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This study indicates that there is only modest agreement between diagnoses youth receive from community clinicians and those they receive from standardized diagnostic interviews. The current study found that the prevalence of diagnoses on the Diagnostic Interview Schedule for Children (Version IV) was significantly higher than clinician-based diagnoses for Attention Deficit Hyperactivity Disorder (ADHD), Disruptive Behavioral Disorders, and Anxiety Disorders. Conversely, clinician-assigned diagnoses for Mood Disorder were significantly higher than those endorsed by the DISC-IV.

Participants were a subset of youth (N = 240) ages 6-18 from the Patterns of Care (POC) study in San Diego County who were receiving services through the mental health service sector between 1996-1997, and whose mental health diagnoses were assessed with the DISC-IV. Over half of youth were male (61%) and Caucasian (52%), followed by Latino (23%), African American (16%), biracial (5%), and Asian/Pacific Island or Other (4%). Sixty percent of youth were active in at least one additional service sector (i.e., child welfare, juvenile justice, special education [SED], or alcohol/drug). Activity in service sectors was defined as having at least one treatment episode within the year, and youth averaged 1.3 (SD = 1.2) episodes per year.

Most participating clinicians were master's level counselors or social workers. Clinician diagnoses were gleaned from the county database, and were usually arrived at through a multidisciplinary team that included the child and a psychiatrist. Diagnoses for each treatment episode were made after consultation with the DSM-IV (substance abuse and developmental disorder diagnoses were not included in the analysis). In an effort to capture diagnoses based on having known the child for the longest period of time, the authors based their analysis on diagnoses made at discharge.

Selected modules of the DISC-IV (i.e., anxiety, mood, and disruptive) were administered to youth between the ages of 11-18, and to parents of youth ages 6-10. In addition, the disruptive module was administered to parents of youth ages 11-18. A diagnosis was deemed present if the parent or youth report reflected diagnostic criteria as measured by the DISC-IV, and if functional impairment was endorsed. Mental health diagnoses generated by either the DISC-IV or clinician assessment were broadly classified as ADHD, Disruptive Behavioral Disorders, Mood Disorder, or Anxiety Disorder. The Child Behavior Checklist (CBCL) was also used to assess youth externalizing and internalizing problems (clinicians did not have access to these data). The average length of time between a youth's last clinic appointment and a DISC-IV assessment was 168.2 days (SD = 105.1).

Table 1. Prevalence of DISC-IV and Clinician Diagnoses

Diagnostic Category	DISC-IV		Clinician	
	n	%	*n*	%
ADHD	112	46.7	56	23.3
Any DBD	158	65.8	63	26.3
Any Mood Disorder	26	12.6	81	39.1
Any Anxiety Disorder	45	18.8	11	4.6

As shown in Table 1, there was poor overall agreement between diagnoses endorsed by the DISC-IV and clinician assignment. When youth were assessed with the DISC-IV, 77% met criteria for a mental health diagnosis, and 50% of those youth had more than one diagnosis. Twenty-eight percent of all diagnoses assigned by clinicians were not endorsed by the DISC-IV (e.g., adjustment, impulse control, psychotic, learning, somatoform and elimination disorders, etc.), and clinicians assigned multiple diagnoses for 28% of all youth.

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Although the length of time between clinician-assigned diagnoses and a DISC-IV endorsement was lengthy, the authors found no significant relationship between time interval and diagnostic agreement. However, one possible explanation for the poor agreement between clinician assessment and DISC-IV endorsement may be related to the fact that clinicians had to assign a diagnosis in order to be reimbursed for services. It is possible that the frequency of Mood Disorder and Not Otherwise Specified (NOS) diagnoses may be related to this requirement, particularly if clinicians perceived them to be less "pejorative" than other diagnoses (p. 355). According to the authors, a major limitation of the study concerns the lack of a "gold standard" (p. 355) against which DISC-IV endorsed or clinician-assigned diagnoses can be compared. That is, the study does not provide insight into which of the two diagnostic methods are most valid.

Of studies that have examined agreement between structured interviews and clinician assessment, this is the first to use the most current version of the DSM to assign diagnoses, and is also the first study with "sufficient statistical power to examine predictors of agreement between structured interviews and clinician diagnoses" (p. 355). Because clinician-assigned diagnoses influence subsequent treatment and interventions, it is important to understand how clinicians assign diagnoses. Yet some clinicians may be ambivalent about the utility of data gleaned from standardized instruments. Thus, the authors suggest that researchers need to find ways to increase clinician support of such instruments. Furthermore, because clinicians may have much to contribute toward improving instruments used in the clinical setting, more instrumentation research that incorporates their insights and judgments into standardized measurements should be conducted.

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