



CPS news

CANADIAN PAEDIATRIC SOCIETY | SPRING • SUMMER 2024

Risk is not a 4-letter word

It may seem counterintuitive for a group focused on injury prevention (IP) to come out in favour of risky play, but that's exactly what the CPS IP Committee did earlier this year. The committee's position statement, *Healthy childhood development through outdoor risky play*, made headlines across the country and has already played a role in how some municipalities assess the risks and benefits of keeping outdoor play spaces open in the winter.

The *CPS News* spoke to statement authors Drs. Emilie Beaulieu and Suzanne Beno – who did over 70 interviews combined – about why the statement made such a big splash.

"I think it speaks to the appetite that people have for this topic, in terms of parenting styles and school styles," said Dr. Beno, chair of the Injury Prevention Committee.

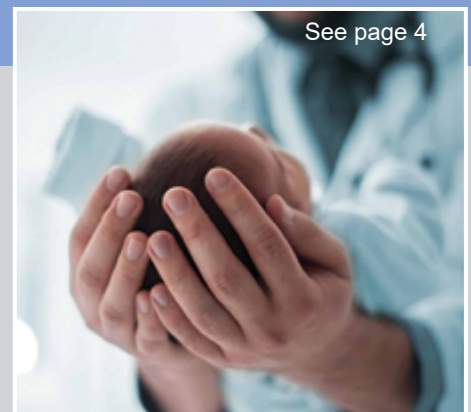
As so-called helicopter-parenting and other high-input caregiving styles gain popularity, some parents who allow their children to engage in risky play feel judged. Some families may feel like the statement gives them "permission to...not be on top of your kid all the time," said Dr. Beno.

Risky play can improve physical, mental, and social health, and help prevent or manage health conditions like obesity,

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“Based on the research, we know that risky play is very helpful for physical health: Kids are more active and improve their motor skills. It is also beneficial for mental health, including better self-esteem and better friendships and positive interactions with their peers.”

Dr. Emilie Beaulieu

anxiety, and behavioral issues. During risky play, children learn to recognize and evaluate challenges, which will in turn help them develop confidence in their decisions and abilities. Risky play can also help children with disabilities develop autonomy and reduce social exclusion.

While adults may worry about the potential for injury with this type of play, Dr. Beaulieu says the benefits outweigh the risks.

“Keeping our children active and mentally healthy is so important,” she noted. “Based on the research, we know that risky play is very helpful for physical health: Kids are more active and improve their motor skills. It is also beneficial for mental health, including better self-esteem and better friendships and positive interactions with their peers.”

Risky play does not involve ignoring safety measures, leaving children unsupervised in hazardous areas, or pushing children to take risks outside their comfort levels. Adults must continue to be aware of hazards, where the potential for harm is greater than the child’s capacity to recognize and manage the risk. And adults should always be ready to intervene if a child’s play becomes dangerous to themselves or others.

Dr. Beaulieu hopes the statement can help daycares, schools, and other groups find the gray areas between danger and overly safe environments when making policies.

“Risk is not a four-letter word,” Dr. Beno said. “My biggest hope is that it actually impacts change so that kids are managing those risk assessments a little bit more smoothly than they are in this cohort of adolescents we have right now.”

Skin-to-skin care is recommended for all newborns

Even for preterm and low birth weight infants, there are many benefits. Supports are available to mitigate risks.

Start skin-to-skin care immediately after birth. Continue for one hour, ideally with the birthing parent.



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Contributors: Genevieve Brouillette
Moira Munaaba
Jennie Strickland
Lindsay Thistle

Layout & Design: Fairmont House Design

Translation: Dominique Paré

For advertising rates, contact Moira Munaaba at 613-526-9397, ext. 238 or info@cps.ca.

Canadian Paediatric Society
100-2305 St. Laurent Blvd.
Ottawa, Ont. K1G 4J8
Tel.: 613-526-9397 • Fax: 613-526-3332
www.cps.ca • www.caringforkids.cps.ca

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“Parents have an opportunity to really be where they always should have been: at the centre of the care team, and we support them.”

Dr. Michael Narvey

Small but mighty: Neonatology in 2024

With a penchant for using his hands, procedures, and an affection for babies, CPS Fetus and Newborn Committee Chair Dr. Michael Narvey was originally interested in maternal-fetal medicine. But after a rotation in newborn intensive care, he was hooked.

“I found the ability to care for babies and still use my hands intubating, putting in UVCs, and so forth, appealing,” he recalled. “The hands-on aspect of it, but also the cerebral intellectual approach of using your physiology that you learned in medical school and in paediatrics and applying that in a critical environment, I found thrilling.”

Twenty years into the gig, Dr. Narvey is still impressed by the resilience of newborns. “The public perception is that babies are fragile. And of course, in many ways, they are fragile,” he said, but notes that “they’re quite resilient. As long as you can get them through the tough spot, the challenging period, they are capable of recovery.”

Not a visitor: Putting families front and centre

There has been a major shift toward family-centred care in NICUs over the past several years. Rightfully so, says Dr. Narvey, who notes it should have always been that way.

“Parents have an opportunity to really be where they always should have been: at the centre of the care team, and we support them,” he said.

The new model gives parents the role of advocates, where they can introduce their baby on rounds and, in some centres, report on how they’re doing and identify any questions or concerns for the medical team to address.

Another similar change, which the Canadian Premature Babies Foundation helped usher in, is the widespread recognition that families are not visitors, but an essential and central part of the care team. Primary caregivers now, in many NICUs, are not restricted to rigid visiting hours.

On the edge of viability

In the mid-2010s, the CPS received pushback from neonatologists across the country for a statement on the management of anticipated extreme preterm birth that was deemed overly simplistic and paternalistic. The revamped statement, published in 2017, looked at the whole patient instead of gestational age alone.

“That was a really transformative thought,” Dr. Narvey said, to “move away from the doctors saying we understand your values or what your values *should* be and, instead, let’s have a collaborative model where obstetrics and neonatology come together and evaluate the data on an individual basis.” So now the team will look at all the risk factors for a poor outcome, give parents as accurate a picture as possible, and then consider the family’s beliefs and background to inform decision-making.

Eat, sleep, console: How management of neonates exposed to opioids is changing

Opioid use by pregnant women has escalated over the past two decades, with rates of neonatal opioid withdrawal syndrome (NOWS) rising alongside.

Guidance for the management of NOWS is moving away from the traditional model – administering morphine in a NICU – and toward a model called “eat, sleep, console.”

As the name implies, the new protocol has three main categories of assessing babies: Will they eat? Are they relatively easy to console? Are they sleeping?

“If they’re doing that, in conjunction with keeping babies with mom, breastfeeding, skin-to-skin care, a lot of babies can avoid lengthy hospital stays,” Dr. Narvey said, noting that this model also promotes parental bonding.

Stay tuned to cps.ca for clinical guidance on NOWS, as the Fetus and Newborn Committee is in the process of authoring a statement.



“A lot needs to go wrong for a baby to be born with syphilis.... It’s pointing at multiple failures along the path.”

Dr. Jared Bullard

Protecting new babies from an old disease

Syphilis rates have resurged in Canada in recent years, and while higher case rates do not necessarily lead to more deaths in adults, that is not the case when mothers inadvertently pass this infection to their unborn child. This infection is called congenital syphilis (CS), and more babies die when syphilis rates increase in women of child-bearing age.

A new CPS statement on this growing public health crisis was published in March by the CPS Infectious Diseases and Immunization Committee. Written by Drs. Michelle Barton-Forbes, Ari Bitnun, Sergio Fanella and Laura Sauvé, it replaces a practice point published 2009 and updated in 2018. The statement revisits the prevalence, diagnostics and treatment of this completely preventable infection, with new algorithms and tables to aid clinical care and management across care settings.

Why is it that despite decades of physician awareness, standardized testing, and routine treatment protocols, case numbers are on the rise?

As Dr. Jared Bullard, co-investigator with Dr. Carston Krueger on a one-time survey and a current Canadian Paediatric Surveillance Program (CPSP) study on CS has observed: “A lot needs to go wrong for a baby to be born with syphilis.... It’s pointing at multiple failures along the path.” In other words, enhanced spread is occurring for multiple reasons.

One leading cause is suboptimal screening for syphilis during pregnancy due to inadequate prenatal care, a gap further aggravated by the pandemic noted in the recent CPS statement on this topic.

There are also diagnostic reasons, such as maternal infection that is often asymptomatic or presents with only transient, non-specific signs like fever or rash that are easy to ignore or mistake for something else. Treatment failures can occur, such as when the sexual partners of women are not concurrently tested and treated. Vulnerable women, such as those impacted by unstable housing, substance use or other social determinants of health, are at higher risk of not receiving the health care and supports they need.

However, while any sexually active person can get syphilis, the disease is both easy to test for and easy to treat effectively.

Because physical symptoms of CS are so often non-specific, serology remains the cornerstone of diagnosis, and if a prospective or new mother tests positive, the clinician’s first care step is to review her records to make sure that previous treatment has been adequate and effective. All newborns should be physically examined for signs of CS, but because these may not show for weeks or even months post-birth, comparing maternal-infant blood samples in the immediate post-partum period is key to diagnosis and early treatment.

When a mother who tests positive has not been properly managed before or during pregnancy, her baby will need to have a more extensive workup and receive a treatment course of penicillin. A statement algorithm clearly defines risk levels for CS, with appropriate responses for managing, treating and following up each scenario.

The Public Health Agency of Canada is also re-evaluating its guidance on syphilis this year.

CONGENITAL SYPHILIS

Addressing a public health crisis

Since 2018, congenital syphilis has undergone a resurgence in Canada.

Rates rose from 4.6 cases per 100,000 live births in 2018 to 13.4 in 2020.



Risk factors for syphilis in pregnancy

- A lack of or inadequate prenatal care
- Multiple sexual partners
- Inadequate or no treatment of prior syphilis infection
- Other sexually transmitted and bloodborne infections
- Methamphetamine or other substance use

Evaluating infant risk



- Are there maternal risk factors? Are maternal test results available?
- If maternal syphilis is diagnosed, determine treatment adequacy. If concerned about risk, retest mother and compare to infant's test.
- Examine infant for signs of congenital syphilis. Key signs include neonatal sepsis, rash, hepatosplenomegaly and anemia/thrombocytopenia, but any organ system can be affected.

And remember:

- At birth, 50% to 90% of newborns are asymptomatic.
- Signs of disease may take months to manifest.
- Symptoms can be broad and mimic other conditions, making diagnosis challenging.
- If untreated, sequelae may take years to develop.

Key takeaways:

#1.

No infant should be discharged home without documenting maternal syphilis status, treatment as required, or a plan to test the mother or baby with secure follow-up.

#2.

Every newborn, regardless of risk should have a physical examination looking for signs of congenital syphilis.



Learn more at www.cps.ca

First-ever Dr. Kent Saylor Bursary recipient aims to advance Indigenous health care

Taylor Stoesz, the first-ever recipient of the Dr. Kent Saylor Bursary for Indigenous Medical Students was inspired to pursue a career in health care while in the final stages of her law degree.



Taylor Stoesz

The bursary, established through Healthy Generations, was named for Dr. Kent Saylor, a Mohawk paediatrician and former chair of the First Nations, Inuit and Métis Health Committee and provides \$2,500 to an Indigenous medical student interested in expanding their knowledge of paediatrics.

Taylor is a third-year-medical student at McGill University in Montreal and a member of the Manitoba Métis Federation who studied law at the University of Manitoba. During her articling year at an Indigenous law firm, she worked with Indigenous communities and learned about the barriers they face in accessing quality healthcare. That's when she decided to pursue a career in medicine with the hope of one day working in remote and rural Indigenous communities and improving access and quality of care for children.

"Children in Indigenous communities in rural areas may face additional barriers to accessing quality healthcare. I am determined to help increase access to healthcare for [these] children." Taylor says.

At McGill, Taylor has done research focused on improving healthcare access for Indigenous children and families with a focus on cultural safety. She recently finished a project identifying culturally safe health and social services for Indigenous children in paediatric hospitals across Canada.

She has also assisted her mentor, Dr. Patricia Li, in a retrospective chart review analyzing clinical outcomes of using high-flow nasal cannula to treat paediatric patients with bronchiolitis. Taylor also participated in research with Dr. Emilie Trinh to explore the effects of end-stage renal disease on Indigenous patients. She plans to conduct further research to help Indigenous children, thanks in part to a grant from the Canadian Institutes of Health Research.

In addition to her studies, Taylor is a busy volunteer. She has contributed to an Indigenous Health Professions Program initiative to connect tutors with Indigenous students. Taylor has also volunteered with a program to foster friendships with children and adolescents with disabilities. She has mentored youth from minority and underrepresented backgrounds interested in healthcare through the McGill Mentorships in Healthcare Program.

Taylor intends to use the bursary funds to support studies while she takes a visiting elective in paediatrics this year. She says the elective is an opportunity to network with paediatricians and deepen her knowledge of child health, especially neonatology.

CPS grant supports resident-led advocacy projects

Two resident-led advocacy projects that aim to fill gaps for underserved children and youth received grants from Healthy Generations in 2023. We spoke to both grant recipients to learn more about their work.

Dr. Taylor Heinzlmeir is a paediatric resident at Dalhousie University whose grant will be used to help develop health-oriented curriculum for youth in foster care in Halifax.

“[Youth in care] are often forced to take a more active role in their autonomy than some of their peers. That includes managing their health care,” said Dr. Heinzlmeir. “Our project is about empowering youth who have been otherwise excluded or have had significant trials in their past.”

He says the project aim is to help youth feel more comfortable and confident when it comes to understanding their health needs and seeking care. Dr. Heinzlmeir and his colleagues will collaborate with a local school and agency that runs group homes in Halifax.

Dr. Heinzlmeir was thrilled to get involved. He was already working with youth in care, and grew up in a family that fostered children in care. He had also worked at a similar facility before entering medicine.

“I had many foster brothers and sisters, and [this has] always been something I was passionate about. One of the reasons I chose paediatrics was because I knew that there were a lot of struggles involved in the lives of kids in care,” said Dr. Heinzlmeir.

He encourages other paediatricians to get involved with projects that can have long-term health benefits for youth.

“I think coming up with ways to include vulnerable people in our society builds stronger communities.”



Dr. Taylor Heinzlmeir



Dr. Carolyn Akladious

Dr. Carolyn Akladious, a paediatric resident at Sick Kids in Toronto, received a grant to help translate discharge information from the emergency room.

As Canada continues to become more diverse, Dr. Akladious says the health system needs to ensure patient care is accessible and effective for these populations.

“There’s a lot of focus on ensuring we’re using interpretation services in our patient encounters, which is amazing, but it seems counterproductive to then provide these patients with discharge information in English, knowing that is not their preferred language,” she said.

The Healthy Generations grant will be used to hire professional medical translators to create information in five languages on common ED presentations. The resources will also be added to the EMR for families who indicate a non-English language preference.

She hopes a similar system may eventually be available for colleagues in other hospitals. In the meantime, she encourages paediatricians to consider the importance of making written discharge information more accessible for all families.

“We need to strive to make translated discharge information a standard of care. The emergency department can be a stressful environment, and any verbal information given during the encounter might understandably become hard to recall. It is important to provide written resources in a family’s preferred language, to empower them to manage symptoms at home and recognize when to return to hospital.”

Through the Paediatric Resident Advocacy Grant, Healthy Generations supports community-based projects led by trainees. Learn more at healthygenerations.ca/Grants/paediatric-resident-advocacy-education



“A lot of young people don’t really know how much they should be using or what they should do if they experience a side effect.”

Dr. Kyle Ganson

One-time survey on the use of APEDS among Canadian children and adolescents

A one-time Canadian Paediatric Surveillance Program survey on the use of appearance and performance-enhancing drugs and substances (APEDS) among children and adolescents will go out to paediatricians this spring. Principal investigators Dr. Debra Katzman and Dr. Kyle Ganson hope to use the results to shed light on gaps in the literature regarding adverse events and complications related to APEDS use among youth, particularly in Canada. Currently, the reporting of adverse events to public databases in both the U.S. and Canada is underutilized, preventing a comprehensive understanding of the issue.

In recent years, the use of APEDS has risen among adolescents and young adults. Dr. Ganson said the rise is in part due to body ideals emphasizing muscularity and leanness for boys and young men, and a toned and fit body for girls and young women. The use of APEDS is purported to help achieve these specific body ideals. Additionally, there has been a general cultural shift towards “healthism,” an ideology he characterizes as an overemphasis on keeping healthy to “optimize the body’s performance, increase longevity [and] decrease negative impacts on health.”

He and Dr. Katzman agree that social media play a considerable role in perpetuating this trend.

“Most people are getting their information through informal sources, like fellow athletes, influencers, or websites,” said Dr. Katzman. “Most are not going to peer-reviewed literature.”

Both authors warn that information shared from these informal sources can range from accurate to potentially misleading.

Young people seeking to modify their bodies have easy access to a variety of dietary supplements, including whey protein, creatine, amino acids, pre-workout powders, and collagen.

However, Dr. Ganson points out that there is evidence suggesting that misuse, particularly for performance enhancement or muscle building, can lead to adverse effects.

The lack of clarity regarding appropriate usage and potential side effects also poses a risk to young people, Dr. Ganson said.

“A lot of young people don’t really know how much they should be using or what they should do if they experience a side effect.”

He added that while substances like whey protein and creatine are often considered safe, they lack robust regulation in Canada, leaving room for potential adulteration with stimulants or steroids, contamination, or mislabeling.

The ultimate goal for Dr. Katzman and Dr. Ganson is to educate young people and their families about the potential risks associated with these substances. Dr. Katzman also hopes the survey will be “an opportunity to educate paediatricians about the fact that young people are indeed using [APEDs].”

The investigators will use the upcoming survey as a tool to gauge how many paediatricians are screening, assessing, or inquiring about APEDS use in their interactions with young patients. They also plan to eventually expand the survey into a detailed case analysis to gain a better understanding of individual instances where young people may have experienced adverse events related to APED use.

Ultimately, the survey will serve as a crucial step towards addressing the gaps in knowledge and promoting awareness of APEDS use in Canada’s youth population. The investigators hope it will empower both families and paediatricians to effectively confront this growing concern.



“IMPACT brought not just a counting of cases, but also a clear interpretation of cases and a broader understanding of the disease and disease burden – including economic analysis of the cost effectiveness of vaccination.”

Dr. Scott Halperin

A lasting IMPACT

When physicians noticed an unusual number of children presenting with aseptic meningitis in the 1980s, they wondered if something wasn't quite right with the recently approved mumps vaccine. That vaccine was found to not be adequately attenuated, and it was pulled from the Canadian market.

The weakness of a passive system for monitoring vaccine safety had been demonstrated, and the federal government approached the CPS to lead an active surveillance program (eventually known as “IMPACT”) based out of children's hospitals across the country.

“It was very reassuring to the public,” said IMPACT founding co-director Dr. Scott Halperin, who noted it was a period when vaccines were under intense public scrutiny.

A two-year pilot project was established out of five children's hospitals, expanding to 10 sites in 1993 and 12 in 1999. Recently, McMaster Children's Hospital in Hamilton and the Children's Hospital at London Health Sciences have brought the number of sites to 14, representing over 90% of all paediatric tertiary care beds in Canada.

Since 1990, IMPACT has monitored not only for adverse events following immunization, but also for the incident rate of vaccine-preventable diseases. Data collected through the program provided real-time information to Health Canada and PHAC during the busy respiratory virus season, demonstrated the need for and effectiveness of new vaccines, and helped grow the knowledge base as high-quality peer reviewed studies were published. The program was so successful that it was used as a model to implement similar programs in other countries, including Australia.

Beyond counting cases or, why fix what's not broken?

In the fall of 2023, PHAC awarded the contract for adverse events following immunization (AEFI) and respiratory virus



Dr. Scott Halperin

monitoring to another group, interrupting 33 years of robust, consistent data collection.

“IMPACT brought not just a counting of cases, but also a clear interpretation of cases and a broader understanding of the disease and disease burden – including economic analysis of the cost effectiveness of vaccination,” Dr. Halperin said, noting that the IMPACT network involves nearly all paediatric infectious disease specialists in Canada. “And that's being lost because the infectious disease expertise is not going to be there anymore with this new system of counting cases that the Public Health Agency has implemented.”

By switching reporting systems during the fall respiratory season, Dr. Halperin worries about a knowledge gap. “It's a bad time,” he said, noting that the coinciding circulation of influenza, COVID and RSV is still new. “National data is more than just the ten provinces and three territories added up; it's surveillance done in the same way by highly trained people doing the same thing the same way every day.”

The future of IMPACT

Early this year, CPS was awarded the contract for national surveillance of certain vaccine-preventable diseases through the IMPACT network. Notably, surveillance for invasive group A streptococcal was included for the first time – a welcome addition with greater numbers and complexity across the country. Data collected will help paint a clearer picture of complications and may help shed light on whether it is becoming more virulent.

As for what may come next for the network?

“Ultimately, our strength comes from the people. The heartbeat of IMPACT are the investigators and the nurse monitors, and CPS coordination of all that,” said co-principal investigator, Dr. Manish Sadarangani. “We have a really good understanding of where the field is right now and so we'll be considering opportunities for how IMPACT can support decision-making and improve child health going forward.”



“We can now use all the tools that are at our disposal to help families manage their diabetes well, whereas before, we weren’t able to do that for everybody.”

Dr. Beth Cummings

Nova Scotia prioritizes optimal diabetes management at school

Parents of children with type 1 diabetes in Nova Scotia now have more choice about their child’s insulin regimen thanks to a provincial policy that expands the care students can receive at school. The policy—fully implemented for the start of the 2023-24 school year—makes Nova Scotia only the second province (after British Columbia) to have a policy that ensures students who need support with insulin injections can receive help from trained staff.

Dr. Beth Cummings, a paediatric endocrinologist at the IWK in Halifax, was a leader in bringing this policy to life.

“For a long time, we’ve recognized there needs to be better support for diabetes care for children in school. [Since the province implemented the policy], we’re seeing that families are getting better results with their blood sugars, which is what we’re all working towards,” said Dr. Cummings, one of the physician leads on the CPS Diabetes@School project.

Like adults with type 1 diabetes, children and youth need a continuous level of basal insulin—whether delivered through a pump or injection—along with bolus doses when they eat. Until recently in Nova Scotia, students who couldn’t administer their own insulin at school by injection or pump had to rely on intermediate-acting insulin delivered at home in the morning. If a parent could not go to school each day to give lunchtime insulin, students needed to eat a pre-planned amount of food at specific times to avoid drops in blood sugar. Not only was this regimen less than ideal for children, it also resulted in suboptimal glucose control.

“We can now use all the tools that are at our disposal to help families manage their diabetes well, whereas before, we weren’t able to do that for everybody. We sometimes felt like we should

push people to a pump faster than maybe they felt they were ready for,” said Dr. Cummings.

The policy has been a significant win for children and youth with diabetes, but it didn’t come quickly or easily.

“It was at least a ten-year journey and involved the support of multiple players to get this into place,” said Dr. Cummings.

The CPS statement on diabetes management at school, which Dr. Cummings helped to author, was one resource that supported this advocacy work.

“Having the force of the guideline behind us helped move the processes forward, but it also took a lot of work and [long-term] relationship building with people from the department of education and within the school system,” she said.

A key factor in the success of the policy, she added, is Nova Scotia’s system of School Health Partnership (SHP) nurses. They were tasked with facilitating staff training because they already train school personnel to support students with chronic health issues during the school day.

Initially, school staff were nervous about administering insulin injections but once training began, they became engaged.

“They’ve taken it and owned it,” said Dr. Cummings.

She said it was important to acknowledge school staff’s fear of administering injections and to use accessible language, such as “insulin pens” instead of “needles” or “injections.”

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DIABETES AT SCHOOL

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“Words matter, and so does being ready to empathize,” said Dr. Cummings. “This isn’t what school staff are trained for, but we were able to find a common ground: Everybody wants the best for the students.”

The success of this story comes down to three factors, said Dr. Cummings: perseverance, collaboration and understanding.

“Part of what is different than the day-to-day of seeing patients in clinic is building partnerships outside of our silo, and listening to what everyone’s challenges are,” she said. “For example, there was a union issue at the school board when this happened. Sometimes, we’re impatient but listening and understanding why things take so long and what the other side is doing is important. Remember that everyone wants the same thing, and don’t give up. To keep going back is what helped it happen and is a satisfying part of my career as a paediatric endocrinologist.”

CPS provides diabetes education for school staff

A learning module to help school staff across Canada support students with type 1 diabetes has become an important part of the implementation of Nova Scotia’s new policy on insulin administration in schools.

Managing type 1 diabetes at school: An online course for educators and school staff is a one-hour self-directed module, available in English and French, that covers the basics of diabetes and specific considerations for the school day. Based on materials on the Diabetes@School website, it was developed with paediatric endocrinologists Dr. Beth Cummings and Dr. Sarah Lawrence.

Nova Scotia requires that all staff in a school where there is a student with diabetes complete the module. To date, thousands of school staff members in Nova Scotia have completed the education.

Development of the module was supported by Abbott Diabetes Care, Dexcom Canada Co., embecka, Novo Nordisk Canada Inc., and Sanofi.

For more information, visit diabetesatschool.ca and click on “Online Education.”

Conference on Indigenous child and youth health is a place to ‘be the change we want to see’

The 11th International Meeting on Indigenous Health will be held in March 2025 in Winnipeg, located in Treaty One Territory and the homeland of the Red River Métis.

The Canadian Paediatric Society and the American Academy of Pediatrics are welcoming a new partner to the meeting: the National Collaborating Centre for Indigenous Health. After many years of involvement in IMICH, the NCCIH is now a conference co-sponsor along with the CPS and the AAP.

“This conference is an opportunity for conversations about being in relationships and being the change we want to see,” said Dr. Margo Greenwood during the 10th IMICH, held in 2023 in Tulsa, Oklahoma. Dr. Greenwood is the former academic lead of the NCCIH, and was appointed to the Canadian Senate in 2022.

IMICH is the only conference focused on the health needs of First Nations, Inuit, Métis, American Indian, and Alaska Native children and youth. It also attracts presenters and delegates from Indigenous communities around the



world—from Australia to South America.

The last time the biannual conference was held in Canada was in 2019: IMICH alternates between the United States and Canada, and 2021 was a virtual event. The first was held in 2003 in Seattle, Washington.

While the call for session proposals closed in May, abstracts will be accepted until November 6. Registration will open in November as well.

The conference planning committee—co-chaired by Dr. Ryan Giroux (CPS) and Dr. Kate Golski (AAP)—includes representatives from the Alaska Native Medical Center, Assembly of First Nations, Association of American Indian Physicians, Canadian Indigenous Nurses Association, Indian Health Service, Inuit Tapiriit Kanatami, Métis National Council, National Indian Health Board, Native Health Initiative, and The Aspen Institute, Center for Native American Youth.

For information about IMICH, visit cps.ca/en/imich, or follow the conference at facebook.com/IMICH2025.



Canadian Conference on Child & Youth Mental Health

NOVEMBER 1-3, 2024 • TORONTO

Building resilience in a complex world

The CPS will host the first-ever Canadian Conference on Child and Youth Mental Health in Toronto, from November 1 to 3.

Co-chaired by Dr. Daphne Korczak, a child and adolescent psychiatrist and CPS Mental Health Task Force chair, and Dr. Jae-Marie Ferdinand, a community paediatrician and chair of the CPS Continuing Professional Development Committee, the conference will bring together leading experts in child and youth mental health to help paediatricians manage the increasing needs of patients and families.

Dr. Ferdinand recently described the forum's purpose this way: "Paediatricians are increasingly the main resource for children and youth with mental health disorders, often managing complex medical, social and psychoeducational issues. This gathering of experts is important as adequate training, ongoing education, and support from our child psychiatry, psychology and social work colleagues is key to optimizing the care of these children and their families." The timing could not be more opportune, as consultation with members, results from recent Canadian Paediatric Surveillance Program (CPSP) surveys, and research emerging in the post-pandemic period all indicate that the mental health needs of children and youth have never been greater.

In 2019, the CPS and the Canadian Academy of Child and Adolescent Psychiatry (CACAP) co-hosted a popular three-day CME course focused on mental health conditions and approaches to care, and participants said they would welcome more in-depth content on these issues. More recently, a membership needs assessment conducted in 2023—and in-depth consultation since—indicate that mental health remains a top priority for paediatricians in Canada.


Many faculty already engaged to speak are CPS or CACAP members, and all are experts in their fields. The program is designed to interest a wide range of learners: paediatric care providers of every stripe, family physicians, nurse practitioners, educators, and social workers. Planned sessions include managing complicated ADHD, diagnosing and managing OCD, pharmacology use for anxiety,

depression and eating disorders, and responding to self-harm, to name a very few. Screening tools and diagnostics are another focus, with established therapies such as CBT, parent training and FBT are workshop topics, with much, much more on offer.

Due to the conference, there will be no Lifelong Learning in Paediatrics course this fall.

For more information, visit www.cps.ca

Caring for children living with intimate partner violence (IPV)



7.9 % of children are exposed to IPV at home before age 16
2012 Canadian Community Health Survey

When children live in a home with IPV

→


Their relationships and physical and mental health suffer

WHAT CAN HEALTH PROFESSIONALS DO?

- Don't use universal screening**
- Do ask questions (when safe) if you suspect IPV**

WHEN IPV IS SUSPECTED OR DISCLOSED

- Meet family members alone, ask about home life
- Listen and respond with empathy
- Assess risk for all family members
- Continue to provide care
- With consent, refer to supportive resources
- Discuss harm to children with child welfare authorities



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DO YOU SEE ADOLESCENTS IN YOUR PRACTICE?

www.cps.ca/en/cannabis

For resources to help you counsel
youth and parents about cannabis.



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