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ORIGINAL ARTICLE

Medicine Science International Medical Journal

Medicine Science 2026;15(2):895-902

# A retrospective evaluation of repeated applications for the special needs report for children (SNRC): An analysis of sociodemographic and clinical variables

**Huriye Berna Devecioglu, Yusuf Selman Celik, Meryem Kasak, Muhammed Coskun, Vuslat Sena Yavuz Kaynak, Yusuf Ozturk**

*Etlik City Hospital, Department of Child and Adolescent Psychiatry, Ankara, Türkiye*

Received 28 November 2025; Accepted 04 April 2026
Available online 27 May 2026 with doi: 10.5455/medscience.2025.11.331



**Abstract**

This study aimed to examine the sociodemographic and clinical characteristics of children with repeated Special Needs Report for Children (SNRC) applications and to assess child-level and domain-specific changes in diagnoses and special need levels over time. A retrospective review was conducted of all SNRC applications submitted between May 2023 and May 2025. Repeated applications with an interval of at least six months and available diagnostic data were included in the analysis. Among 387 children with repeated SNRC evaluations, approximately one-third exhibited a change in at least one diagnostic domain at the child level, and nearly 40% showed a change in special need level. At the domain level, speech–language and learning-related diagnoses demonstrated lower stability over time compared with autism spectrum and cognitive diagnoses. SNRCs are important tools for identifying children with special needs and guiding their access to support. This study shows that repeated evaluations are valuable in childhood, and larger, longer-term studies are needed to better understand the factors behind diagnostic change.

**Keywords:** Disabilities in children, special needs report for children, neurodevelopmental disorders, diagnostic stability

## Introduction

Neurodevelopmental and psychiatric disorders may lead to a variety of consequences that extend beyond core symptomatology, affecting individuals' functional capacity, social participation, and overall quality of life [1]. In this context, the World Health Organization (WHO), conceptualizes health-related special needs across three interrelated dimensions: impairment (a loss or abnormality in body structure or function), disability (a restriction or lack of ability to perform activities), and handicap (a disadvantage experienced in social or environmental contexts). In order to reduce the barriers and inequalities that arise from impairments and disabilities, it is essential to identify the unique functional needs of each child and to implement individualized support mechanisms accordingly [2,3].

Internationally, various systems have been developed to identify and support children with developmental, functional, or educational needs, reflecting different policy priorities and service models. Education-centered frameworks such as the U.S. Individuals with Disabilities Education Act (IDEA) and multi-agency models such as England's Education, Health and Care Plan (EHCP) include periodic reviews; however, these reviews primarily aim to determine service eligibility and update support plans rather than to systematically capture longitudinal changes in diagnostic classification or standardized levels of functional need. Within this international context, Türkiye has implemented the Special Needs Report for Children (SNRC; ÇÖZGER) since 2019 as a nationally standardized, medically based reporting system integrating developmental, cognitive, and psychiatric assessments. Because the SNRC requires formal reassessment and generates comparable categorical outcomes

**CITATION**
Devecioglu HB, Celik YS, Kasak M, et al. A retrospective evaluation of repeated applications for the special needs report for children (SNRC): An analysis of sociodemographic and clinical variables. Med Science. 2026;15(2):895-902.

**Corresponding Author:** Huriye Berna Devecioglu, Etlik City Hospital, Department of Child and Adolescent Psychiatry, Ankara, Türkiye
Email: huriyebernayilmaz@gmail.com

DOI: 10.5455/medscience.2025.11.331

over time, it provides a unique framework for examining changes in diagnostic status and functional need levels, which constitute the primary outcomes of the present study [4–6].

The SNRC includes multiple domains based on the child's area of disability. Child and adolescent psychiatrists are authorized to diagnose schizophrenia and other psychotic disorders, autism spectrum disorder (ASD), mood and anxiety disorders, cognitive and psychiatric impairments due to organic brain damage, and specific learning disorder (SLD) within the child psychiatry domain. They are also authorized to diagnose intellectual disability in the cognitive development domain, as well as speech and language problems in the speech, language, and communication domain. Following the identification of diagnostic categories, the SNRC replaces disability rates with the concept of "special need," and a child's level of special needs ranges from "Has Special Need (HSN)" to "Has Special Condition Need (HSCN)" [7].

Due to the ongoing nature of development in children and adolescents, as well as the fluctuating course of psychiatric disorders, SNRC reports are issued for limited periods of time, and children's diagnoses and special needs levels must be reassessed at regular intervals. Such evaluations may result in changes to the child's level of special need, modifications to the existing diagnosis, or even the complete removal of a diagnosis—leading to a new report indicating that the child no longer has a relevant special need.

When examined in the context of ASD, the literature indicates that diagnostic stability is generally high in clinical samples, yet notable variability exists. While many children maintain their ASD diagnosis over time, some may lose the diagnosis as symptoms attenuate, and others may only meet diagnostic criteria at later stages as features become more apparent [8-10]. This variability underscores that both diagnostic loss and new diagnoses can be observed during follow-up, reflecting the heterogeneous and evolving nature of ASD. Although long-term data on SLD are limited, studies show that targeted educational interventions can lead to significant academic improvement [11]. In such cases, children may no longer require special support in later assessments. Similarly, many children with speech and language problems benefit from therapy and may no longer meet criteria for special needs in this domain in follow-up evaluations [12].

In cases of intellectual disability, special needs levels within the SNRC framework are determined along a broad spectrum, ranging from "HSN" to "HSCN". Especially during childhood, a developmental perspective is adopted, and instead of assigning an immediate diagnosis of intellectual disability, ICD-10 code R62.0 — Delayed milestone in childhood — is often used [4]. As a result, even when the diagnostic category remains the same across repeated SNRC evaluations, a child's cognitive needs may be reassessed based on their current level of functioning, which can lead to changes in their special needs classification. While some children may fall further behind their peers as they age, others may gradually catch up [13].

Although the SNRC has been in use in Türkiye since 2019, there is currently no published research examining diagnostic changes across repeated applications. This study aims to address this gap by conducting a retrospective, longitudinal review of SNRC reports to explore changes in diagnoses over time. Given that children undergo continuous physical and psychological development, a significant proportion are expected to show variation in their diagnostic status. It was hypothesized that, consistent with previous literature, diagnoses such as speech disorders and specific learning disorders would show a higher likelihood of remission or diagnostic loss across repeated SNRC evaluations, whereas intellectual disabilities would be more persistent and less likely to change over time.

## Material and Methods

### Study Design and Ethics

This retrospective chart review was conducted with the ethical approval of the Ethics Committee of Ankara Etlik City Hospital (Date: 16/07/2025; No:AEŞH-BADEK1-2025-258). It was carried outfollowing the Declaration of Helsinki.

### Study Setting: The Special Needs Report for Children (SNRC; ÇÖZGER) System in Türkiye

In Türkiye, the Special Needs Report for Children (SNRC; ÇÖZGER) is a standardized medical board evaluation used to determine children's diagnoses and special-need levels. When a child presents for an SNRC assessment, child and adolescent psychiatrists assign ICD-10 diagnoses in three authorized domains—cognitive, child psychiatry, and speech–language—and determine the corresponding special-need levels specified in the national regulation. These levels range from "no special need" to "has special condition need," with graded categories in between. Because SNRC reports are time-limited and children's developmental profiles may change, evaluations are often repeated, with diagnoses and special-need levels reassessed at each application [4].

### Participants, Inclusion and Exclusion Criteria

All SNRC applications recorded between May 2023 and May 2025 (n=8,488) were screened. Among these, 1,228 applications belonged to children who had more than one SNRC report, indicating repeated applications. During eligibility screening, application records were evaluated for completeness and validity.

Applications with incomplete diagnostic or reporting data were excluded. These cases involved reapplications submitted before completion of a previous SNRC evaluation, administrative duplicate entries, or reporting procedures that were not finalized, resulting in intervals shorter than six months.

DOI: 10.5455/medscience.2025.11.331

After applying these exclusion criteria, 774 SNRC report records were identified as valid repeated applications. Importantly, within the two-year study period, no child had more than two complete and valid SNRC evaluations. Accordingly, the final study sample consisted of 387 children, each contributing exactly two valid SNRC reports, yielding 774 paired reports for longitudinal analysis (Figure 1).

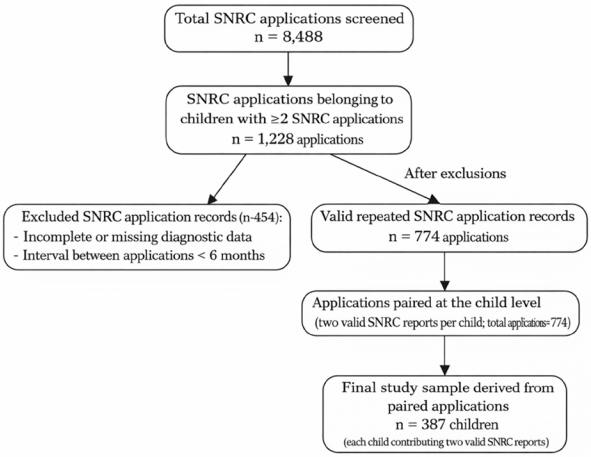


**Figure 1.** Flowchart of SNRC application screening and selection. Counts are presented at the application level throughout the screening process. A total of 774 valid SNRC application records were retained and paired at the child level, yielding a final analytic sample of 387 children, each contributing two valid reports. No child had more than two complete and valid SNRC applications during the study period

### Data Collection

From hospital records, the following sociodemographic data were extracted: age, sex, family status, and socioeconomic level. Socioeconomic status (SES) was derived from medical records and categorized as low, middle, or high based on available clinical information. As SES was not based on standardized measures, it should be interpreted as a descriptive indicator.

Clinical information recorded for each SNRC evaluation included the diagnostic domain in which the child was classified (child psychiatry, cognitive development, or speech–language/communication), the specific ICD-10 diagnosis assigned, and the corresponding special need level determined according to national regulation.

For children with repeated evaluations, data were recorded separately for each assessment. Diagnostic change was defined at two analytic levels. At the child level, it was defined as any addition, removal, or substitution of a diagnosis in at least one SNRC domain between evaluations; children with no change across domains were considered diagnostically stable. At the domain level, changes were examined separately within each diagnostic domain to assess diagnostic stability or transition over time. This approach enabled longitudinal assessment of both diagnostic status and special-need level changes across evaluations.

### Statistical Analysis

Statistical analyses were performed using IBM SPSS Statistics, Version 26.0 (IBM Corp., Armonk, New York, USA). The distribution of continuous variables was assessed using normality tests and visual inspection. As normality assumptions were not met, continuous variables were summarized as medians with interquartile ranges (IQRs), and nonparametric tests were applied. Categorical variables were expressed as frequencies and percentages. Group comparisons for categorical variables (e.g., gender differences in family structure, socioeconomic level, diagnostic changes, and special need levels) were performed using the Chi-square ($\chi^2$) test of independence. In cases where expected cell counts were small, the binomial test was used. Continuous variables (age and interval between evaluations) were compared using the Mann–Whitney U test. For within-subject comparisons between the first and second SNRC evaluations, the McNemar test was used to assess changes in diagnostic categories and special need classifications. For McNemar analyses, matched-pair odds ratios and 95% confidence intervals were calculated using discordant pairs (OR=c/b). A two-tailed p-value<0.05 was considered statistically significant for all analyses.

## Results

Sociodemographic and clinical data are presented in Table 1, showing that most children came from nuclear, low-SES families, with a median age of 63 months at first evaluation; approximately one-third experienced diagnostic changes and nearly 40% showed shifts in special need levels.

Across the two SNRC evaluations, specific learning disorder and childhood autism were the most frequent psychiatric diagnoses, while delayed milestone in childhood and speech disturbances were most common in the cognitive and speech-language domains. Children were distributed across varying levels of special need, from no special need to higher categories of support. In addition, a subgroup of children did not receive any rating in psychiatric, cognitive, or speech-language domains. Table 2 summarizes the distribution of diagnoses and special need levels across the first and second SNRC reports.

As shown in Table 3, domain-specific diagnostic distributions across the first and second SNRC evaluations were compared using the McNemar test. While most diagnostic categories did not show statistically significant changes over time, a significant shift was observed within autism spectrum disorder (ASD) subtypes. Specifically, childhood autism (F84.0) showed a significant increase at the second evaluation (p=.007), whereas atypical autism (F84.1) decreased over the same period. Taken together, these findings suggest diagnostic reclassification within ASD subtypes rather than an overall increase in ASD diagnoses. Although statistically significant changes were limited at the diagnosis-specific level, a substantial proportion

DOI: 10.5455/medscience.2025.11.331

of children experienced domain-specific diagnostic transitions, including the loss of a previously assigned diagnosis or the emergence of a new diagnosis in at least one domain, indicating meaningful diagnostic variability across repeated evaluations.

Figure 2 presents the number of children whose diagnoses were not retained at the second SNRC evaluation, grouped by their initial diagnostic category. In absolute terms, speech disorders (n=39), SLD (n=22), and delayed developmental milestone (n=21) appeared similar in magnitude. However, when considered relative to the number of children with each diagnosis at the first evaluation, the proportion of diagnostic loss differed substantially. While 34% of children initially diagnosed with SLD did not retain the diagnosis, the corresponding proportion for delayed developmental milestone was considerably lower (14%), reflecting greater diagnostic stability within the cognitive domain. In contrast, ASD showed the lowest rate of diagnostic loss (6%).

Among the 13 children who were newly diagnosed with childhood autism (F84.0) in the second SNRC report, 6 had previously received a diagnosis of atypical autism (F84.1), 5 had been categorized under delayed developmental milestones, 1 had a diagnosis of speech delay, and 1 had received a rating only in non-psychiatric specialties during the first evaluation.

Given that 58 children were identified as receiving a speech-language domain rating only in the second SNRC evaluation, and this finding approached statistical significance, a further analysis was conducted to examine their initial diagnostic profiles. Among the 58 children who later received a speech-language diagnosis, most had an initial classification of delayed milestone (55.2%), followed by ASD (25.9%), while smaller proportions were diagnosed with SLD (8.6%) or non-psychiatric conditions (10.3%) (Figure 3).

Although the McNemar test did not show a statistically significant change ($p = 0.064$), a notable number of children received a delayed milestone (R62.0) diagnosis only at the second SNRC evaluation (n = 36). To further characterize this pattern, the initial diagnostic profiles of these children were examined. Among them, eight had previously received a speech-language disorder diagnosis, seven had specific learning disorder, and two had childhood autism (F84.0) at the first evaluation. The remaining children had no psychiatric diagnosis recorded in their initial report and were classified as having non-psychiatric conditions.

A total of 21 children received a diagnosis of SLD only at the second evaluation. Their initial classifications included speech and language delay in 10 cases, mild or borderline cognitive delay in 7 cases, and non-psychiatric conditions in 4 cases.

**Table 1.** Sociodemographic and clinical profiles of children with repeated SNRC applications by gender

| Variables | Female N (%) | Male N (%) | Total N | Statistics* | p |
|---|---|---|---|---|---|
| | 160 (41.3) | 227 (58.7) | 387 | | |
| **Family status** | | | | | |
| **Nuclear family** | 146 (91.3) | 212 (93.4) | 358 | $\chi2$ =1.496 | 0.683 |
| **Extended family** | 3 (1.9) | 2 (0.9) | 5 | | |
| **Single parent** | 11 (6.8) | 13 (5.7) | 24 | | |
| **Socioeconomic status** | | | | | |
| **Low** | 117 (73.1) | 141 (62.1) | 258 | $\chi2$ =6.827 | 0.033 |
| **Middle** | 43 (26.9) | 84 (37.0) | 127 | | |
| **High** | 0 (0) | 2 (0.9) | 2 | | |
| **Age of the child at the first SNRC evaluation, months-Median (IQR)** | 62 (30-105) | 65 (46-121) | 63 (32-99) | U=17511 | 0.550 |
| **Age of the child at the second SNRC evaluation, months-Median (IQR)** | 75.5 (35-97) | 77 (46-121) | 77 (48-119) | U=17726 | 0.689 |
| **Time interval between two SNRC evaluations, months-Median (IQR)** | 14 (11-20) | 13 (11-20) | 14 (11-20) | U=17314 | 0.433 |
| **Change in diagnosis N (%)** | | | | | |
| **No** | 106 (66.3) | 145 (63.9) | 251 (64.9) | $\chi2$ =0.232 | 0.630 |
| **Yes** | 54 (33.7) | 82 (36.1) | 136 (35.1) | | |
| **Change in special need level N (%)** | | | | | |
| **No** | 98 (61.3) | 136 (59.9) | 234 (60.5) | $\chi2$ =0.070 | 0.791 |
| **Yes** | 62 (38.7) | 91 (40.1) | 153 (39.5) | | |

N, number; IQR, interquartile range; SNRC, Special Needs Report For Children; $\chi2$, Chi-square

DOI: 10.5455/medscience.2025.11.331

**Table 2.** Comparison of diagnoses and special need levels between first and second SNRC reports

| Diagnosis and special need categories | First SNRC N (%) | Second SNRC N (%) |
|---|---|---|
| **Diagnosis and ICD codes in child psychiatry domain** | | |
| **Specific learning disorder (F81.3)** | 63 (16.3) | 62 (16.0) |
| **Atypical autism (F84.1)** | 10 (2.6) | 4 (1.0) |
| **Childhood autism (F84.0)** | 34 (8.8) | 45 (11.6) |
| **Special need level in child psychiatry domain** | | |
| **NSN** | 279 (72.1) | 276 (71.4) |
| **HSN** | 66 (17) | 62 (16.0) |
| **ModSN** | 0 (0) | 4 (1.0) |
| **HSCN** | 42 (10.9) | 45 (11.6) |
| **Diagnosis and ICD code in cognitive domain** | | |
| **Delayed milestone in childhood (R62.0)** | 144 (37.2) | 159 (41.1) |
| **Special need level in cognitive domain** | | |
| **NSN** | 225 (58.1) | 228 (58.9) |
| **HSN** | 63 (16.3) | 41 (10.6) |
| **MSN** | 39 (10.1) | 42 (10.9) |
| **ModSN** | 31 (8.0) | 36 (9.3) |
| **SSN** | 3 (0.8) | 9 (2.3) |
| **PSN** | 3 (0.8) | 5 (1.3) |
| **HSCN** | 23 (5.9) | 26 (6.7) |
| **Diagnosis and ICD code in speech and language domain** | | |
| **Speech disturbances (R47.8)** | 104 (26.9) | 123 (31.8) |
| **Special need level in speech and language domain** | | |
| **NSN** | 285 (73.7) | 264 (68.2) |
| **HSN** | 98 (25.3) | 121(31.3) |
| **MkSN** | 4 (1.0) | 2 (0.5) |
| **Children without ratings in psychiatric, cognitive, or speech/language domains** | 61 (15.8) | 90 (23.3) |

Totals may exceed 387 because some children received multiple diagnoses. Abbreviations: N, number; SNRC, Special Needs Report For Children; NSN, No Special Need; HSN, Has Special Need; MSN, Mild Special Need; ModSN, Moderate Special Need, SSN, Severe Special Need; PSN, Profound Special Need; HSCN, Has Special Condition Need; MkSN, Marked Special Need

**Table 3.** Matched diagnoses across the first and second SNRC reports: mcnemar test results

| Diagnosis (ICD-10) | Both SNRCs, diagnosis present | Both SNRCs, no diagnosis | Only first diagnosis | Only second diagnosis | Statistic | P | OR (95% CI) |
|---|---|---|---|---|---|---|---|
| **Delayed milestone (R62.0)** | 123 | 207 | 21 | 36 | $\chi^2$=3.439 | .064 | 1.71 (1.00–2.94) |
| **Speech disturbances (R47.8)** | 65 | 225 | 39 | 58 | $\chi^2$=3.340 | .068 | 1.49 (0.99–2.23) |
| **Specific learning disorder (F81.3)** | 41 | 303 | 22 | 21 | $\chi^2$=0.000 | 1.000 | 0.95 (0.52–1.74) |
| **Atypical autism (F84.1)** | 2 | 375 | 8 | 2 | Exact McNemar* | 0.109 | 0.25 (0.05–1.18) |
| **Childhood autism (F84.0)** | 32 | 340 | 2 | 13 | Exact McNemar* | 0.007 | 6.5 (1.47–28.80) |

asymptotic McNemar $\chi^2$; * Exact McNemar test (binomial) The exact McNemar (binomial) test was used when discordant cell counts were small (b + c<25); otherwise, the asymptotic McNemar $\chi^2$ test was applied

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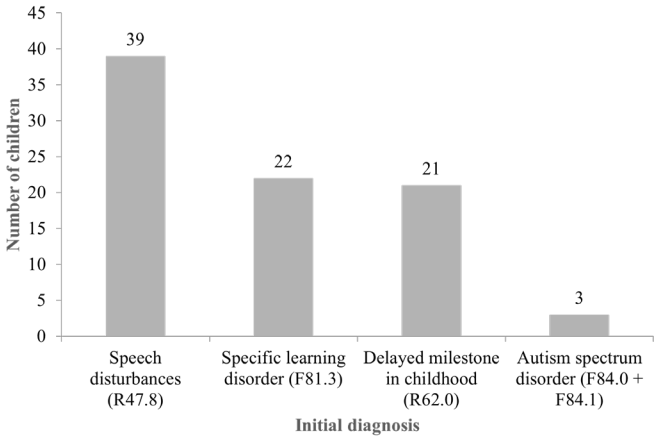


**Figure 2.** Distribution of initial diagnoses among children who no longer had a diagnosis at the second SNRC evaluation

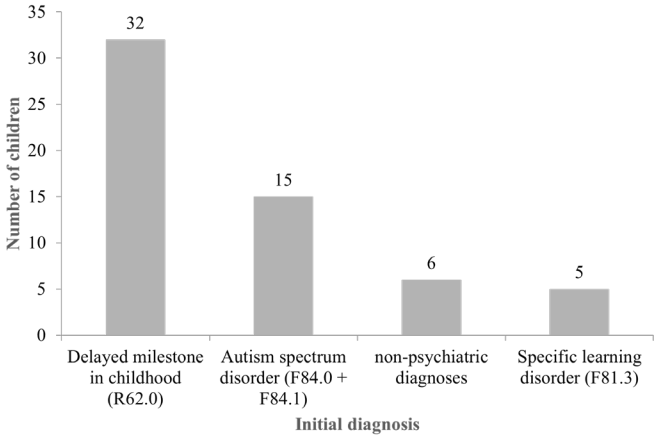


**Figure 3.** Initial diagnoses among children who received a speech–language domain diagnosis only at the second SNRC evaluation

## Discussion

This study represents the first longitudinal examination of SNRC (ÇÖZGER) reports in the literature, focusing specifically on diagnostic trajectories and changes in levels of special needs. Consistent with our hypothesis, the findings demonstrated that diagnoses such as speech and language disorders and specific learning disorders exhibited a higher rate of diagnostic loss or reclassification across repeated evaluations. In contrast, intellectual disability diagnoses were more stable, showing minimal change over time.

When sociodemographic characteristics were analyzed, it was found that the mean age at first application was 63 months, and that the majority of children came from families with a low socioeconomic background. The mean age observed in this study differs from findings reported in other research examining SNRC data [14,15]. This discrepancy is likely due to the study design, which included only children who had repeated applications within a two-year period. Younger children are more prone to changes in both symptoms and diagnoses, which may increase the likelihood of reassessments—either because of the time-limited validity of reports or due to changes in their clinical presentation.

In this study, boys were more frequently represented in the middle- and high-SES groups, whereas no sex difference was observed among children from low-SES backgrounds. Neurodevelopmental disorders are generally reported to be more common in boys; however, the variation observed across socioeconomic strata in our sample suggests that contextual and environmental factors may play a meaningful role in shaping the expression and recognition of neurodevelopmental difficulties, alongside biological vulnerability. In disadvantaged settings, limited access to cognitively and emotionally supportive environments, interruptions in early educational experiences, and reduced opportunities for stimulation may influence developmental trajectories and how difficulties are reflected in SNRC evaluations [16,17].

At the same time, these patterns should be interpreted cautiously. Differences in service access, referral pathways, caregiver help-seeking behavior, clinician assessment practices, or differential likelihood of reapplication across SES groups may also contribute to the observed sex distribution. In addition, SES in the present study was derived from clinician-reported documentation and categorized for descriptive purposes rather than based on standardized or objective socioeconomic measures, which limits the precision of SES-related interpretations. Nevertheless, the broader literature consistently links socioeconomic disadvantage with increased risk for neurodevelopmental delays, particularly in cognitive and language domains [18,19].

Our findings indicate that the median interval between the two SNRC reports was 14 months, and diagnostic or special need level changes were observed in more than one-third of the cases. Even within this relatively short period, substantial shifts in diagnostic classifications and need levels were identified. While the present study did not assess treatment exposure or intervention intensity, these changes may reflect developmental progression, diagnostic refinement over time, or the potential impact of clinical and educational interventions. These findings underscore the importance of maintaining relatively short reassessment intervals during early childhood, when development is dynamic and diagnostic formulations may evolve, in order to ensure timely identification and appropriate support. In the literature, close-interval longitudinal follow-up is recommended in the monitoring of developmental delays, as this approach allows differentiation of transient developmental lags from persistent disabilities [20].

In our study, consistent with previous literature [14,15,21], the most frequent diagnosis at the first and second SNRC applications were delayed developmental milestone. Following this, speech disturbances emerged as the second most common diagnosis, while SLD ranked third. However, previous studies in the literature have reported higher rates of SLD compared

DOI: 10.5455/medscience.2025.11.331

to speech disturbances. This discrepancy may be related to the mean age of our sample, which largely consisted of preschool and early school-age children, a group in which speech and language difficulties are more commonly observed than learning disorders.

Most repeated SNRC applications were concentrated in the child psychiatry, cognitive, and speech-language domains, while 36 children were assessed exclusively in non-psychiatric specialties. This may be explained by the comparatively short duration of our SNRC reports; in contrast, medical reports issued for chronic conditions such as type 1 diabetes or congenital disorders—including congenital heart defects—often remain valid for longer periods, reducing the need for frequent reassessment.

When comparing the first and second evaluations, the overall number and proportion of diagnoses appeared similar across the two assessments. However, at the individual level, some children lost a previous diagnosis while others received a new one. Thus, although the aggregate figures were comparable, a closer case-by-case analysis revealed meaningful diagnostic shifts between evaluations. In particular, attention was directed to children who had received a diagnosis at the first assessment but did not retain it in the second. Within this subgroup, nearly one-third of those initially identified with speech or SLD experienced diagnostic loss, consistent with previous findings [22,23]. In contrast, diagnoses in the cognitive domain and ASD appeared more stable. This pattern is consistent with prior literature, which has reported lower diagnostic stability for speech and learning disorders, whereas cognitive impairments tend to show greater persistence. Findings regarding ASD are mixed: while many clinical samples report relatively high diagnostic stability, some studies suggest that in early childhood certain children may no longer meet diagnostic criteria over time, whereas in others the diagnosis may become more clearly defined as development progresses [24,25]. This latter pattern is consistent with our findings and suggests diagnostic reclassification rather than new onset, as a small number of children who were initially classified with atypical autism (F84.1) were later classified with childhood autism (F84.0) at the second evaluation.

When examining the first reports of children who were later identified with speech and language needs only in the second evaluation, we observed that the majority had initially been diagnosed with developmental delay (R62.0) or ASD. This pattern may reflect the fact that some children require a period of individualized intervention to develop foundational skills such as joint attention and following commands [26]. Once these abilities emerge, they may then become ready for more targeted speech and language therapy, which could explain the subsequent assignment of speech-related needs in the second report.

Among the children who received a diagnosis in the cognitive domain only at the second evaluation, the majority had initially been classified in non-psychiatric domains rather than in psychiatry, language, or cognition. This finding may reflect the subtle cognitive effects of certain genetic or metabolic disorders in early childhood, which can be difficult to detect at initial assessments but become more apparent over time as developmental demands increase [27].

Nearly half of the children who received an SLD diagnosis only at the second evaluation had initially been classified in the speech and language domain. This pattern aligns with evidence in the literature indicating that deficits in phonological awareness, difficulties in language acquisition, and impairments in auditory processing not only serve as early risk markers for SLD but may also play a central role in its underlying pathophysiology [28].

In addition, a considerable number of applications were found to be incomplete due to unfinished diagnostic processes and psychometric evaluations. Such cases not only impose an additional burden on the healthcare system but may also cause delays and difficulties for families and patients. It may be beneficial to ensure that SNRC applications are initiated only after the completion of the relevant diagnostic procedures and upon referral from the appropriate departments, as this could reduce the frequency of incomplete or repeated applications.

**Strengths and Limitations**

One of the strengths of this study is its longitudinal design, which enabled the examination of diagnostic changes across a large sample of repeated SNRC applications. However, several limitations should also be noted. First, standardized diagnostic instruments were not systematically reported, which may have affected the precision of diagnostic classification. Second, SES was derived from clinician-reported documentation rather than a standardized measure and should therefore be interpreted with caution. Third, diagnoses assigned in non-psychiatric domains were not further detailed, limiting the ability to contextualize findings outside the psychiatric, cognitive, and speech–language domains. In addition, children with multiple concurrent domain classifications within a single evaluation were not analyzed as a separate subgroup, which may have obscured more complex diagnostic profiles. Also the inclusion of only two evaluation time points limited our ability to explore developmental trajectories or the timing of diagnostic change. Another limitation relates to the administrative and regulatory context of SNRC reporting. Diagnostic classifications within the SNRC framework may partly reflect coding practices, regulatory criteria, or clinician-level variability, including potential transitions between closely related categories (e.g., F84.1 to F84.0). Furthermore, repeated SNRC evaluations may in some cases be initiated for non-clinical reasons, such as school requests, benefit eligibility renewal, or administrative requirements. These factors could influence observed diagnostic or special need level changes and should be considered when interpreting longitudinal shifts. Finally, given the retrospective and observational nature of the study, no causal inferences can be drawn regarding factors associated with diagnostic or special need level changes.

## Conclusion

SNRCs play a crucial role within the healthcare system in identifying children with special needs and ensuring that they receive the necessary interventions. By conducting a longitudinal examination of SNRC reports, this study has shed light on diagnostic processes and changes over time, emphasizing the importance of close monitoring and repeated diagnostic evaluations in the pediatric population, where development is ongoing. Future research should include larger samples, extend over longer follow-up periods, and incorporate more detailed analyses of socioeconomic and clinical variables in order to further clarify the factors that influence diagnostic stability and change in this context.

**Ethical Approval**
*Ethics Committee of Ankara Etlik City Hospital (Date: 16/07/2025; No:AEŞH-BADEK1-2025-258).*

**Patient Consent**
*Informed consent was waived due to the retrospective design.*

**Conflict of Interest**
*The authors declare no conflict of interest.*

**Funding**
*The authors received no financial support for this study.*

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