providers on cultural safety.^{4, 11, 12}
 - Involve “Elders/knowledge keepers and traditional healers in setting goals and providing intervention supports.⁴ It should be noted that PABC is the only allied health association that is fortunate to have the leadership and wisdom of an Indigenous Knowledge Keeper, Tania Dick: <https://bcphysio.org/indigenous-knowledge-keeper/>
 - Facilitate and promote Indigenous-run services with culturally relevant programming, including recruitment and training of Indigenous service providers to support their communities.^{4, 11, 12}
 - Consider expanding the Travel Assistance Program in order to address the frequently cited barriers of internet access and transportation in rural and remote communities.^{11, 12}
 - Clearly delineate CYSN supports and MCFD protection services. This could be achieved through better system navigation or through a restructuring of Ministries. A significant barrier to CYSN services is some families’ perception and



mistrust of MCFD’s role in child apprehension and foster care. This mistrust is clearly stated in the Reciprocal Consulting report ¹² that references families’ fear of “how MCFD would use their information” as well as “fear of child apprehension when visiting resource centers.” This culturally unsafe environment and resulting barrier to access is evident on the MCFD’s main landing page, which after “Children & Youth with Support Needs” immediately lists “Adoption,” “Teens in foster care,” and “Protecting Children” as subsequent services.¹⁹ Other engagement projects also cited the lack of cultural safety as a barrier to accessing care.⁹



Conclusion

PABC would like to thank the ministry for your willingness to reopen the discussion on the FCC's and what the appropriate model should be for children and youth services in British Columbia. Our preference would be to engage in further consultation and discussion as part of a larger group, with the ministry present. This would allow concerns and issues to be addressed before decisions are made.

We believe there is a great amount of expertise and knowledge within the allied health community that could ensure quality CYSN service implementation.

Please do not hesitate to contact us if you have any questions about this submission or would like further information.

We look forward to collaborating!

Andrea Burton CEO

Jason Craig, Physical Therapy Knowledge Broker



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