The aim of this study was to assess the effectiveness of a family-centered approach, designed to support infants’ social-emotional development in Preventive Child Healthcare (PCH). To get a broad overview, a family-centered approach (in Dutch “DMO-protocol”, further referred to as “the family-centered approach”) was studied from various perspectives. In this general discussion the main findings are summarized and discussed. Furthermore, methodological issues and the implications for PCH practice, policy and future research will be addressed.

**Research questions and main findings**

**Research question 1:** Does a family-centered approach contribute to better identification of (risks for) social-emotional problems in infants?

We found that in the family-centered condition more (risks for) social-emotional problems were identified between ages 2 and 18 months compared to in the care-as-usual condition (24.7% versus 22.0%), but the effect was small. Furthermore, we found that the family-centered approach contributed to a better identification of families who need additional care, as reflected by higher problem scores in the family-centered condition on several questionnaires regarding the child and its broad developmental context.

**Research question 2:** Does a family-centered approach contribute to the early identification of (risks for) social-emotional problems in infants?

The family-centered approach seems to contribute to the early identification of (risks for) social-emotional problems in infants. With Kaplan-Meier analyses, we found that risks were identified earlier in the family-centered condition compared to in the care-as-usual condition for children between 2 and 18 months.

**Research question 3:** Does a family-centered approach contribute to the psychosocial wellbeing of infants of 18 months of age?

No differences were found between the family-centered and care-as-usual condition for the total group of children regarding the scores on the Child Behaviour Checklist (CBCL) 1.5-5 as filled in by parents. This indicates that the family-centered approach does not contribute to the psychosocial wellbeing of infants of 18 months at age. Further research is needed on long term effects.
Research question 4: *What beliefs do PCH professionals have regarding the family-centered approach?*

We assessed PCH professionals’ beliefs regarding the family-centered approach during focus groups with nurses and medical doctors. All PCH professionals, nurses as well as medical doctors, appreciated the family-centered approach for enabling empowering communication skills, and also used these communication skills in daily practice. However, the opinion about the checklist with questions was mixed: Nurses were more positive than doctors in that the checklist provided them relevant information, but all PCH professionals presumed that it could lead to an interrogation and loss of trust if the professional’s communication skills were insufficient. Furthermore, the checklist with questions yielded several, mostly practical, barriers, like a lack of time and a poor integration of the format of questions in the medical record.

Research question 5: *Is a family-centered approach associated with better attunement of care to parents’ needs and wishes, compared to care-as-usual?*

We assessed the attunement of care to parents’ needs and wishes by first asking parents (with children around 3 months of age) to rate their opinion on the importance of several aspects of family-centered care. This importance was assessed for the *attitude* of PCH professionals, *empowerment* through PCH professionals, and being asked about the *broad developmental context* by PCH professionals. On these same aspects, parents had to rate to what extent PCH professionals did perform these. Compared to care-as-usual, the family-centered approach was associated with a better attunement of care to parents’ preferences on all three aspects that were assessed. Differences that we found were relatively small (effect sizes small to medium). Findings applied regardless of the child’s social-emotional well-being and parents’ socio-economic status (SES).

Research question 6: *Is a family-centered approach associated with a higher willingness to disclose concerns of parents, compared to care-as-usual?*

Parents’ willingness to disclose concerns was assessed by asking parents to rate how free they felt to discuss all kinds of concerns with PCH professionals. The willingness to disclose was similar in both the family-centered and care-as-usual group at the child age 3 months; in the family-centered condition 86.7% and in the care-as-usual condition 84.9% of the parents scored high on the willingness to disclose concerns, odds ratio: 6.06, *p*-value .08.
Research question 7: Is a family-centered approach a valid method for identifying risk and protective factors regarding the child and its developmental context?

Findings partially support the convergent validity of a family-centered approach in well-child care to assess infants’ social-emotional wellbeing and their developmental context. Pearson’s correlation coefficients between PCH professionals’ assessments and gold standards ranged from 0.17 to 0.51. Children who were assessed as at risk by PCH professionals using the family-centered approach had overall higher scores on questionnaires regarding the broad developmental context compared to children assessed as not at risk for social-emotional problems. Furthermore, we found reasonable to excellent agreement regarding the absence of risk factors (negative agreement rates: 0.38 - 0.99), but lower agreement regarding the presence of risk factors (positive agreement rates: 0.00 - 0.68). Regarding the disagreement on risk factors, we found children for whom PCH professionals registered a risk factor on one of the domains of the family-centered approach, but parent-reported questionnaires did not and vice versa, with rates of disagreement varying from 12 to 29%. The first (where the PCH professional registered a risk factor whereas parents scored low (i.e. protective) on questionnaires) occurred more frequently than the latter.

Discussion of the main findings
Monitoring children’s social-emotional development is a core task of Dutch PCH. Several methods exist to assess children’s social-emotional development and their developmental context, however, especially for children younger than 18 months evidence on these lacks.\(^5\)\(^7\) Our study thus provides important knowledge about the value of using the family-centered approach as a screening tool in PCH.

To summarize, we found several positive outcomes related to the family-centered approach, (in Dutch the “DMO-protocol”). The approach seems to contribute to more and earlier identification of risks for social-emotional problems and to a better identification of families who need extra care. Next, both PCH professionals and parents positively valued the family-centered approach for various aspects. Finally, findings partially support its validity. We will discuss our findings subsequently in the following.

The effectiveness of the family-centered approach for the identification of (risks for) social-emotional problems and children’s social-emotional wellbeing
We found that the family-centered approach was associated with more and earlier identification of (risks for) social-emotional problems and a better identification of children and/or families that needed extra care. As our study is, to our knowledge, the
first on the relationship between a family-centered approach and the early identification of (risks for) social-emotional problems, we cannot fully compare it to other studies, but some of the available evidence is related, e.g., some studies show that training regarding the identification of psychosocial problems is associated with an improved identification.\textsuperscript{8,9}

Next to our finding of more and earlier identification, we found that with the family-centered approach, PCH professionals actually seemed to better identify which families needed extra care as compared to care-as-usual. They provided additional care to families with overall higher scores on several questionnaires (meaning worse outcomes), which might indicate that professionals in the family-centered condition actually more properly identified the families that needed extra care compared to those in the care-as-usual condition. This seems of major importance, as it provides a way to improve PCH care. Additional care was provided to somewhat older children and to more severe cases in the family-centered condition. An explanation may be that the family-centered approach can be seen as an intervention in itself and leads to empowerment of parents in such a way that most parents feel that they can handle noted risks or problems themselves and that only more severe cases still need additional care. This would fit with the duty of PCH services to ‘normalize’ (i.e. to counter unnecessary focus on common issues that are no problems that need specialized care or labeling\textsuperscript{10}) as recently advised by commission De Winter on the future core tasks of PCH.\textsuperscript{11} This would also provide economical benefits, as it implies that only families that actually need care do receive it. An alternative explanation could be that in the care-as-usual condition PCH professionals provided earlier, preventive, care to families with less severe problems to prevent worsening of problems. However, if this would have been the case, we would also expect an effect of this on the psychosocial wellbeing of children, which we did not find as we explain in the following.

We did not find an effect of the family-centered approach on children’s overall psychosocial wellbeing at 18 months as measured by the CBCL. We had expected to find lower scores in the family-centered condition because of the earlier identification of risk factors that might contribute to children’s social-emotional development, as PCH professionals were able to discuss these factors with parents and might intervene if needed. We did find an effect of the family-centered approach on the externalizing problems when we only took into account children for whom assessments were rated as “a problem” (not described in this thesis). It is unclear why this difference was not found between groups for children for whom assessments were rated as “not optimal” or “a problem”. This issue remains unclear because we were not able to clearly differentiate
between the use of the definitions “not optimal” or “a problem”. Apparently, further research is needed on this topic, e.g. with the use of more extensive assessments of psychosocial problems.

In this study we assessed the effectiveness of a family-centered approach that focuses on early identification of factors contributing to social-emotional problems. It should be noted that family-centered care is broader than only the family-centered approach that we studied as it is often applied in settings where actual care is provided because of problems (see 4,12,13 for examples). In such settings the emphasis of family-centered care also entails providing information on the problem or provision of care, shared-decision making based on this information, and respecting choices of families in this regard. It would be interesting for future research to also study such aspects in the population of families that actually received additional care.

The family-centered approach from the perspective of PCH professionals

Professionals’ adherence to the family-centered approach is an important prerequisite for being able to study the possible added value of the family-centered approach. In Chapter 4, we described that PCH professionals did adhere to the basic principles of the family-centered approach; they did use the communication skills and often asked more questions regarding the child’s broad developmental context than before. Based on our focus groups, it thus seems justified to relate outcomes of our effectiveness study indeed to the family-centered approach.

Adherence to guidelines in primary pediatric care is not always self-evident as has been illustrated by studies regarding the identification of overweight 14, the management of asthma15, and the use of developmental screening tools.16 Several studies have mentioned different barriers to using guidelines17,18 and providing family-centered care.19-22 In our study, we also found barriers regarding working with the family-centered approach, but overall the adherence to the basic principles of the family-centered approach was quite good, especially regarding the empowering communication skills. This may be due to the fact that professionals were involved in the development of the family-centered approach. Moreover, the basic principles seem to fit their working methods and aligns with needs of some professionals. Finally, it may indicate a rather successful implementation trajectory at the service concerned. Further research may help to disentangle the effects of these potentially contributing factors.

Initially, we hypothesized that PCH professionals might have ethical considerations, like fear of stigma, which hampered registration of information within the format of the family-centered approach, but our hypothesis was not confirmed. PCH
professionals mentioned several, mostly practical, barriers for using the approach to its full extent, especially for filling in the checklist with questions within the electronic medical file. All professionals mentioned lack of time as a barrier, which fits with findings of other studies on barriers for implementation\textsuperscript{21,22}. Furthermore, the introduction of electronic medical files that we found has in literature also been described as a general source of resistance for physicians\textsuperscript{23} These practical barriers are easier to solve than ethical barriers which would require a very different approach. In the PCH organization where our study took place, some practical barriers have already been solved, fitting with the demands of PCH professionals. However, to further improve PCH practice, it may be profitable to assess whether practical barriers still exist and can be overcome, since professionals have to continue working with the family-centered approach. This in particular concerns the overlap between items of the family-centered approach and regular items from the medical file and the answer categories. Consensus is for example needed on what information is essential to report in what way (e.g. are multiple choice answers needed, and if so, what categories are useful, or do professionals and/or children benefit more from free text). Furthermore, during trainings it should be stressed that the checklist with questions is meant as a guide, and not as a rigid questionnaire. However, the importance of asking the questions, also the more delicate ones, also needs ongoing attention.

The family-centered approach from the perspective of parents

We found that the family-centered approach contributed to a better attunement to parents’ needs and wishes than care as usual. These higher attunement scores are consistent with a core principle of family-centered care: a tailored approach\textsuperscript{1}, which thus seems to be met. Measuring the quality of family-centered care by looking at parents’ preferences as well as their actual experiences seems valid since only by taking into account both these aspects, one gains insight into the extent to which care is tailored to parents’ preferences and needs. Insight in the extent of attunement seems important since good attunement might contribute to disclosure of concerns, adherence to recommendations by PCH professionals, and parents that keep visiting PCH services. Results of another study on meeting needs of parents in well-child care, though not specifically focused on family-centered care, showed that meeting needs of parents is not always self-evident, since 94% of parents reported unmet needs for parenting guidance, education and screening.\textsuperscript{25} Results of our study might indicate that a family-centered approach may help to reduce the percentage of unmet needs.
We found small to medium positive effects of the family-centered approach on meeting parents’ needs and wishes at the child age of 3 months, but we also found such effects at 18 months (findings on the latter are not shown in this thesis). The latter shows that the family-centered approach contributes to a better attunement of care over a longer age-period. The attunement of care was high in both groups and the effect sizes of the differences ranged from small to medium in both measurements at 3 and 18 months. However, within a care system like PCH in the Netherlands, finding large differences is unlikely since the quality of care is overall high. Small differences thus might already be meaningful. Moreover, the differences that we found applied to all children, regardless of the child’s social-emotional wellbeing and parents’ socio-economic status (SES). Attunement of care to more vulnerable groups is of major importance.\textsuperscript{26} If these families gain trust in care providers and experience these as helpful, care providers may gain credits which may prevent these families from dropping out of care later on as well.

The family-centered approach did not contribute to parents’ willingness to disclose concerns at the child age of 3 months (nor for children for which the PCH professional assessed that the social-emotional development was not optimal), and slightly contributed at child age of 18 months (findings on the latter have not been presented in this thesis. At 18 months, we found an effect size $r$ of .04 for the total group of children, and for children for whom the PCH professional assessed that the social-emotional development was “not optimal” or “a problem” an effect size of .06.) The willingness to disclose concerns was high in both groups (around 85%), which is in line with other studies reporting a high willingness.\textsuperscript{27,28} For daily PCH practice it is very important that the majority of parents is willing to disclose their concerns. This may also support PCH professionals in asking the questions of the family-centered approach to all parents, without major risks of causing parental anxiety. However, most important is that parents are not only willing to, but indeed do disclose concerns when these arise, since literature suggests that this is not always the case.\textsuperscript{28,29}

To gain more specific insight in parents’ willingness to disclose concerns, we asked parents to rate this on the five domains of the family-centered approach at the child age of 18 months (results were not described in this thesis). We found that for all domains, parents in the family-centered condition were significantly more willing to disclose concerns compared to parents from the care-as-usual condition, though effect sizes were small. This higher willingness to disclose concerns may also have contributed to a better identification of (risks for) social-emotional problems as we found.
**The validity of the family-centered approach**

Our findings partially supported the convergent validity of the family-centered approach to assess infants’ social-emotional wellbeing and their developmental context. Furthermore we found that agreement between PCH professionals’ assessments and parent-reported questionnaires was reasonable to excellent regarding protective factors, but poorer regarding risk factors as covered by this approach (i.e. regarding parents’ competence, role of the partner, social support, life events and the child’s wellbeing). Our study was the first to assess the validity of the family-centered approach in this way. Our results fit with previous findings on the validity of this approach, and with findings on a similar approach, i.e. the Structured Problem Analysis of Raising Kids (SPARK), which also showed only partial support for its validity. Furthermore, our results fit with those studies on the identification of psychosocial problems in children, which indicate that this is not optimal.

Actually, two types of discrepancy occurred in our study. On the one hand, we found that PCH professionals registered risk factors whereas parents scored protective on questionnaires. This may be due to the keenness of PCH professionals on identifying risk factors (which however incorporates the risk that the family-centered approach does not fully reflect parents’ experience, but might be used by professionals to be able to monitor the situation properly.

On the other hand, we also found situations in which PCH professionals registered protective factors whereas parents scored as at risk on the accompanying questionnaires. An explanation for this may be that professionals did not ask the right questions, or that parents did not always disclose concerns, both would influence the agreement between PCH professionals and parents regarding risk factors. Or it may also be that the PCH professionals observed relatively strong protective factors which counterbalance the risk factors, which would fit with the empowerment oriented family-centered approach. A methodological explanation for the discrepancies is that some questionnaires only covered only partial a domain of the family-centered approach so that the comparison between the family-centered approach and the questionnaires could not always be made very specifically.

**The family-centered approach in relation to other approaches to improve children’s psychosocial wellbeing**

Our results specifically concerned the family-centered approach, but this approach is not the only method or instrument that has been implemented and/or studied in Dutch PCH to improve children’s psychosocial wellbeing. For example De Wolff et al. describe the
pros and cons of several questionnaires that can be used in PCH to improve the identification of psychosocial problems in children. The family-centered approach differs from these questionnaires in that it also takes into account the broad developmental context and in that it is a communication based instrument; questions are asked in a natural conversation with parents. This aspect was appreciated by PCH professionals and they reported several advantages of using it as compared to using questionnaires, like better attuned care and more satisfied parents.

Besides the family-centered approach that we studied, the Structured Problem Analysis of Raising Kids (SPARK) is also a communication based instrument to assess needs of parents on several domains regarding children’s broad developmental context in PCH. Some positive results for the SPARK regarding the validity and added value according to PCH professionals have been reported. Compared to the SPARK, an advantage of the family-centered approach that we studied is that it can be used during all routine well-child visits, whereas the SPARK is used at 18 months and takes 20-40 minutes to complete (during a home visit). Furthermore, the family-centered approach is empowerment oriented and builds on the strengths of parents, which can help them to solve possible problems within the developmental context if there are any (and if possible).

The family-centered approach provides an overall view of possible risks and problems. In addition, questionnaires can be used to further specify any problems, but also the SPARK home visit at 18 months might be a valuable addition to the family-centered approach as it provides an extra in depth analyses of the child and its developmental context. Both the use of questionnaires and the use of the SPARK in addition to the family-centered approach, would require more time for PCH professionals.

Methodological considerations
In this section, we will discuss methodological issues regarding the study sample, the quality of obtained information, and the strength of inferences on effect.

Sample
Our study had a high response rate (70%), with participants that were overall representative of the Dutch speaking parents who visit PCH, the return rates of questionnaires were high (both at the start and the end of the study; respectively 86% and 80%), and we had a low loss to follow-up (at 18 months 97% of parents were still participating).

The high response rate (70% of the parents that were asked to participate) may possibly be due to the effort we put in informing and motivating PCH professionals to ask
parents for their consent to participate. However, mostly due to time constraints and also novelty at the start of our study, only 84% of all eligible parents were asked. Small differences were found between parents that were and were not asked to participate on several background characteristics. Since differences were small, we do not think that these differences will have influenced our outcomes to a large extent. Differences between parents that gave and gave no consent for participation were also small, indicating that the participants were overall representative of the Dutch speaking parents visiting PCH. The parents that comprised the 70% that agreed to participate formed a culturally homogeneous group. Both the high return rate of questionnaires and the low loss to follow-up may also be due to the effort we put in motivating parents and getting questionnaires back from parents.

For the qualitative study, as described in Chapter 4, the focus groups were small, as is inherent to use of focus groups. As the focus groups consisted of a heterogeneous group of PCH professionals, based on their varying opinions regarding the family-centered approach, we do not think that this has influenced our results.

Quality of the information obtained
We had to deal with missing values regarding the data provided by PCH professionals in the medical files of children. Missing values in general can cause problems for the robustness of findings. However, we minimized the impact of missing values by tracing back a lot of information and by imputing missing values consistent with the principles of the family-centered approach. Therefore we think that it is unlikely that missing values will have influenced results to a large extent.

In our study, we intended to make a distinction between children and families that received additional care and children and families that did not. For the first group, we asked PCH professionals to rate assessment as ‘a problem’ and as ‘not optimal’ for the latter. However, in practice PCH professionals did not fully adhere to the definitions of ‘not optimal’ and ‘a problem’, which led us to combine both groups into one group of children for whom risks or problems had been identified. This might have added error since we could not link PCH ratings in full to whether or not extra care was provided.

To measure attunement of care on several family-centered care aspects, we developed a new measure that was partly derived from existing questionnaires that are used in Dutch PCH (CQI-questionnaires) and partly from existing questionnaires on family-centered care. In addition, we took into account advice of trainers of the family-centered approach, professionals working with the family-centered approach and experts on the family-centered approach. In the questionnaire, we not only took into account parents’
experiences, but also their preferences, since insight in whether parents’ preferences are met, is necessary to truly measure family-centered care. MacKean indirectly stresses the importance of doing so in measuring family-centered care by stating that “Family-centered care is beginning to sound like something that is being defined by experts and then carried out to families, which is ironic given that the concept of family-centered care emerged from a strong family advocacy movement.” We might also have asked parents during the design of the questionnaire what items they would find important to further increase validity, and this certainly deserves additional attention. The role of parents could, or should, still be further broadened in a truly family-centered setting, as we will describe under ‘implications’.

The questionnaires that were used in the validation study, as described in chapter 5, represented the domains of the family-centered approach as good as possible, but not fully as some questionnaires only covered a part of such a domain. This means that comparisons between the questionnaires and the family-centered approach could not be made very specific in all cases. This may have contributed to a lower agreement between parent-reported questionnaires and risk assessments based on the family-centered approach. Unfortunately, comparing specific questionnaires with specific questions of the family-centered approach domains was not feasible because data often lacked on these specific questions.

**Strength of inferences on effect: the quasi experimental design**

We used a quasi-experimental design, embedded in daily practice, which contributes to the external validity of results. A randomized controlled trial would have had the advantage of a higher certainty that effects were due to the family-centered approach but this was not feasible. It was not possible to randomize either PCH professionals or parents to the family-centered condition, since professionals were bound to the region in which they work. If we would have taken the alternative approach, randomization within a region, contamination would have been very likely. We therefore think that with the quasi-experimental design we chose the best possible design for the study.

We tried to minimize potential contamination by preventing that professionals would work in both the family-centered and care-as-usual condition. Furthermore, we informed PCH professionals about the study separately per group. Finally, no innovations regarding the social-emotional development of children aged 0-18 months were implemented in either the family-centered or the care-as-usual condition, during the study period. With these precautionary measures, contamination seems to have been minimized, but we cannot fully rule out any contamination. It may be for example that
PCH professionals within the care-as-usual condition also looked up information on the family-centered approach on the internet. However, the effect is likely to be minimal because those professionals lacked the extensive training and regular supervision meetings.

A disadvantage of our study was that we had no baseline information on regions. Differences beforehand between regions seem to be rather unlikely, but we can never be one hundred percent sure whether the effects that we found can truly be related to the family-centered approach. This uncertainty is somewhat larger in quasi-experimental designs compared to randomized controlled trials, since possible unknown confounders may not be randomly distributed over the two conditions. As we accounted for some background characteristics of parents in our analyses, these measured background variables do not seem to have influenced outcomes (to a large extent). However, there is always a chance that some other, to us unknown, regional differences might have played a role.

**Implications**

In this section, the implications of this study are discussed regarding PCH practice and policy and further research.

*Implications regarding PCH practice and policy*

The family-centered approach seems to contribute to more, better, and quicker identification of risks regarding the social-emotional development of infants. Given the importance of the early development of children for later life, our results support further implementation of the family-centered approach. Several measures can be taken to facilitate implementation of the family-centered approach in PCH practice.

A first measure may be the removal of the practical barriers experienced by PCH professionals. These concern in particular the format of the checklist with questions, maybe in combination with the time that is available. Regarding the checklist of questions, some changes were already made in the PCH organization where the study took place, however, for wider implementation further removal of barriers is advisable, so that an even more serviceable variant of the checklist with questions can be constructed. The Dutch National Center for Child Health (NCJ) currently manages the family-centered approach and supports several other instruments for the early identification of psychosocial problems. This is likely to facilitate a further exchange of experiences and coordination of improvements to be made.
Further measures to be taken into account concern aspects like the costs and practical organization that are involved with working with the family-centered approach. These aspects deserve attention in policy and practice.

Implications for further research
Our findings of more, earlier and better identification need replication in other settings, preferably combined with an assessment of costs and benefits too. In such confirmative studies, some aspects that we encountered should be taken into account as well, like collecting baseline data, preventing missing values, and taking into account the concordance between subsets of similar questions with corresponding questionnaires, instead of the domain as a whole for the validation of the family-centered approach (if feasible).

An option for future research would be to study multiple outcomes of the family-centered approach in the longer term. Long-term positive effects of early interventions have been described in relation to, among other things, social and emotional development, but also in terms of cost-benefits. Furthermore, outcomes like parental stress or parental competence would be interesting to measure in light of the empowerment-oriented approach of the family-centered approach.

To assess what the actual differences between the family-centered and care-as-usual condition are, qualitative research, like the analyses of videotapes of well-child visits, could be used to shed more light on the interaction between parents and PCH professionals during well-child visits. The differences between conditions may be subtle and might never be captured by quantitative research. Instead, videotapes would provide a wealth of information. Furthermore, future studies should point out whether the results that we found in our study are also generalizable to other populations (next to Dutch speaking parents with a relatively high educational level). Although a qualitative study by an expertise center for health differences (Pharos) showed that the family-centered approach is suitable for ethnic minorities as long as parents have sufficient mastery of the Dutch language, future research could further differentiate between ethnic minorities or people with low health literacy.

Future research could also assess other aspects of family-centered care, more related to the provision of care instead of only on the preventive aspects that we studied. When risks or problems are identified and care is needed, it could be assessed to what extent this is done in a family-centered way, also during well-child visits themselves, in terms of for example well-informed parents and shared decision making.
Finally, future research might assess the similarities and differences between methods that are family-centered or incorporate family-centered aspects. This enables progress towards a more unified method and prevents that for similar methods separately the wheel has to be reinvented in research as well as in daily practice.

**Future perspectives**

Investment in a universal method to support children’s social-emotional wellbeing is warranted because the investment in the early years will pay out in later life. The family-centered approach is a promising method to support children’s social-emotional wellbeing during these early years and can be used during routine care, for all children. Within the changed care system for children who have or are at risk for emotional and behavioral problems in the Netherlands, it seems wise to invest in such a universal method that takes into account both the child as well as its developmental context. Although it is not possible to prevent all problems and not everything in life is “engineerable”, with the family-centered approach, one looks for those aspects that seem possible to improve, to contribute to children’s wellbeing.

**Conclusion**

The family-centered approach seems to contribute to more, better, and earlier identification of risks regarding the social-emotional development of infants. Given the importance of the early development of children for later life, results support further implementation of the family-centered approach. The effects that we found were relatively small, but concern all children, making the population effects rather big. Moreover, this study showed that the family-centered approach contributes to the quality of PCH.
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