

James

Diagnosis drives treatment
 Wrong diagnosis wrong treatment
 Best case
 Worst case

OVER-DIAGNOSIS

Impact
Positive
Negative
1 million
Definitely have it
Some do not
Disruptive Mood Dysregulation Disorder (DMDD)

Changing, modifying or ignoring diagnostic criteria can result in children/teens being dx with MH disorders they may not necessarily have

UNDER-DIAGNOSIS

ADHD IN GIRLS

- · Symptoms can look different
- · Referral bias
- Teachers, parents
- Provider bias
 - Minimal training
- · Research
- Boys
- Shapes diagnosis
- · Potential life-long negative impact
- Growing up
- As adult women

MIS-DIAGNOSIS

- * Youth Involved w/ Juvenile Justice
 - · Oppositional Defiant Disorder
 - Conduct Disorder
 - ADHD
 - · What about.....Trauma?

Interpersonal trauma

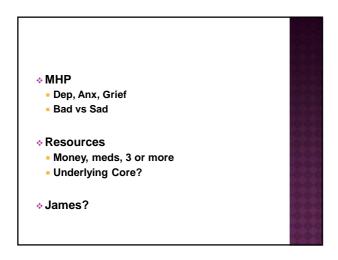
- « More trauma, more damage
- « Complicated diagnostic picture
- ⋄ Poly-traumatized/Poly-victimized
- Often no "trauma" diagnosis

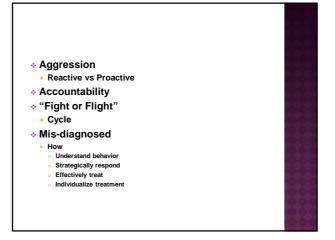
Trauma and the Brain

- Threatening sit
- Fight or flight
- Chemicals
- ChronicChanges
- Bio wired for survival
 - Revved up
 - Tense, Reactive
 - Scan for possible threat
- Impulsively respond



ADHD
Bipolar
Substance Use Disorder
Conduct Disorder
Antisocial
PTSD
Complex Trauma





Over, Under & Mis-Diagnosis

- ♦ What Can We/YOU Do?
- *Key steps—Big results
- Very complex youth

When we primarily rely on a youth's self-report, the chance they will be Over, Under or Mis-Diagnosed is much higher

1) More Likely to Obtain **Accurate Information** If Utilize More Than **Clinical Interview**

- Empirically-validated
 - Rating scales or checklists Many still self-report
- Psychological testing
- Objective, projective
- Access to a psychologist
 Have psychiatrist?
 Medicating right thing?
- * Information cannot get from interview
 - Not know what asking
 - Layers below
- Information from
 - Previous providers, family, teachers, caseworkers, PO
 - Phone/rating scales

<u>Comprehensive</u> "Psychological" Assessment

- Diagnostic picture not clear—guide tx plan
- Still struggling
- Significant resources
- Multiple meds
- * "Know" the system
- Harder to craft answer when unsure what evaluating
- Minimizing/exaggerating sxs
- MMPI & "validity" scales
- More effective—TX targeted to right issue(s)
 - Saves time
 - Saves money

2) Direct-Care Professionals
(at every level)
Key Members of the
Diagnostic & Treatment Team

- Eyes/ears
- Self/others
- Formal channels
 - · Communicate what see/hear
 - Individual youth
 - Evaluation/diagnosis

 Psych Assess/Med Eval
 - Dynamics
- Encourage questions/understanding
- More effective observers and reporters
- Columbo

3) Ensure Professionals Diagnosing Have the Education, Training, Experience & License To Do So

❖ Know
Strengths/limitations of DSM-5
Co-occurring or work closely with SA/MH
r/o Head Injury prior to MH
Trauma-responsive
r/o trauma prior to MH
Provisional or r/o
Obtain additional training/CE
❖ Contract if not staff
Share
New
Neuropsych
HI screen
▼ Travel?
Rural—bad vs no assess
1-2 visits

4) When youth have already been diagnosed, find out <u>details</u>

- When?
- By whom?
- How long?
- What include?

Re-Assess When Necessary

