

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

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.**

_____	_____	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 is anticipated to persist for a year or longer or is of such a <i>significantly high severity</i> 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.
Yes	No	

ORIGINAL 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** _____