

Work Experience and Style Explain Variation Among Pediatricians in the Detection of Children With Psychosocial Problems

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ABSTRACT

OBJECTIVE: To assess whether variation in the proportion of children identified as having psychosocial problems by individual preventive pediatricians can be explained by pediatrician characteristics, over and above variations in the mix of children. Furthermore, to assess whether the characteristics of preventive pediatricians were related to the quality of problem identification.

METHODS: We used data from approximately 3070 children ages 5 to 6 years who were assessed during a routine well-child visit by a preventive pediatrician in the Netherlands (response rate 85.2%). We obtained data about parent-reported child problems by using the Child Behavior Checklist (CBCL), sociodemographic background of the family, and characteristics of the preventive pediatrician. After each assessment, preventive pediatricians reported whether they had identified any psychosocial problem in the child. Multilevel logistic regression analyses were used to assess whether variation in the proportion of children identified by preventive pediatricians as having a psychosocial problem could be explained by the characteristics of preventive pediatricians and whether these characteristics were related to the quality of problem identification.

RESULTS: Preventive pediatricians varied widely in the proportion of children identified as having psychosocial problems. Pediatrician characteristics such as work experience and work style (for example, on indication use of behavior questionnaires like the CBCL in routine care) explained about a quarter of this inter-pediatrician variation; child characteristics did not explain this variation even though characteristics like gender and parental education level were associated with likelihood of problem identification. More use of the CBCL and less use of the Teacher Report Form in routine care resulted in a better problem identification by preventive pediatricians. Work experience was not related to better problem identification.

CONCLUSIONS: Preventive pediatricians identify psychosocial problems in children in a standardized way, but important inter-pediatrician variation remains. This variation may be reduced further and quality improved by changing their work style and targeted training.

KEYWORDS: child mental health; physician decision making; public health

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WHAT'S NEW

The proportion of children identified with psychosocial problems varies widely between individual preventive pediatricians. This variation can partly be explained by preventive pediatrician characteristics such as work experience and style (ie, using behavior questionnaires).

INTRODUCTION

MANY CHILDREN SUFFER from psychosocial problems, such as social–emotional and behavioral problems.^{1,2} These children are likely to experience difficulties in various aspects of their daily functioning, which may be severe and persist over time.^{3,4} Early detection and treatment may improve the prognosis of these children.^{5,6}

Community pediatric services, offering routine health care services to the population as a whole, may provide

strong support in the early identification of psychosocial problems for children not yet under treatment. In the Netherlands, this early identification is a routine task for the Preventive Child Healthcare system (PCH).

Although the PCH is important for the early identification of psychosocial problems, several studies have shown a need for improvements in the identification of psychosocial problems by preventive pediatricians.^{1,7–9} Preventive pediatricians failed to identify psychosocial problems in approximately one-half the children whose parents reported serious problems on the Child Behavior Checklist (CBCL).^{1,8}

Vogels et al¹⁰ show that the proportion of children identified as having problems varies widely between individual preventive pediatricians. This variation could not be explained by the prevalence of problems or by differences in child background characteristics such as gender and age. However, it may be that variation between individual

preventive pediatricians can be explained by preventive pediatricians characteristics. For instance, one of the predictors of the identification of psychosocial problems is whether mothers disclose concerns about their child's psychosocial functioning to the physician.¹¹ Specific aspects of physician interview style and communication skills have been shown to increase the disclosure of these concerns.^{12,13}

The aim of this study is to assess whether characteristics of preventive pediatricians explain the variation between them in the identification of children as having psychosocial problems. Furthermore, we investigated whether the characteristics of preventive pediatricians were related to better problem identification by preventive pediatricians.

METHODS

A randomized controlled trial (RCT) was conducted in 2001/2002 to evaluate the effects of a training program for improving preventive pediatricians' diagnostic skills ($n = 58$) in a national sample of children aged 5 to 6 years ($n = 7737$, response 85.2%). The baseline data from the RCT were used to answer our research questions.¹⁴

SAMPLE

The sample was obtained in a 2-stage procedure. In the first step, all PCH services in the Netherlands (at that time 43) were asked to provide preventive pediatricians for the study; 25 agreed to do so. In total, 58 preventive pediatricians varying from 1 to 6 per PCH service participated. Further information on differences between participating and other preventive pediatricians was not available. The participating preventive pediatricians were a homogenous group. They were all physicians who had the same specialization, this training (specialization) was undertaken at institute, and they had a salaried employment of the PCH service. Preventive pediatricians have obligatory Continuous Medical Education, with evaluations every 5 years, similar to almost all other specialized Dutch physicians. Most participating PCH services operated in a mixed area (ie, a combination of urban and rural area), and 2 services of 25 operated in a large city. The participating services covered populations ranging from 162,000 to 760,608 in 2002.

In the second step, each of the participating preventive pediatricians had to provide a sample of 150 children ages 5 to 6 years. The sample was representative for the Dutch population.¹⁴ We included only the children who were assessed during baseline measurement periods of the RCT (ie, before the initial training of the preventive pediatricians; $n = 4007$). We excluded children of non-Dutch ethnicity, that is, those with at least one parent born outside the Netherlands, from the analysis because previous research has shown that preventive pediatricians have more difficulty in identifying psychosocial problems in non-Dutch children than in Dutch children.^{7,15} We also excluded children receiving treatment for psychosocial problems because their psychosocial problems could be expected to be known to preventive pediatricians already. We were left with a sample of 3070 children.

MEASUREMENTS AND PROCEDURE

The data were collected as part of the routine preventive health assessments provided regularly for all Dutch children. The parents completed the CBCL, a well-validated questionnaire about behavioral and emotional problems in the preceding 6 months.¹⁶⁻¹⁸ The CBCL comprises 120 problem items that are used to compute a Total Problems Score. We dichotomized the CBCL Total Problems Score for the analyses; children were allocated to a normal range or an elevated range, using the 90th percentile gender-specific cut-off points. The CBCL was mailed to parents with the standard invitation for the preventive health assessment. The completed CBCL was returned to the preventive pediatrician in a sealed envelope. The preventive pediatrician forwarded the envelopes to the research institute without opening them.

The preventive pediatrician routinely examined each child; part of this examination is a physical assessment of the child and an interview with the parents about mental health and background. The national guidelines for PCH were followed. After each assessment, the preventive pediatrician answered the following question: "Does the child have a psychosocial problem at this moment?" (yes or no) and scored the severity and type of problem(s) that had been identified. Preventive pediatricians generally have a time frame broader than only "at this moment" because they identify a psychosocial problem on the basis of the interview with the parents, and parents generally refer to a longer period before the routine examination.

The preventive pediatrician recorded the sociodemographic characteristics of the child and family: child age and gender, parental educational level and employment status, and family composition. Parental educational level concerned the greatest level of education completed successfully by a parent. Family composition focused on the number of parents in the family (two parents or one parent). These child characteristics are presented in Table 1.

We also obtained data about preventive pediatrician characteristics. At the start of the study, all participating preventive pediatricians completed a questionnaire about their own background. This questionnaire covered the preventive pediatrician's age and gender, work experience, use of behavior questionnaires as aids for early detection, and previous participation in courses for the identification of psychosocial problems. Work experience was expressed as the number of years working as a preventive pediatrician. "Use of questionnaires" concerned the extent (ie, always/on indication or never) to which each preventive pediatrician used the National Checklist for Indicating Psychosocial Problems in Five/Six Year Olds (LSPPK)¹⁹ and/or the CBCL and Teacher Report Form (TRF) during assessments.²⁰

In the Netherlands, the LSPPK is a frequently used questionnaire in PCH for detecting psychosocial problems among 5- to 6-year-old children during routine examinations. In services that use the LSPPK, all parents of 5- and 6-year-olds completed the LSPPK. The LSPPK has a cut-off point that results in 8% elevated scores.¹⁹ The CBCL and TRF were sometimes used by preventive

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