

Texas Department of Mental Health and Mental Retardation



**Child and Adolescent Texas Recommended Authorization Guidelines
(CA-TRAG Version 1.0):
A Study of Reliability and Validity**

ABSTRACT

The Texas Department of Mental Health and Mental Retardation (TDMHMR) developed the Child and Adolescent Texas Recommended Authorization Guidelines (CA-TRAG) as part of its Benefit Design Disease Management initiative. A study was conducted to examine the reliability and validity of the CA-TRAG version 1.0. The CA-TRAG was designed to provide a standardized method and a common framework for assessing the need for services and for making decisions on the level of care for children and adolescents served in the public mental health system. The study involved rating 10 representative case vignettes using the CA-TRAG. The primary group of raters consisted of eight clinicians (two from each of the four local Mental Health and Mental Retardation centers that are participating in the Benefit Design Disease Management initiative) who made domain and level of care recommendations (LOC-R) ratings for each vignette using the CA-TRAG. Level of care recommendations were also made by a panel of experts, using a consensus process, and a single expert rater. In addition, a computer program was written to generate a LOC-R based on the clinicians CA-TRAG domain ratings. To examine the inter-rater reliability of the CA-TRAG, intra-class correlations were computed for the clinician's CA-TRAG domain ratings. The average across all the intra-class correlations was $r = .87$, indicating a generally high level of reliability. Systematic assessment of a consumer's level of need, as operationalized by the CA-TRAG domain ratings, is used to place a consumer in an appropriate service package, the LOC-R. On average the proportion of individual clinicians agreeing with the computer generated LOC-R was 86.25%. As an indicator of the criterion validity of the CA-TRAG, on average, the proportion of individual clinicians agreeing with the consensus panel's LOC-R was 72.5%. On average, the proportion of individual clinicians agreeing with the single benefit design expert's LOC-R was 70%. Overall the results of this study were generally favorable, indicating the CA-TRAG version 1.0 had good rating scale reliability for the CA-TRAG domains and moderate but adequate levels of inter-rater reliability and criterion validity. The results suggest that the CA-TRAG can facilitate relatively consistent levels of care recommendations for children and adolescents. The study also revealed a number of specific modifications to Version 1.0 of the CA-TRAG that were used to develop Version 2.0.

INTRODUCTION

The Child and Adolescent Texas Recommended Authorization Guidelines (CA-TRAG version 1.0) provide a standardized method for assessing the need for services among children and adolescents in the public mental health system and recommending a level of care for them. The purpose of this study was to examine the reliability and validity of the CA-TRAG version 1.0.

The CA-TRAG was created in response to clinicians and administrators who called for the development of a common framework for making decisions on the level of care for children and adolescents in the Texas public mental health system. The CA-TRAG is intended to reduce inequities in care and to appropriately assign levels of care based on diagnosis and functioning. More specifically, the goal of the CA-TRAG is two-fold. First, the goal is to develop a systematic assessment process for measuring mental health service needs among children and adolescents based on their principal diagnosis and ten domains. Second, the aim is to propose a methodology for quantifying the assessment of needs that allows reliable recommendations for the various levels of care that consist of specified types and amounts of services.

The format of the CA-TRAG is based on the Adult Texas Recommended Authorization Guidelines (Adult-TRAG), but has been adapted to reflect a developmental perspective, family focus, and acknowledgment of the array of services in systems that serve children and adolescents with severe emotional disturbances. The CA-TRAG may be applied to children and adolescents ages 3 to 17.

CA-TRAG Domains

The CA-TRAG consists of ratings or scores in 10 domains. The domains assessed were designed to be quantifiable and to promote consistent clinical judgment. The domains are: the Ohio Youth Problem Severity Scale score (Ogles, Lunnen, Gillespie and Trout, 1996), the Ohio Youth Functioning Scale score (Ogles, Lunnen, Gillespie and Trout, 1996), Risk Of Self-Harm, Severe Disruptive or Aggressive Behavior, Family Resources, History of Treatment, Co-occurring Substance Use, Juvenile Justice Involvement, School Behavior and Psychoactive Medication Treatment. The first two domains are the scores from the Ohio scales (problem severity and functioning) which are collected either through self-report or completion of the scales by the parent/guardian or a clinician. The remaining eight CA-TRAG domains are ratings based on clinician judgment, generally using a rating scale ranging from 1 (No Notable Limitations) to 5 (Extreme Limitations). Specific behavioral anchors are provided for each point on the rating scale.

Service Packages

There are five broad levels of care provided as part of TDMHMR's (Texas Department of Mental Health and Mental Retardation) Benefit Design Disease Management initiative: Crisis Services, Service Package 1: Brief Outpatient, Service

Package 2: Intensive Outpatient, Service Package 3: Treatment Foster Care and Service Package 4: Aftercare. Each level of services, with the exception of Level 4, represents an increasing level of service intensity.

The *Crisis Services* package is intended for children and adolescents who are at serious risk of harm to themselves or others, or who are currently actively psychotic, or experiencing significant impairment due to substance use or other acute psychiatric crisis.

Level 1, **Brief Outpatient** is generally considered short-term and time-limited. The Brief Outpatient service package has specific formats for both Externalizing and Internalizing disorders. Examples of Externalizing disorders are Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder and Conduct Disorder. Examples of Internalizing disorders are Generalized Anxiety Disorder, Specific Phobias and Major Depressive Disorder. In Level 1.1, for Externalizing disorders, the focus of the intervention is on psychosocial skill development in the child and the enhancement of parenting skills, especially in child behavior management. In Level 1.2, for Internalizing disorders, the focus of the intervention is on child and family counseling using a cognitive behavioral approach. If clinically indicated, medication and medication management are available. Access to parent support groups is available.

Level 2, **Intensive Outpatient** service package is also time-limited with a specific course of treatment, but represents an increase in service intensity from Level 1. The primary difference from Level 1 is the addition of intensive case management, a family partner providing peer-to-peer support, and four specific treatment models based on diagnostic characteristics. If clinically indicated, medication and medication management are available. Flex funds may also be available to augment the treatment plan. The specific treatment models address children and adolescents with Internalizing disorders, Externalizing disorders, Bipolar-Schizophrenic-Psychotic Disorders and Multisystemic Therapy (MST) for children or adolescents who are involved with the juvenile justice system and who are also severely disruptive or aggressive.

Level 2.1, Multisystemic Therapy (MST), is targeted at youth who have Externalizing disorders and high levels of severe disruptive or aggressive behaviors and who are involved with the juvenile justice system. MST is a comprehensive, intensive in-home and community-based treatment model. Service components include intensive case management, counseling, and skills training and average 8 hours/week. Family service planning is done through a wraparound planning approach. Extensive collaboration with juvenile probation is required.

Level 2.2 is targeted at children and adolescents with Externalizing disorders and moderate to high functional impairment at home, school or in the community. The need for intensive case management, skills training and significant parent support is indicated.

Level 2.3 is targeted at children and adolescents with Internalizing disorders and a moderate to high level of problem severity or functional impairment. The focus of the intervention is on child and family counseling, using a cognitive behavioral approach. Multiple family concerns and significant parental stress indicate the need for intensive case management and the availability of parent-to-parent peer support. The family service plan is developed using a wraparound planning approach.

Level 2.4 is targeted at children and adolescents who are diagnosed with Bipolar Disorder, Schizophrenia, or other Psychotic disorders and are not yet stable on medication. The major focus is on stabilizing the child and providing information and support to the family.

Level 3, **Treatment Foster Care** is targeted at children and adolescents at imminent risk of residential treatment placement. Parents retain custody although the child may be at high risk of relinquishment to TDPRS in order to access residential mental health treatment. It is clinically determined that the child and family can progress with intensive community treatment, including treatment foster placement for the child on a time-limited basis.

Level 4, the **Aftercare** service package is intended to provide on-going medication monitoring for those children and adolescents who have completed a course of treatment in one of the other service packages or for the small number of patients who transfer into the system from other treatment facilities (in-state or out of state, public or private) and who are currently stable.

CA-TRAG Level of Care Recommendation (LOC-R)

For each level of care, criteria are specified that indicate the principal diagnosis and CA-TRAG domain ratings (individual or in combination) that are sufficient to recommend a level of care (e.g. a specific service package). A simplified summary of the criteria required for recommending a particular level of care is provided in the Level of Care Decision Grid, as found in the User's Manual for the CA-TRAG and displayed in Table 1. An automated version is also planned for the future to provide CA-TRAG level of care recommendations instantly following ratings on the CA-TRAG in addition to the child or adolescents principal diagnosis. The CA-TRAG was reviewed by clinicians, administrators and program specialists in the TDMHMR public mental health delivery system, and the domain content, ratings and level of care definitions were refined. The level of care recommendation (LOC-R) is made by clinicians based on the CA-TRAG ratings and principal diagnosis, and should be an objective assignment.

Table 1

CA-TRAG Level of Care Decision Grid used in study (VERSION 1 - NOT the current version)

CA-TRAG Version 1 (not current)	Crisis Services	Level 1: Brief Outpatient		Level 2: Intensive Outpatient				Level 3: Out of Home Treatment Placement	Level 4: Aftercare
Necessary Principal Diagnosis	Any	Externalizing Disorder	Internalizing Disorder	Externalizing Disorder with Disruption/ Aggression (MST)	Externalizing Disorders	Internalizing Disorder	Bipolar, Schizophrenia and Related Disorders	Any	Any
I. Ohio Problem Severity		OYPSS = 18+ or OYFS = 50+						OYPSS =>60 or OYFS = >60	
II. Ohio Functioning									
III. Risk of Self-Harm	4 or 5*								
IV. Severe Disruptive or Aggressive Behavior		2 or 3*		4 or 5*	4 or 5*			4 or 5*	
V. Family Resources					4 or 5*	4 or 5		4 or 5*	
VI. History of Treatment					5	5*			
VII. Co-occurring Substance Abuse	5								
VIII. Juvenile Justice Involvement				3, 4 or 5*					
IX. School Behavior		2 or 3*			4 or 5*				
X. Psychoactive Medication									
Note: Service package eligibility is determined by the combination of domains, diagnosis and Ohio Scale Scores.	Children at serious risk of harm to self or other, actively psychotic or experiencing significant impairment due to substance use are eligible for this service package	*A score of 2 or 3 in the Severe Disruptive or a 2 or 3 in the School Behavior domains is necessary for eligibility in this LOC.		*A score of 4 or 5 in the Severe Disruptive and a 3, 4 or 5 in the Juvenile Justice domains is necessary for being eligible for MST Services. If MST services are not offered the child/adolescent will be eligible for Level 2/2 services.	*A score of 4 or 5 in the Severe Disruptive or a 4 or 5 in Family Resources or a 5 in History of Treatment or 4 or 5 in the School Behavior domains is necessary for eligibility in this LOC.	*A score of a 4 or 5 in the Family Resources or a score 5 in the History of Treatment domains is necessary for eligibility in this LOC.	*A diagnosis of Bipolar Disorder, Schizophrenia or Related Disorders is necessary to qualify for this level of service. If the child or adolescent is medically stable they will be considered for After Care Services.	*A score of 4 or 5 in the Severe Disruptive and a score of a 4 or 5 in the Family Resources domains is necessary for eligibility in this LOC.	This level of care is intended for children and adolescents who have transitioned from levels 1, 2 or 3 and have not other resources. Initial assignment to this level can only be done via the clinical over- ride procedure under specific exceptions

Note: The LOC-R Grid displayed is an OLD version that was used in the study. It should NOT be used for current children's LOC-R.

METHOD

Case Vignettes

Ten case vignettes were developed to reflect typical children and adolescents served by local community MHMR centers. Clinicians in the two samples described below rated these vignettes and determined level of care recommendations.

Clinician Sample

Eight experienced clinicians from four local community mental health and mental retardation centers were recruited to participate in the study. Two clinicians, from each of the following centers participated: Texas Panhandle MHMR, MHMR of Tarrant County, Hill Country Community MHMR Center and Lubbock Regional MHMR Center. These four centers are the first four implementation sites for TDMHMR's Benefit Design Disease Management initiative. This clinician sample provided both CA-TRAG domain ratings and a level of care recommendation.

Consensus Panel Sample

A consensus panel was recruited from TDMHMR's Central Office. All of the members had clinical experience and were familiar with TDMHMR's Benefit Design Disease Management initiative. This group represented the expert, objective clinical decision-making that the CA-TRAG was intended to replicate and standardize. After meeting as a group to discuss disagreements, members of the consensus panel provided a single level of care recommendation (LOC-R) for each vignette. The purpose of this group was to use their combined expert clinical knowledge to recommend a level of care for each case independent of the CA-TRAG.

Benefit Design Expert

A single expert highly familiar with TDMHMR's Benefit Design Disease Management initiative, from TDMHMR's Central Office also provided a LOC-R for each case. Because of this expert's knowledge of TDMHMR's Benefit Design Disease Management initiative, his/her ratings represent another gold standard against which the clinicians' CA-TRAG level of care recommendations can be compared.

Material and Procedures

Training and materials for the CA-TRAG were provided to the centers. A CA-TRAG manual and two practice vignettes were provided to the centers. A conference phone call was held to review the material and answer any questions. Clinicians were instructed to use the CA-TRAG scoring sheets and manual to rate each vignette on the domains and determine a recommended level of care. The expert panel members were instructed to identify the appropriate level of care for the child in each vignette, based on their clinical opinion.

Statistical Analysis

For each case vignette, the group of variables to be analyzed included eight of the ten CA-TRAG domain ratings and the level of care recommendation. The Ohio scales (Domains I and II) are completed by the parent, clinician or youth and their reliability and validity was analyzed in a separate report, available upon request. Vignettes were assigned reasonable scores on the Ohio scales for clinicians to use in determining the level of care.

Intraclass correlations were used to measure the inter-rater reliability of the CA-TRAG domains rated by the clinicians. Intraclass correlations are similar to other correlations in that variables with higher correlations are more similar than those with lower correlations. Intraclass correlations measure the similarity of observations within a group or class relative to the total variability across groups or classes of observations.

A random model was chosen as the most appropriate for analysis. This model assumes that each case is measured by each judge and that the judges are considered representative of a larger population of judges. This corresponds to Shrout and Fleiss's (1976) Model 2, a two way random effects model in which both judges and vignettes are treated as samples from larger populations.

Intraclass correlations were calculated for clinicians' CA-TRAG domain ratings and provide an estimate of what the reliability will be in the future when a clinician uses the CA-TRAG to assess a child or adolescents' level of need. These intraclass correlations are displayed in Table 2.

The psychoactive medication domain and the level of care recommendation (LOC-R) are not linear scales, therefore intraclass correlations could not be computed for them. These variables are categorical (such as race/ethnicity or principal diagnoses) and a percent agreement among raters was used.

Two previous studies have used expert ratings or consensus panels to examine the validity of levels of care. Goldman, Weir, Turner and Smith (1997) compared the results of their system with assessments made by a consensus panel of expert psychiatrists. Sowers, George and Thompson (1999) suggest that their assessment instrument could make recommendations similar to that of clinicians who were naive to the specific assessment and placement methodology used in their study. In both studies, the goal was to determine the agreement between the new assessment system and the experts' consensus.

In this study, both the consensus panel and the single benefit design expert were used as standards against which to compare the CA-TRAG level of care recommendations made by the eight clinicians. For each case vignette, the percent of clinicians who agreed with the consensus panel and the single benefit design expert was calculated. An overall average was also calculated. The distribution of clinicians' LOC-R for each case vignette is displayed in Table 3. The percent of agreement

between the clinicians and the consensus panel and the single benefit design expert is displayed in Table 4.

In addition, to examine the reliability of clinicians' use of the domain ratings to determine the LOC-R, a computer program was created to generate a LOC-R from the clinicians' domain ratings. Agreement between each clinician's LOC-R and the computer generated LOC-R was determined. An overall percent agreement was then calculated.

The tables displaying the distribution of the clinicians' ratings for the CA-TRAG domains are displayed in Appendix A. Appendix B includes a copy of the rating instrument used. Appendix C shows the behavioral anchors for the CA-TRAG domains. Appendix D displays the vignettes used in the study.

RESULTS

Table 2

Summary of CA-TRAG domain reliability for the eight Benefit Design site clinicians.

CA-TRAG Domain	
	Intraclass correlations
Risk of Self-Harm	.90
Disruptive or Aggressive Behavior	.91
Family Resources	.70
History of Treatment	.99
Co-occurring Substance Use	.93
Juvenile Justice Involvement	.92
School Behavior	.72
	Percent Agreement
Psychoactive Medication Treatment	95%

Notes. There were a total of eight clinicians (two at each of the Benefit Design implementation sites) that served as judges. Not all judges provided information for every rating.

Table 2 summarizes the intraclass correlations computed for the clinicians' ratings on seven of the CA-TRAG domains. The overall average was $r = .87$ ($SD = .11$) with a range of .70 to .99. This represents a good to excellent level of reliability.

Ratings for psychoactive medication treatment are not linear so intraclass correlations were not computed. For psychoactive medication treatment only 4 of the 80 possible ratings (8 clinicians x 10 vignettes) disagreed, with 95% agreement across all 10 vignettes.

Table 3
Frequency distribution of LOC-R for the eight Benefit Design site clinicians.

Vignette	0 Crisis	1.1 BO- EX	1.2 BO- IN	2.1 IO- MST	2.2 IO- EX	2.3 IO- IN	2.4 IO- BSP	3 TFC	4 AC	5 NE	Percent for the most frequent LOC-R
1		1	6			1					75%
2	1			2	1			4			50%
3				5	3						62.5%
4			8								100%
5		1			7						87.5%
6					5	3					62.5%
7					2		6				75%
8	2	1	5								62.5%
9			7							1	87.5%
10		1	7								87.5%

Notes: Most frequent LOC-R in boldface type. Table abbreviations: BO = Brief Outpatient, IO = Intensive Outpatient, TFC = Treatment Foster Care, AC = Aftercare, NE = Not eligible, IN = Internalizing, EX = Externalizing, MST = Multi-systemic therapy, BSP = Bipolar, Schizophrenic, Psychotic.

The table above shows the distribution of the LOC-R that the eight clinicians from the Benefit Design sites selected for the 10 vignettes. The majority of clinicians selected the same level of care (LOC-R) for most of the vignettes. On average, 75% of the clinicians agreed on the same LOC-R for each vignette. This indicates a relatively high level of agreement across the eight clinicians.

Recall that a LOC-R was generated using a computer program to assess how accurate clinicians were when using the CA-TRAG to make level of care recommendations. Comparison of the individual clinician's LOC-R with the computer LOC-R generated from the clinician's CA-TRAG domain ratings resulted in a 86.25% agreement rate. This indicates that the clinicians are generally following the correct procedures to assign patients to the appropriate level of care.

Table 4

Percent agreement between clinicians and the consensus panel LOC-R and between clinicians and the single Benefit Design expert LOC-R.

Vignette	Consensus panel LOC-R	Percent of clinicians agreeing with the consensus panel LOC-R	Single benefit design expert LOC-R	Percent of clinicians agreeing with the single benefit design expert LOC-R
1	1.2	75%	1.2	75.0%
2	2.1	25%	2.1	25.0%
3	2.1	62.5%	2.1	62.5%
4	1.2	100%	1.2	100.0%
5	2.2	87.5%	2.2	87.5%
6	2.2	62.5%	2.3	37.5%
7	2.4	75%	2.4	75.0%
8	1.2	62.5%	1.2	62.5%
9	1.2	87.5%	1.2	87.5%
10	1.2	87.5%	1.2	87.5%
	Average	72.5%	Average	70%

On average 72.5% of the individual clinicians agreed with the consensus panel's LOC-R. On average, 70% of the individual clinicians agreed with the single benefit design expert's LOC-R. Disagreements for vignettes on the appropriate LOC-R were discussed to determine possible problems with the CA-TRAG or differences of interpretation of the vignettes.

DISCUSSION

Overall the intraclass correlations for the CA-TRAG domains were good. The clinicians appeared to be able to use the anchors to make reliable ratings for the CA-TRAG domains. In part, this may be due to the fact that similar scales, the Community Functioning and Problem Behavior Rating Scales, have been used by the centers for several years. Many of the CA-TRAG domain scales are refinements of these earlier scales. Therefore, the clinicians were familiar the type of ratings required by the CA-TRAG domains. The domains Family Resources and School Behavior were somewhat lower than the other five domains. Both scales were modified slightly in an attempt to make differentiation between levels more clear. Although agreement between the clinician-derived level of care, using the level of care grid, and the computer-derived level of care were reasonable, use of the computer-derived level of care will be recommended to eliminate this source of error.

Validity of the level of care recommendation (LOC-R) was acceptable. The results suggest that there is a relatively high level of agreement between the CA-TRAG and level of care recommendations made by clinicians/administrators not using the CA-TRAG methodology. Disagreements about the LOC-R for specific vignettes were discussed to determine the source of the differences. Due to clinicians occasionally having difficulty determining if a diagnosis should be categorized as “internalizing” or “externalizing”, a chart was added to the manual that categorized most DSM-IV diagnoses, as well as definitions of “externalizing” and “internalizing”.

Some discrepancies between the center clinicians and the expert consensus panel appeared to be a result of problems in the CA-TRAG. In several instances, CA-TRAG ratings placed a patient in a level of care that was too intensive, as determined by the expert panel. The criteria for Crisis Services were adjusted to require a Risk of Self-Harm rating of 5 (previously 4 or 5) or a Substance Abuse rating of 5 (previously 4 or 5). In addition, the criteria for Treatment Foster Care (LOC 3) was adjusted to require a Severe Disruptive or Aggressive Behavior rating of 5 (previously 4 or 5).

While the results were generally positive, this study had several limitations. Although the case vignettes were selected to be representative of typical children and adolescents seen in the TDMHMR community system, using only 10 of them clearly is a limited group that can only represent a small sample of the actual cases seen in the field. In addition, written vignettes clearly differ from the actual clinical situations that the CA-TRAG will have to be used in. In the future, standardized training for raters will need to be developed.

The consensus panel was designed to establish a "gold standard" to which the CA-TRAG level of care recommendations could be compared. However, it is difficult to define a gold standard. Members of the panel bring their own disciplinary expertise (and potential biases) to the panel. Each member of the consensus panel may have had his or her own method and process for arriving at a level of care recommendation. Even in reaching a consensus, results may have been skewed toward agreement with the most persuasive panel member. These limitations to the purported gold standard should be kept in mind. Nevertheless, a relatively high level of agreement with consensus panel level of care recommendations was obtained.

Overall the results of this study were generally favorable, indicating the CA-TRAG version 1.0 had adequate inter-rater reliability and criterion validity. Problems identified through the study were addressed through minor revisions to the instrument. The results of the present study suggest that the CA-TRAG can facilitate consistent recommendations for the authorization of children and adolescents for mental health services in the Texas public system.

REFERENCES

- Goldman, R. L., Weir, C. R., Turner, C. W., & Smith, C. B. (1997). Validity of utilization management criteria for psychiatry. *American Journal of Psychiatry*, 154, 349-354.
- Ogles, B. M., Lunnen, K. M., Gillespie, D. K. & Trout, S.C. (1996) Conceptualization and initial development of the Ohio Scales. In C. Liberton, K. Kutash & Friedman, (Eds.) *The 8th Annual Research Conference Proceedings, A system of care for Children's Mental Health: Expanding the Research Base*. (pp. 33-37). Tampa, FL: University of South Florida, Florida Mental Health Institute, Research and Training Center Children's Mental Health.
- Shrout, P. & Fleiss, J. (1979) Intraclass correlations: Uses in assessing rater reliability. *Psychological Bulletin*, 86, 420-428.
- Sowers, W., George, C., Thompson, K. (1999). Level of care utilization system for psychiatric and addiction services (LOCUS): A preliminary assessment of reliability and validity. *Community Mental Health Journal*, 35, 545-563.

APPENDIX A
FREQUENCIES OF BD SITE CLINICIAN'S RATINGS FOR VIGNETTES.

Table 5
BD site clinicians ratings for principal diagnostic group

vignette	Bipolar	external	internal
1		1	7
2		8	
3		8	
4			8
5		8	
6		5	3
7	6	2	
8			8
9		1	7
10		1	7

Notes: Specific vignettes are identified in the left column. Principal diagnoses groups spans the top row of the table. Frequency of specific ratings are displayed in the body of the table. The most frequent rating for each vignette is in boldface type.

Table 6
BD site clinicians ratings for Risk of Self Harm

vignette	1	2	3	4	5
1		2	6		
2				8	
3	8				
4	8				
5	8				
6	3	3	1	1	
7	8				
8				7	1
9		6	2		
10	8				

Notes: Specific vignettes are identified in the left column. Severity ratings of 1 (no notable limitations) to 5 (extreme limitations) span the top row of the table. Frequency of specific ratings are displayed in the body of the table. The most frequent for each vignette is in boldface type.

Table 7
BD site clinicians ratings for Severe Disruptive or Aggressive Behavior

vignette	1	2	3	4	5
1		5	3		
2				8	
3				2	6
4	8				
5			1	4	3
6			1	2	5
7			1	7	
8	2	6			
9	8				
10	4	4			

Notes: Specific vignettes are identified in the left column. Severity ratings of 1 (no notable limitations) to 5 (extreme limitations) span the top row of the table. Frequency of specific ratings are displayed in the body of the table. The most frequent rating for each vignette is in boldface type.

Table 8
BD site clinicians ratings for Family Resources

vignette	1	2	3	4	5
1		1	6	1	
2				7	1
3	4	1	2	1	
4	7	1			
5				8	
6		3		3	2
7			7		1
8		2	6		
9	1	7			
10	1	7			

Notes: Specific vignettes are identified in the left column. Severity ratings of 1 (no notable limitations) to 5 (extreme limitations) span the top row of the table. Frequency of specific ratings are displayed in the body of the table. The most frequent rating for each vignette is in boldface type.

Table 9
BD site clinicians ratings for History of Treatment

vignette	1	2	3	4	5
1		7			
2	8				
3	8				
4	8				
5	8				
6				2	6
7					8
8	8				
9	8				
10	8				

Notes: Specific vignettes are identified in the left column. Severity ratings of 1 (no notable limitations) to 5 (extreme limitations) span the top row of the table. Frequency of specific ratings are displayed in the body of the table. The most frequent rating for each vignette is in boldface type.

Table 10
BD site clinicians ratings for Co-occurring Substance Use

vignette	1	2	3	4	5
1	8				
2			3	5	
3			6	2	
4	6	2			
5	8				
6		1	7		
7	8				
8	8				
9	8				
10	8				

Notes: Specific vignettes are identified in the left column. Severity ratings of 1 (no notable limitations) to 5 (extreme limitations) span the top row of the table. Frequency of specific ratings are displayed in the body of the table. The most frequent rating for each vignette is in boldface type.

Table 11
BD site clinicians ratings for Juvenile Justice Involvement

vignette	1	2	3	4	5
1	8				
2			8		
3		1		4	3
4	8				
5	8				
6	8				
7	8				
8	8				
9	8				
10	8				

Notes: Specific vignettes are identified in the left column. Severity ratings of 1 (no notable limitations) to 5 (extreme limitations) span the top row of the table. Frequency of specific ratings are displayed in the body of the table. The most frequent rating for each vignette is in boldface type.

Table 12
BD site clinicians ratings for School Behavior

vignette	1	2	3	4	5
1	8				
2				8	
3				1	7
4	8				
5	5				3
6				8	
7			1	1	6
8		3	3	1	
9	1	3	3	1	
10	5	1			2

Notes: Specific vignettes are identified in the left column. Severity ratings of 1 (no notable limitations) to 5 (extreme limitations) span the top row of the table. Frequency of specific ratings are displayed in the body of the table. The most frequent rating for each vignette is in boldface type.

Table 13
BD site clinician ratings for psychoactive medication treatment.

vignette	1	2
1	8	
2	8	
3	1	7
4	8	
5	8	
6	2	6
7	1	7
8	8	
9	8	
10	8	

Notes: Specific vignettes are identified in the left column. Ratings of 1 indicate no current psychoactive medication prescribed and ratings of 2 indicate a current psychoactive medication prescription. Frequency of specific ratings are displayed in the body of the table. The most frequent rating for each vignette is in boldface type.

**APPENDIX B
CA-TRAG STUDY VIGNETTE SCORE SHEET**

1. Principle Diagnosis

- Externalizing
- Internalizing
- Bipolar Disorder, Schizophrenia or Related Psychotic Disorders

2. Domains

Domain Rating

1. Ohio Youth Problem Severity Scale(OYPSS)	_____				
2. Ohio Youth Functioning Scale(OYFS)	_____				
3. Risk Of Self-Harm	1	2	3	4	5
4. Severe Disruptive or Aggressive Behavior	1	2	3	4	5
5. Family Resources	1	2	3	4	5
6. History of Treatment	1	2	3	4	5
7. Co-Occurring Substance Use	1	2	3	4	5
8. Juvenile Justice Involvement	1	2	3	4	5
9. School Behavior	1	2	3	4	5
10. Psychoactive Medication Treatment	1	2			

3. CA-TRAG Level of Care Recommendation (consult Level of Care Decision Grid and check one)

- Crisis Services**
- Service Package 1: Brief Outpatient**
- Service Package 1/1: Brief Outpatient (Externalizing Disorders)
- Service Package 1/2: Brief Outpatient (Internalizing Disorders)
- Service Package 2: Intensive Outpatient**
- Service Package 2/1: Intensive Outpatient (MST Option)
- Service Package 2/2: Intensive Outpatient (Externalizing Disorders)
- Service Package 2/3: Intensive Outpatient (Internalizing Disorders)
- Service Package 2/4: Intensive Outpatient (Bipolar, Schizophrenia or other Psychotic Disorders)
- Service Package 3: Treatment Foster Care**
- Service Package 4: After Care**
- Not Eligible for Services**

Consumer's First Name: _____

APPENDIX C BEHAVIORAL ANCHORS FOR CA-TRAG DOMAIN RATINGS

III. Risk of Self-Harm

1. No Notable Limitations
 - No current suicidal/homicidal ideation
2. Mild Limitations:
 - Fleeting suicidal/homicidal ideation with no plan
3. Moderate Limitations:
 - Suicidal/ homicidal ideation with no plan
4. Serious Limitations:
 - Ideation with a plan but have no harm contract with adequate safety plan
 - Ideation with no plan but has a history of self-harm attempts
5. Extreme Limitations:
 - Ideation with intent, plan and means w/o adequate safety plan

IV. Severe Disruptive or Aggressive Behavior

1. No Notable Limitations
 - Interacts appropriately with others
 - Respectful towards others
2. Mild to Moderate Limitations:
 - Frequently irritable or easily annoyed but behavior/moods are easily resolved.
 - Occasional verbal outbursts or aggression towards objects (yells at someone; slams door)
 - Seen as being "quick tempered"
3. Moderate Limitations:
 - General or vague threats of aggression towards others with no clear intent (e.g. "I'm going to get you!")
 - Assault resulting in no or minimal physical harm to another
 - Frequent verbal outbursts or aggression towards objects without provocation
4. Serious Limitations:
 - Significant verbal threats of physical harm towards others with no weapon
 - Assaults resulting in moderate physical harm to another
 - Intentionally damages property resulting in moderate damage (e.g., breaks furniture or windows)
 - Repeatedly plays with fire such that damage could likely result
 - Has been sexually inappropriate with others such that adults are concerned about supervision with other children
5. Extreme Limitations:
 - Assault resulting in serious physical harm to another that necessitates medical care
 - Significant verbal threats of physical harm towards others with a weapon
 - Deliberate and severe damage to property (e.g., fire setting)
 - Sexually assaultive towards another
 - Runs away from home overnight repeatedly or cannot be located for more than 5 days
 - Imminent risk of out of home placement as a result of behavior that places his family or other at serious risk of harm

V. Family Resources

1. No notable limitations:
 - Family environment is stable and family feels able to meet the current needs of the child
 - Caregivers report little or no pressure or stress from lack of external resources (material or social supports)
2. Mild to Moderate Limitations:
 - Caregiver expresses concerns regarding their ability to cope with child's problems
 - Caregiver has a slight deficit in problem solving, parenting strategies and/or communication skills but is willing to participate in treatment.
3. Moderate Limitations:
 - Caregiver/other family member's physical or mental health issues interfere to some extent with the ability to adequately meet child's needs
 - Caregiver reports pressure from unmet material or social supports
 - Caregiver is somewhat dissatisfied with the relationship with their child Caregiver is often dissatisfied with the relationship with the child, but generally feels capable of handling the child's behavioral and emotional needs
4. Serious Limitations:
 - Caregivers expresses significant concerns regarding their ability to cope with child's problems
 - Caregivers demonstrate limited ability or willingness to participate in treatment
 - Caregiver expresses hostility and resentment toward child
 - Appropriate community supports are lacking to help meet the needs of the child or family
5. Severe Limitations:
 - Caregiver reports being overwhelmed by pressure or stress and incapable of dealing with their child right now
 - Family/caregiver expresses an unwillingness to participate in treatment right now and feels pessimistic about their child's future
 - Child requires extensive supervision that prevents the caregiver from being employed or completing other responsibilities
 - Due to child's behavior, caregiver refuses to allow the child to return home or is considering parental relinquishment of custody or juvenile justice referral in order to place the child outside the home
 - Sexual or physical abuse or neglect or severe or frequent domestic violence present in the home

VI. History of Treatment

1. No Residential Treatment or Hospitalizations
2. Residential Treatment or Hospitalizations has not occurred within the last 12 months
3. Only one Residential Treatment Placement or Hospitalizations has occurred within the last 12 months
4. More than one Residential Treatment or Hospitalization within the last 12 months but none within the last 90 days
5. Discharged from Residential Treatment or Hospital in the last 90 days or has 3 or more hospitalizations within the last 180 days

VII. Co-occurring Substance Abuse Disorder

1. No Notable Limitations
 - No substance use reported
2. Mild to Moderate Limitations:
 - Occasional use of substances with no identifiable negative consequences
 - Experimented with substances but does not use
3. Moderate Limitations:
 - Occasional use of substances with mild to moderate negative consequences (e.g., beginning to interfere with school attendance, relationships, work performance)
 - Regular use of substances to intoxication (1 to 2 times per week)
4. Serious Limitations:
 - Evidence of an inability to control use of substances
 - Regular use of substances with serious negative consequences (beginning to affect health, suspended or expelled from school, fired from job)
 - Chronic use of substance to intoxication (more than 2 times per week)
5. Extreme Limitations:
 - Has blackouts associated with substance use
 - Evidence of physical addiction to substances, including need to increase use to maintain effect (tolerance), withdrawal symptoms when not regularly using substances, or craving substance in order to feel “normal” or to get through the day

VIII. Juvenile Justice Involvement

1. No history or evidence of juvenile justice involvement.
2. Community interventions/diversions (including Child in Need of Supervision or CINS offenses)or informal proceedings with juvenile probation department within past 90 days
3. Arrested and adjudicated for a non-CINS misdemeanor within the past 90 days or currently on probation or parole for non-CINS misdemeanor.
4. Arrested and adjudicated for a felony within the past 90 days or currently on probation or parole for a felony.
5. Rearrested within past 90 days regardless of the nature of the offense or the outcome.

IX. School Behavior

1. No notable limitations:
 - No behavior problems reported
 - . School domain is not applicable for the individual
2. Mild to Moderate Limitations:
 - Inattentiveness in classroom setting
 - Some problems in school as a result of minor disruptive behaviors
 - Occasionally breaks school rules

3. Moderate Limitations:

- Disruptive behavior has resulted in classroom behavior management interventions
- Disruptive behavior that leads to frequent disciplinary referrals
- Requires several prompts to begin or complete assignments

4. Serious Limitations:

- Ongoing behavior that disrupts the entire class
- Disruptive behavior results in additional behavior management interventions (e.g., 1:1 classroom supervision, in-school suspension)
- Breaks multiple school rules, regardless of consequences
- Refusal to complete homework or turn in work
- Frequent absences or truancy from school

5. Severe Limitations:

- Suspended, expelled or dropped out of school
- Harmed or made serious threats to teachers or other students
- Behavior has lead to placement in special educational due to emotional disturbance or to a Juvenile Justice Alternative Education placement
- Chronic absences or truancy from school

X. Psychoactive Medication Treatment

1. Not Receiving Psychoactive Medication
2. Currently Receiving Psychoactive Medication

**APPENDIX D
VIGNETTES USED IN STUDY****Vignette 1**

Erin is a 10-year-old Caucasian female diagnosed with Depressive Disorder NOS. Her mother reports "I'm afraid Erin is going to use drugs or be promiscuous and I can't lose a daughter like my family's history for many generations". Erin's mother is concerned that Erin is depressed. Erin's mother reports that she was depressed and suicidal at Erin's age. When asked, Erin reports that her mood is often sad and she occasionally feels like she doesn't want to live. Erin's mother reports that Erin is critical of everything, fusses all the time, and can't be pleased. Erin's mother says she thinks Erin's energy may be increased, that "she bounces around and can't sit still" but later says that she spends all her time watching TV.

Both Erin and her mom report Erin does not follow directions often, especially with chores. Erin says she has too many chores and gets too little allowance and that she is allowed to do nothing. Erin's mom says Erin is lazy. Sleep and appetite are good. Erin admits to some suicidal ideations but denies any intent to act on them. Erin's mother reports Erin has talked about killing herself since she was 5, but has never made an attempt. Erin's mother reports Erin has been known to go into the woods with boys but Erin's mother can't say exactly what she means by this. Erin reports she tends to get along better with boys than girls. Erin is concerned that she has no privacy and that her sister gets into her things and reads her diary. Although they don't usually fight physically, there was one recent incident in which Erin threw a nail file at her sister. Erin is an excellent student both academically and behaviorally and reports she enjoys school. Both Erin and her mother deny she has any problems with substance use or the legal system. Erin's mother reports Erin was hospitalized once when she was 7 due to threatening to hurt herself.

Erin lives with her mother, father, and two siblings. Her mother has had a significant history of bipolar symptoms and was diagnosed as a young adult. Her father has a long-term history of chronic back pain and is not able to be employed, causing the family to be stressed about financial matters.

Ohio Problem Scale = 47

Ohio Functioning Scale = 45

Vignette 2

Sam is a 16-year-old Hispanic male currently diagnosed with Polysubstance Abuse and Mental Disorder NOS. Sam was referred by his school counselor. His mother reports he began having problems in Jr. High. He began skipping school and disobeying her. His mother believes he also began actively using drugs at this time. His current school problems include truancy and refusing to put forth any effort on school work. He has been in a special program at school due to his truancy and will have to attend summer school to pass this grade. Sam's mother feels he is not openly disobedient at school but reports his behavior at home is more of a problem.

His mother reports his current problems in the home include being aggressive towards her and his siblings when he doesn't get his way and using profanity with all family members. Currently he is on probation for misdemeanor assault of mom and his sister. Mother reports he lies, has been gone from home overnight once, and has stolen money from mom. This is worse when he is using drugs. Sam reports he has kicked dogs before but denies firesetting. He admits he occasionally gets in fights with peers. Mom states he is very aggressive with his siblings though (ages 13, 8 and 3) and has left significant bruises and cuts.

Sam's mood is "grouchy and sad". His energy is low. He reports no worries or guilt. Sam reports he constantly thinks about killing himself because both his mom and some kids at school call him "fag". In the past, he tried to hang himself and "self-mutilate" (scratch arms). He denies any intent to act on his thoughts but states that he feels his drug use may be a way to slowly kill himself. Sam reports he has used marijuana since he was 13. He has also used acid, inhalants, alcohol, and stimulants. Sam reports he last used drugs 2 months ago. His mother reports he is still using drugs but not as often as before.

Sam's mother states she is at her wit's end and doesn't know how to handle Sam anymore. She states that calling the police seems to be the only way to handle when he gets real aggressive.

Ohio Problem Scale = 65

Ohio Functioning Scale = 64

Vignette 3

William is a 14-year-old African-American male referred by the juvenile justice system and diagnosed with Conduct Disorder. William's mother reports that he has few problems at home, although on occasion he will be slow to obey her and complete tasks and occasionally talks back or lies to her. She denies any problems with firesetting, animal cruelty, stealing, or being gone overnight. William's sleep and appetite are good, although he recently lost weight while in a boot camp. William reports his mood is "happy" and denies any suicidal ideations.

William's mother reports most of his problems are in school. His mother reports he gets in trouble for talking back to teachers and administrators, being the "class clown", and getting in fights with peers. He has received numerous suspensions and mom reports he was expelled from elementary school. His grades are mostly in the 70's but he reports he will probably fail this year. His placement in boot camp was due to fighting in school. William reports he is participating in gangs and engaging in behaviors such as beating up members as initiation and fighting with rival gangs. He reports, however, that he would not murder anyone. William is currently awaiting a court date for aggravated assault with a deadly weapon. He expresses no desire to change his behavior. William admits to the occasional use of marijuana, cocaine, and Ritalin (before it was prescribed), and admits he was using cocaine on the evening he was arrested.

William lives at home with his mother and has no contact with his biological father. His mother denies being concerned about William's behavior and feels that the school is overreacting. William's mother denies significant financial stressors, but admits that they don't live in a very safe neighborhood. William's pediatrician began treatment with Ritalin two months ago, but he has had no other previous mental health treatment.

Ohio Problem Scale = 33

Ohio Functioning Scale = 49

Vignette 4

Jennifer is a 17-year-old Caucasian female currently diagnosed with Depressive Disorder NOS. The client's presenting problems include decreased energy and motivation, excessive sadness, low self-esteem, excessive dependency, being overly passive, and some problems with sleeping excessively. She reports she has to push herself to do anything. She states that its difficult to get enough energy to care for her baby and she frequently lets her husband or mother-in-law do things. Jennifer also reports problems with excessive anxiety and has some repetitive behaviors, such as checking to make sure doors are locked and electrical appliances are not on. She also reports obsessive thoughts, including worrying that her husband may leave her or start seeing other women. Jennifer has no significant problems with anger or irritability and denies any suicidal ideation.

Jennifer reports she was raised in a dysfunctional family and witnessed a lot of family violence and discord over financial stress. She was a marginal student, had significant problems with truancy, and left school in 10th grade. Jennifer reports significant past drug use, including marijuana, LSD, and alcohol but denies any current use. She became pregnant approximately two years ago and moved to Texas with the baby's father and his parents. The client and the baby's father eventually married and their baby was born 11 months ago. The client and her husband live with his parents who are supportive and have a close relationship with Jennifer. The client currently is not in school or working but is considering getting into a GED program. Jennifer had one incident in which she was caught shoplifting at age 12, but has not been in trouble with the legal system since. She has never received mental health treatment.

Ohio Problem Scale = 22

Ohio Functioning Scale = 41

Vignette 5

Peter is a 5-year-old Caucasian male diagnosed with ADHD. His father reports that he talks back, is bossy and demanding, is impulsive, accident prone, and has poor attention. He reports that Peter can be very aggressive to both adults and other children, doesn't follow rules, and has sneaked out of the house on several occasions. He reports that Peter has been kicked out of 5 day cares. Peter frequently destroys his toys, sometimes burning them. Peter's father reports he fell off a playscape and lost consciousness briefly at age 4. He has never received any mental health treatment.

Peter will start school in several months, but is currently being cared for at a new daycare. Peter's mother left the home when Peter was 2 and is not currently a part of his life. Peter's father reports he works a lot, and is frustrated with all of the calls he gets from daycare because of Peter's behavior. He states that he may lose his job if Peter gets thrown out of this daycare. There is no other family or support systems in the area.

Ohio Problem Score = 31

Ohio Functioning Score = 53

Vignette 6

Julie is a 15-year-old Caucasian female referred for treatment following discharge from Restful Pines Psychiatric Hospital. Julie is currently diagnosed with Depressive Disorder NOS, Oppositional Defiant Disorder, and Cannabis Abuse. The patient's current problems in the home include being depressed, angry and irritable, oppositional, demanding, argumentative, and sometimes threatening aggression, suicide, or that she will run away when angry. She has engaged in some self-abusive cutting on herself but no apparent suicide attempts. Currently, Julie denies any suicidal thoughts. Julie is very disrespectful to adults, including parents and teachers, and has a lot of problems getting along with peers. Julie admits she smokes cigarettes daily and marijuana once or twice a week. She has experimented with LSD. Julie's parents feel that the few friends she has are a bad influence.

The patient's problems in school include difficulty following directions, talking out of turn, excessive talking, failure to carry out assigned tasks, attendance problems, conflicts with teachers, often refusing to do work, and is currently failing most of her classes. Julie reports that she will attend classes but will not do any work until she is able to quit and get her GED. Julie has not been involved with the legal system, although the school has threatened to file truancy charges soon.

Client apparently had few or no problems until the 8th grade. Client and parents attribute the onset of her problems to teasing by peers at school. Symptoms have gradually increased over the past one to two years. Patient's father feels that her problems with aggressive behavior increased after a recent incident at the Mountain View residential treatment program, where a female peer allegedly sexually fondled her. Over the past few months, client has been in residential treatment center for three weeks and has been hospitalized for one week. The client has also been in day treatment at the psychiatric hospital for two weeks. The client's latest hospitalization occurred after she became angry and out of control and threatened to stab her mother when she was sleeping. The client is currently being treated with a combination of Zoloft and Wellbutrin, with Trazodone for sleep. The client and parents are vague about whether either the hospitalization or medication have helped her.

Both parents appear willing to participate in treatment but the family situation is stressful, due to frequent fighting with patient and high emotionality. The patient's frequent threats of suicidal behavior and aggression maintain a constant crisis mode. Julie's parents aren't sure what else they can do and are concerned that counseling will not work, due to patient's unwillingness to participate. They are supportive of residential treatment placement or hospitalization.

Ohio Problem Scale = 48

Ohio Functioning Scale = 48

Vignette 7

John is a 10-year-old Caucasian male referred following discharge from Happy Hills Hospital, where he was diagnosed with Bipolar Disorder, ADHD, Oppositional Defiant Disorder, and Enuresis. John's parents report he has had problems with disruptive, hyperactive, and aggressive behavior since he was 3 years old. He has an extensive history of treatment, including other psychiatric hospitalizations. He has been tried on a wide variety of medications in the past with only partial benefit.

John was identified with ADHD at age 3 and was treated with medication since that time. He was generally manageable until 5 months ago when his problems seem to have escalated. Problems in the home include having mood swings, being hyperactive and impulsive, having anger control problems and being oppositional. No clear problems with feeling depressed or sad exist, and mood problems are predominantly related to anger. Neither the client nor family report any problems with suicidal ideations. John has no known problems with substance use and has never been in trouble with the legal system. John's problems in school include inattention and impulsivity, often being in conflict with teachers, being aggressive, having tantrums when he doesn't get his way and having difficulties getting along with peers. John has hit and bit peers on several occasions when angry and continues to need close monitoring to ensure classmates' safety. He is currently in a special education program for children designated ED, in a special classroom with a teacher and aide.

John has been in a psychiatric hospital on 5 different occasions over the last 5 months. His last hospitalization was due to out-of-control behavior and aggression. He was discharged from the hospital yesterday and has done all right at home so far. John was discharged on Risperdal, Neurontin, Concerta, Clonazepam, Benztropine, Ditropan, and DDAVP.

John lives with his mother and 7-year-old sister. John's mother reports his father has had no contact with the family for 5 years and had problems with alcohol abuse. His mother admits she has problems with depression which makes it difficult to keep up with John's problems.

Ohio Problem Scale = 39

Ohio Functioning Scale = 50

Vignette 8

Mary is a 15-year-old Caucasian diagnosed with Major Depressive Disorder. Her mother reports she has a 4-year history of mood problems. Her mother describes her mood as “withdrawn”, “overwhelmed”, and occasionally as “irritable”. She does sometimes have a “normal” mood, but is never overly joyful or extremely irritable. Mary has little problems falling asleep but wakes 4 to 5 times a night for no reason. She naps whenever possible. Although she does stay awake at school, she states she is always tired. Mary is doing okay in school this year but sometimes refuses to complete her homework, claiming to be too tired.

Mary has no interests or hobbies. She sometimes enjoys being with friends, but is becoming increasingly irritable with them. Mary’s mother states that she can go “days” without eating and has had periods of no appetite or interest in eating for the last 2 or 3 years. She denies any concern about her weight. Mary’s mother reports that 2 years ago Mary took sleeping pills in a suicide attempt. Mary stated she did it because “I just can’t stand my mom.” No treatment was sought related to this attempt, and Mary has never received mental health treatment. Mary stated that she sometimes thinks about killing herself. She states that she would probably take pills again. Mary and her mother are able to agree to a plan to keep all medication locked up and to call the crisis number if Mary is feeling suicidal. Mary denies use of drugs or alcohol and has never had contact with law enforcement.

Mary’s relationship with her mother and father is strained. She feels her mother doesn’t care what she wants or needs. Mary says she is always worried about her father, because he might go back to using drugs. Mary’s mother reports that she has been diagnosed with depression as well, and it currently taking Prozac, which seems to help.

Ohio Problem Scale = 33

Ohio Functioning Scale = 44

Vignette 9

Samantha is a 12-year-old Caucasian female diagnosed with Obsessive Compulsive Disorder. Samantha's mother reports that she has always been a "worrier" since she was a toddler, but her problems intensified last year. Samantha's mother reports that she is very worried about her school performance, despite being very bright. She states that Samantha takes three times too long to complete her work and checks all of her answers many times. Samantha acknowledges that she sometimes never turns her work in because she can't get it right. She reports that after she turns it in, she worries about things she might have answered incorrectly and frequently asks the teacher to check it again. Samantha's difficulties have resulted in her making C's in most courses. Samantha also has difficulties with "checking" doors to be sure they are locked and pulling the hair on her eyebrows and forearms. Samantha frequently complains of stomachaches or headaches and misses about 4 days of school in a typical month.

Samantha's teachers report that she is very well-mannered, but doesn't always pay attention in class. Samantha reports that she doesn't have very many friends in school, but doesn't appear to have any conflicts with other children. She states that she sometimes thinks about "just going to sleep forever" when she is very frustrated with herself, but denies that she would act on this. She denies any use of substances and has never been in trouble with the law. Samantha's parents took her to see her pediatrician 6 months ago but have not sought any other mental health treatment. Samantha's parents appear appropriately concerned about Samantha and report that they try not to put any pressure on her to do well in school. However, they are not sure how to help her get past this problem.

Ohio Problem Scale = 22

Ohio Functioning Scale = 33

Vignette 10

Mandy is a 5-year-old Caucasian female diagnosed with Separation Anxiety, Simple Phobia, and Enuresis. Her mother reports she is extremely agitated, crying frequently, very disturbed, and not eating, all related to increasing fear of attending school. Signs of anxiety began on the 3^d day of school and rapidly increased so that Mandy's mother had to take her out on the sixth day. Mandy's mother reports she had past fears of going to the bathroom alone and has always been very clingy to mom. Mom also reports she continues bedwetting, despite going to the bathroom 2 or 3 times per night. Mandy's mother states that she has not had any other significant emotional or behavioral problems. She states that Mandy's teacher did not know of any problem or difficulty that Mandy has experienced at school.

Mandy lives with her mother and father. Mandy's mother appears very worried about her daughter and unsure how to handle this difficulty.

Ohio Problem Scale = 20

Ohio Functioning Scale = 22