# APPENDIX 1

Mental Health Dashboard questionnaire PARENT FORM Anchor points

| | | Circle the best response | | | Comment |
|---|---|---|---|---|---|
| MY CHILD'S EXPERIENCES | Trauma | never | mild | severe | |
| | Separations from parent | Never long | Longer than I month | Out of home placement | |
| | Parent Stresses: (specify) | no | mild | serious | |
| | Parent with depression Mother __ Father ___ | no | mild | significant | |
| | Parent with mental health or substance abuse concerns | no | mild | significant | |
| | Divorce or separation | no | yes | currently | |
| | Someone harmed my child | never | A little bit | seriously | |
| MY CHILD'S HEALTH | | 0 No | 1 Yes, but not a problem now | 2 Yes, and still is a problem | |
| | Illness or health problem | none | Mild or occasional | Severe or ongoing | |
| | Asthma or respiratory condition | no | Mild or occasional | Severe or ongoing | |
| | Other medical problem | no | Mild or occasional | Severe or ongoing | |
| MY CHILD'S DEVELOPMENT | I have concerns about how my child is developing | no | possibly | yes | |
| | I am concerned whether my child is autistic | no | possibly | yes | |
| | I know where to get support for my child's development | yes | possibly | no | |
| MY CHILD'S FEELINGS AND BEHAVIOR | Compared to other children, my child: | | | | |
| | Has trouble learning or communicating | no | somewhat | yes | |
| | Is overactive | no | somewhat | yes | |
| | Has trouble paying attention | no | somewhat | yes | |
| | Is impulsive, or has risky behaviors | no | somewhat | yes | |
| | Has negative or aggressive behaviors | no | somewhat | yes | |
| | Is anxious/ has fears | no | somewhat | yes | |
| | Is sometimes too sad or too happy | no | somewhat | yes | |
| | Has trouble getting along with others | no | somewhat | yes | |
| | Is shy or withdrawn | no | somewhat | yes | |
| | Has had traumatic experiences | no | somewhat | yes | |
| | Has trouble with sleep, eating, caring for him/herself | no | somewhat | yes | |
| MY FAMILY & NEIGHBORS | I have someone to rely on in an emergency | yes | maybe | no | |

Adapted from Knapp, P, Laraque-Arena D, & Wissow LS. Iterative Mental Health Assessment IN Foy JM (Editor) Mental Health Care for Children and Adolescents – A guide for Primary Care Clinicians. Istaca (IL) American Academy of Pediatrics 2018. Pp 217-217.


https://dx.doi.org/10.21037/pm-20-72

Mental Health Dashboard questionnaire PROVIDER FORM Anchor points

| | | 0 | 1 | 2 | Comment |
|---|---|---|---|---|---|
| CHILD'S LIFE EX-PERIENCES | Trauma | no | At risk | confirmed | |
| | Separations from parent | Never for long | Longer than I month | Out of home placement | |
| | Parent Stresses: (specify) | no | mild | serious | |
| | Parent with depression Mother __ Father ___ | no | suspected | Significant/ confirmed | Total: experience |
| | Parent with mental health or substance abuse concerns | no | suspected | Significant/ confirmed | |
| | Involvement of both parents in child's care | yes | somewhat | no | |
| | Abuse or neglect | no | suspected | confirmed | |
| CHILD'S HEALTH | Child's overall health status | OK | Significant problems in past | Ongoing problems | |
| | Child's use of health care services | Up to date | Episodic | Usual care is urgent care/ER | |
| | Medical vulnerability, e.g. Asthma | no | Mild or intermittent | Severe or ongoing | |
| | Child with special health care needs | no | Yes- with medical home | Yes- but No medical home | Total: Health |
| CHILD'S DEVELOP-MENT | Developmental status | On track | Some delays | Global delay | |
| | Assessment | no | checklist | Standardized measure | Total: Development |
| | Autism or PDD | no | possible | yes | |
| | Developmental support or resources | Not needed | Receives services (EI, MH, ECE etc) | Needs but does not receive services | |
| SOCIAL EMOTIONAL BEHAVIORAL | | 0 = strengths/ no problem | 1= Child has symptoms requiring time for advice etc | 2 = Active problem receiving treatment | |
| | Communication or Learning problem | no | Needs some extra support | Dx of LD | |
| | Hyperactivity | no | somewhat | ADHD Dx | |
| | Inattention | no | somewhat | ADHD Dx | |
| | Impulsive or risky behaviors | no | Upper bounds of normal. | Active problem | |
| | Negativity, Aggression | no | somewhat | ODD, CD or DBD | |
| | Anxiety | no | Appropriate to age or experience | Significant, with functional impairment | Total: Social-Emotional-Behavioral |
| | Mood: sad, depressed, labile or manic | no | Appropriate to age or experience | Significant, with functional impairment | |
| | Shy or withdrawn | no | Occasional or in some situations | Limits age-appropriate experiences | |
| | Relationship difficulties | no | Occasional or in some situations | Limits age-appropriate experiences | |
| | Traumatic exposure | no | Yes, but no trauma–specific symptoms | Yes, with ongoing symptoms | |
| | Regulatory problems: sleep, eating, self-care | no | Appropriate to age or experience | Significant, with functional impairment | |
| | Referral for mental health services | Not needed | Referred and receiving Rx | Needs, but not receiving RX | |
| | Psychotropic medication | Not needed | Receives and is responding | Needs, but not receiving or not responding | |
| FAMILY RESOURCES/ SUPPORT | Adequate social support network | Yes | Maybe | No | |

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https://dx.doi.org/10.21037/pm-20-72

## APPENDIX 2

**Vignette #2 Ricky**

8-year old Ricky, an established patient, is seen acutely after a skateboard accident. He sustained bruises, abrasions and a right wrist sprain. His mother commented that he is struggling in third grade, especially reading and handwriting, and she has had to use access to his skateboard as reward for finishing his homework, so "when he finally gets outside, he tries to make up for lost time and takes too many risks."

Social History: Ricky is the middle of three children, with sisters one year younger and two years older. His older sister is in a talented and gifted school track, and his younger sister reads better than he does. Both parents work, and Ricky's after-school program is large and somewhat unstructured. Ricky's maternal grandmother has terminal breast cancer, and his mother spends much time on evenings and weekends taking care of her. His father's job requires frequent travel.

Medical History: surgical correction of pyloric stenosis in infancy, treated x 4 for otitis media, multiple allergies.

Developmental History: Slight delay in language acquisition.

Social-Emotional: Ricky has always been more active than his sisters, and his mother describes him as "loveable but demanding." He is eager to spend time with his father, and his mother says she has more difficulty managing his behavior when his father is away. It is most difficult to get him to go to bed and get to sleep on school nights. He had night terrors when he was younger, and still has occasional nightmares and very infrequent bed-wetting. His pediatrician previously identified that Ricky may have ADHD inattentive type, but his father is opposed to medication, and in the last couple of

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months, neither of his parents have been able to consistently help him with homework. His mother reports that his school has been responsive in making accommodations to his learning style. A student study team has conferred about his progress, but an Individualized Educational Plan (IEP) has not been developed.

Screening: On the Strengths and Difficulties Questionnaire (SDC) (42), Ricky previously scored 9 (abnormal range) on the Hyperactivity scale, but his overall difficulties score was in the normal range, as was the impact score. On an ADHD Parent Rating Scale, he previously scored in the abnormal range on the Predominantly Inattentive scale, with abnormal scores in academic performance.

Observations: Ricky is cooperative with the examination, talkative and eager to know if he can get out of doing written homework while he wears a wrist brace. When the pediatrician suggests he could do his work on a computer, he brightens briefly, but then confides that “I’m dumb anyway, so I’ll probably get way behind.”

Clinical presentation: Ricky’s pleasant, talkative demeanor is a strength, but it also helps him conceal his real struggles to learn. He knows he is “a hyper kid” and that he has to work harder than other kids at his homework. The school is aware of Ricky’s ADHD and possibly attributes his lack of academic progress to this. His mother is attempting to show firmness by requiring him to finish his homework before he can use his skateboard, but other demands on her make it difficult for her to help him, and his frustration propels him to increased risk-taking, already a feature of his ADHD.

This clinical information is consistent with findings on previous screening, but provides more detail about the current family stress, and the academic problem. Ricky’s initial Dashboard observations are shown on Table 8.

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INSERT Table 8 ABOUT HERE

Collaborative treatment planning. Ricky's mother recognized that she was less available but said she hadn't considered that the school should also be doing more to help him academically. She agreed that she should request academic testing and individualized educational plan (IEP).

Pediatric pre-referral intervention, referral: The PCC urged that Ricky's father bring him in for follow-up examination of the wrist so that he could also discuss Ricky's need for support from both parents both for ADHD and schoolwork, and possibly reconsider a trial of psychostimulant medication. They agreed that the PCC would send a note to the school endorsing the recommendation for academic testing and stating that his ADHD was mild and did not explain his reading difficulties. Ricky's intervention plan is shown on Table 9.

INSERT Table 9 ABOUT HERE

Follow-up: Four months later, Ricky's academic evaluation and Individualized Educational Plan (IEP) had been completed. A diagnosis of Dyslexia was identified and Ricky began receiving daily assistance in the school resource room. Ricky's father continued to be reluctant to consider medication for his son, but purchased a small computer for Ricky and had begun to help him do his homework on the computer, also emailing him and helping when he is on the road. Ricky's grandmother is in remission, and his mother is able to spend more time with him. Ricky is beginning to have more academic success and feels less frustrated.

Ricky's Dashboard at follow-up is shown on Table 10

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INSERT Table 10 ABOUT HERE

**Vignette #3 John**

14 year old John is seen for cough, fever and myalgia of 5 days duration, responding incompletely to NSAIDs, rest and fluids. He is accompanied by his mother, who hands the physician a note saying John's grades have dropped in the last 4 months, there has been a change in patterns of his friendships, and his behavior at home is withdrawn or irritable. She asks the physician to ask him if he is using drugs.

Social History: John is an established patient. He is the oldest of 3 children in an intact family. Mother currently working (RN), but father was laid off from work (engineer) and unable to find work for 6 months. John is in 8$^{th}$ grade with above-average academic skills and talent in guitar and piano.

Medical History: Tonsillectomy age 6. L radial fracture age 8. Mild asthma.

Developmental History: normal

Social-Emotional: Father has had history of alcohol abuse but now attends AA. Mother describes him as distant and relatively un-involved in raising the children. He spends most of his day on-line on the computer. Maternal grandfather committed suicide when John was an infant; maternal aunt and paternal uncle both have history of major depression.

Screening: on the Strengths and Difficulties Questionnaire (SDQ) (42) John's mother endorsed items totaling 8, in the normal range. On the CRAFFT screening tool (43), John endorsed that he uses marijuana to relax, and uses it when he is alone, for a score of 2.

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Observations: Physical examination was consistent with symptoms of a viral syndrome. Interviewed alone, John reports being "bummed" after he did not make the basketball team; he says he "can't shake it off." He worries because he hears his parents arguing at night and knows the family can't afford much. He is embarrassed because he wears "tacky clothes" and has acne, so "all the girls think I'm a geek". He doesn't see his best friends as much since they are more involved in sports. He admits to "smoking some weed with this new buddy of mine" on several occasions, and says it makes him feel calmer. When asked about thoughts of self-harm or suicidal thoughts, he seemed genuinely surprised and answered "Oh no, I'm not that bad off."

Clinical presentation: John's strengths are his intelligence and sensitivity. This may contribute to his vulnerability to worry about his family's situation, and his prolonged reaction to the disappointment of not making the team.

While screening with the SDQ, completed by his mother, did not identify concerns in the clinical range, the interview suggests otherwise. Typically, children and adolescents disclose more about internalizing problems than do their parents on standardized screening and assessment tools. Moreover, it is appropriate for adolescents themselves to complete screening tools. A tool such as the PHQ-A for depression (44), available in the public domain, would be more specific to this question.

The Dashboard pattern/profile for John is shown on Table 11

INSERT Table 11 ABOUT HERE

Collaborative intervention planning: Two issues require addressing: John's low mood and anxiety and his substance use. Maintaining confidentiality with an adolescent is necessary, but this need not lead to a breakdown of communication between the

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physician and the parent, if the youngster is given some control about the pacing and degree to which information is shared. John agreed to meet together with his parents and the pediatrician focusing on their shared concerns about how things were going for him in school. In this conversation, he disclosed but minimized his marijuana use and was able to communicate how worried and sad, and also how helpless he felt about the family's financial strain, and even to say he thought there was a connection with his trying out marijuana. His father was particularly sympathetic and said that he knew from his own experience how dark mood and substance abuse were connected.

Following this pre-referral intervention, the family discussed ways to improve John's situation. Referral for mental health services was not financially possible for them, but John's father said he wanted to spend more time with him and his parents said that as he was the oldest child, they would share more information with him about their plans to deal with their reduced income. The intervention plan for John is shown on Table 12.

INSERT Table 12 ABOUT HERE

Follow-up:

John met with the school counselor and developed a plan to catch up on his studies. He joined the swim team and began lifting weights with his father. His parents made themselves more available to him, particularly when his mood seemed low. He found opportunities to make his own money to buy some clothes by delivering papers and helping neighbors with yard work. He began to spend more time with his former friends. John's Dashboard at follow-up 2 months later is shown on Table 13:

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INSERT Table 13 ABOUT HERE

**Table 8 Clinical Silhouette: Ricky – initial evaluation (time 1)**

| Domain | Strength | Expectable Situation | Risk/ Problem RED FLAG | Possible Diagnosis |
|---|---|---|---|---|
| Psychosocial environment | | X | | |
| Traumatic Experiences | | X | | |
| **Primary support** | | X | | |
| **Care-giving** | | X | | |
| **Functional change** | | | mom less available | |
| Environment | | | needs more school support? | |
| Events | | | | |
| Health | | | | |

| Dashboard Domain | Strength | Expectable Situation | Risk/ Problem RED FLAG | Possible Diagnosis |
|---|---|---|---|---|
| Developmental level | | X | T1 behind in reading and writing | R/O Dys-lexia 315.00 |
| Cognition, language | | | Established DX | ADHD 314.01 |
| Attention, executive function | | | | |
| Control of impulses | | T1 consistent with ADHD | | |
| Anxiety | | X | | |
| Mood | | X | | |
| Capacity for Relationships | | X | | |
| Self-regulation | | X | | |

Table 9 Intervention Plan: Ricky

| **FOCUS (Circle target domain)** | **OBJECTIVE** Specific changes in pt. behavior in measurable and behavioral terms, w. target date for completion. | **CHILD/FAMILY STRENGTHS/ CHALLENGES** Past accomplishments, current aspirations, motivations, personal attributes etc. | **INTERVENTIONS** Clinical activity/treatment modality, provider of care, intended purpose or impact, as well as attention, incentives etc |
|---|---|---|---|
| 1-Development<br>2-Cognition, language<br>3-Attention/executive<br>4-Impulse control<br>5-Anxiety<br>6-Mood<br>7-Relationships | 2- Ricky to achieve grade-level reading & writing skills by end of year.<br>3- Ricky to maintain current level of | 2- Educated parents who are invested in child's progress<br>3- Ricky aware that he is "hyper" and | 2- Academic testing and IEP.<br>3- Discuss ADHD treatment with father. |


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| | | | |
|---|---|---|---|
| 8-Self-regulation (including, for adolescents: substance abuse | functional adaptation despite ADHD | that he has to work hard to focus etc. | |

**Table 10 Clinical Silhouette Ricky (time 2)**

| Domain | Strength | Expectable Situation | Risk/ Problem RED FLAG | Possible Diagnosis |
|---|---|---|---|---|
| Psychosocial environment | | X | | |
| Traumatic Experiences | | X | | |
| **Primary support** | | X | | |
| **Care-giving** | | X | | |
| **Functional change** | | both parents more engaged | | |
| Environment | | adequate educational support | | |
| Events | | X | | |
| Health | | X | | |

| Dashboard Domain | Strength | Expectable Situation | Risk/ Problem RED FLAG | Possible Diagnosis |
|---|---|---|---|---|
| Developmental level | | | Still behind in reading and writing | Dys-lexia 315.00 |
| Cognition, language | | | Established DX | ADHD 314.01 |
| Attention, executive function | | | | |
| Control of impulses | | | consistent with ADHD | |
| Anxiety | | X | | |
| Mood | | X | | |
| Capacity for Relationships | | X | | |
| Self-regulation | | X | | |

**Table 11 Clinical Silhouette John Initial evaluation (Time 1)**

| Domain | Strength | Expectable Situation | Risk/ Problem RED FLAG | Possible Diagnosis |
|---|---|---|---|---|
| Psychosocial environment | | X good | | |
| Traumatic Experiences | | X none | | |
| **Primary support** | | | Father “distant” | |
| **Care-giving** | | X adequate | | |
| **Functional change** | | | Father depressed? | |
| Environment | | | Economic strain | |


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| | | | | |
|---|---|---|---|---|
| Events | | Disappointment re basketball team | | |
| Health | | x | | |

| Dashboard Domain | Strength | Expectable Situation | Risk/ Problem RED FLAG | Possible Diagnosis |
|---|---|---|---|---|
| Developmental level | | | | |
| Cognition, language | | X | | |
| Attention, executive function | | X | | |
| Control of impulses | | X | | |
| Anxiety | | | worries @ parent stresses | |
| Mood | | | low self esteem, withdrawn irritable | R/O Depression |
| Capacity for Relationships | | x | | |
| Self-regulation | | x | | |
| (For adolescents): Substance abuse | | | marijuana use with loss of function | R/O Substance use/abuse |

**Table 12 Treatment plan: John**

| FOCUS (Circle target domain) | OBJECTIVE Specific changes in pt. behavior in measurable and behavioral terms, w. target date for completion. | CHILD/FAMILY STRENGTHS/ CHALLENGES Past accomplishments, current aspirations, motivations, personal attributes etc. | INTERVENTIONS Clinical activity/treatment modality, provider of care, intended purpose or impact, as well as attention, incentives etc |
|---|---|---|---|
| 1-Development<br>2-Cognition, language<br>3-Attention/executive<br>4-Impulse control<br>5-Anxiety<br>6-Mood<br>7-Relationships<br>8-Self-regulation<br>(including, for adolescents: Substance abuse | 5,6 John will receive more support when sad and anxious<br><br>8 John will not use marijuana to relieve anxiety or low mood. | 5 Anxiety about finances shared with parents<br>6 Family history of depression – potential vulnerability<br>8 Father with past history of substance abuse | 5, 6<br>family support<br>school counselor<br>exercise<br>Monitor for recurrent episodes of depression |

**Table 13 Clinical Silhouette John Follow-up evaluation (Time 2)**

| Domain | Strength | Expectable Situation | Risk/ Problem RED FLAG | Possible Diagnosis |
|---|---|---|---|---|
| Psychosocial environment | | X good | | |
| Traumatic Experiences | | X none | | |
| **Primary support** | | T2 closer to both parents | Father “distant” | |
| **Care-giving** | | X adequate | | |


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| | | | | |
|---|---|---|---|---|
| **Functional change** | | | Father depressed? | |
| Environment | | | economic strain | |
| Events | | T 2 Swim team | | |
| Health | | x | | |

| **Dashboard Domain** | **Strength** | **Expectable Situation** | **Risk/ Problem RED FLAG** | **Possible Diagnosis** |
|---|---|---|---|---|
| Developmental level | T1 Bright, musical talent | | | |
| Cognition, language | | X | | |
| Attention, executive function | | X | | |
| Control of impulses | | X | | |
| Anxiety | | aware of but coping with parent stresses | | |
| Mood | | | At risk, but currently few symptoms | Monitor for MDD NOS 315.09 |
| Capacity for Relationships | | x | | |
| Self-regulation | | x | | |
| (For adolescents): Substance abuse | | | T2 occasional marijuana use –no loss of function | |


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