Severe Emotional Disturbance (SED) Definition/ Criteria Checklist
At-Risk Severe Emotional Disturbance (SED) Definition/ Criteria Checklist
Feedback on 1-12-2010 Drafts

NOTE: COMMENTS AND RECOMMENDATIONS are inserted after each of the component parts of the definitions. Comments were received from 18 persons as well as the membership of the NM-AACAP (American Academy of Child and Adolescent Psychiatry). There were considerably fewer comments on the At-Risk definition than the SED definition.

NOTE ALSO that the Infant Mental Health Workgroup provided additional comments after this document was distributed. New comments are inserted below in red.

THE DEFINITION - SED

SED determination is based on the age of the individual, functional impairment or symptoms, diagnoses and duration of the disorder. The child/adolescent must meet all of the following four criteria:

1. Age
   - be a person under the age of 18; OR
   - be a person between the ages of 18 and 21, who received services prior to the 18th birthday, was diagnosed with an SED, and demonstrates a continued need for services

COMMENTS AND RECOMMENDATIONS - AGE

Change “an SED” to “a SED.”

2. Functional Impairment or Symptoms

Functional Impairment in two of the following capacities (compared with expected developmental level):

- Functioning in self-care - Impairment in self-care is manifested by a person’s consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
- Functioning in community - Impairment in community function is manifested by a consistent lack of age-appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement in the juvenile justice system.
Functioning in social relationships - Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

Functioning in the family - Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable expectations that may result in removal from the family or its equivalent).

Functioning at school/work - impairment in any one of the following:

- The inability to pursue educational goals in a normal time frame (e.g. consistently failing grades, repeated truancy, expulsion, property damage or violence toward others)
- Identification by an IEP team as having an Emotional/Behavioral Disability
- The inability to be consistently employed at a self-sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job)

Symptoms – the child/adolescent must have one of the following:

- Psychotic symptoms - serious mental illness (e.g. schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.
- Danger to self, others and property as a result of emotional disturbance. The individual is self-destructive, e.g., at risk for suicide, runaway, promiscuity, and/or at risk for causing injury to persons or significant damage to property.

COMMENTS AND RECOMMENDATIONS - FUNCTIONAL IMPAIRMENT OR SYMPTOMS

Functional impairment: There is a general consensus among the members of NM-AACAP that while the general categories that are used to measure functional impairment are useful and accurate, the examples seem to have in mind children who are involved in protective services and juvenile justice more than community children and youth. This bias, whether unconscious or not, can be seen to limit the scope of the eligible population.

Symptoms: Comments of NM-AACAP members were unanimous regarding this comment. There are disorders and conditions which are severely disabling but do not necessarily manifest either of the two conditions (danger to self or others or psychosis) which are represented in the definition as mandatory symptoms. None of the most experienced clinicians in the group believes that these two isolated conditions in themselves have any real merit as mandatory criteria for this determination, which should be based upon the presence of a serious, chronic disorder that causes a substantial functional impairment. Who inserted these, and why?

Functioning in the Family section: recommend with the phrase "unprovoked violence to siblings and parents" adding "caretaker" or some similar language to allow situations such as foster care or children/adolescents being cared for by others besides their parents. This would include foster care situations in which the child/youth displays violence to the caretaker once placed within this family situation, and yet these are not the parents or guardians.
INFANT MENTAL HEALTH WORK GROUP: None of the categories of functional impairment include criteria appropriate for assessing emotional and social functioning of children 0-3. We have not come up with a way to fix this, except to recommend we insert language into the social relationship and family functioning categories that reflect the 6 rating capacities for emotional and social functioning from the DC:0-3r (Axis V, pg 61).

3. Diagnoses: The child/adolescent has an emotional and/or behavioral disability that has been diagnosed by a licensed psychiatrist, licensed psychologist, LISW, LMFT, or LPCC under the classification system in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) from the following list:

Adult diagnostic categories appropriate for children and adolescents

- Substance Dependence Disorders (303.90 - 304.90)
- Schizophrenia and Other Psychotic Disorders (293.81, 293.82, 295.10 – 295.90, 297.1, 297.3, 298.9)
- Mood Disorders (293.83, 296.00 – 296.90, 300.4, 301.13, 311)
- Anxiety Disorders (293.89, 300.00 – 300.02, 300.16 – 300.3, 300.7, 308.3, 309.81)
- Somatoform Disorders (300.11, 300.81)
- Sexual and Gender Identity Disorders (302.2 – 302.6, 302.85, 302.89, 302.9)
- Impulse Control Disorders (312.30, 312.33, 312.34)

Disorders usually first diagnosed in infancy, childhood, or adolescence

- Attention-Deficit and Disruptive Behavior Disorders (312.8, 314.00 – 314.9)
- Reactive Attachment Disorder of Infancy or Early Childhood (313.89)

COMMENTS AND RECOMMENDATIONS - DIAGNOSES

NM AACAP

The members of AACAP were in unanimous agreement that the list of DSM disorders that are required as a prerequisite for eligibility lacks any clear rationale. In fact the idea of designating certain disorders to be allowed at the expense of others is illogical in itself. Look below (in red) to see how gerrymandered the list has become. It gives the strong impression of some unknown bias, but some of the inclusions are as crazy as the exclusions, so that charge cannot be accurate. All agree that a particular diagnosis per se cannot be a serious deciding criterion, and that the entire DSM IV needs to be included.
Substance Dependence Disorders (303.90 - 304.90) (Deletes all inhalant, opiate, phencyclidine, sedative, hypnotic and anxiolytic disorders)

Schizophrenia and Other Psychotic Disorders (293.81, 293.82, 295.10 – 295.90, 297.1, 297.3, 298.9)

Mood Disorders (293.83, 296.00 – 296.90, 300.4, 301.13, 311)

Anxiety Disorders (293.89, 300.00 – 300.02, 300.16 – 300.3, 300.7, 308.3, 309.81) (leaves out all the dissociative disorders)

Somatoform Disorders (300.11, 300.81) (picks out singly somatization disorder and conversion disorder and leaves out the others) (leaves out all the factitious disorders)

Sexual and Gender Identity Disorders (302.2 – 302.6, 302.85, 302.89, 302.9) (decides to include pedophilia and frotteurism but arbitrarily excludes sexual masochism and sadism!!)

Impulse Control Disorders (312.30, 312.33, 312.34) (includes pyromania, intermittent explosive disorder and NOS, but arbitrarily excludes the others)

Disorders usually first diagnosed in infancy, childhood, or adolescence

Attention-Deficit and Disruptive Behavior Disorders (312.8, 314.00 – 314.9) (includes conduct disorder but excludes ODD and a few others)


Reactive Attachment Disorder of Infancy or Early Childhood (313.89)

OTHERS’ COMMENTS

Add Encopresis; Learning Disorders; Cognitive Disorders; Mental Retardation; Trichotillomania and Kleptomania (with other impulse disorders); Sleep Disorders; Adjustment Disorders; Dissociative Disorders; Acute Stress Disorder; Personality Disorders; Oppositional Defiant Disorder; Voyeurism, Sadism and Masochism (with Sexual Disorders).

INFANT MENTAL HEALTH WORKGROUP:

• When considering the behavioral health needs of infants and young children, it is most clinically appropriate to use the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: REVISED EDITION (2005) when referring to both diagnosis and risk factors for this specific population. “because of the failure of the current DSM system to include (1) sufficient coverage of syndromes of early childhood that needed clinical attention or (2) sufficient consideration of developmental features of early disorders.” (DC:03R, pg4).

• Under “Diagnoses first diagnosed in infancy, childhood or adolescence,” we do not understand why the list is limited to only four diagnoses when DSM-IV-TR lists 10.

• Make note that some of the Adult diagnostic categories appropriate for children and adolescents are NOT appropriate for infants and young children. And Disorders usually first diagnosed in infancy, childhood, or adolescence is misleading in its brevity and omissions.
• We think this list of early diagnoses should be inclusive, both from the DSM and the DC:03R and the ICD 10 which includes developmentally relevant categories.

There is no reference to trauma (PTSD), depression, relationship disorders and other infant and toddler diagnoses as described in the DC:03r. Given that a service definition for treatment of infant mental health disorders, including those listed in the DC:03r, has been approved, it seems that this important information should be included in any SED (and At-Risk SED) definitions for children. Might there be (as in the past for CYFD funded services) some identified number of risk factors that create SED eligibility in lieu of formal diagnosis for infants and toddlers?

We should use the DC:0-3 as the diagnostic framework in lieu of the DSM-IVTR for young children. The DC:0-3 offers a better approach than the DSM-IVTR for diagnosis. While we want to avoid diagnosing any young children, we may actually do a disservice to those who need and would benefit from treatment if we do not.

Since diagnosis leads to intervention and treatment I doubt the DSM is an adequate tool for infants and very young children unless we can use the V Codes. These codes at least acknowledge and consider more of the appropriate and important areas of the child's life, such as family and environment, that must be a part of the child's clinical treatment. Optimally we should use the DC: 0-3r.

Add brain injury.

4. Duration:

☐ has an emotional disability that has persisted for at least six months; AND

☐ that same disability must be expected to persist for a year or longer.

COMMENTS AND RECOMMENDATIONS - DURATION

Align with adult definition: Delete requirement that emotional disability must have persisted for at least six months (i.e., it is not in the adult definition and shouldn’t be in this one).

• this is not clinically or empirically based
• many acute disorders (anxiety, mood, etc.) have rapid onset; distinction is simply not theoretically, clinically or empirically based
• There is a limited consensus (in NM-AACAP) that for a disorder to last six months is an unnecessary burden, particularly if a disorder is inherently chronic by definition, like schizophrenia. Six months is a comparatively greater percentage of time in a young child’s life compared to an adult. No member opposed this idea of deleting this requirement, but it received limited circulation and few people commented upon it.
Align with adult definition: Change expected “length to persist” to 6 months (i.e., make the same as adult).

One member (of NM-AACAP) noted that the adult SMI criteria set the requirement that the disorder must be expected to persist for 6 months or more. There is no logical reason why the adult standard should be shorter than the child standard. Again, as in the case above, a year is a comparatively greater percentage of time in a young child’s life compared to an adult. This criterion should match or be less than the adult time requirement.

INFANT MENTAL HEALTH WORK GROUP: Language “has an emotional disability that has persisted for at least six months; AND that same disability must be expected to persist for a year or longer is inappropriate for the birth to three age group as the developmental time frame and impact is much shorter for emotional disturbances and waiting for six months to persist consists of malpractice at best. Likewise, if properly trained infant mental health clinicians can provide treatment, the expectancy of persistence for a year or longer may not be the expected outcome. Babies cannot be held to the same time frame standard as older children, adolescents or adults. 

Recommendation: Add or change language that addresses a different time frame for duration for symptoms in infants that is developmentally appropriate.

GENERAL COMMENTS AND RECOMMENDATIONS - SED DEFINITION

This is essentially a good definition and set of criteria (2)

The definition and criteria are lacking in reference to “neurobiological.” Mental illness diagnoses in children and youth are neurobiological disorders. Mental illness carries its own stigma but SED is even worse in its implication of “bad parenting.”

The definitions/criteria lack clear rationale/rhyme and reason. It is hard to find the logic behind what is included and what is not.

This is a flawed document and needs to be redrawn around sounder principles.

Since it looks like only CSAs will be able to bill for services, and only SED (and possibly at-risk SED) will be able to receive services, (except under the most generous private insurance), does it make much difference what those who are not or do not want to receive their services from CSAs might give as feedback at this point? And, if only SED (and possibly at-risk) can receive services, does it make any difference what the criteria are? Anyone needing to bill will stretch them as far as possible.

What or how will these definitions help our kids? These definitions fit all my adopted kids. We have gone through hell and back getting them services.
THE DEFINITION – AT-RISK SED

At-risk SED determination is based on the age of the individual, involvement in children’s service systems, and psychological stressors. The child/adolescent must meet all of the following three criteria.

INFANT MENTAL HEALTH WORKGROUP: The most serious exclusion of young children (not just 0-3, but at least 0-8) comes from the requirement that all three criteria (age, system involvement and psychosocial stressors) must be met. Younger children needing services will mostly NOT be involved with the system or at high risk for imminent involvement. They will meet age and stressor criteria only. Interventions with young children are preventive. They are intended to keep current serious problems from growing to the point where systems become involved. Recommendation: We recommend a change that the “child/adolescent must meet two of the following three criteria.” Or specify that children younger than 8 years need meet only two of three criteria.

☐ 1. **Age**: Child/adolescent must be a child under the age of 21; *and*

**COMMENTS AND RECOMMENDATIONS – AGE**

No comments or recommendations were received.

☐ 2. **System Involvement**: Child/adolescent must be involved with or at high-risk for involvement with CYFD Protective Services (PS) and/or Juvenile Justice Services (JJS) and/or Tribal Social Services; *and*

**COMMENTS AND RECOMMENDATIONS – SYSTEM INVOLVEMENT**

Allow criterion #2 to be at risk for PS, JJS, Tribal Social Services, Inpatient and/or RTC

Add “CYFD Youth and Family Services.” Given changes to CYFD’s Service Areas, JJS now only refers to committed facilities. Youth and Family Services includes Probation and Aftercare Services, as well as Transition Services. In this way we would not be limited to only the small number of high-end youth actually committed to facilities, but all of the youth at risk for involvement with probation as well.

☐ 3. **Psychosocial Stressors**: Child/adolescent must be experiencing *at least two* of the following specific circumstances:

☐ Significant behavioral, emotional, or mental health issues that do not meet all of Severe Emotional Disturbance (SED) criteria.

☐ Suicide attempt within the past year.

☐ Suicide attempt by parent/guardian of child/adolescent within the past year.

☐ Substance abusing behaviors by child/adolescent.
Substance abusing behaviors by parent/guardian.

Multiple delinquent acts and/or involvement with law enforcement within the past year.

Multiple school problems, including suspension or expulsion from school, within the past year.

Currently precariously housed/at-risk of homelessness, homeless and/or runaway.

Incarcerated parent(s)/guardian.

Physical, sexual, emotional abuse or neglect of child/adolescent – current or known history.

Multi-generational history of familial maltreatment, neglect or abuse.

Current teen parent or involvement in a teen pregnancy within the past year.

Current experience of cultural, sexual and/or gender identity issues.

Witness to or participant in violence in school or community.

COMMENTS AND RECOMMENDATIONS – PSYCHOSOCIAL STRESSORS

There needs to be a way for environmental and relationship issues to be considered in determining "at risk" status for infants and toddlers, e.g., parental mental health diagnosis, substance use, history of maltreatment, etc. There are very young children who are clearly suffering and truly at risk for negative outcomes. The experience of neglect, abuse, clear relationship disturbance, etc. could be a criterion for at risk status and thus eligibility for treatment services for infants and toddlers. Currently it is impossible to find the experiences/stressors of infants and very young children in this list of psychosocial stressors without a real stretch.

Gender identity issues need to be included in the list of psychosocial stressors.

Suicide attempt by parent/guardian of child/adolescent within the past year: Need to add suicide attempt by siblings; need to also consider adding suicide attempt by extended family members.

Witness to or participant in violence in school or community: Need to add “violence in home,” to address domestic violence. Also, this language might be expanded to "violence and/or trauma". This would for then include children/adolescents who have experienced trauma, beyond what is described in abuse/neglect, such as traumatic accidents, medical situations/experiences, disasters, dating violence, etc.

INFANT MENTAL HEALTH WORKGROUP: The list of psychosocial stressors should be increased to include the following:

- Disruptions in primary attachments
- Exposure to or experiencing trauma
- Psychiatric illness in parent that affects caregiving
- Eligible for any clinical diagnosis in the DC:0-3r