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EVALUATION OF DISABILITY HEALTH COMMITTEE REPORTS OF PATIENTS APPLYING TO THE CHILD AND ADOLESCENT PSYCHIATRY UNIT OF A UNIVERSITY HOSPITAL

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Abstract

Objective: The aim was to investigate the reasons for admission, sociodemographic background, psychiatric diagnoses, additional physical diseases and special needs levels of children and adolescents who applied to Kocaeli University Faculty of Medicine disability health committee for a special needs report in order to expand the literature on individuals with special needs.

Methods: Between 1st August 2021 and 31st August 2022, the data of 616 patients aged 0-18 years who applied for a special needs report to the Department of Child and Adolescent Psychiatry was retrospectively examined.

Results: The mean age of the group was 7.74±3.64 years, with most cases being between 7-12 years of age and male. The most common diagnosis was "delayed milestone in childhood (ICD R 62.0)" in 45.3% (n=279). The most commonly reported special needs level was "Requires Special Needs" in 33.5% (n=206), and the most common reason for application was to renew the report, in 40.4% (n=249). In this cohort, 34.6% had an additional medical disease, most commonly genetic diseases, including Down, Fragile X, and Angelman syndromes.

Conclusion: Special needs report evaluation in children and adolescents is commonly encountered in a Psychiatry outpatient clinic. It is important that both patients and their families can benefit from their existing rights and that patients with special educational needs can be identified as early as possible to begin educational interventions promptly. Thus, child psychiatrists should be informed of the demographics and clinical presentation in this patient group.

Keywords: *Special Needs Report for Children (SNRC), disability health committee, child, adolescent.*

Introduction

An individual with special needs is defined as a person who loses his/her physical, mental, psychologic, sensory and social skills at various rates for any reason, at birth or later, who has difficulty in adapting to social life and meeting their daily needs and who needs protection, care, rehabilitation, counseling and support services.[1] In recent years, the use of the term "individual with special needs" has become widespread in order to prevent labeling instead of the term "disabled".[2]

According to the World Disability Report published by the World Health Organization (WHO) in 2011, more than one billion individuals in the world live with disabilities in at least one area, and more than 200 million have difficulty in daily living.[3] The disability rate estimated by the WHO for developing countries is 12%[3] and this rate was 12.3% in the Turkey Disability Survey conducted by the State Institute of Statistics (SIS) in 2002. In the same survey, the rate of disabled children and adolescents between the ages of 0-19 was 8.8%.[4] In the Population and Housing Survey conducted by the Turkish Statistical Institute (TSI) in 2011, the rate of disability the 3-9 year-old age group was 2.1% in girls and 2.5% in boys, for the 10-14 age range these rates were 1.8% for girls and 2.4% for boys and in the 15-19 age range, it was 2% in girls and 2.6% in boys.[5] The most common diagnoses in the field of child and adolescent mental health in the population applying to disability health committees are mental retardation and developmental retardation, while autism spectrum disorders (ASD) and specific learning disability (SLD) are also common reasons for presentation.[6,7]

Individuals with special needs experience behavioral, physical, economic and social difficulties in many areas of their lives. In order to increase the participation of these individuals in social life and to realize their potential, many families apply to disability health committees in order for their children to benefit from their rights to health, rehabilitation and education.[8] The goals of special education are to develop children with deficits in certain areas, to increase their participation in social life and daily chores, to prevent them from transforming deficiency into a disability, to bring the disabled individual into society, to ensure that they are independent and productive individuals and to maximize their abilities.[9] Each of the children is different physically, sensorily and mentally. Although the development of children with normal development is not very different, this difference may be more obvious in children with special needs. Every child learns in different ways, so individualized education programs are created, taking into account details such as the characteristics of individuals, how and where they communicate and learn more easily.

The provisions for the execution of education and training services to be available for children with special educational needs have been amended with the regulations published in the Official Paper No. 30692 dated February 20, 2019, in the Special Needs Report for Children (SNRC). This new report focused on the child's special needs, rather than specifying the rate of disability. The section about child and adolescent mental health includes cognitive development and child-adolescent psychiatry. The 2019 SNRC recommends not to use mental retardation and similar definitions within the scope of cognitive development, to use the diagnosis of "delayed milestone in childhood" ICD (R 62.0) if the individual has a deficiency in this area and to specify the level of special needs. In contrast to the earlier regulations, the diagnoses of atypical autism and attention deficit hyperactivity disorder (ADHD) were abolished in SNRC, and the diagnoses of atypical autism, Asperger's syndrome and disintegrative disorder were collected under the title of ASD.[10]

The quality of life and education of individuals with special needs are part of the development and progress of society. More detailed information about the diagnostic distributions, sociodemographic information and clinical picture of individuals with special needs are helpful, both in Turkey and globally, and are facilitated by technological development. However, the evidence is still sparse and more research is still required. This data will contribute to central policy formation and to continue to improve all aspects of support for affected individuals.

The aim of the present study was to investigate the reasons for the application, sociodemographic background, psychiatric diagnoses, accompanying additional organic diseases, clinical features, and treatment of children and adolescents who apply to the disability health committee of a single tertiary referral university hospital for SNRC and to contribute to the national data about individuals with special needs.

Methods

The data of cases between the ages of 0-18 years, who applied to the outpatients of Department of Child and Adolescent Psychiatry of Kocaeli University Faculty of Medicine, between 1st August 2021 and 31st August 2022, were retrospectively reviewed. Totally, 19552 patients were admitted to the child psychiatry department in this date range, and 3.15% of these patients were disability health committee patients. The diagnostic evaluation of the patients whose files were reviewed was performed by two pediatric psychiatry physicians working in a separate unit, the health board outpatient clinic. Patients were diagnosed after at least 2 interviews. The ages, genders, reasons for admission, psychometric test results, psychiatric diagnoses, special needs rates and additional medical diagnoses were collected. Ethical approval was obtained with the decision of Kocaeli University Non-Interventional Clinical Research Ethics Committee (Approval No: 80418770-020-388390).

The cases were evaluated on the basis of the "Regulation on Special Needs Assessment for Children" published in the Official Paper on 20.02.2019. In this hospital, cases who applied to the SNRC disability health committee and obtained child-adolescent mental health admission were clinically evaluated by the child-adolescent psychiatry specialist and parents and teachers were routinely given parents' and teachers' information sheets during the diagnosis process. Intelligence or development tests were applied to determine the intelligence or development level of the cases. These included the Wechsler Intelligence Scale for Children (WISC-R or WISC-4) for determination of intelligence levels in children older than 6 years of age, and the Ankara Development Screening Inventory (ADSI) or Denver II Developmental Screening Test for development levels of children younger than 6 years of age. Intelligence and developmental tests conducted by clinical psychologists.

Psychometric Tests

Denver II Developmental Screening Test (Denver II)

The Denver II Developmental Screening Test is used to screen the development of children between the ages of 0-6. The items are filled by a healthcare professional, by observing the child and based on the information received from the caregiver. The development of the child is evaluated under four headings: personal social development; fine motor development; gross motor development; and language development. This tool was developed by Frankenburg in 1967 and revised in 1992. Adaptation studies in Turkey were first carried out in 1982 and were reviewed and standardized in 1996 and 2009.[11]

Ankara Development Screening Inventory (ADSI)

This scale was developed by Sezgin et al. in 1994 and is used to determine the developmental level of children aged 0-6 years based on information received from the parents[12]. The ADSI consists of 164 items and four subtests (Language-Cognitive, Fine Motor, Gross-Motor, Social Skill-Self-care). If the developmental level determined using the ADSI is between 20% and 30%, the child is at risk from a developmental point of view, and if the developmental level is below 30%, the child has a developmental delay.

Wechsler Intelligence Scale for Children Revised Form (WISC-R)

This is a revised version of the Wechsler Intelligence Scale for Children (WISC) developed by Wechsler in 1949.[13] The WISC-R consists of performance and verbal subtests. Performance subtests consist of code, pattern with cubes, piece assembly, picture editing and picture completion. Verbal Subtests consist of general knowledge, judgment, arithmetic, similarities, and number sequences. It was translated and validated in Turkish by Savasır and Sahin (1995) for the age range 6-16 years.[14] Intelligence is classified as follows: 0-35 point range is evaluated as severe mental retardation; 35-50 point range as moderate mental retardation; 50-70 point range as mild mental retardation; 70-80 point range as borderline; 80-90 point range as "dull normal", and above 90 points as normal intelligence.

Wechsler Intelligence Scale for Children-4 (WISC-IV) reference added

This is an intelligence test consisting of ten basic and five complementary subtests, which are administered individually to assess the mental abilities of children between the ages of 6 and 16 years. It is a development of WISC-R, and has been implemented since the 1970s. The translation and validation of the Turkish version was carried out by Oktem et al. in 2016. The WISC-IV assesses the child's mental skills, such as verbal comprehension, perceptual reasoning, processing speed, working memory and the whole scale intelligence score.[15]

Statistical Analysis

The data were analyzed with SPSS, version 22.0 (IBM Inc., Armonk, NY, USA). Descriptive information is expressed in numbers (n) and percent (%). A Monte-carlo, Fisher Exact Chi-square test was used in comparisons between nominal data, and student t test was used in intergroup comparisons of numerical data. Significance was assumed when the *p* value was <0.05.

Results

A total of 616 children or adolescent with a mean age of 7.74±3.64 years, and of whom 385 (62.5%) were male, were reviewed. Of these, 252 (40.9%) cases were between 0-6 years of age, 280 (45.5%) cases were between 7-12 years of age and 84 (13.6%) cases were between 13-18 years of age. For parental education levels, 43.2% of mothers and 54.4% of fathers stated their education level as high school and above but 74.4% reported socioeconomic level as medium and below. When sociodemographic variables between genders were analyzed, it was found that the age of female subjects was significantly higher than that of male subjects (p=0.015), but there was no difference in terms of parental age, educational level and socioeconomic status. The most common reason for application to the disability health committee was to renew a report (40.4%). All reasons for applying are shown in Figure 1.

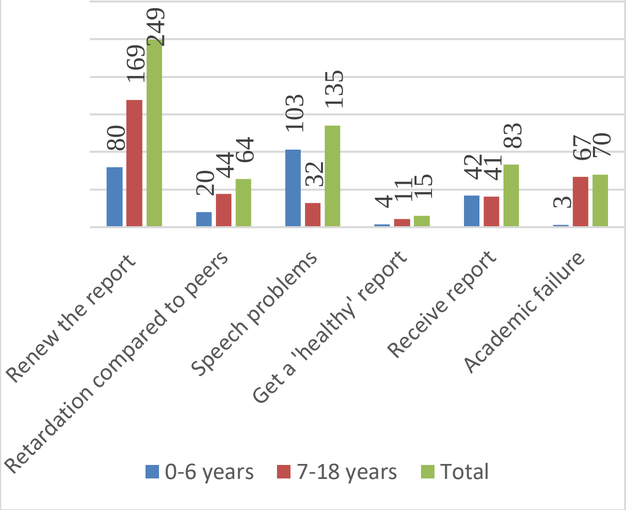

Figure 1. Application complaints according to age

Fifteen children who applied for a medical board report were evaluated with ADSI, 233 children with Denver II, 88 children with WISC-R and 178 children with WISC-IV tests. Test scores are shown in Table 1.

Table 1. Psychometric test results according to gender

Tests	Female (Mean ±SD)	Male (Mean ±SD)	Total (Mean ±SD)	*p*
ADSILanguage (month)	11.6±7.0	19.8±11.0	16.6 ±10.2	0.10
ADSISocial (month)	12.0 ± 9.0	22.6±13.0	18.4 ±12.4	0.10
ADSIGross Motor (month)	12.1± 6.8	24.6±13.6	19.6 ±12.7	0.06
ADSIFine Motor(month)	13.3± 13.6	20.3±12.7	17.5 ±10.1	0.20
Denver II Language(month)	30.5 ± 19.3	27.2 ±17.4	28.4 ±18.1	0.10
Denver II Personal Social (month)	29.6± 28.7	28.7± 17.0	29.0±18.6	0.70
Denver II Gross Motor (month)	30.5 ± 23.1	30.9 ±18.8	19.6 ±12.7	0.40
Denver II Fine Motor(month)	34.4± 20	33.7 ±18.8	33.9 ±19.2	0.70
WISC-R Verbal	72.3± 19	79.5 ±21.5	76.3 ±20.6	0.10
WISC-R Performance	88.7 ± 23.3	93.6 ±20.9	91.4 ±22,0	0.30
WISC-R Total	79.7±20.8	86.4 ±21.0	83.4 ±21.0	0.10
WISC-4 Verbal Comprehension	70.7 ±17	74.7 ± 18.6	73.3 ±18.1	0.10
WISC-4 Perceptual Reasoning	68.3 ± 14.2	79.1 ±19.1	75.4 ±18.2	*0.00*
WISC-4 Working Memory	65.3 ±12.1	73.7±15.8	70.8 ±15.1	*0.00*
WISC-4Processing Speed	71.9 ± 15.8	75.0 ±18.4	74.2 ±17.6	0.20
WISC-4 Total	59.3 ± 15.5	68.0 ±20.2	65.0 ±19.1	0.40

SD: Standard Deviation, ADSI: Ankara Development Screening Inventory, WISC-R: Wechsler Intelligence Scale for Children Revised Form, WISC-IV: Wechsler Intelligence Scale for Children-4

According to clinical interviews and evaluations with patients, the primary psychiatric diagnoses they received and proportions according to gender are shown in Table 2. The most common diagnoses in the whole group were delayed milestone in childhood (n=279, 45.3%), SLD (n=116, 18.8%) and ASD (n=106, 17.2%). In 4.5% (n=28), no psychiatric problems were detected. The most common psychiatric diagnosis in both girls (49.8%) and boys (42.6%) was delayed milestone in childhood.

Table 2. Diagnoses according to gender

Diagnoses	Female n (%)	Male n (%)	Total n (%)	*p*
Delayed milestone in childhood	115 (49.8)	164 (42.6)	279 (45.3)	0.083
Specific Learning Disability	49 (21.2)	67 (17.4)	116 (18.8)	0.242
Autism Spectrum Disorder	25 (10.8)	81 (21.0)	106 (17.2)	*0.001*
Language-Speech Disorder	25 (10.8)	56 (14.5)	81 (13.1)	0.186
No Psychiatric Pathology	13(5.6)	15 (3.9)	28 (4.5)	0.318
Attention Deficit Hyperactivity Disorder	3 (1.3)	2 (0.5)	5 (0.8)	0.369
Psychotic Disorder	1 (0.4)	0 (0)	1 (0.2)	0.375
Total	231 (100)	385 (100)	616 (100)	

An additional disease was found in 34.6% of the 616 cases who applied for the SNRC report. Genetic diseases, such as Down, Fragile X, and Angelman syndromes, were the most common concomitant diseases. Other additional diseases are presented in Table 3. An additional disease was detected in 40.9% of the patients admitted in the 0-6 age range and in 30.3% of the 7-18 age group, and this difference was significant.

Table 3. Additional medical problems detected according to age groups

	0-6 years n (%)	7-18 years n (%)	Total n (%)
None	150 (59.1)	253 (69.7)	402 (65.4)
More Than One	36 (14.3)	36 (9.9)	72 (11.7)
Genetic	30 (11.9)	24 (6.6)	54 (8.8)
Cerebral Palsy	19 (7.5)	22 (6.1)	41 (6.7)
Epilepsy	5 (2.0)	14 (3.9)	19 (3.1)
Hydrocephalus-Shunt	4 (1.6)	2 (0.6)	6 (1.0)
Neuropathy	4 (1.6)	2 (0.6)	6 (1.0)
Cardiac	1 (0.4)	4 (1.1)	5 (0.8)
Hearing Loss	3 (1.2)	1 (0.3)	4 (0.7)
Hypothyroidism	1 (0.4)	2 (0.6)	3 (0.5)
Cataract	0 (0.0)	2 (0.6)	2 (0.3)
Diabetes Mellitus	0 (0.0)	1 (0.3)	1 (0.2)
Total	253 (100)	363 (100)	616 (100)

In the cases applying for SNRC, the reports are given according to the special requirement level as specified in the SNRC guide. When the cases were examined, there was a special need at the level of requires special needs (RSN)' for most (Table 4).

Table 4. Levels of special needs according to age

	0-6 years n (%)	7-18 years n (%)	Total n (%)
None	12 (4.8)	21 (9.8)	33 (5.4)
RSN	55 (21.8)	151 (41.6)	206 (33.5)
Mild RSN	4 (1.6)	9 (2.5)	13 (2.1)
Moderate RSN	61 (24.2)	91 (25.1)	152 (24.7)
Severe RSN	8 (3.2)	10 (2.8)	18 (2.9)
Very Severe RSN	15 (6.0)	21 (5.8)	36 (5.9)
Marked RSN	1 (0.4)	1 (0.3)	2 (0.3)
Special Conditions Needs Present	97 (38.1)	59 (16.3)	155 (25.2)
Total	253 (100)	363 (100)	616(100)

RSN: Requires special needs, (RSNs by disability ratio (DR) are as follows; DR 20-39%: RSN, DR 40-49%: Mild RSN, DR 50-59%: Moderate RSN, DR 60-69%: Severe RSN, DR 70-79%: Very Severe RSN, DR 80-89%: Marked RSN, DR 90-99%: Special Conditions Needs Present)

Discussion

In this cohort the most common diagnosis was "delayed milestone in childhood" and the most frequently given special needs level was "requires special needs" (RSN) in terms of child and adolescent mental health on SNRC.

The male/female ratio was 1.66:1. This may be due to the higher incidence of ASD, intellectual disabilities and speech disorders in the male gender.[16] According to TSI (2010) and SIS (2004) data, there are more males in the disabled population.[4, 17] The results of the present study were consistent with previous studies on SNRC. [6, 8, 9, 18, 19]

In the present study, the mean age was 7.74±3.64 years but the most common age range of application (45.5%) was in 7-12 years old children. This may have been because children's special needs may have been noticed when they started school. Yektas and Kaplan (2017) found that the majority of patients applying to the health committee were between the ages of 7-12 years. Similarly, in a study conducted by Sahin et al., it was reported that 68.6% of the cases applying to the health committee were between the ages of 6-18 yrs.[6, 20]

The most common diagnosis was "delayed milestone in childhood" in the present study. Kayhan and Ozturk[19] conducted the first study in the field of child and adolescent psychiatry related to SNRC in Turkey, published in 2020 and also found the diagnosis of "delayed milestone in childhood" to be the most common diagnosis. In another study conducted in 2013, it was reported that developmental retardation was the most common diagnosis in children and adolescents who applied to the disability health committee.[20] Similarly, in a study conducted in the field of otolaryngology related to SNRC, it was reported that the most common diagnosis received in the mental field was the 'delayed milestone in childhood'.[18]

In terms of special needs levels of the cohort of the present study, 'RSN' was the most frequently given special needs level. Recently, Aktas Terzioglu et al. reported that the most common level of special needs was also RSN.[9] This may be because of the frequent diagnosis of SLD and delayed milestone, the most common condition observed within the scope of delayed milestone was a mild delay in cognitive development and the fact that RSN was a frequently given level in these diagnoses.[21] In mild delay, significant differences may not be observed in preschool children. In this group, problems such as difficulties in academic skills, underage skills in communication and speech skills, and limitations in risk perception are observed. It has been reported that cases with mild delay may not apply to a doctor until the school period.[22] 'Special Conditions Needs Present' was the second most common type of special need and was often advised when the diagnosis of ASD is made which was the second most common diagnosis made.

A proportion of the cohort had pre-existing medical diagnoses, including 8.8% with a genetic disease, 3.1% with epilepsy, 6.7% with cerebral palsy, 2% with another neurological disease, and 11.7% of the group had additional diseases involving more than one system. Neurological diseases are the most common in the additional diagnosis of cases. Kayhan and Ozturk[19] reported that neurological diseases were similarly ranked first as additional diagnosis. Previous reports found that SNRC applicants were most likely to have neurological disease co-diagnoses, and cerebral palsy and epilepsy were the most common of these.[20, 23] When the additional diagnoses of the cases according to age range were examined, patients in the 0-6 age range had significantly more co-morbidities than patients in the 7-18 age range. We hypothesize that neurological problems in the younger age group may make the family more alarmed and seek treatment, or families may not request reports because of the increase in hopelessness with age. Since genetic and neurological diseases constitute a large proportion of the comorbidities, some of the cases with additional diagnosis may have died in the early years of life.

The reasons for applying to disability health committees for children are usually to benefit from social and educational rights, such as obtaining a special education report, benefiting from tax deduction, receiving home care fees, benefiting from education rights, using them in appointments and similar situations.[19] The literature suggests that the most common reason for applying to disability health committees is to receive special education.[19, 24] In the present study, the most common reason for applying to the disability health committee was to renew the report. This may be interpreted as children with special needs and their families already benefiting from social and educational rights and consequently demanding the continuation of these rights. As most of the mothers in the group were housewives and that more than half of the mothers were educated at the secondary school and below levels, it may be that these mothers cannot help their children's lessons sufficiently, so the need for additional educational support arises. In addition, around three-quarters of the families reported a socioeconomic level of medium and below. Thus, financial difficulties may also have led to families being unable to cover individual tuition fees or needing additional financial support and requesting reports.

In the present study, there was no significant difference between the test scores and developmental levels of boys and girls. In two studies conducted in 2018 and 2020, children who applied to the disability health committee were evaluated with WISC-R and ADSI according to their age groups, and no significant difference was found between the test scores and developmental levels of boys and girls.[19, 24] In another study, when the subtests of children who underwent ADSI were examined, it was found that growth retardation in the gross motor area was more prevalent in males, but this was not significant.[9] Although the data from our study are compatible with these results, it is probable that more studies are needed to obtain more data on this subject.

Only 5.4% of the cohort who applied for SNRC were reported as "no special requirements". It was observed that 24 of the 33 (72.7%) individuals who were found to have no special requirements did not have a previous health committee report. For those who had a previous health committee, the most common diagnoses were delayed milestone (n=3), speech disorder (n=2) and specific learning disability (n=2). It was thought that they may not have been re-diagnosed due to the improvement of the symptoms of speech disorder and specific learning disability as a result of the supportive education and speech therapy received with the report. This rate is substantially less than in an earlier study which reported that 10.1% of the patients evaluated had no problem.[24] In another study on SNRC, it was reported that 3.6% of the cases ended their applications as "there are no special needs".[19] The results suggest that careful evaluation should be carried out if patients apply to the child and adolescent psychiatry outpatient clinic only with a request for a medical board report. In such cases, it would be useful to evaluate whether the intelligence or development tests performed in non-official institutions, if any, are compatible with the clinical evaluation, and if there is doubt about the diagnosis, to direct the patient to get a report after being followed in the outpatient clinic for a while.[25]

The present study has some limitations. The foremost is the retrospective examination of the data. Other limitations may be that the results may not reflect other populations in other centers or in the community due to the fact that only cases who applied to the disability health committee in one center have been reviewed, that diagnoses such as ASD and SLD are made clinically and that diagnostic interviews were not conducted by more objective methods.

Physicians working in the field of child psychiatry should refer patients in need to the disability health committee in order to receive special education, to determine disability rates and to benefit from their social and educational rights. At the same time, it is important to identify patients with special educational needs as early as possible to start educational interventions promptly in cases of need to prevent loss of function in the academic and social fields. Earlier support will also contribute to minimizing the workload and mental impact on parents with children with special needs.

Disability health committee application evaluations are one of the most common presentations to the child and adolescent psychiatric outpatient clinic. In another study conducted at a university hospital, 21.9% of the cases who applied to the child and adolescent psychiatry outpatient clinic within six months obtained their applications to the disability health committee.[26]

Conclusion

In conclusion, the publication of data from children and adolescents who apply to the disability health committee, which makes up one fifth of all child and adolescent psychiatric patients, will both help in the approach to these cases in the clinical evaluation of child psychiatry and create a data pool about the existing problems. Furthermore, this data will contribute to planning for children and adolescents with special needs. At present there is insufficient data from

Turkey, so further studies, in which cases from other centers and disability health committee units are evaluated, will be beneficial in illuminating this common area for child psychiatrists.

Conflict of Interest

The authors have no conflicts of interest to disclose.

Compliance with Ethical Statement

This study was performed with the approval of the local ethics committee (KÜ GOKAEK-2023/80418770-020-388390) in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and all subsequent revisions.

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Author Contribution

İDÇ, BK: Study idea/Hypothesis; İDÇ, BK: Study Design; ASG, SY, TK: Data Preparation; İDÇ, BK, ASG, SY, TK: Literature Search; İDÇ, BK, ASG, SY, TK: Writing.

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