

# Regular psychiatric follow-up and the resolution of court-mandated health measures in children

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## Abstract

### *Regular psychiatric follow-up and the resolution of court-mandated health measures in children*

**Objective:** This study aimed to identify factors associated with the resolution and duration of court-mandated health protection measures among children and adolescents in Türkiye.

**Methods:** A retrospective analysis was conducted on 160 cases followed between January 2015 and December 2024 at the Child and Adolescent Psychiatry Clinic of Ordu University Training and Research Hospital. Data were extracted from judicial decisions, psychiatric assessments, and social service records. Variables were categorized into sociodemographic, familial, clinical, service-related, and legal domains. Outcomes included case status (ongoing, terminated, or transferred) and duration. Multinomial logistic regression and Cox proportional-hazards models were used for analysis.

**Results:** Regular psychiatric follow-up (57.5%) was strongly linked to successful resolution (aRRR = 6.85,  $p < 0.001$ ) and shorter protective duration (aHR = 2.91,  $p < 0.001$ ). Legal reason, mandate orientation, and referral source had no significant effect. Although 49.4% of the cases had multiple psychiatric diagnoses, regular follow-up significantly increased both the likelihood of case termination (aRRR = 6.85,  $p < 0.001$ ) and the speed of resolution (aHR = 2.91,  $p < 0.001$ ). In unadjusted analyses, depressive symptoms, as well as behavioral risk factors such as conduct disorder and smoking, were associated with longer case durations.

**Conclusion:** Consistent psychiatric engagement emerged as the key determinant in resolving protective orders, surpassing diagnostic complexity or legal basis. These findings underscore the importance of sustained, structured care in driving recovery in vulnerable children.

**Keywords:** Court-mandated health protection, psychiatric service engagement, child welfare outcomes, mental health follow-up, child protection law

## Öz

### *Düzenli Psikiyatrik Takip ve Çocuklara Yönelik Mahkeme Kararlı Sağlık Tedbirlerinin Sonuçlanması*

**Amaç:** Bu çalışma, Türkiye'de çocuk ve ergenlere yönelik mahkeme kararıyla uygulanan sağlık koruma tedbirlerinin süresi ve sonlanmasıyla ilişkili faktörleri belirlemeyi amaçlamıştır.

**Yöntem:** Ocak 2015 ile Aralık 2024 tarihleri arasında Ordu Üniversitesi Eğitim ve Araştırma Hastanesi Çocuk ve Ergen Psikiyatrisi Kliniğinde izlenen 160 vaka retrospektif olarak analiz edilmiştir. Veriler, mahkeme kararları, psikiyatrik değerlendirme raporları ve sosyal hizmet kayıtlarından elde edilmiştir. Değişkenler sosyodemografik, ailesel, klinik, hizmetle ilişkili ve hukuki olmak üzere beş ana alanda sınıflandırılmıştır. Sonuç değişkenleri vaka durumu (devam eden, sonlandırılan veya devredilen) ve tedbir süresi olarak belirlenmiştir. Analizlerde çok kategorili lojistik regresyon ve Cox orantılı risk modelleri kullanılmıştır.

**Bulgular:** Düzenli psikiyatrik takip (%57,5), başarılı sonlanma ile güçlü şekilde ilişkili bulunmuştur (aRRR = 6,85,  $p < 0,001$ ) ve koruyucu tedbir süresinin kısalmasıyla anlamlı düzeyde bağlantılıdır (aHR = 2,91,  $p < 0,001$ ). Hukuki neden, tedbir yönelimi ve sevk eden kurumun anlamlı bir etkisi bulunmamıştır. Vakaların %49,4'ünde birden fazla psikiyatrik tanı yer almasına rağmen, düzenli takip hem tedbirin sonlandırılma olasılığını (aRRR = 6,85,  $p < 0,001$ ) hem de sürecin hızını (aHR = 2,91,  $p < 0,001$ ) anlamlı biçimde artırmıştır. Ayarlanmamış analizlerde depresif semptomların yanı sıra davranım bozukluğu ve sigara kullanımı gibi davranışsal risk etkenlerinin daha uzun süren vakalarla ilişkili olduğu bulunmuştur.

**Sonuç:** Tutarlı psikiyatrik katılım, koruyucu tedbirlerin sonlandırılmasında tanınan karmaşıklık veya hukuki gerekçeden daha güçlü bir belirleyici olarak öne çıkmıştır. Bu bulgular, kırılgan çocukların iyileşme süreçlerinde sürekli ve yapılandırılmış bakımın önemini vurgulamaktadır.

**Anahtar Kelimeler:** Mahkeme kararlı sağlık tedbiri, psikiyatrik hizmet katılımı, çocuk refahı sonuçları, ruh sağlığı takibi, çocuk koruma kanunu

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## 1. INTRODUCTION

Child maltreatment together with neglect represent essential matters for both public health and social welfare worldwide. The experience of adverse childhood events including abuse and neglect and family dysfunction elevates a child's risk of developing psychiatric disorders and creating developmental issues and lasting psychosocial problems (1). Numerous worldwide jurisdictions created protective laws and safety protocols to protect children when their families cannot supply proper safety and care (2). These protective interventions use multidisciplinary methods to integrate social educational and mental health support services through court-ordered mandates. International jurisdictions now use court-mandated protective measures because states recognize their final authority in protecting child development when parental care fails or becomes dangerous (3,4). These interventions focus on helping children who face severe neglect or abuse situations and those showing major emotional and behavioral needs that need professional help. Despite their common use worldwide there is a lack of global research which studies factors that lead to successful protective measure outcomes including both the speed of case resolution and family reunification (5,6). Research performed primarily in North America and Europe show service engagement and family involvement and consistent therapeutic interventions as positive outcome factors but these determinants require further study in different socio-cultural settings (7-9).

Turkish protective measures for at risk children follow the guidelines set by Child Protection Law No. 5395 (2005) that allows juvenile courts to order supportive interventions which include health and education along with care and counseling measures (10). Among these, health measures specifically ensure that children with identified medical or psychiatric needs receive mandatory treatment and ongoing professional follow-up. Research on predictors of case resolution which defines the termination or transfer of court-ordered measures for Turkish children remains scarce even though studies have described their socio-demographic and clinical profile (11-14). Few research studies have evaluated how individual factors together with family factors and clinical variables and administrative elements affect both the length and successful termination of protective interventions. The absence of clear evidence about effective protective intervention elements makes it challenging for clinicians and policymakers to determine which specific components lead to positive outcomes. Research shows that both psychiatric follow-up visits and formal service participation lead to better outcomes

in protective interventions according to international studies (15,16). The relationship between these factors has not received systematic examination in the Turkish child welfare system. The current Turkish child protection service development requires identification of actual factors leading to successful resolution and shorter protective durations. The evidence obtained about these determinants would produce substantial value for service provision enhancement along with policy modifications and inter-agency coordination strategies. The current research fills an essential knowledge gap by analyzing factors which influence the completion and length of court-ordered health protective measures for children in Türkiye. The research investigates which variables among psychiatric follow-up consistency and clinical complexity together with socio-demographic characteristics and family status and administrative requirements determine successful case resolution speed. The answers to these research questions will enhance Turkish child welfare practices while adding to global understanding about psychiatric care effects on protective cases.

## 2. METHODS

### 2.1 Study Design and Sample

This retrospective cohort study included 160 children and adolescents who were placed under court-mandated health protection measures and were followed at the Child and Adolescent Psychiatry Clinic of Ordu University Training and Research Hospital between January 2015 and December 2024. Data were collected from complete case files containing judicial rulings, psychiatric assessments, and social service reports.

### 2.2 Inclusion and Exclusion Criteria

To be eligible for inclusion, participants had to be under the age of 18 at the time of the initial court decision, have an official health-related protection mandate issued under the Turkish Child Protection Law (Law No. 5395), and have complete documentation on psychiatric evaluation, family environment, and service utilization. Cases with missing or ambiguous outcome data were excluded from the analysis. Three cases with unresolved outcome status at the time of data collection were excluded from statistical analysis.

### 2.3 Variable Domains and Definitions

Variables were categorized into five major domains, as outlined below:

- **Sociodemographic characteristics:** age (in years), sex, educational level, type of residence (urban center, district town, or village), and reported household income (low, middle, high, or unknown).

- **Parental and family context:** maternal and paternal education levels, employment status, presence of documented parental mental illness, and family structure (e.g., intact, separated, or alternative guardianship).
- **Clinical and Behavioral Profile:** psychiatric diagnoses based on clinical assessments, psychiatric comorbidity, substance use (including tobacco, alcohol, and illicit substances), and psychosocial risks such as documented abuse history, runaway behavior, family conflict, and legal involvement.
- **Service Engagement:** presence of structured social worker reports, regular psychiatric outpatient follow-up, psychiatric hospitalizations, and psychotropic medication use. Regular follow-up was operationalized as consistent attendance at scheduled psychiatric appointments (defined as attending at least 75% of scheduled visits) over the duration of protective supervision, as documented in clinic records.
- **Legal and Administrative Details:** orientation of the protective order (health, education, care, or combined), referring authority (e.g., Child Protection Board, Social Services, judicial court), the legal rationale for the order (e.g., neglect, abuse, behavioral risk), and the calendar year of the court decision.

#### 2.4 Outcome Measures: Two main outcomes were assessed:

1. **Case Status at Follow-Up:** Whether the protective order was ongoing, terminated, or administratively transferred to another institution.
2. **Duration of the Protective Order:** Measured in months from the date of initiation to resolution (termination or transfer).

The study protocol received ethical approval from the Clinical Research Ethics Committee of Ordu University Training and Research Hospital (Decision No: 213, Date: 20.12.2024). All procedures adhered to the ethical standards of the Declaration of Helsinki.

#### 2.5. Statistical Analysis

Data were analyzed using IBM SPSS Statistics (version 22) and R software (version 4.3.2). Descriptive statistics were calculated for all variables. Categorical predictors were compared using chi-square tests, with False Discovery Rate (FDR) adjustment applied for multiple comparisons.

Multinomial logistic regression was used to identify independent predictors of protective-order status (ongoing, terminated, transferred). Cox proportional-hazards modeling was employed to assess time to resolution, defined as either

termination or transfer of the protection mandate. Model performance was evaluated using McFadden's  $R^2$ , the area under the ROC curve (AUC), and Schoenfeld residuals. Effect sizes were reported as adjusted relative risk ratios (aRRRs) and adjusted hazard ratios (aHRs) with 95% confidence intervals.

### 3. RESULTS

A total of 160 children and adolescents under court-mandated protective-health orders were included in the study. The mean age of participants was 12.4 years (SD = 4.6, median = 14, range = 1–17), and 55% were female (n = 88).

#### 3.1. Sociodemographic Characteristics

The majority resided in district towns (62.5%) or the provincial capital (31.9%), while only 5.0% lived in rural villages. Educational attainment was diverse: 41.9% were in high school, 15.6% in middle school, 10.6% in primary school, and 16.2% in preschool. A notable portion had dropped out of school (12.5%), received special/home-based education (1.9%), or had undocumented status (1.2%). Family structures varied: 56.2% of participants lived with both parents, 28.1% had separated parents, and 15.7% resided in single-parent, extended, or foster arrangements. Household income was reported as low in 40.6% of families, middle in 42.5%, and high in 11.3%; income status was unknown in 5.6%.

#### 3.2 Family and Parental Factors

Maternal mental illness was documented in 11.9% of cases and paternal mental illness in 14.4%. Most mothers (46.3%) had only primary education or less, while 29.4% had secondary education, and 20.6% had at least high school. Paternal education followed a similar pattern. Employment rates were markedly higher among fathers (56.2%) compared to mothers (17.5%).

#### 3.3 Clinical and Psychosocial Characteristics

Psychiatric diagnoses were common: 38.1% had conduct disorder, 28.7% depressive disorders, 25.6% substance dependence, 25.0% anxiety disorders, 21.9% ADHD, and 11.3% PTSD. Other diagnoses included specific learning disorders (13.8%), bipolar-spectrum conditions (6.9%), OCD (5.6%), and autism spectrum disorders (4.4%). Nearly half (49.4%) met criteria for two or more psychiatric conditions. Substance use was also present, with 24.4% currently smoking, 13.1% using alcohol, and 5.0% having experimented with illicit substances. Documented psychosocial risks included family conflict (53.1%), physical abuse (21.9%), sexual abuse (7.5%), runaway behavior (17.5%), and involvement in police or delinquent activity (25.0%).

#### 3.4 Service Engagement and Legal Parameters

Structured social-work reports were available for 83.1% of cases. During protective supervision, 57.5% received

regular psychiatric outpatient follow-up, 11.3% had at least one psychiatric hospitalization, and 41.3% were prescribed psychotropic medications.

The primary orientation of court orders was health-related (56.2%), followed by education (28.1%), care (13.8%), or combined mandates (1.9%). The main sources of referral were the Child Protection Board (41.3%) and Social Services (35.6%). Neglect was the most cited legal justification (48.8%), followed by abuse (24.4%), behavioral threats (17.5%), and other reasons (9.4%).

At the time of data collection, 45.0% of the cases were still active, 30.0% had been terminated, and 23.1% were administratively transferred. Outcome status was unknown for three cases. The median duration of protective orders was 14 months (IQR = 8–26 months; range = 1–60 months).

Table 1. Bivariate associations with protective-measure status				
Thematic Domain	Primary Predictive Variable(s)	Outcome Distribution Across Status Categories (%) <sup>*</sup>	$\chi^2$ (df)	p <sup>**</sup>
Service engagement	Regular outpatient follow-up	ongoing 52.8 % < terminated 81.3 % ≈ transferred 81.1 %	21.8 (2)	< 0.001
Administrative	Calendar year of decision	steady decline in “ongoing” orders from 2015 → 2024	25.3 (9)	0.003
Mood pathology	Depressive disorder	ongoing 36.1 % > terminated 16.7 %	8.9 (2)	0.012
Disruptive behaviour	Conduct disorder	ongoing 47.2 % > terminated 31.3 %	5.7 (2)	0.058
Family strain	Documented conflict	ongoing 63.9 % > terminated 45.8 %	6.4 (2)	0.040
Socio-economics	Low household income	ongoing 48.6 % > terminated 29.2 %	6.9 (2)	0.032
Parental resources	Maternal education ≤ primary	ongoing 55.6 % > terminated 33.3 %	7.1 (2)	0.029
Substance use	Current cigarette	ongoing 31.9 % > terminated 12.5 %	7.9 (2)	0.019
Trauma	Run-away history	ongoing 25.0 % > terminated 8.3 %	7.2 (2)	0.027

<sup>\*</sup>Outcome Distribution Across Status Categories (%)= proportion of children in the specified category whose order is ongoing. <sup>\*\*</sup>All p-values are FDR-adjusted to control the false discovery rate.

Table 1 shows bivariate associations between candidate predictors and protective-order status. Factors significantly associated with lower likelihood of ongoing status included regular follow-up, later calendar year of decision, and higher parental education. Psychosocial risk factors (e.g., family conflict, substance use, and run-away history) were more prevalent among those whose cases remained active.

Table 2. Multinomial logistic regression predicting terminated or transferred status			
Outcome Comparison Group	Independent Variable	Adjusted Relative Risk Ratio (95% Confidence Interval)	p <sup>*</sup>
Terminated vs ongoing	Regular follow-up	6.85 (2.62 – 17.9)	< 0.001
	Calendar year (per unit)	0.67 (0.55 – 0.82)	< 0.001
	Depression	0.41 (0.17 – 1.01)	0.054
	Age (per year)	1.07 (0.97 – 1.19)	0.15
	Female sex	0.92 (0.42 – 2.02)	0.84
Transferred vs ongoing	Regular follow-up	7.24 (2.50 – 21.0)	< 0.001
	Calendar year (per unit)	0.78 (0.63 – 0.97)	0.028
	Depression	0.48 (0.18 – 1.28)	0.14
	Age (per year)	1.09 (0.97 – 1.22)	0.15
	Female sex	1.11 (0.47 – 2.66)	0.81

Reference category = ongoing; values are adjusted relative risk ratios (aRRR) with 95 % confidence intervals (CI). Model fit: log-likelihood = -112.4; McFadden R<sup>2</sup> = 0.29; AUC = 0.84. <sup>\*</sup>All p-values are FDR-adjusted to control the false discovery rate.

Table 2 presents results from the multinomial logistic regression. Regular psychiatric follow-up was a strong predictor of both terminated and transferred status (aRRR = 6.85 and 7.24, respectively, both p < .001). Later calendar year of the protective order was also associated with reduced likelihood of cases remaining ongoing. Depression showed a borderline significant association with reduced likelihood of termination (aRRR = 0.41, p = .054).

Cox regression results (Table 3) indicated that regular follow-up (aHR = 2.91, 95% CI: 1.83–4.63) and later calendar year (aHR = 1.14, 95% CI: 1.07–1.22) significantly predicted shorter time to case resolution. No significant associations were found for sex, age, or presence of depressive symptoms in this model. The proportional-hazards assumption was satisfied, and model discrimination was acceptable (Harrell’s C = 0.77).

**Table 3. Cox proportional-hazards model for time to termination or transfer**

Independent Time-to-Event Predictor	Adjusted Hazard Ratio (aHR) (95% Confidence Interval)	p*
Regular follow-up	2.91 (1.83 – 4.63)	< 0.001
Calendar year (per unit)	1.14 (1.07 – 1.22)	< 0.001
Depression	0.72 (0.49 – 1.06)	0.10
Age (per year)	1.02 (0.99 – 1.05)	0.21
Female sex	0.96 (0.66 – 1.39)	0.82

Diagnostics: proportional-hazards assumption satisfied (global Schoenfeld  $p = 0.46$ ); Harrell's  $C = 0.77$ . \*All p-values are FDR-adjusted to control the false discovery rate.

#### 4. DISCUSSION

This study demonstrates that psychiatric follow-up which occurs consistently plays an essential role in closing court-ordered protective health cases for children. Regular psychiatric appointments proved to be the leading predictor of both successful case outcomes and shorter case lengths compared to other studied variables. Children who kept their psychiatric appointments regularly faced seven times higher chances of closing their case successfully and had their protective order terminated three times quicker than children who missed appointments. The research demonstrates that children who receive continuous mental health treatment achieve stability which enables authorities to end protective orders in a manner similar to previous youth mental health service findings (17,18). The establishment of continuous care through scheduled psychiatric appointments led to better case results because it supported complete health service delivery along with proper medical documentation. Follow-up irregularity resulted in prolonged protective status because it indicated ongoing medical concerns and interrupted healthcare services and unstable family environments. National data tracking follow-up compliance of protected children in Türkiye remains limited yet previous US research shows how transportation problems create barriers to ongoing care and result in treatment termination (19). Some children in this study experienced transportation challenges which might have interfered with their psychiatric appointments thus requiring extended protective oversight. UK research supports the necessity of specific post-placement services for adolescent care stability but needs more empirical evidence to understand their relationship with family reunification success rates (20).

The study data showed positive case outcome improvements across time within the observation period. The duration of cases initiated in subsequent years decreased substantially because of Turkish child protection system improvements. The Turkish and European institutions have launched policy initiatives which aim to strengthen the justice systems' service for vulnerable populations even though no direct national data exists to demonstrate their effect (21). Structural interventions that include family-centered services along with coordinated case management have proven effective in improving stability and reducing placement duration according to child welfare reform efforts in the United States and South Korea (22–24). Legal parameters together with administrative specifications (referring institution, reason for referral and mandate orientation) did not serve as independent outcome predictors after controlling for other variables. The delivery quality and process of care provided during the mandate period determines final results instead of the referral source. Such findings support the development of service delivery models that focus on individual needs instead of using case labels. The absence of a single European framework does not stop the child welfare sector from adopting individualized evidence-based practices that adapt to children's changing needs instead of using categorical distinctions (25). The study shows that documentation compliance through structured social work reports is high but resolution requires active engagement according to the research findings. From a clinical viewpoint the evaluation process showed no bias in institutional decision-making because sex and age factors did not serve as significant predictors. Univariate models revealed psychosocial vulnerabilities including depression together with conduct disorder and substance use and family conflict and runaway behavior as factors linked to prolonged case durations. Follow-up and calendar year variables in the multivariate analysis reduced or eliminated several risk factor effects thus showing that psychiatric care from an early start and continuous basis protects against socioeconomic and behavioral risks. Depression showed a significant trend to reduce the likelihood of case closure according to the risk ratio analysis (aRRR = 0.41,  $p \approx .054$ ). Depression symptoms create barriers to patient engagement because they cause patients to withdraw emotionally while experiencing hopelessness and decreasing their parental involvement. Research has shown variable patterns of adherence among different diagnostic groups in international literature yet some studies indicate that children with internalizing disorders face specific obstacles when caregivers lack support (26). The results demonstrate the necessity of early mental health screening followed by appropriate interventions which

address emotional regulation problems in protective settings. Prolonged cases displayed high frequencies of behavioral dysregulation which included conduct problems and runaway behavior and smoking. The statistical analysis did not confirm these behaviors as clinical indicators for complex patient trajectories but they might signal potential issues in patient care. The literature shows externalizing behaviors link to placement instability but additional evidence is needed to prove their effectiveness in protective health settings (27). Our study data matches worldwide research patterns which demonstrate how patients often present with multiple health conditions simultaneously. Research on foster care youth indicates that approximately 50% need psychiatric diagnosis treatment for two or more conditions which demonstrates their clinical complexity (28). The evidence shows that maintaining structured care can help minimize negative results even when patients belong to high-risk groups. Follow-up procedures eliminated the initial association between family-level stressors such as low maternal education and ongoing conflict and prolonged case durations. The research findings support previous studies which show that both service continuity and caregiver involvement act as protective factors against negative effects of structural disadvantages (29,30).

The protective orders had a range of durations from one month to sixty months with the midpoint at fourteen months. A significant portion of cases continued for more than three years because the clinical needs remained unresolved or the system experienced delays and the parents failed to engage with the program. The child's developmental trajectory requires prompt case resolution because institutional uncertainty prolongs more than two years causes emotional distress and attachment difficulties (31-34).

The results provide multiple practical implications: Psychiatric follow-up must remain a top priority. Several approaches can be used to improve appointment attendance including flexible scheduling and community outreach with caregiver involvement. Telehealth services combined with school and local community center integration represent more effective solutions to accessibility problems. Home visits together with caregiver education programs create trust-based environments which support family participation. Systematic reviews demonstrate that service uptake for children and adolescents can be improved by using school-based programs and peer support and culturally specific outreach strategies (35). National databases with structured monitoring systems enable regional disparities detection and help identify cases with low engagement (36). The implementation of routine judicial reviews could serve as a preventive measure

against procedural stagnation by maintaining stakeholder accountability.

### Limitations of the Study

The study has several limitations. First, its single-region retrospective design limits the generalizability of the findings. Second, detailed information on the type of psychiatric follow-up services provided (e.g., medication management or psychotherapy) and post-termination outcomes was not available in the dataset. Future studies should employ prospective, multi-site cohort designs to better establish causal relationships and to examine the effectiveness of specific therapeutic approaches. In addition, further studies exploring the role of multidisciplinary teams and community-based supports in improving follow-up adherence may help identify optimal practices in child protection settings.

## 5. CONCLUSION

The results show that consistent psychiatric monitoring strongly affects results in court-ordered health protection cases for children. Research demonstrates that recovery results from well-organized and continuous care rather than from the initial legal classification or initial clinical assessment. The core objective of child protection systems requires service quality enhancement and universal access alongside ongoing monitoring to achieve safety alongside healing for children.

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### Peer-Review

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### Conflict of Interest

The authors declare that they have no conflict of interests regarding content of this article.

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### Ethical Declaration

The study protocol received ethical approval from the Clinical Research Ethics Committee of Ordu University Training and Research Hospital (Decision No: 213, Date: 20.12.2024). All procedures adhered to the ethical standards of the Declaration of Helsinki.

### Previous Presentation

A preliminary version of this study was presented as an oral presentation at the 5th Turkish Congress of Forensic Sciences (TURAZ) and the 16th Forensic Medicine Workshop, held in Ordu, Turkey, on May 16–19, 2024.

### Author Contributions

Concept: HCA, YGÇ, HYT; Design: YGÇ, HCA; Supervision: YGÇ, HYT; Materials: YGÇ; Data Collection or Processing: YGÇ, HCA, HYT; Analysis and Interpretation: YGÇ, HCA, HYT; Literature Review: YGÇ, HCA; Writing: YGÇ, HCA, HYT; Critical Review: HYT.

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