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An examination of the sociodemographic and clinical characteristics of children and adolescents presenting to the child and adolescent psychiatry outpatient clinic under a health protection order

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Abstract

This study aimed to investigate the sociodemographic and clinical characteristics of children and adolescents evaluated subject to court-mandated health protection orders in a child and adolescent psychiatry outpatient clinic in Türkiye. A cross-sectional design was employed between October 2024 and March 2025 at the Child and Adolescent Psychiatry Department of a regional hospital. The sample included 53 participants (26 males, 27 females) evaluated following a judicial health protection order. Data were collected using the K-SADS-PL diagnostic interview and a researcher-designed sociodemographic questionnaire. Participants predominantly came from socioeconomically disadvantaged backgrounds. Psychiatric diagnoses were present in over half of the sample, with attention-deficit/hyperactivity disorder (ADHD) more prevalent among boys, and major depressive disorder (MDD) and post-traumatic stress disorder (PTSD) more common among girls. Although most clinical and demographic features showed no significant gender differences, parental marital status differed significantly (p=0.008): the majority of boys came from separated families, whereas girls more often lived in intact family settings. This was consistent with the higher rate of institutional placement among males. The most frequent reason for health protection orders was neglect and poverty in both genders. Counseling services were more commonly offered to girls. Children and adolescents under health protection orders demonstrate high rates of psychiatric morbidity and family instability. The significant association between parental separation and male institutional placement underscores the role of family structure in shaping mental health trajectories. These findings emphasize the necessity of trauma-informed, multidisciplinary approaches that integrate family-based interventions and long-term follow-up in child welfare systems.

Keywords: Health protection order, child and adolescent psychiatry, psychiatric comorbidity

Introduction

Following birth, human development unfolds across sequential stages involving language, cognitive, social, emotional, and motor domains. While this process follows a generally structured course, individual differences frequently emerge, with some children experiencing delays in specific developmental areas. During these critical developmental windows, children and adolescents may be subjected to adverse life events—directly or indirectly—such as war, forced migration, neglect, or abuse, which may leave them psychologically vulnerable, particularly during early childhood when brain development is most dynamic [1].

Children can become victims of traumatic experiences or may, under certain conditions, engage in legally defined criminal acts. Rather than being labeled as "criminals," such minors are referred to as "children driven to crime," acknowledging that their actions often arise not only from personal intent but also from environmental and social determinants such as poverty or inadequate family support [2]. Importantly, neurodevelopmental and psychiatric disorders such as attention deficit hyperactivity disorder (ADHD) and conduct disorders have been shown to significantly elevate the risk of juvenile delinquency [3].

In response, both international agreements and national legal frameworks have been established to protect the rights and

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welfare of these children. Türkiye, as a signatory to the United Nations (UN) Convention on the Rights of the Child since 1989, has implemented national statutes like the Child Protection Law No. 5395. This law provides for five core protective measures: counseling, care, health, education, and shelter [4]. Among them, health protection measures are particularly critical in ensuring both the physical and mental well-being of children exposed to traumatic conditions, including those with substance use problems [5].

Existing studies suggest that children under protective orders are more likely to suffer from psychiatric disorders, including mood, anxiety, and disruptive behavior disorders. In addition, neglectful or abusive parents often present with their own psychiatric and substance-related challenges, further compromising the child's psychosocial development [1,2]. Despite the clinical relevance of this population, research focused on children monitored under health protection orders in Türkiye remains limited. This study seeks to fill that gap by investigating the sociodemographic and clinical characteristics, psychiatric diagnoses, additional protective decisions, and familial factors among children and adolescents under health protection monitoring in a child and adolescent psychiatry outpatient setting.

Material and Methods

Study Design and Participants

Ethical clearance for this research was granted by the Non-Interventional Clinical Research Ethics Committee of Karabük University, Republic of Türkiye (Approval No: 2024/1934; Approval Date: October 15, 2024). Prior to participation, written informed consent was obtained from all adolescents and their legal guardians.

This research was designed as a cross-sectional study and was conducted at the Department of Child and Adolescent Psychiatry, Karabük Training and Research Hospital Hospital, between October 2024 and March 2025. The study sample consisted of children and adolescents evaluated in the forensic outpatient clinic under a court-mandated health protection order.

The inclusion criteria for the study were as follows: participants had to have a court-issued health protection order, and both the adolescent and their parent(s) were required to voluntarily agree to participate by providing signed informed consent. The only exclusion criterion was the failure to provide this informed consent.

Data Collection Tools

The Schedule for Affective Disorders and Schizophrenia for School-Age Children–Present and Lifetime Version (K-SADS-PL)

K-SADS-PL is a semi-structured diagnostic interview originally developed as K-SADS-P by Chambers et al. [6] and later revised by Kaufman et al. in 1997 for use with both children and adolescents [7]. It includes five main diagnostic areas—mood, psychotic, anxiety, behavioral, and substance-related disorders—plus submodules and a global functioning scale [7].

The Turkish reliability and validity study was conducted by Gökler et al. in 2004. The first section gathers sociodemographic and clinical background, while the second evaluates around 200 symptoms using a 0–3 severity scale. Positive screens are followed by domain-specific modules to confirm diagnoses. The third section assesses overall functioning [8]. Diagnoses based on K-SADS-PL showed significant concordance with clinician-based Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) diagnoses, with excellent agreement for externalizing disorders, good for ADHD and tic disorders, and moderate for mood, anxiety, and obsessive-compulsive disorder (OCD)-related conditions [8].

Sociodemographic Data Form

A comprehensive questionnaire was developed specifically for this study to gather detailed information on participants' age, gender, educational level and school type, academic performance, medical history, medication use, number of siblings, family structure, parental marital status, parental age, employment, education, psychiatric and medical history, substance use, household income, and prior psychiatric diagnoses. In addition, the form includes information related to the health protection order—such as reason for the order, additional protective measures, current living arrangements, psychiatric follow-up regularity, and psychiatric medication use.

Statistical Analysis

Descriptive analyses were performed for all variables included in the study. Categorical data were summarized using frequencies (n) and corresponding percentages (%). Assessment of whether data conformed to a Gaussian distribution was conducted via the Kolmogorov–Smirnov procedure. Categorical comparisons across cohorts employed Pearson chi-square analyses, with Fisher's exact test substituting when expected cell counts were low. For interval data exhibiting normality, group means were contrasted using the independent-samples t-test. Statistical significance was defined at $p<0.05$. All computations were executed in IBM SPSS Statistics for Mac (version 26.0; IBM Corp., Armonk, NY).

Result

A total of 53 participants (26 males, 27 females) were included the study. Table 1 provided a detailed comparison of sociodemographic and clinical variables between male (n=26) and female (n=27) participants. The mean age was slightly lower in males (11.19±4.39 years) compared to females (12.40 years), though no statistically significant difference was found. Educational status did not differ significantly between groups (p=0.520); both genders had similar rates of preschool and irregular attendance, while a higher proportion of females were in high school. Academic performance also showed no significant gender differences (p=0.286), although females more frequently

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reported "good" performance, while "average" and "poor" levels were more common among males.

The prevalence of medical illness was somewhat higher in males (26.9%) than in females (18.5%), but this difference was not statistically significant (p=0.465). Psychiatric diagnoses were also not significantly different between genders (p=0.624). ADHD was more frequently observed in males, while major depressive disorder (MDD) and post-traumatic stress disorder (PTSD) were more common in females. Both groups had similar rates of intellectual disability, speech delay, and co-occurrence of multiple disorders.

Regarding medication use, no significant difference was found (p=0.488). The majority in both groups were not on medication, but selective serotonin reuptake inhibitors (SSRI) use was slightly more common in females. Lastly, regular follow-up at child and adolescent psychiatry outpatient clinics was common in both groups, with no significant gender difference (p=0.501).

Table 2 displayed the comparison of family characteristics between male and female participants. There was no statistically significant difference in family type between the groups (p=0.076), though nuclear families were more common among females. Parental marital status differed significantly between genders (p=0.008); most males had separated parents, while most females came from intact families. The number of siblings did not show a significant difference (p=0.444). Regarding family income level, no significant difference was observed (p=0.100), although females more frequently reported high income, while low income was more common among males.

Table 3 summarized the comparison of parental sociodemographic and clinical characteristics between male and female participants. No statistically significant differences were observed between the groups in terms of parental employment status, age, psychiatric history, smoking or alcohol use, or education level. Mothers of female participants were slightly older on average. MDD was the most common psychiatric condition reported in both mothers and fathers. The educational levels of both parents were mostly at the middle school level, and smoking rates were relatively high in both paternal groups.

Table 4 provided a detailed comparison of the characteristics related to health protection orders among male (n=26) and female (n=27) participants. Regarding the reason for the health protection order, the most common reason among males was neglect/poverty (73.1%), followed by intra-family conflict (15.4%), involvement in criminal behavior (7.7%), and abuse (3.8%). Among females, the most frequently reported reasons were neglect/poverty (44.4%) and abuse (22.2%), followed by intra-family conflict (22.2%) and involvement in crime (11.1%). The difference between groups was not statistically significant (p=0.120). For additional protection measures, 57.7% of males and 44.4% of females did not receive any additional intervention. Counseling services were more commonly reported among females (33.3%) than males (11.5%). Educational support was reported equally in both groups (3.8% males, 3.7% females). Multiple additional measures were documented in 26.9% of males and 18.5% of females. This variable also showed no statistically significant difference (p=0.274). In terms of living arrangements after the implementation of the health protection order, 57.7% of males continued living with their mother and/or father, compared to 85.2% of females. Living with relatives was reported in 19.2% of males and 3.7% of females. Only one female was placed with a foster family (3.7%), and no males were placed in foster care. Institutional placement was more common among males (23.1%) than females (7.4%). The p-value for this variable was 0.050.

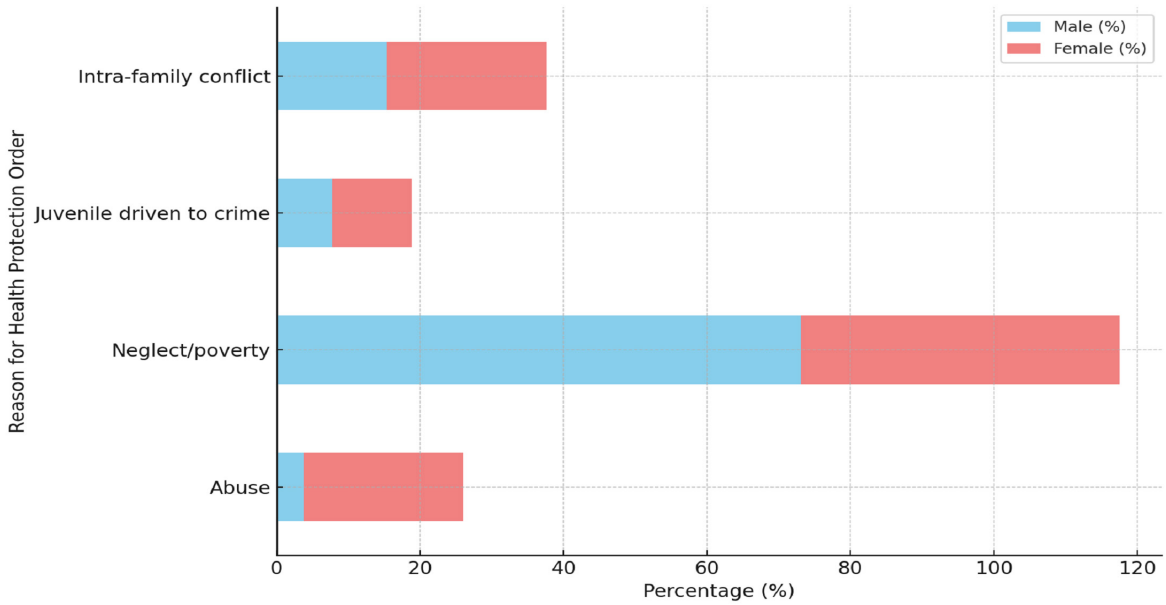

Figure 1. Distribution of reasons for health protection orders by gender

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Table 1. Comparison of sociodemographic and clinical data between the genders

Variables	Male (n=26) n (%) or mean±std	Female (n=27) n (%) or mean±std	p-value
Age, years	11.19±4.39	12.40	
Educational status			
Preschool	3 (11.5)	3 (11.1)	0.520
Primary school	6 (23.1)	5 (18.5)	
Middle school	8 (30.8)	4 (14.8)	
High school	6 (23.1)	12 (44.4)	
Irregular attendance	3 (11.5)	3 (11.1)	
Academic performance			
Excellent	1 (3.8)	0 (0)	0.286
Good	3 (11.5)	9 (33.3)	
Average	10 (38.5)	6 (22.2)	
Poor	7 (26.9)	7 (25.9)	
Irregular attendance	5 (19.2)	5 (18.5)	
Presence of medical illness	7 (26.9)	5 (18.5)	0.465
Psychiatric disorder			
None	8 (30.8)	8 (29.6)	0.624
ADHD	6 (23.1)	2 (7.4)	
SLD	0 (0)	2 (7.4)	
MDD	4 (15.4)	7 (25.9)	
Anxiety disorder	1 (3.8)	0 (0)	
Mood disorder	1 (3.8)	1 (3.7)	
PSTD	1 (3.8)	3 (11.1)	
Speech delay/stuttering	2 (7.7)	1 (3.7)	
Intellectual disability	2 (7.7)	1 (3.7)	
Multiple diagnoses	1 (3.8)	2 (7.4)	
Medication use			
None	17 (65.4)	15 (55.6)	0.488
Psychostimulant	4 (15.4)	2 (7.4)	
SSRI	3 (11.5)	6 (22.2)	
Antipsychotic	2 (7.7)	1 (3.7)	
Mood stabilizer	0 (0)	2 (7.4)	
Multiple medications	0 (0)	1 (3.7)	
Regular CAP outpatient follow-up	20 (76.9)	23 (85.2)	0.501

The chi-square test and independent samples t-test were used. A p-value of less than 0.05 was considered statistically significant. ADHD: Attention Deficit Hyperactivity Disorder, SLD:Specific learning disorder, MDD: Major depressive disorder, PTSD: Post-traumatic stress disorder, SSRI: Selective Serotonin Reuptake Inhibitor, CAP: Child and Adolescent Psychiatry

Table 2. Comparison of sociodemographic and clinical data between the genders

Variables	Male (n=26) n (%)	Female (n=27) n (%)	p-value
Family type			
Nuclear	19 (73.1)	25 (92.6)	0.076
Extended	7 (26.9)	2 (7.4)	
Parental marital status			
Together	7 (26.9)	17 (63.0)	**0.008**
Separated	19 (73.1)	10 (37.0)	
Number of siblings			
1	4 (15.4)	4 (14.8)	0.444
2	7 (26.9)	9 (33.3)	
3	4 (15.4)	9 (33.3)	
4	8 (30.8)	3 (11.1)	
5	1 (3.8)	1 (3.7)	
6	1 (3.8)	1 (3.7)	
10	1 (3.8)	0 (0)	
Family income level			
High	2 (7.7)	8 (29.6)	0.100
Medium	7 (26.9)	8 (29.6)	
Low	17 (65.4)	11 (40.7)	

The chi-square was used. A p-value of less than 0.05 was considered statistically significant

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Table 3. Comparison of sociodemographic and clinical data between the genders

Variables	Male (n=26) n (%) or mean±std	Female (n=27) n (%) or mean±std	p-value
Mother's employment status			
Employed	4 (16.7)	5 (18.5)	1.000
Unemployed	22 (83.3)	21 (77.8)	
Retired	0 (0)	1 (3.7)	
Mother's age, years	39.75±7.55	43.26±7.89	0.112
Psychiatric illness in mother			
MDD	8 (33.3)	4 (14.8)	
Anxiety disorder	2 (8.3)	2 (7.4)	0.468
OCD	2 (8.3)	2 (7.4)	
Multiple diagnoses	0 (0)	1 (3.7)	
Maternal smoking	10 (41.7)	12 (44.4)	0.842
Maternal alcohol use	1 (4.2)	1 (3.7)	1.000
Mother's education level			
Illitirate	5 (20.8)	4 (14.8)	
Middle school	12 (50.0)	14 (51.9)	0.446
High school	7 (29.2)	6 (22.2)	
University	0 (0)	3 (11.1)	
Father's employment status			
Employed	15 (65.2)	19 (73.1)	0.226
Unemployed	6 (26.1)	2 (7.7)	
Retired	2 (8.7)	5 (19.2)	
Father's age, years	46.09±8.10	48.31±8.12	0.344
Psychiatric illness in father			
MDD	4 (17.4)	2 (7.7)	
OCD	1 (4.3)	1 (3.8)	1.000
Psychotic disorder	1 (4.3)	1 (3.8)	
Other	1 (4.3)	1 (3.8)	
Paternal smoking	17 (56.7)	20 (71.4)	0.242
Paternal alcohol use	7 (23.3)	3 (11.1)	0.304
Father's education level			
Illitirate	1 (4.3)	1 (3.8)	
Middle school	14 (60.9)	15 (57.7)	0.904
High school	7 (30.4)	7 (26.9)	
University	1 (4.3)	3 (11.5)	

The chi-square test and independent samples t-test were used. A p-value of less than 0.05 was considered statistically significant. MDD: Major depressive disorder, OCD: Obsessive-compulsive disorder

Table 4. Comparison of health protection order characteristics between the genders

Variables	Male (n=26) n (%)	Female (n=27) n (%)	p-value
Reason for HPO			
Abuse	4 (16.7)	5 (18.5)	
Neglect/poverty	22 (83.3)	21 (77.8)	0.120
Juvenile driven to crime	0 (0)	1 (3.7)	
Intra-family conflict	39.75±7.55	43.26±7.89	
Additional protection measure	10 (41.7)	12 (44.4)	
Education	1 (4.2)	1 (3.7)	
Counseling			0.274
Multiple	5 (20.8)	4 (14.8)	
None	12 (50.0)	14 (51.9)	
Living arrangement after HPO	7 (29.2)	6 (22.2)	
With mother and/or father	0 (0)	3 (11.1)	
With relatives			0.050
Foster family	15 (65.2)	19 (73.1)	
Government institution	6 (26.1)	2 (7.7)	

The chi-square was used. A p-value of less than 0.05 was considered statistically significant. HPO: Health protection order

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Discussion

This study investigated the psychiatric and sociodemographic profiles of children and adolescents followed under a health protection order. In alignment with previous literature, our findings reinforce that these children frequently come from socioeconomically disadvantaged families and are exposed to adverse experiences such as neglect, abuse, and family dysfunction [1,4]. As supported by international and national policy frameworks, including the UN Convention on the Rights of the Child and Türkiye's Child Protection Law, such children require comprehensive, multi-disciplinary care that addresses both clinical and environmental risk factors [4,9].

Health protection orders typically address not only the psychiatric needs of the children but also broader issues including housing instability, school attendance, and parental behavior. The inclusion of structured reports, such as the Social Investigation Report mandated by courts, is crucial for tailoring effective interventions [10]. In our study, the high rates of psychiatric disorders—including mood disorders and disruptive behavioral conditions—underscore the psychological burden carried by this vulnerable population. These results are consistent with prior reports indicating increased prevalence of mental health disorders in children residing in institutional care or protective environments [11,12].

Further, the mental health of parents—particularly those with histories of substance abuse or antisocial tendencies—was frequently found to be compromised in this cohort, indicating a multigenerational pattern of psychosocial stress and dysfunction [13]. This highlights the necessity of family-inclusive treatment plans and long-term monitoring for achieving sustainable outcomes.

The present study illustrates that children and adolescents under a health-protection order carry a substantial burden of socioeconomic adversity and psychopathology. Neglect and poverty were the leading reasons for court involvement, and nearly half of the participants met criteria for at least one psychiatric disorder—most commonly ADHD in boys and MDD or PTSD in girls. These findings parallel a large meta-analysis showing that childhood physical or emotional abuse and neglect elevate risks for depression, substance misuse, suicidality, and other health problems across the life-course [14]. Long-term cohort work likewise indicates that maltreatment predicts persistent anxiety, depression, and impaired physical health into adulthood even after socioeconomic factors are controlled [11].

A study conducted by Alşen Güney and Bağ during the first 45 days of the COVID-19 pandemic at the Izmir Child Advocacy Center highlighted how traumatic experiences in children may remain undetected due to disrupted access to health and social services. The authors emphasized that while the risk of domestic violence and neglect increased during lockdowns, formal reporting mechanisms weakened—particularly because remote education and social isolation hindered school-based detection and intervention systems [1]. These findings resonate with the patterns observed in our study, particularly the underreporting of neglect and trauma, and further underscore how child protection mechanisms become more fragile during periods of societal crisis.

Additionally, a larger retrospective analysis of 135 children under court-mandated health measures at Bursa Dörtçelik Children's Hospital revealed similarly high rates of psychiatric comorbidity and family risk factors. In that cohort, over three-quarters of children met criteria for at least one disorder—most commonly PTSD (14.1%), ADHD (11.1%), conduct disorder (11.1%), and MDD (11.1%)—and only 21.5% were free of any diagnosis. Notably, the presence of parental psychopathology was significantly linked both to increased domestic abuse and to court-mandated foster placement, underscoring the role of caregiver mental health in shaping child welfare outcomes [2]. These findings mirror our own observations of elevated psychiatric morbidity and family instability, and they reinforce the need to integrate parental mental-health support into child protection interventions.

Risk appeared cumulative. Many participants experienced multiple adversities, echoing systematic-review evidence that polyvictimization is more strongly linked to both internalizing and externalizing psychopathology than any single type of abuse [15]. Such results highlight the importance of comprehensive trauma screening rather than focusing on isolated events.

Contact with child-protection systems did not uniformly translate into better outcomes. In the present sample, roughly one in five boys and one in thirteen girls were placed in government institutions, and a substantial share of children continued to live in economically strained or conflict-laden households. National data show similar limitations: propensity-weighted analyses have found that simple contact with child-protective services, irrespective of substantiation status, predicts higher levels of adolescent smoking, emotional symptoms, and school difficulties [16]. Six-year follow-up of youths reunified with biological families after foster care revealed more internalizing problems and lower competence than peers who remained in care [17]. Notably, delinquency risk can be mitigated when placement stability and high-quality caregiver bonds are preserved [18], underscoring the need to embed attachment-focused supports within protection mandates.

Programmatic responses remain uneven. Statewide implementation of the Wraparound Service Model achieved only modest reductions in internalizing symptoms and failed to curb new protection reports, a shortfall attributed to fidelity drift [19]. Meta-analytic synthesis confirms that high-fidelity wraparound can lower out-of-home placement rates and maintain community tenure for youths with serious emotional disturbance, but methodological weaknesses and variability in implementation quality persist [20]. Similarly, "service cascade" approaches linking welfare and mental-health systems have reduced parent-

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reported behavior problems at 12 months, yet fidelity erosion in later stages is common [21]. In the current study, fewer than half the children received additional counseling or educational measures, suggesting service gaps that mirror these broader implementation challenges.

This study has several limitations. First, its cross-sectional design prevents causal inferences between identified risk factors and psychiatric outcomes. Second, the sample was limited to a single center and a relatively small group of participants, which may reduce the generalizability of findings to broader populations. Third, data on parental psychiatric history and family dynamics were based on self-report, which may be subject to recall or reporting bias. Lastly, while standardized diagnostic tools were used, the absence of longitudinal follow-up restricts insights into the progression or resolution of psychiatric symptoms over time.

Conclusion

Despite these insights, national data on children under health protection orders remain scarce. Therefore, our study contributes not only to the empirical literature but also serves as a foundation for the development of targeted mental health policies and protective services in Türkiye. Further multi-center, longitudinal research is recommended to better understand the needs and trajectories of these children and to inform scalable intervention models.

Conflict of Interests
The authors declare that there is no conflict of interest in the study.

Financial Disclosure
The authors declare that they have received no financial support for the study.

Ethical Approval
The study received ethical approval from the Non-Interventional Clinical Research Ethics Committee of Karabük University, Republic of Türkiye (Approval No: 2024/1934; Approval Date: October 15, 2024).

References

1. Güney SA, & Bağ Ö. Features of Childhood Sexual Abuse During Initiation Period of Lockdown due to COVID-19 Pandemic in Turkey. Turk J Child Adolesc Ment Health 2021;28:27–34.
2. Güller B, & Yaylacı F. Socio-demographic and Clinical Characteristics of Children and Adolescents Followed for Court-mandated Treatment. Turk J Child Adolesc Ment Health 2022;29:67–74.
3. Karadağ, M. Investigation Of Sociodemographic And Clinical Features Of Forensic Cases Evaluated In A University Hospital Child And Adolescent Psychiatry Clinic. Dicle Med J 2021;48:187–96.
4. Republic of Türkiye. (2005). Child Protection Law No. 5395. Official Gazette No. 25876. https://www.mevzuat.gov.tr/mevzuat?MevzuatNo=5395&MevzuatTur=1&MevzuatTertip=5
5. Er Fazlıoğlu A. Evaluation of Psychosocial Features of Children and Their Families under Treatments in the Scope of Health Precaution in Socıal Work Perspective. Journal of International Social Research 2019;12:735–42.
6. Uğurlu Z, Gülsen İA. Children's rights and protection of children from neglect and abuse in the legal context. IJOSES 2014;1:1-24.
7. Chambers WJ, Puig-Antich J, Hirsch M, et al. The assessment of affective disorders in children and adolescents by semistructured interview. Test-retest reliability of the schedule for affective disorders and schizophrenia for school-age children, present episode version. Arch Gen Psychiatry 1985;42:696-702.
8. Kaufman J, Birmaher B, Brent D, et al. Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL): initial reliability and validity data. J Am Acad Child Adolesc Psychiatry 1997;36:980-8.
9. Gökler B, Ünal F, Pehlivantürk B, et al. Reliability and Validity of Schedule for Affective Disorders and Schizophrenia for School Age Children-Present and Lifetime Version-Turkish Version (K-SADS-PL-T). Turk J Child Adolesc Ment Health 2004;11:109–16.
10. Yolcuoğlu İG. An Evaluation on Child Protection System in Turkey. Journal of Social Policy Studies 2009;5:43-57.
11. Uluğtekin S. Çocuk Mahkemeleri ve Sosyal İnceleme Raporları. (2. baskı). Türkiye Barolar Birliği Yayınları. Ankara. 2004;89-92.
12. Herrenkohl TI, Hong S, Klika JB, et al. Developmental Impacts of Child Abuse and Neglect Related to Adult Mental Health, Substance Use, and Physical Health. J Fam Violence 2013;28:10.1007/s10896-012-9474-9.
13. Hussey DL, Falletta L, Eng A. Risk factors for mental health diagnoses among children adopted from the public child welfare system. Child Youth Serv Rev 2012;34:2072-80.
14. Skinner D, Tsheko N, Mtero MS, et al. Towards a definition of orphaned and vulnerable children. AIDS Behav 2006;10:619-26.
15. Norman RE, Byambaa M, De R, et al. The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. PLoS Med 2012;9:e1001349.
16. Haahr-Pedersen I, Ershadi AE, Hyland P, et al. Polyvictimization and psychopathology among children and adolescents: A systematic review of studies using the Juvenile Victimization Questionnaire. Child Abuse Negl 2020;107:104589.
17. Evangelist M, Thomas MMC, Waldfogel J. Child protective services contact and youth outcomes. Child Abuse Negl 2023;136:105994.
18. Taussig HN, Clyman RB, Landsverk J. Children who return home from foster care: a 6-year prospective study of behavioral health outcomes in adolescence. Pediatrics 2001;108:E10.
19. Ryan JP, Testa MF, Zhai F. African American males in foster care and the risk of delinquency: the value of social bonds and permanence. Child Welfare 2008;87:115-40.
20. Connell CM, Kim HW, Shipe SL, et al. Effects of Community-Based Wraparound Services on Child and Caregiver Outcomes Following Child Protective Service Involvement. Child Maltreat 2024;29:190-201.
21. Olson JR, Benjamin PH, Azman AA, et al. Systematic Review and Meta-analysis: Effectiveness of Wraparound Care Coordination for Children and Adolescents. J Am Acad Child Adolesc Psychiatry 2021;60:1353-66.
22. Bunger AC, Yoon S, Maguire-Jack K, et al. Implementation and Mental Health Outcomes of a Service Cascade Linking Child Welfare and Children's Mental Health Systems: A Case Study of the Gateway CALL Demonstration. Adm Policy Ment Health 2023;50:327-41.