

ADVANCE Network Report:

Access and Exclusion

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Disability Policy
Research Program



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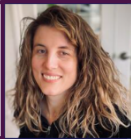
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About this Report

This report synthesizes the joint efforts of the ADVANCE Network Fellow and the working group dedicated to research stream four: Access and Exclusion. The 2025-2026 ADVANCE Fellowship is a joint initiative of Kids Brain Health Network (KBHN) and the Disability Policy Research Program (DiPo) at the University of Calgary.

We acknowledge that this work took place online, with collaborators located on the traditional territories of the Musqueam, Squamish and Tsleil-Waututh, the traditional territories of the peoples of Treaty 7, which include the Blackfoot Confederacy (comprised of the Siksika, the Piikani, and the Kainai First Nations), the Tsuut'ina First Nation, the Stoney Nakoda (including Chiniki, Bearspaw, and Goodstoney First Nations), the Métis Nation within Alberta (including Nose Hill Métis District 5 and Elbow Métis District 6), the traditional territories of the peoples of Treaty 6, which include the Plains Cree, Woodland Cree, Saulteaux, Blackfoot, Métis, Dene, Denesuline, and Nakota Sioux people and Métis Region 2 territories.

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The co-authors of this report are the working group members whose lived/living, family, professional, policy, and community-based experiences informed and guided the writing, without treating those contributions as representative of all people, families, or experiences.

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Executive Summary

In June of 2025, the Kids Brain Health Network (KBHN) and the University of Calgary's Disability Policy Research Program (DiPo) named four ADVANCE Network Fellows to lead an initiative for improving disability programs and policies across Canada.¹ ADVANCE, which stands for Alliance for Disability Voices, Advocacy, and National Community Empowerment, is a network and national collaboration of scholars, community partners, and people with lived and living experience. Dr. Jennifer Zwicker, Dr. Lucy Lach, Dr. Keiko Shikako, and Sharon McCarry direct this network to drive meaningful change for neurodiverse youth and their families across Canadian jurisdictions and territories.

In the first phase of the fellowship, the work completed by the four fellows built on the existing 2025 disability policy report completed for KBHN to add more comprehensive information about disability policy affecting children and young people with disabilities, their families, and their communities across Canadian provinces and territories.² Each fellow initially focussed their work on one of four geographic regions:

- **Western Canada** (British Columbia, Yukon, and the Northwest Territories)
- **The Prairies** (Alberta, Saskatchewan, and Manitoba)
- **Central Canada** (Ontario, Quebec, and Nunavut)
- **Atlantic Canada** (New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador)

This geographic focus enabled the fellows to update the previous disability policy report where relevant, and results were presented to ADVANCE Network partners in the Fall of 2025.

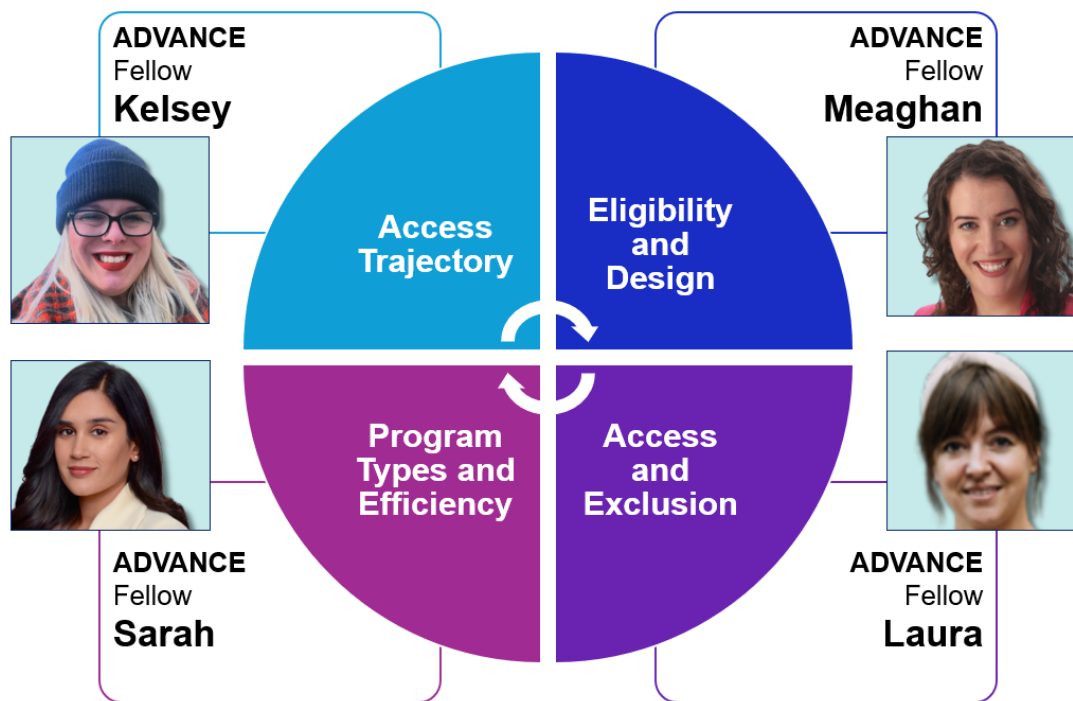
In the second phase of the fellowship, ADVANCE Network partners and community members completed a survey to establish important areas of focus to guide each of the fellows. This survey led the ADVANCE Network and project partners to identify four broader research streams: **1) Access Trajectory**, **2) Eligibility and Design**, **3) Program Types and Governmental Efficiency**, and **4) Access and Exclusion (Figure 1)**. These four areas of focus

¹ Important consultation and communications with Indigenous project partners led to the appointment of a research fellow specifically dedicated to gathering and reporting on Indigenous relations and experiences within Canadian disability policy landscapes in 2026.

² For more information and the full report, see Kids Brain Health Network, Réseau pour la santé du cerveau des enfants. (2025, July 30). *Disability Policy in Canada: Provincial and Territorial Report* | Kids Brain Health Network - Réseau pour la santé du cerveau des enfants. Kids Brain Health Network - Réseau Pour La Santé Du Cerveau Des Enfants. <https://kidsbrainhealth.ca/disability-policy-in-canada-provincial-and-territorial-report/>

or research streams led to the formation of four working groups, each coordinated by an ADVANCE Network Fellow for the final phase of the fellowship.³

Figure 1: Four research streams and associated fellows



This report is to communicate the shared efforts of the working group dedicated to the fourth research stream: **Access and Exclusion**. Working group members included six individuals with multiple roles, including professional, academic, parental/caregiver, and personal/living experiences and responsibilities related to children and young people with disability-related needs and disability policy and services in Canada. The working group operated with a working title that was informed by the ADVANCE Network community event in October of 2025:

***“Who is missed or is falling through the cracks
in the uptake of disability-related supports and services?”***

³ For more details about the four research streams, see also O’Connor, K. (2026, January 15). *ADVANCE Network Fellows showcase research at Disability Without Poverty’s 2025 Research Symposium*. Kids Brain Health Network - Réseau Pour La Santé Du Cerveau Des Enfants. <https://kidsbrainhealth.ca/advance-network-fellows-showcase-research-at-disability-without-povertys-2025-research-symposium/>

In preparation for the working group activities and with feedback from ADVANCE Network leadership, the 2025-2026 Fellow had to set further parameters for the collaborative effort. The time allotment and feedback led to a focus on access and exclusion experiences during early childhood, referred to as early childhood intervention and disability-related support services for infants and children aged 0 to 5 years of age.⁴

During the first online meetings with working group members, it was identified that the method of co-production would be most effective and important in guiding the collective output.⁵ The project partners included in this fourth theme and working group specifically focused on foundational questions and experiences of exclusion for individuals and families missed or unable to access early childhood disability-related supports. The current report synthesizes the co-production process and includes sections engaging with cross-Canadian data, policy-based information, academic and legal backgrounds, and lived and living experiences trying to access supports during early childhood in British Columbia, Alberta, and Ontario.

This report finds that the existence of early childhood intervention and developmental supports does not ensure that infants, young children, and their families can obtain timely and meaningful assistance. Across the literature, jurisdictional scan, and ADVANCE working-group contributions, families encountered diagnosis-dependent eligibility, multi-stage waiting periods, limited service capacity, fragmented referral and funding pathways, and substantial responsibility for locating and coordinating supports. These barriers were not experienced equally: children without a diagnosis and families affected by poverty, housing insecurity, geographic isolation, language barriers, racism, colonial relations, or limited access to professional and institutional networks were identified as particularly likely to be missed. Delays were also cumulative, reducing the time available within age-limited programs and creating further discontinuity when responsibility transferred among health, childcare, disability, social-service, and education systems.

The report consequently recommends that governments:

- 1) provide foundational supports according to need before diagnosis.
- 2) establish coordinated entry, navigation, and referral pathways.

⁴ At times, the age range ran from 0 to 2, 3, 4 or 6 years of age depending on the jurisdiction, program, support, service, and experiences of exclusion prior to young children entering any type of educational system.

⁵ For the principles of co-production, see also Jull, J., Giles, A., & Graham, I. D. (2017). Community-based participatory research and integrated knowledge translation: advancing the co-creation of knowledge. *Implementation Science*, 12(1), 150. <https://doi.org/10.1186/s13012-017-0696-3> and NIHR Guidance on co-producing a research project. (2024, October 3). Learning for Involvement. <https://www.learningforinvolvement.org.uk/content/resource/nihr-guidance-on-co-producing-a-research-project/>.

- 3) protect continuity across waiting periods and institutional transitions.
- 4) invest in equitable service capacity.
- 5) support culturally safe and Indigenous led approaches.
- 6) publicly report eligibility, waiting, denial, and service-use information.
- 7) assign clear accountability when responsibilities cross programs, ministries, or jurisdictions.

Together, these changes would shift the burden of making fragmented systems work away from individual families and toward the public institutions responsible for ensuring substantive and equitable access.

In turn, practical options exist for provinces and regions to create tools for service providers, parents and caregivers, and other interested parties to find out what available supports and services might be worth exploring related to early childhood intervention and developmental supports. Specifically, various AI companions would be able to create tools regarding available supports and services and 'step-by-step' suggestions for people on how to access supports at different levels. Integrative AI can build such tools quickly with a built-in updating feature for publicly available program/service updates. The outstanding limitations or elements to address for operationalizing these tools are:

- ➔ Setting up human tool support or a human-computer interface for fact checking components/changes AI suggests and making sure the information is accurate when updating.
- ➔ Establishing liability/legal parameters to make clear to users that the tool is not a diagnostic or medical tool.
- ➔ Communicating to potential users of the tool that suggested supports or services in their area do not establish entitlement to those supports and services and that no rights can be obtained from accessing any information through these tools.
- ➔ Eliciting cooperation from provinces/programs/governments to stay up-to-date and transparent about programs and services as such an AI tool can only access publicly available information.

Given the call among members of various communities about making tools such as these available and the relative ease with which these can be created with AI interfaces, this report also puts out recommendations for the creation of such area-specific tools with an appointed employee to provide the human-AI interface for continuous updating of available supports and services.

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Introduction

During the ADVANCE Network partner event in 2025, attendants voiced that a major area of concern in disability policy and services is accessibility. This concern was translated in a broader area of research focus titled Access and Exclusion. Topics related to access and exclusion therefore directly connect to concerns from project partners and community members across Canadian jurisdictions about the complicated disability policy landscape. During breakout room discussions, participants raised concerns for vulnerable populations experiencing marginalization and an inability to navigate this landscape. This lack of access or exclusion was highlighted by breakout room participants' personal struggles in accessing supports while acknowledging that their struggles were in the context of social positions of relative privilege and occupying less marginalized socio-economic positions in society than other more vulnerable individuals and groups.

Simultaneously, the topic of exclusion is complicated by scarce or absent data on who is missed in accessing disability-related supports and services. This absence is both a methodological limitation in existing research and a disability policy design limitation, leading to a lack of, or ineffective policies that fail to reach those missed and multiply marginalized (e.g., Cerilli et al., 2024; Mont et al., 2022). According to Stienstra (2018), the Canadian disability policy landscape is “complicated [by] material inequalities experienced by people with disabilities and [is] evident in the intersections of disability, gender, Indigenouness, race, and age” (p. 1). These material inequalities were also recognized in a rapid review by Gerlach and McFadden (2022), who looked at how Canadian “government policies and legislation coupled with status-quo social hierarchies create structural violence when they infringe upon individuals' and population groups' human rights, safety, agency and well-being” (p. 4). This context of status-quo social hierarchies in Canada is historically and continually influenced by the settler-colonial socio-economic context that informs narrow definitions of disability and access to supports (e.g., Casale et al., 2023; Gerlach et al., 2022; Ineese-Nash, 2020; Underwood et al., 2019b).

As the previous paragraph indicates, the field of disability access and exclusion is complex and impacts diverse populations in Canada in intersectional ways. This complexity required a further narrowed down scope of the research that the ADVANCE Network Fellow and the working group could reasonably address within the timeframe allotted.⁶ This year's

⁶ Future iterations of the ADVANCE Network Fellowship will allow for further exploration of this research stream and the theme of Access and Exclusion.

focus for the theme of Access and Exclusion is infants and children aged 0 to 5 since early childhood intervention and disability-related supports have been widely recognized as central to children's development, family wellbeing, and equitable participation in society (Van Rhijn et al., 2021), with this early age range presenting a critical developmental and policy window. The questions guiding the working group and this report are:

- ➔ What services exist?
- ➔ Who can access them?
- ➔ Under what conditions?
- ➔ Who is missed when supports are fragmented, diagnosis-gated, difficult to navigate, or unevenly available across jurisdictions?

The project partners lived and professional experiences and relative geographic locations of those experiences led to the current report's focus on working group members' experiences with early childhood intervention and accessing disability-related developmental supports in British Columbia, Alberta, and Ontario.

Early working group meetings established that project partners' experiences with early childhood intervention and support services were both diverse and sharing in commonalities. All members of the working group identified that the complex needs and available disability-related supports during early childhood (roughly) 0 to 5 years of age were inaccessible for a variety of reasons. Overall, early childhood interventions and disability-related supports fell short in providing welfare and basic wellbeing to infants and young children with complex needs and their families and caregivers. Specifically, members of the working group highlighted inequities caused by the need for official diagnoses to access any or all supports. Getting diagnoses was further complicated by not addressing intersecting complex needs or diagnoses were not available in the early childhood stage. These diagnosis-gated supports presented barriers in accessing support, knowledge, and adequately trained professionals. This puts strain on parents, caregivers, and alternative support channels to navigate multiple siloed systems seeking access to services.

Furthermore, from a policy perspective, this focus on early childhood intervention and disability-related supports emphasizes the pre-school and pre-kindergarten period when developmental concerns may be identified and when families are expected to navigate multiple systems before school-based supports might be available. The early years matter because delays in assessment, diagnosis, referral, funding, therapy, inclusive childcare, family support,

and/or service coordination can push children and families beyond the period when early intervention is most strongly emphasized (Jia et al., 2026). This is particularly concerning for children with neurodevelopmental conditions, complex or rare health conditions, suspected fetal alcohol spectrum disorder (FASD), developmental delay, autism, communication differences, or emerging support needs that may not (yet) fit neatly into institutionally recognized developmental diagnoses. Autism spectrum disorder (ASD) appears to be one of the institutionally recognized developmental diagnoses, with dedicated funding and service pathways available in several Canadian provinces. However, according to Smith-Young et al. (2020) and Zwaigenbaum et al. (2021) getting a categorical or definitive ASD diagnosis has become a gateway to intervention or supports. This gateway function combined with assessment and support wait times can therefore make support during early childhood hard to obtain, even for the more widely and institutionally recognized developmental diagnoses of ASD (Penner et al., 2018, 2019; Smith-Young et al., 2020). This underscores the need for timely assessment and access to needs-based support before any diagnosis as also identified by the Canadian Academy of Health Sciences (2022) and the Public Health Agency of Canada (2023).

The next sections of this report address various contexts and backgrounds to the question of who is missed during early childhood stages. The first two sections on methodology and working group experiences present an important consideration for all research: co-production as method (Sutherland et al., 2025). Specifically, this report was synthesized with co-production in mind where disability-lived expertise and family/caregiver engagement in (childhood) disability research is central and valid as an equity-oriented method for knowledge transfer (Pozniak & Gorter, 2024). Especially, in the absence of adequate data collection by systems that structurally omit the perspectives of the multiply marginalized, the lived or living experiences shared through co-produced research should inform policy design and practices.

After sections dedicated to methodology and working group experiences, this report connects that data to some of the current academic literature, policy and legal landscapes, and other available data and resources. The academic literature, as briefly addressed in a previous paragraph, acknowledges the complexity of mapping who is missed in disability-related policies in Canada. The section addressing the academic literature is not exhaustive but rather serves as a background for the experiences and realities shared by the working group members. The sections of this report dedicated to policy and legal landscapes address how early childhood access to disability-related supports and experiences of exclusion have been

identified as areas of high priority in Canada (e.g., *Shared Health Priorities* CIHI, 2025; Statistics Canada, 2025a; 2025b; United Nations, 2006).

In connection with the working group, academic, policy, and legal backgrounds, two later sections to this report and an appendix feature tables with information about the identified disability-related supports and services available to families and caregivers with infants and children approximately 0 to 5 years of age who need early childhood interventions.⁷ The tables look specifically at provincial disability-related services and supports relevant for early childhood interventions and developmental needs. In addition, this report features some of the community-based supports and services that might be in part funded by provincial and/or federal grants but that are not centrally organized or available across jurisdictions.

Finally, the report contains a research synthesis section combining previous sections into a central overview. This section logically flows into a discussion about access and exclusion, and the central recommendations informed by the working group. These final sections also try to answer the central questions set out at the beginning of phase three of the ADVANCE Fellowship and research theme four about access and exclusion for early childhood intervention and disability-related supports and services.

⁷ Important to note is that these are tables referencing programs and services that are subject to change (i.e., eligibility, access, funding) and tables have been compiled with online publicly available data as of July 2026.

Research Approach and Methodology

National health and child development data, including the Canadian Health Survey on Children and Youth and related Statistics Canada reporting, point to the importance of understanding children's access to developmental supports, and disability-related services during early childhood (*Shared Health Priorities* [CIHI], 2025; Statistics Canada, 2025a; 2025b). At the same time, available evidence suggests that the existence of early childhood programs does not guarantee timely or equitable access. The questions guiding this report are therefore what services exist, who can access them, under what conditions, and who is missed when supports are fragmented, diagnosis-gated, difficult to navigate, or unevenly available across jurisdictions.

These research questions and a research endeavour of this kind require a thoughtful approach to be able to capture who is missed and who is not represented in the available data and/or evidence. The current report uses a complementary conceptual and methodological framework. It combines ecological systems theory as a conceptual and analytical framework with co-production or Community-Based Participatory Research (CBPR) as the methodological orientation. The (bio-)ecological framework guides a conceptual analysis of how children's development and access to early intervention and disability-related supports are shaped by interacting systems at individual, family, service, community, policy, cultural, and temporal levels (Bronfenbrenner & Morris, 2007; Guralnick, 2011, 2020). The principles of co-production, sometimes framed as CBPR, operationalize the conceptual framework (i.e., what does it mean to fall through the cracks with these interacting systems at various levels). As an approach, principles of co-production recognize that people embedded within these systems possess knowledge that cannot be obtained from academic literature or policy documents alone. Without the knowledges of the people embedded in these systems, the conceptual framework remains abstract and removed from the lived/living experiences navigating the many systems that impact the lives and wellbeing of people seeking access and facing exclusion when it comes to disability-related supports and services (Jull et al., 2017).

Bioecological Conceptual Framework and Disability Models

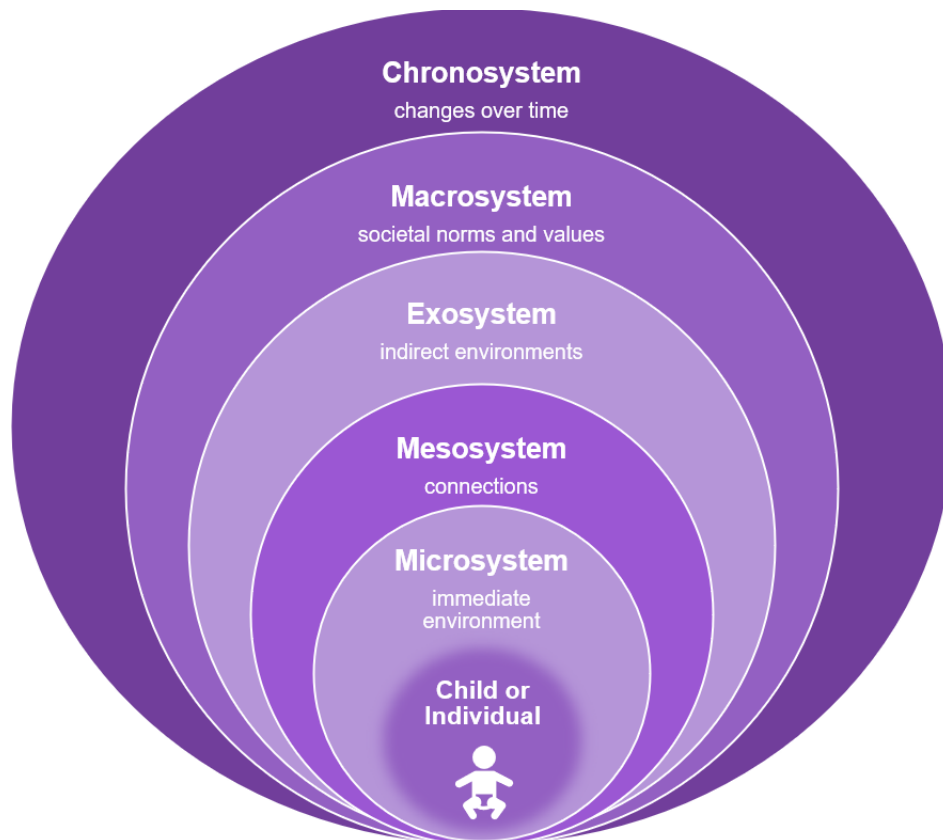
The (bio-)ecological model that shapes the conceptual framework is based on work of Urie Bronfenbrenner (1979). This model, sometimes referred to as Bronfenbrenner's Ecological Systems Theory, is often featured in textbooks related to child psychology and human development (Bronfenbrenner, 1979). As per the original publication, at the time, this theory or

model was “new in its conception of the developing person, of the environment, and especially of the evolving interaction between the two” (p. 3). Since 1979, the model has been adapted, and this fluidity is in part why it is applicable and allows for an analysis of the evolving interactions between people and their environments. As Bronfenbrenner and Morris (2007) explain, “The bioecological model is an evolving theoretical system for the scientific study of human development over time” (p. 793).

As a conceptual framework, this ADVANCE Report uses the central premise of Bronfenbrenner’s Ecological Systems Theory to visualize and map how complex evolving interactions between peoples and systems present tensions for accessing disability-related supports and services. The next sections visualize and explain the use of this theory in the context of the ADVANCE Network research stream on access and exclusion. In line with the 2007 update to Bronfenbrenner’s Ecological Systems Theory, this conceptualization provides a theoretical overview “on proximal processes as engines of development [...] which involves four principal components (process, person, context, and time), and the dynamic, interactive relationships among them” (Bronfenbrenner & Morris, 2007, p. 793). After this conceptualization, the later methodological sections detail the working group’s use of co-production to emphasize the validity of lived/living experiences in giving life to this more abstract conceptual framework and unpacking what it means to be missed or to fall through the cracks when trying to access early childhood interventions and developmental services and supports.

Visualized in Figure 2, the basic diagram used to explain Bronfenbrenner’s Ecological Systems Theory, features concentric circles. Each of the circles represents a layer and emphasizes the role of these different environmental systems in shaping a child or person’s growth and development. Each of these five circles or layers is part of multiple interconnected processes or systems.

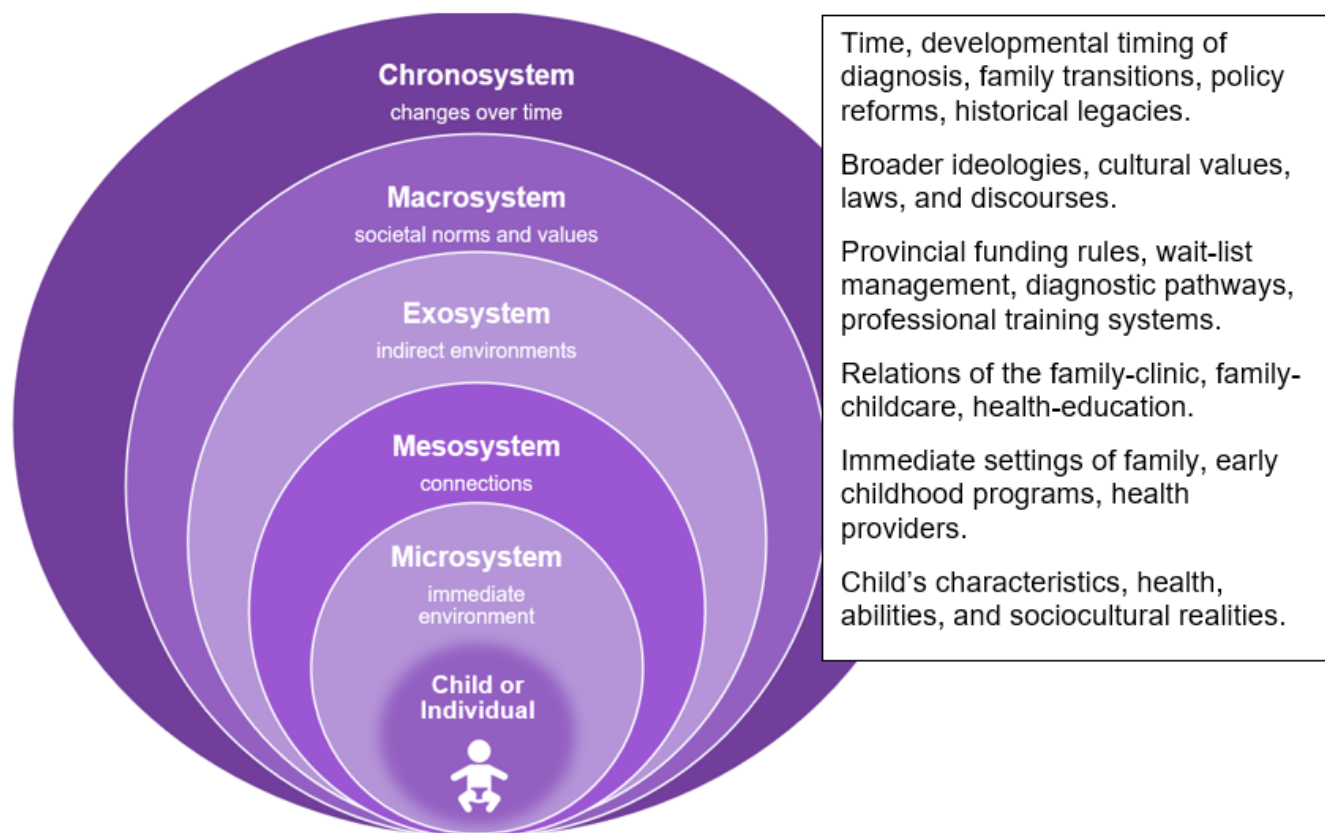
Figure 2: Bronfenbrenner's Ecological Systems Theory



At the bottom of Figure 2 in the smallest circle, we have the child or the individual. The immediate environment to this child or person and their biology is titled the microsystem. The microsystem encompasses the immediate surroundings, including family/caregivers, other children in the household, and those responsible for the immediate wellbeing of the child and interactions between the child and their microsystem. The second circle is the mesosystem which represents the interactions between a child's microsystems and less immediate connections, such as the relationship between childcare providers and home parenting. The next circle, the exosystem, refers to the indirect influences and interactions felt by a child, such as their family/caregiver's workplace or community resources. The macrosystem circle represents societal norms and values including values, customs, and laws. The chronosystem as the outermost and largest circle represents changes over time, as experiences within the child and with/in relation to their environments and other systems.

These five interconnected systems in Figure 2; the microsystem, mesosystem, exosystem, macrosystem, and the chronosystem, are visualized again in Figure 3. On the right side of the diagram, a textbox provides examples of each system and the potential processes and contexts related to accessing developmental supports.

Figure 3: Bronfenbrenner bioecological framework and disability



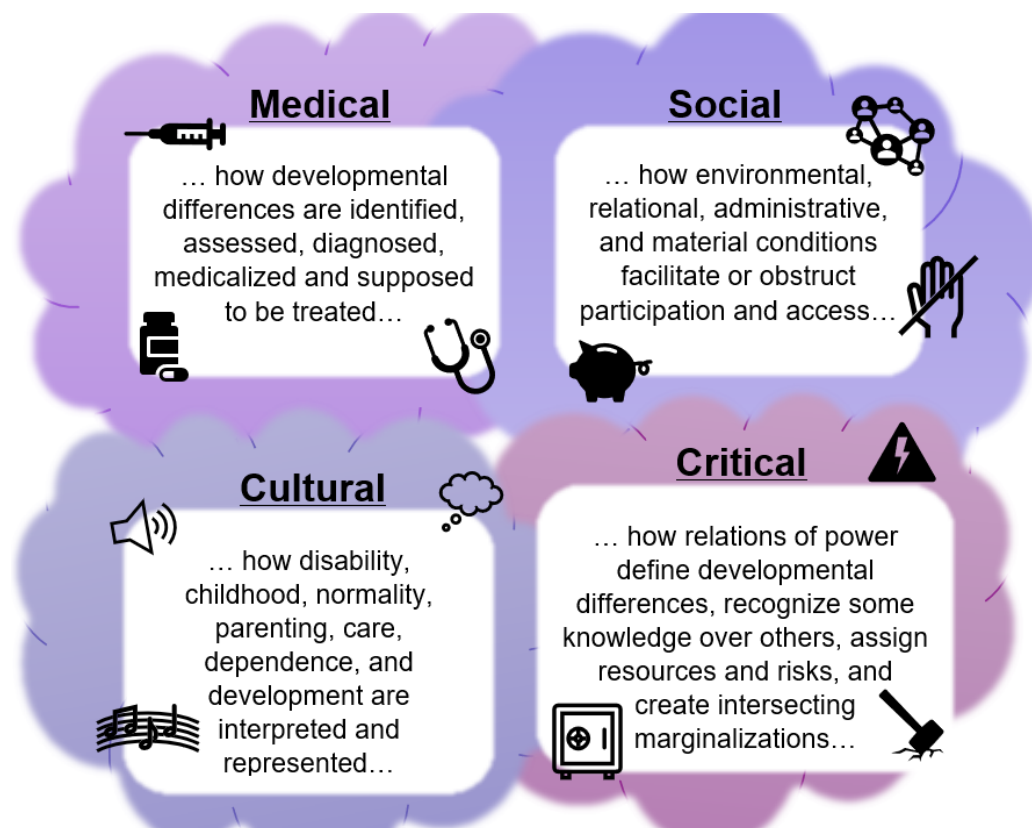
With the addition of some examples in Figure 3, Bronfenbrenner's theory can be used as a framework to address multi-system-based tensions or failures as they emerge in and between the various layers. Inequities in the availability and accessing of early childhood developmental services and supports can be seen as the product of interactions across ecological layers. Bronfenbrenner and Morris (2007) also emphasize not to treat these circles as separate spheres of development or potential barriers. Instead, the model is most effective when focussing on relationships (e.g., process, person, context, time) between them; or the "progressively more complex reciprocal interactions" (p. 797; see also Tudge et al., 2009).

In addition, these "complex reciprocal interactions" are often marked by more complexity due to different definitions of disability or developmental needs. Each system as visualized in Figures 2 and 3 can present a multi-system break-down for a child with early intervention and developmental support needs. Embedded in and between each system are potential conflicts of medical, social, cultural, and/or critical definitions of disability. These different models of defining disability have been voiced over time and in response to one another. Indigenous knowledges and scholarship add more dimensions and definitions to 'disability' in the context of supports in Canada. These models and definitions are not exclusively assigned to one ecological circle in the Bronfenbrenner system. Different

assumptions about disability can co-exist in family interactions, interagency relationships, funding rules, legislation, and public discourses. This means that this report's conceptual framework uses the ecological levels to organize the analysis and the disability definitions to interrogate assumptions, meanings, and power relations within and across those levels.

This conceptual framework provides a system-level perspective to examine inequities in access to early childhood intervention and disability-related supports through reciprocal relationships among process, person, context, and time (Bronfenbrenner & Morris, 2006).⁸ The microsystem, mesosystem, exosystem, and macrosystem represent different contexts of navigating early childhood and seeking supports, while the chronosystem is useful to assess continuity and change over time. This allows us to unpack how children, families, service providers, institutions, policies, and historical conditions interact with and influence one another (Tudge et al., 2009).

Figure 4: Medical, social, cultural, and critical definitions of disability



⁸ Process refers to interactions among children, caregivers, extended families, clinicians, early childhood educators, intervention professionals, community organizations, and public systems. Person refers to children's developmental characteristics, support needs, and the social positions and circumstances of children and caregivers, including Indigeneity, racialization, migration history, language, gender, income, geography, and family structure. Context refers to immediate family and service relationships, connections among institutions, program and policy design, and cultural and political ideologies. Time refers to developmental timing, family transitions, waiting periods, policy reforms, and histories of institutionalization, colonialism, ableism, racism, and disability-rights advocacy.

The medical, social, cultural, and/or critical perspectives on disability are overlapping analytical lenses to look at the reciprocal relationships between processes, persons, contexts, and time (Figure 4). The medical model of disability, also referred to as the biomedical or neurodevelopmental approach, centres developmental differences through screening, clinical assessment, diagnostic classification, genetic research, and standardized measures (Gillberg, 2010; Lord et al., 2020; Scherer & Dawson, 2011). Medical definitions of disability can facilitate recognition and access to specialized interventions. This approach can also contribute to diagnosis-gated systems in which diagnostic classifications become the primary mechanisms for determining eligibility and allocating support. The medical model of disability has been criticized as classifying disabled bodies and minds as abnormal, treating a ‘cure’ or correction as the best response, and expecting disabled people to become ‘normal’ to conform to society’s standards of normality (Zaks, 2024).

The social model of disability redirects the focus from medical impairment to the environmental, institutional, and economic conditions that create restrictions for people with disabilities to participate and make people experience exclusion due to limited access (Goodley, 2025; Oliver, 1990; Thomas, 1999). This perspective emphasizes that individuals and families are made disabled in relation to society. Inaccessible transportation, inflexible appointments, fragmented programs, administrative requirements, inadequate income supports, shortages of professionals, geographic disparities, and policies create an inability for people to participate in society. Research in this field asserts that exclusion can be reproduced through institutional design, fragmented accountability, and continued disconnects between disability rights and access to practical supports (Prince, 2009; Stienstra, 2020).

A cultural model of disability shifts our focus to examine how disability, ability, childhood, development, care, dependence, and normality acquire meaning through language, (mis)representation, cultural narratives, bodily practices, and institutional conventions (Waldschmidt, 2018). This means that to study disability or unpack its definitions, researchers look at cultural narratives about normality, independence, productivity, care, dependency, gender, family responsibility, and deservingness (Davis, 1995; Garland-Thomson, 1997; Snyder & Mitchell, 2006). These perspectives recognize that disability meanings are shaped by culture and history rather than being produced solely by individual pathology, clinical knowledge, or societal exclusion.

Finally, critical perspectives of disability involve the study of power relations to unearth whose interests are served by definitions, classifications, policies, and institutions related to people with disability-related needs. Scholars adhering to this model often connect these

relations of power to show how powerful interests might limit meaningful change to improve access and inclusion. This perspective emerged from critiques and limitations associated with other perspectives and models (Goodley et al., 2019; Meekosha & Shuttleworth, 2009). A critical disability lens problematizes previous lenses as it invites us to unpack who benefits from disability as medically classified, socially produced, or culturally represented and how particular classifications distribute resources, opportunities, surveillance, and institutional control. Many Indigenous scholars and scholars in the 'Global South' have made important contributions to this critical lens (e.g., Gerlach et al., 2017; Ineese-Nash, 2020; Khanlou et al., 2017).

These three disability models and the critical perspective help further investigate the complex inter- and intra-system relations that can impact an infant or young child with developmental and/or disability-related needs. In combination with the bioecological conceptual framework discussed above through Bronfenbrenner's theory, each perspective or lens provides an analytical question:

- **Medical model:** How is developmental difference identified, classified, diagnosed, and treated?
- **Social model:** What environmental, institutional, relational, and material barriers produce disability?
- **Cultural model:** How are disability, normality, childhood, care, and development culturally understood and represented?
- **Critical perspective:** How do settler colonialism, ableism, neoliberalism, and intersecting structures of power shape disability definitions, practices, institutions, and outcomes?

Putting Bronfenbrenner's theory and these analytical questions together, we start to see how access and experiences of exclusion when seeking developmental supports and services during early childhood are complex and built into the various systems of Canadian society. The next sections provide a literature review to elaborate on the integration of Bronfenbrenner's theory and these analytical questions.

Early Intervention and the Microsystem

Looking back at Figures 2 and 3, the infant or young child is at the centre of the microsystem in Bronfenbrenner's bioecological theory. This microsystem includes children's individual developmental characteristics, communication styles, identities, strengths, and support needs.

The microsystem also includes the circumstances that shape how other people respond to the infant or child. As the immediate environment, the microsystem impacts an infant or child's access to early childhood interventions because this is often where developmental differences are noticed, interpreted, communicated, and acted upon or not. During early intervention stages, access and exclusion are processes that involve recognition of need, identification or diagnosis, and intervention or other support (Sapiets et al., 2021). According to an international narrative review by Sapiets et al. (2021), ecological systems thinking shows that access to early interventions spans all systems and the interactions among them combined with time pressures (p. 696).

From the perspective of the medical model of disability, microsystem levels are where developmental differences are potentially diagnosed and translated into clinical concerns. Immediate connections to the infant or the child, like family and caregivers may notice differences in communication development, sensory processing, social interactions, motor development, and/or emotional regulation. If available and accessible, various professionals might become involved using screening tools, developmental surveillance, diagnostic assessments, and clinical observations. Reports and diagnostics can also provide important pathways to further services and supports. On the one hand, diagnoses can validate family concerns, help professionals coordinate intervention, and unlock specialized programs. On the other hand, this medical perspective can be exclusionary if a clear diagnosis is not available or the developmental concern is not severe enough. According to Zaks (2024), when a child's difference is pathologized as an individual abnormality, demonstrating deviation from standardized developmental norms, this reflects a normalization logic (p. 3234). What this medical perspective risks, is that those infants and children diagnosed as needing additional services and supports become represented as incompatible or deviant to what society deems acceptable or normal (Bunbury, 2019). This often creates an environment of exclusion rather than a societal push to accommodate developmental diversity.

A social perspective of the microsystem would address the conditions or contexts in which children and families can act on developmental concerns in connection to meso- and exosystem arrangements. When an infant or child's immediate environment, such as a caregiver, recognizes a need, access can be complicated by transportation difficulties, costs, limited childcare options, insufficient leave from employment, shortages of local professionals, and other barriers (e.g., Fellin et al., 2013; Gosse et al., 2024; Kerr et al., 2024; Khanlou et al., 2017). These barriers are characteristics of systems and organizations that impose unequal demands on families. This means that those families with flexible employment, reliable

transportation, financial resources, extended family support, and familiarity with professional systems may be better positioned to act on developmental concerns than families facing precarious employment, poverty, rural isolation, housing instability, or intensive caregiving responsibilities. Canadian and international research on access to early intervention finds that socioeconomic status, informal support and family resources, service fragmentation, professional availability, interactions between families and services, and rural or remote geography affect whether needs are recognized, and intervention is received (e.g., Gosse et al., 2024; Khanlou et al., 2017; Sapiets et al., 2021).

The cultural model of disability provides a perspective that examines how children's development and disability are interpreted within the microsystem and in relation to other systems. As research by Davis (1995) and Garland-Thomson (1997) shows, normality and disability are culturally constituted and not neutral descriptions. Families and professionals may attach different meanings to the same developmental characteristic. Canadian disability-related language may not resonate across languages and the categories used in clinical and administrative systems may not correspond with families' understandings of childhood, care, or development. According to Waldschmidt's (2018), a cultural model asks how disability and normality are produced through symbolic meanings, embodied practices, and institutions to reveal how stigma, fears about labelling, community narratives, or expectations affect whether and how families approach services.⁹ Ineese-Nash (2020) argues that dominant Canadian disability discourses can conflict with Indigenous ontologies grounded in relationality, community membership, and culturally situated understandings of difference (pp. 28-9). The application of Canadian disability classifications is therefore not culturally neutral (see also Underwood et al., 2019b). In a critical scoping review, Gerlach et al. (2022) found that literature and services concerning autistic Indigenous children in Canada frequently relied on Western medical and deficit-based discourses presenting a disconnect involving stigma, diagnostic assessment tools, inadequate funding, and unmet needs (p. 24).

The critical perspective asks whose interpretation of a child becomes authoritative within these microsystem relationships. Even though family members and caregivers may hold extensive experiential knowledge of their child, clinical or professional knowledge may dispute those knowledges, treating medical pathology as more legitimate (e.g., Burns et al., 2025; Fong et al., 2026; Pozniak & Gorter, 2024). According to a study by Zuckerman et al. (2015), in

⁹ A cultural analysis of disability across the ecological systems framework must not resort to groupism and reducing families to fixed beliefs associated with an ethnic or cultural group. Interpretations are internally diverse and fluid (see also Khanlou et al., 2017).

the context of autism spectrum disorder diagnosis, families who repeatedly raise concerns may be characterized as anxious, while families who hesitate to accept a professional interpretation may be labelled uninformed, resistant, or non-compliant. These judgments are not distributed evenly. Racism, colonialism, ableism, language discrimination, gender expectations, and class-based assumptions can influence whose concerns are believed, whose parenting is scrutinized, and whose inability to complete administrative requirements is interpreted as an individual failure (e.g., Gallegos et al., 2021; Gerlach et al., 2017a, 2017b; Lindsay et al., 2024). The critical question at this microsystem level is whether services create equitable, accessible, and culturally safe conditions for family engagement with early childhood intervention and developmental supports.

Intersectional and gendered expectations are significant considering inequitable access to early childhood interventions and developmental supports at the microsystem level. Mothers are frequently expected to perform unpaid caregiver labour and notice developmental differences, arrange appointments, complete forms, communicate with providers, change or quit their employment, and implement intervention strategies (Balter et al., 2025; Corriveau et al., 2025; Masfield et al., 2020). These gendered caregiving expectations are often compounded or leading to further marginalization when seeking to access early childhood interventions for minority groups. For example, Khanlou et al. (2017) found that immigrant mothers often assume extensive responsibility for care and service navigation, sometimes alongside employment insecurity, social isolation, and limited informal support (see also Casale et al., 2023; Fellin et al., 2013). A critical model of disability as analytical lens makes these invisible labours or caregiver responsibilities visible; resisting societal tendencies in framing difficulties with service and support navigation as evidence of poor parenting (e.g., Underwood et al., 2019a, 2024; Xu et al., 2025). At the infant or young child and microsystem levels, access and exclusion are therefore produced through the interaction of developmental recognition, clinical judgment, material resources, family meanings, professional relationships, and unequal distributions of credibility and caregiving labour.

Mesosystem Connections and Navigation

In Bronfenbrenner's bioecological framework (Figures 2 & 3), the mesosystem refers to the relationships among the child's microsystems. In early childhood intervention, this could include connections between the family home, primary health care, pediatric services, childcare, community programs, early intervention agencies, and rehabilitation services. An analysis of an infant or child's mesosystem concerns the quality, continuity, and power

dynamics of the relationships among services and supports (Bronfenbrenner & Morris, 2007; Tudge et al., 2009). In two studies by Michael Guralnick (2011, 2020), using a developmental-systems approach, the author emphasizes that effective early intervention depends on coordinated relationships between systems. The effective interactions and supports at micro- and mesosystem levels proved more meaningful than isolated interventions directed toward the infant or the child that did not incorporate family and environmental supports (Guralnick, 2011, 2020). Access to supports and services can be strengthened with care coordination; when referrals result in active connections, information is transferred appropriately, professionals communicate across health, childcare, and rehabilitation settings, and intervention plans are responsive to children's everyday participation across home and community environments (Currie et al., 2023; Pozniak et al., 2024). Meaningful care coordination at the mesosystem level can reduce duplication and uncertainty when responsibility is shared and not offloaded onto families.

From a medical model perspective of disability, a mesosystem experience for infants, young children, and their families can be dominated by diagnostic reports, standardized assessments, clinical records, and professional referral language. This language, accompanied by documents, may give professionals a shared description of a child's developmental profile to support continuity across providers and establish eligibility for programs requiring clinical evidence. According to research by Underwood et al. (2018, 2019a) in Ontario, the problem that arises is that often only clinical documentation attains a high degree of authority or the only legitimate way to communicate need. The "supremacy of labels" becomes a recurring experience that determine children's transitions from early childhood to educational institutions and what needs are recognized and supported (2019a). Often family knowledge and observations of children's functioning carry less institutional weight. Research into family interactions with Ontario early-years services raised concerns about whether access is treated as a right or is dependent on families' ability to navigate clinical settings (Underwood et al., 2018; see also Wertlieb, 2018).

In addition, complications often arise when infants and children do not neatly fit into clinically determined categories of needs or available diagnoses. One complication would be that assessment waiting periods become longer or inaccessible when an infant or child presents complex needs that are difficult to classify in siloed systems. According to research by Sapiets et al. (2021, 2024) access to early childhood supports is a multistage process, where treating diagnosis as the sole gateway to support presents barriers by converting complexity to clinical uncertainty and administrative ineligibility. For example, a Canadian

systemic analysis of speech-language pathology by Underwood et al. (2024) shows that speech and language services may be the first or only early interventions encountered by families. The authors illustrate “the pervasiveness, organizational structure, and governance of speech and language pathology (SLP) in early childhood, leading to professional discourses of childhood and disability in early intervention [...] which reinforce individualized pathology as the dominant way of understanding development” (p. 1). Such a medical perspective of disability and early childhood development is a barrier to access for any infant, child, and/or family that does not conform to or fit into SLP’s understanding of development and/or need.

From a social model of disability perspective (Figure 4), a central question is whether institutional relationships at the mesosystem level are fairly distributing responsibility of care, or on the contrary, offload coordination to families alone. According to Underwood et al. (2019a), offloading care coordination to families at the microsystem level requires families to perform extensive work to connect programs that are formally part of the same early childhood system and inform transitions into school environments (see also Siddiqua & Janus, 2017). Canadian research by Balter et al. (2025) demonstrates that early childhood services continue to rely on mothers and primary caregivers to initiate referrals, communicate, and advocate for access, making available natural supports and family members’ ability to function as case managers central to access and exclusion experiences. Families with higher socioeconomic status, including but not limited to having a greater income, flexible employment, professional familiarity, administrative literacy, transportation, and reliable social networks may be better positioned to function as case managers and navigate mesosystem level services (Kerr et al., 2024; Underwood et al., 2018). Infants, young children, and their families (or natural supports if available) with a lower socioeconomic status more likely struggle to access Canadian early childhood systems that require active labour and social capital from caregivers (Balter et al., 2025).

Research by Balter et al. (2025) and Khanlou et al. (2017) address how ableist, racialized, gendered, and class-based institutional expectations shape whose advocacy for early childhood intervention access or administrative visibility are treated as appropriate. Khanlou et al. (2017) found that immigrant mothers of autistic children in Canada had to navigate fragmented and geographically dispersed services (p. 239). Service fragmentation and geographic disparities were further complicated by language barriers, precarious employment, reduced informal support after migration, financial pressures, and uncertainty about unfamiliar systems (pp. 246-7). From a social model of disability perspective, service

fragmentation, not infants, young children, and their families, magnifies existing institutional inequities and barriers to access.

Mesosystem connections (Figures 2 & 3) are further consequential for early childhood intervention and developmental supports in terms of referrals and transitions. In relation to caregiver and parental capacity, a qualitative study by Camden et al. (2020) shows how “the level of concern and parents' knowledge and perceived access to resources seemed to influence their decision whether or not to consult health care professionals,” in the context of expected developmental delay (p. 9). Lack of accessible information and the absence of pre-established connections between mesosystem institutions and caregivers, when for many parents these were first encounters with potential developmental delay, affected help-seeking (p. 16). According to Abouzeid et al. (2025), testimonials from families, practitioners, and researchers reflecting on diagnostic evaluations and trajectories for young children in the province of Québec indicate that mesosystem connections require improvement. Specifically, families, practitioners, and researchers highlighted the need to improve mesosystem level to family microsystem level information-sharing and collaboration practices (p. 1). In addition, Rivard et al. (2023) studied the perspectives of parents in metropolitan Montréal and their diagnostic trajectories according to five dimensions of access: accessibility, continuity, validity of information, flexibility, and provider–family relationships (p. 2). Using these five dimensions, Rivard et al. (2023) discuss how “critical barriers and facilitators related to the system of services,” and that “the majority of the barriers or obstacles that parents identified pertained to the steps that preceded their referral to an assessment center” (p. 9). For transitions from early childhood intervention and developmental supports to kindergarten, Rivard et al. (2020, 2026) completed two studies which found that parents’ perceptions of service quality for them and their children declined. These studies together highlight how mesosystem level connections are fundamental for accessing early childhood interventions and developmental supports, and, how those connections remain fundamental during times of transition. The Government of British Columbia acknowledges this in a recent Service Plan report (2025) and key strategies to break down siloed system experiences for families during early childhood and in transitions beyond early childhood years (pp. 12-3).

Furthermore, Canadian research by Rivard et al. (2023) and Currie et al. (2023) illustrate the importance of care coordination and what can happen when these mesosystem level connections are disrupted or actively supported by care coordination. According to Rivard et al. (2023), for parents in metropolitan Montréal, the presence of care coordination signified a facilitator to navigating early childhood services, while absence of care coordination presented

a barrier. Similarly, research by Currie et al. (2023) for Alberta families of children with neurodevelopmental disabilities and medical complexity, interruptions to care coordination contributed to lost access, increased unmet needs, and greater impacts on children and caregivers. Broadly speaking, Canadian research has identified that continuity, communication, practical assistance, and responsive services are central features for family-centred care (Pozniak et al., 2024). This means that most positive institutional relationships at the mesosystem level do not offload care coordination to families but see care coordination as an essential intervention available to all infants, young children, and their families/caregivers (see also Sapiets et al., 2021).

The cultural model of disability helps examine how meaning and expectations impact different settings and mesosystem level connections. Questions incorporating this cultural perspective at the mesosystem level investigate how understandings of disability, development, parenting, intervention, and service participation vary and overlap across a child's home, health care, childcare, rehabilitation, community, and early interventions. According to Casale et al. (2023), caregivers and professionals may interpret disability, behaviour, and intervention differently. Canadian newcomer caregivers, navigating and accessing autism-related services, may disagree with the terminology or labels used by professionals (pp. 1-2). A recent scoping review by Fenn et al. (2025) similarly found that caregivers and professionals may present different understandings of parenting and disability, shaping intervention goals, recommendations, and expectations for family participation (pp. 351-2). In addition to studies by Casale et al. (2023) and Fenn et al. (2025), research from Shafi et al. (2024) specifically pertains to South Asian parents' perspectives in Canada, where developmental differences are interpreted through family histories, gendered expectations, community knowledge, and/or culturally available language at odds with Canadian clinical interpretations. As the authors suggest, "not having an adequate understanding of autism, alongside being a community-level barrier, is also a structural barrier and needs to be addressed through system-level approaches to engage and inform the community" (p. 10). Adequate understanding of autism in this quote refers to the cultural understanding and definitions of autism in Canadian clinical diagnostics as at odds with or absent in cultural understanding and language for the South Asian parents interviewed in this study. Cultural differences are present in those clinical and administrative categories as well and must be interpreted, translated, and negotiated across settings.

Cultural and linguistic differences affect the literal transfer of information and influence whether families understand diagnoses, eligibility, professional roles, available supports, and

expectations for family-based interventions at home. Both studies by Shafi et al. (2024) and Casale et al. (2023) found recurring language and communication barriers that lead to disagreements related to terminology and labels, difficulties trusting providers, and differences in how intervention should be pursued. According to Fong et al. (2022), Korean immigrant parents in British Columbia identified barriers and facilitators at the mesosystem level and in connection to provider, family, and cultural levels. Interpretation of semi-structured interviews with Korean immigrant parents revealed that “the most frequently reported barrier was related to language and communication difficulties,” where “limited English proficiency impacted parents’ ability to seek and understand information available, and negatively impacted their willingness to engage with support services and communicate their desires and needs to professionals” (p. 531). Together, these studies and their findings relay the complexity for families with culturally different or absent interpretations of disability, parenting, and early childhood interventions navigating Canadian institutions that clinically define disability, divide care responsibilities, and expect caregivers to participate (see also Lee & Zhu, 2021).

Any cultural analysis of early childhood intervention and developmental supports also must avoid cultural determinism, where Canadian professional knowledges are presented as ‘the norm’ or culturally neutral. Two mothers, ‘Kate’ from Korea and ‘Claire’ from China, central to the article by Lee and Zhu (2021) criticize this cultural determinism and instead conceptualize autism diagnoses as a sociocultural practice shaped by intersections of race, gender, class, migration, and disability (pp. 1656-7). Cultural perspectives of disability within the mesosystem therefore relate how different forms of knowledge meet and often compete in efforts to access a diagnosis, meet eligibility criteria, receive intervention, and understand access as reliant on caregiver advocacy.

This cultural perspective of disability, connected to critical perspectives of the unequal power relations and authority assigned to clinical Canadian perspectives of disability, is particularly complex in the settler colonial context. Relationships involving Indigenous families, health care, early childhood intervention, childcare, and child-welfare systems are historically complex and diverse. Gerlach et al.’s (2017a) study of an Indigenous early childhood intervention program in British Columbia demonstrates that cultural safety depends on having the perspectives of service and support recipients determine whether care is safe. Ball and Benoit-Jansson (2023) similarly conclude that quality Indigenous child and family services foster cultural connectedness and are situated within specific First Nations, Métis, and Inuit frameworks under Indigenous leadership (p. 34). Mesosystem level coordination and connections involving Indigenous families from a cultural perspective should increase family

and community authority, cultural continuity, trust, and control. Overall, culturally responsive access depends on connecting institutions and requires the development of shared yet flexible understandings of early childhood intervention and developmental support across different settings and knowledge systems. Exclusion occurs when one interpretation becomes deterministic and related processes make services and supports inequitable, incomprehensible, irresponsive, or culturally unsafe.

A critical perspective of disability is an analytical lens that helps examine hierarchies of knowledge and authority operating among the institutions at the mesosystem level and in relation to the microsystem (Figure 4). When thinking about early childhood intervention and developmental supports, clinical specialists and various professionals possess recognized authority to define an infant or child's developmental characteristics to determine which assessments (if any) are valid. These channels of knowledge also produce the documentation required, such as diagnostic reports and standardized assessments that function as gatekeepers and influence whether an infant, child, or caregiver's needs are recognized as legitimate. In contrast, family accounts and community knowledge may not carry the same administrative weight (e.g., Rivard et al., 2023; Underwood et al., 2024). On the one hand, clinical evidence, diagnostic, and specialist knowledge can help families understand a child's needs and coordinate intervention. On the other hand, when clinical evidence and professional documentation become the only recognized evidence, displacing contextual knowledge from children, families, community, and cultural knowledge holders, this presents concerns. For example, a critical mesosystem analysis using Gerlach et al.'s (2022) review of autism services involving Indigenous children in Canada, identifies the dominance of Western medical and deficit-oriented discourses as problematic when standardized assessments and diagnostics lead to the exclusion of Indigenous infants, young children, and their relations.

Another critical perspective to assess mesosystem level connections and access and exclusion is to distinguish genuine family-centred collaboration from professional-centred coordination. Research with Canadian caregivers to infants and young children with disabilities and/or complex needs identified that effective communication, individual, yet coordinated care, practical assistance, accessibility, and attention to the entire family/community-level support system are central to genuine family-centred collaboration (e.g., Currie et al., 2023; Hurd et al., 2024; Pozniak et al., 2024). According to a study by Hurd et al. (2024), perspectives from parents participating in intensive rehabilitation for young children in Alberta, demonstrate that genuine family-centred collaboration requires the recognition of caregivers' perspectives, capacities, and experiences; not transferring therapeutic perspectives from clinicians to

families (p. 7). Similarly, a community-based participatory method study by Jacques et al. (2024) in Québec promotes the development of a genuine family-centred diagnostic-service model rather than relying only on professional or organizational perspectives (p. 1; see also Abouzeid et al., 2025).

In connection with a critical analysis of genuine family-centred practices and care, such an analysis can also support an examination of how institutions define the “appropriate” participant or recipient. Several studies include a critical analysis of the Canadian institutional landscape to address the power dynamics of those institutions directly and/or indirectly defining ideal family-participant and their ideal behaviour in seeking supports (Pozniak et al., 2024a, 2024b; Smith-Young et al., 2022; Underwood et al., 2019a). Research by Underwood et al. (2019a) indicates that institutions are more likely to recognize families seeking out those services that are deemed necessary by professionals and that poverty and perceived parental education influence how professionals understand families’ capacity to undertake the services deemed necessary for early childhood intervention (p. 145). This means that families with the time and resources that satisfy these institutional procedural and relational expectations may be more likely recognized as engaged and capable participants. A study by Smith-Young et al. (2022) illustrates how “the process of parental advocacy, skill development, and the barriers parents encounter in advocating for their children with ASD” is informed by institutional definitions of the “appropriate” family (p. 1). In addition, the connection between socioeconomic status and professional familiarity changes families’ capacity to navigate services and advocate in accordance with institutional language and settings (Pozniak et al. 2024a, 2024b). As pointed out through the social model of disability as well, Canadian institutional research indicates that early childhood disability systems rely heavily on mothers, and by extension, that type of reliance on mothering or unpaid caregiving becomes idealized. From a critical point of view, this means institutional definitions of appropriate family systems reward those with higher income, employment flexibility, education, transportation, language, and social capital (Balter et al., 2025).

Knowledge and power relationships prove to be especially significant for Indigenous families and their access and exclusion to early childhood intervention and developmental supports. For example, a study by Gerlach et al. (2017b) found that Aboriginal Infant Development Program workers used relational approaches to counter Indigenous mothers’ experiences of being made to feel “like a bad parent” due to child-welfare authorities (p. 1). Workers and Indigenous mothers had to navigate a close and contested relationship between early childhood intervention and child welfare. Structural violence, poverty, inadequate family

supports, colonial histories, and institutional practices historically and continually are converted into individualized judgments about Indigenous parenting styles as ‘bad parenting.’ Mesosystem level connections and available supports, even when adhering to interagency care coordination are not inherently supportive for Indigenous infants, young children, and their support networks. According to Ineese-Nash (2020), dominant disability categories can function as colonial constructs when they position Indigenous children through Western deficit-oriented frameworks that conflict with Indigenous understandings of relationality, community membership, and difference (pp. 28-9). Gerlach et al. (2022) similarly identify the dominance of settler colonial medical worldviews, the interaction of ableism and racism, and a tendency for research and services to be conducted *on* Indigenous children rather than *with* Indigenous children and communities (p. 4). Power relations inherent to the dominant mesosystem interactions mean that Indigenous supports are often segregated and complicated by Canadian institutions’ failure to give authority to Indigenous families, communities, knowledge holders, and organizations to define infant and children’s strengths and needs, determine appropriate supports, and govern the relationships among services. Ball and Benoit-Jansson (2023) conclude that quality services for First Nations, Métis, and Inuit children and families preserve cultural connectedness and rely on distinctions-based cultural frameworks that are Indigenous-led (p. 42). From this critical perspective, reform or improved coordination of mainstream systems does not necessarily address the underlying unequal distribution of authority and power in the context of settler colonial Canada.

At the mesosystem level, a critical perspective therefore asks whether services communicate with each other and what their communication accomplishes in terms of knowledge and power relations; whose knowledge is recorded, transferred, and acted upon; who defines needs and intervention goals; can families and communities contest professional interpretations; and does increased coordination expand assistance or expand surveillance?

Taken together, mesosystem level connections and interactions related to early childhood intervention and developmental supports for infants, young children and their families can strengthen access when family, community, childcare, cultural, and professional knowledges are brought into genuine dialogue. Research continually points out that access is strengthened when families share authority over goals and decisions and institutions assume responsibility for creating trustworthy, accessible, and culturally safe relationships. By contrast, exclusion is reproduced when clinical and professional documentation is seen as the only credible evidence, family participation is symbolic, and interagency connections increase professional control without increasing genuine recipient-centred support.

Exosystem Architecture and Resource Administration

The exosystem encompasses indirect environments (Figures 2 & 3). This level of Bronfenbrenner's theory relates to decisions that infants and young children do not directly participate in. Yet, these decisions shape access to early childhood intervention and developmental supports. In the context of early childhood interventions in Canada, the exosystem includes provincial and territorial ministries, health authorities, funding bodies, professional and regulatory systems, childcare policies, service agencies, workforce-planning structures, administrative data systems, and program eligibility rules (Employment and Social Development Canada, 2021; Routhier et al., 2023). According to Guralnick's developmental-systems approach, effective early childhood intervention depends on practices directed toward individual children and coordinated community resources, family supports, and service systems capable of responding to children's needs across settings (Guralnick, 2011, 2020). In Canada, provincial and territorial responsibility for most health, disability, social, and early childhood intervention services and supports produces jurisdictional variation in diagnostic pathways, eligibility requirements, funding arrangements, and service availability (Canadian Academy of Health Sciences [CAHS], 2022; Public Health Agency of Canada [PHAC], 2024).

From the perspective of the medical model of disability, the exosystem is where clinical classifications, diagnostic and standardized assessments, and eligibility criteria are administratively kept. For example, a 2022 CAHS assessment found that access to Canadian autism services commonly depends on a formal clinical diagnosis and may be restricted through age-based and/or intellectual-functioning thresholds. The same 2022 assessment consequently recommended a tiered system that can provide needs-based early childhood supports that are not constrained by a completed diagnosis or a single intervention model. Exosystem diagnosis-dependent eligibility for early childhood interventions and developmental supports is further problematic when publicly funded diagnostic pathways are delayed or unevenly distributed. According to Penner et al. (2018), a survey established that "Canadian ASD diagnostic practices vary widely and wait times for these assessments are substantial" (p. 1).¹⁰ According to a study by Sapiets et al. (2021), access to early childhood intervention is a multistage process that is defined in part by the exosystem and the recognition of a possible need, identification or diagnosis, and receipt of support. In this multistage process, delays at every stage can prevent infants, young children, and families from progressing to the receipt of support. The medical perspective becomes restrictive when an infant or child that has

¹⁰ At the time of writing, there are newer Canadian sources talking about diagnostic wait times, but none currently provides a new or comparable national average wait time to replace Penner et al.'s (2018) national estimate.

observable developmental needs remains administratively ineligible awaiting formal diagnosis and classification (see also Sapiets et al., 2024). Exosystem level formal service availability therefore does not ensure access as families move through diagnostic, administrative, and relational gateways before receiving support.

A social model of disability provides a perspective that examines whether the architecture of services at the exosystem level make formally available supports substantively accessible. Conditions to assess substantive accessibility of early childhood interventions and developmental supports include the geographic availability and distribution of professionals/specialists, local and regional program capacity, transportation and travel requirements, childcare availability, hours of operation, language access, wait lists practices, continuity transitioning between programs, and the availability of support in everyday settings. According to research by Sapiets et al. (2021), family resources, characteristics of services, interactions between micro- and mesosystems, and wider social and policy contexts at the exo- and macrosystem levels all present interrelated influences on access. The CAHS assessment (2022) also identified an interrelatedness between geography, income, race and ethnicity, age, sex and gender (p. 132), workforce capacity, and urban-rural discrepancies as marginalizing dimensions of unequal access and exclusion in Canada (pp. 134-5). An example to differentiate between formal and substantive accessibility of services would be how families in rural and remote locations may formally qualify for support, but substantively these supports are inaccessible due to lengthy travel, additional expenses, limited local diagnostic and allied-health capacity, and few to no alternatives when a local provider is unavailable (Gosse et al., 2024; Kerr et al., 2024). According to research by Kerr et al. (2024), 44.7% of the complete sample of 1189 parents had trouble finding childcare for their disabled child (p. 27, 32). In addition, “approximately one-third of parents of children with disabilities in child care reported issues accessing therapeutic services within child care” (Kerr et al., 2024, p. 32). The authors also report that infants and young children between the ages of 0 and 5 in low-income families were less likely to try to find childcare, to participate in non-parental childcare, and to be able to afford specialized care or therapies (p. 29). These findings connect exosystemic decisions about formal early childhood intervention and developmental supports to actual substantive access and exclusion.

Exosystem level service architectures also determine how much unpaid administrative labour families are expected to perform to convert formal eligibility into actual supports. According to Finlay et al. (2023), Canadian caregivers experienced difficulties locating government disability programs, initiating applications, completing documentation, obtaining

professional assistance, and responding to refusals (pp. 6, 11). Although research findings of Finlay et al. (2023) include caregivers of children beyond the early childhood, quantitative and qualitative results provide strong evidence of the administrative mechanisms through which formally available programs can remain inaccessible during early childhood (p. 12). In addition, Russell et al. (2021) found “that social determinants of health affect family disability service use” in combination with assigned ‘codes’ of severity as based on linked administrative data from ministries in Alberta (p. 87). Higher exosystem level ‘coding’ of young children’s severity of need (aged 3 to 8) was linked to family disability service use, their involvement with other services, and service use was higher when compared to young children with mild or absent coding (p. 86). Together, these findings from Finlay et al. (2023) and Russell et al. (2021) suggest that children become visible due to severity of need and the extent to which families can successfully move through referral and application systems before formal eligibility becomes actual service use. Importantly, the linked administrative demands affect families differently as systems requiring extensive documentation, appointments, internet access, transportation, institutional literacy, and persistent advocacy advantage families with greater socioeconomic status and capital. In sum, a social model of disability analysis of the exosystem level experiences asks if services accommodate families’ circumstances or make access contingent on families’ ability to perform independently.

A cultural model of disability is a perspective that examines the meanings and assumptions embedded in policy and program design at the exosystem level (Figure 3). This cultural model does not attribute experiences of exclusion to cultural minorities, to families ‘lacking know-how,’ or to families being out of sync with dominant cultural beliefs. It provides a way to study whether administrative systems recognize different knowledges and understandings of childhood, caregiving, disability, and relationality. Standardized eligibility rules and administrative application procedures are not culturally neutral because they are applied uniformly to everyone. As Waldschmidt (2018) shows, administrative systems embody cultural understandings of disability, evidence, childhood, family/caregiving responsibilities, and legitimate need. Programs are constructed with these cultural understandings in the design. As such, eligibility criteria both identify developmental difference and present cultural values that determine which developmental differences become recognizable, legitimate, and fitting intervention (para. 41). The central question is what programs prioritize and based on what culturally normative values. Canadian research with newcomer, immigrant, refugee, and Indigenous caregivers identified how language barriers, complex paperwork, fragmented information, financial and employment pressures, service structures, and disconnect with

professional terminology function as recurring mechanisms of exclusion (Casale et al., 2023; Fong et al., 2024; Khanlou et al., 2017). In response to these barriers, Fong et al. (2024) found that tailored information, cultural and linguistic continuity, rural outreach, and culturally safe services are some of the priorities that programs at the exosystem level should consider.

A critical perspective of disability and the power relations associated with early childhood interventions and developmental supports asks how administrative classifications at the exosystem level distribute resources based on recognition and institutional authority. A critical analysis helps unpack how seemingly technical processes and administrative bureaucracy operate with power in trajectories impacting families' experiences with access and exclusion. The theoretical sociolegal work of Valverde (2003) explains this by showing how formal policies and entitlements do not operate independently of the administrative, professional, scientific, and common-sense knowledges used to interpret them. Similarly, Valverde's (2003) analysis elucidates how exosystemic power operates through administrative and professional knowledge practices that are less publicly visible than legislation or formal policy, yet function as gatekeeping mechanisms. When eligibility rules are implemented through clinical diagnostics, standardized assessments, administrative categories, and other institutional requirements, these practices determine which infants, young children, and their families become institutionally legible (formally visible), and which needs are converted into administratively actionable claims (substantively visible). This means that exclusion may occur without an explicit decision to deny support, where routine practices authorize some accounts of need and marginalize others.

This inequitable process that can lead to institutional blind spots and substantive exclusion presents concerns that is both significant for the entirety of this report's research stream on who is missed or falling through the cracks and multiply marginalized equity-deserving groups. According to Gerlach et al. (2022), Indigenous children are often absent in Canadian data related to disability-related needs, unmet health, educational, social needs, and inadequate funding. In part, this can be explained by a lack of trust and concerns about standardized assessment tools, stigma, colonial oppression, and the dominance of Western medical and deficit-oriented discourse. More importantly, the authors argue that as an outcome of this limited data, Indigenous infants and children are institutionally invisible which can be mistaken for an absence of disability-related needs. Underrepresentation reflects barriers to recognition, culturally safe assessments, geographic accessibility, suitable tools, or services that run the risk of infants, young children, and their families/communities remaining in under-supported environments (Fong et al., 2024). At the same time, at the exosystem level,

underrepresentation can obscure people's lack of access and result in the offloading of responsibilities to alternative resources for vulnerable populations (Jordan's Principle Working Group, 2015).

Absence or illegibility at the exosystem level also occurs because of jurisdictional fragmentation in Canada, also termed cooperative federalism. Responsibilities for health, early learning, childcare, disability support, child welfare, Indigenous services, and income assistance are distributed among different governments, ministries, health authorities, and agencies. The CAHS assessment of 2022 describes Canadian autism supports as operating across complex multi-ministry systems, while the federal framework acknowledges significant differences in services, supports, and funding models across jurisdictions (PHAC, 2024). This leads to a fragmented responsibility of care in early childhood intervention and developmental supports that can create situations in which several institutions treat an infant or young child's need as falling outside its mandate (falling through the cracks). In the settler-colonial context this is further complicated for Indigenous children as jurisdictional arrangements also function in relation to colonial authority and self-determination. Ineese-Nash (2020) argues that Western disability classifications operate as colonial constructs that tend to displace Indigenous understandings of children, relationality, community membership, and difference.

At the exosystem level, exclusion is produced through diagnostic prerequisites, age or functioning thresholds, assessment wait times, limited workforce capacity, rural distance, inadequate childcare support, complex applications, fragmented jurisdiction, unsuitable assessment tools, and data systems that record service users over unmet need. Furthermore, intersections at the families' level and intersections of services at the exosystem level run the risk of both entrenching existing marginalization and obscure how people fall through the cracks and become further edged out of culturally safe and substantive supports.

Macrosystem Ideologies

Located at one of the outer circles of Bronfenbrenner's bioecological theory (Figures 2 & 3), the macrosystem refers to broader cultural, political, legal, and economic patterns in society that shape other systems (Bronfenbrenner & Morris, 2007). Tudge et al. (2009) caution that the macrosystem as a contextual level does not refer to background variables alone but exists as a proximal and interactive system level (p. 204). The macrosystem, and the use of Bronfenbrenner's bioecological theory in the twenty-first century, reinterprets the macrosystem's societal norms and values as interacting with proximal processes, person-specific characteristics, wider environmental context, and historical time (PPCT). As Tudge et

al. (2009) summarize, “the macrosystem envelops the remaining systems, influencing (and being influenced by) all of them” (p. 201). In early childhood intervention, a macrosystem level analysis explores how dominant understandings of disability, childhood, parenting, rights, and public care responsibility are embedded in professional training, funding priorities, eligibility systems, interventions, and representations of disabled children and their families (Bronfenbrenner & Morris, 2007; Tudge et al., 2009).

The medical model of disability defines developmental differences through screening, clinical assessment, diagnostic classification, genetic research, and standardized measures (Gillberg, 2010; Lord et al., 2020; Scherer & Dawson, 2011; see also Figure 4). This perspective is evident at the macrosystem level through broad societal confidence in diagnosis, standardized ideas about developmental knowledge, clinical expertise, and intervention intended to ‘cure,’ or reduce developmental risk/delay. Although medical perspectives and practices can improve healthcare access, social supports, inclusion and participation, or family wellbeing, a societal focus on clinical authorities alone can create a societal expectation that successful and deserving interventions aim to ‘cure’ infants and young children to be able-bodied or conforming to normativity. According to Zaks (2024), this medical model presents a societal orientation towards normalization. The problem is the expectation that disabled people should change to fit dominant standards; “stigmatizing human variance and sustaining disability oppression” (p. 3234). Instead, scholarship on early childhood intervention and neurodiversity calls for interventions to focus on improving quality of life, autonomy, communication, relationships, and life goals rather than ‘treating’ developmental or intellectual difference to ‘cure’ or ‘mask’ that difference (Leadbitter et al., 2021; Schuck et al., 2022; Zaks, 2024).

Making a distinction between medical intervention and normalization (i.e., renaming it as the normalization model rather than medical model of disability), as suggested by Zaks (2024), can help people reframe the validity of clinical support simultaneously with disability affirmation. A medical model can still benefit infants and young children that require impairment-related intervention and health-related supports without those types of interventions being defined as most legitimate or health outcomes being prioritized for all. For example, Leadbitter et al. (2021) argue that early childhood intervention should engage with wellbeing priorities, paying attention to mental health, autonomy, quality of life, and person/family/community-centred outcomes. Similarly, Schuck et al. (2022) assert that collaboratively determined and strength-based supports should be central and replace interventions organized around making a child ‘appear less autistic’ (p. 4633). In connection to

the macrosystem level, these sources suggest ways of shifting norms and values surrounding interventions related to early childhood intervention and developmental support (Leadbitter et al., 2021; Schuck et al., 2022; Zaks et al., 2024).

Switching to the social model of disability to assess macrosystem level processes that impact access and exclusion for early childhood intervention and developmental supports means looking at legal and policy commitments. These commitments are often expressed as accessibility, inclusion, participation, and the removal of disabling barriers. An important legal commitment at the macrosystem level Canada being a signatory to the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006). Specifically, article 7 requires states to ensure that children with disabilities fully enjoy human rights and fundamental freedoms on an equal basis with other children. Formally, Canada's federal early learning and childcare legislation recognizes inclusion and supports services that include children with disabilities and other systematically marginalized groups as human rights matters and responsibilities of system design (Canada Early Learning and Child Care Act, 2024; United Nations, 2006).

However, formal macrosystem level commitments to rights discourse does not necessarily lead to substantive realization of access to early childhood interventions and developmental supports. Canadian research by Kerr et al. (2024) and Underwood et al. (2018) found that across Canadian jurisdictions and Ontario, families face substantial difficulty obtaining childcare, accessing therapeutic services, and navigating fragmented services. Despite legal and policy recognition of the importance of early intervention and inclusion, evidence suggests a policy to practice implementation gap: rights-based language can coexist with limited access and exclusion (Kerr et al., 2024; Underwood et al., 2018).

The cultural model of disability provides a way to examine how certain understandings of childhood and development come to be treated as natural, universal, or self-evidently desirable on a macrosystem level and proximal levels and processes. These understandings of childhood and development can be useful in shaping policy and tools for recognizing support needs, while simultaneously adopting professional and cultural assumptions about desirable sequences, communication, behaviour, autonomy, and access to those policies and tools. According to research by Burman (2017, 2024) developmental psychology has contributed to systems of classifying, comparing, and regulating children according to culturally and historically situated expectations. In children's rehabilitation, Mosleh and Gibson (2022) found that normal/abnormal discourse continue to function as a primary organizing concept,

with disabled children being constructed as abnormal subjects expected to move toward normality (p. 122).

At the macrosystem level, research regarding societal norms and values expose how rhetoric considering a “normal child” is not a neutral description of average development but an institutional and cultural standard. Waldschmidt (2018) argues that disability and ability are relational cultural categories produced through social institutions and symbolic systems (i.e., language). Such relational cultural categories also inform macrosystem level expectations concerning parenting (Balter et al., 2025). For example, Woodgate et al. (2015) documented extensive labour performed by Canadian caregivers raising children with complex care needs, where “parents of children with complex care needs can feel constrained by a society that does not value their efforts” (p. 13). These studies by Balter et al. (2025) and Woodgate et al. (2015) support the notion that ‘good’ caregivers are evaluated according to whether they perform intensive and recognizable forms of caregiving and advocacy, while also demonstrating how this celebrated parental advocacy obscures parental exhaustion and impacts on parental health, parental requirement to respond to service gaps, and transfers of responsibility. In turn, extraordinary caregiving persistence and advocacy that is necessary to account for service gaps creates a culture of ‘bad’ versus ‘good’ parenting that negatively impacts those caregivers with less socioeconomic means (Balter et al., 2025; Gibson, 2019).

A cultural model of disability also helps examine representations of disability as tragedy, burden, vulnerability, exceptional achievement, or inspiration. According to an article by Grue (2016), a dominant cultural representation of disability can be termed ‘inspiration porn’; “the representation of disability as a form of disadvantage that can be overcome for the titillation of other people/observers” (p. 838). Grue (2016) asserts that positive inspiration narratives and disability affirmation can continue to represent disability to societal publics as an individual disadvantage to be overcome for the benefit of a nondisabled audience. Mannor and Needham (2024) connect this to narratives about public health to show that assumptions concerning normality, independence, individual responsibility, and productivity are recurring components of ableism in health (p. 14). Such representations help establish the cultural language through which disability and legitimate public support are understood; even in early childhood (Grue, 2016; Mannor & Needham, 2024).

Cultural representations of disability in relation to public health are furthermore intertwined with economic discourse on government spending. For example, Mannor and Needham (2024) show links between disability, reduced or future productivity, public-health policy, and fiscal or cost discourse representations in the public sphere. Although economic

evidence can demonstrate costs of service, at times, these representations fail to represent service gaps, the financial effects on families, or the value of early public investment in early childhood intervention and developmental supports. Narratives regarding future productivity, dependence, or public savings risk becoming the principal measures of a disabled infant or young child's social value. As Goodley et al. (2019) asserts, these broad cultural narratives or assumptions omit the interdependence and social conditions that permit and/or celebrate certain forms of human flourishing. Marquis et al. (2024) identified economic growth as one of three meta-narratives shaping health policy for people with intellectual and developmental disabilities. The authors argue that policies justified primarily through productivity or fiscal benefit may represent disabled people as costs rather than as people entitled to equitable health and social support (p. 57; see also Borrás, 2023; de Oliveira & Tanner, 2023; Xu et al., 2025). The concern is that economic focus and analysis and a culture of future economic return define children's rights, belonging, relationships, and wellbeing.

Critical disability perspectives connect the three models of disability to a macrosystem level analysis of access and exclusion. This critical lens helps examine how cultural meanings connect to power relations and material distributions of resources. At the macrosystem level, attitudes inform decisions about which children qualify for services, which interventions receive public funding, which outcomes count as success, and how responsibility is transferred to families (Goodley et al., 2019; Meekosha & Shuttleworth, 2009). From this perspective, ableism is reproduced and the effects of these arrangements are not distributed evenly (Kerr et al., 2024). For example, Casale et al.'s (2023) review of Canadian research found that immigrant and refugee caregivers encountered interacting barriers involving language, finances, employment, unfamiliar service systems with complex administration, stigma, and fragmented information. These findings demonstrate that microsystem level economic and social position intersect with macrosystem level power structures that affect the resources families have available to take care of their loved ones (Casale et al., 2023; Kerr et al., 2024).

As a critical point of view, Indigenous disability scholarship is essential at the macrosystem level. It challenges the assumption that Western disability and developmental classifications are culturally and politically neutral (Ineese-Nash, 2020). Disability discourse and categories operate as colonial constructs that often displace Indigenous knowledges and understandings of early childhood intervention and developmental stages. Hutcheon and Lashewicz (2020) trace historical and continuing connections between ableism and settler colonialism in Canada, including the use of pathologization, institutionalization, eugenic reasoning, and deficit representations as tools of colonial governance (p. 697). Western

macrosystems frequently defined children's differences through individualized diagnoses and deficits, displacing Indigenous understandings of children as embedded within families, communities, lands, and reciprocal relationships (Hutcheon & Lashewicz, 2020; Ineese-Nash, 2020). These colonial relationships remain visible in early childhood intervention and developmental supports. Indigenous early childhood workers report supporting families amid poverty, child-welfare surveillance, colonial institutional relationships, and judgments about parenting (Gerlach et al., 2017b). Canadian autism research similarly identifies the continued authority of Western medical and deficit-based knowledge (Gerlach et al., 2022). These studies demonstrate that societal awareness is insufficient when macrosystem processes define the underlying distribution of institutional authority, funding, surveillance, and decision-making.

A more equitable macrosystem incorporates Indigenous governance and self-determination. For example, the Indigenous Early Learning and Child Care Framework describes early learning and childcare as distinctions-based, culturally grounded, and Indigenous led. This simultaneously gives control over program design, delivery, administration, data, and evaluation connected to self-determination to Indigenous communities in question. By extension, the United Nations Declaration on the Rights of Indigenous Peoples Act (2021) provides a federal framework recognizing Indigenous rights to self-determination, self-government, participation in decisions, and non-discriminatory access to social and health services. This could be an authoritative basis for evaluating whether early childhood intervention and connected welfare systems transfer meaningful authority and resources to Indigenous governments and communities (Employment and Social Development Canada, 2018; United Nations Declaration on the Rights of Indigenous Peoples Act, 2021).

Overall, the macrosystem contains competing, and at times coexisting, understandings of early childhood intervention. The various analyses (e.g., medical, social, cultural, critical) help address the central macrosystem question of how governments, professions, and societies define disability-related needs and distribute resources accordingly.

Chronosystem Trajectories, Changes, and Legacies

The outermost circle of the Bronfenbrenner ecological theory regarding child development that is represented in Figures 2 and 3 signifies the chronosystem. This system pays attention to how time shapes interactions across all ecological levels. In early childhood intervention, time includes changing moments in development, frequency and duration of support, family transitions, transition and connections between services, policy reforms, and contextual

histories of place and time (e.g., ableist and colonialist attitudes). Access and exclusion can be assessed by moments in time; when concerns are recognized, how long assessment and referral take, whether support remains relevant when it arrives, and whether it continues across transitions (Bronfenbrenner & Morris, 2006; Sapiets et al., 2021).

Using a medical model of disability perspective at the chronosystem level in Canada, infant and child development is timed according to developmental milestones. Commonly, developmental milestones are monitored by a primary-care provider (e.g., family physician, nurse practitioner, pediatrician) if the family or caregivers in question have access to those in the Canadian medical system (Canadian Paediatric Society, n.d.; Rourke Baby Record, 2024). The Rourke Baby Record (2024) provides an age-organized framework for developmental surveillance clinicians might use during so-called preventive health visits from infancy to five years of age (Rowan-Legg et al., 2025; Rourke Baby Record, 2024). Public health nurses can also provide clinical developmental monitoring depending on a family or caregivers' place of residence, province, territory, and community. In general, a primary-care provider functions as the point of contact and gatekeeper for developmental screening, diagnostic assessment, consultation, and referrals in early childhood (World Health Organization [WHO] & United Nations Children's Fund [UNICEF], 2023; Zubler et al., 2022). Ideally, developmental screening and milestones are tools to support a timely recognition of developmental differences and/or support need. According to research by Zubler et al. (2022), the revised milestone checklists in the United States aims to provide clearer guidance about when developmental concerns should prompt additional screening. In Canada, the Rourke Baby Record is a resource that provides checklists and milestones for clinicians and caregivers to similarly flag potential developmental delay (Rourke Baby Record, 2024). Nevertheless, screening, and developmental surveillance in line with a medical model do not guarantee timely access to assessment or intervention.

Various Canadian and international reports on early childhood development and intervention present organizational contradictions as clinically informed policy frameworks emphasize timely identification as pivotal in early intervention while most service systems lack capacity to provide recommended equitable and timely access. Canadian research involving families of infants and young children with suspected or diagnosed developmental disabilities has documented prolonged waits and delays in diagnostic assessment (e.g., Abouzeid et al., 2025; Rivard et al., 2023), complex eligibility and administrative requirements (e.g., Finlay et al., 2023), limited availability of appropriate services (e.g., Gerlach & McFadden, 2022; Pozniak et al., 2024b; Underwood et al., 2018), financial barriers to obtaining disability-related

assistance (e.g., Finlay et al., 2023; Russell et al., 2021; Salvino et al., 2022), and difficulties navigating fragmented support systems (e.g., Abouzeid et al., 2025; Christianson-Barker et al., 2025; Gerlach & McFadden, 2022; Rivard et al., 2023; Underwood et al., 2019a). Similarly, the joint WHO-UNICEF report (2023) and other international studies identified organizational contradictions between early childhood intervention policies and practices. Research identified fragmented care systems, limited service capacity, difficult navigation processes, financial and geographical barriers, and inadequate service or care coordination as continuing obstacles to early intervention (Gosse et al., 2024; Sapiets et al., 2021, 2023, 2024; Tollan et al., 2023; WHO & UNICEF, 2023, pp. 19, 32, 40, 44). These access barriers are compounded by shortages of culturally safe and appropriately trained professionals and specialists (Gosse et al., 2024; WHO & UNICEF, 2023, pp. 51-3) and underfunded services and gaps in the multisystem coordination needed to provide timely and equitable support (Sapiets et al., 2021, 2023; WHO & UNICEF, 2023, pp. 32, 76-9, 85-7).

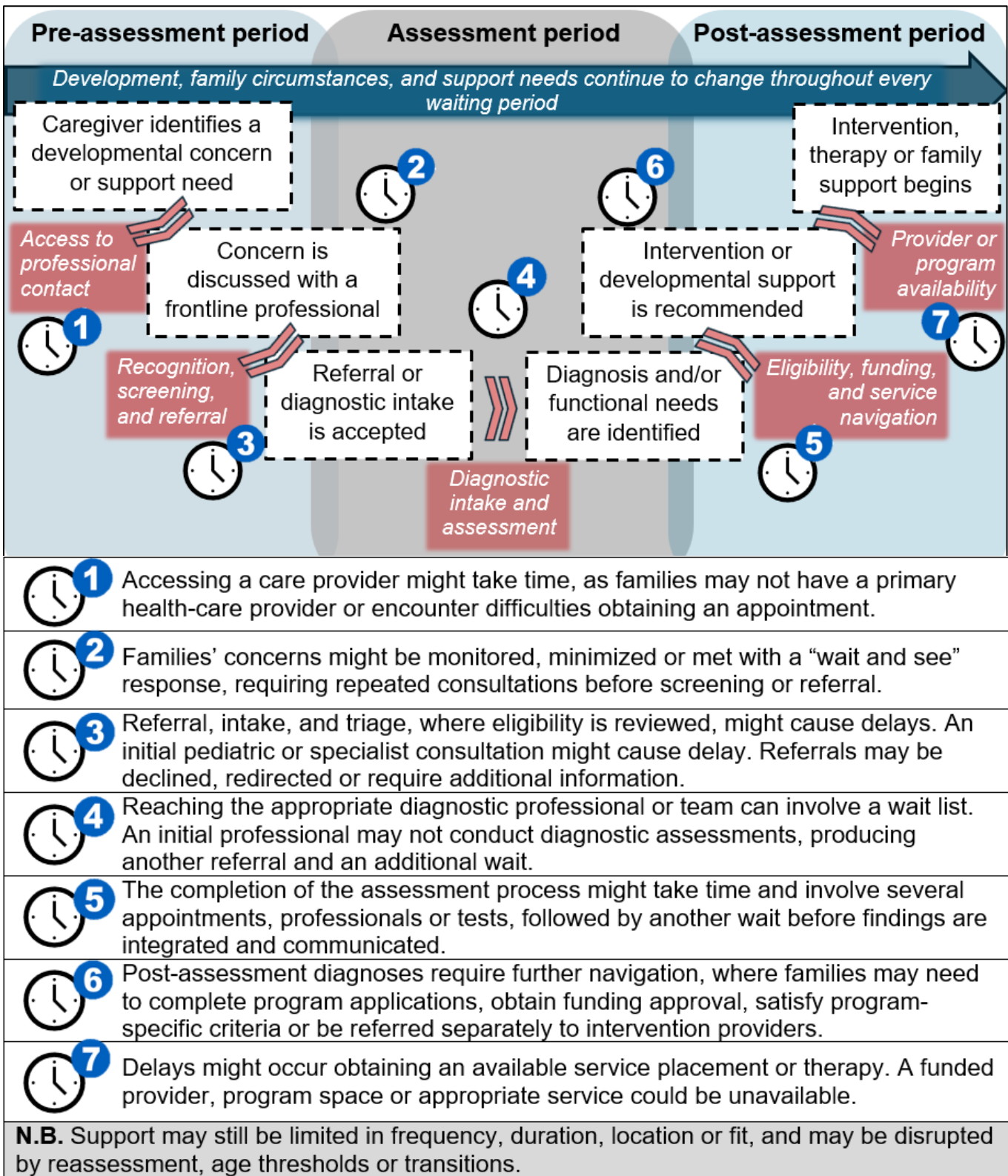
Consequently, policies, institutional practices, and developmental assumptions operating across the chrono- and macrosystems frame early childhood as a time-sensitive period for intervention, while exosystem-level arrangements (i.e., funding, eligibility requirements, workforce capacity, and service availability) and mesosystem-level processes (i.e., referral pathways, information sharing, and coordination between organizations) delay assessment and support (Abouzeid et al., 2025; Gerlach & McFadden, 2022; Rivard et al., 2023; Underwood et al., 2019a). This contradiction illustrates the distinction between the formal availability of early childhood intervention and substantive access to supports. That means a service can formally exist without being accessible early enough to assist a child and family before school entry, age-based eligibility restrictions, or service transitions. In practice, this contradiction and distinction between formal and substantive access causes families to encounter gaps in support or ‘fall through the cracks’ that exist between health, rehabilitation, early childhood, disability-support, and education systems (Gerlach & McFadden, 2022; Rivard et al., 2023; Tollan et al., 2023; Underwood et al., 2019a).

A well-documented Canadian example of this temporal contradiction in accessing early childhood developmental supports is research regarding autism spectrum disorder and diagnostic pathways. In a study by Smith-Young et al. (2020), parents described successive periods waiting while pursuing diagnosis and treatment. The authors state that there is a discrepancy between “the recommended maximum wait time between initial referral and ASD diagnosis” and “the average time between parents’ initial concerns with their child’s development and diagnosis” (p. 1). Often, clinical guidelines recommend shorter wait times

between getting a referral and receipt of a diagnostic assessment (3 to 6 months). According to research from 2018 and 2019, Canadian clinicians reported a median of seven months for that period between referral and diagnosis (Brian et al., 2019; Penner et al., 2018). However, this referral to diagnosis wait period does not capture the multi-stage period during which families may seek recognition and assistance. Qualitative research findings from the city of Québec (Rivard et al., 2019, 2021) and Northern Ontario (Cermak et al., 2026) describe various other periods and potential delays associated with developmental concerns and potential diagnosis. These research findings demonstrate that the discrepancy between recommended and actual wait times should be assessed beyond a single period as wait times and delays accumulate from the first expression of concern to referral, assessment, diagnostic confirmation, access to intervention, and receiving supports.

Figure 5 visualizes different waiting stages families might be experiencing in seeking early childhood intervention and developmental supports. From left to right, Figure 5 includes multiple potential waiting periods and distinguishes the trajectory from caregivers' initial developmental concerns to the intervention taking place. This figure was inspired by research related to the autism spectrum disorder diagnoses but kept more generic to visualize the multi-stage experience of waiting that might occur in other diagnostic pathways. Research in Québec confirms similar wait experiences in diagnostic trajectories for young children with a range of developmental disabilities (Abouzeid et al., 2025; Rivard et al., 2023).

Figure 5: Visualization of waiting stages accessing early childhood intervention and support



In general, a medical model of disability at the chronosystem level helps investigate the conditions of accessing early childhood intervention and developmental supports. What in a

medical model may be characterized as a missed milestone or developmental delay simultaneously can refer to the reduced capacity and disorganization of service systems.

A social model of disability offers a perspective that emphasizes that waiting - as an aspect of the chronosystem - and as visualized and described in Figure 5, is not idle time. Infants, young children, and families' needs and environments continue to change while waiting. In addition, a social model of disability shifts the interpretation of early childhood intervention access delay and exclusion because of impairment or caregiver actions to an examination of how service capacity, eligibility, funding, professional authority, and administrative procedures produce disabling barriers (e.g., Goodley, 2025; Oliver & Barnes, 2012; Thomas, 2012). This perspective asks how resources are organized, who can obtain them, and how those societal contexts impact infants, young children, and families while they wait. From a chronosystem perspective, the various potential waiting periods visualized in Figure 5 represent intervals during which infants, young children, and family contexts continue to develop.

Moreover, as Sapiets et al. (2021, 2023) assert, during waiting periods, caregivers, families, and potential other natural supports are expected undertake substantial unpaid work to compensate for absent or delayed formal assistance. While waiting for formal assessment or receiving intervention, research by Rivard et al. (2021) shows how caregivers continue monitoring their child's development and communicate their concerns with different professionals. As Abouzeid et al. (2025) discuss,

[I]mportant delays in accessing services caused by wait lists and continuity issues within and between services [and] insufficient public sector resources to meet the demand for these services, receiving a diagnosis often involves simply moving from one waiting list [...] to another [..., where] parents are provided with little to no resources to help them promote their child's optimal development. (p. 9; see also Smith-Young et al., 2020)

According to research by Balter et al. (2025), mothers navigating Ontario early childhood interventions and developmental support services described providing unpaid support and coordinating childcare, therapy, transportation, and appointments (p. 1876; see also Ferrant et al., 2019 and Lightman & Kevins, 2021). In addition, families seeking government disability programs reported spending time locating information, completing applications, supplying documentation, and communicating with multiple programs and professionals (Finlay et al., 2023). These family and caregiver expectations were also reportedly easier to manage for

families with more social capital, a higher socioeconomic status, and those who fit within the dominant cultural context (Abouzeid et al., 2025; Balter et al., 2025; Corriveau et al., 2025; Finlay et al., 2023; Jia et al., 2026; Smith-Young et al., 2020).

In relation to Figure 5, this means that nominal waiting periods families might encounter do not represent an equivalent burden. In a recent study of families with young children with emerging developmental disabilities, waiting for diagnosis or services in Quebec, British Columbia, Nova Scotia, and Manitoba, 73% reported out-of-pocket (OOP) expenses where “a wide variation in OOP costs was observed across provinces and groups during the early childhood period when children were on waitlists for diagnoses or therapies” (Jia et al., 2026, p. 5). Research by Corriveau et al. (2025) and mothers’ experiences raising children with complex care needs adds that rural location can create additional burdens due to limited local service availability, travel requirements, weather conditions, and long waiting lists (p. 2). Consequently, delays are socially and geographically distributed and can reproduce or widen existing inequities in access.

Moreover, a central aspect of a chronosystem level analysis of early childhood intervention and developmental supports (commonly for infants and children aged 0-5 years old) is that age-based eligibility can transform delay into exclusion. When a program has an upper age limit, every month spent waiting can reduce the period of access for a child to receive that service. In an Ontario study, publicly funded services commonly required a diagnosis before a child could even be placed on a waiting list, and families described waiting months or years for assistance (Underwood et al., 2018, p. 64). Underwood et al. (2018) add that after a child qualified for a service, they could encounter further delays or only short periods of intervention that families considered insufficient (p. 65).

A subsequent institutional ethnography found that most early childhood intervention services and therapies ended during transitions into other age-based institutional sectors; a transition process that families described as out of tune with their children’s lives and needs (Underwood et al., 2019, pp. 142-3). In British Columbia, research findings of Basualto et al. (2026) based on interviews with service providers and decision-makers concluded that “barriers and facilitators intertwine within the system before, during and after the disability system establishes interaction with families and their children” seeking services and supports (p. 14). These findings demonstrate that time-sensitive early childhood intervention and a lack of access to services can have an impact on transitions into other systems (e.g., exclusion in early childhood continues into youth services, discontinuity of service or therapy). Findings from Tollan et al. (2023), based on narrative review, synthesizes the emerging evidence and

research on interventions in early childhood. The authors identify barriers as avenues for improvement on the system level that policymakers and professionals could use to “address the causes of bias and racism within systems and further promote wellness and equity” (p. 148; see also Casale et al., 2023; Khanlou et al., 2017).

Taken together, a social model of disability and a chronosystem analysis demonstrate that time is not neutral within early childhood intervention and developmental supports. Formal access can coexist with an absence of timely and appropriate support. Substantive access requires support that begins early enough to be usable, remains available for an adequate duration, corresponds with the child’s and family’s circumstances, and continues across institutional transitions.

As previously detailed, a cultural model of disability examines the attachment of meaning to concepts such as childhood, development, normality, and disability. From a chronosystem level perspective, these cultural meanings can be further unpacked as (re)produced through historical systems of knowledge, language, representation, and institutional practice. Waldschmidt (2018) reminds us that this means that disability and ability are not self-evident or culturally neutral categories and vary across cultural settings and historical periods. A chronosystem-level cultural analysis considers how understandings of a child’s differences change during a family’s interactions with relatives, communities, professionals, diagnostic systems, and service organizations. In turn, categories and understandings used by those relatives, communities, and institutions also shift and change over time.

At the various system levels of Bronfenbrenner’s theory, families and their communities do not necessarily define a child’s developmental differences at all or through clinical terminology. One clear example comes from a critical integrative review by Gelech et al. (2026) including 17 Canadian English-language studies concerning Indigenous perspectives on childhood disability (p. 363). According to the authors, their review “revealed five themes significantly relevant to Indigenous conceptualizations of childhood disability in Canada. These themes, which refer to cultural values, understandings of human development, forms of social organization, and worldviews, shape the experience of childhood disability in local contexts” (p. 364). Apart from differences in defining disability in comparison with dominant settler-colonial clinical definitions, Gelech et al. (2026) emphasize diversity across Nations, communities, families, and individuals and characterize cultural understandings as dynamic rather than fixed (p. 360; see also Ineese-Nash, 2020). This highlights the importance of cultural differences between a myriad of knowledges related to child development, where a family’s interpretation

of developmental difference that diverts from Western biomedical terminology can produce conflicting interpretations of developmental time. For example, some of the Indigenous literature Gelech et al. (2026) reviewed emphasized that children develop according to their own trajectories and timelines, rather than according to milestones established by biomedical systems. According to some of the Indigenous Elders represented in the review, one can understand that a child has developmental challenges while rejecting the premise that only one legitimate developmental timeline exists (p. 378). Informed by a cultural model of disability perspective, tension can arise between various families, communities, and professionals, with all interpreting the meaning of time, development, and support need through different knowledge systems.

Nevertheless, dominant cultural understanding in Canada means that clinical diagnoses are of practical importance for families' ability to enter formal service systems to seek support. A diagnosis can make a child's needs institutionally recognizable and provide access to services (Underwood et al., 2018, p. 61), even when the labels and categories do not reflect how the child, family, and/or community understands the child's identity and ability (Gelech et al., 2026, pp. 373-4). What is more, the cultural and practical meanings of disability-related supports in early childhood are fluid and may change over time. Lee and Zhu (2021) provide critical personal narratives from a Korean and a Chinese immigrant mother's perspective to illustrate how their children's autism diagnoses led to ongoing learning and reconstruction of maternal identity while negotiating with Canadian medical institutions (pp. 1644, 1653). According to research with South Asian immigrant parents of autistic children in Canada by Shafi et al. (2024) diagnoses can occur within cultural contexts marked by stigma at various levels, which may affect available natural supports, disclosure, and seeking access to services (pp. 8-9). Furthermore, embedded institutional meanings are cultural as well and while often guided by developmental psychology, subject to change within the context of changing cultural, political, and economic relations (e.g., Burman, 2017, 2024; Mosleh & Gibson, 2022). This means that changes in public knowledges and diagnostic classifications can have contradictory consequences in terms of recognition and diagnosis-dependent eligibility requirements and can intensify cultural expectations that differences should be identified and corrected.

Overall, a cultural model of disability and a chronosystem level analysis demonstrate that meanings assigned to developmental differences are neither fixed nor culturally universal. Studies referenced in this report and other knowledges communicated by the co-authors therefore assert and recommend that service systems should refrain from treating clinical

terminology as the only legitimate account of child development and should refrain from interpreting potential hesitation in pursuing diagnosis or intervention as parental failure, denial, or ignorance. Culturally substantive access requires professionals and institutions to examine how their own understandings of development, normality, disability, and appropriate intervention are culturally and historically situated.

A critical disability studies perspective extends the chronosystem level analysis beyond the medical, social, and cultural model to assess the timing and context of early childhood intervention and developmental support. This means that a critical perspective of development and service access or exclusion examines how disability is produced historically, normatively, and politically (Goodley et al., 2019). In the context of Canada, such an analysis is provided by Hutcheon and Lashewicz (2020) who consider how ableism and settler colonialism historically and continually intersect, both relying on violent bodily classifications and productivity narratives to distinguish the 'good' and governable lives from the 'bad' and deviant lives (pp. 707-8). Similarly, a study by Dickson and Linton (2025) connects colonial Canadian history and present to systemic ableism, as "systemic ableism in Canada shares a heritage with the discriminatory logic of settler colonialism, which broadly categorizes 'whole groups of people as being undeveloped, underdeveloped and/or wrongly developed'" (Mills & LeFrançois, 2018, p. 504 quoted in Dickson & Linton, 2025, p. 567). Dickson and Linton (2025) argue that logics of both ableism and colonialism informed histories of segregation, institutionalization, and eugenic governance. The authors also connect the three logics of exclusion, elimination, and extraction to periods of deinstitutionalization and institutional reform to show that such reform often fails to displace the violent logics on which it was built (p. 568). From a critical disability and Indigenous studies' perspective, historical change captured at the chronosystem level can be evaluated by assessing whether colonization, segregation, surveillance, dependency, and professional control are reproduced in contemporary revised forms.

At the same time, the study by Dickson and Linton (2025) provides a critical analysis of disability services as policy time, another dimension of a chronosystem analysis of disability policy and early childhood intervention and developmental supports. Historical processes of disability policy (e.g., segregation, institutionalization, deinstitutionalization, individualization) form an important context to the support landscape today. For example, a national mapping study by Salvino et al. (2022) reveals that Canadian financial-support programs for families of children with neurodisabilities have been developed over time in jurisdictionally uneven ways, creating a patchwork with discrepancies in eligibility and available benefits (p. 169). Various studies demonstrate that access and exclusion are organized through policy-defined

institutional boundaries rather than through a continuous pathway centred solely on the child (Basualto et al., 2026; Underwood et al., 2019a). The effect of a policy reform over time can create better access but also additional short-term and long-term disruptions for children and families going through assessment and eligibility processes.

By extension, despite positive intentions, policy reform can lead to the accumulation of administrative requirements and burden over time. According to Herd et al. (2023), “the gap between people’s needs and the policies that are supposed to provide for them is filled with administrative burdens” (p. 1). These administrative burdens include the learning costs of finding and understanding a program, the compliance costs of documenting eligibility and following procedures, and the psychological costs of uncertainty, stigma, frustration, and loss of autonomy in encounters with public institutions (Herd et al., 2023). At the same time, policy reform can present additional administrative burden for those responsible for implementation and families having to adapt to new program requirements (Herd et al., 2023, pp. 11, 17). Disability policy reform can itself produce transitional administrative burdens when families must learn new program requirements and service providers must interpret new rules, revise procedures, and complete implementation-related training (Camillo, 2021, pp. 6-8).

Taken together, a critical disability studies and chronosystem analysis demonstrates that time is a complex feature of early childhood intervention programming. Historical asymmetric power relations imposed through ableism and colonialism shape the institutions through which families seek support, while policy changes, institutional transitions, and repeated eligibility procedures shape what formal assistance is substantively available over time. The chronosystem, together with the other ecological system levels, is analytically distinguishable but relationally interdependent. Infant, young children, and family experiences with accessing early childhood intervention and developmental supports represent complex immediate encounters that are altogether shaped by connections among settings, institutional arrangements, cultural and political structures, and processes that accumulate over time (Bronfenbrenner & Morris, 2007). For example, a caregiver’s interaction with a primary care provider can be influenced by referral relationships among providers, program eligibility rules, culturally dominant assumptions about childhood, prior experiences of discrimination, and delays already encountered elsewhere in the system. Similarly, difficulty attending or completing a required service step may reflect the travel and limited formal supports experienced by some rural families (Corriveau et al., 2025), the language, financial, migration-related, and caregiving pressures documented among some immigrant mothers of autistic children (Khanlou et al., 2017), or concerns about judgment and child-welfare surveillance

reported in research involving Indigenous families (Gerlach et al., 2017b). Collectively, these wide variety of experiences demonstrate why ‘falling through the cracks’ is easier and more common than available data and program enrollment might suggest.

In conclusion, this integrated framework helps provide a partial literature review on who is missed to examine early childhood intervention uptake and experiences of exclusion. Infant, children’s needs, and family circumstances interact with service design, professional relationships, cultural meanings, historical conditions, and institutional authority. Medical analysis explains how needs become clinically recognized; social analysis identifies barriers to participation; cultural analysis examines how children and interventions are understood; and critical analysis identifies whose knowledge receives authority and how resources and responsibilities are distributed (Goodley et al., 2019; Meekosha & Shuttleworth, 2009). Apart from this integrated framework guiding the ADVANCE research stream on access and exclusion, it also provides a background and context for working-group members lived/living experiences and professional knowledges. Experiences of diagnostic delay, confusing referrals, inaccessible services, cultural unsafety, rural shortages, age-based transitions, administrative burden, and/or exclusion from eligibility can be examined as interactions among family circumstances, proximal relationships, service coordination, policy architecture, disability discourse, and change over time. Consistent with participatory and community-engaged research detailed in the next section of this report, working-group accounts can be treated as situated knowledges of systemic interactions rather than presented as isolated examples of individual difficulty (Cargo & Mercer, 2008; Wallerstein et al., 2018).

Co-Production Principles and Working Group Collaboration

This report presents the results of a one-year period of working group collaboration, established through an examining the question: *Who is missed in the uptake of disability-related supports and services?* The project focused on early childhood intervention and developmental supports for children aged 0–5 years and their families and caregivers, with particular attention to British Columbia, Alberta, and Ontario. Its scope included supports that require a formal diagnosis and those that can be accessed without one, as well as families’ experiences navigating health care, childcare, early intervention, education, child welfare, funding, and disability-service systems.

The working group collaboration relied on a co-production approach. Participatory and co-creative approaches recognize that people with lived and living experience, caregivers, community-based organizations, practitioners, and policy actors hold forms of essential and

contextual knowledge that should be placed on an equal footing with academic research and administrative evidence (Cargo & Mercer, 2008; Jull et al., 2017; Wallerstein et al., 2018). Accordingly, the ADVANCE working group consisted of six members who contributed to defining the policy problem, identifying priority questions, describing where children and families may be missed, interpreting patterns across service systems, and determining which outputs would be useful to family, community, professional, and policy audiences.

For the purposes of this report, principles of co-production were operationalized through shared problem framing, iterative discussion, priority setting, interpretation, and co-authorship. It does not mean that every working group member performed every research or writing task. The ADVANCE fellow retained the responsibility to provide the literature review, policy and jurisdictional analysis, synthesis, drafting, and integration of the final report. The working group process included preliminary discussions with community partners and people contributing family, caregiver, professional, and policy-relevant perspectives. These conversations helped narrow the project from a broader examination of disability supports across childhood and young adulthood to a focused analysis of early childhood intervention and developmental supports. Working group members directed attention toward the interaction of diagnostic requirements, service availability, navigation demands, family circumstances, and jurisdictional differences.

Working Group Survey

In February 2026, a short Qualtrics survey was circulated to working group members to provide a structured snapshot of their observations and priorities. Five respondents completed the survey. The ADVANCE Fellow designed the survey questions after presenting an issue statement related to access and exclusion to the ADVANCE co-directors and leadership. The questions of the Qualtrics survey were adapted to the known expertise of the working group members as ADVANCE community partners. The opening screen of the survey presented in Figure 6 set the stage:

Figure 6: Qualtrics survey introduction

This short survey is meant to help ensure that my **research focuses on what matters most to you**, as families, advocates, and community partners.

The research question that I am to dedicate my time to is especially interested in **early childhood intervention and developmental supports** for children from birth to age 6, and **understanding who is being missed by current systems**.

This survey is meant to give me some efficient guidance that will be supplemented with meetings of our workgroup to make sure I stay on track and that the work is meaningfully engaging with early childhood intervention and developmental supports for children from birth to age 6, and understanding who is being missed.

This survey should take approximately **10–12 minutes**

After demographic questions regarding the members of the working group and their positionality, the survey asked for their opinions and interpretations with these ten questions:

- 1) What are the most important elements of effective early childhood intervention and developmental supports?
- 2) Which of those elements is most often missing or overlooked in policy/practice?
- 3) Which infants, children, families, groups, and/or communities are at a higher risk of being missed or missing supports?
- 4) What are some of the main reasons to cause these higher risks for certain groups?
- 5) To what extent are/were early childhood intervention and developmental supports accessible without or before a formal diagnosis?
- 6) How can diagnostic timelines impact access to meaningful early supports?
- 7) Are there particular conditions or child profiles (e.g., FASD, rare conditions, complex needs, multiple diagnoses), that are especially poorly accessible in early childhood intervention and support systems?
- 8) What is/are your insight(s) into why certain systems are poorly designed to support these families, groups, and/or communities?
- 9) What should be the focus of the working group's research regarding early childhood intervention and developmental supports?
- 10) What is/are elements that researchers or policymakers often misunderstand about early childhood intervention systems that you wish was better understood?

Collected responses were organized to reflect recurring priorities, barriers, populations of concern, and interpretations shared by the respondents. The survey was used to establish working group priorities, and it was not designed or analyzed as a representative population survey.

After completion of the survey, online working group meetings were held to unpack survey results and ask for clarification where needed. The survey together with these meetings informed the selection of topics that were also briefly examined in the academic literature, policy documents, administrative data, legal and rights-based frameworks, and jurisdictional scans. They also confirmed that the issue statement as set up by the ADVANCE fellow was in line with working group objectives and the ability to organize the complexity of researching access and exclusion with the bioecological and disability-model framework. This framework enables a more complex interpretation of families' experiences with early childhood intervention access and exclusion. Foremost, the analytical framework and the working group members' perspectives confirm that diagnostic delay, inaccessible services, cultural unsafety, rural scarcity, administrative burden, and/or exclusion from supports should not be treated as isolated difficulties. On the one hand, the framework displays how experiences could arise through interactions among family circumstances, professional relationships, service coordination, policy architecture, disability discourse, and change over time. On the other hand, the working group material presents situated knowledges that further identify the complexity of intersecting systems that people might experience.

The next sections provide a survey snapshot, the collective outputs from working group meetings, and lived/living experience vignettes concerning early childhood intervention and experiences of missing or being excluded from support. The survey results and vignettes are intended to illuminate processes, identify questions, and show how different system components may interact. They should not be interpreted as estimates of how frequently particular experiences occur or as representative accounts of all children, families, communities, practitioners, or jurisdictions. Where the report discusses populations not directly represented within the working group, it relies on observations and interpretations of the working group members, which in turn can be verified by population-specific research rather than presenting workgroup members as speaking on behalf of those populations.

Working Group Results

For the first survey question (i.e., what are the most important elements of effective early childhood intervention and developmental supports?), respondents were provided with a list of

potential elements and an ‘other’ open answer option. Table 1 presents the answer options and how often those elements were selected. Respondents could select more than one answer option.

Table 1: Answers for question one of the Qualtrics survey (N=5)

<i>Important Elements of Effective ECI</i>	n
Early identification without long diagnostic delays	4
Services available before formal diagnosis	2
Coordinated care across systems (health, welfare, education)	4
Support for families navigating systems	3
Flexible needs-based supports (not diagnosis-gated)	3
Culturally safe and trauma-informed services	0
Services accessible in rural or remote areas	1
Support for complex care needs or multiple disabilities	3
Stable, long-term funding (not short-term programs)	3

The subsequent survey question was open-ended. It asked respondents which of those elements listed in the previous question are most often missing or overlooked in policy/practice. Respondents were allowed to select more than one of the listed elements and/or suggest additional elements. Answers for question two included:

- support for complex or multiple disabilities (n=2)
- coordination of care across systems/problems of fragmented siloed care (n=3)
- flexible needs-based supports, which are not diagnosis-gated (n=2)
- stable, long-term funding (n=1)
- early identification (n=1)

During online working group discussions about survey questions one and two, members indicated that, all the listed elements are important and require more attention from policy makers. Members suggested that culturally safe and trauma-informed care and services are very important but are superseded by concerns about substantive access to any supports or services. The discussion showed that for those with lived/living experiences in trying to access early childhood intervention and/or any type of supports, cultural safety became of secondary importance to trying to get any supports for their loved one and themselves as primary caregivers.

During the discussion and sharing of stories, members also discussed that elements listed in the survey question might obscure what those elements entail or what it looks like in everyday life to not have services, coordinated care, or a diagnosis. Group members identified

that if pre-diagnosis supports are available, it varies widely by location or care needs, and that services without a diagnosis are poorly supported in current systems. Furthermore, members shared that early access to support, even with a diagnosis, is minimal or inaccessible due to a lack of communication of what services are available (if any). After waiting for a diagnostic assessment (if a diagnosis is available and care needs have been recognized), other timelines result in more waiting for funding, services, and equipment. Having complex care needs often means that infants and young children fall outside of recognized disability categories and/or complexity means information and diagnoses are hard to obtain within the early childhood intervention age window.

For question three (i.e., which infants, children, families, groups, and/or communities are at a higher risk of being missed or missing supports?), respondents were also provided with a list of options and potential demographic profiles, including an ‘other’ open answer option. Table 2 presents the answer options and how often those checkboxes were selected. Respondents could select more than one answer option.

Table 2: Answers for question one of the Qualtrics survey (N=5)

<i>Group/Demographic/Profile</i>	<i>n</i>
Children with rare or complex medical conditions	3
Children with medical AND developmental/intellectual disabilities	3
Children with suspected/confirmed FASD	2
Children without a diagnosis	4
Indigenous children and families	3
Newcomer/refugee families	5
Families with limited income/unstable housing	5
Families in rural, northern, or remote communities	4
Families involved with child welfare systems	3

The next survey question four was open-ended to ask respondents what they thought some of the main reasons are for these children and/or groups being at higher risk for being missed. Respondents were allowed to list more than one reason. Answers for question four included:

- Waitlists (n=1)
- Fear of the system (n=1)
- Not enough trained professionals/lack of provider understanding (n=3)
- Reliance on parents to fight for everything (n=1)
- Lack of funds/resources in health and social care services (n=1)
- Lack of transparency with supports and services (n=2)

- Families do not know what is available or how to access supports (n=2)
- Stigma (n=2)
- Lack of diagnostic options for children under the age of 7 (e.g., PAE, FASD dx) (n=1)
- Lack of care coordination and family support (n=1)
- Language and cultural barriers (n=1)

In the working group meetings, discussion of questions three and four highlighted the members' own frustration with accessing supports and/or their professional frustration that some of these barriers continue to exist. Simultaneously, members voiced their own perception about their relatively privileged position in trying to navigate these obstacles (e.g., socio-economic status, education, social capital). Some members noted that, taking their own strained and complex experiences into consideration, this further underscores the potential added strain or impossibility of navigating these systems and barriers for less-/under privileged/equity-deserving children, families, and groups trying to navigate access to supports.

For question five, members were asked to answer how well current systems support children before age 6 who do not (yet) have a diagnosis. Answer options included: "Very well," "Somewhat well," "Somewhat poorly," "Very poorly," and "Varies widely by location or condition." Of the five members that completed the survey, three answered "Very poorly" (60%) and two answered "Varies widely by location or condition" (40%). In discussing this question, group members pointed out that both answer options can be true and are not mutually exclusive. On reflection, all members agreed that support is very poor for children without a diagnosis and that this is compounded negatively due to complexity of the condition and/or geographic location.

The sixth question on the survey (i.e., how can diagnostic timelines impact access to meaningful early supports) was an open-ended question. Responses included the following paraphrased observations:

No diagnosis means no support. (Respondent 1)

Often, someone needs a diagnosis to get the resources and support. But there are timelines to get a diagnosis and then timelines to get funding to help with supports, and a lack of providers to provide support. (Respondent 2)

Children with PAE/FASD are not recognized unless they have other identifiable conditions (e.g., ADHD, physical impairments, cognitive delay). Not considering

PAE/FASD in early childhood does not help the child and by the time most children or youth get an FASD diagnosis, they have already experienced significant failures, traumas, and/or negative experiences. (Respondent 3)

Even with an early diagnosis, we still did not know we could have had access to more supports until we met other parents who told us what services they had. (Respondent 4)

This open-ended question was followed by question seven, which asked working group member whether there are, in their opinion or experience, particular conditions, or child profiles (e.g., FASD, rare conditions, or multiple diagnoses) that are especially poorly designed for early childhood intervention and developmental support in Canada. The unifying element in answers to this question was that the system is poorly designed to understand and support FASD, rare conditions, or multiple diagnoses and complex needs, especially when there are so-called “behaviours” or behavioural complexities.

The last three questions of the survey were open-ended questions and discussed during online working group meetings. Each question was identified as complex and answers were layered in response. Question eight (i.e., what is/are your insight(s) into why certain systems are poorly designed to support children, families, groups, and/or communities) proved to be cyclical in nature and looped back to question one about those essential elements for effective early childhood intervention and developmental supports. Question nine regarding the ideal focus of the working group’s efforts connected with these elements as well and members pointed out that they would like to contribute to making early childhood intervention needs-based support without a diagnosis that is accessible, available, and transparent to children and families. Another identified focus for the ADVANCE Network and potentially early childhood supports was the creation of better service navigation that will help families know where to start and for providers to know how to help families.

The tenth question finally (i.e., what is/are elements that researchers or policymakers often misunderstand about early childhood intervention systems that you wish was better understood) brought it back to communication and understanding. Responses included the perspective that researchers and policymakers should not dismiss families, nor the rights of the child. In addition, one respondent answered that families should not be constantly expected to “figure it out and navigate systems on their own.” In addition, one workgroup member voiced that policymakers might have attitudes about services as being a “luxury” or

“nice addition,” reframing fundamental rights as optional perks. Finally, the lack of adequate transparency and communication of available services was addressed:

You can have all the programs you want but if you do not tell families or providers, they are useless. (Respondent 4)

To integrate the survey responses and the online meetings discussing the results, Figure 7 provides a dashboard of the various areas of interest, experiences, and priorities. Figure 8 provides explanation of the symbols used that are incorporated below with the vignettes from the working group members, sharing examples of their experiences with some of these components.

Figure 7: Snapshot overview of working group survey results (February 2026)

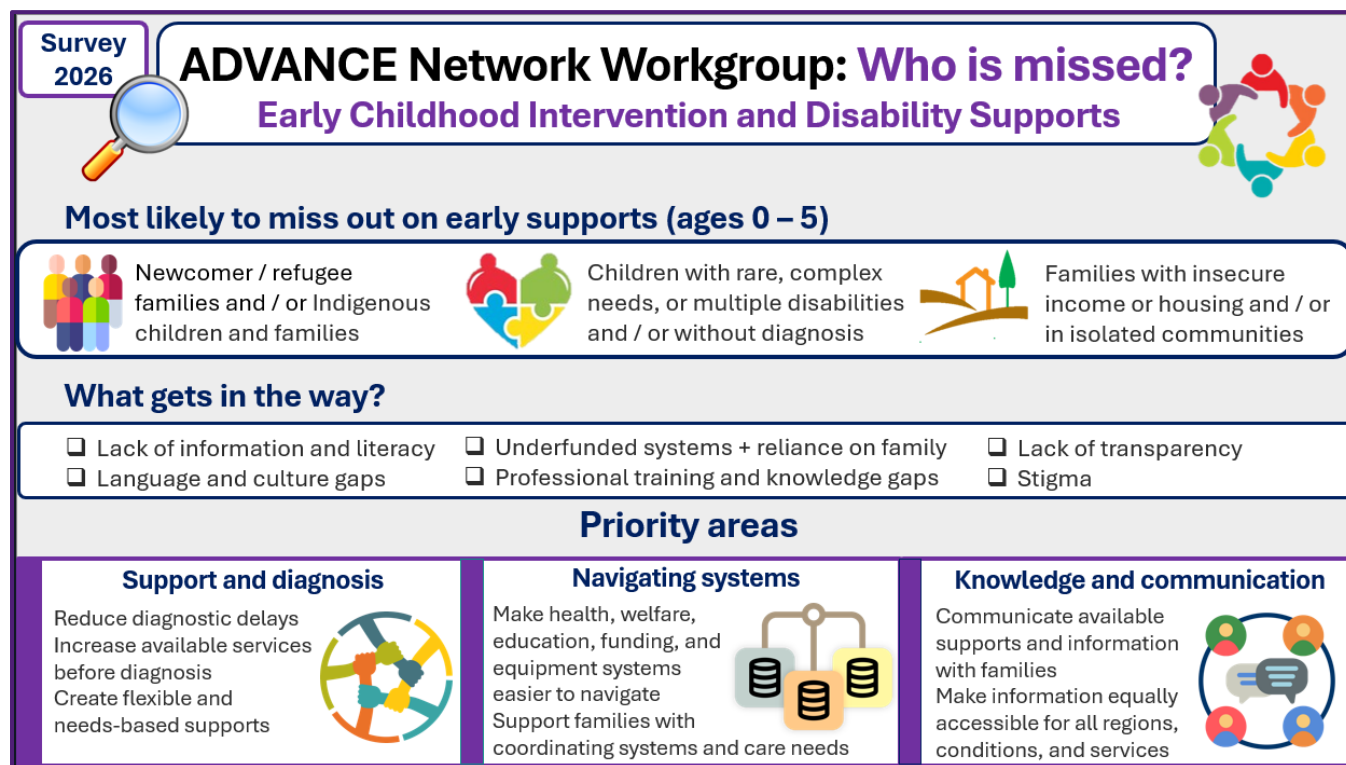


Figure 8: Overview of icons in Figure 7 and their meaning

	A magnifying glass to symbolize the survey and investigative purpose of gathering the perspectives of the working group members.
	Six individuals depicted in a circle that are connected but distinguishably different by colour to symbolize the six perspectives the working group members contributed as a group for the ADVANCE Network.
	Different figures with various complexions symbolize the equity-deserving communities that workgroup members identified as most likely to miss out on early childhood intervention and developmental supports.
	A heart with four different puzzle pieces in different colours to symbolize those infants and children the working group identified as most likely to miss out on early childhood intervention and developmental supports.
	A house surrounded by hills and trees to symbolize infants, young children, and their families more likely to miss out on supports due to insecure, rural, and or remote living or housing arrangements.
	A circle with five different hands reaching out and supporting each other to symbolize the need for coordinated care, increased support, and needs-based eligibility identified by working group members as a policy priority.
	Three different drums or barrels that are linked but independent to symbolize the multiple systems families must navigate. The working group identified the need for easier navigation and transitions between system as a priority area.
	A circle with different individuals in communication to symbolize the need for communication and information sharing. Members identified information about available supports should be accessible for all regions, conditions, and services.

During the online working group discussions, it became clear that capturing who is missed or falling through the cracks for early intervention and developmental supports is complicated by absence or missingness. The lack of data and the inability to research what is not there or who is not represented or seen in formal policy and/or unable to access substantive supports led to the suggestion to co-author experiences of being missed or almost missed through personal and professional story work. This is where working group members were asked to share experiences related to any of the topics discussed in the survey and in our online space. The next sections visualize and relate how program exclusion and barriers were experienced.

Most likely to be missed

Located just above the middle of Figure 7, a horizontal bar represents those children and their families/communities most likely to miss out. The multiple profiles as shared in Table 2 were consolidated into three main icons of representation, which are not exclusive categories. This means that an infant, young child, and/or family's experience can be reflected by more than one category.

Most likely to miss out on early supports (ages 0 – 5)



Newcomer / refugee families and / or Indigenous children and families



Children with rare, complex needs, or multiple disabilities and / or without diagnosis



Families with insecure income or housing and / or in isolated communities

Newcomer, refugee, and Indigenous children and families

Our working group members did not represent or felt like it would be appropriate to speak to the potential experiences of newcomer and refugee families, or Indigenous children and their families. This experience of ‘missing’ has been briefly addressed through research featuring the lived and living experiences that has been summarized in earlier sections of this report. In part, this underrepresentation points at both a limitation in collective networks such as ADVANCE and that access and inclusion are complicated by the entrenching marginalization of equity-deserving groups in multiple systems and communities.

Children with rare, complex, multiple, or missing diagnoses

The other two aggregated categories or groups were addressed by the personal and professional input of the working group members. During online meetings, several working group members expressed that their experiences accessing supports and services during early childhood were complicated by their infants and young children not neatly fitting into any of the diagnostic categories or developmental needs established by those categories. According to one working group member:

Children that do not fit nicely or neatly into any pre-established category of developmental support need are often missed because their caregivers do not have groups for families to readily turn to or belong to such as advocacy groups, Facebook groups, or support groups that might exist for common and officially recognized diagnoses. (Working group member 4)

During online sharing between working group members, people pointed out that experiences of ‘falling through the cracks’ were often caused by multiple systems working in siloes and parents not knowing where to go. Children with rare, complex, or multiple diagnoses often were seen to miss out on essential early childhood intervention and developmental supports because their needs straddled multiple ministries, such as health and social care. Parents and caregivers shared that this meant they were faced with having to find and explore alternatives

for support, compounded by a lack of professional knowledge among healthcare professionals, service providers, and community agencies.



One structural challenge for infants, young children, and their families/caregivers is the **inaccessibility of early childhood intervention and developmental supports** based on Prenatal Alcohol Exposure (PAE) and/or suspected Fetal Alcohol Spectrum Disorder (FASD)

One working group member and their work with Canada's FASD Research Network adds further context to the complexity of accessing supports when early childhood needs have not been recognized. Drawing on papers related to FASD, evidence demonstrates that FASD remains under-identified, inconsistently diagnosed, and unevenly supported across Canada (Cook et al., 2023; Flannigan et al., 2020; Hanlon-Dearman et al., 2023). An issue paper by Flannigan et al. (2020), presents the unique complexities of FASD and how it "is more common than most other neurodevelopmental disabilities combined" (p. 1). The Canada FASD Research Network (CanFASD) identifies that the current minimum estimate of the general population conforming to the diagnostic measure of FASD in Canada is at least 4%, with a higher estimate of 8% for the broader North American general population (Flannigan et al., 2024, pp. 1-2). To illustrate the prevalence of FASD, using the Canadian estimates assembled by CanFASD, this 4% minimum estimate is numerically greater than published estimates for autism, cerebral palsy, Down syndrome, and Tourette syndrome combined (Flannigan et al., 2024, p. 3). According to McMahon et al. (2025), despite experts believing that at least 4% of the population has FASD and the impact on an individual's cognition, emotions, behaviour, social interactions, and physical health, it is highly misunderstood (p. 1). One aspect of this misunderstanding is that PAE and FASD are not interchangeable; where prenatal alcohol exposure is necessary for FASD, approximately 1 in 13 pregnancies involving PAE result in FASD (Canadian Academy of Health Sciences, 2025, p. 29).

From this research-based perspective, FASD is a critical, yet deficient focus in early childhood public policy and support systems despite the prevalence of FASD and the alleged impact of unaddressed FASD on infants and young children's development and diagnostic pathways. The working group survey results and meetings established that this presents a demographic that is most likely to be missed or to be 'falling through the cracks' when assessing access to and exclusion from early childhood intervention and developmental supports. According to Cook et al. (2023), this is an important issue to be addressed. In the article titled 'Why FASD Diagnostic Assessment is Important,' the authors assert that "early

diagnosis can mitigate the development of difficulties in daily living associated with this neurodevelopmental disability and promote healthier outcomes” (p. 1). In terms of early childhood intervention and developmental supports, the CanFASD research network advocates for multidisciplinary assessment processes for infants and young children who have had PAE to guide care and supports. Hanlon-Dearman et al. (2023) present a diagnostic assessment of preschoolers (aged 0-5) with PAE to show how “assessment of physical growth, facial features, and neurobehavioural characteristics allowed for an accurate diagnosis of most children with FASD as early as 9 to 18 months” (p. 3). Experts represented in the issue paper by Cook et al. (2023) argue that multidisciplinary assessments of those infants and young children with PAE should be pro-active, even if infants and young children in question do not meet (all) the criteria for a diagnosis of FASD.

Despite these studies, people living with FASD are undiagnosed or misdiagnosed due to limited diagnostic capacity across Canada. Based on diagnostic activity in Alberta, British Columbia, Manitoba, Ontario, and the Northwest Territories, Popova et al. (2024) estimate that 98% of people with FASD were undiagnosed or misdiagnosed (pp. 1, 7-8; see also Dugas et al., 2022). According to one of the working group members, this estimate regarding limited knowledge and diagnostic capacity intersects with other structural challenges, such as age-based restrictions, missed early identification, waitlists, service access constraints, and infants and young children starting out being left behind. Paraphrased from meeting transcripts and co-authored contributions, this means that:

Diagnosis functions as a critical pathway to services and supports. When individuals with PAE remain unassessed and undiagnosed, they are frequently unable to access appropriate educational supports, disability services, informed mental health interventions, or community accommodations. Over time, this lack of support can contribute to school disengagement, substance use, early pregnancy, homelessness, unemployment, involvement with child intervention systems, and contact with the criminal legal system. (Working group member 1)

Families with insecure income and/or housing and/or living in rural, remote, or isolated areas



Challenges for children without a diagnosis and FASD are **compounded by other socioeconomic factors such as insecure income and/or housing arrangements and living in more remote or isolated locations**

According to research and expertise shared among the working group members, diagnosis-gated access and exclusion to receiving early childhood intervention and/or supports related to FASD are compounded by other socioeconomic and cultural factors. In line with the third aggregated category visualized in Figures 7 and 8, the impact of waitlists and limited service access can be further restrictive in rural, northern, and remote communities. Long distances to diagnostic clinics (if available), limited transportation options, high travel and accommodation costs, adverse weather conditions, and difficulties recruiting and retaining specialized health and allied-health professionals can further delay or prevent access to multidisciplinary FASD assessment (Canadian Academy of Health Sciences, 2025, pp. 66-9, 176-8; Harding et al., 2024; Whittingham & Coons-Harding, 2021). As an example, data from one of the two available clinics in the Northwest Territories who responded to the survey and study by Popova et al. (2024), estimated an approximate 4.5-year wait for FASD assessments (p. 6).

In connection to the other aggregated category of individuals most likely missed as perceived by working group members and visualized in Figures 7 and 8, for some Indigenous families and communities, geographic barriers intersect with limited availability of culturally safe and community-based services, concerns about stigma and child apprehension, and histories of harmful institutional intervention (Canadian Academy of Health Sciences, 2025, pp. 53-71, 176-8). Research involving Inuit communities has identified limited local diagnostic services, restricted funding for travel, and the need to travel considerable distances through complex transportation connections as barriers to assessment (Pauktuutit Inuit Women of Canada, 2021).

What gets in the way?

The middle of Figure 7 communicates the barriers to early childhood intervention and developmental supports as shared by working group members in the survey and during online meetings. Group members provided vignettes to speak to their experiences with these themes. The next six sections include those vignettes as valuable knowledge and insight as to what these themes mean in real life.

What gets in the way?

☐ Lack of information and literacy

☐ Underfunded systems + reliance on family

☐ Lack of transparency

☐ Language and culture gaps

☐ Professional training and knowledge gaps

☐ Stigma

Lack of information and literacy

One of the working group members shared their experiences with not knowing where to go for information when this was not offered and having to increase their knowledge and literacy for the sake of their loved one:

If it hadn't been for Dr. Google, my child would not be alive. Our older kids were born overseas, and we missed what other families do to get supports for their children, such as having a pediatrician.

*When our youngest slowed in meeting developmental milestones around 4 months old (**we knew this solely because we were experienced parents**), we went to our family doctor who was thankfully knowledgeable enough to refer us to a pediatrician for a consult. With a letter sent to an organization which no one seems to know, this helped us get some early childhood intervention services.*

*A PT [Physical Therapist] or maybe an OT [Occupational Therapist] would come by the house, **but they were not trained in family-centred care. The things they said only scared us more than ever.** Around the age of 6 months, my child began having infantile spasms.*

*It was Google who helped me "diagnose" our child and get into the ER right away where we advocated to be seen and given medication. **It was still a fight [in the ER], even though prolonged infantile spasms are detrimental and potentially fatal.***

In addition, lack of information and literacy can exist both for families and caregivers as well as professionals and service providers. The implications are that the language and cultural gaps surrounding for instance FASD lead to misdiagnoses and failed supports for the infant or young child:

*The absence of an FASD diagnosis during early childhood also contributes to **misunderstanding and misinterpretation of behaviours**. Challenges that emerge can include difficulty with emotional regulation, learning, sensory processing, or adaptive functioning. These challenges are frequently viewed as behavioural issues, trauma responses, attachment concerns, or parenting difficulties rather than indicators of underlying neurodevelopmental disability. As children enter school without formal assessment or support plans, many struggle academically, socially, and behaviourally. Families often report increasing frustration as they attempt to advocate for services in systems that rely heavily on formal diagnosis to determine eligibility for supports.*

Language and culture gaps

The lack of information and potential knowledge or experience related to having a child that is presenting concerns to parents and caregivers intersects with experiences of language-based and cultural gaps:

*I think **it took me at least 3 years** after my child was born to understand **the new ‘medical’ language people were using** around me and to find my voice to advocate.*

In addition, working group members reflected on personal difficulties navigating language and culture gaps and what that could mean for groups multiply marginalized relative to their experiences:

*After we got a diagnosis, **it wasn't until we were at a special needs preschool program that I discovered we had been missing some critical services.** This was despite weeks spent at a major children's hospital and now having a pediatrician. I had to find out from other parents. It was devastating to hear this at the time especially as we kept being told that the first five years are critical for development and doing any and all therapy was crucial.*

***We had missed out on two years' worth of therapy ...
at a children's rehabilitation centre.***

*I had to advocate for my child to be given blocks of therapy at this centre and to be seen by a developmental pediatrician. **I always think back to how difficult it was for me, despite being fluent in English, having time to spend on the phone on multiple occasions, and having the skills to advocate. I can't imagine what it would be like to have to do this without all these privileges.***

Underfunded systems and reliance on families

As the previous vignette also addresses, working group members discussed the continued need for vigilance in an underfunded system to make sure to have some services. Discussions with members highlighted the feeling of being left to figure it out alone, navigating multiple systems that rely on families' natural supports and resources (if present) and being refused formally acknowledged supports and services:

*When I asked to have a PSW [Personal Support Worker] come help, I was told that **I'd have to wait until our child was at least 4 or 5 years old as "parents normally take care of their young children anyway".***

*When we **finally convinced them to send a PSW** around the age of 4, I was given 7 hours a week of help, and they had to be spaced out so **I could only have someone come for 1 hour a day.***

*I asked for help in the mornings so I could get my other children off to school and **they said, "they had no one to help but could send someone in the early afternoon,"** during a time when my child was at a preschool program. **If more funding was available and if PSWs were paid more, I don't think this would be a problem.***

As a working group member shared, when systems and services are underfunded, families have little other options to care for and ensure their infant or young child's needs are met:

There was never a question of whether we would care for my child's medical needs. I had to work part time for the first three years of my child's life to meet their medical needs and manage all the appointments. I became a navigator, advocate, case coordinator, case manager, therapist, and hypervigilant caregiver. I continue to fight for treatments, medications, services, therapies, and interventions to give my child the best outcomes they can have with their complex care needs. Every system we encounter; health, disability supports, social care, education - they rely on the families to meet these needs as under-resourced systems.

This reliance on families to perform as caregivers and advocates comes amidst other life and household responsibilities, such as employment to provide basic life necessities that further create caregiver burden and stress when support is not available:

Life would have been chaotic enough with four young children, but when you add medical complexity and disability to the mix, it borders on unmanageable. On top of this, the housing market was horrendous, making a house purchase seem impossible when only one parent could work since we couldn't afford childcare and I had to be a medical caregiver for my child. Due to a lack of funding and space, the special needs preschool only had half-day programs so that more kids would have access, which means that only families with the resources to send their child for 2.5 hours a day program could attend. In one of the major cities in Canada, there are only 4 specialized preschool programs, so waitlists are long and with the programs being only half-days, it shuts out so many families who can't take time off to shuttle their child to and from them.

Professional training and knowledge gaps

In addition, being the primary caregiver and advocate for an infant or young child with disability-related and complex needs presents a paradox in an underfunded system that relies on families to provide supports themselves. As shared by working group members, the paradox is that, as the most knowledgeable people of their child's various needs, this expertise

is often questioned and must be (re)negotiated with different service providers, professionals, and specialist who lack the specific knowledge and training required, and fail to communicate with one another:

*From my experience in having a child with complex care needs and a rare disorder, **as the caregiver, you must tell your child's and family's story over and over again, with each new medical resident and specialist healthcare provider.***

*... **Who do not appear to talk to each other.***

*Information is not brought forward and shared with and within medical teams. Instead, your child's **issues are treated as separate entities not related to the original disease or syndrome.***

*The **neurologist** orders one medication and then the **GI doctor** questions you "**why your child is on this medication which interferes with gut motility.**" The **specialist** for your child's syndrome suggests a modified ketogenic diet to lower blood sugar surges and your **endocrinologist** questions "**why you would give your child this type of diet.**"*

*I had one doctor say to me: "**What kind of mother gives her child 1% milk?**" even though **this was a recommendation from the experts dealing with my child's disease.***

You are on your own coordinating others.

In medical or clinical settings, whether disability or health related, professionals appear to operate differently or separated from the everyday living experiences and realities. In the context of referrals and assessments, standardized tests do not capture or include the witnessing of an infant or child's every minute. According to one working group member, this presents another paradox for diagnostic clinics and standardized assessment tools that were not created for early childhood intervention. This means that diagnoses are centred on the assessment tool and medical or clinical thresholds, rather than infant and child focused or needs-based:

*In the context of FASD, many **diagnostic clinics use age thresholds as part of their referral or assessment criteria because neurodevelopmental impairments may not yet be fully observable or measurable in preschool aged children.***

*Clinicians are often **cautious about assigning an FASD diagnosis before executive functioning, adaptive behaviour, learning, attention, memory, and self-regulation challenges can be more reliably evaluated through standardized assessment tools.***

Consequently, many clinics primarily assess children after the age of six, when diagnostic criteria can be applied with greater medical or clinical confidence.

According to working group discussions and lived experiences, use of thresholds and assessment-based supports can be outdated and fail to meet a child's needs as identified by caregivers. Nevertheless, professional work cultures tend to be hard to work with and medical specialists can be reticent to acknowledge or communicate with parents regarding their potential knowledge gaps:

*... sometimes **specialists have a limited understanding of the disorder/syndrome of your child, using outdated knowledge they may have learned in medical school.***

*I have been surprised so many times, even when my child was hospitalized, that **they did not do a current search of the literature.** If you don't have the knowledge, would you not look it up and **ask the parent for more information?***

*As well, some **practitioners continue to provide medical treatment and suggest social care supports with little knowledge or understanding of the full experience at home and what parents actually require for their children.** Again, ask the parent what they need at home to care for their child.*

*Better yet, **let's invite parents to be able to share their voice within the integrated team of providers providing care and continue to involve them along the way.***

Lack of transparency

In connection with previous vignettes, communication between systems and with parents and caregivers can be strained and lacking in transparency:

*We did not know where to find supports for my child when they were given their diagnosis of a rare neurodevelopmental disorder. **I quickly learned to ask other parents because this information was not forthcoming.** This has continued that way for 18 years.*

*When I would meet with a government disability worker, **if I did not ask for the service or support directly, they would not offer it. It was like they were holding back on sharing resources to save money for the government. I finally asked if there was an algorithm or something that they were using. They said ‘No;’ it was the case workers who decided what children needed.***

I learned to ask other parents what supports I could request that my child was eligible for, which I did not know existed before hand.

This is not a great model for getting those needed supports for families and their children to improve their health and social outcomes.

The lack of transparency and equitably accessible information was navigated by relying on other parents. This advocacy skill and information sharing with other parents as valuable resources, points to the hostile service and support environments reluctant to provide formally approved resources due to underfunding:

*I was told that **we had to present the “worst day scenario” of our child to obtain the most funding.** It’s very traumatic to ask parents to do this, especially when we’ve been trying to learn to embrace our child for who they are. **We’re still not sure if this was necessary, but with no transparency, we had to do whatever it takes to maximize the quality of life our child could have.***

*In other cases, we **heard from other parents that there were “checklist tools” that determined the level of funding our child could qualify for.***

*When I asked our care coordinators about them, we were told that **they were not allowed to share this information.** A lot of funding seemed to be **dependent on the coordinator and your relationship with them and how savvy and willing they were to help your family figure out how to maximize what funding you got.***

Stigma

In line with previous themes and a previous vignette that “you are on your own coordinating others,” there can be potential stigma against caregiver knowledges among professionals and

service providers. Some working group members also shared the impact of stigma from people in their social circles, who do not comprehend what being a caregiver and advocate means and requires:

*I remember getting a second diagnosis of autism for my child, just before their fifth birthday and **my extended family saying, “why did you have to get another thing?”***
I remember the sting of those words thinking to myself, ‘my child is no different than yesterday; we just now have more tools in our toolbox...’
But the stigma of having an autism diagnosis was present.

During working group meetings, members discussed the complexity of experiencing stigma on multiple levels. Stigma can be felt in relation to societal parenting expectations and the roles that they are expected to fulfill for their child’s needs. At the same time, stigma related to ‘good’ and ‘bad’ parenting can emerge from funding bodies and professional work cultures that assume superiority of their knowledges against that of caregivers. In turn, advocacy work was also identified as coming with stigma, especially when caregivers are asking for basic supports for access and inclusion which other people consider that as asking for non-essential supports and funding. Finally, people might experience a form of internalized stigma due to the role tension between being a parent and a caregiver. A parental relationship and what it means to be in parent-child relationships can become secondary or absent when having to be the unpaid personal support worker and caregiver, further complicating cultural assumptions and ideals regarding parenting and having to provide unpaid care out of unconditional love.

Priority areas

At the bottom of Figure 7, the working group on access and exclusion, specifically early childhood intervention and developmental supports, provides the main priority areas identified. Answers shared in the survey and discussions during online meetings are complemented by vignettes to further clarify what these priority areas should and could improve for access, limiting experiences of exclusion.



Support and diagnosis

One significant theme that came forward consistently as a priority area is connected to the diagnostic delays, requirements, and absence which are identified as acting as gatekeeping mechanisms to access and, consequently, increasing people's likelihood of being missed or excluded from accessing needs-based supports. For example, the lack of support and diagnoses for FASD during early childhood appears to be based on inflexible assessment-based service systems:

*Evidence consistently demonstrates that **FASD remains under-identified, inconsistently diagnosed, and unevenly supported across Canada, resulting in predictable and preventable adverse outcomes.** Diagnosis functions as a system gatekeeper, yet current diagnostic capacity across Canada remains insufficient, inconsistent, and inequitable.*

A policy priority area linked to this vignette about FASD is to make supports available prior to any diagnosis as needs-based and/or reform standardized testing tools to accommodate for the multidisciplinary assessment of all infants with PAE that could lead to an FASD diagnosis if appropriate. The central twist in thinking about support and diagnosis here is to place people first to avoid exclusion:

*FASD age-based restrictions and missed early identification represents a **system failure in which known prenatal alcohol exposure (PAE) and early developmental concerns do not result in timely assessment, intervention, or support.** This creates a substantial service gap during the years when brain development is most rapid, and intervention may be most effective. **Children with known PAE might end up with deferred diagnoses, provisional findings, or no diagnosis at all, despite clear developmental concerns.** This often leaves families without access to targeted supports, specialized programming, or clear guidance regarding how to support their child.*

Navigating systems

The second policy priority area identified is to simplify and better coordinate care and support across various system levels and services. Failure to do so was visible in the vignettes through siloed systems and lack of communication between different professionals and how a lack of care coordination can further entrench marginalization and exclusion of some children, groups, and diagnoses:

*Although several provinces and territories have established FASD assessment and diagnostic clinics, **existing capacity is insufficient to meet current demand, let alone address the number of children born each year who may require assessment.***

*Most **clinics maintain lengthy waitlists that can discourage families, caregivers, educators, physicians, and service providers** from pursuing referrals. Access is also highly inequitable across the country. Some provinces and territories have established diagnostic systems, while others have minimal or no dedicated FASD diagnostic capacity for children, youth, or adults. **Across most jurisdictions, diagnostic systems remain fragmented, under resourced, and difficult to navigate.***

In addition, lived experiences of navigating siloed systems shared by working group members reveal how a lack of care coordination can result in extra caregiver burden and missed supports:

*From birth, we were connected to **multiple clinics within our local children's hospital. It was up to me to coordinate all the appointments and make sure I brought the correct information with me to those appointments.***

It wasn't until my child was at least 9 years old that I finally heard that I could access a social worker in those clinics and that they - professionals - could see the notes from other professionals within the hospital.

That information could have really supported us in the early days.

Knowledge and communication

The previous vignette connects the identified priority of cross-system collaboration and care coordination to the priority of knowledge sharing and communication. During working group

meetings, members talked about professional services, agencies, and/or ministries withholding information about their child or a failure to communicate the full picture with the family members who function as the child's primary caregivers. According to one working group member:

*The best information I heard about in the early days wasn't from my child's medical team.
It was from other parents*

Although this lived experience showcases that a caregiver's connections and networks are important and can aid with advocating for services and supports, group members agreed that it should be a policy priority for systems to communicate available supports and information with families transparently and that information should be equally accessible across all regions, conditions, and services. Another group member puts this priority area into perspective:

*In the early days, I was still in the stage of "I need to find a cure" and that wasn't always a healthy frame of mind to be in. **What I needed from my healthcare team was knowledge and communication.***
This knowledge and communication would be to keep one foot rooted on the ground and not both feet on "the crazy train" – as I called it.

This vignette hints at the sense of overwhelm parents can experience during their child's infancy and early childhood when expectations about development, childhood, and parenting are shook-up by their child's needs. In parents' efforts to support and keep their child alive and well, this can be harder without clearly communicated information about conditions and supports from those professionals assessing their child. According to the working group members:

Early childhood interventional and developmental support works best when services are needs-based, easy to navigate, and coordinated across support systems

In addition, one group member shared alternative channels of information they found helpful:

*There was a lot of fear about what services I should access
and what would be best for our family.*

***What I found really helpful was to ask other parents and they were able to explain
the services in a way that was practical and how it would benefit my family.***

Another point raised, related to the use of social media as a potential resource, but a resource requiring caution:

Facebook has been an invaluable resource for peer-to-peer support.

*I evaluate the Facebook groups that I'm in every 6 months to make sure they still feel
meaningful for me and that the groups are positive*

Finally, as working group members were discussing and thinking about all three priority areas, one more important policy consideration was voiced from a parental/caregiver perspective:

Stop making parents and caregivers beg for services families need every year.

*I know that ministry budgets change but it is very degrading when I have to beg for
supports when my child's needs haven't changed.*

Disability-Related Services and Supports

In the ADVANCE fellow's effort to support the priority area identified by the working group, Appendix A and Tables A1 to A4 include a federal Canadian table of available disability-related services and supports as of July 2026 and provincial tables for available public disability-related services for children 0-5 with/without diagnoses for British Columbia, Alberta, and Ontario.¹¹ Columns in each of the four tables in Appendix A provide information about:

- 1) Age-based restrictions
- 2) Whether a formal diagnosis is required
- 3) Whether access is possible prior to diagnosis

¹¹ Appendix A and B both refer to services and supports, where the former refers to those supports and services listed on government websites and the latter to supports and services not listed on government websites. It is important to note that this separation of supports and services between Appendix A and B emerged from a logistic standpoint and not because these programs are neatly belonging to either category based on funding or local availability. Their separation into two appendices is therefore an organizational choice.

- 4) Eligibility requirements
- 5) Referral pathway
- 6) Type of support
- 7) Whether there is public information about wait lists
- 8) Potential access implications or barriers from an analytical standpoint

Federal disability-related services and supports (Table A1)

In relation to Table A1, the inclusion boundaries for federal programs were that the program/support had to be publicly described as supporting children, families, early childhood development, disability-related needs, health/social supports, childcare, or caregiver support before school systems become the main pathway. Programs were separated into two types, based on being a direct/request-based or family benefit supports, where a family/caregiver can request, apply, or receive a benefit or being a federal funding/community-delivered program, where the federal government funds organizations, Indigenous communities, or provinces/territories, but families access the support through a local, community, or provincial pathway.

Overall, the strongest federal authorities related to disability-related access pathways for children before school entry are Jordan's Principle, the Inuit Child First Initiative, and Non-Insured Health Benefits for eligible First Nations and Inuit children. These pathways can include assessment, therapy, medical equipment, transportation, mental health services, and other supports, depending on eligibility and need. For the general population, the federal supports are mostly income and/or tax benefit based or indirect federal funding streams. There do not appear to be direct early intervention service programs on the federal level. The Child Disability Benefit and Disability Tax Credit can provide financial relief but are tied to impairment documentation and CRA approval and are not needs-based early intervention access pathways. As an interpretive note, federal program existence does not necessarily mean a family can directly obtain timely assessment, therapy, inclusive childcare, respite, or service coordination.

Disability-related services and supports in BC (Table A2)

Table A2 draws primarily on publicly available, online, and official sources from the BC government and provincial health authority. BC's early childhood intervention page describes various supports for children who have, or are at risk of, developmental delay or disability. Important to note, is that BC is currently implementing major changes to the Children and

Youth with Support Needs (CYSN) operations. Government sources list 2026 as a CYSN transition period, where Autism Funding remains in place until March 31, 2027, while new and expanded CYSN services, the BC Children and Youth Disability Benefit, and the Disability Supplement are phased in across four different regions. The central intent for this updated CYSN system is to make supports easier to navigate, to improve access to services, and to focus on needs-based supports for every child, rather than relying only on diagnosis.

Overall, BC has several early-childhood and community-based pathways that are formally described as available without a confirmed diagnosis or based on risk or developmental need. At the same time, other major supports remain gated by assessment, diagnosis, the CRA's approval of the Disability Tax Credit application, or by functional eligibility. Autism Funding, considering the CYSN transition, requires new applications to provide formal diagnosis up to March 2027. After March 31, 2027, Autism Funding is slated to be replaced by the BC Children and Youth Disability Benefit which is stated to be based on functional or needs-based eligibility, and in July 2027 with the added BC Children and Youth Disability Supplement, accessible for low- and middle-income families to cover the costs of raising a child with support needs.

Disability-related services and supports in Alberta (Table A3)

Table A3 relates those Alberta-based programs, services, and supports relevant to early childhood intervention, developmental supports, disability-related supports, inclusive childcare, diagnosis and assessment pathways, complex medical needs, and family or caregiver supports before school systems become the primary access point. Consequently, the Alberta Education's Program Unit Funding (PUF) was not included in Table A3. It is relevant to early intervention in Alberta but is education-administered.

The disability-related supports and services in Alberta appear to have a pronounced family-support pathway through Family Supports for Children with Disabilities (FSCD) and a broad health or developmental pathway through Early Childhood Intervention Programs (ECIP) and pediatric rehabilitation services. However, pathways are organized around different access logics, with some appearing to be needs-based or developmental-concern oriented, while others require medical documentation confirming a child's disability or that the child is awaiting diagnosis. Families may need to move across health, disability services, childcare, and assessment or diagnostic pathways that do not have a single point of access, where some depend on local referral rules, zone-based services, and capacity.

Disability-related services and supports in Ontario (Table A4)

Table A4 lists the programs, services, and supports in Ontario that would be relevant to early childhood intervention, developmental supports, disability-related supports, inclusive childcare, diagnosis, or assessment pathways, complex needs, and family or caregiver supports before school systems become the primary access point. For Ontario, SmartStart Hubs appear to be designed as the main access point to children’s services for families with concerns about development and day-to-day functioning, where families do not need a referral or diagnosis to access SmartStart Hub services. In addition, Ontario has diagnosis- or condition-specific pathways. Those major condition-specific or funding pathways remain diagnosis-, documentation-, age-, or eligibility-gated.

This two-pronged approach to supports and services shows a needs-based approach through the SmartStart Hubs whereas families must move through separate child development, autism, rehabilitation, childcare inclusion, respite, severe-disability funding, and complex-needs pathways for those services and supports.

Community-Based Supports

In the ADVANCE fellow’s effort to support the policy priority areas identified by the working group, Appendix B and Tables B1 to B3 include community-based and non-profit supports for families as of July 2026 for British Columbia, Alberta, and Ontario.¹² Columns in each of the three tables in Appendix B provide information about:

- 1) Age-based restrictions
- 2) Whether a formal diagnosis or documentation is required
- 3) Whether families have access to this service or support before formal diagnosis
- 4) Eligibility
- 5) Referral pathway
- 6) Type of support
- 7) Public access or wait times if available
- 8) What this resource may be useful for

¹² Appendix A and B both refer to services and supports, where the former refers to those supports and services listed on government websites and the latter to supports and services not listed on government websites. It is important to note that this separation of supports and services between Appendix A and B emerged from a logistic standpoint and not because these programs are neatly belonging to either category based on funding or local availability. Their separation in two appendices is therefore an organizational choice.

Because of the nature of community-based and non-profit supports being local and sometimes inconsistent in nature, these three tables are not including all potential supports that families could access. In turn, working group members also shared that families might rely on, or advocate for services and supports available to all families to avoid constant segregation of their child and be included in local community activities, services, or supports.

Research and Report Synthesis

Early childhood intervention and developmental supports operate as an interconnected early-years system rather than as a collection of isolated clinical programs. Inclusive childcare, primary and pediatric health care, developmental assessment, rehabilitation, family support, income assistance, and service coordination jointly shape whether children and families can participate in their communities and obtain meaningful support (Brown & Guralnick, 2012; Tollan et al., 2023; van Rhijn et al., 2021). The jurisdictional scan undertaken for this report identified multiple public and community-based programs in British Columbia, Alberta, and Ontario. However, the existence of a program, formal eligibility for it, or placement on a waiting list does not establish that assistance is timely, sufficient, continuous, or usable. Formal access can therefore coexist with limited substantive access (Sapiets et al., 2021; Underwood et al., 2018).

Diagnosis has an important but contradictory role within these systems. Assessment and diagnosis can provide explanatory information, validate families' concerns, inform intervention, and establish eligibility for supports. At the same time, diagnosis-dependent eligibility can delay assistance when assessment pathways are lengthy, diagnostic capacity is limited, or a child's presentation does not correspond neatly with established categories (Abouzeid et al., 2025; Basualto et al., 2026; Sapiets et al., 2023). This concern was reflected in the working-group survey: four of five respondents identified children without a diagnosis as particularly likely to miss supports, while respondents consistently prioritized needs-based assistance that could begin before diagnostic confirmation. Taken together, the evidence supports separating access to foundational developmental, and family supports from access to specialized services for which diagnosis is clinically necessary.

Fragmentation across health, childcare, disability, social-service, funding, and education systems is another central source of exclusion. Different programs use different eligibility definitions, referral routes, documentation requirements, age limits, and administrative processes. Families may consequently be required to locate services, obtain referrals, transfer records, repeat their histories, reconcile conflicting professional advice, and coordinate providers that do not routinely communicate with one another (Baumbusch et al., 2019; Salvino et al., 2022; Underwood et al., 2019a, 2024). Working-group vignettes make the practical consequences of this fragmentation visible. Members described becoming navigators, advocates, case coordinators, therapists, and hypervigilant caregivers while also managing employment, housing, other children, and their own wellbeing. These accounts should be

interpreted as situated evidence of how system organization transfers work to families, rather than as representative estimates of how frequently these experiences occur.

The ability to perform this navigation work is unequally distributed. Income, housing security, transportation, geographic location, language access, employment flexibility, social networks, familiarity with professional systems, and the availability of private alternatives affect whether a family can persist through lengthy pathways or work around public delays. Canadian research documents how migration-related stress, financial pressure, language barriers, limited social networks, racism, and culturally inappropriate services can interact with caregiving and service-navigation demands (Casale et al., 2023; Fong et al., 2024). Research concerning Indigenous children further demonstrates that present-day service relationships cannot be separated from colonial child-welfare intervention, professional surveillance, jurisdictional disputes, and the displacement of Indigenous understandings of childhood, disability, family, and collective responsibility (Gerlach & McFadden, 2022; Ineese-Nash, 2020). Consistent with this evidence, all five survey respondents identified newcomer or refugee families and families experiencing limited income or housing insecurity as particularly likely to miss supports. Four respondents identified barriers experienced by families in rural, northern, and/or remote communities.

Time is therefore not a neutral feature of early-intervention systems. Waiting occurs while children develop, family circumstances change, caregivers perform additional labour, and eligibility periods continue to elapse. Delays before referral, during assessment, between diagnosis and service authorization, and while awaiting an available intervention place can accumulate across the pathway (Sapiets et al., 2021, 2023). Age thresholds can convert these delays into shortened intervention, transition disruption, or exclusion when a child reaches a program limit before meaningful assistance begins. Families may then have to establish new eligibility and service relationships as responsibility transfers among early-intervention, child-care, health, disability, and education systems (Tollan et al., 2023; Underwood et al., 2019a). Evaluating access therefore requires attention to when support begins, how long it remains available, and whether it continues across institutional transitions.

Finally, existing information systems provide an incomplete account of who is missed. Program and administrative data generally describe people who become visible to a service but may not identify families who never learn about a program, cannot obtain a referral, abandon an application, receive an informal refusal, pay privately, remain indefinitely on a waiting list, or age out before service begins. Broader disability-measurement research similarly identifies continuing problems with the consistency and comparability of disability data

(Cerilli et al., 2024; Mont et al., 2022). Quantitative and administrative information should consequently be combined with lived and living experience, community knowledge, and co-produced interpretation (Jull et al., 2017; Sutherland et al., 2025). The combined evidence in this report indicates that children and families are missed not because of a single failed program or individual decision, but through the cumulative interaction of eligibility rules, diagnostic pathways, limited capacity, fragmented administration, social inequities, cultural and colonial relations, and change over time.

Limitations

This report is a co-produced, interpretive policy analysis rather than a representative population study or systematic review. The five Qualtrics survey responses provide a structured snapshot of working-group priorities and experiences. They cannot establish the prevalence of identified barriers, compare jurisdictions statistically, determine causation, evaluate program effectiveness, or quantify population-level unmet need. Working-group vignettes provide important, situated evidence of system interactions but should not be interpreted as representative of all children, families, communities, or service providers.

Participation through the ADVANCE network may have favoured people already connected with disability, service, advocacy, academic, or policy networks. The working group did not directly represent every population identified as likely to miss supports. Findings concerning Indigenous, newcomer, refugee, rural, remote, low-income, and housing-insecure families draw on published research and working-group observations rather than direct engagement with every affected community. The report should not be interpreted as speaking on behalf of these populations. Future work should include appropriately resourced, accessible, and community-directed engagement, including distinctions-based engagement with First Nations, Inuit, and Métis organizations and communities.

The academic and grey-literature components constitute a targeted narrative synthesis. Search, selection, and interpretation were shaped by the report's questions, available time, public accessibility, and the fellow's analytical judgment. Evidence is unevenly distributed across disabilities, jurisdictions, service sectors, and populations. Autism, FASD, rare conditions, and complex medical needs are more visible in parts of the literature than many other developmental and disability-related experiences. Findings from a particular diagnosis or population have therefore been used illustratively and should not automatically be generalized to all children with suspected or confirmed developmental disabilities.

The jurisdictional and program tables represent a point-in-time scan of publicly available information. Websites, eligibility rules, funding arrangements, contact information, and service structures may change after publication. Public descriptions may also differ from local implementation and do not consistently report actual capacity, regional variation, waiting time, denial, abandonment, or informal gatekeeping. Appendix B is not an exhaustive directory of community organizations because local and non-profit supports change frequently and may not maintain complete public information.

The focus on British Columbia, Alberta, and Ontario does not capture the full diversity of early-childhood intervention arrangements across Canada or all local variation within those provinces. The project also does not provide a comprehensive analysis of services across ages 0-25, every disability, or every health, child-care, education, child-welfare, income-support, and community-service pathway. Legal material is provided for policy analysis and public education and should not be interpreted as individualized legal advice. Finally, available data cannot identify all children and families who are missed before becoming visible to a program. The report cannot quantify families who did not know that support existed, could not obtain a referral, discontinued an application, encountered an informal refusal, remained on an unreported waiting list, paid privately, or aged out before receiving assistance. This absence is both a methodological limitation and a substantive finding: systems that primarily count successful service entrants cannot provide a complete account of equitable access.

Recommendations

The following recommendations respond to the barriers identified across the academic and grey literature, jurisdictional and program scans, and ADVANCE working group survey, discussions, and vignettes. They are guided by the distinction between formal access, such as the existence of a program, eligibility determination, referral, or placement on a waiting list, and substantive access, in which appropriate assistance begins when needed, remains available for sufficient duration, and continues across service and family transitions.

Collectively, the recommendations seek to reduce diagnosis-dependent exclusion, prevent fragmented systems from transferring navigation and coordination responsibilities to families, address inequities in service capacity and accessibility, and establish clearer institutional accountability for ensuring timely, continuous, culturally safe, and meaningfully usable support.

1. Provide foundational support according to needs before diagnosis

Evidence shows that diagnostic delay and restrictive eligibility can postpone or prevent early support (Basualto et al., 2026; Sapiets et al., 2021, 2023). Provincial systems should provide a comprehensive and accessible package of supports. Developmental, family, communication, child-care inclusion, and navigation support should be based on needs, not gated by a diagnosis. Diagnoses should remain available where it informs clinical care or specialized intervention but not as the only gateway to supports.

2. Establish a coordinated entry and navigation pathway

Research demonstrates that fragmented pathways transfer information, advocacy, and coordination work to families (Baumbusch et al., 2019; Salvino et al., 2022; Underwood et al., 2019a, 2024). Families should have access to clearly identified entry points, a named navigation contact, and active referrals that confirm connection with the receiving service. Health, childcare, early intervention, disability, social-service, and education providers should share information, with informed consent, so that families are not repeatedly required to reconstruct their child's history or to coordinate disconnected professionals independently.

3. Protect continuity across waiting periods, age limits, and transitions

Children should not lose access because system delay consumed eligibility periods and transition planning should begin before responsibility transfers to another authority (Tollan et al., 2023; Underwood et al., 2019a). Being referred, declared eligible, or placed on a waiting list should not be treated as successful access. Systems should record when concerns were first raised, when referrals and assessments occurred, when support began, whether service was received, and whether the child aged out before receiving the intended assistance.

4. Invest in service capacity using an equity-based allocation model

International evidence identifies inadequate workforce capacities, inaccessible services, fragmented systems, and insufficient financial commitments as continuing barriers to early-childhood intervention (World Health Organization & UNICEF, 2023). Funding and workforce planning should respond to population need, regional shortages, waiting times, and costs of providing services in rural, northern, and remote communities. Strategies should include stable multidisciplinary teams, mobile and outreach services, appropriate virtual options, travel assistance, interpretation, inclusive childcare, respite, and culturally safe support for families, especially for those families whose income is affected by caregiving.

5. Support culturally safe and community-directed services

Cultural safety should be treated as an organizational responsibility with accountability measures (Gerlach & McFadden, 2022; Ineese-Nash, 2020). Research with immigrant and racialized families supports investment in language access, trusted community partnerships, and service models responsive to migration and settlement circumstances (Casale et al., 2023; Fong et al., 2024). Services should be available in accessible languages and formats and developed with the communities expected to use them. First Nations, Inuit, and Métis services should be distinctions-based and support Indigenous authority, relational models of care, and community understandings of children, disability, family, and belonging.

6. Make access pathways, decisions, and performance publicly transparent

Reporting should be appropriately disaggregated while respecting privacy, Indigenous data sovereignty, and risks of small population counts (Cerilli et al., 2024; Mont et al., 2022). Governments and delegated providers should publish eligibility rules, documentation requirements, referral pathways, expected timelines, service availability, reasons for denial, and review or appeal mechanisms in accessible formats. Public reporting should distinguish each stage of the waiting time during diagnostic pathways. Data should include inquiries, referrals, screening outcomes, assessment waits, service-start dates, interruptions, denials, withdrawals, aging out, and reliance on private payment.

7. Assign cross-system accountability and sustain co-production

Participation should be accessible, compensated where appropriate, and connected to documented government responses and implementation timelines (Jull et al., 2017; Sutherland et al., 2025). Each jurisdiction should identify which authority is responsible for ensuring continuity when multiple ministries, funding streams, or service providers are involved. Jurisdictional or administrative disputes should be resolved by responsible institutions, not transferred to children and families. Families, disabled people, Indigenous organizations, community providers, and groups underrepresented in consultation should be actively included and asked to participate in designing, implementing, and evaluating reforms.

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Appendix A: Early Childhood Interventions and Development Supports

The tables below identify publicly documented early childhood interventions and developmental supports at the federal level (Table A1) and in British Columbia (Table A2), Alberta (Table A3), and Ontario (Table A4). They include disability-specific programs, assessment pathways, financial supports, and selected universal early-years programs relevant approximately from birth to age 6. Program rules and official source links were rechecked on July 26, 2026.

Verification notes: “No public wait-time data located” means that no current, centralized figure was identified in the official public sources reviewed. This does not establish that individual providers do not collect operational data. Program availability and local intake practices vary and can change, which means it is important to inquire and confirm current local access/wait lists.

Interpretive note: The final column in each of the four tables records potential access implications inferred from published eligibility and delivery rules. These represent analytical observations, not official program findings or estimates of how often a barrier occurs or whether this implication affects every family similarly.

Table A1: Available Early Childhood Interventions and Development Supports on the Federal Canadian Level (verified July 26, 2026)

Jordan’s Principle							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
First Nations children under the age of majority in their province/ territory	Not stated; Based on unmet health, social, or educational needs	Potentially; Request may require access to assessment, screening, therapies, transportation, respite, equipment, and other supports	First Nations children needing health, social, or educational products, services, or supports	Parent/guardian, child over 16 in some cases, authorized representative, First Nations community/ service coordinator/ navigator, or	Child-first funding for products, services, health, social, educational, therapeutic, equipment, transportation, respite, assessment-related supports;	Public reporting exists on approved products/ services/ supports, but no public data on waitlists or unmet-need data	Child-first pathway, but eligibility is specific to First Nations children. Access may still depend on family/ community

		depending on the child's need		other eligible requester may submit a request	Parents/ guardians can submit requests to receive payments; Supports may reduce family burden		
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Inuit Child First Initiative

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Inuit children under the age of majority in their province/ territory	Not stated; Based on unmet health, social, or educational needs	Potentially; Examples include assessments/ screenings, speech therapy, physiotherapy, occupational therapy, mental health services, equipment, transportation, and medical respite care	Inuit children needing health, social, or educational products, services, or supports	Requests submitted through regional offices; parents/ guardians, service coordinators, navigators, communities, organizations, or authorized representatives may help	Child-first funding for substantively equal access to essential supports and services; Regional offices and service coordinators support applicants; Family/caregiver needs may be supported through child-specific supports	No public waitlist/ capacity data found	Important parallel to Jordan's Principle for Inuit children; Not a general-population program; Access depends on recognition or eligibility and navigation of request

Non-Insured Health Benefits Program

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Registered First Nations and recognized Inuit clients, including an eligible client's child	Not diagnosis-gated, but benefits are limited to eligible goods/ services and may require prior approval	Potentially, for covered health-related needs. It is not an early intervention program, but may support health-related	Eligible First Nations and Inuit clients requiring covered health benefits not otherwise covered by	Eligible client/ provider claims; Providers may bill directly where enrolled	Drugs, dental, vision care, medical supplies/ equipment, mental health counselling, medical transportation, and other eligible	No public waitlist/ capacity data found	Not a comprehensive early intervention pathway; Coverage depends on benefit

under age 2; not restricted to early childhood.	or documentation	equipment, transportation, counselling, and other eligible benefits	other plans/ programs		health benefits; Indirect family/caregiver support as covered benefits reduce family costs or support caregiving		categories, prior approvals, and coordination with other systems
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Child Disability Benefit

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children under the age of 18	No named diagnosis is required; the child must be approved for the Disability Tax Credit (DTC), which requires practitioner certification of severe and prolonged functional impairment.	Potentially. A formal diagnostic label is not required, but payment cannot begin until the DTC is approved and Canada Child Benefit eligibility is established.	Severe and prolonged impairment in physical or mental functions; DTC-approved	Automatic when family receives Canada Child Benefit (CCB) and child is DTC-approved	Tax-free monthly payment to families caring for a child with a severe and prolonged impairment; Family/caregiver support paid through the child benefit system	Not a waitlist-based program; Public benefit rules exist, but unmet-need data are not captured	DTC- and tax-administration-gated. Barriers can include obtaining certification, completing CRA processes, filing annual tax returns, and maintaining CCB eligibility.

Disability Tax Credit

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Not child-specific; Children under 18 that qualify can access the Child	No named diagnosis is required. An eligible medical practitioner must certify severe and	Potentially. Eligibility is based on functional effects rather than a diagnostic label, but practitioner	Severe, prolonged impairment in physical/ mental functions, significant	CRA application using Form T2201; Medical practitioner completes certification; Some	Non-refundable tax credit; Unlocks CDB and other tax-linked supports; Supporting family members may benefit through	Not a waitlist-based program; CRA processing data exists; No public unmet-	Certification, documentation, application, and review can create barriers. As a non-refundable

Disability Benefit (CDB)	prolonged functional impairment, cumulative significant limitations, or qualifying life-sustaining therapy; CRA must approve the application.	certification and CRA approval are required.	limitations or therapy to support a vital function	practitioners require payment	reduced tax bracket or linked benefits	need/ access-barrier data	credit, its direct tax value can be limited where little tax is payable, although linked benefits may still be important.
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Canada Child Benefit

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children under the age of 18	No disability diagnosis required	Not applicable; General family benefit	Eligible families with children under 18; Canadian citizen/ permanent resident/ protected person/ qualified temporary resident/ registered under the Indian Act	CRA application/ tax benefit system	Monthly tax-free payment to families/ caregivers to help with the cost of raising children	Not a waitlist-based program	Family income support; Not disability-specific; Not an early intervention; Interacts with the CDB and DTC if eligible; Not accessible for refugee claimants

Canada caregiver amount for infirm children under 18

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children under 18 at	No named diagnosis is specified. CRA	Potentially. It may be claimed without a named	Child under 18 with mental or physical	Claimed through personal income tax return; CRA	Non-refundable tax amount; Recognizes	Not a waitlist-based program	Does not provide direct services; May

the end of the tax year	may request a practitioner's statement about the duration of the impairment and the child's need for substantially greater ongoing help than same-age peers.	diagnosis if the functional and documentation requirements are met.	infirmity causing substantially greater care needs	may request medical practitioner statement	additional caregiving responsibility for an infirm child		have limited benefit for low-income families with little tax payable; Requires tax filing and possible medical documentation
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El family caregiver benefit for children

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Critically ill or injured child under 18	Medical certification required; Not a diagnosis-gated developmental support	Not applicable to general developmental delay/ disability awaiting diagnosis; It applies to critical illness, injury or end-of-life	Child under 18 who is critically ill or injured, where baseline health has changed significantly and life is at risk	Employment Insurance (EI) application; Medical doctor or nurse practitioner certification required	Up to 35 weeks of EI caregiving benefits for eligible caregivers; Provides income replacement support to caregivers away from work	Not a waitlist-based program	Relevant for children with acute/ critical complex medical needs; Not a general early intervention or disability-support pathway

Medical expense tax credit / disability supports deduction

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Not child-age-specific on CRA rules	Depends on expense; Some expenses require DTC approval, prescription, or	Not a service pathway; It reimburses/ offsets eligible expenses after	Eligible medical expenses and, for the disability supports	Claimed through income tax return with receipts/ documentation	Non-refundable medical expense credit and/or deduction for eligible disability supports where	Not a waitlist-based program	Favours families able to pay upfront, keep documentation, file taxes, and

	medical practitioner certification	payment through tax measures	deduction, expenses connected to impairment-related supports		family/ caregiver paid expenses are eligible		benefit from tax credits/ deductions
Community Action for Prenatal and Child Health Program (CAPCHP)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Pregnant people, infants, young children ages 0–6, parents/ caregivers facing health equity barriers	No diagnosis requirement stated	Program is not diagnosis-dependent; Program is not a disability-specific early intervention program	Families facing health equity barriers, poverty, social/ geographic isolation, teen pregnancy, substance use, family violence, systemic barriers, Indigenous families, racialized communities, newcomers, gender-diverse families	Access through funded community projects; Federal funding goes to community groups, not directly to individual families	Prenatal/ postnatal health, parenting and child health, child development activities, home visiting, drop-ins, nutrition supports, referrals, and community capacity-building; Program explicitly includes parents/caregivers and family support	Public federal funding page reports broad project reach; No local waitlist/ capacity or unmet need reported	Not disability-specific; Availability depends on funded projects; Access varies by community
Community Action Program for Children (CAPC) Quebec							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)

Birth to age 6; Quebec projects continue under CAPC until March 31, 2028	No diagnosis requirement stated	Program is not diagnosis-dependent; Program is not a disability-specific early intervention program	Young children and parents/ caregivers facing health-risk conditions, poverty, teen pregnancy, social/ geographic isolation, substance use, and family violence	Access through community projects; Outside Quebec, the program is now unified under CAPCHP as of April 1, 2026	Healthy child development, culturally sensitive programs/ supports, parenting knowledge, parent-child relationships, positive health practices, reduced isolation; Parent/ caregiver support is central	No public local waitlist/ capacity data found	Not a disability-specific service; Current structure and available funds differ in Quebec during transition
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Canada Prenatal Nutrition Program (CPNP) Quebec

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Pregnant people, new mothers/ parents, babies; Quebec projects continue under CPNP until March 31, 2028	No diagnosis requirement stated	Not applicable; Prenatal/ infant health support rather than disability intervention	Pregnant people, new parents, babies facing health-risk conditions, poverty, teen pregnancy, social/ geographic isolation, substance use, family violence; Support for Indigenous women and recent immigrants	Access through funded community sites/ projects; Outside Quebec, unified under CAPCHP as of April 1, 2026	Nutrition counselling, prenatal vitamins, food/ coupons, breastfeeding education/ support, infant care and child development education, referrals; Supports parents/ caregivers and infants	Public page reports project counts/ reach; No local waitlist/ capacity or unmet need listed	Not disability-specific and not an intervention pathway for developmental delay

Healthy Early Years Program

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children 0 to 6 years and families in official language minority communities facing risk conditions	No diagnosis requirement	Not diagnosis-dependent; Not disability-specific	Children/ families in official language minority communities facing risk conditions, poverty, social/ geographic isolation, family violence, limited education, Indigenous identity, recent immigrant/ refugee status	Access through funded projects in official language minority communities	Health promotion, child development, parental/ family supports, knowledge/ resource development, capacity-building, and training	No public local waitlist/ capacity data	Not a disability-specific early intervention entitlement; Availability depends on funded projects

Nobody's Perfect Parenting Program

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Parents of children birth to age 5	No diagnosis requirement	Not diagnosis-dependent; Not disability-specific	Parents who are young, single, socially/ geographically isolated, low income, or have limited formal education	Delivered across Canada through provincial/ territorial organizations and trained facilitators	Facilitated community-based parenting program; Child health, safety, behaviour, development, coping, mutual support, and connection to	No public local waitlist/ capacity data found	Not disability-specific; Availability depends on local facilitators and provincial/ territorial delivery

					community services		
Aboriginal Head Start on Reserve (AHSOR)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
First Nations children aged 0–6 living in First Nations communities on reserve	No diagnosis requirement	Not diagnosis-dependent; Not disability-specific	Young First Nations children and families on reserve	First Nations community-designed and delivered; Funded/ administered through Indigenous Services Canada	Early childhood development and school readiness; Education, health promotion, culture and language, nutrition, social support, parent/ guardian/ family/ community involvement	Program/ evaluation reporting; No public local waitlist/ capacity data	Culturally grounded early-years support; Not a disability-specific service; Not universally available in every community
Aboriginal Head Start in Urban and Northern Communities (AHSUNC)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Indigenous preschool children living off-reserve/ territory or in urban/ northern communities; Aged 0–6 and for ages 3–5	No diagnosis requirement	Not diagnosis-dependent; Not disability-specific	First Nations, Inuit, and Métis children and families living off-reserve/ territory or in northern/ urban communities	Local Indigenous community organizations with funding and management support from PHAC	Early childhood development; Culture/ language, education, health promotion, nutrition, social support, parental/ family involvement	Program evaluation exists; No public local waitlist/ capacity data	Access depends on local site availability and capacity
Indigenous Early Learning and Child Care Framework / Indigenous ELCC Transformation Initiative							
Age	Formal diagnosis /	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access

	documentation required?						implications (analytic)
Indigenous children aged 0–6; Specific program age ranges vary	No diagnosis requirement stated at the federal level	Not diagnosis-dependent at the federal level	First Nations, Inuit, and Métis children and families; Community- and distinctions-based early learning and childcare priorities	Funding and implementation through Indigenous partners, communities, and existing programs such as FNICCI, AHSOR, and AHSUNC	Indigenous-led early learning and childcare; quality, cultural appropriate, accessibility, governance, and service transformation; Family/ community-centred Indigenous ELCC programming	Evaluation identifies broad implementation/ outcome evidence; No public local waitlist/ capacity data	Federal funding initiative; Not a direct individual application; Local availability varies
First Nations and Inuit Child Care Initiative (FNICCI)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Specific age range depends on program/ site, with some childcare supports extending beyond preschool	No diagnosis requirement stated at the federal level	Not diagnosis-dependent at the federal level	First Nations and Inuit children/ families accessing federally supported Indigenous childcare programming	Delivered through Indigenous/ community partners and linked to broader Indigenous ELCC investments	Childcare and early learning support; Family and caregiver support indirectly through childcare access and family/ community programming	No public local waitlist/ capacity data	Less directly documented in public-facing family eligibility terms; Federal funding/ program; Not a direct individual application; Local availability varies
Canada-wide Early Learning and Child Care Agreements							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children in early	No diagnosis requirement	Not diagnosis-dependent at the	Families using regulated early	Families access services through	Federal-provincial/ territorial funding to	Federal progress	Not a direct federal early

learning and childcare; Age ranges and eligibility set by provincial/territorial systems and agreements	stated at the federal agreement level	federal agreement level	learning and childcare; Inclusion and affordability are part of the federal vision	provincial /territorial childcare systems	support affordable, high-quality, flexible, inclusive early learning and childcare	reporting exists, but local waitlist /capacity data are provincial/territorial	intervention service; Disability inclusion depends on provincial/territorial implementation, local childcare capacity
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Table A2: Available Early Childhood Interventions and Development Supports in British Columbia (verified July 26, 2026)

Infant Development Program (IDP)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Up to age 3	No formal diagnosis requirement	Yes	Infants and young children with signs or risk of developmental delay or disability	Public health nurse or physician; Families may can contact local service provider to ask about eligibility	Home-based prevention and early intervention; Developmental consultation; Family support; Connection to community services; Consultants can link families to other services	Not found	Pre-diagnosis pathway, but access varies by community provider capacity

Aboriginal Infant Development Program (AIDP)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Up to age 3	No formal diagnosis requirement	Yes	Indigenous infants and young children with signs or risk of developmental delay or disability	Referral through public/ community health or local AIDP provider; Families can connect with local provider	Culturally grounded home-based prevention and early intervention; Developmental support; Family support	Not found	Availability depends on local/ community provider capacity

Supported Child Development (SCD)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Main public source does not specify a hard age limit; Childcare inclusion support for children with extra support needs	No diagnosis requirement identified; BC inclusive childcare materials state children do not require a diagnosis to access SCD	Yes	Children with (extra) support needs who require support to participate in inclusive childcare	Families or childcare providers refer; Families can ask a public health nurse, physician, or local MCFD* office	Consultation and support to children, families, and childcare centres; Inclusion planning; Support for participation in inclusive childcare; Works with families and childcare professionals	Not found in official source	Access may depend on childcare placement, local SCD capacity, and availability of consultants/ support workers

*Ministry of Children and Family Development

Aboriginal Supported Child Development (ASCD)							
Age	Formal diagnosis /	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access

	documentation required?						implications (analytic)
Main public source does not specify a hard age limit; Childcare inclusion support for children with extra support needs	No diagnosis requirement identified; BC inclusive childcare materials state children do not require a diagnosis to access ASCD	Yes	Indigenous children with support needs who require support to participate in inclusive childcare	Families or childcare providers refer; Families can contact ASCD or ask a public health nurse/ physician	Culturally relevant consultation and support for children, families, and childcare centres	Not found in official source	Access may vary by local Indigenous/ community provider capacity

Early Intervention Therapy (EIT)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Birth to kindergarten entry	No diagnosis requirement	Yes	Children with or at risk of developmental delay or disability	Referrals accepted from all sources, families and professionals; Professional referrals can be based on clinical judgment or informal screening	Occupational therapy, physiotherapy, speech-language pathology, screening, referral, assessment, family education/ support, service planning, intervention, consultation, monitoring, and school transition planning	Not found	Access may vary by region/ provider capacity; Public source does not provide wait times

Child Development Centres / Local child development agencies

Age	Formal diagnosis /	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access
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	documentation required?						implications (analytic)
Infants and young children; Some sources describe services from birth to school entry, usually age 5	Depends on program/ service accessed through the centre; Not a single eligibility rule	Potentially, depending on the local program offered through the centre	Children with physical, neurological, developmental, communication, or functional support needs	Families can be connected through ECI* programs, local Child Development Centres, physicians, public health, or community providers	Local delivery of ECI-related services, IDP, SCD, EIT, therapy, family support, and referral coordination; Local program dependent	Not found	This is a service-delivery structure; Eligibility, capacity, and wait times vary by local agency

**Early Childhood Intervention*

BC Early Hearing Program (BCEHP)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Newborns/ infants; Babies identified as Deaf or hard of hearing from birth to age 2, with early language service providers for birth to age 5	Hearing screening/ identification required for access; Not framed as developmental diagnosis requirement	Screening and early services accessible with identification of hearing loss; No other diagnoses required	Babies/ young children identified as Deaf or hard of hearing	Newborn hearing screening through hospitals/ public health; Follow-up testing and BCEHP service coordination	Hearing screening, hearing testing, early language support, service coordination, family support and coordination; Links to early language providers	Not found	Scope and access are specific to hearing and language supports; Potential local wait times for screening and/or BCEHP testing

BC Autism Assessment Network (BCAAN)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children and youth up to	Assessment/ diagnostic	Not a support program; Public	Suspected autism	Referral from a physician	Free public autism	PHSA and HealthLink BC	Assessment delay can

age 19; Priority is given to children under six	pathway; Diagnosis is the purpose of the service	diagnostic assessment pathway			diagnostic assessment; Families receive results/ clinical documentation; Support is not the primary service	publish pathway information, but no current centralized regional wait-time dataset was located in the official sources reviewed on July 26, 2026.	postpone access to diagnosis-gated autism funding. A public diagnostic assessment does not itself provide a therapy place.
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*No current official BCAN regional wait-time figure was located during the July 26, 2026 verification. Secondary estimates were removed from this appendix because they were not official administrative data.

Complex Developmental and Behavioural Conditions (CDBC) assessment

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
HealthLinkBC states 18 months to 19 years	Assessment/ diagnostic pathway; Diagnosis is the purpose of the service	Not a support program; Public diagnostic assessment pathway	Children/youth with significant difficulties in multiple areas of function; Suspected FASD; Complex developmental-behavioural needs	Physician referral required	Developmental/ diagnostic assessment; Families receive results/ clinical documentation; Support is not the primary service	Not clearly specified	Access to later supports may depend on assessment outcome and other program eligibility

FASD Key Worker and Parent Support Program

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children/ youth under 19	Program standards state parents may self-refer without or	Yes; Explicitly available before assessment/ diagnosis	Confirmed or suspected FASD, probable	Families contact key worker; Support is free	Education, information, emotional/ practical	Program standards include service targets; No	Important pre-diagnosis pathway for suspected

	during assessment		FASD, similar neuro-developmental conditions		support, adapting child's environment, accessing assessment/ diagnosis and community services; Parent support, mentoring, support groups	current public waitlist/ capacity data were found	FASD/ CDBC; Early childhood availability varies by community agency*
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* BC POPFASD is funded by the ministry and supports school divisions that have early years programming before kindergarten. They do not provide direct service but FASD informed guidance and training and resources for these sites.

Family Connections Centres (pilot)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children and youth from birth to age 19 in pilot areas*	Pilot is described as needs-based; Not requiring diagnosis or professional referral	Yes; No diagnosis or professional referral required in pilot areas	Developmental delay, confirmed developmental need, or disability	Direct access in pilot areas; No MCFD referral or professional referral required	Behaviour supports, individual/ group interventions, OT/ PT/ SLP**, inclusive childcare support, developmental supports, family-centred planning	Pilot evaluation exists, but not province-wide waitlist/ capacity data	Pilot only; Not available province-wide; Needs-based/ no-diagnosis access geographically limited

*As of July 10, 2026, the pilot areas are Kelowna (Central Okanagan: Operated by ARC Programs); Prince Rupert / Haida Gwaii (Operated by North Coast Community Services); Terrace / Kitimat (Operated by Terrace Child Development Centre); Smithers / Bulkley Valley (Including Houston to Atlin; Operated by Northwest Child Development Centre); **Occupational Therapy, Physical Therapy, and/or Speech-Language Pathology

Current and expanded Children and Youth with Support Needs (CYSN) community-based services

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children and youth with	Expanded services aim for	Yes, for some community-	Developmental, behavioural,	Families directed to community-	Pediatric therapies,	Not found as current	System is in transition;

support needs; Age range depends on service	support without waiting years for a diagnosis; Existing pathways still vary	based supports; Based on BC's description of expanded services	mental health, communication, mobility, self-care, daily functioning, other support needs	based providers and local CYSN pathways; Families not currently receiving supports are directed to existing pathways	behavioural supports, mental health supports, navigation/ family support; Other CYSN services are phased in	service-level waitlist/ capacity data	Some supports are current while others are phased for 2026–2028; Families may experience uncertainty during transition
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Respite and family support services through CYSN

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Families or households with children or youth with support needs under 19	Families of children and youth with a diagnosis of a developmental disability, autism or eligible for the At Home Program	No, diagnosis is required for eligibility; Child needs to be confirmed to reside in family home, have a confirmed diagnosis, and CYSN/MCFD social worker	Children with support needs whose parents/ guardians need help for family quality of life; Diagnosed developmental disability; Eligible for autism funding/ At Home Program/ Disability Services pilot	Direct and local CYSN pathways/ referral from MCFD support workers	Caregiving support, household management, child/ youth care worker access, behaviour supports, counselling, parenting skills training/ support groups, social/ life-skills training	Waitlist data and times are depending on location	Respite funding requests and family support services may not be available; Some families may be prioritized for service; Transitions in services impact families

At Home Program Medical Benefits

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Ages 0 to 17	Diagnosis-based with eligibility based on severe disability/	No broad pre-diagnosis early intervention pathway; Some	Severe disabilities and complex health care needs;	Application through At Home Program; In-home	Medical equipment, medical supplies, nursing	No current centralized public wait-time dataset	Narrow eligibility; Some at Home Program

	complex health needs and functional dependence criteria; Direct eligibility through specified medical pathways	medical exceptions might include access prior to formal diagnoses	children otherwise requiring hospital-level support without equipment/ supplies/ supports	assessment of functional activities of daily living; Direct referral through medical pathways	support, medical transportation, PharmaCare Plan F, dental/ orthodontic/ optical benefits, other medical benefits; Indirectly family/caregiver support to enable children to live at home; CYSN worker may discuss family needs	was located in the official provincial sources reviewed on July 26, 2026.	benefits are transitioning, but medical benefits remain
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Nursing Support Services (NSS)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children and youth aged 19 and under	Diagnosis requirement not specified; Eligibility tied to referral from licensed BC physician or nurse practitioner detailing complex medical needs	Referral is required for access	Complex medical needs; Respiratory care dependency, nutrition and medication requiring nursing support, specialized disease management, palliative care	Physician or nurse practitioner referral required	Nursing support, including in-home and/or in-school support depending on need and program stream	Referrals are assessed according to medical need. No current centralized public wait-time dataset was located on July 26, 2026.	Access requires a physician or nurse-practitioner referral and clinical eligibility; service availability can vary with assessed need and capacity.

Autism Funding

Age	Formal diagnosis /	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access
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	documentation required?						implications (analytic)
Children and youth under 19. Until the program ends March 31, 2027, funding is up to \$22,000/year for children under 6 and \$6,000/year for ages 6–18.	Yes; Funding application requires autism assessment and diagnosis	No	Children/youth diagnosed with autism	Online/ email/ local CYSN office application after diagnosis; Required documents vary by BCAAN/ private/ out-of-province assessment	Individualized autism funding for eligible services/ therapies, RASP* providers for under age 6, family counselling/ therapy, travel/training/ equipment within rules	The funding program is not described as waitlist-based; access depends on an eligible diagnosis and application. Families may separately encounter diagnostic and provider queues.	Diagnosis-gated and in transition. Autism Funding ends March 31, 2027; eligible families are being moved to the Disability Benefit and expanded community services.

**Registry of Autism Service Providers; For children under the age of 6 Autism Funding requires the use of professionals who are part of the government-maintained directory of qualified professionals*

BC Children and Youth Disability Benefit

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Birth to age 19	Not always. Eligibility has a direct pathway for specified diagnoses/criteria and a needs-assessment pathway based on significant or complex functional support needs.	Potentially. The needs-assessment pathway can include children with significant or complex support needs who do not qualify through the direct pathway, including some children	Lifelong disability with significant and/ or complex support needs; Direct-admit categories; Needs-based review rare, complex, functional needs	Existing service recipients are transitioning in phases. Families currently receiving Autism Funding were invited in July 2026 to submit clinical/supporting documents; direct access for new families follows the provincial	Direct funding/ coordinated community-based services; Base tier \$6,500/year; Higher tier \$17,000/year; Funding tied to functional goals/ support plan	Implementation and caseload information are published, but no mature wait-time series is yet available for this new benefit.	The benefit broadens access beyond autism-specific funding, but phased implementation, evidence requirements, needs assessment, and transition between programs may affect timing.

		awaiting diagnosis.		implementation schedule.			
BC Children and Youth Disability Supplement							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children under the age of 18	No named diagnosis is required, but federal DTC approval, income eligibility, and annual tax filing are required.	Potentially only after DTC approval; the first payments are scheduled for July 2027.	Severe and prolonged impairment in physical or mental functions recognized through DTC	Automatic through CRA/ CCB/ B.C. family benefit if child has DTC and family meets income/ tax-filing criteria	Monthly income-tested payment flexible household support up to \$6,000/year per eligible child, beginning July 2027	Not applicable yet; first payments begin July 2027 based on 2026 tax return	Tax/DTC-gated; Misses families without DTC approval, documentation, tax filing, capacity for CRA processes
Affordable Child Care Benefit: Support Needs Supplement / support-needs adjustment							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Childcare age eligibility depends on childcare arrangement	Requires support-needs documentation by authorized professional; Not necessarily formal diagnosis	No, forms and documentation of support needs must be filed	Families using eligible childcare where a child has support needs/ requires additional support services	Parent/ caregiver applies for Affordable Child Care Benefit and support-needs supplement/ adjustment where applicable	Childcare fee support; Income adjustment for each child with support needs; Additional supplement up to \$150/month toward childcare	Not publicly available	Access depends on having/ finding childcare and meeting eligibility; Documentation may create barriers
Indigenous Early Childhood Development Funding							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Generally Indigenous early childhood	No, funding is based on support needs and not	Yes	First Nations, Métis, and Inuit families with children in BC	Funding to Indigenous agencies across BC, on- and off-	Early childhood development, health/ wellbeing,	No provincial data available	Funding stream availability depends on funded

development services up to 12	medical diagnosis model			reserve; Families access through local/ community programs	language/ culture, community capacity, outreach, culturally appropriate services		agencies/ programs in the area
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Aboriginal Head Start in BC

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Birth to age 6	No, access to program is based on funding to local agencies and is support-needs based	Yes, program is not diagnosis-dependent; Not disability-specific	Indigenous children and families in BC	Access through local Aboriginal Head Start programs	Culturally relevant early learning and childcare; Language/ culture, nutrition, school readiness, social supports, wraparound family support, inclusion services	No provincial data available	Funding/ program responsibility is federal/ Indigenous-partnered; Local differences in availability and capacity

BC Aboriginal Child Care Resource and Referral (ACCRR)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children birth to 12 years; Primary focus on early childhood development birth to 6	No, funding is based on support needs and not medical diagnosis model	Yes	Child age; Indigenous identity; Developmental need (physical, cognitive, communicative, social/	Through BC Aboriginal Child Care Society / ACCRR program	Childcare resource and referral support; Connects Indigenous/ non-Indigenous educators, Indigenous	ACCRR does not have a centralized childcare waitlist; Local CCRR centres and ACCRR connect	Indigenous childcare navigation/ culturally responsive access bound by local

			emotional/ behavioural		families, communities, urban settings	Indigenous families directly	capacity and availability
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Table A3: Available Early Childhood Interventions and Development Supports in Alberta (verified July 26, 2026)

Early Childhood Intervention Program (ECIP)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Public AHS listings vary by zone/ service listing: Children from birth to 3.5/ birth to 5 years	Not necessarily; AHS listings vary between diagnosed disability and concern or risk for developmental delays	Yes, public descriptions of children at risk for developmental delay or families having concerns	Developmental delays, disabilities, developmental risk, concerns about attention, movement, feeding, speech, hearing, social interaction	Varies by zone/ listing; Some require professional referral through Alberta Referral Directory; Some state parents can self-refer, Providers/ agencies/ public health nurses can refer with family permission	Home/ community-based navigation, education, developmental screening, support, monitoring, activity ideas, child/ parent groups, referrals, planning for preschool years	Not found as public or provincial waitlist/ capacity	Age range and access route vary by zone or service listing. Families may face confusion if local referral rules differ
<i>*Alberta Health Services (AHS) integrated provincial healthcare system</i>							
Pediatric Community Rehabilitation (PCR)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)

Ages 0–18. A broad range of developmental services is offered at ages 0–5; ages 6–18 generally require a significant change in medical or neurodevelopmental condition, injury, intervention, surgery, or illness.	No diagnosis clearly stated; Based on development/functional needs and age	Yes, based on developmental/functional needs	Ages 0–5: broad health and developmental needs. Ages 6–18: qualifying significant change in medical or neurodevelopmental condition, injury, intervention, surgery, or illness.	AHS states health providers consult the Alberta Referral Directory; Some listings state patients/families may call a clinic directly or parent/ legal guardian/ health professional with consent contact intake	Speech-language pathology, occupational therapy, and physiotherapy developmental services; Social work/ child development support, assessment, intervention, consultation, parent strategies, rehabilitation planning	Some listings state estimated wait is provided at appointment booking; No public system-level waitlist/ capacity data	Pre-school developmental pathway where access and referral vary by zone; Children receiving Alberta Education or FSCD* supports may be ineligible for some services in some listings
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**Family Support for Children with Disabilities (FSCD) the provincially funded assistance program*

Children's Allied Health Services / Children's Rehabilitation Services

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Birth to 18; Distinguishes supports birth to 5 pre school entry, from 6 to 18	No diagnosis requirement clearly stated	Yes, for birth to five years old; Services based on developmental/functional needs	Children with, or at risk for developmental delays or disabilities; Communication, feeding/ swallowing, AAC*, movement/ function equipment, play/ participation, self-care, emotional regulation	Health providers consult Alberta Referral Directory; Access details vary by location	Skill-building, assessment, treatment, pediatric OT/ PT/ SLP, social work, child development support, rehabilitation services	Some locations state wait time provided at appointment booking; No public system-level waitlist/ capacity data	Regional/ service naming variation overlapping with pediatric rehab; Availability of either or both differs across Alberta

**Augmentative and Alternative Communication*

Early Hearing Detection and Intervention (EHDI) Program

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Newborns/ infants; Babies born or living/ registered in Alberta offered screening for permanent hearing loss within 90 days of birth	No diagnosis required for initial screening; Hearing identification/ diagnostic pathway follows screening results or risk factors	Yes; Screening before diagnosis; Follow-up diagnostic testing and intervention are part of the pathway	All infants born or registered in Alberta; Permanent congenital hearing loss or risk of hearing loss	Screening in NICUs, postpartum hospital units, community health centres; Community screening/ referral pathways for babies not in hospital or with risk factors	Newborn hearing screening, diagnostic audiology follow-up, family resources, and links to intervention/ supports	No provincial reporting on local waitlist/ capacity data	Early-identification pathway is hearing-specific; Families outside hospital screening sites or with missed screening may need referral/ community follow-up

Autism in Infants and Young Children Primary Care Clinical Pathway

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Infants and young children where autism is suspected; Age boundaries pathway-specific	Not applicable; Clinical pathway for surveillance, early support, referral, and assessment when autism is suspected	Yes; Early support/ resources while developmental concerns are monitored or autism assessment is considered	Developmental concerns/ suspected autism; Directs providers to consider hearing loss or language disorders; Refers to early intervention/ PCR/ ECIP if appropriate	Primary care/ provider-led pathway; Referrals to PCR, ECIP, specialists, and autism assessment pathways	Clinical guidance, developmental surveillance, referral guidance, early support, caregiver pathway, and coordination with other services	Not applicable as a service; No public waitlist/ capacity data for the pathway itself	Not a funded intervention program; Actual service access depends on local PCR/ ECIP/ specialist/ autism assessment availability

Infant and Preschool Assessment & Outreach Service (IPAS/PAS)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children aged 6 months to kindergarten	Children require community or school-based SLP, OT, or psychologist test that supports ASD test needed	Not general pre-diagnosis support pathway; For children where ASD cannot be confirmed/ further assessment needed	Developmental concerns where autism is suspected and cannot be confirmed in the community	Health providers consult Alberta Referral Directory	One- to two-day assessment, virtual assessment where needed, family receives summary and detailed report	Not found	Assessment pathway requires prior community testing which may itself create access barriers
Autism Spectrum Disorder Diagnostic Clinic							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Ages 1 to 17 years 6 months; the child must be 17 years 6 months or younger at referral.	Not applicable; Diagnosis is the purpose of the service	Not a support program while awaiting diagnosis	Suspected autism requiring tertiary expertise beyond community providers; Calgary/Southern Alberta catchment and supporting evidence requirements apply.	Healthcare providers refer through Alberta Referral Directory	Tertiary-level diagnostic assessment and consultation; No treatment or support after	Estimated wait time provided at appointment booking; No public system-level waitlist/ capacity data	Region-specific and tertiary-level; Requires evidence tertiary is needed; Not a general intervention program
Child Development Services Clinic							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Birth to 18 years	No diagnosis requirement; Referral for complex developmental, behavioural,	No broad pre-diagnosis service available; Clinics assess suspected or known neuro-developmental	Multiple, complex developmental, behavioural, learning challenges; suspected/ known	Physician-led tertiary consultation; Requires primary care physician	Assessment, diagnostic clarity, medical treatment/ management recommendati	Not found	Tertiary service where access depends on referral, evidence of

	learning, medical, genetic, neurological, neuro-developmental questions	disorders where community needs cannot be met	neurodevelopmental disorders; Intellectual disability, ASD, ADHD, global developmental delay, genetic/medical/neurological comorbidities	involvement and referral evidence	ons, consultation, and follow-up recommendations		complexity, and community resources already being insufficient
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FASD* Programs and Service Networks

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Child-specific ages vary by network/ clinic; Some pediatric assessment clinics list ages 3–17 but young children may not fit diagnostic pathways	Not diagnosis-gated for all supports; FASD programs include prevention, assessment/ diagnosis, and supports for people with FASD and families/ caregivers	Potentially for support/ navigation through networks, but diagnosis/ assessment availability and age limits vary by region/ clinic	FASD, prenatal alcohol exposure, suspected FASD, and related family/ caregiver needs	Regional FASD Service Networks and clinics; Access/ referral varies by region	Awareness/ prevention, assessment/ diagnosis, coordinated supports, caregiver support, outreach, targeted prevention, and community services	No current public local waitlist/ capacity data	Child age eligibility and availability vary; Some diagnostic services start at age 3 or 6, missing earlier developmental windows

**Fetal Alcohol Spectrum Disorder*

Family Support for Children with Disabilities (FSCD)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children under 18	A confirmed diagnosis is not always required.	Limited but explicit. A child awaiting diagnosis may meet disability-	Children under 18 living in Alberta and meet citizenship/ permanent	Guardian applies online or with Alberta Supports	Family support services, respite, counselling,	No public waitlist/ capacity data; MyHealth	Medical documents and eligibility can be

	Medical documentation must confirm that the child has a disability or is awaiting diagnosis.	documentation requirements; some Family Support Services may begin after eligibility and before the full needs assessment.	residency and guardian criteria	assistance; Medical documentation and proof of citizenship/ residency/ guardianship required	medical costs, disability-related clothing/ footwear, childcare supports, aides, medication/ prescribed diet/ ambulance/ medical supplies, coordination, transition planning	Alberta autism pathway notes families should apply early because of long wait for needs assessment	barriers; Not a direct therapy program and does not replace other programs
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FSCD Specialized Services

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children under 18	Yes; Child diagnosis of severe disability limiting daily living and critical service needs in two or more areas; Diagnosis letters/ reports/ clinical assessments/ progress reports	No; Families must first be FSCD-connected and provide documentation	FSCD approved; Severe disabilities with critical service needs in two or more areas: behaviour, communication/ social skills, physical abilities, cognitive abilities, self-help/ adaptive functioning	Family with FSCD worker; Documentation submitted; FSCD may consult a multidisciplinary team	Coordinated individualized specialized service team; Could include PT, SLP, OT, psychologist, behavioural specialist, aide; Individualized Service Plan	Not found in public source	Eligibility-gated; Requires severe disability, documents, assessment, and absence of other programs to meet needs

Children's Home Care

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Birth to 18 years	Not diagnosis-specific but need for proof in unmet needs	Limited; Eligible based on needs rather than diagnosis alone	Complex physical, medical, or developmental needs requiring support to remain safely at home/ community; transition from hospital to home, acute health needs, long-term health needs, end-of-life support/ care	Health providers consult Alberta Referral Directory; Parental/ client consent, contact Community Care Access/ central intake depending on zone	Case management, health and developmental services/ supports in home/ community; RN, OT, PT, respiratory therapy, SLP, social work, therapy assistants	Not publicly shared online	Eligibility is assessment-based and varies by zone/ intake pathway

Alberta Aids to Daily Living (AADL)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Not child-specific; Albertans with long-term disability, chronic illness, terminal illness	Not diagnosis-only; Eligibility is based on health care needs assessed by AADL and eligible equipment/ supplies	Limited; Based on health and other assessments	Long-term disability, chronic illness, or terminal illness requiring basic medical equipment/ supplies	AADL authorizers determine eligibility and identify products; equipment/ supplies AADL-approved vendors	Funding assistance for basic medical equipment and supplies to support living at home/ community	Not found	Cost-sharing, authorizer access, benefit limits, and vendor availability may create barriers

Inclusive Child Care Program

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
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Available to licensed childcare programs, not directly to children by age	No clear diagnosis requirement; Program framed for children with extra support needs	Potentially; Supports based on extra support needs in childcare, not confirmed diagnosis	Children with extra support needs in licensed childcare settings; Educators/ programs needing capacity-building to include children in childcare with extra support needs	Licensed childcare programs access support through Inclusive Child Care agencies; Families speak directly with provider about inclusion supports	Short-term supports up to 6 months; Consultation, coaching, training, individualized strategies, funding to provide short-term supports, inclusive capacity-building	Depending on childcare program; No central public waitlist/ capacity data	Depends on licensed childcare program participation; Local agency capacity; Child needs childcare placement
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Child Care Affordability Grant / reduced childcare fees

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children up to kindergarten age	No diagnosis requirement	Affordability support is not diagnosis-dependent	Families using eligible licensed daycares, family day homes, and preschool programs	Funding goes directly to eligible licensed providers; Families pay reduced fees to participating providers	Fee reduction/ affordability funding; Flat monthly parent fees for full-time and part-time care in funded programs; Preschool fee reduction	Public reporting on space-creation progress and affordability funding; Not disability-specific waitlist/ capacity data*	Not disability-specific; Families need inclusive childcare space; New for-profit providers ineligible due to funding cap rules

*The Affordability Grant remains subject to funded-space caps under the federal–provincial agreement. As of July 26, 2026, Alberta states that new for-profit and non-profit licensing applicants are not eligible for affordability funding.

Canada–Alberta Canada-Wide Early Learning and Child Care Agreement implementation (CWELCC)*

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
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Children from birth to kindergarten	No diagnosis requirement at agreement level	Not applicable; Not diagnosis-dependent	Families seeking affordable, high-quality childcare; Agreement includes funding to increase equitable/inclusive childcare spaces	Implemented through provincial childcare funding to providers; Families access through licensed childcare programs	Affordability funding, space creation, inclusive/equitable childcare investment, workforce supports	Provincial government reported 57,699 net new spaces as of April 2026; No disability-specific access/waitlist data	Policy-level funding does not guarantee access to inclusive childcare for children with disability-related needs; Availability varies by local supply, inclusion capacity, and provider participation
*Overarching 2021-2026 bilateral agreement was extended to March 31, 2027 between the Government of Canada and the Province of Alberta							

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Table A4: Available Early Childhood Interventions and Development Supports in Ontario (verified July 26, 2026)

SmartStart Hubs							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Birth to age 19 or 21	Families do not need a referral or diagnosis to access SmartStart Hub services	Yes; Designed for families with concerns about child’s development/ day-to-day functioning for	Concerns about development/ day-to-day functioning; Not driven by	Families contact local Children’s Treatment Centre/ SmartStart Hub; Referral	Intake, discussion of family concerns, identification of strengths and functional needs, navigation, connection to	Not found as public waitlist/ capacity data	Service availability after intake depends on local service capacity, eligibility, and wait times for

		help determining next steps	mental health concerns alone	possible through service provider, health care provider, childcare provider, school	assessments and services		downstream services
Infant and Child Development Program (ICDP)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Birth to school entry	No diagnosis requirement	Yes; Access for children with developmental disabilities/ risk of developmental delay	Developmental disability/ risk developmental delay/ developmental concerns	Parents, physicians, community agencies; Families can contact local ICDP program or SmartStart Hub	Home and community-based early intervention, developmental support, parent coaching/ support, service coordination/ referral	Not found as public waitlist/ capacity data; Target to have an average wait time of 90 days or less	Local access and eligibility interpretation may vary by region/ provider
Healthy Babies Healthy Children Program							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Prenatal period through early childhood	No diagnosis requirement	Yes; Not diagnosis-dependent; Not disability-specific	Families who may benefit from screening, targeted assessment, intervention, home visiting, referrals to community resources	Public health pathway; Families connect through hospitals, public health units, primary care, or community referrals depending on local process	Screening, targeted assessment, home visiting, intervention, parenting support, and referrals to community resources	Not found as public waitlist/ capacity data	Broad early-childhood support; Not disability-specific intervention; Access to developmental/ disability services depends on referral and local capacity
Enhanced 18-Month Well-Baby Visit / developmental surveillance							

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Around 18 months of age	No diagnosis requirement	Yes; Intended to identify concerns early and support referral	Developmental, health, behavioural, communication, or social-emotional concerns identified during primary care surveillance	Scheduled with a primary care provider when the child is 18 months old; Parent-completed checklists and physician evaluation tools	Developmental screening/ surveillance, anticipatory guidance, referral to early intervention and child development services	Not found as public waitlist/ capacity data	Depends on having access to primary care and follow-through on referrals
Preschool Speech and Language Program (PSL)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Birth until school transition/ start of school	No formal diagnosis requirement; Children with speech and language disorders; Permanent hearing loss	Yes; Early identification and intervention framing	Speech and language disorders; Permanent hearing loss where language/ communication support need	Families do not need a doctor's referral; Families contact the local preschool speech and language program	Speech-language assessment; Early identification, intervention, parent/ caregiver strategies, school readiness support	Service data collected in Ontario's HCD-ISCIS system*; No public local waitlist/ capacity data	Local wait times and service intensity vary; Children with broader developmental needs need referrals beyond PSL
<i>*Healthy Child Development – Integrated Services for Children Information System (HCD-ISCIS); A centralized, multi-tier electronic case management system used by Ontario's Public Health Units and the Ministry of Children, Community and Social Services</i>							
Infant Hearing Program (IHP)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Newborns/ infants and young	No diagnosis required for initial newborn	Yes; Screening and follow-up assessment	Babies born with permanent hearing loss or	Newborn hearing screening and	Universal screening, diagnostic	IHP assessment statistics	Hearing-specific; Public assessment

children with some services until school transition or age 6	screening; Confirmed permanent hearing loss required for later services	before confirmed diagnosis; Supports available after identification/ confirmation depending on pathway	at risk of developing permanent hearing loss in early childhood	follow-up regional IHP providers; Families referred for diagnostic audiology and early language supports	audiology, communication/ language supports, family support, and referrals	dataset listed, but data under review/ not publicly available	statistics not currently available, limiting transparency on diagnostic access
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Blind-Low Vision Early Intervention Program (BLV)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Birth to school entry	Yes; Child must have blindness, low vision, or visual impairment	No	Blindness, low vision, or visual impairment	Families contact a local Blind-Low Vision program; Referral through health/ vision professionals depending on local process	Home and community-based early intervention, family support, specialized intervention, consultation, and developmental support related to vision	Not found as public waitlist/ capacity data	Condition-specific and diagnosis - gated; Does not address broader developmental needs unless linked to other services

Children's Rehabilitation Services / Children's Treatment Centres and Surrey Place

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children and youth up to age 19	For ages 0-5 no need for confirmed diagnosis to access initial intake, early intervention, or developmental service hubs; Requirements	Depending on service and local intake; SmartStart Hubs may act as a front door for families unsure where to go	Physical disabilities, developmental disabilities, rehabilitation needs, communication, mobility, motor, self-care, feeding,	Delivered by Children's Treatment Centres and Surrey Place in Toronto; Families enter through SmartStart Hubs or local	Occupational therapy, physiotherapy, speech-language pathology, rehabilitation services, assessment, intervention, consultation, and	Not found as public waitlist/ capacity data	Local service availability, eligibility, intensity, and wait times vary; Not a single uniform service across all regions

	vary by specific service for children over 5		participation, and functional needs	intake/ referral pathways	family-centred supports		
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Autism assessment and diagnostic hubs

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children and youth under the age of 18	It is an assessment/ diagnostic pathway; Diagnosis is the purpose of the service	Not an intervention pathway; Assessment can unlock OAP* eligibility	Suspected autism requiring diagnostic assessment	Families may contact a hub, but referral/intake requirements vary. A diagnosis from a qualified professional outside a ministry-funded hub can also support OAP registration.	Autism diagnostic assessment	Ontario's service objectives require hubs to report average wait time and other service data to the ministry. A current consolidated provincial wait-time result was not located in the public sources reviewed on July 26, 2026.	OAP registration requires a written autism diagnosis; assessment delay can therefore defer OAP registration. No unsupported third-party wait-time range is used here.

*Ontario Autism Program (OAP)

Ontario Autism Program (OAP) registration / AccessOAP

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children and youth under the age of 18	Yes; Requires a written diagnosis of autism from a qualified professional	No	Autism spectrum disorder diagnosed by a qualified professional	Families create an AccessOAP account and submit supporting documentation	Intake, registration, care coordination, navigation, and access to OAP service pathways	OAP service-objective pages have limited public child-level waitlist/ capacity data	Diagnosis-gated; Families awaiting assessment/ diagnosis need to use SmartStart

							Hubs, PSL*, rehabilitation, ICDP**, or other services
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**Preschool Speech and Language; **Infant and Child Development Program*

OAP Foundational Family Services

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Families/ caregivers of children/ youth registered in OAP; Child/youth must be under 18 to be registered	Yes, child must be registered in OAP, which requires an autism diagnosis	No	Families/ caregivers of children/ youth on the autism spectrum who are registered in OAP	Access through OAP/ AccessOAP and listed service providers	Family/ caregiver capacity-building, workshops, coaching, information, navigation, and supports	Not found as public waitlist/ capacity data	Families waiting for diagnosis are excluded

OAP Caregiver-Mediated Early Years Programs

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children 12 to 48 months old who are registered in OAP	Yes; Requires OAP registration and confirmed autism diagnosis	No	Young children with autism who are 12–48 months and registered in OAP	Families are connected through OAP/ AccessOAP and invited/ connected to eligible programs	Caregiver-mediated programs to help young children learn new skills and meet individualized goals	Service providers report wait-time/service indicators to the ministry under annual service objectives; no current consolidated provincial result was located in the	Age-specific and diagnosis-gated; Children diagnosed after 48 months miss this early-years pathway

						public sources reviewed.	
OAP Core Clinical Services							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children and youth under age 18 registered in OAP	Yes; Requires OAP registration/ autism diagnosis	No	Children/ youth with autism whose clinical needs include behavioural, speech-language, occupational therapy, or mental health supports	Children are invited to enter core clinical services in the order they registered for OAP	Applied behaviour analysis, speech-language pathology, occupational therapy, mental health supports, and related clinical services	Service providers report wait-time/service indicators to the ministry under annual service objectives; no current consolidated provincial result was located in the public sources reviewed.	Diagnosis-gated and queue-based; Families may register but wait for invitation to core services
OAP Urgent Response Services							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children/ youth under 18 registered in OAP with urgent specified needs	Yes; Requires OAP registration/ autism diagnosis	No	Urgent needs related to autism; Specific eligible behaviours/ risks defined by the program	Families contact their area's urgent response lead organization	Time-limited urgent supports for up to 12 weeks, including interdisciplinary consultation, service navigation, direct family/professional support, and respite where	Service providers report wait-time/service indicators to the ministry under annual service objectives; no current consolidated	Limited to urgent needs and registered OAP families

					eligible; not a 24/7 crisis service.	provincial result was located in the public sources reviewed.	
OAP Entry to School Program							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children registered in OAP who are starting kindergarten	Yes. Requires OAP registration/ autism diagnosis	No	Children with autism entering kindergarten or Grade 1	Families are invited/ connected through OAP	Six-month group-based skill-building program, transition supports, and consultation to support school entry	Service providers report wait-time/service indicators to the ministry under annual service objectives; no current consolidated provincial result was located in the public sources reviewed.	Diagnosis-gated and tied to OAP registration
Special Services at Home (SSAH)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children under the age of 18	Yes; Child must have a developmental and/ or physical disability and need extra support	Not; Application form frames eligibility around disability-related extra support needs	Developmental and/ or physical disability; Extra support needed to participate in daily activities at home and community	Parent/ legal guardian applies to MCCSS* with SSAH application form	Direct funding for supports in or outside the home; Personal development/ growth, participation, and family respite	Not found as public waitlist/ capacity data	Funding is not automatic; Application/ documentation and regional funding availability may be barriers

Assistance for Children with Severe Disabilities (ACSD)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children under the age of 18	Yes; Child must have a severe disability	No	Severe disability resulting in extraordinary care-related costs; Family income is considered	Parent/ guardian applies through MCCSS/ regional office process	Monthly financial assistance, drug/ dental/ vision/ hearing benefits, and help with extraordinary disability-related costs	Not found as public waitlist/ capacity data	Income-tested and severe-disability-gated; Families with moderate but significant needs may not qualify

In- and Out-of-Home Respite Services

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children with special needs up to age 18 who live at home	Child required to have a confirmed physical, developmental, or intellectual disability	Limited; Crisis support and access to respite services without a formal medical diagnosis in cases of risk or harm	Children with special needs who live at home and whose families need respite support	Access varies by region/ service provider; Linked through MCCSS-funded agencies, respite service networks, SSAH/ ACSD-related pathways, or local children's service providers	In-home and out-of-home respite care to provide caregiver relief	Not found as centralized provincial public waitlist/ capacity data	Access is regional and capacity-limited; Respite availability may not match family need, complexity, or location

Out-of-Home Care for Children and Youth with Complex Medical Needs

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)

Children/ youth under the age of 18	Yes; Children/ youth with complex medical needs/ technology- dependent, medically fragile, or requiring specialized care	No	Complex medical needs; Medically fragile or technology- dependent children/ youth who require specialized supports	Access through MCCSS-funded complex special needs/ out-of- home care pathways; Detailed local access process varies	Out-of-family- home care and respite/ supportive care for children/ youth with complex medical needs	No central public waitlist/ capacity data	High-threshold service for complex medical needs; Not a general developmental or disability support
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Coordinated Service Planning (CSP)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children/ youth under the age of 18	No diagnosis required according to CSP target population guidance	Yes; Diagnosis is not required if needs meet the CSP criteria	Multiple and/or complex special needs and service coordination needs	Families connect with a local coordinating agency/ service planning coordinator	Dedicated service planning coordinator, coordinated service plan, cross-provider coordination, family-centred planning	No provincial public waitlist/ capacity data	Important for complex needs without diagnosis, but families need to be identified and connected to coordinating agency

Integrated Pathway for Children and Youth with Extensive Needs (Extensive Needs Integrated Pathway)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children/ youth with extensive/ complex needs	No, a formal diagnosis is not strictly required to access	Yes; If eligibility criteria are met	Unmet needs where family accessed three or more providers/ agencies across different sectors, with complex needs	Pilot pathway through selected providers/ regions/ hubs; Detailed public family-facing eligibility varies	Integrated, multidisciplinary, specialized care coordination and service pathway for extensive needs	Ontario described this as a three-year pilot begun in 2023–24. Continued province-wide availability for 2026–27 was	Pilot and geographically limited; it should not be presented as a province-wide entitlement without current confirmation.

			remaining unmet; Living with multiple co-occurring complexities spanning medical, physical, developmental, and mental health areas			not confirmed in the public sources reviewed; verify current local access.	
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Child and Parent Resource Institute (CPRI): Home Visiting Program for Infants (HVPI) and specialized clinics

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Infants and children up to age 6	Depends on program/ clinic; HVPI is framed around developmental delay/ risk; Specialized clinics have specific clinical criteria	Yes; For HVPI, access is based on having or being at risk of developmental delay; No; For specialized clinics	HVPI: children up to age 6 who have or are at risk of developmental delay in London–Middlesex, Oxford, Elgin, Huron, and Perth counties. Specialized CPRI clinics have program-specific criteria.	CPRI referral/ intake; HVPI has a local referral pathway, while specialized clinics have specific referral criteria	Home visiting, consultation, specialized assessment/ treatment, family education/ resources, and professional learning	Not found as public waitlist/ capacity data	HVPI is regional rather than province-wide; specialized clinics have narrower clinical and referral criteria.

Special Needs Resourcing (SNR) in licensed childcare

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children with special needs in	No formal diagnosis requirement	Yes; SNR is need/ support-	Children whose cognitive, physical, social,	Funding to Consolidated Municipal	Inclusion supports in licensed childcare,	Ontario does not provide a centralized	Long wait securing spot in licensed

licensed childcare and early years settings		based rather than diagnosis-based	emotional, communicative, or overall developmental needs require additional supports in licensed childcare/ early years settings	Service Managers, District Social Services Administration Boards, and First Nations; Families connect to SNR childcare/ service-system manager	including staff support, adaptive equipment, class-wide strategies, professional development, and specialized equipment/ supplies	waitlist or unmet-need data	daycare; Shortage of Early Childhood Educators (ECEs) to operate licensed childcare; SNR Resource Consultant access varies by region
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Childcare fee subsidy / Canada-wide Early Learning and Child Care implementation in Ontario (CWELCC)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children under 6 in participating licensed programs	No diagnosis requirement	Not applicable; Not diagnosis-dependent	Families in licensed childcare who meet local fee subsidy rules; CWELCC applies to eligible participating licensed childcare	Families apply to local service system managers/ municipalities for fee subsidy; CWELCC fee reductions implemented through licensed providers	Childcare affordability support and fee reductions	Ontario publishes annual report data childcare spaces, fees, SNR spending, and children supported; Not comprehensive disability-specific access/ waitlist data	Financial support does not guarantee inclusive childcare space; Access depends on local supply, childcare availability, SNR capacity, and provider willingness/ capacity to include children with support needs

Assistive Devices Program (ADP)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
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Not child-specific; Ontario residents with long-term physical disabilities	Yes; Diagnosis of long-term physical disability and assessment/ authorization for eligible equipment/ supplies	Potentially; If the child meets disability/ equipment criteria	Long-term physical disability requiring customized equipment; Mobility, hearing, communication, visual aids; Respiratory equipment, or other eligible devices	Application through ADP-authorized health care professionals/ vendors depending on device category	Funding assistance for basic, personalized assistive devices and supplies	Not found as public waitlist/ capacity data	Equipment-focused; Requires health card, authorization, eligible device category, and family coordination with providers/ vendors
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Home and Community Care Services

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
People of all ages who require care at home, school, community	Not diagnosis-specific; Eligibility based on assessed need for home/ community care	Potentially; If assessed need exists as determined through an in-home assessment	Need for nursing, personal support, therapy, homemaking, community support, or other home/ community care services	Contact Ontario Health atHome/ home and community care services; Referral through health providers/ hospitals	Nursing, personal support, therapy, community support, school/ community-based supports, and care coordination	Not found as child-specific public waitlist/ capacity data	Not an early intervention program; Availability and eligibility vary by assessed need, region, and service capacity

EarlyON Child and Family Centres

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	Potential access implications (analytic)
Children from birth to age 6 and	No diagnosis requirement	Not diagnosis-dependent	All families with young children; Families seeking child	Families attend local EarlyON programs; No cost	Drop-in programs, play and learning, parent/ caregiver support, child	No disability-specific access data for EarlyON	Broad universal early-years support, not disability-

their parents/ caregivers			development information, parenting support, and connections to services		development information, referrals to community services		specific; Staff may help with referrals, but EarlyON does not replace clinical/ developmental intervention
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Appendix B: Community and Non-Profit Supports for Families

The three tables below identify publicly documented community-based and non-profit resources that families in British Columbia, Alberta, and Ontario may be able to use alongside, or while waiting for, formal early childhood intervention and developmental services. The scan completed in July of 2026 prioritizes resources that a family can approach directly for navigation, peer support, grants, equipment, communication support, respite, crisis care, culturally grounded support, travel accommodation, or pediatric palliative care. Organizations serving a wider age range are included where their services are relevant to families of infants and children aged 0–5.

Scope and coverage notes: These tables complement Appendix A and intentionally exclude government programs already logged there, private fee-only clinics, and organizations without a clearly identifiable family-facing service. They relate an extensive scan of publicly discoverable resources, not a complete census of every local, volunteer-run, time-limited, or condition-specific organization. Program status, geographic coverage, funding, fees, and capacity can change; families should confirm current requirements directly.

Verification notes: Information was checked against current organizational or official directory webpages on July 26, 2026. “No public wait-time data located” means that no current centralized figure was identified in the public sources reviewed; it does not mean that access is immediate or that the organization holds no internal data. The final column provides a plain-language summary of potential practical use and is not an eligibility decision, clinical recommendation, or guarantee of funding.

Table B1: Community and Non-Profit Supports Accessible to Families in British Columbia (verified July 26, 2026)

Family Support Institute of BC (FSI)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes families of infants and young children	No diagnosis required for family support	Yes	BC families supporting a family member with a disability or support need	Family may contact FSI directly; peer support can be requested online or by phone	Free family-to-family peer support, information, systems navigation, workshops, and	Province-wide network; no centralized public response-time or wait-list data located	A first contact when a family needs practical navigation, a knowledgeable parent peer, help understanding systems,

					help locating community resources; Support Worker Central connects families and support workers		or assistance finding and hiring support workers
Inclusion BC							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes childhood and family advocacy	No diagnosis stated for information or advocacy inquiries	Yes	People with intellectual or developmental disabilities and their families; support is provincial and issue-based	Self-contact by telephone, email, or website; local-member organizations may provide additional services	Information, rights-based advocacy, family support, inclusive education resources, and connection to local organizations	No public wait-time data located; individual assistance depends on issue and staff capacity	Understanding rights and inclusive options, preparing for school or service discussions, and finding a local community-living organization
Diverse Family Roots Society							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes early childhood	No diagnosis stated for family connection and navigation	Yes	Families in the Kootenay region supporting a person with a disability or diverse need	Family may contact the society directly	Peer mentoring, family connection, systems navigation, resources, workshops, and advocacy	Regional service; no public wait-time data located	Local peer support and navigation for Kootenay families, particularly where provincial information is difficult to translate into regional options

FamilySmart Parent Peer Support							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Parents and caregivers of children and youth; includes the early years	No diagnosis required	Yes	BC parents and caregivers concerned about a child's mental health, substance use, or wellbeing	Self-contact; virtual and community-based parent peer support options are listed online	Free parent peer support, information, workshops, and help preparing for or navigating service conversations	No centralized public wait-time data located; availability varies by community and format	Support when developmental concerns coexist with behaviour, emotional wellbeing, or family stress, including before a formal diagnosis
211 British Columbia							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages	No diagnosis required	Yes	Anyone seeking community, social, health, or government-service information in BC	Search the online directory or contact 211 by available phone, text, or web channels	Free information and referral to local community services, including disability, food, housing, family, transportation, and crisis-related supports	Public service listings are available; program-level wait times are generally not reported by 211	Finding location-specific services and basic-needs supports that may affect a family's ability to attend assessments or sustain intervention
Variety – the Children's Charity of BC: Individual Grants							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
0–19 years	Yes—health or developmental need must	Sometimes; private autism or psychoeducation	BC or Yukon resident for at least three months with	Parent or guardian applies; professional	Partial funding for equipment, mobility, therapy, counselling,	Published grant limits and application	Filling selected cost gaps after public or insurance options are insufficient, including

	generally be recognized by a qualified professional; program-specific documents and financial information are required	nal assessment is an eligible grant category, subject to criteria	a health card; household income and program-specific criteria apply	documentation and quotes are required	assessments, tutoring, and other approved needs; category maximums apply	rules; no public processing-time data located and funding is not guaranteed	some private assessments, therapies, and equipment
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CKNW Kids' Fund: Individual Grants

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Children and youth; program forms should be checked for current age limits	Needs and circumstances must be supported by a medical, health, social-service, or educational professional	Potentially, depending on the requested item and supporting evidence	Families facing financial barriers whose child has an identified need that fits current funding priorities	Family submits the current individual-grant application with professional support and required financial information	Charitable grants toward health, mobility, developmental, educational, or quality-of-life needs not otherwise fully funded	No public processing-time or acceptance-rate data located; charitable funds and priorities may change	A potential last-resort or gap-funding option when a professional has identified a need, but public funding is unavailable or insufficient

Bear Essentials (Children's Health Foundation of Vancouver Island)

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
0–19 years	Yes—health condition, challenge, or disability confirmation; financial information and a	Potentially, if a professional can document the health-related need	Children living on Vancouver Island or surrounding islands whose families	A health, social-service, or education professional applies or supports the application	Funding for health-related travel and specialized equipment not otherwise covered; lifetime maximum applies	Program posts an initial-contact target of five business days for travel requests and an initial	Travel and equipment costs for Island families who must leave their community for care or cannot obtain an essential item through public coverage

	professional referral are required		demonstrate financial need; program limits apply			equipment response of approximately two to three weeks	
Developmental Disabilities Association: Family Support							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes children and their families	No diagnosis stated for initial information and support; particular programs may require documentation	Yes, for information and navigation	Primarily families in Vancouver and Richmond supporting a person with a developmental disability	Self-contact by phone or email	Information, navigation, advocacy, forms and funding guidance, and family support; multilingual materials are available	Regional service; no public wait-time data located	Help understanding applications, locating services, and navigating local disability and family-support systems
BC Family Hearing Resource Society							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Birth to 5 years is the principal early-intervention focus	Hearing-status documentation or referral is generally relevant for specialized intervention; families may contact the society for information	Yes, for information and family connection	Families of infants and young children who are Deaf or hard of hearing; service availability and funding may depend on provincial early-hearing pathways	Contact the society directly or connect through the BC Early Hearing Program or another professional	Family-centred early intervention, ASL and communication support, Deaf and hard-of-hearing role models, parent support, and information	No centralized public wait-time data located; service locations and formats vary	Exploring communication approaches, meeting other families and Deaf or hard-of-hearing adults, and obtaining specialized early-years guidance

Children's Hearing & Speech Centre of BC							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Early intervention from infancy; preschool programs generally serve ages 3–5	Hearing information is needed for specialized hearing-loss services; some childcare programming is open to hearing children	Families may inquire before all assessments are complete	Children who are Deaf or hard of hearing and their families; specific program and location criteria apply	Family inquiry and intake; professional or provincial-program connections may also be used	Listening and spoken-language intervention, family coaching, preschool and childcare programming, and educational support	No centralized public wait-time data located; fees, funding, and capacity vary by program	Specialized listening and spoken-language support and an inclusive early-learning setting for families choosing that communication approach

BC Hands & Voices							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Primarily families of children who are Deaf or hard of hearing from birth to 5 years	No diagnosis stated for general parent-to-parent connection; the focus is childhood hearing difference	Yes	BC families of children who are Deaf or hard of hearing, regardless of communication approach	Family may join events, contact the organization, or subscribe to information directly	Parent-led peer support, family events, workshops, information, and unbiased support across communication choices	No public wait-time data located; activities are scheduled rather than continuous clinical services	Meeting other families and exploring communication, identity, education, and service options without committing to one communication philosophy

Cerebral Palsy Association of BC: Family Support and Equipment Funding							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Family support	Equipment funding	Family information may	BC families affected by	Self-contact for family support;	Navigation, advocacy, family	Grant cycles and deadlines	Condition-specific navigation and help with

spans ages; equipment grants for minors generally serve 0–18 years	requires cerebral-palsy documentation, membership, professional support, and item information	be accessed before funding documentation is complete	cerebral palsy; grant eligibility, membership, dates, and limits apply	equipment application with medical or allied-health documentation	support, crisis or appeal assistance, and partial equipment funding	are posted; no public processing-time or unmet-demand data located	an equipment cost that remains after public or insurance funding is explored
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Down Syndrome Resource Foundation

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Services begin at birth and continue across the lifespan	Down syndrome is the service focus; documentation requirements vary by service	Information and family connection can begin immediately after birth	People with Down syndrome and their families; program, location, fee, and capacity rules vary	Family contacts the foundation for intake, consultation, or program registration	Family information and community connection plus speech-language, occupational, educational, behavioural, and mental-health services	No centralized public wait-time data located; some services are fee-based and capacity-dependent	Early Down syndrome-specific information, interdisciplinary support, and connecting with a specialized learning community

AutismBC

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes early childhood and pre-assessment families	No diagnosis required for general information, resource-team contact, or many community activities	Yes	Autistic people, people exploring an autism assessment, and their families in BC	Self-contact with the resource team or registration for learning and community activities	Information, navigation, workshops, peer and community connection, and assessment-waiting resources	No public response-time data located; programs and events vary by region and date	Understanding assessment and service options while waiting, locating community resources, and connecting with other autistic people and families

Canuck Place Children's Hospice							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Infants, children, and youth with serious illness; program eligibility is clinical rather than a single age band	Yes—clinical information is required to determine pediatric palliative-care eligibility	Family may inquire or refer when a serious condition is suspected or established; acceptance follows clinical review	BC and Yukon children with life-threatening or life-limiting conditions and their families	Referral may come from family, friends, or the health-care team; clinical review follows	Pediatric palliative care, symptom management, respite, counselling, sibling and bereavement support, and care coordination at no cost	No public referral-to-admission time located; access depends on clinical eligibility, urgency, location, and capacity	Relief, symptom support, care coordination, and family respite when a child has a serious or life-limiting condition
Ronald McDonald House BC & Yukon							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Child under 19 receiving eligible medical care	Hospital confirmation and referral are required; a developmental diagnosis is not required	Not applicable to diagnosis; access is tied to medical treatment	Families generally living at least 50 km outside Metro Vancouver whose child receives care at BC Children's Hospital or another nearby eligible facility	Hospital social worker or other authorized hospital staff submits the referral	Low-cost accommodation, meals and practical family support near pediatric care; hospital Family Rooms offer respite space	Room availability is capacity-dependent; current suggested nightly contribution is posted and inability to pay does not exclude a family	Reducing travel, accommodation, meal, and family-separation burdens when a child must receive specialized care away from home

Rare Disease Foundation: Parent-to-Parent Resource Network							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes parents of infants and young children	No formal diagnosis stated for peer-network participation; rare or undiagnosed conditions are within the organization's scope	Yes	People and families affected by rare disease across Canada, including BC	Self-register or contact the foundation for online peer-network activities	Free virtual peer connection, caregiver discussion, information exchange, and community support	No public wait-time data located; scheduled groups and activities vary	Reducing isolation and learning from other families when a child has a rare, complex, or not-yet-confirmed condition

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Table B2: Community and Non-Profit Supports Accessible to Families in Alberta (verified July 26, 2026)

211 Alberta							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages	No diagnosis required	Yes	Anyone seeking community, social, health, or government-service information in Alberta	Call, text, chat, or search the online directory	Free multilingual information and referral to local services, including disability, family, food, housing, transportation, and crisis supports	Public service listings are available; individual program wait times are generally not reported by 211	Finding local supports and comparing entry points when a family does not know which agency or system to contact first
Gateway Association: Family Resource Centre							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes families of young children	No diagnosis stated for general information and navigation	Yes	Albertans with disabilities and their families or caregivers	Self-contact by phone, email, online booking, or attendance at workshops	Free disability-system navigation, family coaching, workshops, support planning, information, and connection to community resources	No centralized public wait-time data located; individual and group availability varies	Help understanding FSCD and other systems, organizing next steps, preparing applications, and connecting with disability-informed family support

Inclusion Alberta							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes children and families	No diagnosis stated for initial advocacy contact; intellectual disability is the organization's focus	Yes, for advice and family connection	Children and adults with intellectual disabilities and their families across Alberta	Self-contact; regional staff and member organizations may provide local connections	Family advocacy, inclusive education and community-living guidance, workshops, networks, and systems-level assistance	Province-wide organization; no public wait-time data located	Rights-based advice and advocacy when a child encounters exclusion in childcare, school, community life, or disability systems
Caregivers Alberta							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Caregivers of any age; includes parents and kin caring for children	No diagnosis required	Yes	Unpaid caregivers in Alberta	Self-contact through the caregiver support line, programs, groups, or online resources	Caregiver coaching, peer groups, mental-health support, resource navigation, education, and practical tools	No public wait-time data located; some offerings are scheduled or regional	Supporting caregiver wellbeing and decision-making when navigation, unpaid care, or prolonged waiting is becoming overwhelming
Family Resource Networks (community delivery partners)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Prenatal to 18 years; particular programs target	No disability diagnosis required for universal and many targeted	Yes	Alberta children, youth, caregivers, and families; services	Find the local network and contact its community agency; some targeted	Free parenting programs, home visitation, early-childhood-development support, family	Provincial network information is public; local program schedules,	Non-diagnostic early support for parenting, child development, family stress, and connection to local

different ages	family supports		depend on local network and program	services use referral or intake	connection, and referral to community services	capacity, and wait times vary and are not centrally reported	services while disability pathways are pending
Easter Seals Alberta / Children's Link							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Family navigation includes childhood and transition years; equipment applications serve ages 0–18	Navigation may begin without diagnosis; equipment funding requires disability-related professional documentation, quotes, and other funding decisions	Yes, for information and navigation	Alberta families of children with disabilities; equipment applicants must meet age, residency, funding-exhaustion, and item criteria	Self-contact for family support; parent or guardian submits equipment application with required professional documents	Family resource navigation, a service database and workshops, plus partial funding for eligible specialized equipment	Equipment limits and cycles are published; no centralized public navigation-response or equipment-processing time located	Finding services, understanding disability systems, and filling selected equipment gaps after public and insurance options have been tried
Children's Ability Fund							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Children and young adults; current program should be contacted for precise age limits	Yes, for equipment—professional recommendations, quotes, and funding information may be required	Potentially, if functional need can be professionally documented	Alberta children or young adults needing specialized equipment; geographic and funding priorities apply	Family or professional contacts the fund and completes the current application process	Charitable funding and equipment support for mobility, communication, positioning, technology, and related needs	No public processing-time, acceptance-rate, or wait-list data located	An additional equipment-funding avenue when public plans do not cover an item or leave a substantial family contribution

Kids Included (formerly GRIT Program)							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Early childhood; its education and consultation work focuses on young children	Program-specific assessment or eligibility documentation may be required; general resources do not require diagnosis	Families and educators may seek information before diagnosis	Young children with disabilities or developmental support needs, primarily in the Edmonton region; program criteria vary	Family or early-learning program contacts Kids Included; some supports are coordinated through education or funders	Inclusive early-learning support, family-centred early-childhood programming, consultation, professional learning, and practical resources	No centralized public wait-time data located; availability depends on program, funding, and region	Supporting meaningful inclusion in preschool or childcare and helping early educators adapt environments and routines
Connect Society: Family Support Services							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
0–18 years; early-intervention programming has narrower age criteria	No formal referral is required for general family support; hearing-related documentation applies to specialized early intervention	Yes, for family information, ASL learning, and peer support	Alberta families with a child or parent who is Deaf, hard of hearing, or DeafBlind; program and region criteria vary	Family may contact or register directly; specialized early intervention may also receive professional referral	ASL instruction, social-work and navigation support, parent connection, family activities, and hearing-related early intervention	211 Alberta lists no wait for the general family-support service, but specialized program capacity is not centrally reported	Communication access, family ASL learning, parent connection, and navigation for families affected by childhood hearing difference

Cerebral Palsy Alberta							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes children 0–5 and their families	Cerebral palsy or a related disability is the service focus; requirements vary by program	Families may contact the association for information before all documentation is complete	Albertans affected by cerebral palsy or related disabilities	Self-contact or program registration	Peer and family support, advocacy, information, equipment support, recreation, and selected early-intervention services	211 Alberta reports no wait for its general support service; program-specific capacity may vary	Condition-informed peer support and help locating therapy, equipment, recreation, and community options
CP Kids & Families							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Children and youth; includes babies and preschool-aged children	Cerebral palsy or a similar physical disability is the program focus; documentation varies by support	Yes, for family connection and navigation	Calgary-area families of children with cerebral palsy or similar physical disabilities	Self-contact; families register or apply for particular programs	Parent-to-parent and staff support, FSCD navigation, equipment loans, baby groups, recreation, mental-health help, and limited crisis assistance	No centralized public wait-time data located; programs and loan inventory are capacity-dependent	Local practical support after a motor-disability concern or diagnosis, including borrowing equipment and understanding funding systems
PREP Society for Individuals with Down Syndrome: Family Support							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
0–18 years	Down syndrome is the service focus; no	Support may begin after birth without a separate	Families in the Calgary health-region area with a	Parent, school, FSCD, or health professional	Free intake, ongoing family support, referrals, workshops,	211 Alberta lists no waiting period for this service	Early Down syndrome-specific family guidance and hands-on support

	professional referral is required for family support	service-system diagnosis	child who has Down syndrome	may contact the Family Support Liaison; appointment required	parent connection, and FSCD navigation		navigating referrals and FSCD
AdaptAbilities							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Children, youth, and adults; includes early childhood	Disability or support need is relevant; funding-source documentation may be required	Families may inquire before formal funding or diagnostic processes are complete	People with visible or invisible disabilities in the Edmonton area; program and funding criteria vary	Self-contact and intake; families may use FSCD or other funding where eligible	In-home respite, community programs, caregiver relief, skill development, and family support	No centralized public wait-time data located; fees, funding, staffing, and space affect access	Respite and participation support when a family needs immediate caregiver relief or a community option outside clinical intervention
Autism Edmonton							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes families in early assessment and early childhood	No diagnosis stated for general information, peer support, and navigation	Yes	Autistic people, people exploring autism, and families in Edmonton and surrounding areas	Self-contact or registration for programs and support	Information, family navigation, peer support, workshops, social connection, and community resources	No centralized public wait-time data located; programs have schedules and capacity limits	Local navigation and peer connection before or after an autism assessment, without relying solely on clinical services

Autism Calgary							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes early childhood	No diagnosis stated for general family support and information	Yes	Autistic people and their families in Calgary and surrounding communities	Self-contact by telephone, email, or online resources	Family support, information, peer connection, provider and program finding, and navigation of funding and service systems	No public wait-time data located	Local help interpreting service options and funding pathways while waiting for, or following, assessment
Kids Kottage Foundation: Crisis Prevention and Intervention							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Birth to 10 years	No disability diagnosis required	Yes	Edmonton-area families experiencing crisis who need safe temporary care for a child	Parent or caregiver contacts the 24-hour crisis line; intake and safety review apply	Short-term overnight crisis care, family support, referrals, and stabilization	Service operates 24/7, but admission depends on safety, eligibility, and bed capacity; no public occupancy data located	Immediate caregiver relief and child safety during acute family crisis, preventing a missed appointment or service breakdown from escalating
Children's Cottage Society: Crisis Nursery							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Newborn to 9 years	No disability diagnosis required	Yes	Calgary-area parents or legal guardians experiencing crisis; intake	Parent or guardian calls the crisis nursery; care may be arranged for up	Free 24-hour temporary childcare, crisis support, daytime respite, and	Open continuously, but admission depends on current capacity; no	Emergency or planned brief relief when family crisis, illness, appointments, or exhaustion make safe childcare difficult

			and safety criteria apply	to approximately three days	connection to family services	public occupancy or turn-away data located	
Otipemisiwak Métis Government: Flourishing Futures Accessibility Grant							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Métis early learners 0–11 years	Program application and citizenship/residency evidence are required; supporting information for requested services or items may be required	Potentially; eligibility is based on an early learner's accessibility needs rather than a stated requirement for one diagnostic label	Alberta residents where the child or parent/guardian meets current Otipemisiwak Métis Government citizenship criteria; annual program rules apply	Parent or guardian applies through the Children and Family Services program	Funding toward eligible services and supports that address accessibility and developmental needs	Application windows and program rules are posted; no public processing-time or unmet-demand data located	Culturally grounded financial support for Métis families facing costs related to an early learner's disability or accessibility needs
Ronald McDonald House Charities Alberta							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Children generally 18 or younger receiving medical care; high-risk pregnancy programs	Medical-treatment confirmation and hospital referral are required; a developmental diagnosis is not required	Not applicable to diagnosis; access is linked to medical treatment	Out-of-town families meeting the distance and hospital-treatment rules for the Calgary, Edmonton, Medicine	Hospital or health-care-team referral and House intake	Low-cost or no-cost accommodation, meals, family support, and hospital Family Rooms	Room availability is capacity-dependent; current local contribution and distance rules are posted by location	Reducing travel and accommodation burdens when a child must leave home for assessment, surgery, or specialized treatment

also operate			Hat, or Red Deer House				
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Table B3: Community and Non-Profit Supports Accessible to Families in Ontario (verified July 26, 2026)

211 Ontario							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages	No diagnosis required	Yes	Anyone seeking community, social, health, or government-service information in Ontario	Call or text 211, use online chat, email, or search the directory	Free multilingual information and referral to local services, including disability, family, food, housing, transportation, and crisis supports	Helpline operates 24/7; individual program wait times are generally not reported by 211	Finding postal-code-specific services and non-disability supports that can make assessment or intervention attendance more feasible
Ontario Caregiver Organization							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Caregivers of any age; includes parents, guardians, and kin caregivers	No diagnosis required	Yes	Unpaid caregivers in Ontario	Self-contact through the helpline, online resources, peer programs, or caregiver coaching	Free information, navigation, peer support, coaching, webinars, counselling resources, and caregiver wellbeing tools	Helpline availability is public; no centralized wait-time data located for all programs	Caregiver support when unpaid care, coordination, or prolonged service navigation is causing stress or isolation
Community Living Ontario and local member associations							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes early	No diagnosis stated for provincial	Yes, for information and connection	People who have an intellectual	Contact Community Living Ontario	Rights-based advocacy, family information,	Provincial association information is	Locating a community-based developmental-disability organization

childhood and family support	information or advocacy; local service eligibility varies		disability and their families; local agencies set program criteria	or use its member directory to find a local association	inclusive education resources, community connection, and local services through member agencies	public; local program capacity and wait times are not centrally reported	and obtaining advocacy or inclusion guidance beyond government intake systems
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Partners for Planning

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes families planning from early childhood onward	No diagnosis required for public planning resources; some individualized services may have registration or fees	Yes	People with disabilities and their families in Ontario	Self-use of online resources or direct registration for workshops and one-to-one help	Planning tools, webinars, family networks, and guidance on relationships, funding, legal and financial planning, housing, and future support	Many resources are free; individualized-service availability and fees are posted by offering, with no centralized wait-time data	Building a long-term family plan and understanding benefits, wills, trusts, support networks, and community participation before a crisis

Family Alliance Ontario

Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes families of young children	No diagnosis stated for network information; developmental disability is the main focus	Yes	Families supporting a person with a developmental disability in Ontario	Self-contact or connection through an affiliated local family network	Family-led networks, information, advocacy, workshops, and government-program resources	No centralized public wait-time data located; local network activity varies	Connecting with other families who have practical knowledge of local developmental-service and education systems

Extend-A-Family community organizations							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; local programs include children and families	No diagnosis stated for general inquiries; developmental disability or other disability criteria vary by local organization and program	Often yes for information and community connection	Families in communities served by an independent Extend-A-Family organization, including Toronto, Waterloo Region, and Hamilton	Contact the local organization; intake, registration, and funding pathways vary	Relationship-building, community inclusion, family support, respite or host relationships, recreation, and navigation depending on location	No province-wide wait-time data; availability differs substantially among independent local organizations	Developing natural community relationships and inclusive participation rather than relying only on clinical or segregated services
Easter Seals Ontario: Equipment Funding							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Under 19 years	Yes—OHIP, permanent physical-disability information, professional prescription or assessment, quotes, and other funding details are required	Potentially, when the permanent functional need is established before a broader diagnosis is finalized	Ontario residents registered with Easter Seals who meet physical-disability and mobility criteria; annual and item limits apply	Parent or guardian registers and applies before purchasing the item	Partial charitable funding for eligible mobility, accessibility, communication, and daily living equipment	Annual maximum and application rules are public; funds can be exhausted before year-end, and no processing-time data were located	Filling a remaining equipment cost after ADP, insurance, or other funders have been explored

Ontario Federation for Cerebral Palsy: Assistive Devices Funding							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes children	Yes—cerebral-palsy membership and item or professional documentation is required	Generally, no for the main funding stream because cerebral palsy eligibility must be established	Ontario members with cerebral palsy who meet current funding rules	Member applies during the annual funding process with required documents and quotes	Partial funding for equipment and assistive devices; a smaller Life Enriching Activity Fund may also be available	Current grant amounts and cycles are posted; no public processing-time or unmet-demand data located	A condition-specific equipment or participation grant when public coverage leaves a gap
Down Syndrome Association of Ontario and local associations							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes support from birth	No separate referral required for general family information and peer connection; Down syndrome is the focus	Support may begin immediately after birth	People with Down syndrome and their families in Ontario; local association activities vary	Self-contact or use the provincial directory to connect with a local association	New-parent information, peer connection, events, education, advocacy, and links to local services	No province-wide wait-time data; local services and schedules vary	Immediate family connection and condition-specific information after prenatal or postnatal identification of Down syndrome
Autism Ontario							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; includes early childhood	No diagnosis stated for general information and many	Yes	Autistic people, people exploring autism, and	Self-contact with regional staff, service navigators,	Information, navigation, workshops, family events, peer connection,	No centralized public wait-time data located; programs	Understanding Ontario autism and community-service options before or after diagnosis and

	family events; program-specific eligibility varies		families across Ontario	webinars, or local events	French-language resources, and regional service links	have dates, regions, and capacity limits	connecting with regional family supports
SAAAC Autism Centre							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Children, youth, adults, and caregivers; includes early childhood	Autism or related developmental support needs are relevant; documentation varies across free, subsidized, and funded programs	Some caregiver, navigation, and community supports may be accessed before diagnosis	Families able to use SAAAC's locations or virtual offerings; culturally and linguistically diverse communities are a central focus	Self-contact and program intake; Ontario Autism Program funding is used for some services	Culturally responsive caregiver support, navigation, respite, clinical services, life-skills and community programming	No centralized wait-time data located; cost, funding, and capacity differ by program	Culturally responsive navigation and caregiver support, including for families facing language, stigma, or service-system barriers
Kerry's Place Autism Services							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; early-years and caregiver programs are available	Diagnosis and Ontario Autism Program eligibility apply to some funded services; education and caregiver supports vary	Yes, for selected information, caregiver, and First Steps offerings	Autistic people and families in the regions served by Kerry's Place; program-specific criteria, fees, and funding apply	Self-contact, online registration, or intake through the relevant funded program	Caregiver education and groups, navigation, respite, clinical and behavioural services, social and community programs	Program calendars and fees are public; no single organization-wide wait-time figure located	Caregiver learning and regional service navigation while waiting, as well as funded or fee-based support after eligibility is established

VOICE for Deaf and Hard of Hearing Children							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Children and youth; includes the early years	No professional referral stated for parent support or membership; hearing difference is the organization's focus	Yes, for family information and connection	Ontario families of children who are Deaf or hard of hearing	Family contacts VOICE, becomes a member if needed, or joins regional and virtual activities	Parent-to-parent support, mentoring, advocacy, information, workshops, and education focused on listening and spoken language	No public wait-time data located; membership fees and scheduled activities apply	Peer support, school and service advocacy, and listening-and-spoken-language information from other families
Safehaven							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Birth to 18 years for many children's programs	Yes, medical and support information is required for intake; eligibility varies by program and funder	A family may inquire before all funding arrangements are complete, but service acceptance requires assessment	Children with disabilities and medically complex needs in Toronto and surrounding regions; geography and program criteria apply	Family or professional contacts intake; funded respite may require referral or service-system authorization	In-home, residential, and community respite; transitional care; recreation; and caregiver support	No centralized public wait-time data located; access depends on funding, staffing, clinical needs, and available space	Specialized respite or transitional support when a child's medical and personal-care needs exceed what generic childcare can safely provide

Holland Bloorview Family Resource Centre, Family Mentor Program, and Family Support Fund							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Families of children and youth; the fund generally serves clients under 19	Peer and information services do not require a new diagnosis; the fund requires current or recent Holland Bloorview service connection, OHIP-related eligibility, and expense documents	Yes, for public family resources; financial assistance follows client and application criteria	Families connected with Holland Bloorview; program-specific client, age, expense, and annual-limit rules apply	Self-request for resources or mentoring; eligible families submit the support-fund application	Peer mentoring, information, workshops, and limited financial help for equipment, respite, recreation, medication, or related family needs	Fund limits are published; no public response-time or acceptance-rate data located	Peer guidance from another family and limited help with disability-related costs for current or recent Holland Bloorview clients
Emily's House Children's Hospice							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Infants, children, and youth with life-limiting illness	Yes—clinical information and palliative-care eligibility review are required	Family may inquire or be referred when a life-limiting condition is identified; acceptance follows clinical review	Children and families meeting pediatric palliative-care criteria in the service region	Family or health-care professional contacts the hospice and submits referral information	Pediatric hospice care, medical respite, symptom management, end-of-life care, grief and family support	No public referral-to-admission time located; access depends on clinical need and capacity	Respite, symptom support, and family-centred care when a child has a serious life-limiting condition

Ontario Federation of Indigenous Friendship Centres and local Friendship Centres							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
All ages; local family and early-years programs vary	No disability diagnosis required for general community and family programming	Yes	Urban Indigenous children and families in communities served by a Friendship Centre; local program criteria apply	Contact a local Friendship Centre or use the provincial federation to identify the appropriate location	Culturally grounded family support, early-years activities, healing and wellness, advocacy, referrals, and community connection; offerings vary locally	No centralized wait-time data; local program availability and funding vary	A culturally safer community entry point for Indigenous families seeking family, early-years, wellness, or navigation support alongside disability services
Ronald McDonald House Charities programs in Ontario							
Age	Formal diagnosis / documentation required?	Access before formal diagnosis?	Eligibility	Referral pathway	Type of support	Public access / wait-time data	What this resource may be useful for
Children receiving medical treatment; precise maximum age varies by regional House	Hospital treatment confirmation and referral are generally required; a developmental diagnosis is not required	Not applicable to diagnosis; access is tied to treatment away from home	Out-of-town families meeting the distance, treatment, and hospital rules of a regional Ontario House; Family Rooms serve families at participating hospitals	Usually hospital social-worker or care-team referral; regional application and intake rules apply	Low-cost or no-cost accommodation, meals, practical family support, and hospital-based Family Rooms	Space is capacity-dependent; regional fees, distance rules, and referral requirements vary and should be confirmed directly	Reducing travel, accommodation, meal, and family-separation burdens during out-of-community pediatric assessment or treatment

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Appendix C: Legal and Policy Framework for Early Childhood Intervention and Developmental Supports in Canada

This appendix maps some of the international, federal, British Columbia, Alberta and Ontario authorities that are relevant to early childhood intervention and developmental supports, as well as principles of inclusive childcare, disability equality, caregiver accommodations, and support for Indigenous children and families. This appendix was designed as an additional resource for the ADVANCE report 2025-2026 dedicated to research stream 4: Access and Exclusion. This document is not meant to provide a comprehensive legal opinion.

This appendix is not legal advice.

Legal-status notes: The tables below distinguish constitutional and statutory law, jurisprudence, ratified treaties, UN interpretive guidance, policy frameworks, and failed legislation. At the time of writing, Canada does not have one general statute that guarantees every child a particular early intervention program or therapy. Legal questions are complex and depend on the accountability taken by the responsible government or provider, the benefit or service at issue, the governing statute, the protected ground, the evidence of adverse impact, and the available justification and remedy.

Treaty-use notes: Canada's ratification of the United Nations Convention on the Rights of the Child (CRC) in 1991 and the Convention on the Rights of Persons with Disabilities (CRPD) in 2010 creates international obligations, but the treaties are not self-executing domestic statutes. Both conventions can inform interpretation of Canadian law and policy but cannot be cited as though Canada's ratification creates an enforceable entitlement to a specified service, like early childhood intervention and/or developmental supports.

Verification and currency notes: Included links, consolidations, and legislative or procedural status were checked against publicly available primary or authoritative sources in July, 2026. It is expected that legislation and ongoing litigation change some of the information in this document. Use of this appendix as a resource requires people to recheck any authority used for an updated legal conclusion, especially when considering Jordan's Principle orders, implementing regulations, bilateral funding agreements, and provisions shown as 'not in force'.

Terminology and scope notes: "Early childhood intervention and developmental supports" was used descriptively across multiple systems. However, these interventions and supports do not have one single term or legal definition that is uniformly used across

Canada. Childcare, health, education, child and family services, disability programs, and Indigenous services can each use different statutory language and eligibility rules.

Analytical notes: The instruments summarized in this appendix do not have equivalent legal force and can present legal complexity when assessed for substantive access to rights. The instruments summarized in this appendix occupy different positions within the Canadian legal order. The Constitution is the supreme law of Canada, whereas the Supreme Court of Canada characterized federal, provincial, and territorial human-rights statutes as quasi-constitutional legislation (*Constitution Act, 1982*, s. 52(1); *B. v. Ontario (Human Rights Commission)*, 2002 SCC 66).¹³ While statutes and valid regulations are legally binding, regulations derive their authority from powers delegated through an enabling statute (Department of Justice Canada, n.d.).¹⁴ Ministry policies, program guidelines, and funding criteria do not constitute a single category of law: they may influence administrative decisions and determine access in practice, but their legal effect depends on their wording, statutory authorization, incorporation into another binding instrument, and application by decision-makers (Daly, 2023).¹⁵ Professional standards similarly operate within statutory and disciplinary frameworks established for each regulated profession; their authority depends on the applicable legislation, regulations, bylaws, and regulatory processes rather than on their designation as standards alone (Ellaway & Orkin, 2024).¹⁶ Intergovernmental agreements also vary in legal effect. Some are political arrangements without the force of law, whereas others create binding obligations between governments. However, neither automatically creates an individually enforceable entitlement for a child or family (*Reference re Pan-Canadian Securities Regulation*, 2018 SCC 48; *Canada (Attorney General) v. British Columbia Investment Management Corp.*, 2019 SCC 63).¹⁷

These distinctions affect both accountability and the availability of a remedy. A shortage of service capacity does not necessarily constitute a discrete administrative decision that can be appealed. By contrast, a refusal of eligibility may be subject to reconsideration,

¹³ *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c. 11, s. 52(1). <https://www.justice.gc.ca/eng/cs/sj/rfc-dlc/ccrf-cddl/check/art521.html>; *B. v. Ontario (Human Rights Commission)*, 2002 SCC 66, [2002] 3 S.C.R. 403. <https://decisions.scc-csc.ca/scc-csc/scc-csc/en/item/2008/index.do>

¹⁴ Department of Justice Canada. (n.d.). *How new laws and regulations are created*. Government of Canada. <https://www.justice.gc.ca/eng/laws-lois/index.html>; An enabling statute refers to a law/act passed by a legislature that gives power and legal authority to a government agency, official, or lower body to do things as a delegation.

¹⁵ Daly, P. (2023). How binding are binding guidelines? An analytical framework. *Canadian Public Administration*, 66(2), 211–229. <https://doi.org/10.1111/capa.12519>

¹⁶ Ellaway, R. H., & Orkin, A. M. (2024). Standards and accountabilities for professional resistance. *Canadian Medical Education Journal*, 15(4), 134–135. <https://doi.org/10.36834/cmej.79395>

¹⁷ *Reference re Pan-Canadian Securities Regulation*, 2018 SCC 48, [2018] 3 S.C.R. 189. <https://decisions.scc-csc.ca/scc-csc/scc-csc/en/item/17355/index.do>; *Canada (Attorney General) v. British Columbia Investment Management Corp.*, 2019 SCC 63. <https://decisions.scc-csc.ca/scc-csc/scc-csc/en/item/18075/index.do>;

a statutory appeal, or judicial review, depending on the governing legislation and program structure (*Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65).¹⁸ An allegation of discrimination could fall within a federal, provincial, or territorial human-rights process as the appropriate complaint body, depending on the responsible organization and area of jurisdiction (Department of Canadian Heritage, 2024).¹⁹ Canadian research demonstrates that barriers arise both along families' navigation pathways and across ministries, creating a complex and intersectoral service environment (Basualto et al., 2026).²⁰ Canadian disability-law scholarship documents persistent procedural and substantive barriers between the formal recognition of disability rights and meaningful access to disability justice (e.g., Sheldon et al., 2024).²¹ Canadian public-administration research cautions that governments can transfer burdens of complex administrative systems onto potential program users, while a lack of transparency can make political and administrative responsibility difficult to locate (Robson, 2024).²²

Consequently, research on services for children with neurodisabilities finds that families are often left to locate information and coordinate supports across systems, where caregivers describe these responsibilities as burdensome and overwhelming (Gardiner et al., 2022).²³ The scoping review by Gardiner et al. (2022) also found that inconsistent terminology for navigation and coordination roles can make it difficult for families to determine which professional or service is appropriate (p. 13). Recent research by Basualto et al. (2026) in British Columbia similarly identified barriers in navigating across ministries and throughout service-navigation pathways. The authors describe a complex service-delivery environment that impedes equitable access (p. 14). Navigation difficulties become consequential when families must determine if a child qualifies for assistance, which organization is responsible, or where service eligibility decisions can be appealed or reviewed. Canadian public-administration scholarship cautions that governments can transfer

¹⁸ *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, [2019] 4 S.C.R. 653. <https://decisions.scc-csc.ca/scc-csc/scc-csc/en/item/18078/index.do>

¹⁹ Department of Canadian Heritage. (2024, August 8). *About human rights complaints*. Government of Canada. <https://www.canada.ca/en/canadian-heritage/services/human-rights-complaints/about.html>

²⁰ Basualto, P., Senevirathna, A. M., Seth, A., Dimitropoulos, G., & Zwicker, J. (2026). Improving equitable access to disability services and support for children with neurodevelopmental disabilities: Service provider and decision-maker perspectives. *Child: Care, Health and Development*, 52(1), Article e70213. <https://doi.org/10.1111/cch.70213>

²¹ Sheldon, C. T., Spector, K. R., & Dhand, R. (2024). From rights to justice: Perspectives on access to disability justice in *British Columbia (Attorney General) v. Council of Canadians with Disabilities*. *The Supreme Court Law Review: Osgoode's Annual Constitutional Cases Conference*, 115. <https://doi.org/10.60082/2563-8505.1445>

²² Robson, J. (2024). State capacity and administrative burdens on citizens: Time for export controls and transparency. *Canadian Public Administration*, 67(4), 598–608. <https://doi.org/10.1111/capa.12584>

²³ Gardiner, E., Wong, V., Lin, G., & Miller, A. R. (2022). Terminology and descriptions of navigation and related practices for children with neurodisability and their families: A scoping review. *BMC Health Services Research*, 22, 1–16. <https://doi.org/10.1186/s12913-022-07617-y>

internally generated procedural and administrative burdens to program users and argues for greater transparency and governmental responsibility (Robson, 2024, p. 598). This transfer requires families caring for infants and young children to independently acquire and apply specialized knowledge of law, public administration, program eligibility, and jurisdictional arrangements. The recommendations section in the main report addresses this as an unduly burdensome effect of exporting specialist knowledge and navigation onto families. The eight tables that follow (Tables C1 to C8) can be read as a map of relevant legal and policy instruments and as an illustration of the navigation and accountability work that fragmented systems can transfer to families.

Table C1: International human-rights instruments and interpretive guidance

International human-rights instruments and interpretive guidance — verified July 26, 2026				
Authority / source	Legal status and jurisdiction	What the authority establishes	Relevance to early childhood intervention and developmental supports	Limits, cautions, or current-status note
Convention on the Rights of the Child, 20 November 1989, 1577 UNTS 3 (CRC), arts 2, 3, 5, 12, 18, 23, 24, 28 and 31	Binding international treaty for Canada; not automatically a freestanding domestic cause of action.	Protects non-discrimination and best interests; recognizes disabled children's rights; requires appropriate assistance to parents and legal guardians; and addresses health, education, participation and play.	Supports a child-rights and family-support lens, including attention to participation, development and assistance to caregivers.	The CRC does not itself prescribe a particular Canadian program, therapy, eligibility rule or waiting-time standard. Domestic effect depends on implementation and may also arise through interpretation of Canadian law.
UN Committee on the Rights of the Child, General Comment No 7 (2005): Implementing child rights in early childhood, UN Doc CRC/C/GC/7/Rev.1 (20 September 2006)	Authoritative treaty-body interpretation; not treaty text or directly binding Canadian legislation.	Explains that young children are rights-holders and that early childhood is a critical period for realizing CRC rights; emphasizes evolving capacities, family support, non-discrimination and coordinated services.	Supports analysis of how timing, family environments and service systems affect substantive enjoyment of rights in the early years.	General comments guide interpretation but do not create an individualized entitlement to a specified Canadian intervention.
UN Committee on the Rights of the Child, General Comment No 9 (2006): The rights of children with disabilities, UN Doc	Authoritative treaty-body interpretation; not treaty text or directly binding	Applies the CRC to children with disabilities and addresses non-discrimination, family support, early identification, services, education, participation and data.	Provides disability-specific interpretive support for coordinated, accessible, and family-supportive early-years systems.	Its recommendations are not a Canadian statutory service schedule and must be used with applicable domestic law.

CRC/C/GC/9 (27 February 2007)	Canadian legislation.			
Convention on the Rights of Persons with Disabilities, 13 December 2006, 2515 UNTS 3 (CRPD), arts 7, 9, 19, 23(3), 24, 25 and 26	Binding international treaty for Canada; not automatically a freestanding domestic cause of action.	Protects the equal enjoyment of rights by children with disabilities; addresses accessibility, community inclusion, family life, education, health and habilitation. Article 23(3) calls for early and comprehensive information, services and support for children with disabilities and their families.	Strong international basis for treating barriers, family support, accessibility and habilitation as rights questions rather than solely clinical matters.	The CRPD does not guarantee a particular therapy or override Canadian jurisdictional and remedial rules. “Habilitation and rehabilitation” should not be equated with normalization.
United Nations Declaration on the Rights of Indigenous Peoples, UNGA Res 61/295 (13 September 2007) (UNDRIP)	UN declaration; its Canadian legal significance is shaped by constitutional law and federal/provincial implementation legislation.	Affirms self-determination, culture, language, equality, participation in decisions, and rights concerning health, education, children and persons with disabilities.	Supports Indigenous-led, culturally grounded early-years services and scrutiny of colonial or jurisdictionally fragmented systems.	UNDRIP is not a treaty. Specific legal consequences require attention to the federal UNDRIP Act, BC’s Declaration Act, section 35 of the Constitution Act, 1982, and the facts.

Source note. Hyperlinked citations lead to official legislation, official government or UN material, CanLII, or a full-text tribunal document. Short descriptions are analytic summaries, not substitutes for the complete authority.

Sources for Table C1

Convention on the Rights of the Child, November 20, 1989, 1577 U.N.T.S. 3. <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child>

United Nations Committee on the Rights of the Child. (2006). *General comment No. 7 (2005): Implementing child rights in early childhood* (CRC/C/GC/7/Rev.1). https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?Lang=en&symbolno=CRC%2FC%2FGC%2F7%2FRev.1

United Nations Committee on the Rights of the Child. (2007). *General comment No. 9 (2006): The rights of children with disabilities* (CRC/C/GC/9). https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?Lang=en&symbolno=CRC%2FC%2FGC%2F9

Convention on the Rights of Persons with Disabilities, December 13, 2006, 2515 U.N.T.S. 3. <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities>

United Nations General Assembly. (2007). *United Nations Declaration on the Rights of Indigenous Peoples* (A/RES/61/295). <https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html>

Table C2: Federal constitutional, human-rights, accessibility and early-years framework

Federal constitutional, human-rights, accessibility and early-years framework — verified July 26, 2026				
Authority / source	Legal status and jurisdiction	What the authority establishes	Relevance to early childhood intervention and developmental supports	Limits, cautions, or current-status note
<u>Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, ss 15 and 32</u>	Constitutional law; applies to Parliament and government and, under the jurisprudence, to governmental action.	Section 15 guarantees equal protection and equal benefit of the law without discrimination, including on the ground of mental or physical disability.	Supports substantive-equality analysis of government laws, benefits and delivery arrangements, including adverse effects and the need for effective access.	The Charter does not apply to every private provider. Section 15 does not create a general right to a chosen therapy or every beneficial service; the impugned law, benefit and government connection matter.
<u>Canadian Human Rights Act, RSC 1985, c H-6</u>	Federal statute; applies within federal jurisdiction.	Prohibits discriminatory practices on listed grounds including disability and family status in federally regulated services and employment.	May be relevant to federal departments, agencies or federally regulated entities and underpins the Caring Society/Jordan's Principle proceeding.	It is not the human-rights statute for ordinary provincially regulated health, child-care or social services. A complaint remains fact-, respondent- and service-specific.
<u>Accessible Canada Act, SC 2019, c 10</u>	Federal accessibility statute; applies to federal entities and federally regulated sectors.	Creates a framework to identify, remove and prevent accessibility barriers through planning, reporting, standards and enforcement mechanisms.	Useful for barrier-removal and accountability principles where the responsible entity is within federal jurisdiction.	It does not govern most provincially delivered early childhood intervention and does not itself confer an individualized entitlement to a particular service.
<u>Canada Early Learning and Child Care Act, SC 2024, c 2, ss 5–8 and 16</u>	Federal statute governing federal vision, funding principles and accountability for	Requires federal investments to be guided by accessibility, affordability, inclusiveness and quality; expressly includes children with disabilities and	A current statutory anchor for inclusion, equity and reporting in childcare, including progress on availability,	It is a funding-and-governance statute, not a comprehensive early-intervention statute or a direct guarantee of a space, assessment or therapy. Some

	Canada-wide early learning and childcare.	rural and remote communities; commits to long-term funding primarily through agreements.	accessibility and inclusiveness.	National Advisory Council provisions are shown as not in force in the current consolidation.
United Nations Declaration on the Rights of Indigenous Peoples Act, SC 2021, c 14	Federal implementation statute.	Affirms UNDRIP's application in Canadian law and requires consultation and cooperation on measures to make federal laws consistent with the Declaration, an action plan and annual reporting.	Relevant to federal early-years and disability policy affecting Indigenous peoples and to analysis of self-determination and culturally grounded services.	The Act does not itself specify an individual early-intervention benefit; it does not replace section 35 analysis or applicable Indigenous law.
An Act respecting First Nations, Inuit and Métis children, youth and families, SC 2019, c 24; Reference re An Act respecting First Nations, Inuit and Métis children, youth and families, 2024 SCC 5	Federal statute upheld as constitutionally valid in 2024 SCC 5; addresses Indigenous child and family services.	Affirms Indigenous jurisdiction and establishes national principles/standards concerning best interests, cultural continuity and substantive equality in Indigenous child and family services.	Relevant where developmental supports intersect with child and family services, cultural continuity, prevention and Indigenous jurisdiction.	It is not a general statute governing all early childhood intervention. Application depends on whether the matter is a child and family service within the Act.

Source note. Hyperlinked citations lead to official legislation, official government or UN material, CanLII, or a full-text tribunal document. Short descriptions are analytic summaries, not substitutes for the complete authority.

Sources for Table C2:

Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11. <https://laws-lois.justice.gc.ca/eng/const/page-12.html>

Canadian Human Rights Act, RSC 1985, c H-6. <https://laws-lois.justice.gc.ca/eng/acts/h-6/>

Accessible Canada Act, SC 2019, c 10. <https://laws-lois.justice.gc.ca/eng/acts/a-0.6/>

Canada Early Learning and Child Care Act, SC 2024, c 2. <https://laws-lois.justice.gc.ca/eng/acts/C-3.55/FullText.html>

United Nations Declaration on the Rights of Indigenous Peoples Act, SC 2021, c 14. <https://laws-lois.justice.gc.ca/eng/acts/u-2.2/>

An Act respecting First Nations, Inuit and Métis children, youth and families, SC 2019, c 24. <https://laws-lois.justice.gc.ca/eng/acts/F-11.73/>

Reference re An Act respecting First Nations, Inuit and Métis children, youth and families, 2024 SCC 5.

<https://www.canlii.org/en/ca/scc/doc/2024/2024scc5/2024scc5.html>

Table C3: Jordan's Principle and First Nations child and family services: selected legal milestones

Jordan's Principle and First Nations child and family services: selected legal milestones — verified July 26, 2026				
Authority / source	Legal status and jurisdiction	What the authority establishes	Relevance to early childhood intervention and developmental supports	Limits, cautions, or current-status note
<u>First Nations Child & Family Caring Society of Canada et al v Attorney General of Canada, 2016 CHRT 2</u>	Canadian Human Rights Tribunal merits decision under the Canadian Human Rights Act.	Found discrimination in Canada's provision/funding of First Nations child and family services and in its narrow implementation of Jordan's Principle; ordered Canada to cease the discriminatory practice and reform the system.	Foundational authority linking delay, underfunding and jurisdictional approaches to legally recognized discrimination against First Nations children and families.	The case concerns federal services for First Nations children; it is not a general entitlement for every child in Canada.
<u>First Nations Child & Family Caring Society of Canada et al v Attorney General of Canada, 2016 CHRT 10</u>	CHRT remedial/implement ruling.	Required a broader, child-first approach to Jordan's Principle, not confined to jurisdictional disputes between governments or to children with multiple disabilities.	Supports timely access based on the child's needs rather than permitting jurisdictional disputes to delay service.	Must be read with later clarification, eligibility and compliance orders.
<u>First Nations Child & Family Caring Society of Canada et al v Attorney General of Canada, 2017 CHRT 14 and 2017 CHRT 35</u>	CHRT remedial and clarification rulings.	Further specified child-first implementation, substantive equality and the scope of Jordan's Principle, including First Nations children on and off reserve.	Directly relevant to delays, gaps and needs-based access to health, social and educational products, services and supports.	Eligibility and processes have evolved through subsequent orders and current federal guidance; use current operational criteria for individual cases.
<u>First Nations Child & Family Caring Society of Canada et al v Attorney General of Canada, 2019 CHRT 39</u>	CHRT compensation ruling.	Ordered compensation for specified First Nations children and caregivers affected by discriminatory practices, subject to later proceedings and implementation.	Demonstrates that discriminatory delay, denial and removal can produce compensable harm.	Compensation implementation was subsequently addressed through litigation and a class-action settlement; this ruling should not be summarized as the entire current compensation scheme.
<u>First Nations Child & Family Caring Society of Canada et al v Attorney General of</u>	CHRT eligibility rulings.	Addressed categories of First Nations children eligible under Jordan's Principle and related implementation questions.	Important for understanding that identity/eligibility rules themselves can determine whether timely supports are available.	For a current individual request, consult the operative orders and Indigenous Services Canada's current

<u>Canada, 2020 CHRT 20 and 2020 CHRT 36</u>				eligibility guidance rather than relying on a short summary.
<u>Canada (Attorney General) v First Nations Child and Family Caring Society of Canada, 2021 FC 969</u>	Federal Court judicial-review decision.	Dismissed Canada's applications challenging the CHRT compensation and eligibility decisions, while recognizing the complexity and ongoing nature of the remedial process.	Confirms that the challenged CHRT orders survived this judicial review.	Subsequent settlement and remedial developments must also be consulted; the decision does not freeze Jordan's Principle law or administration as of 2021.
<u>First Nations Child & Family Caring Society of Canada et al v Attorney General of Canada, 2025 CHRT 6</u>	Recent CHRT compliance/remedial ruling.	Addressed backlogs, urgent requests, payment delays and compliance in Jordan's Principle administration, including risks of hardship and interruption after approval.	Current authority that delay can persist at multiple administrative stages and that approval alone is not necessarily substantive access.	The ruling is part of continuing supervision. Current orders, service standards and any judicial-review developments should be checked before stating present obligations.
<u>First Nations Child & Family Caring Society of Canada et al v Attorney General of Canada, 2025 CHRT 80</u>	CHRT ruling in ongoing long-term-reform proceedings.	Directed the parties to move forward on national First Nations child and family services long-term reform outside Ontario through specified consultation, planning and reporting steps.	Shows that the remedial phase remains active and that national reform outside Ontario is proceeding separately from the Ontario process.	The ruling is subject to ongoing proceedings and reported judicial-review activity. Later orders and court developments should be checked before stating current obligations.
<u>CHRT letter-decision approving the Ontario Final Agreement (30 March 2026; reasons stated to follow)</u>	CHRT letter-decision in ongoing long-term-reform proceedings; no published neutral citation or reasons located by the verification date.	Approved the Ontario Final Agreement on long-term reform of First Nations child and family services in Ontario, with written reasons stated to follow.	Confirms that Ontario's long-term-reform process had reached an approval stage distinct from the national process outside Ontario.	Do not cite the letter as though it were a fully reasoned final judgment. Verify whether reasons, a neutral citation, implementation orders or judicial-review proceedings have since been issued.

Source note. Hyperlinked citations lead to official legislation, official government or UN material, CanLII, or a full-text tribunal document. Short descriptions are analytic summaries, not substitutes for the complete authority.

Sources for Table C3

First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada, 2016 CHRT 2.
https://fncaringsociety.com/sites/default/files/2016_chrt_2_access_0.pdf

First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada, 2016 CHRT 10.
https://fncaringsociety.com/sites/default/files/2016_chrt_10.pdf

First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada, 2017 CHRT 14.
<https://www.canlii.org/en/ca/chrt/doc/2017/2017chrt14/2017chrt14.html>

First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada, 2017 CHRT 35.
<https://www.canlii.org/en/ca/chrt/doc/2017/2017chrt35/2017chrt35.html>

First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada, 2019 CHRT 39.
https://fncaringsociety.com/sites/default/files/2019_chrt_39.pdf

First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada, 2020 CHRT 20.
<https://www.canlii.org/en/ca/chrt/doc/2020/2020chrt20/2020chrt20.html>

First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada, 2020 CHRT 36.
<https://www.canlii.org/en/ca/chrt/doc/2020/2020chrt36/2020chrt36.html>

Canada (Attorney General) v. First Nations Child and Family Caring Society of Canada, 2021 FC 969.
<https://www.canlii.org/en/ca/fct/doc/2021/2021fc969/2021fc969.html>

First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada, 2025 CHRT 6.
https://fncaringsociety.com/sites/default/files/2025-01/2025%20CHRT%206%20-%20Full%20reasons%20Jordan%27s%20Principle%20on%20motions-T1340_7008.pdf

First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada, 2025 CHRT 80.
https://fncaringsociety.com/sites/default/files/2025-08/2025%20CHRT%2080%20-%20Ruling%20on%20long-term%20reform-FNCF CSC%20and%20AFN%20v%20AGC_T1340%5B44%5D.pdf

Canadian Human Rights Tribunal. (2026, March 30). *Letter decision approving the Ontario Final Agreement in First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada* (Tribunal File T1340/7008).
https://fncaringsociety.com/sites/default/files/2026-03/2026-03-30%20Letter%20decision%20reasons%20to%20follow-Ontario%20Final%20Agreement-FNCF CSC%20and%20AFN%20v%20AGC_T1340.pdf

Table C4: Selected Canadian jurisprudence: principles, applications and limits

Selected Canadian jurisprudence: principles, applications and limits — verified July 26, 2026				
Authority / source	Legal status and jurisdiction	What the authority establishes	Relevance to early childhood intervention and developmental supports	Limits, cautions, or current-status note
<u>Baker v Canada (Minister of Citizenship and Immigration), [1999] 2 SCR 817, 1999 CanLII 699 (SCC)</u>	Supreme Court of Canada; administrative-law and international-law interpretation.	Explains that unimplemented international instruments do not have direct application, but international human-rights values may inform statutory interpretation and administrative-law analysis.	Supports careful use of the CRC/CRPD as interpretive context rather than describing them as self-executing Canadian service entitlements.	The precise interpretive weight is context-dependent; treaty provisions cannot displace clear Canadian legislation merely by citation.
<u>Eldridge v British Columbia (Attorney General), [1997] 3 SCR 624, 1997 CanLII 327 (SCC)</u>	Supreme Court of Canada; Charter section 15.	Held that failure to fund sign-language interpretation in publicly funded medical services violated equality rights; meaningful access may require positive accommodation measures.	Strong authority that formal availability is insufficient where disability-related barriers prevent effective access to a public benefit.	It does not establish a universal right to every health or developmental service; government action, the benefit and the accommodation at issue must be identified.
<u>Eaton v Brant County Board of Education, [1997] 1 SCR 241, 1997 CanLII 366 (SCC)</u>	Supreme Court of Canada; education and equality.	Emphasized individualized assessment and the child's best interests; integration is not an irrebuttable presumption in every case.	Supports individualized, child-centred decision-making and caution against one-size-fits-all placement rules.	School-placement case; it does not create a preschool intervention entitlement and should not be used to justify segregation without rigorous individualized analysis.
<u>Auton (Guardian ad litem of) v British Columbia (Attorney General), [2004] 3 SCR 657, 2004 SCC 78</u>	Supreme Court of Canada; Charter section 15.	Rejected a claim that section 15 required public funding of the specific ABA/IBI treatment then sought because the claimed benefit was not one provided by law.	A central limit on arguments that equality law automatically compels funding of a chosen or emerging therapy.	Autism-specific and decided on the benefit claimed and evidentiary/legal record. It should not be generalized to defeat all accommodation or meaningful-access claims.
<u>Wynberg v Ontario, 2006 CanLII 22919 (ON CA), 82 OR (3d) 561</u>	Ontario Court of Appeal; Charter challenge involving an autism early-intervention program.	The Court of Appeal rejected challenges to the program's age-six cut-off and related education arrangements.	Directly relevant to age-based early-intervention windows and the legal difficulty of challenging program design.	Autism- and program-specific. The decision does not establish that age cut-offs are always equitable, evidence-based or immune from human-rights review.

<u>Moore v British Columbia (Education), [2012] 3 SCR 360, 2012 SCC 61</u>	Supreme Court of Canada; provincial human-rights law.	Held that adequate special education is how students with learning disabilities obtain meaningful access to the general education service; confirmed the ordinary prima facie discrimination test.	Supports analysis of substantive rather than merely formal access and is relevant when children transition into education systems.	School-education case, not a general early-intervention entitlement. The relevant service must be correctly identified.
<u>Health Sciences Assn of British Columbia v Campbell River and North Island Transition Society, 2004 BCCA 260</u>	BC Court of Appeal; family-status discrimination in employment.	Recognized family-status discrimination where an employer-imposed change seriously interfered with a substantial parental obligation involving a child with significant needs.	Illustrates that disability-related caregiving can have legal significance and may require workplace accommodation.	Employment case; it does not create a right to a public service. The BC test was later clarified in Gibraltar Mines.
<u>Canada (Attorney General) v Johnstone, 2014 FCA 110; Canadian National Railway Co v Seeley, 2014 FCA 111</u>	Federal Court of Appeal; family-status discrimination in federally regulated employment.	Recognized that substantial childcare obligations can fall within family status and engage accommodation under the Canadian Human Rights Act.	Supports recognition that inflexible work rules may conflict with genuine caregiving duties.	Employment cases with a specific federal test; they do not create early-intervention service entitlements or a general preference-based scheduling right.
<u>Misetich v Value Village Stores Inc., 2016 HRTO 1229</u>	Human Rights Tribunal of Ontario; family-status discrimination in employment.	Rejected a special, more restrictive family-status test and applied ordinary discrimination principles.	Relevant to Ontario caregiver-accommodation analysis and to avoiding assumptions that caregiving claims are categorically weaker than other discrimination claims.	Tribunal-level employment decision; service claims and other jurisdictions may be analyzed differently.
<u>British Columbia (Human Rights Tribunal) v Gibraltar Mines Ltd, 2023 BCCA 168</u>	BC Court of Appeal; family-status discrimination in employment.	Clarified that an employer need not have changed a term or condition before family-status discrimination can be established; applied the ordinary Moore framework.	Current BC authority supporting legal recognition of caregiving barriers without an artificial “employer-caused change” threshold.	Still an employment case. It does not determine whether a particular child-development service must be funded or provided.

Source note. Hyperlinked citations lead to official legislation, official government or UN material, CanLII, or a full-text tribunal document. Short descriptions are analytic summaries, not substitutes for the complete authority.

Sources for Table C4:

Baker v. Canada (Minister of Citizenship and Immigration), [1999] 2 SCR 817, 1999 CanLII 699 (SCC).

<https://www.canlii.org/en/ca/scc/doc/1999/1999canlii699/1999canlii699.html>

Eldridge v. British Columbia (Attorney General), [1997] 3 SCR 624, 1997 CanLII 327 (SCC).

<https://www.canlii.org/en/ca/scc/doc/1997/1997canlii327/1997canlii327.html>

Eaton v. Brant County Board of Education, [1997] 1 SCR 241, 1997 CanLII 366 (SCC).

<https://www.canlii.org/en/ca/scc/doc/1997/1997canlii366/1997canlii366.html>

Auton (Guardian ad litem of) v. British Columbia (Attorney General), [2004] 3 SCR 657, 2004 SCC 78.

<https://www.canlii.org/en/ca/scc/doc/2004/2004scc78/2004scc78.html>

Wynberg v. Ontario, 2006 CanLII 22919 (ON CA), 82 OR (3d) 561.

<https://www.canlii.org/en/on/onca/doc/2006/2006canlii22919/2006canlii22919.html>

Moore v. British Columbia (Education), [2012] 3 SCR 360, 2012 SCC 61.

<https://www.canlii.org/en/ca/scc/doc/2012/2012scc61/2012scc61.html>

Health Sciences Association of British Columbia v. Campbell River and North Island Transition Society, 2004 BCCA 260.

<https://www.canlii.org/en/bc/bcca/doc/2004/2004bccca260/2004bccca260.html>

Canada (Attorney General) v. Johnstone, 2014 FCA 110. <https://www.canlii.org/en/ca/fca/doc/2014/2014fca110/2014fca110.html>

Canadian National Railway Company v. Seeley, 2014 FCA 111. <https://www.canlii.org/en/ca/fca/doc/2014/2014fca111/2014fca111.html>

Misetich v. Value Village Stores Inc., 2016 HRTO 1229. <https://www.canlii.org/en/on/onhrt/doc/2016/2016hrto1229/2016hrto1229.html>

British Columbia (Human Rights Tribunal) v. Gibraltar Mines Ltd., 2023 BCCA 168.

<https://www.canlii.org/en/bc/bcca/doc/2023/2023bccca168/2023bccca168.html>

Table C5: British Columbia: principal legal framework

British Columbia: principal legal framework — verified July 26, 2026				
Authority / source	Legal status and jurisdiction	What the authority establishes	Relevance to early childhood intervention and developmental supports	Limits, cautions, or current-status note
Human Rights Code, RSBC 1996, c 210, s 8	Provincial human-rights statute; services customarily	Prohibits service discrimination on listed grounds including family status and physical or	Potential route where a public or private service provider creates disability- or family-status-related barriers.	Does not guarantee every program or erase eligibility rules. Jurisdiction, service, protected characteristic,

	available to the public.	mental disability, subject to statutory defences.		adverse impact, connection and justification/undue hardship are fact specific.
Accessible British Columbia Act, SBC 2021, c 19; Accessible British Columbia Regulation, BC Reg 105/2022	Provincial accessibility framework; current to July 14, 2026 (Act) and July 21, 2026 (Regulation) when verified.	Requires prescribed organizations to establish accessibility committees, plans and feedback mechanisms; enables accessibility standards. The 2026 regulation includes health authorities among prescribed organizations.	Supports systemic barrier identification, planning and public accountability across designated bodies relevant to families.	Not an individualized service-entitlement statute. Parts 5 and 6 were shown as not in force in the current Act; the applicable organization and operative requirements must be checked.
Declaration on the Rights of Indigenous Peoples Act, SBC 2019, c 44	Provincial UNDRIP implementation statute.	Requires BC, in consultation and cooperation with Indigenous peoples, to take measures to ensure provincial laws are consistent with UNDRIP and to prepare and report on an action plan.	Relevant to provincial early-years, disability and child-care policy affecting Indigenous children, families and governing bodies.	Does not itself list a specific early-intervention benefit; legal analysis must include Indigenous rights, applicable agreements/laws and implementation measures.
Early Learning and Child Care Act, SBC 2021, c 22	Provincial early-learning and child-care statute; current to July 14, 2026 when verified.	Provides a statutory framework for provincial early learning and childcare, including planning, accountability and agreements.	Relevant to inclusive child-care system design and the interface between childcare and developmental support.	It is not a comprehensive disability-services statute or an individual guarantee of a child-care space, assessment or therapy.
Child Care Licensing Regulation, BC Reg 332/2007, under the Community Care and Assisted Living Act	Provincial regulation governing licensed childcare.	Sets licensing, staffing, health, safety, program and care-plan requirements for licensed child-care settings.	Important to the regulatory conditions within which inclusion and supports are implemented in licensed care.	Licensing standards are not the same as a publicly funded entitlement to specialized intervention or one-to-one support.

Source note. Hyperlinked citations lead to official legislation, official government or UN material, CanLII, or a full-text tribunal document. Short descriptions are analytic summaries, not substitutes for the complete authority.

Sources for Table C5:

Human Rights Code, RSBC 1996, c 210. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96210_01

Accessible British Columbia Act, SBC 2021, c 19. <https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/21019>

Accessible British Columbia Regulation, BC Reg 105/2022. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/105_2022

Declaration on the Rights of Indigenous Peoples Act, SBC 2019, c 44.

<https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/19044>

Early Learning and Child Care Act, SBC 2021, c 22. <https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/21022>

Child Care Licensing Regulation, BC Reg 332/2007. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/332_2007

Table C6: Alberta: principal legal framework and accessibility-legislation status

Alberta: principal legal framework and accessibility-legislation status — verified July 26, 2026				
Authority / source	Legal status and jurisdiction	What the authority establishes	Relevance to early childhood intervention and developmental supports	Limits, cautions, or current-status note
Alberta Human Rights Act, RSA 2000, c A-25.5	Provincial human-rights statute.	Prohibits discrimination in specified areas, including services and employment, on listed grounds including physical disability, mental disability and family status.	Potential route for challenging barriers or seeking accommodation in provincially regulated services and employment.	The precise protected ground, social area, adverse effect, connection and justification/undue hardship must be established. It does not automatically confer a program or therapy.
Family Support for Children with Disabilities Act, SA 2003, c F-5.3	Provincial program-enabling statute.	Authorizes agreements and assistance to guardians in obtaining child-focused services and supports for eligible children with disabilities and provides review/appeal mechanisms.	One of the clearest statutory links between disability-related child supports and the family/guardian in the three focal provinces.	Eligibility, assessment, agreements, available services and statutory discretion remain important. The Act does not guarantee every requested service or eliminate capacity limits.
Early Learning and Child Care Act, SA 2007, c E-0.1; Child Care Licensing Regulation, Alta Reg 143/2008	Provincial child-care statute and regulation.	Govern licensing, certification, standards and oversight for early learning and childcare.	Relevant to how licensed child-care settings operate and to the regulatory setting for inclusion.	They do not create a general right to disability-specific intervention, an inclusive placement or a publicly funded support worker in every setting.
Early Childhood Services Regulation, Alta Reg 126/2022, under the Education Act	Provincial education regulation.	Regulates early childhood services programs within Alberta's education framework.	Relevant to the transition/interface between early-years programming and the education system.	Application depends on the program and education authority; it is not a general clinical early-intervention entitlement.

<u>Bill 206, Accessible Alberta Act (31st Leg, 2nd Sess, 2026) — defeated at second reading, 23 March 2026</u>	Failed private member's bill; not law.	Would have created an accessibility-planning and standards framework, but the second-reading motion was defeated.	Confirms that, as verified on July 26, 2026, Alberta did not have an enacted comprehensive accessibility statute comparable to the federal, BC or Ontario frameworks.	Do not cite Bill 206 as current legislation. Human-rights duties and sector-specific statutes still apply despite the absence of a comprehensive accessibility Act.
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Source note. Hyperlinked citations lead to official legislation, official government or UN material, CanLII, or a full-text tribunal document. Short descriptions are analytic summaries, not substitutes for the complete authority.

Sources for Table C6

Alberta Human Rights Act, RSA 2000, c A-25.5. <https://www.canlii.org/t/81xx>

Family Support for Children with Disabilities Act, SA 2003, c F-5.3. <https://www.canlii.org/en/ab/laws/stat/sa-2003-c-f-5.3/latest/sa-2003-c-f-5.3.html>

Early Learning and Child Care Act, SA 2007, c E-0.1. <https://www.canlii.org/en/ab/laws/stat/sa-2007-c-e-0.1/latest/sa-2007-c-e-0.1.html>

Child Care Licensing Regulation, Alta Reg 143/2008. <https://www.canlii.org/en/ab/laws/regu/alta-reg-143-2008/latest/alta-reg-143-2008.html>

Education Act, SA 2012, c E-0.3. <https://www.canlii.org/en/ab/laws/stat/sa-2012-c-e-0.3/latest/sa-2012-c-e-0.3.html>

Early Childhood Services Regulation, Alta Reg 126/2022. <https://www.canlii.org/en/ab/laws/regu/alta-reg-126-2022/latest/alta-reg-126-2022.html>

Bill 206, Accessible Alberta Act, 31st Leg, 2nd Sess, Alberta, 2026.
https://docs.assembly.ab.ca/LADDAR_files/docs/bills/bill/legislature_31/session_2/20251023_bill-206.pdf

Legislative Assembly of Alberta. (2026, March 23). *Votes and proceedings: Second reading of Bill 206, Accessible Alberta Act (31st Leg, 2nd Sess)*.
https://docs.assembly.ab.ca/LADDAR_files/docs/houserecords/vp/legislature_31/session_2/20260323_1200_01_vp.pdf

Table C7: Ontario: principal legal framework

Ontario: principal legal framework — verified July 26, 2026				
Authority / source	Legal status and jurisdiction	What the authority establishes	Relevance to early childhood intervention and developmental supports	Limits, cautions, or current-status note
Human Rights Code, RSO 1990, c H.19, ss 1 and 12	Provincial human-rights statute.	Section 1 protects equal treatment in services on grounds including disability and family status; section 12 addresses discrimination because of association or dealings with a person identified by a prohibited ground.	Potentially relevant to barriers affecting disabled children and caregivers associated with them in provincially regulated services.	A claim remains service-, respondent- and fact-specific and subject to applicable justification/undue-hardship analysis. The Code does not guarantee every requested intervention.
Accessibility for Ontarians with Disabilities Act, 2005, SO 2005, c 11	Provincial accessibility standards statute.	Provides for development, implementation and enforcement of accessibility standards to identify, remove and prevent barriers.	Supports systemic accessibility duties and organizational compliance in areas covered by standards.	It is not an individualized developmental-service entitlement; compliance with a standard does not necessarily resolve a Human Rights Code duty.
Child Care and Early Years Act, 2014, SO 2014, c 11, Sched 1; O Reg 137/15	Provincial child-care and early-years statute and regulation.	Establish licensing, funding/administration and regulatory requirements; statutory purposes include children's learning, development, health, well-being and safety and support for parents.	Primary legal framework for licensed childcare and early-years programs, including the setting in which inclusion must be operationalized.	Not a general guarantee of a child-care space, individualized intervention or a specified level of special-needs resourcing.
Child, Youth and Family Services Act, 2017, SO 2017, c 14, Sched 1	Provincial child, youth and family services statute.	Contains purposes, service principles, rights and governance rules for services within the Act, including attention to prevention, early intervention, family strengths, identity and First Nations, Inuit and Métis children.	Relevant where developmental supports intersect with services governed by the Act and with child/family service planning.	It does not govern every health, child-care, education or disability program and should not be cited as a universal ECI entitlement.
Education Act, RSO 1990, c E.2; Ontario Human Rights Commission, Policy on	Provincial education statute plus non-binding	The Act governs school education; OHRC guidance explains Code duties,	Relevant to continuity and substantive access when children transition from early-years systems into school.	The OHRC policy is persuasive guidance, not legislation or a tribunal order. School-age duties do not

accessible education for students with disabilities (2018)	human-rights policy guidance.	accommodation and systemic barriers in education.		automatically determine pre-school service entitlement.
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Source note. Hyperlinked citations lead to official legislation, official government or UN material, CanLII, or a full-text tribunal document. Short descriptions are analytic summaries, not substitutes for the complete authority.

Sources for Table C7:

Human Rights Code, RSO 1990, c H.19. <https://www.ontario.ca/laws/statute/90h19>

Accessibility for Ontarians with Disabilities Act, 2005, SO 2005, c 11. <https://www.ontario.ca/laws/statute/05a11>

Child Care and Early Years Act, 2014, SO 2014, c 11, Sched 1. <https://www.ontario.ca/laws/statute/14c11>

General, O Reg 137/15. <https://www.ontario.ca/laws/regulation/150137>

Child, Youth and Family Services Act, 2017, SO 2017, c 14, Sched 1. <https://www.ontario.ca/laws/statute/17c14>

Education Act, RSO 1990, c E.2. <https://www.ontario.ca/laws/statute/90e02>

Ontario Human Rights Commission. (2018). *Policy on accessible education for students with disabilities*.

<https://www.ohrc.on.ca/en/policy-accessible-education-students-disabilities>

Table C8: Selected intergovernmental and interpretive policy sources

Selected intergovernmental and interpretive policy sources — verified July 26, 2026				
Authority / source	Legal status and jurisdiction	What the authority establishes	Relevance to early childhood intervention and developmental supports	Limits, cautions, or current-status note
Federal, Provincial and Territorial Ministers Responsible for Early Learning and Child Care, Multilateral Early Learning and Child Care Framework (2017)	Intergovernmental policy framework; not legislation.	Sets shared principles of quality, accessibility, affordability, flexibility and inclusivity while recognizing provincial and territorial system responsibility.	Useful benchmark for comparing policy commitments with program rules, capacity and family experience.	Does not create an enforceable individual right or uniform national program; implementation occurs through jurisdictional systems and agreements.
Government of Canada and Indigenous partners, Indigenous Early Learning and	Co-developed policy framework; not legislation.	Sets a shared vision and distinctions-based principles for high-quality, culturally rooted,	Important policy benchmark for self-determination, culture, language, flexibility, accessibility and coordination.	Must not be treated as a substitute for Indigenous law, treaty/section 35 rights,

Selected intergovernmental and interpretive policy sources — verified July 26, 2026				
Authority / source	Legal status and jurisdiction	What the authority establishes	Relevance to early childhood intervention and developmental supports	Limits, cautions, or current-status note
Child Care Framework (2018)		Indigenous-led early learning and childcare.		funding agreements or the specific rules of a program.
Government of Canada, Early Learning and Child Care Agreements portal	Current repository of bilateral and Canada-wide funding agreements and action plans.	Documents negotiated commitments, funding, targets and reporting for provincial and territorial child-care systems.	Useful for verifying the policy architecture and time-limited commitments applying in BC, Alberta and Ontario.	Agreements may be amended, renewed or expire. They are not interchangeable with statutes and do not necessarily confer directly enforceable rights on individual families.
Ontario Human Rights Commission, Policy and guidelines on discrimination because of family status	Non-binding human-rights commission policy guidance.	Explains the Commission's interpretation of family-status protection, caregiving and accommodation under Ontario's Human Rights Code.	Useful for framing caregiver barriers and associative discrimination in Ontario.	Persuasive rather than binding; courts and tribunals determine the law on the evidence before them.
Alberta Human Rights Commission, Duty to accommodate	Non-binding commission guidance, principally framed for employment.	Explains accommodation, protected grounds and undue hardship in accessible language.	Useful for describing the accommodation process and the difference between equality and identical treatment.	Guidance is not legislation or a decision and cannot be transferred uncritically from employment to every service context.

Source note. Hyperlinked citations lead to official legislation, official government or UN material, CanLII, or a full-text tribunal document. Short descriptions are analytic summaries, not substitutes for the complete authority.

Sources for Table C8:

Federal, Provincial and Territorial Ministers Responsible for Early Learning and Child Care. (2017). *Multilateral early learning and child care framework*. Government of Canada. <https://www.canada.ca/en/employment-social-development/programs/early-learning-child-care/reports/2017-multilateral-framework.html>

Government of Canada and Indigenous partners. (2018). *Indigenous early learning and child care framework*. <https://www.canada.ca/en/employment-social-development/programs/indigenous-early-learning/2018-framework.html>

Employment and Social Development Canada. (n.d.). *Early learning and child care agreements*. Government of Canada. <https://www.canada.ca/en/early-learning-child-care-agreement/agreements-provinces-territories.html>

Ontario Human Rights Commission. (2007). *Policy and guidelines on discrimination because of family status*.

<https://www.ohrc.on.ca/en/policy-and-guidelines-discrimination-because-family-status>

Alberta Human Rights Commission. (n.d.). *Duty to accommodate at work*. <https://albertahumanrights.ab.ca/issues-at-work/duty-to-accommodate-at-work/>