HEARTSMAP CME - HOME

<table>
<tr><td colspan="2">HEARTSMAP Domain Home</td></tr>
<tr><td colspan="2">Number of articles 4</td></tr>
<tr><td>General Theme</td><td>Clinician Bottom Line</td></tr>
<tr><td>Divorce:
The quality of parenting, parent-child interaction, and the presence of familial conflict or violence influence child and adolescent's adjustment after separation. (Level of Evidence: II.1)</td><td>Providing families with information on supportive community programs can improve parent and child/youth's adjustment to separation or divorce.
See article #1</td></tr>
<tr><td>Sexual orientation
LGBTQ youth face elevated risks in physical, mental, and social domains due to stigmatization, and stigmatization at home can especially predispose the youth to become street-involved. (Level of Evidence: II.1)</td><td>Social work can help address the psychosocial concerns of the LGBTQ youth, especially pertaining to stigmatization at home.
See article #2</td></tr>
<tr><td>Street-involvement
Familial dysfunction often predisposes youth to become street-involved. This poses a unique healthcare challenge, especially with regard to scheduling follow-ups. (Level of Evidence: II.1)</td><td>Youth should be connected to a social worker to ensure the fulfillment of basic needs and the arrangement for follow-up visits.
See article #3</td></tr>
<tr><td>Co-morbid anxiety and depression
Youth with co-morbid anxiety and depression self-reports higher family dysfunction than youth with anxiety alone. (Level of Evidence: II.2)</td><td>Improving the family dynamic can be a potential point of intervention in reducing comorbidity of depression in youth with anxiety.
See article #4</td></tr>
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1. Clark, B. (2016). Supporting the mental health of children and youth of separating parents: Position statements and practice points. Canadian Paediatric Society. Retrieved from http://www.cps.ca/documents/position/mental-health-children-and-youth-of-separating-parents
    a. **Objective**: to identify risk and protective factors for children and youth of divorcing or separating parents.
    b. **Method**:
        i. **Population**: children and youth of separating or divorcing parents
        ii. **Design:** a systematic summary of census, descriptive, ecological, cross-sectional, and longitudinal cohort studies
        iii. **Primary outcome measure:** social, emotional, and psychological adjustment of children and youth after the separation of parents.
    c. **Result:** Divorce and separation can potentially have harmful effects on the physical, mental, educational, and psychosocial well-being of children and youth. Although many children experience distressing emotions initially, the majority do not sustain serious outcomes. The extent of negative outcomes varies, but some of the common risk factors have been identified. For instance, the quality of parenting, parent-child interaction, and the presence of familial violence and abuse influence the degree of adjustment after divorce. In terms of therapeutic support, counselling through a family counsellor or social worker has shown improved outcomes, as it enhances the separated couples' ability to co-parent, resolve conflicts, and

remain involved in the child's life. Group support for youth of divorced families also shows a positive impact on social adjustment, school performance, and reduced anxiety.

   d. **Conclusion**: There is strong evidence for the article's finding that the quality of parenting, parent-child interaction, and the presence of hostile conflicts and violence predict the degree of child's adjustment after divorce. Support programs that target these family processes can mitigate the harmful effects of divorce on children and adolescents.
   e. **Level of evidence**: II.1 (a systematic summary of various types of studies)

2. Kaufman, M. (2016). Adolescent sexual orientation: Position statements and practice points. Canadian Paediatric Society. Retrieved from http://www.cps.ca/documents/position/sexual-orientation.
   a. **Objective:** Review what is the best clinical guideline in assisting lesbian, gay, bi-sexual, transgender, questioning (LGBTQ) youth in navigating their sexual orientation, family dynamics, relationships, and stigmatization.
   b. **Method**:
      i. **Population:** LGBTQ adolescents
      ii. **Method:** a systematic summary of census, demographic studies, and cross-sectional studies on LGBTQ youth and their risks, behaviours, and health needs.
      iii. **Primary outcome measure:** prevalence of stigmatization in LGBTQ youth; odds ratios of psychosocial maladjustments and risks that LGBTQ youth face compared to heterosexual youth
   c. **Result:** LGBTQ youth face elevated psychological, social, and health risks, almost all of which stem from stigmatization they face from their family, peers, and society. Stigmatization at home especially puts LGBTQ youth at a risk of harassment, running away from home, and street involvement. Furthermore, in the absence of familial support, these adolescents struggle to develop a healthy identity without their parents' help.
   d. **Conclusion:** The position statement presents solid evidence that LGBTQ youth face elevated risks in psychosocial and health domains due to stigmatization. Clinically, physicians can mitigate the stigmatization they face by listening to their concerns in a warm, non-judgemental way. The clinician can also assist the teens in bringing up the issue of LGBTQ to their parents, should they wish to do so. At any time during the process, a physician should not disclose the teen's sexual orientation to the parents without the adolescent's consent. If the parents were already aware of the child's sexual orientation, the physician can encourage the parents to still love their children, even if they struggle to accept the teen's sexuality. In addition, physicians can help connect the teen to youth health or social work to address the psychosocial issues in greater depth.
   e. **Level of evidence:** II.1 (a systematic summary of various types of studies)

3. Elliott, A. (2013). Meeting the health care needs of street-involved youth: position statements and practice points. Canadian Paediatric Society. Retrieved from http://www.cps.ca/documents/position/health-care-needs-of-street-involved-youth
   a. **Objective:** to identify the risk factors and special health care needs of street-involved youth
   b. **Method:**
      i. **Population:** street-involved youth
      ii. **Design:** systematic review (MEDLINE search) of studies on street-involved youth between 1950 and 2012. Involves descriptive and ecological studies of street-involved youth, as well as cohort and cross-sectional studies on prevalence and incidence rate of various infections in street-involved youth
      iii. **Primary outcome measure:** risk factors that predispose youth to street involvement; risk factors associated with street-involvement

c. **Result:** Street-involved youth face elevated risks in physical, emotional, mental, and social domains. Risk factors that predispose youth to street-involvement are often familial, which include poverty, family dysfunction, violence, sexual and physical abuse, and parental substance use.
d. **Conclusion**: The meta-analysis of various studies provides robust evidence for the presence of various risks that street-involved youth face. Therefore, in managing street-involved youth, a clinician or social worker should include a brief socioeconomic assessment that covers the youth's basic needs such as housing and food. As long-term management, the youth should be connected to social work to ensure a sustained satisfaction of youth's basic needs and the arrangement for follow-up visits.
e. **Level of Evidence**: II.1 (a systematic summary of various types of studies)

4. O'Neil, K. A., Podell, J. L., Benjamin, C. L., & Kendall, P. C. (2010). Comorbid Depressive Disorders in Anxiety-disordered Youth: Demographic, Clinical, and Family Characteristics. *Child Psychiatry & Human Development*, *41*(3), 330–341. http://doi.org/10.1007/s10578-009-0170-9
    a. **Objective**: to observe the family characteristics of youth with co-morbid anxiety and depressive disorders.
    b. **Method:**
        i. **Population**: 200 children and adolescents aged 7-17 presenting to anxiety disorder clinic at Temple University.
        ii. **Design**: a cross-sectional study involving multiple interviews and self-reported questionnaires to measure anxiety, co-morbid depressive disorders, and family functioning.
        iii. **Primary Outcome**: statistically significant mean difference in self-reported family functionality between youth with co-morbid anxiety and depression and youth with anxiety alone
    c. **Results:** 12% of youth with anxiety had co-morbid depressive disorders, which was lower than the literature value of 28% to 54% based on previous research. Compared to anxious youth without co-morbid depression (M= 22.79, SD = 5.57), youth with comorbid depression and anxiety reported significantly higher family dysfunctionality on the general family functioning scale (M = 25.69, SD = 3.18). Youth with comorbid depression and anxiety also reported more anxiety and depressive symptoms than youth with anxiety alone.
    d. **Conclusion:** Given the small to moderate sample size, this cross-sectional study carries fair evidence that family dysfunction could be a risk factor in developing co-morbid depression among youth with anxiety. Potentially, an intervention aimed at reducing familial conflict could alleviate the comorbid development of depression and anxiety.
    e. **Level of evidence:** II.2 (cross-sectional study with a limited sample size)

Appendix: Guide for Level of Evidence

Canadian Task Force on the Periodic Health Examination's Levels of Evidence*

Level	Type of evidence
I	At least 1 RCT with proper randomization
II.1	Well designed cohort or case-control study
II.2	Time series comparisons or dramatic results from uncontrolled studies
III	Expert opinions