Transcript: Integrating Pediatric Social Determinants of Health for Children in Canada

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Katharine: Welcome to SPARK: Conversations which is Children's Healthcare Canada's monthly podcast series. At the crossroads of children's healthcare system improvement and leadership, SPARK: Conversations is a solution-focused podcast that connects the child and youth health community with systems leaders who tackle wicked problems and discuss ideas to inform the development of innovative and integrated systems serving children and youth. SPARK: Conversations is one component of our SPARK Knowledge Mobilization Program. SPARK is the Shared Platform for Advocacy, Research and Knowledge.

I'm Dr. Katherine Smart, and today I'm delighted to be speaking with Dr. Justine Cohen-Silver. Dr. Cohen-Silver is an Investigator with MAP Centre for Urban Health Solutions in the Li Ka Shing Knowledge Institute of St. Michael's Hospital. She is also a staff pediatrician practicing in the Women and Children's Health Program at St. Joseph's Health Centre and St. Michael's Hospital. Dr. Cohen-Silver is an Assistant Professor within the Department of Pediatrics at the Temerity Faculty of Medicine, the Research Director of the Department of Pediatrics at St. Joseph's Health Centre, and the medical site lead for the Model Schools Pediatric Health Initiative at Parkdale Public School at Unity Health Toronto.

Today's podcast is timely as it relates to a project that is important to Children's Healthcare Canada, our members, and the broader child health community- Inspiring Healthy Futures (IHF). Inspiring Healthy Futures was founded in 2021 by UNICEF Canada, CIHR IDHCYH, Pediatric Chairs of Canada, and Children's Healthcare Canada in response to the UNICEF Report #16 (which was done in 2020); where Canada ranked a shocking 30th out of 38 wealthy countries in the health and well-being of our children and youth. Inspiring Healthy Futures is a pan-Canadian, cross-sector action that includes 1500 diverse group of youth, parents, service providers, youth serving agencies, cross-sector experts, researchers, educators, advocates, policymakers, and others. The Inspiring Health Futures community will reconvene on October 27 to celebrate the awareness and tangible actions taken in the 3 years since the initiative began to work towards our shared goal of improving outcomes for kids.

Today we are chatting about an extremely important topic – pediatric social determinants of health. Hello Justine, and welcome to SPARK: Conversations.

Justine: Hi, Katharine, thank you so much for having me. I was so excited to have the opportunity to speak with you today. Thank you.

Katharine: Well, thank you for being here. And I'm really excited to learn from you and all about your programs in Toronto. It's going to be a very interesting conversation. So as we know, you are a pediatrician with a focus in inner city health in Toronto and your research area focuses on pediatric social determinants of health screening and intervention and school-based health services in disadvantaged communities. So thank you for joining us today and sharing with us about your work and the breadth of knowledge you are going to bring to our discussion today.

So as a pediatrician, who is a site lead for one of the model schools programs at St. Joseph's Health Center at Unity Health Toronto, could you share with us what's innovative about this program as the first of its kind in Canada and the potential of school-based programs and improving outcomes for children in underserved communities?

Justine: I would love to try to answer that question. Thank you so much.

So I'm really excited that you did bring up the Model Schools program because it is a really unique collaboration between the Toronto District School Board, which is Canada's largest school board, and Unity Health Toronto; under the leadership of my colleague and mentor Dr. Sloane Freeman, who founded this program and has built it from the ground up. School-based health clinics have been something that is very popular and well-defined in the United States. It's been a wonderful access point of care, especially for families that are underserved, because it eliminates barriers, because it's co-located in their school, and so they can walk into the doctor's office on their way out of class and have that access. And while we're in the school, it's a wonderful opportunity to make connections with the educators in order to optimize helping children in a holistic way, which is vital when we are addressing determinants of health.

So whenever I have a new research student join me or am teaching anyone, I will always say first, I'll say it before and I'll say it again - that social determinants of health determine health. It really is true. If we do not address social determinants or consider them when thinking of someone's health, we are not going to help them be healthy. I then usually say we don't want to be open. We want to help everyone to stay in the community, stay healthy. But coming to the physician's office is a great point of care to address these issues because families develop a relationship with their physician and feel comfortable perhaps to bring up issues that they didn't realize we may be able to help. So, the school-based health center in particular, the Model Schools Pediatric Health Initiative, was founded in 2010. Opened first at Sprucecourt Public School in Toronto. And then a couple years later, there was a second site opened at Nelson Mandela Park Public School; both in the east end of Toronto. And now since 2015, we have opened the site at Parkdale Public School at St. Joseph Health Center that I'm helping to be the medical lead for. Ultimately, we help serve 75 feeder schools in areas that have been determined to be underserved based on the learning opportunity index. So families attending the school clinic tend to

face increased social adversity including: being newcomers to Canada, not being comfortable speaking English for their medical or school-based issues, English is not their first language, single parent homes and families generally with lower socio-economic status. These barriers have previously been determined to impact health. There is an increased prevalence for children with social adversity to face chronic health issues such as asthma, eczema, have exposure to much more adversity and trauma. It's a wonderful opportunity.

So what we do is unique because we help see children. They can walk in the door and self-refer. So that's a unique access point, usually the family physician refers to a specialist. As well, the teachers, the educators can refer to us if they're noticing that his family is struggling and they'd like to see us. And from the family's perspective, that's helpful because when the school is coming to them and suggesting that there's an issue with their child, whether learning or behavior; they may feel stigmatized, they may feel worried, that their child will not receive a certain level of support if they are presenting as being impulsive in class, etc. So what's nice about when we come in is we help. We are the family’s advocate. Whatever they choose to share we share; whatever they do not wish to choose is confidential. But we're trying to look at it from a medical perspective and understand if this presentation may be related to a lot of other issues that are going on that the school may not realize that we can help with. Such as traumatic experience the families face receiving therapy for that. If there's an issue with food insecurity, housing insecurity, that's relating to this behavior presentation, we can help address that through our patient navigator. Look at communicating back to the school to help the families close that loop of communication so that everybody knows what's going on. And we have found it really helpful for families.

Katharine: Oh that's fantastic. I love that idea of meeting the child in community with the people who know them, and that sort of group of adults that are around that child and bringing that family, child and those caregivers all together to solve those complex problems. And again that idea of access to care, right, by taking away that need for referral, makes a huge difference in terms of children being able to get the care they need so there's so many interesting and innovative ideas there that sounds like they're really helping you serve that community really well.

We know that childhood adversity has a major influence on both childhood well-being and our lifelong trajectory of both physical and mental health. Can you speak a bit about your clinical and research work that's focused on screening and intervening to help mitigate social determinants?

Justine: Absolutely, thank you so much. So as we've already mentioned, social risk factors impact the health and well-being of children. They are associated with worse health outcomes over the life course including cardiovascular disease, diabetes, depression, hypertension. Children facing social risk, actually access health services more. So it's an opportune time to screen for social adversity and potentially intervene if we have available resources. So one research project that I am leading is a creation of a new pediatric social risk screening tool called the Pediatric Social Risk Index, along with CO-PI primary principal investigator, Dr. Jonathan McGuire. In order to do this, we did a systematic review of literature to look at all possible social-risk screening tools and determine that none were exclusively pediatric specific. So we took all 546 existing questions anyone's ever asked and we put them in front of panel of experts, and had them come to consensus on 86 questions that seemed most

relevant to pediatric health care. We then tested that 86 six question tool in the hospital setting, and asked 100 parents to complete the tool and then complete it a few days later, so we can validate it. So we have validated the tool and done a factor analysis in order to make it shorter. The factor analysis is a fancy mathematical method to basically look at which questions represents the whole thing the most. 20 were selected - 16 were selected actually. We are now going to be asking, we're currently asking those questions in the outpatient setting, in order to validate it in the outpatient setting, and make sure that the new questions that families are comfortable with them, and that it kind of meets their needs. So that's one thing I'm doing and I'm really excited about it for screening.

Now, in terms of intervening, I have another active project that I'm doing with Dr. Andrew Pinto, who's a family physician at Unity Health, and the scientific lead of the upstream lab at the Map Center for urban solutions. So, Andrew Pinto and I had met a few times and had some kind of off the record discussions about the challenges we face supporting our families accessing social care. And it's because we are physicians. So we would love, we can recognize what social care might be beneficial for a family, but we do not directly provide it. And conversely, in the social care setting, it is not well-known what health care people are receiving and how they're accessing that support. They exist in silos in most ways. And most of the time families come to ask us for help when they are in a crisis. And so that's a difficult time for them to be able to manage accessing all the social care, we might suggest. And so we hope to try and think about how to reinvent the system. So currently, we are doing an asset map and focus groups in three chosen communities in Toronto that have high social needs. Moss Park and Regent Park in Eastern Shore, East End of Toronto, and at Parkdale in the West End; where we are going to be interviewing families that access social care, but also practitioners and ask them what the barriers are. Also ask them how they would imagine if we could do it, how to reinvent the system. And then we wish to share these results across Canada, we've received a grant to go across Canada to a few select provinces, and meet with experts there that are supporting families with high social risk and try and share our results and see what they think would be a solution and put it all together and try and provide information to Canadian leaders in health and social care to help the system. So especially after COVID and lock downs, where children were even also locked out of school. You know, we're doing school online for a long time. People were not necessarily attending medical visits unless there was an emergency. And certainly, we couldn't access all families because not everyone has virtual access. People lost their jobs, people had health consequences from COVID. So it's a very important time to reassess what's there now that the hopefully the dust has landed and kind of see what we can do to help.

Katharine: Absolutely, I love that. And again, it's just that idea really of that integrated approach to care and trying to break down those silos so that people are seen as whole people. And I think that's so important for children so it's really interesting to hear what you're doing in that space and that idea of sort of trying to scale that for learning for the rest of the country. We also know that positive childhood experiences can counter the impact of adversity. How does your clinical work, including the Model Schools Program address adverse childhood events, and create positive childhood experiences?

Justine: So I like to think you know, when we meet with a family, I always preface by saying to the child, I know we're going to talk about I wish we could spend the whole visit talking about what's awesome, and what's been amazing about you, and I know there's a lot; but today we're going to talk

about your challenges so I can help with them. However, we will start the visit always by asking what's been amazing what's been great since the last visit, what are the improvements. We want to try and give a positive angle to help, you know, children have a positive kind of perception about what's happening with them, and all the small changes they're making that can be impactful. And there can be a lot of resilience seen, you know, a lot of changes can happen in small steps. And if we can make those changes early on, then we can potentially change a child's trajectory.

But we can't do that without assessing the family as a whole. So a lot of the time when we are doing a school clinic visit and we're asking, which we do for every patient, about their social history, we may learn what challenges their parent is facing - their primary caregiver. We may learn they just lost their job, or they have their own mental health struggle that they are going through. And we need to try and think of ways that we can support them as well. Because that then they can support their child. And together, there can hopefully be some new beginnings and a new path. So we really try and look to ask families what they need. In order to address their needs I always ask what can I do for you today? What would be helpful to you, whatever the answer is, let's try and figure it out. And that and if when you're doing it in a way, then it can be trauma-informed, it's kind of patient-centered. And I think that can really help kind of move the dial about making adverse childhood events, like moving into a more positive childhood experience. We cannot take those away. But I think we should address them for families, we should ask them what they are when they feel comfortable to share, and trying to provide support around that.

So support we do have at the school clinic includes a developmental counselor that meets with families and helps work on children kind of facing the trauma through therapy through we, you know, sometimes through art therapy, etc. And also helping the parents in how to relate to the child to help support them when they're having a struggle related to any adverse event. Because sometimes it's hard to know how to support the child when they are, you know, having a meltdown and it may be related to that. And that way we're empowering parents as well to continue the work when they go home. And just kind of empowering them to see how important they are in the process, of course, and how much you know, their support is making an impact.

The other thing we offer is we have a Patient Navigator, so it's very lucky to have that and I wish that all clinics had this type of resource available and there was funding for this. Because our Patient Navigator has a social work background but she in this case, will review what the family's needs are and really help them get there. So even if we tell a family, for example, you have your child has a diagnosis of autism. But we have a number of resources to suggest you can go access now that will help enable you the support you need. The family may, for lots of reasons have a lot of trouble getting to that resource. Connecting with them, there may be a language barrier. They're not familiar with this process, it may be overwhelming, they're just adjusting to the diagnosis themselves. So the Patient Navigator helps walk them through that. And it really is helpful for families.

The last thing I want to mention is we try and offer programs that can help create a positive childhood experience at the school clinic. We recognize especially after the pandemic that there is a lot of paucity of mental health care access available, and a huge need. So prior to the pandemic, oh, I don't remember the statistic. Let me let me try and remember it in a moment. But there was a huge uptick in

patients mentioning mental health difficulties. And so we wanted to bring a mental health program to the school clinic. And so what we did was we worked with the CAMH mental health institute, their pediatric psychiatrist to learn their Coping Power Program, which is a kind of manualized health mental health program. You can follow a manual and have training to provide it to children having behavior outbursts at school and negative behavior. And the program is designed to have two groups at the same time. We have a child group that are the children that we have referred and then there's their parents or primary caregivers that are in a kind of parallel peer group at the same time. And so now that we have learned how to give this program. We - when I say we, the physicians at the clinic have learned how to do it, and so have the educators at the schools locally. And so together, we run the program on an evening once a week, for about eight weeks, three times a year. We can have three different groups that way. And give families the tools they need to try and help address this behavior, to help empower the children and for the parents to receive that peer support. So I'm proud of that program. It's just growing. But we continue to try and think about ways to help families and eliminate barriers.

Katharine: Thank you for sharing all those amazing things. You know, two things really stood out for me and I think are really similar to the experiences I've had in my practice. One that idea of, of treating the child and the family together, right. I think when we're pulling children away from their parents and not sort of treating them as a unit often, we're not really getting the interventions where they need to be. So that really resonated with me. And also that idea of asking people what would help them. You know, sometimes it's not the things we would necessarily expect to be helpful. It's amazing how something as simple as just saying, you know, what can I do for you today or what would actually be helpful for you can really A build trust, but B get to the heart of what matters for folks in that moment. So I really love that idea. And then, of course, that idea of navigation and helping people get where they need to be, so that they can actually access the services. So some really, I think, exciting ideas and I think those things are so important in the work we do as pediatricians so thanks for sharing that perspective.

You know like you I'm also a pediatrician. And one of the things that I've really learned in the last 20 plus years of practice is that this concept of “developmental trauma”, which isn't something I really heard about when I was in training, and it's really made me sort of rethink and reframe some of the diagnoses we traditionally give to children. So I'm curious about your perspective on how we should consider the concept of “developmental trauma” and chronic stress when diagnosing behavioral challenges and kids? And do you think it's time for a diagnostic “reframe” of some of the language we use around certain mental health diagnoses?

Justine: That is an excellent question. And it's something I've definitely been thinking about a lot myself, even at the last year's Canadian Pediatric Society yearly annual conference that was in Montreal, the term developmental trauma was coming up a lot. And it really does make so much sense. So, you know, it technically hasn't been defined, you know, given kind of some sort of criteria to meet official diagnosis. But there's no doubt that, you know, we can see objectively subjectively, I suppose, in practice, that children that have experienced developmental trauma may present with symptoms that are very similar to autism, ADHD, anxiety, depression, oppositional defiant disorder. And as we learn their history, we may understand a lot of reasons why they may have the symptoms, and it may not necessarily be kind of kind of connected to those original, kind of more mainstream diagnosis. That

said, sometimes children do have autism, ADHD, anxiety, depression, and developmental trauma. The developmental trauma did impact kind of how they received support around their presentation. It might have kind of caused some delay in presentation because the family was dealing with so much at the same time. And there can be a lot of guilt for parents around that they, a lot of the time, they may ask, if this didn't happen would that have caused. It's natural for a parent or primary caregiver to feel to try and want to explain, you know, did I do something wrong, but I mean, that always breaks my heart, when we would discuss that in clinic. And that couldn't be less the case, right. So ultimately, I do think we need to reframe and think about this diagnosis, I have noticed that I start to think about this diagnosis more when I might have a standard diagnosis. And I start to proceed down a treatment path. And it's not exactly meeting the expectations, I would think with the usual treatments. So medications don't need to be at such at the dose I usually expect, they may be okay to lower dose or just I'm noticing the behavior may change a lot in the child. As we give them support, some of their presentation may really alter and they may not even seem to have the same symptoms. And that's when I might think, I think that developmental trauma has significantly impacted how they presented in the first place. So I think we need to try and get this term out there and really consider it. And definitely if we recognize it, address and support families around healing from the trauma, and mitigating the issues that are related to the trauma.

Katharine: Thank you so much for sharing your perspective on that. And I agree, I think it's going to be something we continue to hear more about and start to work more into our diagnostic framework of how we look at children and some of the challenges that they have.
How has your work as a pediatrician at Unity Health focused on the social determinants of health, influenced your perspective on what is needed in our healthcare system to meet the needs of children? Where do you think we should be focusing that we're not? And in your view, what's our biggest missed opportunity?

Justine: Okay, I would love to answer this, thank you. So at Unity Health and especially during the pandemic, it's come to the point where I will entirely visit the medical visit around determinants of health. Of course I need to address their medical concern that initially brought them in. But I always want to explore the other variables surrounding their presentation. What has their life been like leading up to this? Because it likely has influenced why they came in or the severity of their presentation by the time I see them.

And so that's been my training I did I had the chance to do an academic fellowship at St. Michael's Hospital pediatric department with a focus in urban health and school medicine. Kind of mentored by Dr. Sloane Freeman and Tony Barozzino, and Michael Sgro. And I learned that they have a very, very unique focus that I wish to take forward in my daily practice, because we just have to meet families where they are at. So in the context of this work, I have seen that we should focus on trying to advocate for more funding for schools generally, for education. So for classroom sizes to be manageable. You know, a lot of times parents will tell me their child is in a class of 36 students, and, you know, 1/3 of them have behavior or learning issues. So it's really impossible for the teacher to address their needs. And it makes a lot of sense why we're not really helping, you know, they haven't really made a lot of progress. As well, there's a huge backlog in psychologists assessing students for learning disabilities, they uniquely can do this through their formal psycho-educational assessment. It's not something we

can do in the medical office. It's something we can advocate for. And so in the context of that, I've just been a part of a group to write a CPS position statement about learning disabilities in Canada and helping to advocate for support around them. But funding and more psychologists would be great in order to address that. As well for language delay, more speech and language support would be important. And so when you know, we recognize that early, there may be a language delay learning issue, or even a social communication issue. One thing that I do try and suggest is for families to help their children to have opportunities to socialize with other children, and have that kind of regular experience, whether that be through a drop-in early learning center or daycare, and advocating for them for daycare support, financial support, should they qualify. Because this may help mitigate the issue, you know, help them to start have treatment around it so that it doesn't worsen and wait until they go to school for them to get support; where there then is little funding and less opportunity to access it. I hope that does answer your question, let me make sure.

Katharine: No, it absolutely it does. And I'm going to sort of ask you to expand a little bit because you know, we're hearing a lot right now about this concept of right sizing child health in Canada and the children's health care system. You know, you've talked, I think here about a lot of ideas around how seeing children in that space at school can really help with the lens that you have on the challenges that they're having and improving their access to care. What do you think the role is of school-based programs like the model schools program in terms of that right sizing of children's health care? And do you see this as something that could be used also in more rural and remote communities, where there may be more challenges for students and children and youth to access health care?

Justine: Is it okay Katharine to ask you to expand about the term right sizing? Like tell me a little bit more about it to make sure..

Katharine: Yeah, absolutely. So we've been hearing a lot of language from children's hospitals about this idea of sort of right sizing the system, meaning because there's been chronic underfunding, which you've touched on in sort of the school setting, that meant many children are waiting longer for care than even adults. And there's that need for investment to bring, you know, bring down wait times and increase access. And, you know, I'm curious if you think tools like your program are ways that we could improve that access to care and bring down barriers to make sure that children are getting health care where they need it and sort of increase capacity in the system.

Justine: Absolutely. So you know, one thing that comes to mind ahead of my answer is just the idea that, fortunately, for the most part, you know, the population of children appear healthy. It appears that they are not accessing the health care system to a great extent, of course, there are children with complex health needs. But you know, just kind of looking at each age group, that seems to be something that stands out. So it's hard to see the need for providing this funding in light of that, I think, and then, as well, it's hard to see the downstream effects of not providing it because it will be a while before the evidence presents itself. So that's the trick about children and even in research that's the difficulty. It's hard for us to prove. For example, we know our school-based health clinic is a very important model of care and we're working and we've in multiple ways, have been publishing about proving that but it's a little bit hard to prove because of the you know, these long-term outcomes in children. We need to see the outcome do they end up. You know, what's their life trajectory, right, what

kind of job do they have and etc. So I think providing programs like the school clinic would be a great way to think about right sizing because we are able to support more children this way.

The program is available, for example, to 75 feeder schools, and the way one of the ways that we help bring children to our clinic is our physicians attend School Support team meetings at the Toronto District School Board every month at every school. There are meetings to talk about the children that are at risk generally, whether academic or behavior issues, etc. The meetings take place standardly without a physician, where the educators meet with the parents, social workers there, speech and language pathologists, psychologists, and they talk about the child's strengths and needs and determine what support they can provide. So we attend those meetings, and then we can therefore give a medical perspective. And we can potentially determine based on the description, would the child benefit from coming to the school clinic to be seen in order to help address their issues. So not every child mentioned may require that, but it's one opportunity to kind of be a part of a bigger discussion, and then determine which children may benefit the most from coming to the school clinic. As well, the programs offered throughout the school board, so children can be referred regardless of which school they're located in, in fact. And what we want to do actually, myself and Dr. Freeman, we want to help teach our approach of school health and focus on social determinants to other pediatricians across Canada and other health practitioners. So they may try this in their own practice and start the work without having to come to a school clinic. So we are the co-leads of a special interest group with the Canadian Pediatric Society for school health, and you're very much invited to join. Come to a meeting! But we are trying to start this discussion across Canada to hear from other leaders in other provinces, what they're doing, and to try and figure out ways to share this information, whether it's through position statements with the Canadian Pediatric Society, or Maine or other modalities.

And I think, you know, in order to give this care from a rural setting, one could potentially luckily now one advantage of the pandemic is access of remote care. And in a lot of the cases with the school clinic, we can do a fair amount virtually in terms of our assessment because some of it is behavioral. So we don't need to necessarily, you know, listen to the patient's heart or look in their ears. We can talk to them, we can observe them. And so I think that it actually there's lots of opportunity to do that potentially, as you know, through remote access, perhaps.

Katharine: Great. Well, thanks for sharing that. And again, I just think it's just one more idea, right? One more way to get to where people are, or one more way to decrease barriers and making sure all children have access to care. And again, that really holistic view. So I really want to thank you for sharing your perspectives today. I think it's been so interesting to hear about your research, the practical application of your research, the models that you're using, I think you've clearly really leaning into this idea of Family Centered co-designed care and really improving access through a simple but yet innovative idea that really could be leveraged across the country. So I really learned a lot from you today and really enjoyed our conversation. So thank you, Justine, for joining us.

Justine: Thank you very, very much for having me today. It was really a pleasure to get to speak to you. Thank you.

Katharine: Thank you. So to our listeners stay safe and be well To stay up to date on all our SPARK offerings, including upcoming podcast episodes, visit our website at ChildrensHealthcareCanada.ca and subscribe to our SPARK: News bi-weekly e-bulletin if you haven't already. Thanks for listening to SPARK: Conversations. And before we go show some love for your new podcast series by leaving us a review and then join us again next month. Thank you!