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Original Article *Özgün Araştırma*

TRANSITION TO THE SPECIAL NEEDS REPORT FOR CHILDREN (SNRC): AN ANALYSIS OF REFERRALS TO CHILD AND ADOLESCENT PSYCHIATRY OVER THE LAST THREE YEARS

Çocuklar için Özel Gereksinim Raporuna (ÇÖZGER) Geçiş: Son Üç Yılda Çocuk ve Ergen Psikiyatrisine Başvuruların Analizi

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ABSTRACT

Objective: Following the enactment of the Special Needs Report for Children (SNRC) regulation on February 20, 2019, several changes were made to the reporting system. The field of child psychiatry is among the leading specialties issuing SNRC reports. This study aimed to evaluate the psychiatric and other medical diagnoses of cases referred to pediatric and adolescent psychiatry for SNRC, determine their level of needs, and discuss the new regulation in the context of existing literature.

Material and Methods: Demographic and clinical characteristics, as well as levels of needs and relevant areas, were retrospectively analyzed for cases aged 0-18 who presented to a university hospital's pediatric and adolescent psychiatry clinic between January 2021 and January 2024.

Results: A total of 986 children and adolescents, comprising 331 (33.6%) females and 655 (66.4%) males, with a mean age of 10.27±3.77 years, were included in the study. The most common reason for SNRC referral in the 0-4 age group was speech delay (n=32, 45.1%) while learning difficulties were predominant in other age groups. Analysis of psychiatric diagnoses under SNRC revealed delayed milestone diagnosis as the most common at 45.7% (n=451), followed by specific learning disorder (n=312, 31.6%) and autism spectrum disorder (n=154, 15.6%). Non-psychiatric diagnoses showed that 28.8% (n=284) of cases had at least one accompanying medical disease, including cerebral palsy (n=65, 6.5%), sensorineural hearing loss (n=47, 4.8%), epilepsy (n=37, 3.8%), and Down syndrome (n=21, 2.1%). Additionally, 20% (n=198) of cases exhibited special needs in at least one non-psychiatric area, with motor development being the most common domain (n=125, 63.1%).

Conclusion: These findings highlight the diversity of needs among children and adolescents receiving SNRC reports. Accurate evaluation and reporting of special needs in child and adolescent psychiatry are crucial for enhancing individuals' quality of life and providing necessary support.

Keywords: *Disabled children, child psychiatry, children's health*

ÖZ

Amaç: 20 Şubat 2019 tarihinde yürürlüğe giren 'Çocuklar İçin Özel Gereksinim Raporu' (ÇÖZGER) ile rapor sisteminde birtakım değişikliklere gidilmiştir. Çocuk psikiyatrisi bölümü en fazla ÇÖZGER raporu çıkaran branşlardan biridir. Bu çalışmada ÇÖZGER için çocuk ve ergen psikiyatrisine başvuran olguların psikiyatrik ve diğer tıbbı tanılarının değerlendirilmesi, gereksinim düzeylerinin belirlenmesi ve yeni yönetmeliğin mevcut literatür eşliğinde tartışılması amaçlanmıştır.

Gereç ve Yöntemler: Ocak 2021 ile Ocak 2024 tarihleri arasında bir üniversite hastanesinin çocuk ve ergen psikiyatrisi kliniğine başvuran 0-18 yaş olguların demografik ve klinik özellikleri ile gereksinim düzeyleri ve ilgili alanlar geriye dönük olarak incelenmiştir.

Bulgular: Çalışmaya 331'i (%33.6) kız, 655'i (%66.4) erkeklerden oluşan ve yaş ortalaması 10.27±3.77 yıl olan 986 çocuk ve ergen dahil edilmiştir. 0-4 yaş grubunda ÇÖZGER'e en sık başvuru nedeni konuşma geriliği iken (n=32, 45.1%), diğer yaş gruplarında öğrenmekte zorluk olmuştur. ÇÖZGER kapsamında psikiyatrik tanılar incelendiğinde, en sık olarak %45.7 (n=451) ile gecikmiş dönüm noktası tanısının konulduğu bunu sırasıyla özgül öğrenme bozukluğu (n=312, %31.6) ve otizm spektrum bozukluğu (n=154, %15.6) tanılarının izlediği belirlenmiştir. Psikiyatri dışındaki tanılar incelendiğinde tüm olguların %28.8 (n=284)'inde en az bir tıbbi hastalığın eşlik ettiği saptanmıştır. Bu tanıların sırasıyla serebral palsi (n=65, %6.5), sensörinöral işitme kaybı (n=47, %4.8), epilepsi (n=37 %3.8) ve Down Sendromu (n=21, %2.1) olduğu belirlenmiştir. Olguların %20 (n=198)'inde en az bir psikiyatri dışı alanda özel gereksinim ihtiyacı mevcut olup bunun en sık Hareket Gelişimi Alanı'ndan (n=125, %63.1) olduğu saptanmıştır.

Sonuç: Bu bulgular, ÇÖZGER raporu alan çocuk ve ergenlerin gereksinimlerinin çeşitliliğini vurgulamaktadır. Çocuk ve ergen psikiyatrisinde özel gereksinimlerin doğru bir şekilde değerlendirilmesi ve raporlanması, bireylerin yaşam kalitesini artırmak ve ihtiyaç duydukları destekleri sağlamak için kritik öneme sahiptir.

Anahtar Kelimeler: *Engelli çocuklar, çocuk psikiyatrisi, çocuk sağlığı*

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INTRODUCTION

Individuals with special needs are defined as those who experience varying degrees of impairment or dysfunction in their physical, mental, emotional, social, sensory, and intellectual abilities due to various internal or external reasons, either from birth or during later developmental stages (1). This condition results in an inability to meet the requirements of normal life and to benefit from general education services. Over time, various terms have been used to describe these individuals, influenced by socio-cultural, and economic characteristics, as well as technological and scientific developments worldwide. Terms such as "abnormal," "privileged," "disabled," "handicapped," "inadequate," and "in need of special education" were used in the past. However, in recent years, the term "individuals with special needs" has been preferred to prevent stigmatization (2). The World Health Organization proposes a three-dimensional approach to special needs in health, comprising impairment, disability, and handicap (3). In the Türkiye Disability Survey, it is stated that 12.29% of the total population and 8.78% of children and young people are "disabled" (4). In child and adolescent psychiatry, health board reports are issued for children with special needs to enable them to benefit from social, educational, and economic rights. The Disabled Health Board Report, which was designed to cater to both children and adults, was superseded by the 'Regulation on Special Needs Assessment for Children,' which came into force on February 20, 2019 (5,6). As a result, a separate report specifically for children called the "Special Needs Report for Children (SNRC)" has been introduced. Consequently, SNRC aims to document children's needs differently from adults to facilitate their access to healthcare, education, rehabilitation, and various social and economic rights and services. The absence of specific provisions for the child age group in the previous regulations posed significant challenges, particularly concerning the evaluation of infants diagnosed with well-known developmental conditions such as Down syndrome. Additionally, the transition from the term "disability" to "special needs" in conjunction with SNRC, along with the removal of terms that could engender prejudice or discrimination from the report, underscores its importance (7,8). In the former regulations, disability rates for each system were expressed as percentages (%) in disability health board reports, whereas in SNRC, these rates are delineated as special need levels for specific special need areas. SNRC's special need levels range from "Has special needs (HSN)" to "Has special condition needs (HSCN)", comprising seven degrees. Three special need areas have been identified in conjunction with psychiatry within SNRC, namely cognitive development, child and adolescent psychiatry, and language-speech-communication development. 'Cognitive Development Area' encompasses cognitive developmental delays (CDD) and intellectual disabilities (ID); 'Child and Adolescent Psychiatry Area' incorporates various disorders such as schizophrenia, autism spectrum disorder (ASD), mood disorders, and specific learning disorder (SLD). It is emphasized that terminology such as "mental retardation" should be replaced with "delayed milestone" in the cognitive development area. Furthermore, diagnoses mostly reported in the Ear Nose Throat (ENT) diseases area, such as receptive expressive language impairment, stuttering, phonological disorder, articulation disorder, social (pragmatic) communication disorder, and voice disorder, are now included in SNRC within the domains associated with child and adolescent psychiatry.

Given the increasing number of psychiatric referrals among children and adolescents in Türkiye in recent years, along with the expanded scope of psychiatric diagnoses through SNRC, it is crucial to ensure accurate and comprehensive psychiatric diagnoses and referrals based on the level of need. There is limited literature available on the psychiatric fields and requirement levels covered in SNRC (7-9). This study aims to investigate the clinical characteristics, and psychiatric and comorbid diagnoses of cases presenting to a tertiary university hospital for SNRC evaluation. It seeks to determine the diagnoses and requirement levels according to SNRC, discuss them with existing literature, and highlight any discrepancies or areas needing further attention.

MATERIALS AND METHODS

A retrospective study was conducted, including all SNRC applications to the Department of Child and Adolescent Psychiatry at the Faculty of Medicine, Başkent University, between January 1, 2021, and January 1, 2024. For recurrent applications, the latest submission information was considered. The study examined the age, gender, reasons for application, psychiatric diagnoses, other medical conditions causing special needs, and the level of special needs among patients aged 0-18 years. Patient information was obtained from hospital records, and diagnoses were classified according to the International Classification of Diseases (ICD-10) codes.

In our hospital, to obtain an SNRC report, the legal guardian of the patient can directly apply to the child psychiatry clinic, or the patient may be referred to child psychiatry for mental and psychological evaluation from other specialties related to their medical condition (such as pediatrics, pediatric neurology, otorhinolaryngology, physical therapy, etc.). However, all SNRC applications in the last 6 months have been subjected to psychiatric examination at the child psychiatry clinic. Cases

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undergo psychiatric examination by child psychiatry specialists, followed by a determination of their mental and cognitive levels by experienced and certified psychologists in the field. For this purpose, the Wechsler Intelligence Scale for Children (WISC-R or WISC-IV) is used for children aged 6 and above, while the "Ankara developmental screening inventory" (AGTE) is applied to evaluate developmental levels in children under 6 years old. "The specific learning difficulties battery" is used for assessing SLD. The ethics committee approval was received from the regional ethics committee to conduct the study (Protocol Number: KA24/98)

Ankara Developmental Screening Inventory: AGTE, developed by Savaşır et al. (1995), assesses the development and skills of children aged 0-6 years based on information obtained from caregivers (10). AGTE comprises four developmental domains: Language-cognition, fine motor, gross motor, and social skills-self care, from which a total developmental score is derived.

Wechsler Intelligence Scale for Children: WISC was developed by Wechsler in 1949 and revised in 1974 (11). The Turkish standardization, validity, and reliability study of WISC-R was conducted by Savaşır and Şahin (12). This intelligence test consists of 12 subtests, including verbal and performance skills, from which verbal, performance, and total intelligence scores are calculated.

The Wechsler Intelligence Scale for Children-IV: WISC-IV was developed to measure the cognitive abilities of children aged 6-16 years. WISC-IV has four factors with established validity through psychometric measurements, comprising 10 core and five supplemental subtests. Five converted scores can be obtained from WISC-IV. This scale has been standardized into Turkish (13,14).

The Specific Learning Difficulties Battery: The SLD Battery used in the study was based on Korkmazlar's (1992) work and expanded with new tests in subsequent studies (15). The expanded battery consists of 9 tests, including a reading test, writing test, alphabet letters, addition, and multiplication table questions according to grade level, questions about months and days and temporal relationships, Gessel shapes, clock drawing test, Head's left-right discrimination test, and Harris lateralization test (16).

Statistical Analysis

The SPSS 25.0 software package was used for statistical data analysis. Descriptive data were presented as numbers and percentages for categorical variables and as the mean and standard deviation for numerical variables. The chi-square test was used to compare categorical variables between independent groups. The normal distribution of numerical data was assessed using the Kolmogorov-Smirnov test. A significance level of $p < 0.05$ was considered.

RESULTS

Within the scope of the study, the mean age of the 986 cases whose reports were examined was 10.27±3.77 years, with 331 (33.6%) being female and 655 (66.4%) being male. It was observed that 41.5% of the cases (n=409) applied to renew their previous reports, 54.8% (n=540) applied for their first report, and 3% (n=29) applied to terminate their current report. The most common reason for the application was academic underachievement (n=459, 46.6%), followed by speech delay (n=164, 16.6%), and social interaction difficulties (n=106, 10.8%). The reasons for application according to the age groups of the patients are shown in Table 1. Consequently, speech delay was the most common reason for application in the 0-4 age group (n=32, 45.1%), while learning difficulties/academic underachievement was the most common reason for application in other age groups (Table 1).

Table 1: Examining application reasons across age groups

	0-4 years n (%)	**5-9 years** n (%)	**10-14 years** n (%)	**15-17 years** n (%)	**Total** n (%)
Speech delay	32 (45.1)	122 (27.9)	7 (2.0)	3 (2.2)	164 (16.6)
Developmental problems	12 (16.9)	51 (11.7)	19 (5.5)	6 (4.4)	88 (8.9)
Articulation problems	0	5 (1.1)	4 (1.2)	0	9 (0.9)
Learning problems	1 (1.4)	138 (31.6)	237 (69.1)	83 (61.5)	459 (46.6)
Social problems	9 (12.7)	56 (12.8)	29 (8.5)	12 (8.9)	106 (10.8)
Hearing loss	3 (4.2)	6 (1.4)	4 (1.2)	0	13 (1.3)
Chronic medical illness	14 (19.7)	31 (7.1)	34 (9.9)	25 (18.5)	104 (10.6)
Behavioral problems	0	6 (1.4)	6 (1.7)	2 (1.5)	14 (1.4)
Cancelation of report	0	22 (5.0)	3 (0.9)	4 (3.0)	29 (2.9)

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WISC-R was administered to 52.8% of the children, AGTE to 39.6%, and WISC-IV to 0.9%. When psychiatric diagnoses were examined within the scope of SNRC, the most common diagnosis was delayed milestone, accounting for 58.1% (n=573) of cases (including cognitive developmental delay, and intellectual disabilities), with Mild Intellectual Disability being the most common diagnosis within this category. When diagnoses within the field of Child and Adolescent Psychiatry were examined, it was found that 31.6% (n=312) of all cases had SLD, and 15.6% (n=154) had ASD. Regarding the gender distribution of diagnoses in SNRC, it was observed that ASD and speech-language-communication disorders were significantly more common in males, while borderline mental capacity (BMC) was more common in females (Table 2).

Table 2: The distribution of diagnoses made within the scope of child and adolescent psychiatry analyzed according to gender

Psychiatric diagnoses	**Female** n (%)	**Male** n (%)	**Total** n (%)	*p*	$\chi 2$
Developmental delay (mild)	52 (15.7)	99 (15.1)	151 (15.3)	0.763	0.09
Developmental delay (moderate/severe)	8 (2.4)	16 (2.4)	24 (2.4)	0.866	0.028
Borderline mental capacity	10 (3)	8 (1.2)	18 (1.8)	**0.023**	5.14
Intellectual disability (mild)	61 (18.4)	104 (15.9)	165 (16.7)	0.126	2.34
Intellectual disability (moderate)	11 (3.3)	26 (4.0)	37 (3.8)	0.614	0.25
Intellectual disability (severe)	18 (5.4)	38 (5.8)	56 (5.7)	0.743	0.11
Learning disability	117 (35.3)	195 (29.8)	312 (31.6)	0.176	1.83
Autism spectrum disorder	33 (10.0)	121 (18.5)	154 (15.6)	**0.001**	12.06

$\chi 2$: Chi-square test

In the context of child and adolescent mental health and disorders, 46.8% of cases (n=461) were identified in the child and adolescent psychiatry area, 58.1% (n=573) in the cognitive development area, and 29.2% (n=288) in the speech-language-communication development area with varying degrees of special needs.

Of 986 cases, 342 (34.7%) were identified with special needs in multiple areas. Among these cases, 127 (37.4%) were identified with special needs in both cognitive development and child and adolescent psychiatry areas, 231 (67.5%) in cognitive development and speech-language-communication areas, 78 (23%) in child and adolescent psychiatry and speech-language-communication areas, and 47 (14%) were found to have special needs in all three areas. In 25 cases (2.5%), BMC and SLD diagnoses were noted together. All cases with special needs in all three areas were diagnosed with BMC, SLD, and speech disorders. When examining the levels of special needs in the child and adolescent psychiatry area in SNRC, it was observed that the majority (n=308, 66.8%) were reported as HSN and (n=152, 33%) as HSCN. Similarly, in the cognitive development area (64.2% HSN, 24% HSCN, and 11% mild HSN) and in the speech-language-communication area, HSN and HSCN were most frequently reported (85% and 13.5%, respectively).

When diagnoses outside of psychiatry were examined, it was found that 28.8% of all cases (n=284) had at least one accompanying medical illness. Among these cases, 65 (6.5%) were diagnosed with cerebral palsy, 47 cases (4.8%) with sensorineural hearing loss, 36 cases with epilepsy (3.7%), and 21 cases with Down syndrome (2.1%). In 20% of cases (n=198), special needs were identified in at least one non-psychiatric area. The majority of these were from the motor development area (n=125, 63.1%), followed by the Hearing Function-ENT Area (n=47, 23.7%). These were followed by the hereditary congenital diseases area (n=41, 20.7%) and the nervous system area (n=37, 18.7%). Table 3 lists the special needs areas of the cases and the most diagnosed conditions in these areas.

In SNRC, the highest special needs level they received among all departments is taken into consideration for the result. Consequently, it was found that 53.9% of cases (n=531) had an HSN, 35% (n=345) had an HSCN, 4.6% (n=45) had a mild HSN, 15.2% (n=198) had a moderate HSN, and 5.5% (n=54) were reported to have no special needs. No statistical significance was found in the comparison of special needs levels between genders ($p>0.05$).

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Table 3: The special needs areas of the cases and the most common medical conditions in these areas

Special Needs Areas	**Total** (n=986) n (%)	**Most common diagnosis**	n (%)
Cognitive development	573 (58.1)	Intellectual disability (mild)	165 (16.7)
Child and adolescent psychiatry	461 (46.8)	Learning disability	312 (31.6)
Motor development	125 (12.7)	Cerebral palsy	65 (6.5)
Auditory function - Ear nose throat	47 (4.8)	Sensorineural hearing loss	47 (4.8)
Genetic disorders	41 (4.2)	Down syndrome	21 (2.1)
Nervous system	37 (3.8)	Epilepsy	36 (3.7)
Visual function	12 (1.2)	Impairment of eye movements	5 (0.5)
Circulatory system	15 (1.5)	Tetralogy of Fallot	3 (0.3)
Metabolic diseases	9 (0.9)	Mucopolysaccharidosis	5 (0.5)
Nephrology	9 (0.9)	Renal transplant recipient	4 (0.4)
Digestive system	3 (0.3)	Liver transplant recipient	3 (0.3)
Genitourinary system/Surgery	2 (0.2)	Bladder dysfunction	2 (0.2)
Hematology-Oncology	1 (0.1)	Medulloblastoma	1 (0.1)

DISCUSSION

In this study, cases that applied to child and adolescent psychiatry for SNRC evaluation over the past 3 years were examined. Unlike previous studies that focused on evaluating SNRC data within the psychiatric scope, our research was conducted on a large sample from a tertiary university hospital in Ankara, where health board reports are issued intensively.

In the study, it was found that most cases (66.4%) applying to SNRC were male; significantly higher rates of ASD and speech-language communication disorders were observed in males, while BMC diagnosis was significantly higher in females. Consistent with our findings, other SNRC studies have reported that applicants ranged from 62.0% to 67.3% males (7-9,17). Furthermore, according to the Türkiye Statistical Institute (TUİK) 2010 data, it has been reported that the proportion of males among the disabled population is higher than that of females (18). Research on health board reports has indicated that the predominant occurrence of males is often attributed to higher rates of neurodevelopmental psychiatric disorders such as ID, ASD, SLD, and speech and language disorders in these reports (19).

Within the scope of our research, we have found that cases most frequently receive diagnoses in the areas of cognitive development, followed by child and adolescent psychiatry, and lastly language speech-communication development. In our study, when psychiatric diagnoses were evaluated according to SNRC, it was observed that the most common diagnosis was delayed milestone, followed by ID and ASD diagnoses. This ranking of special needs areas and psychiatric diagnoses is like that found in previous studies (9,17). Moreover, the frequency of SLD among referrals was found to be 31.6%, while the frequency of ASD was 15.6%. It is thought that the difference in these rates compared to the study by Temeltürk et al., where the rates were reported as 33.4% and 5% respectively, could be due to differences in the age groups studied. In that study, it was observed that preschool children with more frequent diagnoses of ASD and less frequent diagnoses of SLD were not included in the study. Indeed, similar results have been found in other studies that encompass the age range of 0-18 years, which aligns with our findings (7-9,20,21).

In our study, a significant portion of cases (29.6%) were diagnosed in the field of language and speech, which was found to be like the before SNRC period (30.7%) (7). It is known that children with ID have slower language development compared to typically developing children. They use shorter and simpler sentences than their peers, and articulation disorders and stuttering are more common among them (22). Consistent with our study, the literature states that the frequency of cases diagnosed by the health board from departments other than child and adolescent psychiatry varies between 20-57% (9,23); it is also emphasized that the area of special needs most frequently identified by departments other than child psychiatry is the 'Area of motor development' (7,8,17). It is thought that this situation arises because retardation in motor development commonly accompanies ID, cerebral palsy, and various hereditary diseases which are prevalent among SNRC applications (24).

Before SNRC, the disability rate for cases with mild symptoms and a diagnosis of atypical autism, as indicated in reports, was 40%, whereas, in SNRC, a single special needs level (HSCN) has been determined for ASD, corresponding to a disability rate range of 90-99%. Similarly, Type 1 DM and Down syndrome are also conditions that receive a disability rate in the 90-99% range. These changes have led to an increase in reports falling within the 90-99% range compared to

before SNRC reports (7). This situation has facilitated both physicians' evaluations and the access of children with special needs to health, education, rehabilitation, and other social and economic rights and services.

In a study involving physicians from different regions of Türkiye, it was indicated that a considerable number of physicians assigned special needs levels such as moderate, advanced, very advanced, or marked HSN to children whose cognitive development is below -3 standard deviations, in addition to HSCN (25). This demonstrates the provision of diverse levels of special requirements for children with cognitive impairments across similar severity levels. Levels can be specified for children diagnosed with mild intellectual disability. This indicates adopting a common approach; these children are evaluated as moderate HSN based on their functionality or as mild HSN. In our study, it was observed that in children with cognitive development below -3 SD, HSCN was provided according to the regulation, whereas in children with mild ID, HSN, and mild HSN were provided. It was determined that in our clinic, diagnoses of moderate, advanced, very advanced, or marked HSN are rarely used in the field of child and adolescent psychiatry. Reported inconsistencies among physicians could potentially impact the economic and social rights acquired by children and their families. Therefore, it is recommended that physicians undergo online training on the regulations established by SNRC to ensure consistency in reporting (25).

According to the regulations, the physician authorized by the chief physician for SNRC is defined as a trained pediatrician specializing in child health and diseases. However, it has been reported that in many hospitals where SNRC is implemented, there is no designated SNRC-authorized physician (25). In another study, it was noted that unless directed to the child and adolescent mental health by an SNRC-authorized physician, children with special needs in this area may be overlooked. This situation has been linked to the SNRC-authorized physician's insufficient knowledge and experience in the field of child psychiatry. However, child psychiatry is one of the most frequently diagnosed specialties within SNRC (26). Our hospital has decided to routinely direct all SNRC applications to the child psychiatry department six months before the commencement of this study. Thus, this possibility has been reduced in areas where diagnosis is made by child psychiatry.

The findings of our study should be interpreted while considering certain limitations. One significant limitation of the study is the retrospective nature of the data analysis. Another limitation is the mandatory implementation of child and adolescent psychiatry assessment in SNRC applications at our hospital over the past 6 months. Diagnoses made by psychiatry may have been overlooked in SNRC reports before this date. However, the impact of this practice change on the reports has not been investigated in the study. In future research, it is believed that investigating the implications of these practice variations among hospitals, as well as focusing on the ambiguities in the SNRC regulations, will contribute to enhancing the SNRC. In this regard, hospitals that do not routinely involve child psychiatry in assessments should provide training to SNRC-authorized physicians for the comprehensive evaluation of children with special needs, and endeavors should be made to address implementation differences among hospitals.

Conflict of Interest: The authors have no conflicts of interest to declare.

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