In 2006 I began working in our Transitional Age Youth Academy with a group of about 75 people ages 18 to 25 who were already institutionalized, frequently hospitalized, homeless, jailed, and/or aged out of foster care. This article is the first of three I wrote after one year at our Transitional Age Youth Academy.

Even though I've always been ambivalent about DSM diagnosis and I knew that DSM is even weaker for adolescents than for adults, I still thought I could helpfully diagnose these young people. It proved to be much harder than I expected. Too often, though, even when I thought I figured out what was wrong with someone another competent staff would be just as confident in a completely different set of diagnoses. This short article outlines my difficulties and complaints.

I'd like to see more, honest discussion about how difficult and limited our present diagnostic tools really are. I don't think we're well served by pretending that we know more than we do and I think we should be highly suspect of any treatment approach to TAY that is primarily diagnostically based. We need to find some other foundation for our work.

Diagnosis and Transitional Age Youth

(2007)

Even in a recovery-discovery based, "get a life" program like the TAY Academy, it would be helpful to know want people's diagnoses are. Accurate diagnoses would help identify and overcome barriers to success. They would help us focus the treatment, rehabilitation, self-help, personal and social adaptation we integrate into our program. They would help us bill MediCal and obtain services and benefits from other agencies. They would also help us communicate with other programs, policy makers, and the public as we try to describe and promote what we're doing.

Even a "quick and dirty" division into Developmental Disabled/Brain Damaged, Severe Emotional Disturbed/Traumatized, Major Mental Illness, Serious Substance Abuse/Dependence, and Criminal/Antisocial (with many people falling into several categories) would be helpful. Unfortunately, there are a number of serious difficulties in achieving even that level of definition with any confidence.

1) Many people with Developmental Disabilities/Brain Damage do not have prominent intellectual deficits. They may have substantial irritability, poor focus, emotional lability, "touchiness," aggression, "autistic behaviors," hyperactivity, etc. These problems are easy to confuse with the effects of early childhood neglect or trauma or, later on, with symptoms of major mental illnesses. DSM doesn't clearly describe most of these people. The policies of our Regional Centers that serve people with developmental disabilities that aim to highly restrict eligibility for their services discourage identifying these people as Developmentally Disabled. On the other hand, many people with serious early emotional disturbances or who live in multiple placements, hospitals, or are incarcerated are often placed in Special Education classes or specialized programs and/or do very poorly in school. Impaired literacy, special education, and dropping out of school are very common in our program and not necessarily indicative of developmental disabilities.

2) Our present mental health system and its DSM diagnostic tool have a substantial biological rather than emotional emphasis. There is a tendency to diagnose people with major mental illnesses when they meet the criteria for diagnosis even when those problems are more likely the product of developmental disabilities, emotional trauma, and/or substance abuse. A common progression begins with an emotionally disturbed child who is "acting out" and hyperactive in early childhood being diagnosed as ADHD and given stimulants. If they're still disturbed by 10 or 12, they are likely to be sullen and withdrawn and diagnosed as Major Depression and an antidepressant added. By their teens they're likely to become emotionally labile, misbehaved, aggressive, and sexualized and they're given a diagnosis of Bipolar and a mood stabilizer is added to their medications. At 18, often deprived of all resources, experiencing homelessness, jailing, and using substantial drugs they "decompensate" and are diagnosed as Schizoaffective Disorder and an antipsychotic added to their medication regimen. The policies of our adult Mental Health System stating that we serve only people with Major Mental Illness diagnoses regardless of distress or disability contribute to individuals, families, the community, and caring clinicians identifying these diagnoses to get people help. For example, many people with a borderline personality disorder are given an additional "primary" diagnosis of Bipolar, type 2 and many people with PTSD are given an additional "primary" diagnosis of Major Depression. Unfortunately, the treatment for these additional "primary" diagnoses may not be helpful for the now "secondary" condition that is their "emotional" problem.

3) There is a popular though largely inaccurate link between mental illness and violence. We tend to be sensitive to the fear our community has of people with a mental illness and the resultant decrease in available social contacts and opportunities. We are less sensitive of the likelihood of overdiagnosing mental illnesses because of violence itself. Presumably every violent child, teen, and transitional age youth is not mentally ill, yet they're likely to be viewed that way. "Irrational" and "uncontrollable" misbehavior is also likely to lead to a diagnosis of mentally illness or even psychosis.

4) Substantial substance abuse is common in all transitional age youth. When it occurs in the context of a protective and permissive college dorm setting only limited problems arise, diagnoses are rarely made, and adult behavior is often unaffected. When the same behaviors occur in the context of "the system" - Board and Cares, sober living homes, Job Corp, foster care, group homes, etc. - serious problems often result including homelessness, police contact, hospitalization, and/or incarceration. In those contexts the diagnosis of Substance Abuse/Dependence is more often made. Complicating things further, individuals, families, the community, and caring clinicians often want to add mental health diagnoses to make people "dually diagnosed" and eligible for more help and less punishment. On the other hand, early use of drugs and alcohol, by 10 or 13 years old, before the brain is fully developed, that is common in our program, can cause permanent changes that invite more diagnoses, but these too aren't well described in DSM.

5) Being incarcerated or homeless often exposes people to enormous stressors including violence and cruelty, intimidation and fear, physical and sexual assaults, isolation and solitary confinement. These stressors can exacerbate underlying or dormant mental problems or even cause them. Treatment is often cursory or unavailable and many people emerge from jail or the streets with severe symptoms,

incorrect diagnoses, and unhelpful medications. On the other hand, many people who are distressed by the destruction and cruelty of our criminal justice facilities and the streets urge "diversion" for people with developmental disabilities, mental illnesses, and sometimes even substance abuse diagnoses. Accessing "diversion" services or specialized homeless assistance programs can be a substantial incentive to be identified with one or more of these diagnoses.

It is only after knowing people for quite a while, gaining their trust so they're more truthful and open, observing them in a variety of settings and roles, and getting reports, both past and present, from a variety of other people that we even have a chance of making a reasonably accurate and helpful diagnostic assessment. To get to that point we have to focus heavily on building relationships with outreach and engagement, inclusion and acceptance, working on their quality of life goals, and, perhaps most importantly, not giving up on them.