The identification by Dutch Preventive Healthcare of children with psychosocial problems: do short questionnaires help? Discussion and implications

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9.1 Main findings

In Chapter 1 the main questions we sought to answer in this thesis were formulated as:

1. Can differences in the number of children identified as having psychosocial problems by individual health professionals be explained by differences in the prevalence of problems or background characteristics in the groups of children they examine?

2. What are the psychometric qualities of a number of short questionnaires PCH could use to identify children with psychosocial problems and could they improve the identification by PCH?

3. Is it possible to develop a Computerized Adaptive Test, using items from questionnaires on psychosocial problems, in order to achieve a short, yet accurate assessment of the likelihood of psychosocial problems being present?

These questions can now be answered.

Ad 1: Differences between individual health professionals

In Chapter 2 we showed that there are significant differences between individual PCH professionals in the number of children they identify as having problems. Moreover, it was shown that these differences cannot be explained by differences in the prevalence of problems nor by the background characteristics of the children they examined.

Ad 2: Can short paper-and-pencil questionnaires improve the identification of children with problems by PCH?

In Chapters 3 to 7 we evaluated a number of short paper-and-pencil questionnaires and tried to determine whether such questionnaires could help PCH to improve the identification of children with problems. We evaluated five questionnaires given to three different age groups:

- The LSPPK (National Checklist for Indicating Psychosocial Problems in Five Year Olds, Landelijke Signaleringslijst voor Psychosociale Problemen bij Kleuters), for parents of preschool children
- The PSYBOBA (Questionnaire for psychosocial problems for primary-school children, Vragenlijst voor PSYchosociale problematiek in de BOvenbouw van het Basisonderwijs), the Pediatric Symptom Checklist (PSC) and the Strengths and Difficulties Questionnaire (SDQ) for parents of children aged 7 to 12
- The KIVPA (Short Indicative Questionnaire for Psychosocial Problems among Adolescents, Korte Indicatieve Vragenlijst voor psychosociale problematiek bij adolescenten).

We showed that all these questionnaires could indeed improve the identification by Dutch PCH. However, the KIVPA and LSPPK versions which were evaluated do so less well than the other questionnaires in the 7 to 12 age group.

Ad 3: Is a CAT an option?

In Chapter 8 we showed that most of the items from the PSYBOBA, the PSC, the SDQ and the Child Behavior Checklist (CBCL) could be used for an Item Response Theory based Computer Adaptive Test. In a simulation study we also demonstrated that such a
CAT resulted in sensitive and specific distinction between children with or without problems. As expected, this distinction could be made very efficiently, using on average less than 12 items for each individual assessment.

9.2 Discussion

Differences between individual PCH professionals

We showed that there are systematic differences between individual PCH professionals regarding the proportion of children they identify as having problems. These differences could not be explained by differences in problems or risk indicators among the children seen by PCH professionals. We know of no other studies that have used a similar methodology to assess differences between clinical judges. Therefore we cannot compare our results with those of other studies, in the field of PCH or in other settings. It would be interesting to investigate this issue in settings like community-based pediatric centers and primary healthcare, in which staff members with limited psychological and psychiatric training have to identify children or adults with problems. It seems likely that such studies would result in similar conclusions.

This does not mean, however, that our results should not be taken seriously. We showed that differences in clinical judgment about the presence of psychosocial problems are greatest for children with a CBCL Total Problem Score (TPS) at or somewhat above the clinical cut-off point of the CBCL. For children with a TPS of 40 the model predicted probability of being identified as having a problem is on average about 40%. For half of the professionals this probability rate varies between 30% and 50%, an for the other half the variation is even greater.

The identification of children with problems is one of the aims of the uniform part of PCH’s Basic Working Package. This program should be offered to all children in a standardized way. This means, among other things, that the chance of problems being detected should be, as far as possible and feasible, equal and not depend on the particular professional examining the child. Earlier studies\(^1\,2\) showed that PCH did not identify problems in a large percentage of children for whom CBCL data indicated a great likelihood of problems being present when they attempted to identify those children unaided by short questionnaires. Moreover, they identified problems in many children who according to the CBCL were unlikely to have problems. This in itself is no proof that the identification of problems by Dutch PCH must be wrong. The CBCL indicates the likelihood of the presence of problems and the individual health professional may be right in arriving at a different judgment than the CBCL data would suggest.

However, if this were the main reason for the discrepancies between CBCL results and the conclusions of PCH professionals, one would expect such discrepancies to be randomly distributed between individual PCH professionals. We showed that this was not the case. We showed that the chance of a child with a given problem level being identified as having a problem varies, depending on which PCH health professional is examining this particular child.
Clearly, this means that the identification of children with problems based on clinical judgment during the routine health examination, without the use of validated instruments to support this identification, lacks the degree of standardization required for the Uniform Part of PCH’s Basic Working Package.

Evaluating a single questionnaire or comparing available questionnaires

In chapter 6 we reported a randomized comparison between three questionnaires that seemed suitable for use by PCH for children aged 7 to 12. Despite the fact that the results showed that the psychometric qualities of these three questionnaires were quite comparable and that they all could help to improve the identification of psychosocial problems, we feel that comparing available questionnaires, whenever possible, is preferable to an evaluation of a single questionnaire. We know of no other studies that used a similar design. Our approach is comparable to what is now rapidly becoming standard in studies assessing effectiveness and economic evaluations of interventions. Such studies do not try to assess the effectiveness or costs as such, but compare specific interventions with other interventions or with usual care. Such an approach is far more helpful in guiding health policy decisions, such as deciding which instruments to use. We feel that this type of a comparative approach is also worthwhile in the evaluation of questionnaires to be used in other areas of healthcare. Only a systematic comparison can guarantee that the best instrument available will indeed be chosen.

Treatment status and CBCL or YSR as criteria to assess the validity of the questionnaires evaluated in this thesis

All studies presented in this thesis, except the study in chapter 2, assessed the validity of short instruments when used as a method to identify children with psychosocial problems. In chapter 1 psychosocial problems were defined indicatively as emotional and behavioral problems. For the evaluation of instruments that should help improve the identification of such problems we used current treatment status, referral and high scores on the CBCL or the Youth Self Report (YSR) as criteria.

Current treatment status (or more specifically, having been treated during the last 6 months by some professional or institution because of social and behavioral problems) is a criterion which very much resembles criteria used in validation studies: being referred to some form or care. Herjanic and Campbell3 for example used being referred to psychiatric care as validation for the Diagnostic Interview for Children and Adolescents (DICA), a standardized interview developed for the assessment of psychopathology in children, both for clinical and epidemiological use. Yet, criteria such as referral and treatment status should be handled with some care. Research has shown that many children with serious problems are not treated for them.4,5 This may be caused by all kind of factors, such as lack of available facilities, problems not being identified as such, parents who are able to cope with problems without feeling the need for professional help and so on. Also, not all of the children who are being treated will have very serious problems. Anxious parents may seek help for their children far sooner than less anxious parents. It should also be remembered that family doctors or PCH professionals may refer children with less competent parents more often than they would in the case of children with highly competent parents.
Therefore, one cannot expect very high indices of association between current treatment status or referral and instruments identifying problems in children. Even a perfect instrument would show rather imperfect validity, when validated against referral or treatment status. In other words: instruments aiming at identifying children with problems must by expected to show some relationship to treatment status, but one cannot expect very high associations to be found. This, in general, is exactly what we found for the instruments evaluated in this study.

The second criterion we used was the CBCL or the YSR – for adolescents. This is an accepted approach in the literature and is especially recommended for large-scale studies. The reason we chose these measures as a criterion was twofold. First, numerous studies in many different countries and cultures have shown that these instruments are highly valid. They are strong indicators for concurrent problems and are very predictive of future problems and negative developmental outcomes. Few other rating instruments have been so widely validated, if any at all. The second reason that we chose these instruments is that there are few viable alternatives for rating scales. One might consider using a full-blown psychiatric interview or some form of structured psychiatric interview. Such methods are very time-consuming and expensive and were therefore not feasible for these studies, neither is their validity perfect. Edelbrock et al., for example, found that the one-week test-retest reliability of the Diagnostic Interview Schedule for Children (DISC) for children aged 6 to 9 years old was only 0.39. He observed a sharp decline in the number of symptoms reported on the second occasion. Boyle et al. evaluated the Diagnostic Interview for Children and Adolescents for use in general population samples and concluded, among other things, that interview data provided by 6 to 11 year olds to classify internalizing disorders were too unreliable to be useful and that agreement between parent-child/adolescent dyads was generally low. Granero Perez et al. did research in order to explain the low test-retest reliability of the same instrument and found both characteristics of the child and characteristics of the questions to be relevant here. Jensen found lower test-retest kappa coefficients in a community sample than in a clinical sample.

In discussions with representatives from the PCH field, the use of the CBCL or YSR as criterion measures was sometimes criticized because these measures should be seen as focused on psychiatric disorders and PCH must identify not only children with specific psychiatric disorders, but all children with emotional and behavioral problems in need of support. These questionnaires were indeed developed as measures to be used in the context of child psychiatry. However, a psychiatric disorder is diagnosed when a defined combination of symptoms is present, in combination with burden for the patient. Questionnaires like the CBCL and YSR do not assess psychiatric disorders in this sense. They collect information on a variety of aspects of a child’s functioning and all these aspects must be considered as relevant when the phrase ‘psychosocial problems’ is used as indicated by the expert meeting on PCH and Psychosocial Problems in 1999 and Blokland et al. School problems or cognitive problems are also included in their definitions of psychosocial problems. The CBCL and YSR only assess attention problems, ignoring other cognitive problems. In this respect the CBCL and YSR may be less adequate criteria.
This thesis shows that elevated scores on short questionnaires are clearly associated with high scores on the CBCL or the YSR. This, then, justifies the expectation that elevated scores on the questionnaires evaluated will be associated with concurrent and future problems, too. Yet, as the CBCL is not a perfect criterion, but only an indicator of a strong likelihood of the presence of problems, data from instruments validated with the CBCL must be interpreted with care. Suppose, an elevated SDQ score detects 79% of cases with a borderline CBCL TPS¹³ and a borderline CBCL TPS has a sensitivity of 63% of all children referred to mental health services.¹⁴ Then – other things being equal – the sensitivity of the SDQ for being referred for treatment must be expected to be still lower. Similarly, if the specificity of a borderline CBCL TPS is 0.84 and the specificity of the SDQ for a borderline TPS is 0.90, then the specificity of the SDQ – other things being equal – must also be expected to be lower. This means, that a relative large proportion of cases – defined in terms of being referred to mental health institutions – may remain undetected with the SDQ. Similarly, the proportion of non-cases with a false positive elevated SDQ score will also be considerable.

These figures underline the necessity of a very careful interpretation of data from the questionnaires evaluated in this study. They also underline, that these instruments should be used as a first tool, to be used in the context of the standardized health examination and supplemented, as far as possible, by other validated assessment methods and not as a pre-selection tool, used to select those children who need to be seen by PCH.

Further evaluations of the questionnaires validated in this study, using other criteria, need to be carried out. PCH centers are in a unique position to perform such studies, as they use these instruments among large numbers of children and PCH is able to collect information on concurrent and predictive validity. The introduction of the Electronic Health Dossier can facilitate such studies and may contribute to a higher level of a scientifically founded PCH.

Generalizability of the results

All studies presented in this thesis, except the study in Chapter 2, assessed the validity and added value of short instruments when used as a method to identify children with psychosocial problems. The validity of measuring instruments is not an inherent characteristic of the instrument as such, but is related to the population among which and the situation in which it will be used. The studies presented were all done among largely representative samples of the Dutch population examined by PCH. Moreover, data collection took place in the normal, daily practice of PCH, before and during the normal routine health examinations, and thus reflected the situation in which the instruments will be used. This means that the conclusions of these studies may be generalized to the actual practice in Dutch PCH in which these instruments will be used. However, a word of warning is in order here because there are three problems that must be born in mind.

The samples were largely representative. However, the percentage of parents and children from ethnic minority groups participating in these studies is smaller than in the population as a whole. This is a problem, since there are indications that ethnicity is a factor related to the problems reported by parents and to the identification by Dutch
PCH. Reijneveld et al., for example showed that the prevalence of parent-reported problems on the CBCL is higher among children from the former Dutch colonies and children from economic immigrants than among children from the indigenous population. They also showed that PCH identified more problems among children whose parents were economic immigrants and that there was no relation between identification and the CBCL Total Problem Score for this group, whereas there was a clear association among indigenous children. Therefore, the under-representation of children from ethnic minorities may mean that the generalizability cannot be extended to include this entire group.

The under-representation of children/parents from migrant communities may have been caused by three factors. The first is that parents and children from ethnic minority groups may show up less often when invited for a routine PCH health examination. In as far as this is the case, it does not affect the representativeness of the data for the population that does receive PCH care. A second factor may be that parents from ethnic minority groups do show up for routine health examinations, but are not willing or not able to answer paper-and-pencil questionnaires. Vogels et al. showed that 16% of parents from non-OECD countries who showed up for the routine health examination, did not fill in the questionnaires; for parents of Dutch origin this was only 8%. Clearly, our findings are not shown to be valid for children and parents not participating for this reason. Moreover, although a large majority of non-OECD parents did participate, our findings may not yet be considered as valid for these parents either: the number of these parents participating was far too small to determine with any acceptable degree of confidence the sensitivity of the questionnaires for these groups. The third factor that may have contributed to the under-representation of ethnic minorities in our studies is that PCH services in the largest cities did not participate in our studies. Clearly, this also limits the generalizibility of our findings.

A second word of warning concerns the fact that the studies in this thesis evaluated the instruments as questionnaires to be answered prior to a routine health examination. This reflects the way in which most PCH departments use such questionnaires. Sometimes, however, they are used as a pre-selection tool in which only parents or children with a score above a certain cut-off point are invited for a further examination. It may very well be that parents answer the questionnaires in a situation like that with a different attitude from when they know that a standard examination will follow. Based on this thesis, using the questionnaires evaluated prior and in preparation for a routine health examination may be considered as evidence-based; using them as a pre-selection tool may not.

The third warning to bear in mind concerns the way the questionnaires are actually being used as part of the standard health examination. The instruments were evaluated as a method to identify children who may have problems, using certain cut-off points. An elevated score on these questionnaires can be compared to a signal like an alarm clock going off and we determined the sensitivity and specificity of that signal as an indicator for possible problems. Discussions and conversations with individual PCH professionals, however, strongly show a considerable variation in the way in which these questionnaires are used in current day-to-day practice. Sometimes, the cut-off point is changed, sometimes it is not used at all, for example because the individual
professional simply does not know that there is a defined cut-off point. Some professionals tend to consider some items as far more important than other. Sometimes the phrasing of questions or answering categories is changed, based on the feeling that the new phrasing is better. Once again, using adapted questionnaires or using them in a way different from the way they have been evaluated here, must be considered as non evidence-based. It will probably lead to more individual variation between professionals and to a lack of standardization for this part of the PCH’s Basic Working Package.

So, some restrictions can and should be made regarding the generalizability of the results of the studies presented in this thesis, especially regarding children from ethnic minorities and regarding possible deviations in day-to-day practice from the way these instruments should be used. Despite these restrictions, our results can be considered valid for the very large majority of the population under PCH care in the age of 5 to 14. Overall, the proper use of these instruments will enhance the identification of children with problems.

The validity and feasibility of a CAT need to be determined in a real-life situation

Chapter 8 explored the possibilities of an IRT-based Computer Adaptive Test for the identification of children with problems. The results strongly suggested that such a procedure could result in a very accurate identification, similar to or better than short paper-and-pencil questionnaires evaluated in this thesis. We also showed that such a procedure is very efficient, needing, on average less than twelve questions to determine whether a child scores above or below a chosen cut-off point. As a consequence, most parents need to spend only a few minutes filling them in before this result is achieved. This presents the opportunity of asking them for additional information that can be rated on more specific scales, such as Internalizing and Externalizing problems.

Our findings were based on a simulation study. Therefore, the results of this study have not yet proven that such a CAT would be a valid and efficient procedure in day-to-day practice as well. Therefore, before this CAT is implemented, there must be a trial run to evaluate the procedure in real life.

An IRT-based CAT can only be used if a computer is available. This may be a problem, as at the moment, not all parents can use computers. Furthermore, computerized tests offer not only more accurate and efficient measurement; they can also automatically calculate scale scores, so the PCH professional does not need to spend time doing the scoring himself.

In the meantime an Internet-based application has been developed. This will be used in a study that will determine the validity and efficiency in real life and will explore which conditions must be met in order to be able to implement this procedure effectively.

The implementation of questionnaires in day-to-day practice needs attention

Overall, we may conclude that the questionnaires evaluated in this thesis can help PCH to improve the identification of children with psychosocial problems. What we did not determine is whether they actually do so, when used in daily PCH practice. This is not self-evident. Earlier we mentioned that the way in which questionnaires are used by different organizations and different individual PCH professionals varies. This probably reduces the actual added value these questionnaires are capable of providing when used for the identification of children with problems. The fact that the Dutch association of
regional health centers (GGD Nederland) has decided to develop a systematic procedure for the implementation of the SDQ in PCH for 7- to 12-year olds is an important step forward and should be extended to other age groups and other questionnaires. Further research is needed to assess exactly how questionnaires are being used in practice in relation to the question whether their use actually improves the identification of children in need of help. Only then will we be able to label this part of the Uniform Basic Working Package as evidence-based.

9.3 Implications

Implications regarding PCH practice

Clearly, validated questionnaires can improve the identification of children with psychosocial problems. So, PCH should use them in daily practice, whenever possible and feasible. It should ensure that available questionnaires are used as intended. That means that the questionnaires evaluated in this thesis should be used in combination with a high-quality assessment during the routine health examination and not as a pre-selection tool. It also means that such questionnaires should not be changed, even if there are arguments to do so, for example because the phrasing could be improved here and there. Even small changes can seriously impair the validity of a questionnaire. It also means that cut-off points, defined on the basis of research evidence, need to be taken seriously and adhered to.

PCH professionals who are going to use questionnaires have to be taught how to use them, how to interpret the results and what to do when they find an elevated score. This needs to be monitored by some form of quality management. GGD-Nederland has to be complimented for its efforts to develop a well-considered program for the implementation of the SDQ in PCH practice. Such programs should be expanded to encompass other questionnaires, too.

This study addressed the identification of children with problems in the context of standard health examinations. This is an essential part of PCH’s Basic Working Package. However, the number of routine health examinations for children aged 4 and older is limited to just a few and could be considered insufficient for tracking down problems occurring between two consecutive health examinations. Currently, Care and Advice Teams (Zorg- en AdviesTeams, ZAT) are being set up in and around schools for primary and secondary education. These ZATs are an important safety-net for children, providing a service allowing for a more or less continuous identification of children with problems. PCH is expected to participate in these ZATs but its participation is not considered as being part of the uniform part of the Basic Working Package. This anomaly should be addressed as soon as possible.

Unfortunately, when a child is identified as having a problem and in need of help, such help is not always available, or not at the appropriate time. Referring to the criteria developed by Wilson and Junger this fact is sometimes used as an argument against the need to develop or to use good identification methods in PCH. This is both short-sighted and in defiance of one of the essential responsibilities of PCH in the
Netherlands. It is short-sighted because high-quality identification not only means that children with problems will be referred, but also that fewer children without serious problems will be referred. A high-quality identification therefore helps to ensure that the available capacity in mental healthcare and other services is used for those children who need it most.

The argument that high-quality identification procedures are less urgent because health services do not have the capacity needed to handle these problems is also in defiance of one of PCH’s essential responsibilities: PCH is obliged to monitor Public Health, not only for the immediate benefit of individual children, but also in order to provide authorities with information about what kind of health problems need attention and which kind of care has to be developed to ensure that those in need of help can indeed receive such help. Only high-quality identification procedures can result in reliable and valid prevalence data which can be used by policy makers.

Based on this thesis and the discussion of the findings the following recommendations can then be made:

1. For the identification of children with problems PCH should not rely on the clinical judgment of individual professionals alone, but should use methods and instruments which have been shown to be valid.
2. It should use these instruments as they were validated and for the purpose for which they were evaluated; changes should only be allowed after new validation studies.
3. The introduction of instruments in PCH practice should be carefully planned and should be embedded in a continuous implementation and quality management program, ensuring that all staff members know how to use them and continue to use them as intended.
4. A lack of adequate youth healthcare services should be considered as a major argument in favor of a high-quality methods to identify children with problems, not used as an argument against it.
5. The identification of children with problems in the ZAT-context must be seen as an essential addition to their identification in the routine health examination. The participation of PCH in these ZATs must be redefined and included in the Uniform Part of the Basic Working Package.

Implications for research

This thesis reported on the validity and added value of several questionnaires for the identification of children with psychosocial problems in PCH services provided for children aged 5 and 6, 7 to 12 and adolescents. Unfortunately, for children under 5 no validated questionnaires are available. Data clearly indicate that although PCH for younger children identifies many children as having problems, it also misses many children with serious indications that problems are present. PCH is aware of this problem and repeatedly expressed a need for such questionnaires. Therefore, research into ways to filling this gap is clearly needed. Also, although studies showed that the KIVPA and the LSPPK questionnaires can improve the identification, they were shown to have serious shortcomings. In the 7 to 12 age group the SDQ performed better.
Research to assess whether it would be feasible to replace the LSPPK and the KIVPA by the SDQ would therefore be desirable, the more so as this would lead to comparable data between the different assessment moments.

Dutch PCH has a legal obligation to monitor the health of all children from 0 to 19. However, for adolescents above 14 years of age no systematic monitoring or care is provided. This gap needs serious reconsideration. Methods need to be developed and tested to ensure that youngsters in this age group who are in need of support are actually identified as well. Internet-based techniques, based on Computerized Adaptive Tests like the one described in Chapter 7, may be very helpful for this purpose.

It is now generally agreed that using information on psychosocial problems from one source only will inevitably lead to an incomplete picture.\textsuperscript{18,19} Most studies reported in this thesis, however, relied solely on one source, either the parent or the child. The reason for this was that until now, a standardized collection of data from more than one source has not been common practice in PCH. At the moment several PCH centers are considering including multiple-source data collection as part of their care for individual children. At least one center does so already. Internet-based computerized adaptive tests may prove an attractive method in realizing such a multiple-source data collection, as they require a minimal amount of effort from respondents (for example, teachers).

As mentioned earlier, this thesis showed that short questionnaires may improve the identification of children with problems by PCH, but did not prove that they actually do so when used in daily practice. Available evidence suggests that the way in which questionnaires are used varies considerably between individual professionals and PCH centers. This means that more attention should be paid to the actual implementation of questionnaires in daily practice and whether they are used in such a way that they will effectively improve the identification of children with psychosocial problems.

Elevated scores on short questionnaires like those evaluated in this thesis are valid indicators of the likelihood of the presence of certain problems. However, they offer no absolute certainty, neither do they provide enough information to assess the exact nature of the problem, its seriousness and the need for professional support. For this to be achieved a further assessment is required. At least part of this assessment, inevitably, has to be performed by PCH itself, as it would not be feasible to refer all children with an elevated score to a Youth Care Office (Bureau Jeugdzorg, BJZ). Until now, no standardized methods have been developed for PCH to perform such assessments. This may be a contributory factor in variation between individual PCH professionals. Thus, there is a clear need for the development and evaluation of assessment methods assessment to be used by PCH when short questionnaires indicate the likelihood of the presence of problems. Methods which may be considered here are, for example, hiring personnel with specific expertise, using some form of standardized interviews aiming at the assessment of problems, or other assessment systems, like the Development And Well-being Assessment procedure.\textsuperscript{20}

The identification of psychosocial problems by PCH in a well connected chain of care with all its partners is one of the current political priorities. The first identification of children with psychosocial problems, the assessment needed after the first signal, and the determination of the kind of help or support needed, all cost time. So does co-
operation between institutions. How much time is not very clear, and it is necessary to
determine what extra time is needed for children who are identified as having problems.
Then, if the political priorities are to be taken seriously, funding for such a Working
Package should be made available.

So the following recommendations are made:

1. Methods and instruments need to be developed for all groups for which such
instruments are not yet available and/or validated, especially children under 5 and
adolescents over 14.

2. The quality of the identification of children with problems among ethnic minorities
needs to be assessed.

3. Instruments and methods need to be developed and validated which allow for a
systematic assessment by PCH of the nature and seriousness of problems and the
need for professional help, when short questionnaires indicate the likelihood of
problems.

4. Methods need to be developed to collect data from more than one informant;
especially since the Internet and computer adaptive testing may be promising
methods in this respect.

5. The question to what extent and under which conditions short questionnaires do
actually improve the identification of and care for children with problems in daily
practice needs to be addressed.

6. The validity and feasibility of a Computer Adaptive Test in day-to-day PCH
practice needs to be investigated.

7. Evaluating the relative merits of a number of comparable questionnaires is to be
preferred over the evaluation of a single questionnaire.

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