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Original Research

Comparison of Outpatient and Inpatient Consultations Requested from Child and Adolescent Psychiatry

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ABSTRACT

Objective: This study aims to examine the sociodemographic and clinical characteristics of child and adolescent psychiatry consultations and to compare characteristics of outpatient and inpatient consultations.

Methods: A total of 354 patients who were consulted to child and adolescent psychiatry department of a university hospital were included in the study. Data were collected regarding sociodemographic characteristics of patients, departments requesting consultation, diagnoses, and treatment methods.

Results: The cases included in the study had a mean age of 10.6±4.8 years,with 51.4% being girls. Adolescent girls formed the majority of the inpatient group. The pediatric neurology outpatient clinic had the highest frequency of requested consultations (22.3%), and the most common reason for consultation was a suicide attempt (12.1%). Of the cases for which consultation was requested, 67.8% were diagnosed with at least one psychiatric disorder, and the most common diagnoses were anxiety disorders, with 12.7%. In the inpatient group, impulsive suicide attempts and depressive disorders were more frequent compared to the outpatient group, while intellectual disability was less common. Parent education was provided for 97.2% of the cases, pharmacological treatment was recommended for 44.6% of the cases, and the most commonly prescribed medications were selective serotonin reuptake inhibitors. Psychotherapy and special education were significantly more common in the outpatient group compared to the inpatient treatment group.

Conclusion: The current study revealed significant differences in consultations requested from child and adolescent psychiatry between the outpatient and inpatient groups regarding consultation reasons, diagnoses, and treatment modalities. The findings provide valuable information for clinical practice and service development.

Keywords: Consultation, child, adolescent, psychiatry, inpatients, outpatients

INTRODUCTION

Psychiatric problems may occur frequently in both inpatients and outpatients. and psychiatric disorders or problems can significantly impact managing and treating medical and surgical illnesses [1]. Consultation-liaison (C-L) psychiatry for children and adolescents is a specialized field. It focuses on the assessment and treatment of mental disorders in pediatric patients with concurrent medical or surgical conditions [2].

There are differences in the demographic and clinical characteristics of inpatients and outpatients consulted to child and adolescent psychiatry. Studies focusing on child and adolescent psychiatric consultations requested for inpatients display a higher representation of girls during adolescence [3]. Additionally, it is noteworthy that inpatients tend to have more chronic diseases. A recent study suggested that depression and childhood trauma in chronic diseases may contribute to treatment resistance [4]. Furthermore, most studies examining inpatients indicate that depressive disorder is the most frequently diagnosed condition [3,5], and psychopathology may be more prevalent among inpatients [5,6]. Moreover, a study found that the timing of psychiatric consultation in patients hospitalized for medical or surgical reasons shortened the length of hospital stay and was associated with reductions in total hospital costs [7]. On the other hand, our understanding of child and adolescent psychiatric consultations for outpatients, encompassing various medical and surgical reasons [2,8] and our knowledge regarding the comparison between inpatients and outpatients remains limited.

Main Points;

- The most common reasons for consultation were suicidal attempts and irritability.
- Anxiety disorders were the most common diagnoses.
- Parental education was provided for most cases, and SSRIs were frequently prescribed.
- In the inpatient group, impulsive suicide attempts and depressive disorders were more frequent compared to outpatients.
- There were significant differences in the distribution of recommended therapeutic interventions, such as psychotherapy and special education, between outpatient and inpatient consultations.

The characteristics, reasons for referral, diagnoses, and recommended treatments of child and adolescent psychiatric consultations may vary between outpatient and inpatient settings [9]. Identifying these differences can be beneficial for developing child and adolescent psychiatric services, meeting needs, and resolving problems [2,9].

The aim of the current study is to compare the sociodemographic and clinical characteristics of inpatient and outpatient children and adolescents referred to the child and adolescent psychiatry clinic of a university hospital. The study hypotheses are (i) there will be significant differences in age and gender distribution, and (ii) the departments requesting consultations, reasons for requesting consultations, diagnostic patterns, and treatment recommendations will vary between inpatient and outpatient groups.

MATERIALS AND METHODS

Sample

Between July 2014 and June 2016, medical records of patients aged 0-18 in a univesity hospital were reviewed retrospectively. Cases for whom a consultation was requested from the Department of Child and Adolescent Psychiatry were included in the study. Cases with missing archive files were excluded. The data examined included the sociodemographic characteristics of the referred patients, the departments requesting the consultations, the psychiatric diagnoses given following the evaluations, the treatment methods employed, and the preferred psychiatric agents if pharmacological treatment was administered. Our clinic has implemented a routine practice for diagnostic evaluation, especially for consultation cases. Additionally, cases were evaluated by at least two child and adolescent psychiatrists.

This routine practice involved individual interviews with the patients, family interviews, and the administration of the Kiddie Schedule for Affective Disorders and Schizophrenia Present and Lifetime Version – Turkish version (K-SADS-PL-T), which is a semi-structured psychiatric interview. This interview form has been validated and has demonstrated reliability for psychiatric disorders in children and adolescents. The inter-rater reliability of the form is between 0.625 and 0.875[10]. Diagnoses like pervasive developmental disorders that weren't included in the interview form were excluded by the clinician using appropriate scales during the interview. These scales were not included in our study. The localethics committee approved the research protocol under protocol number 2018/1378 on April 12, 2018.

Statistical Analysis

The data were analyzed using IBM SPSS Statistics version 27.0 (IBM Corp. Released 2020. IBM SPSS Statistics for Windows, Version 27.0. Armonk, NY: IBM Corp.) statistical software package. The normality of the data was assessed using the Kolmogorov-Smirnov test. Descriptive statistics were reported in percentages, and the mean and standard deviation were provided for normally distributed data. For non-normally distributed data, the median and minimum-maximum values were reported. Student's t-test was employed to compare the study groups for normally distributed data. Chi-square analysis was used for categorical variables. A significance level of $p < 0.05$ and a 95% confidence interval were considered statistically significant. The figure was created using RStudio, an integrated development environment for R. Additionally, the "Venn Diagram" R package was used [11,12].

RESULTS

According to the data obtained from the information processing center of the hospital, between July 2014 and June 2016, 14,556 pediatric and adolescent patients under 18 received inpatient treatment, while 171,601 received outpatient treatment. Additionally, 405 children with medical or surgical problems were consulted to child and adolescent psychiatry. Of the child psychiatry consultations, 275 were receiving outpatient treatment whereas 130 were receiving inpatient treatment. However, 51 of the inpatient cases did not have any medical records or had outpatient psychiatric clinic visits. Therefore, our study included a total of 354 children and adolescents, consisting of 130 (36.7%) patients receiving inpatient treatment and 224 (63.2%) patients receiving outpatient treatment.

Table 1. Comparison of sociodemographic characteristics between outpatient and inpatient groups

Variables	Outpatient group (n=224)	Inpatient group (n=130)	*Statistics*	*p*
Age, year, mean±SD	9.43±4.78	12.48±4.29	*t=6.17*	**< 0.001**
	n (%)	**n (%)**		
Sex				
Male	124 (55.4)	48 (36.9)	χ^2=*11.19*	**0.001**
Female	100 (44.6)	82 (63.1)		
Type of birth				
Cesarean section	71 (31.7)	26 (20.0)	χ^2=*5.66*	**0.017**
Vaginal delivery	153 (68.3)	104 (80.0)		
Cronic Disease				
Present	75 (33.5)	44 (33.8)	χ^2=*0.005*	0.944
Absent	149 (66.5)	86 (66.2)		
Mother's employment status				
Employed	58 (25.9)	44 (33.8)	χ^2=*2.54*	0.111
Unemployed	166 (74.1)	86 (66.2)		
Maternal psychiatric history				
Present	19 (8.5)	25 (19.2)	χ^2=*8.73*	**0.003**
Absent	205 (91.5)	105 (80.8)		
Father's employment status				
Employed	214 (95.5)	113 (86.9)	χ^2=*8.66*	**0.003**
Unemployed	10 (4.5)	17 (13.0)		
Paternal psychiatric history				
Present	12 (5.4)	10 (7.7)	χ^2=*0.77*	0.380
Absent	212 (94.6)	120 (92.7)		
Consanguineous marriage				
Present	32 (14.3)	19 (14.6)	χ^2=*0.007*	0.932
Absent	192 (85.7)	111 (85.4)		

The mean age of all cases was 10.6±4.8 years. Among the patients for whom consultation was requested, 20.3% (n=72) were under six years old, 28.8% (n=102) were between 6-12 years old, and 50.8% were 12 years and older. The distribution of cases was 51.4% (n=182) female and 48.6% (n=172) male. There were significant differences in age means and gender distributions between the outpatient and inpatient groups (p<.001; p=.001, respectively). Sociodemographic characteristics are presented in Table 1.

Table 2 includes the clinics from which consultations were requested. 92.1% of all consultations (n=326) were requested from departments related to pediatric health and diseases and pediatric surgery. The rate of requesting child and adolescent psychiatry consultations for outpatient cases was 0.9%, while it was 0.16% for inpatient cases. The clinics with the highest number of consultation requests were the pediatric neurology outpatient clinic (n=79), the general pediatrics outpatient clinic (n=77), and the general pediatrics ward (n=34). Non-pediatric clinics refer to ophthalmology, otolaryngology, plastic surgery, dermatology, orthopedics, and physical therapy and rehabilitation departments.

Suicidal attempts (12.1%; n=43) and irritability (11.3%; n=40) were the most common reasons for consultation (Table 3). The consultation was requested for two or more reasons in 18 cases. Other causes included various complaints such as academic failure, hair pulling, and confusion. Further details regarding the reasons for consultation can be found in Table 3.

According to the consulted cases, 32.2% (n=114) received counseling that consisted of general recommendations only. Among them, 67.8% (n=240) received at least one psychiatric disorder diagnosis. Additionally, 45 cases received two different diagnoses, and 6 cases received three different diagnoses. The most common diagnosis among cases referred for consultation from child and adolescent psychiatry were anxiety disorders (12.7%; n=45) (Table 4). Almost all consulted cases (97.2%; n=344) received parental education. It was found that 87.9% of the cases (n=311) received two or more treatment modalities. No treatment method was applied to 7 cases. The diagnoses are provided in Table 4, and the treatment modalities are visualized in Figure 1.

Pharmacological treatment was recommended for 44.6% (n=158) of the consulted children and adolescents. The most frequently recommended psychopharmacological agent was selective serotonin reuptake inhibitors (SSRIs) (21.8%; n=77). The recommended pharmacological treatments are shown in Table 5.

There were significant differences between the outpatient and inpatient groups in terms of impulsive suicide attempts ($p < .001$), intellectual disabilities ($p = .011$), and depressive disorders ($p = .003$). Counseling, psychotherapy, and special education were significantly more prevalent in the outpatient group ($p = .02$, $p < .001$, and $p < .001$). Of all consultations, 13.6% (n=48) began receiving special education following the consultation. Additionally, 66.9% of the cases (n=237) attended three or more follow-up visits. The comparison of diagnoses and treatment modalities between outpatient and inpatient groups is detailed in Table 6.

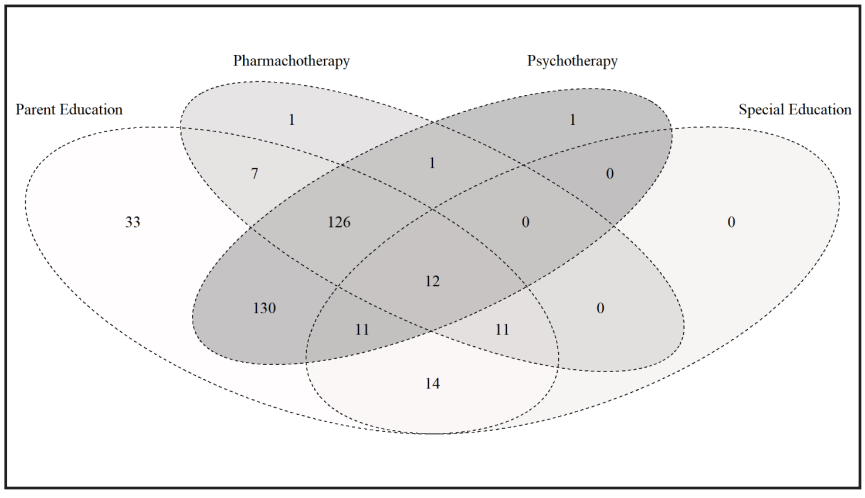

Figure 1. Distribution of treatment methods

Table 2. Clinics requesting consultations from child and adolescent psychiatry

Clinics	Outpatients n=224 (%)	Inpatients n=130 (%)	Total n=354 (%)
General pediatric clinic	77 (34.4)	34 (26.2)	111 (31.4)
Pediatric neurology	79 (35.3)	12 (9.2)	91 (25.7)
Pediatric endocrinology	26 (11.6)	8 (6.2)	33 (9.3)
Pediatric surgery	2 (0.9)	29 (22.3)	31 (8.8)
Pediatric emergency department	-	17 (13.1)	17 (4.8)
Pediatric intensive care unit	-	13 (10.0)	13 (3.7)
Pediatric gastroenterology	11 (4.9)	-	11 (3.1)
Other clinics related to pediatrics	14 (6.3)	4 (3.1)	18 (5.1)
Non-pediatric clinics	15 (6.7)	13 (10.0)	28 (7.9)
Total	**224 (63.3)**	**130 (37.7)**	**354 (100.0)**

Table 3. Reasons for requesting child and adolescent psychiatric consultations

Reasons for requesting consultations	n (%)
Suicide attempts	43 (12.1)
Irritability	40 (11.3)
Non-compliance or resistance to treatment	31 (8.8)
Speech delay	24 (6.8)
Attention deficit/hyperactivity	16 (4.5)
Stuttering / Speech difficulty	11 (3.1)
Enuresis / Encopresis	10 (2.8)
Unhappiness	10 (2.8)
Headache	10 (2.8)
Health council	10 (2.8)
Behavioral problems	9 (2.5)
Suspicion of autism	9 (2.5)
Fears	9 (2.5)
Developmental delay	9 (2.5)
Dizziness	8 (2.3)
Sleep problems	8 (2.3)
Eating problems	8 (2.3)
Crying	8 (2.3)
Syncope	8 (2.3)
Tic	7 (2.0)
Fecal retention	7 (2.0)
Vomiting	7 (2.0)
Abdominal pain	7 (2.0)
Substance use	6 (1.7)
Social withdrawal	6 (1.7)
Obsessions	6 (1.7)
Inability to learn writing and reading	6 (1.7)

Nail biting	6 (1.7)
Chest pain	6 (1.4)
Hallucination	6 (1.4)
Other reasons	37 (10.0)

Table 4. Distribution of psychiatric diagnoses based on evaluation results

Psychiatric disorders	**n (%)**
Anxiety disorders	44 (12.4)
Impulsive suicide attempts	36 (10.2)
Intellectual disabilities	35 (9.9)
Conduct disorder	29 (8.2)
Attention deficit/hyperactivity disorder	29 (8.2)
Depressive disorders	23 (6.5)
Speech and language disorder/delay	19 (5.4)
Enuresis / Encopresis	16 (4.5)
Autism spectrum disorder	13 (3.7)
Adjustment disorder	12 (3.4)
Somatoform disorder	11 (3.1)
Stuttering	6 (1.7)
Sleep disorders	6 (1.7)
Eating disorders	5 (1.4)
Obsessive-compulsive disorder	4 (1.1)
Bipolar disorder	3 (0.8)
Counseling	114 (32.2)

Table 5. Pharmacological treatments recommended as a result of consultation (n=354)

Psychotropic Medications	**n (%)**
Selective Serotonin Reuptake Inhibitors (SSRIs)	59 (16.7)
Antipsychotics	39 (11.0)
Psychostimulants	21 (5.9)
SSRIs + Antipsychotics	17 (4.8)
Tricyclic Antidepressants	16 (4.5)
Anxiolytics	2 (0.6)
Atomoxetine	2 (0.6)
Antipsychotics + Psychostimulants	1 (0.3)
SSRIs + Psychostimulants	1 (0.3)
Total	**158 (44.6)**

Table 6. Comparison of outpatient and inpatient groups in terms of diagnoses and treatments

Variables	Outpatients n=224 (%)	Inpatients n=130 (%)	*Statistics*	*p*
Anxiety disorders	31 (13.8)	14 (10.8)	χ^2=*0.699*	0.403
Impulsive suicide attempts	2 (0.9)	34 (26.2)	χ^2=*57.460*	**< 0.001**
Intellectual disability	29 (12.9)	6 (4.6)	χ^2=*6.408*	**0.011**
Conduct disorder	17 (7.6)	12 (9.2)	χ^2=*0.295*	0.587
Attention deficit/hyperactivity disorder	23 (10.3)	6 (4.6)	χ^2=*3.495*	0.620
Depressive disorders	8 (3.6)	15 (11.5)	χ^2=*8.595*	**0.003**
Counseling	82 (36.6)	32 (24.6)	χ^2=*5.418*	**0.020**
Psychotherapy	166 (74.1)	115 (88.5)	χ^2=*10.36*	**0.001**
Pharmacotherapy	130 (58.0)	66 (50.8)	χ^2=*1.76*	0.185
SSRIs	36 (16.1)	41 (31.6)	χ^2=*2.432*	0.119
Parent education	220 (98.2)	124 (95.4)	χ^2=*2.40*	0.121
Special education	42 (18.8)	6 (4.6)	χ^2=*14.02*	**< 0.001**
Follow-up visits				
<3 visits	71 (31.7)	46 (35.4)	χ^2=*0.506*	0.477
≥3 visits	153 (68.3)	84 (64.6)		

DISCUSSION

In this retrospective study, the sociodemographic and clinical characteristics of outpatient and inpatient treatment groups were compared in consultations requested from child and adolescent psychiatry. Although numerous descriptive studies evaluate consultations requested from child and adolescent psychiatry, studies comparing outpatient and inpatient treatment groups are limited. Our findings revealed several notable differences between the two groups, which have significant implications for clinical practice and service development.

Previous studies revealed that the average age of cases ranged between 10 and 13, with a majority of girls [13-15]. However, only a few studies examining consultations requested fromchild and adolescent psychiatry have shown a predominance of boys [5]. In our current study, there was a higher proportion of adolescent girls. Furthermore, the inpatient group had a much higher proportion of girls than the outpatient group. Previous research found that the majority of child and adolescent psychiatric consults were requested for inpatients [3, 14-16]. In contrast, most patients consulted in this study were outpatients, with more boys as inpatients and girls as outpatients.

According to studies, pediatric clinics request consultations on child and adolescent mental health most often [3, 5] particularly pediatric neurology clinics [14]. Pediatrics was the department that sought the most consultations in our study, with the child neurology outpatient clinic accounting for 22.3% (n=79) of all consultations. Mental and neurological symptoms are known to be inextricably linked and can occasionally overlap [17]. It should be kept in mind that psychiatric symptoms may often accompany neurological symptoms in nervous system diseases, and patients may present to the neurology clinic with psychiatric symptoms.

In studies conducted in our country, the most common reason for requesting consultations from child and adolescent psychiatry were suicide attempts [3, 5, 15, 16, 18]. Suicide risk assessment was the most common reason for referral to child psychiatry in a recent review [2]. In our study, the most common reasons for seeking consultation from child and adolescent psychiatry were suicide attempts and irritability. It is known that suicide attempts are more frequently observed in females and the adolescent and young adult age group [19]. The predominance of female patients and the adolescent group among the consulted cases may have been caused by the predominance of suicide attempts.

Interestingly, despite the high number of consultations related to suicide attempts, emergency department consultations were relatively low (4.8%; n=17). However, previous studies reported

that the emergency department was the most frequent department requesting child and adolescent psychiatry consultations [16, 20]. After the initial intervention of patients who present with a suicide attempt in our emergency service, they are subsequently followed up in either the pediatric ward or the pediatric intensive care unit. After the patients who have attempted suicide achieve stability and are no longer in immediate life-threatening danger, they are referred to child and adolescent psychiatry for consultation Which may have been the primary reason for the lower number of consultations from the emergency department in our study sample.

Two-thirds of the evaluated children and adolescents have been diagnosed with at least one mental disorder. The most common diagnosis is anxiety disorder, with a prevalence rate of 12.7%. Additionally, in the inpatient group, there were significantly higher rates of impulsive suicide attempts and depressive disorders compared to the outpatient group, while intellectual disability was significantly lower. However, there was no significant difference between the two groups regarding anxiety disorders. The rates of obtaining a diagnosis in consultations for child and adolescent psychiatry generally range from 50% to 84% [6, 16, 21]. However, there are variations in the most commonly reported diagnoses across studies. Most studies have reported that depressive disorders are the most frequent diagnosis [5, 15]. Nevertheless, one study identified anxiety disorders as the most common diagnosis in consultation psychiatry [22]. The diagnostic differences can be attributed to our study's combined evaluation of the outpatient and inpatient groups, the higher number of cases in the outpatient group, and the increased likelihood of requesting consultations from the pediatric neurology outpatient clinic.

In our study, at least one pharmacological agent was recommended for 44.6% of the cases, with SSRIs being the most commonly used agents. The outpatient and inpatient groups had no significant difference in pharmacotherapy and SSRI prescription. Significant variations exist in pharmacological agent use in similar studies conducted in our country. Our findings regarding pharmacological agent use are consistent with several recent studies [16, 21]. However, it should be highlighted that some studies show utilization rates higher than 70% [6, 22]and lower than 30% [3, 5], indicating significant variation in practice. In our study, anxiety disorder was the most common diagnosis, influencing the choice of SSRI medication. Medication usage rates varied due to geographical, cultural, and socioeconomic differences. Further research is necessary to assess drug efficacy and safety in child psychiatric consultations.

Finally, there was a higher rate of psychoeducation and special education in the outpatient group than in the inpatient group. Moreover, 13.6% (n=48) of all consultation cases started to receive special education after the consultation. In population-based studies, special education rates are between 10-20% [23]. Notably, a consultation study conducted in our country reported that 28% of the consulted cases were directed to special education [24]. Current findings indicate that cases requiring consultation from child and adolescent psychiatrists require a higher level of special educational support than the general population. Concomitant developmental and mental disorders can significantly affect treatment compliance. Therefore, the high rate of special education in the outpatient group emphasizes the importance of comprehensive evaluation for developmental and mental disorders and subsequent referral to appropriate educational services.

Limitations and Strengths

The most important limitation of the study is its cross-sectional design and retrospective data collection. Some case records were missing or inaccessible. It was also not possible to verify the accuracy and timeliness of the data. Therefore, the generalizability of the research findings is limited. Another limitation is the non-random sampling method. Additionally, the research environment, being a university hospital, may have partially influenced the randomization process. Certain patient groups may be more likely to present to a university hospital, which may lead to selection bias. Therefore, it's essential to acknowledge these potential biases when interpreting the study results. Finally, data should be interpreted with caution due to the lack of inter-rater standardization.

The descriptive and correlational design is a key strength of the study. This design allowed detailed description and comparison of the characteristics and treatment methods of outpatient and inpatient cases referred for psychiatric consultation. Using the K-SADS-PL tool as a data collection tool in our clinic contributed to the objective and standardized diagnosis of the cases. Finally, to the best of our knowledge, another critical aspect of the study is that it is the first comparison of outpatient and inpatient groups and serves as a reference for future research.

CONCLUSION

The current retrospective study examined sociodemographic and clinical characteristics of child and adolescent psychiatry consultations, comparing outpatient and inpatient treatment groups. The findings revealed notable differences between the two groups in terms of age, gender, departments requesting consultation, reasons for seeking consultation, diagnoses, and treatment options. These findings contribute to the understanding of various aspects of child and adolescent psychiatric consultations requested in outpatient and inpatient settings.

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REFERENCES

[1] McBride KE, Solomon MJ, Lambert T, et al. (2021) Surgical experience for patients with serious mental illness: a qualitative study. BMC Psychiatry 21:47. https://doi.org/10.1186/s12888-021-03056-x

[2] Becker JE, Smith JR, Hazen EP (2020) Pediatric Consultation-Liaison Psychiatry: An Update and Review. Psychosomatics 61:467-480. https://doi.org/10.1016/j.psym.2020.04.015

[3] Eraslan AN, Aydın Görücü R, Yılmaz A (2021) Evaluation of Psychiatric Consultations Required for Child and Adolescent Patients Hospitalized in a Training and Research Hospital. Turkish Journal of Pediatric Disease 15:451-458. https://doi.org/10.12956/tchd.778921

[4] Bujoreanu S, White MT, Gerber B, Ibeziako P (2015) Effect of timing of psychiatry consultation on length of pediatric hospitalization and hospital charges. Hospital Pediatrics 5:269-275. https://doi.org/10.1542/hpeds.2014-0079

[5] Ersoy Şimşek EG, Eyüboğlu M, Eyüboğlu D (2019) Evaluation of Child and Adolescent Psychiatric Consultations in A University Hospital. Osmangazi Medical Journal 41:248-256. https://doi.org/10.20515/otd.480686

[6] Alpaslan AH, Kocak U, Cobanoglu C, Gorucu Y (2015) Evaluation of Child and Adolescent Psychiatry Consultations in a University Hospital. New/Yeni Symposium 53:10-16. https://doi.org/10.5455/NYS.20151214020808

[7] Yilgor A, Kurhan F (2024) Is Childhood Trauma a Risk Factor for Resistant Epilepsy? Journal of Interpersonal Violence 39:1228-1244. https://doi.org/10.1177/08862605231203964

[8] Walg M, Avaliani T, Großmeier M, Hapfelmeier G (2021) Reasons for Outpatient Psychiatric Consultations of Unaccompanied Minor Refugees. Deutsches Arzteblatt International 118:597-598. https://doi.org/10.3238/arztebl.m2021.0177

[9] Reinblatt SP, Coble K, Williams JL, Cotton AM, Bettencourt AF (2022) Characteristics of Primary Care Providers' Consultations With a Statewide Child Psychiatry Access Program Regarding Autism Spectrum Disorder. J Acad Consult Liaison Psychiatry 63:463-473. https://doi.org/10.1016/j.jaclp.2022.01.004

[10] Gokler B, Unal F, Pehlivanturk B, et al. (2004) 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 11:109-116

[11] Chen H (2022) VennDiagram: Generate High-Resolution Venn and Euler Plots. R package version 1.7.3. https://CRAN.R-project.org/package=VennDiagram. Accessed Date Accessed 2022 Accessed

[12] Team RC (2023) R: A Language and Environment for Statistical Computing. R Foundation for Statistical Computing, Vienna, Austria. https://www.R-project.org/. Accessed Date Accessed 2023 Accessed

[13] Aktepe E, Kocaman O, Isik A, Eroglu F (2013) An Evaluation of the Child and Adolescent Psychiatry Consultation Services Requested in a University Hospital. TAF Preventive Medicine Bulletin 12:1. https://doi.org/10.5455/pmb.1-1355473983

[14] Dikeç G, Baysan Arabacı L, Uzunoğlu G (2020) Bir Bölge Psikiyatri Hastanesi Çocuk ve Ergen Kliniğinde İstenen Konsültasyonların Değerlendirilmesi. Acibadem Universitesi Saglik Bilimleri Dergisi 11:418-422. https://doi.org/10.31067/0.2019.193

[15] Topal Z, Karadağ M, Çalışgan B, et al. (2021) Characteristics of Child and Adolescent Psychiatry Consultations at a University Hospital and Accuracy Rates of Recognition of Childhood Psychiatric Diseases by Nonpsychiatry Specialists. Middle Black Sea Journal of Health Science 7:88-96. https://doi.org/10.19127/mbsjohs.881342

[16] Özek Erkuran H, Önen Ö (2022) Evaluation of Psychiatric Consultations Requested for Inpatient Children and Adolescents in a Training and Research Hospital. Turkish Journal of Child and Adolescent Mental Health 29:204-209. https://doi.org/10.4274/tjcamh.galenos.2021.36450

[17] Zimmerman M, Morgan TA, Stanton K (2018) The severity of psychiatric disorders. World Psychiatry 17:258-275. https://doi.org/10.1002/wps.20569

[18] Bilginer Ç, Karadeniz S, Aydoğdu S, Bulut Şahin D (2021) Child Mental Health Services in Emergency Department of a University Hospital. Turkish Journal of Child and Adolescent Mental Health 28:12-19. https://doi.org/10.4274/tjcamh.galenos.2020.91300

[19] Miranda-Mendizabal A, Castellví P, Parés-Badell O, et al. (2019) Gender differences in suicidal behavior in adolescents and young adults: systematic review and meta-analysis of longitudinal studies. International Journal of Public Health 64:265-283. https://doi.org/10.1007/s00038-018-1196-1

[20] Çolpan M, Eray Ş, Vural P (2013) Evaluation of Consultations Requested from the Departments of Child and Adolescent Psychiatry of Uludağ University Hospital within the Previous Year. Güncel Pediatri 11:102-106. https://doi.org/10.4274/Jcp.11.63825

[21] Göker Z, Güney E, Dinç G, Üneri Ö (2014) The Evaluation of the Psychiatric Consultations of Children and Adolescents Hospitalised in a Training and Research Hospital. Turkish Journal of Pediatric Disease 8:17-24. https://doi.org/10.12956/tjpd.2014.39

[22] Gokcen C, Celik YI (2011) The Evaluation Of Child And Adolescent Psychiatry Consultations from other Inpatient Clinics in a Training Hospital (The Evaluation Of Child And Adolescent Psychiatry Consultations from other Inpatient Clinics in a Training Hospital). Sakarya Medical Journal 1:140-144. https://doi.org/10.5505/sakaryamj.2011.25744

[23] National Center for Education Statistics. Students With Disabilities. Condition of Education. U.S. Department of Education, Institute of Education Sciences (2023) https://nces.ed.gov/programs/coe/indicator/cgg/students-with-disabilities

[24] Kılıç B, Uslu R, Ayla A (2007) A Preliminary Evaluation of Consultation-Liaison Psychiatry Services For Children at A University Hospital: Lessons Learned to Enhance Efficacy. Yeni Symposium 45:163-169. https://neuropsychiatricinvestigation.org/en/a-preliminary-evaluation-of-consultation-liaison-psychiatry-services-for-children-at-a-university-hospital-lessons-learned-to-enhance-efficacy-13227.

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