UTAH SCALE FOR CHILDREN/ADOLESCENTS WITH SERIOUS EMTIONAL DISORDERS (SED) SED DEFINTITION

Serious Emotional Disturbances (SED) is the inclusive term for children and adolescents whose emotional and mental disturbances severely limits their development and welfare over ***a significant period*** of time and requires a comprehensive coordinated system of care to meet their needs.

SED DETERMINATION

Children/adolescents must be **under** 18 years of age, or under 22 years of age if disabled and receiving special education services or under the jurisdiction of the Court. **All** three (3) of the following criteria must be met in order to be defined as SED. The severity of the child's/adolescent's disorder may place or potentially place him/her at significant risk for out of school, home or community placement. **Indicate the appropriate response to each of the areas below.**

____ Yes ____ No **DIAGNOSIS:** Child/adolescent must have a recent (within 1 year) DSM IV diagnosis. Children diagnosed with a designated V-Code must also have a non-V-Code, Axis I diagnosis to meet this criterion.

____ Yes ____ No **DISABILITY**: Child's/adolescent's degree of impairment consistently prevents appropriate functioning in at **least two** of the following life domains for ages 3 and older:

a) Age appropriate self-care
b) Family life
c) Education
d) Community living
e) Personal hygiene
f) Leisure time management
g) Peer relationships

For infants and toddlers, 0-2 years of age, only one area of significant delay in age appropriate development is required.

____ Yes ____ No **DURATION**: The disorder must have been present for at least one year

or

is anticipated to persist for a year or longer

or

is of such a *significantly high severity* that the impairment of appropriate functioning and the residual effect is anticipated to negatively persist for a year or longer.

____ Yes ____ No **SED DEFINITION: The child/adolescent meets all three of the criteria above.**

ORGINAL DATE ____/____/____.

REVIEW DATE ____/____/____. ____/____/____. ____/____/____.

Review Date: Must be reviewed at least annually, or sooner if there is a significant change in the diagnosis or disability.

Name of Client _____ **ID#** _____

Signature of Therapist _____ _____ **Date** _____

Revised: 06/30/99
Approved: 10/15/99