Pathways to Care

Help-seeking for child an d adolescent mental health problems

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Help-seeking for child an d adolescent mental health problems

Wegen naar zorg
Het zoeken van hulp voor emotionele problemen en gedragsproblemen van jeugdigen
(met een samenvatting in het Nederlands)

PROEFSCHRIFT

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‘In a perfect world, the mere presen ce of symptoms would be sufficient for people to desire and obtain treatment. Since this is not the case, knowing who receives care or who has a propensity to seek care informs us about what happens to people with mental health problems’ (Pescosolido & Boyer, 1999, p. 395).

Contents

1 Introduction

Introduction

The stud y described in this thesis address es the process of help-seeking for child and adolescent psychopathology in professional and informal serv ice settings, and variables influencing this process. This study w as part of the Second Du tch Nation al Survey of General Practice, which was cond ucted between April 2000 and January 2002. Additio nal data were collected fr om parents and children between Janu ary 200 1 and July 2003. This first chapter presents a short overvie w of the prevalence of child and adolescent psychopathology, and the stru cture of the Dutch mental health care system. The stud y objective and main research questions are described within the frame of the theoretical model behind this stud y. After discussing the design of the study, the chapter ends with a description of the outline of this thesis.

Background

Child emotional and behaviou ral problems in the community

Appro ximately o ne quarter of th e Dutch population (four millio n people) is und er 20 years of age (Centraal Bureau voo r de Statis tiek, 2005). The majorit y of these youngsters are doing well. A recent international survey showed that Dutch adolescents generally regard their lives as more positive than their peers in other European countr ies and North ern America. They have few psychosomatic complaints com pared to youn gsters in other countr ies, most of them live in stable family cond itions and they ten d to have relatively large networks of friends (Currie et al., 2004).

Still, a minority of ch ildren and adolescents in the general populatio n fare less well. They show emotio nal or behavioural problems, which impair their everyday functioning and well-being. Prevalence rates for these problems are comp arable over countr ies (Crijnen et al., 1997) and range from 17 % to 26 % for school-aged children (Briggs-Gowan et al., 2000; Costello, 198 9; Lavigne et al., 1996; Verh ulst et al., 198 5), with 7 % being rated as severely distu rbed by clinicians (Ver huls t et al., 1985). Comparable prevalence rates have been reported for adolescents (Ferguss on et al., 1993; McGee et al., 1990; Verhu lst et al., 1997a; Whitaker et al., 1990).

Despite the fact that these problems show considerable persistence (Verhu lst an d Van der Ende, 199 5) and can cause impair ment in children’s lives, they are rarely brought to the attention of general practition ers (GPs) (Foets et al., 1996; Ford et al., 2003) and mental h ealth

care professionals (Burns et al., 1995; Flisher et al., 1997; Leaf et al., 1996; Pavuluri et al., 1996; Saunders et al., 1994; Sourander et al., 2001; Verhulst and Van der Ende, 1997). Early identification and treatment of these problems may, however, be important for preventing persistence into late adolescence and adulthood (Angold et al., 2000). Therefore, insight into the help-seeking process for child and adolescent psychopathology, and possible barriers within this process, is needed. Before turning to the theoretical models of the help-seeking process used in this study, a short overview of the structure of the Dutch health care system for children and adolescents with emotional and behavioural problems is presented.

Health care for child emotional and behavioural problems in the Netherlands

Almost all Dutch inhabitants are registered within general practices. These practices are accessible to all and close to the community. Because every inhabitant is, in principle, covered by a private or public health insurance, major financial constraints to the availability of care are lacking, as opposed to the situation in for instance the USA. General practice is the formal point of entry into the Dutch mental health care system, and the GP is supposed to function as gatekeeper. This indicates that, formally, children are able to enter mental health care only after referral by their GP. Any study on child mental health care utilisation in the Netherlands should therefore include the GP and his role in the help-seeking process.

Dutch mental health care is part of a larger system of youth welfare work, aimed at children and adolescents with psychological, social or pedagogical/educational difficulties, their parents and other caregivers. Apart from child mental health care, this system consists of youth assistance work, judicial youth care, and care for youth with mild mental disabilities. This thesis is focused at the child mental health care part of Dutch youth welfare work.

In the Netherlands, child mental health care comprises institutes for ambulatory mental health care, psychiatric out-patient and in-patient clinics, which provide diagnostic assessment, treatment, and assistance to children or adolescents and their caregivers. In 2002, the capacity for part-time child mental health care consisted of 508 places, and 1,380 beds for clinical care (excluding admissions to psychiatric departments of academic hospitals) were available. The latter figure includes 137 beds

for which the financial means could also be used for other purposes, such as part-time or ambulatory care (College Tarieven Gezondheidszorg, 2003). Based on a population of approximately four million children, this corresponds with 0.13 part-time places and 0.35 clinical beds per 1000 children. The majority of care provided within Dutch child mental health care is ambulatory (67 % in 2002). Twenty-one percent of care is clinical, and 12 % is part-time (Van den Berg et al., 2004a).

As in many countries, demand for child mental health care in the Netherlands exceeds supply, as can be seen from the numbers of children on waiting lists. Table 1.1 presents these numbers for various stages in the process of getting treated. The first stage, the enrolment stage, refers to the period between enrolment in the mental health care system and intake. The diagnostic stage refers to the period between intake and treatment recommendation, and the third stage, the pre-treatment stage, includes the period of time between recommendation and first treatment contact.

Table 1.1 Waiting list data for Dutch child mental health care in 2002

Numbers of children waiting	Absolute	Per 1000 children
– in enrolment stage	4,072	1.0
– in diagnostic stage	7,217	1.8
– in pre-treatment stage	3,446	0.9
Length of waiting period (in weeks)		
– in enrolment stage	8	
– in diagnostic stage	6	
– in pre-treatment stage	18	

Data derived from waiting list registration (Taskforce Aanpak Wachtlijsten, 2002)

At present, changes are taking place within the Dutch system of youth welfare work, following the Law on Youth Welfare Work (Ministerie van Volksgezondheid, Welzijn en Sport and Ministerie van Justitie, 2004). This law aims to strengthen the positions of parents and children within the youth welfare system, to improve the quality of youth welfare work and to increase transparency in its structure. The law officially came into effect on the 1st of January 2005. From this date onwards, Youth Welfare Work Offices are the only entrance points into all youth welfare work. These offices assess each request for help and determine whether care is needed, and, if so, which type of care is appropriate. Thus, youth welfare offices form the link between detectors of child problems (e.g. parents, GPs, youth health care workers, school personnel) and providers of care

(e.g. child mental health care, judicial youth care). In principle, GPs are no longer supposed to refer children to mental health care directly. The sole exception to this rule is when the presence of a serious psychiatric disorder is suspected by the GP.

The study on which this thesis is based took place before the Law on Youth Welfare Work was implemented. At this stage, it is not clear which consequences these rather drastic changes in the structure of youth welfare work will have on the process of help-seeking for child and adolescent psychopathology.

Theoretical models of the help-seeking process

In past decades, several authors have formulated models to describe the process of help-seeking (Aday and Andersen, 1974; Andersen, 1995; Andersen and Newman, 1973; Fischer et al., 1983; Goldberg and Huxley, 1980; 1992), but few of these models specifically apply to help-seeking for child and adolescent psychopathology. Although the models differ in content and emphasis, they have some key elements in common. Firstly, help-seeking is assumed to be a stage-like process. An important example in this respect is the model by Goldberg and Huxley (1980; 1992), who distinguished between five levels at which mental health problems could be manifest: (a) in the community, (b) among attenders of primary care, (c) as recognised by primary care providers, (d) among individuals referred to ambulatory mental health care, and (e) among those admitted to mental hospitals. To move from one level to the next on the pathway to specialist mental health care, individuals are assumed to pass through filters, which separate the five subsequent levels from each other. Since these filters are selectively permeable, some individuals are more likely to pass through than others. The filters refer to (a) problem recognition by the individual and his decision to consult a GP, (b) problem recognition by the GP, (c) referral to mental health care by the GP, and (d) admission to in-patient mental health care (figure 1.1). Because this model is based on the British health care system, which is comparable to the Dutch system with respect to the gatekeeping function of GPs, a central role in the help-seeking process is attributed to the GP.

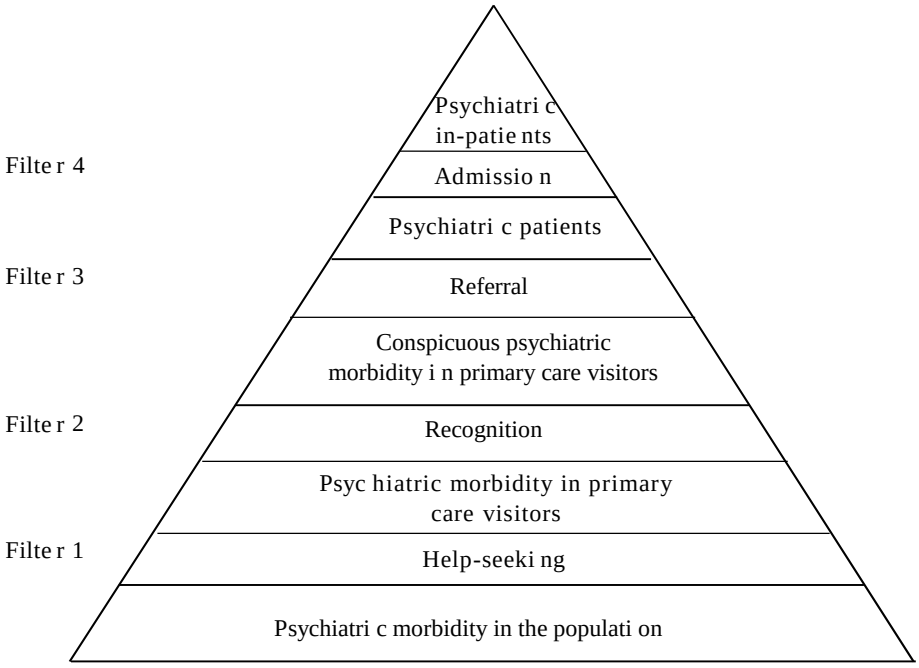

Figure 1.1 The process of help-seeking for mental health problems (Goldberg and Huxley, 1980; 1992)

This model was adapted by Verhulst and Koot (1992) to make it applicable to the process of help-seeking for mental health problems in children and adolescents. What differentiates help-seeking for children and adolescents from help-seeking for adults is the fact that not merely the child or adolescent himself, but also his parents and possibly other caregivers are involved. The first filter in the help-seeking model therefore refers to parents' recognition of problems in their child and their initiative to consult the GP for these problems.

Several investigators have expanded this general model. Logan and King (2001), for example, introduced parents' initial awareness of child problems as a stage preceding parental problem recognition. Costello et al. (1998) stressed the importance of including the broader social context in a model on help-seeking for child psychopathology.

A second central element of help-seeking models is the assumption that progress on the pathway to specialist care is influenced by other

variable s, which can either obstruct or fac ilitate progress through the various help-seeking stages. Not only characteristics of the child or adolescent, but also characteristics of the broader enviro nm ent (parents, family, social context) are hypothesised to influence the help-seeking process.

The filte rs in the model by Goldberg and Huxley repre sent selection processes that determ ine for which individuals help will be sought and at which level treatment will be obtained. Therefore, apply ing this model to the process of help-seeking for child and adolescent psychopathology by taking into accoun t recent adaptations to the model (Costello et al., 1998; Logan and King, 2001; Verhu lst and Koot, 1992), or - more specifically - investigating the filters and their correlates, will provide useful informatio n abou t variables enh ancing or obstru cting progress on the pathway to care. The central research questions of this thesis, which will be described in the following paragraph, focus on these filters.

In addition to studying the pathw ay to professional care provided by GPs and mental health care specialists, this study also explicitly includ ed informal sources of care, because parents more easily turn to friends, relativ es and teach ers than to more formal service provid ers for advice concerning child emotional or behavioural problems (Cohen et al., 1991; Pavu luri et al., 1996). Moreover, factors influencing professional help-seeking are not necessarily the same as those influencing informal help-seeking (Rickwood and Brai thw aite, 1994).

Objective and research question s

The central aim of this study w as to increase unders tand ing of the process of help-seeking for child and adolescent emotio nal and behavioural probl ems. Using the help-seeking models described above as central framework, the following research questions were address ed in the present study:

1. What are determ inants of various stages in the process of help-seeking for child and adolescent emotio nal and behavioural probl ems? Which variables in child, family, and con text are asso ciated with:
    a. parents' need for help for their children's emotional and behavioural problems?
    b. help-seeking in general practice for children's emotional and behavioural problems?

c. identification of children's emotional and behavioural problems by the GP?
d. help-seeking from mental health services for children's emotional and behavioural problems?
e. help-seeking from informal sources of care (teachers and friends or relatives) for children's emotional and behavioural problems?

2. To what extent are parental problem recognition and utilisation of professional and informal services associated with change in children's emotional and behavioural problems over the course of one year?

Study design

This study consisted of three stages, which are summarised in figure 1.2. An overview of variables and measures included in this thesis is presented in table 1.2. A more detailed description of the variables and instruments is given in the following chapters.

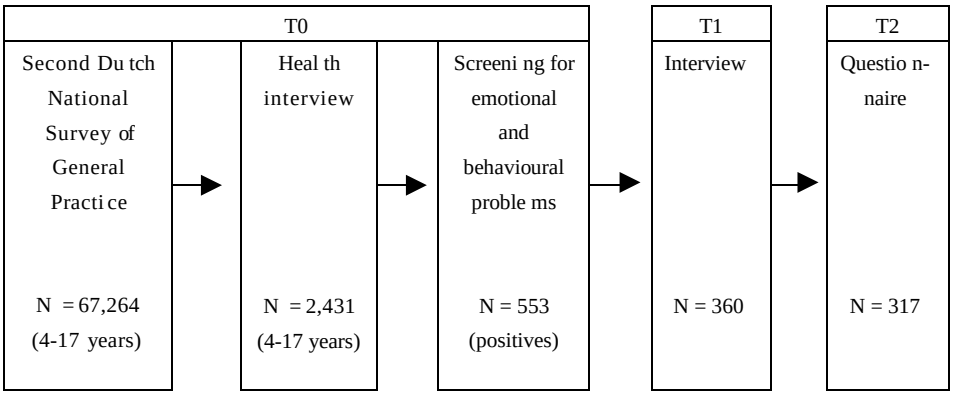

Figure 1.2 Study design and numbers of respondents

Data for the first stage were derived from the Second Dutch National Survey of General Practice, which examined morbidity and treatment in a representative sample of 104 Dutch general practices with 195 GPs and 385,461 listed patients, of whom 67,264 were between 4 and 17 years of age. Data were obtained in the period between April 2000 and January 2002 (Westert et al., in press). The participating GPs were representative for all Dutch GPs with respect to age, gender, region of residence, and urbanisation level. Single practices were underrepresented (Westert et al., in press). The patients listed in the participating general practices were

com parable to the general Dutch populatio n with respect to age, gender, and type of health insurance (Westert et al., in press).

During one calend ar year, all contacts with patients in the participating general practices were record ed, resulting in approxim ately 1.6 million contacts. Morbid ity presented to the GP during these contacts was electro nically registered using the International Classification of Primary Care (ICPC; Lamberts et al., 1993). Morbid ity data of eight practices were exclu ded because of incomplete data collection.

A random sample of the practice population (N = 12,699) particip ated in an extensive health interview survey, for which the total response rate was 64.5 %. The interv iews were carried out between December 2000 and December 2 001, spread over a whole year to avoid seasonal patterns. Participants were comparable to the practice populatio n with respect to gender, age, and place of resi dence (Westert et al., in press). Among them were 2,431 children and adolescents aged 4 to 17 years. For children aged 4 to 11 years , a proxy interv iew was adminis tered to one of the parents, wher eas adolescen ts (12 to 17 years) answered the questions themselves. The interview contained sections concer ning sociodemograph ic characteristics, health indicators, health care utilisation, life style, social context characteristics, and opinions abou t health care.

As part of the health interview, children and adolescents were screened for the presence of emotional and behavioural problems by means of the Child Behavior Chec klist (CBCL; Ac henbac h, 1991a), the Youth Self-Report (YSR; Achenbach, 1991 c), and the Teacher's Report Form (TRF; Achenbach, 1991b). Children and adolescents who sco red in the borderline or clinical range of the CBCL, TRF, or YSR Total Proble ms scale ($T \geq 6$)0were selected for participation in the next stage of the study (T1). Of the total num ber of 553 children and adolescents who were selected, 360 (65.1 %) agreed to participate. Respondents and non-respondents did not significa ntly differ in age, gender, CBCL and TRF Tota l Problems scores, but participating parents were more highly edu cated (Mann-Whitney U-test; $p < .05$) andparticipating adolescents had lower YSR Total Pro blems scores (T-test; $p < .05$).

In the next stage (T1), a standardised psychiatric interview, the National Institute of Mental Health Diagnostic Interview Schedu le for Children, vers ion 4 (DISC-IV; Shaffer et al., 2000), was administered to the child's primary caregiver to obtain psychiatric diagnos es. The youth version of

this instrum ent was used to obtain adolescent self-report data of the presence of psychiatric symptoms. In addition to this, parents were interviewed about child and fam ily characteristics, probl em recognition, and help-seeking for child emotional or behavioural problems in the preceding twelve months.

After one year (T2), parents were contacted again by mail. They were asked to complete the CBCL and a questionnaire that containe d questions com parable to the ones in the help-seeking interview at T1. Children aged 12 years and older were asked to fill in the YSR. In total, 317 of the origin al 360 particip ants respond ed (88.1 %). Respondents and non-respo ndents did not significantly d iffer in gend er, age, parental education level, CBCL Total Proble ms score s, and contact with professiona l or informal service providers at T1.

Table 1.2 Variables and measures include d in this thesis

	Database	Variables	Measu res
T0	Contact registra tion	Contact with general practiti oner	
		Diagnoses for:	ICPC
		- psychological problems (P-codes)	
		- social problems (Z-codes)	
	Health intervie w	Child gender	
		Child age	
		Child emotional and be havio ural proble ms:	
		- parent report	CBCL[a]
		- teach er report	TRF[a]
		- adolescen t report	YSR[a]
		Child school problems	
		Child chronic physical problems	
		General impre ssion of child health	
		Parental mental health problems	GHQ[b]
		Family constellation (single or two-parent family)	
		Parental education level	
		Family income	
		Type of insurance	

- table 1.2 con tinues -

- table 1.2 continued -

	Database	Variables	Measures
T1	Psychiatric interview	Psychiatric symptoms and impairment:	
		- parent report	DISC-IV-P
		- adolescent report	DISC-IV-Y
	Help-seeking interview	Parental problem recognition	
		Child special education	
		Mental health service use by relative	
		Family functioning	FAD[b]
		Presence of siblings	
		Changes in family structure	
		Help-seeking for child emotional/behavioural problems:	
		- in general practice	
		- from mental health services	
		- from teachers	
		- from friends or relatives	
T2	Questionnaire	Emotional and behavioural problems:	
		- parent report	CBCL[a]
		- adolescent report	YSR[a]
		Parental problem recognition	
		Child special education	
		Mental health service use by relative	
		Changes in family structure	
		Help-seeking for child emotional/behavioural problems:	
		- in general practice	
		- from mental health services	
		- from teachers	
		- from friends or relatives	

Note: ICPC = International Classification of Primary Care; CBCL = Child Behavior Checklist; TRF = Teacher's Report Form; YSR = Youth Self-Report; GHQ = General Health Questionnaire; DISC-IV-P = Diagnostic Interview Schedule for Children, parent version; DISC-IV-Y = Diagnostic Interview Schedule for Children, youth version; FAD = McMaster Family Assessment Device.

[a] See Appendix 1

[b] See Appendix 2

Chapter 3 of this thesis is based on data obtained in a previous study on psychopathology and mental health service use, conducted by the Department of Child and Adolescent Psychiatry of the Erasmus MC-Sophia Children's Hospital in Rotterdam, the Netherlands. For a detailed description of sample selection and methodology of this study, see Verhulst et al. (1997a).

Outline of the thesis

First, a literature study was conducted to investigate which factors in the child, parents, family and broader context were associated with help-seeking for child and adolescent psychopathology. *Chapter 2* of this thesis presents the results of this literature review, which was focused on determinants of problem recognition by parents and adolescents, help-seeking, and problem recognition by the GP.

In *chapter 3*, parent, family, and adolescent variables are investigated as correlates of adolescent mental health service utilisation, self-perceived need for help, and unmet need. This chapter is based on data from the Department of Child and Adolescent Psychiatry of the Erasmus MC-Sophia Children's Hospital in Rotterdam, the Netherlands.

Using theoretical models of the help-seeking process and previous findings, in *chapter 4*, a comprehensive model of the help-seeking process for child psychopathology is formulated, which includes several help-seeking stages as well as child, family, and context variables as possible determinants of these stages. This model is tested by means of structural equation modelling.

In *chapter 5*, structural equation modelling is used to investigate a path model concerning stages and actors involved in the process of help-seeking for adolescent internalising psychopathology.

Chapter 6 presents general population data on GP contacts for children and adolescents with psychological problems, and diagnoses of psychological problems by the GP. Various child and family characteristics are investigated as possible correlates of GP consultation and GP psychological diagnoses.

Chapter 7 addresses the association of parental problem recognition and utilisation of professional and informal services with change in child emotional or behavioural problems over the course of one year.

Finally, in *chapter 8*, the main findings of this study are summarised and discussed. Methodological reflections, recommendations for future research, and implications for clinical practice are presented.

2 Help-seeking for emotional and behavioural problems in children and adolescents

A review of recent literature

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Abstract

In order to understand the discrepancy between rates of child and adolescent psychopathology and rates of mental health service use, variables influencing the help-seeking process need to be investigated. The present article aims to extend and refine previous findings by reviewing 47 recent empirical studies on parental and adolescent problem recognition and help-seeking, and problem recognition by the general practitioner. Several variables (child age, the presence of medical and school-related problems, informal help-seeking, past treatment of parents or relatives, family size, and type of maltreatment) were discovered to influence parental/adolescent problem recognition and/or help-seeking, while refinements were found for the effects of type of psychopathology, child gender, adolescent attitudes and personality, parental psychopathology, social support, and sociodemographic variables. Although recent studies uncovered several determinants of problem recognition by the GP (child gender, age, past treatment, academic problems, family composition, life events, type of visit, and acquaintance with child), this aspect of the help-seeking pathway remains relatively uncharted, and therefore needs to be the focus of future research.

Keywords: help-seeking, child and adolescent psychopathology, problem recognition, mental health services

Introduction

Studies have repeatedly shown that a substantial number of children and adolescents suffer from emotional or behavioural problems (Brandenburg et al., 1990; Verhulst et al., 1997a). Although these problems can hamper everyday functioning and well-being, only a minority of disordered children and adolescents receive help from mental health services (Burns et al., 1995; Flisher et al., 1997; Leaf et al., 1996).

In order to improve our understanding of this discrepancy, it is important to investigate factors that influence the process leading to receiving professional help. The model proposed by Verhulst and Koot (1992) provides us with a useful framework in this respect. Following Goldberg and Huxley (1980; 1992), the help-seeking process for child and adolescent psychopathology is described as consisting of five levels, each separated by a filter. The filters refer to (1) parental recognition of the problematic nature of the child's behaviour and the subsequent decision to consult a general practitioner (GP), (2) recognition of the child's problems by the GP, (3) the GP's decision to refer the child to psychiatric

care, and (4) the psychiatrist's decision to refer the child from out-patient to in-patient psychiatric care. Several variables in the child, parents, family, GP and environment were hypothesised to influence these filters (table 2.1).

Although many researchers have acted upon the request for more research in this field, to our knowledge these findings have not been systematically reviewed in the decade following Verhulst and Koot's work. The present article will describe recent results concerning determinants of help-seeking for child and adolescent psychopathology, focusing on the way in which these results extend and refine previous findings. Confirmations of past findings will be mentioned only briefly. Our focus will be exclusively on the first two filters, in which parental and adolescent problem recognition and help-seeking, and problem recognition by the GP are central.

Table 2.1 Variables influencing filters 1 and 2 in the help-seeking process (adapted from Verhulst and Koot, 1992)

	Child	Parents and family	Environment	GP/ paediatrician
1 Parental help-seeking	Type of problems Severity of problems Gender	Awareness of problem Distress threshold Personality Psychopathology Attitudes and beliefs Education level Support from extended family Psychosocial family stress	Sociodemographic factors Availability of services	
2 Problem recognition by GP/ paediatrician	Type of problems Severity of problems		Sociodemographic factors Availability and use of screening measures	Training Interview style Personality Attitudes

Methods

Psychlit and Medline databases were searched for empirical studies published between 1992 and 2001, within a limited age range of 0-18 years, and restricted to publications written in English. To find studies dealing with the first filter, the keywords (child OR adolescent) AND (psychopathology OR psychiatry OR disorder OR behaviour problem OR emotional problem) were combined with the terms (help-seeking OR mental health service use), while studies concerning the second filter

were searched by combining the first keywords with the term s (recognition OR referral) AND (general practitioner OR paediatrician OR clinician). This res ulted in 70 hits for the first, and 36 hits for the second filter. We contin ued searching by means of the 'snowball method'.

Some countr ies provide the possibilit y of directly consulting a mental health profession al. As this kind of help-seeking was believed to be com parable to help-seeking from a GP in coun tries like the Netherlands and Great Br itain, both were in clude d as part of the first filte r.

Exclud ing non-empirical and methodological articles, 47 publications were selected as relevant for our review, with 35 publications apply ing to the first filter (table 2.2), and 12 to t he second filter (table 2.3).

Results

Child characteri stics influencing the first fi lter

Alt hough the presence of child psychopathology does not automatically lead to par ental problem recognitio n (Pavuluri et al., 1996), th e chance of concern about, and help-seeking for child psychopathology was confirmed to increase with comorbidity (Gasq uet et al., 1999; Harris, 1996), and with in creas ing severity and pers isten ce of problems (Bark er and Adelman, 1994; Burns et al., 1995; Farmer et al., 1999; Garland et al., 1996; Harris, 1996; Leslie et al., 200 0; Sourand er et al., 2001). Adolescents' experience of psychological dis tress and fun ction al impairment was confirmed to increase their help-seeking (Leaf et al., 1996; Rickw ood and Braithw aite, 1994; Wu et al., 1999; 20 01).

Recent stud ies have provided contradictory results concerning the effect of type of child psychopathology on problem recognitio n and help-seeking. While several studies have confirmed the hypothesis of an increas ed chance of problem reco gnition and help -seeking for extern alis ing problems (C ornelius et al ., 2001; Pavu luri et al., 1996; Wu et al., 1999), others h ave found an op posite effect (Harris, 1 996), or no effect at all (Gasqu et et al., 199 9; Souran der et al., 2001; Verhu lst and Van der Ende, 1997).

The effect of the child's gender on parental problem recognition and help-seeking is depend ent on the age of the child. In childhood and ear ly adolescence more help is sought for boys, wher eas in late ad olescen ce, girls seek help more frequently (Feehan et al., 1994; Gasquet et al., 1997; 1999; Schonert-Reichl and Muller, 19 96; Zahn er and Dask alak is, 1997).

Table 2.2 Studies conducted since 1992 on filter 1 of the help-seeking process for child and adolescent psychopathology

Authors	N*	Age	Subjects	Sample	Variables included
Angold et al., 1998	1015	9-13	Parents Children	School-based sample of children scoring above a cut-off on part of the Child Behavior Checklist, demographic and service-use questions, as well as matched controls	Child psychopathology and impairment Impact of child's symptoms on family Parental mental health problems Sociodemographic variables Mental health service use
Barker and Adelman, 1994	471	16-20	Children	School-based sample of lower SES, ethnic minority backgrounds	Adolescent psychopathology and distress Social support Sociodemographic variables Accessibility and organisation of help services Mental health service use and attitudes towards seeking help
Briggs-Gowan et al., 2000	1060	5-9	Parents	Paediatric practice-based sample of children scoring at/above the subclinical range of the Child Behavior Checklist or rated as problematic by the Provider Rating Form, as well as controls without problems	Child psychopathology Parental mental health problems Stressors and social support Sociodemographic variables Mental health service use
Burns et al., 1995	1015	9-13	Parents Children	School-based sample of children scoring above a cut-off point on part of the Child Behavior Checklist, demographic and service-use questions, as well as matched controls	Child psychopathology and impairment Impact of child's symptoms on family Parental mental health problems Sociodemographic variables Mental health service use

- table 2.2 continues -

- table 2.2 con tinued I -

Authors	N*	Age	Subjects	Sample	Variables inclu ded
Cohen and Hesselbart, 1993	760	12-21	Parents Children	General population sample	Child psyc hopathology Sociodemograp hic variables Mental health servi ce use
Cornelius et al., 2001	196	14-16	Parents Children	Primarily treatment-admitted sample of fathers who met DSM-III-R criteria for substance abuse, as well as a self-selected control group	Adolescent psychopathology Parental mental health problems Sociodemograp hic variables Mental health servi ce use
Costello et al ., 1997	1256	9-13	Parents Children	School-based sample of American Indian and White children	Child psyc hopathology and impairment Sociodemograp hic variables Family devia nce and fa mily mental illness Mental health servi ce use
Cuffe et al., 1995	478	12-15	Parents Children	School-based sample of adolescen ts scor ing high on a depressi on or suicide scale, as well as a control-group	Adolescent psychopathology and impairment Sociodemograp hic variables Mental health servi ce use
Cunn ingham and Freiman, 19 96	6216	6-17	Parents	General population sam ple	Child mental an d general health and i mpairme nt Family member's mental health status Family str ucture Sociodemograp hic variables Mental health servi ce use

- table 2.2 con tinues -

- table 2.2 con tinued II

Authors	N*	Age	Subjects	Sample	Variables inclu ded
Curry, 1998	94	5-11	Parents	Non-rando m convenience samp le of Black parents	Child psyc hopathology Parents' attitu des towards and satisfaction with professio nal help Sociodemograp hic variables Mental health servi ce use
Farmer et al., 19 97	1015	9-13	Parents Children	School-based sample of children scoring above a cut-of f point on part of the Child Behavior Checkl ist, demograp hic and servi ce-use questions, as well as matched controls	Child psyc hopathology and impairment Impact of child's sym ptoms on family Sociodemograp hic variables Mental health servi ce use
Farmer et al., 19 99	1007	9-13	Parents Children	See Farmer et al., 1997	See Farmer et al., 1997
Feehan et al., 19 94	976	7-15	Parents Children	General population sample	Child psyc hopathology Sociodemograp hic variables Mental health servi ce use
Flis her et al., 19 97	1285	9-17	Parents Children	Multi-site comm unity sa mple	Child psyc hopathology and impairment Attitudes towards mental health servi ces Parental mental health status Percep tions of mental health stat us Sociodemograp hic variables Mental health servi ce use and barriers to servi ce use
Garland et al., 1 996	662	2-17	Caretakers	Sample o f children who were in foster care for at least 5 months	Child psyc hopathology Type of child maltre atment Mental health servi ce use

- table 2.2 con tinues -

- table 2.2 continued III -

Authors	N*	Age	Subjects	Sample	Variables inclu ded
Gasquet et al., 1 997	3287	12-20	Children	School-based sample	Adolescents' somatic and mental health Aspects of adolescen ts' daily life (leisure, sexu al relations) Quality of family relations Sociodemograp hic variables Mental health servi ce use
Gasquet et al., 1 999	868	12-20	Children	School-based sa mple of adolescen ts with probabl e psyc hiatric problems	Adolescent ps ychopat hology Adolescen ts' perceived physical health Social network suppor t Sociodemograp hic variables Mental health servi ce use
Harris, 1996	2881	10-19	Children	School-based sa mple of adolescen ts who did not recei ve professio nal help during the previous 3 months and w ho were never d iagnosed with a mental disorde r	Adolescen t self-reported health status Sociodemograp hic variables Adolescent problem recognitio n
John et al., 1995	1587	6-16	Parents Children Teach ers	General population sample	Child psyc hopathology, medical and sc hool problems Parental mental health Family functioning Sociodemograp hic variables Mental health servi ce use
Lavigne et al., 1 998	388	2-8	Parents Children	Paediatric practice-based sample of children scori ng above the 90 th percentile of the Child Behavior Checkl ist, and a matched control grou p of low scorers	Child psyc hopathology and impairment Parental psyc hopathology Family environm ent and life events Sociodemograp hic variables Mental health servi ce use

- table 2.2 con tinues -

- table 2.2 con tinued IV -

Authors	N*	Age	Subjects	Sample	Variables inclu ded
Leaf et al., 1996	1285	9-17	Parents Children	Multi-site comm unity sa mple	Child psyc hopathology and impairment Sociodemograp hic variables Mental health servi ce use
Leslie et al., 20 00	480	1-17	Caregivers Mental Health data sets	Sample of children who entered long-term foster care	Child psyc hopathology Child maltreat ment history and placem ent pattern Sociodemograp hic variables Mental health servi ce use
Logan, 2000	59	?	Parents Children	Sample of depresse d adolescents and a control group	Adolescent and parental psyc hopathology Quality of adolescent-paren t communicati on Parental awareness of adolescent problems Mental health servi ce use
McMille r and Weisz, 1996	192	7-17	Parents	Sample o f families admit ted to com munity mental health clinics	Parental perception of severity of child problems Parental atti tudes towards mental health servic es Sociodemograp hic variables Mental health servi ce use
Pavul uri et al., 1996	128	2.5-5	Parents	School-based sa mple of children scoring above a cut-of f point on the Behaviour Check List, Hyperact ivity Scale, and Internalising Disord er Scale, as well as matched controls	Child psyc hopathology Sociodemograp hic variables Mental health servi ce use and barriers to servi ce use
Pumariega et al., 1998	2405	11-19	Children	School-based, tr i-ethnic samp le	Adolescent psychopathology Sociodemograp hic variables Mental health servi ce use

- table 2.2 continues -

- table 2.2 con tinued V -

Authors	N*	Age	Subjects	Sample	Variables inclu ded
Rickwood and Braithwa ite, 1994	715	16-19	Children	School-based sample	Adolescent ps ychological i mpair ment/d istress Adolescen t person ality Adolescen t social supp ort Sociodemograp hic variables Mental health servi ce use
Saunders et al., 1994	4274	12-18	Children	School-based sa mple of adolescen ts who identified themselves as havi ng a mental health problem	Adolescen t psychopathology and physical health Adolescen t attitudes towards help-seekin g Adolescen t history of abuse, suici dal ideati on Sociodemograp hic variables Mental health servi ce use
Schonert-Reic hl and Muller, 1996	221	13-18	Children	School-based sample	Adolescent pers onalit y variables Sociodemograp hic variables Mental health servi ce use
Sourander et al., 2001	857	8-16	Parents Children Teach ers	General popu lation samp le	Child psychopathology (reported by parents, teach ers, adolescen ts) Sociodemograp hic variables Mental health servi ce use
Verhuls t and Van der Ende, 1997	2227	4-18	Parents	General population sam ple	Child psyc hopathology, school problems an d ph ysical health Parental psyc hopathology Parental perception of child psychopathology Family functioning and life events Sociodemograp hic variables Mental health servi ce use

- table 2.2 con tinues -

- table 2.2 con tinued VI -

Authors	N*	Age	Subjects	Sample	Variables inclu ded
Wu et al., 1999	1285	9-17	Parents Children	Multi-site comm unity sa mple	Child psyc hopathology, impairment, and phys ical health Parental and child percep tions of the need for services Sociodemograp hic variables Parental history of mental health servi ce use Mental health servi ce use
Wu et al., 2001	206	9-17	Parents Children	Sample of children who met DSM-III-R criteria for depressive disorders	Child psyc hopathology and impairment Parental percep tion of the need for servi ces an d unmet need Sociodemograp hic variables Maternal history of mental health servi ce use Mental health servi ce use
Zahner et al., 19 92	822	6-11	Parents Teach ers	School-based sample	Child psyc hopathology and impairment Parents' and teach ers' percep tion of need for help Sociodemograp hic variables Mental health servi ce use and barriers to servi ce use
Zahner and Daskalakis, 1997	2519	6-11	Parents	School-based sa mple	Child psyc hopathology, i mpair ment, ph ysical he alth, and sc hool problems Parental perception of need for help, and attit udes towards help Family stressors Sociodemograp hic variables Mental health servi ce use

* Number of subjects in last stage of the study

Table 2.3 Studies conducted since 1992 on filter 2 of the help-seeking process for child and adolescent psychopathology

Authors	N*	Age	Respondents	Sample	Variables included
Briggs-Gowan et al., 2000	1060	5-9	Parents	Paediatric practice-based sample of children scoring at/above the subclinical range of the Child Behavior Checklist or rated as problematic by the Provider Rating Form, as well as controls without problems	Child psychopathology and possible child abuse Parental mental health problems Stressors and social support Sociodemographic variables Mental health service use
Brugman et al., 2001	4480	5-15	Parents Child health professionals	General health service-based sample	Parents' perception of child psychopathology Child health professionals' perception of child psychopathology Child academic problems Sociodemographic variables Past treatment for child psychosocial problems Life events
Evans and Brown, 1993	232	8-14	Parents GPs	GP practice-based sample	Child psychopathology Parents' and GPs' perception of the need for services Mental health service use
Horwitz et al., 1992	1886	4-8	Parents Clinicians	Paediatric practice-based sample	Parents' and clinicians' perception of child psychopathology Sociodemographic variables Characteristics of clinical visit
Horwitz et al., 1998	1148	4-8	Parents Paediatricians	Sample of children scoring high on the Child Behavior Checklist or identified as having a psychological problem by their physician, as well as randomly chosen controls	Parental and paediatrician's perception of child psychopathology Sociodemographic variables Parental help-seeking intentions and actual help-seeking

- table 2.3 continues -

- table 2.3 continued I -

Authors	N*	Age	Respondents	Samp le	Variables include d
Kelleher et al., 1 997	10250	4 -15	Parents Clinicians	Primary practice-based samp le	Parents' and clinicians' perception of child psyc hopathology Clinicians' attitud es towards mental healt h care Clinicians' training and experie nce Family functioning Type of insurance Visit charact eristics Sociodemograp hic variables
Kelleher et al., 1 999	14910	4-15	Parents Clinicians	Primary practice-based samp le	Parents' and clinicians' perception of child psyc hopathology Sociodemograp hic variables
Kelleher et al., 2 000	21065	4-15	Clinicians	Primary practice -based samp le	Clinicians' identificatio n of child psychosocia l problems Visit charact eristics Sociodemograp hic variables Type of insurance
Kramer and Garralda, 1998	136	13-16	Parents Children GPs	GP practice-base d sample	Adolescen t psychological and physical healt h and i mpairment GPs' percept ion of adolescent psychopath ology Maternal psycho pathology Sociodemograp hic variables
Lavigne et al., 1 993	3876	2-5	Parents Paediatric ians Child psyc hologists	Paediatric practice-based sample of children scoring above the 90 th percentile of the Child Behavior Checklist, a s well as a matched control grou p of low scorers	Parents' perception of child psychopathology Paediatric ian's perception of child psyc hopathology Psyc hologists' perception of child psyc hopathology/impairment Sociodemograp hic variables

- table 2.3 con tinues -

- table 2.3 con tinued II -

Authors	N*	Age	Respondents	Samp le	Variables include d
Stiffman et al., 1997	792	13-17	Children Servic e provide rs	Health care an d welfare servi ce-based sample	Child psyc hopathology Provide rs' perceptio n of child psychopathology and of problems in identifying child psyc hopathology Sociodemograp hic variables Mental health servi ce use
Wissow et a l., 1994	234	0.5-14	Parents Paediatric ians	Paediatric practice-based sample	Child behavio ur and developme nt Parental psyc hosocial distre ss Patie nt-physic ian comm un icatio n

* Number of subjects in last stage of the study

This finding may result from the fact that externalising problems, which are more prevalent in boys than girls, tend to decrease with age, whereas internalisi ng problems, whic h are more typical for girls, tend to increase with age.

The child's age per se has also been found to be ass ociated w ith professi onal help-seeking, although debate remains concer ning the nature of this asso ciation. Some investigators have found help-seeking to be increa sed in middle and la te adolescence compa red to early adolesce nce (Gasqu et et al., 1997; Leslie et al ., 2000; Schon ert-Reich l and Muller, 1996), whereas others (Cohen and Hess elbar t, 1993) have found a decrease in mental health service use in late adolescence. Verhuls t and Van der Ende (1997) found the child's age only to be related to parental serv ice need, and not to service utilisatio n.

While some researchers found s elf-consciousness and self-worth to be negatively related to adolescents' professio nal help-seeking (Schonert-Reichl and Muller, 19 96), others found s elf-consciousn ess and the willingness to disclose one's mental health only to be related to adolescents' informal help-seeking (Rickw ood and Braithwaite, 1994), which, in turn, was foun d to increase the chance of adolescents seeki ng profession al help (Saund ers et al., 1994).

The presence of additio nal medical and s chool-related pr oblems has repeatedly been shown to increase help-seeking for child psych opathology (Flish er et al., 1997; Gasqu et et al., 1997; Jo hn et al., 1995; Zahner and Daskalak is, 1997). Since school problems did not increase parental problem recognitio n, this may indicate the importance of the teacher in the detection and referral of disordered c hildren (Verhu lst and Van der Ende, 1997).

Parent and family characteri stics influencing the first fi lter

Recent find ings confirmed the notion that parental problem recognition and help-seeking is depend ent on the amoun t of distress or burden parents experie nce in raising their child, rather than on the level of child psych opathology per se (Angold et al., 1998; Farmer et al., 1997; 1999; Logan, 2000; Wu et al., 1999; 2001).

Confirmation has also been foun d for the influence of parental attitud es and beliefs (Flish er et al., 1997; Pavu luri et al., 1996), edu cation level (Farmer et al., 1999; John et al., 1995; Saund ers et al., 199 4), and family

stress (Cunn ingham and Freim an, 1996; Gasqu et et al., 1997; 1999; Lavigne et al., 1998; Sour and er et al., 2001; Zah ner and Dask alakis, 199 7) on help-seeking.

The presence of psy chological problems in th e parents has been shown to increase problem recognitio n, but not to increase mental health service need and utilis ation (Cor nelius et al ., 2001; Flish er et al., 1997; Verhuls t and Van der Ende, 1997). When parents or relatives received mental health care themselves, an increase in help-seeking for child psych opathology did show (Cunn ingham and Freiman, 1996). However, when a differentiation between general and professi onal help-seeking was applied, only the first was significa ntly related to the acquaintance with other mental health car e users (Rick wood and Braithwaite, 1994).

Family size proved to exert a com parable differential effect on parental problem r ecognition and help-seekin g, for it was found that the presence of siblings was related to a smaller chance of parents perceiving child behaviour as problematic (Verhu lst an d Van der Ende, 1997), but not to a decrease in the likelihood of these parents seeking help (Cornelius et al., 2001; Feehan et al., 1994; Ver huls t and Van der Ende, 1997).

The type of maltreatment children experienced has been shown to be asso ciated with service use for children in foster care. Active types, such as sexual or physica l abuse, are related to increa sed service use (Garland et al., 1996), while more passiv e types of maltreatm ent like neglect or caretaker absence are associated with decreased help-seeking (Leslie et al., 2000).

Characteristics o f the environment influencing the fi rst filter

The previou sly found association b etween low social su pport and parental help-seeking disap peared when a differentiation between determinants of informal and profession al help-seeking was applied (Rickwo od and Braithw aite, 199 4).

A negative associ ation bet ween ethnic minority status an d parental and adolescent help-seekin g has been found (Barker and Adelman, 1994; Costello et al., 1997; Cuffe et al., 1995; Cunningh am and Freiman, 1996 ; Leslie et al., 2000; Wu et al., 2001; Za hner and Das kalak is, 1997), but this asso ciation seem ed to disa ppear when socioeconomic variables were controlled for (Pumariega et al., 1998; Zahn er et al., 1992). Infor mal help-seekin g was found to be increased in minority groups and o ther cultures

(Curry, 199 8; McMiller an d Weisz, 1996; Pavuluri et al., 1996; Rick wood and Braithw aite, 1994).

The influence of sociod emograph ic facto rs like SES, income, and type of insurance on help-seeking seems to depend largely on a country's health care system. Whereas studies condu cted in the USA and Australia have found different effects of these variables on help-seeking (Briggs-Gowan et al., 200 0; Burns et al., 1995; Co hen and Hesselbart, 1993; Cun ningham and Freiman, 1996; Farmer et al., 1999; Flis her et al., 1997; Pavuluri et al., 1996; Saunders et al., 1994), stud ies in cou ntries lik e France, Finland and the Netherlands, in which health care is readily available, and where there are no major financial constraints to rece iving professiona l help, have not found an y associatio n between SES and help-seekin g, after controlling for the effect of SES on child psychopathology (Gasquet et al., 1997; 19 99; Sourand er et al., 2001; Verhuls t and Van der End e, 1997).

Child, parent, and family characteri stics influencing the second filter

Although identification of child psyc hosoci al proble ms in primary care increas ed significantly in prev ious decad es (Kelleh er et al., 2000), probl em recognition by the GP or paediatrician still forms an important barr ier on the way to specialis ed psychiatr ic help (Horw itz et al., 1998; Kelleh er et al., 1997; Kr amer and Garralda, 1998; Stiffman et al., 1997), as a significant num ber of disorder ed children are not identified as such by their phys ician (Brugman et al., 2001; Evans and Brown, 1993; L avigne et al., 1993). This could partly be due to the fact that parents and adolescents, who recognise their child's or their own probl ems, often do not mention these problems to th eir p hysician (Br iggs-Gowan et al., 2000; Horwitz et al., 1998; Kram er and Garralda, 1998).

Problem recogn ition was foun d to be greater for boys (Ho rwitz et al., 1992; Kelleh er et al., 1997), older children (Kelleh er et al., 1997), and children of single parents (Horwitz et al., 1992). Kelleher et al. (1997) found a lower proportio n of clinicia ns' recogn ition for African-American versus non-African-American children, but this associ ation failed to reach significance when sociodemograph ic factors were controlled for (Kelleher et al., 1999). This led the authors to be lieve that clinician biases may not be the primary ca use of ethnic differences in mental health serv ice use found in other studies.

Brugman et al. (2001) found problem recognition to be related to the severity of child psychopathology, past treatment for psychosocial problems, life events, and academic problems. When these factors were taken into account, the effect of sociodemographic factors on problem recognition disappeared.

Characteristics of the GP influencing the second filter

Confirmation was found for the effects of training (Stiffman et al., 1997), interview techniques (Wissow et al., 1994), and the availability and use of screening measures (Horwitz et al., 1992; Stiffman et al., 1997) on problem recognition by the GP.

Problem recognition was found to be lower for children with whom the physician was less well acquainted (Horwitz et al., 1992; Kelleher et al., 1997), and for acute care visits versus long visits, probably because developmental and behavioural issues are more likely to be discussed during long visits (Horwitz et al., 1992).

Discussion

Recent studies have provided extensions and refinements of variables described by Verhulst and Koot (1992) to influence parental/adolescent problem recognition and help-seeking and problem recognition by the GP.

The differential effects of several variables on parental/adolescent problem recognition versus help-seeking underline the importance of distinguishing between these aspects of the first filter in future research.

Recent results showed the importance of other sources of help for understanding the help-seeking process, as informal help-seeking and past treatment of parents or relatives proved to increase help-seeking for child psychopathology, and past treatment of the child proved to increase problem recognition by the GP. Moreover, differentiating between determinants of professional and informal help-seeking can be crucial for understanding the effect of certain variables on help-seeking.

School-related problems were found to play an important role in the help-seeking process, influencing both parental help-seeking and problem recognition by the GP. Future research should, therefore, focus on the role of school personnel in the detection, referral and provision of help for

child and adolescent psychopathology, and on the effect this exerts on mental health service use.

In spite of the apparent importance of the second filter, only a few studies have investigated variables influencing problem recognition by the GP. Although these studies have uncovered several determinants of the second filter not mentioned by Verhulst and Koot, it is often unclear whether these results are due to differential problem recognition by the GP or differential patterns of reporting by parents. For example, the increase of clinicians' problem recognition for boys (Horwitz et al., 1992; Kelleher et al., 1997) may also be due to the fact that boys have a greater chance of exhibiting externalising problems that cause disturbance in their environment, thereby increasing the chance of parents mentioning these problems to the GP. Clearly, much more research needs to be done to further unravel factors affecting problem recognition by the GP.

3 Factors associated with adolescent mental health service need and utilization

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Abstract

Objective: To determine the association of parent, family, and adolescent variables with adolescent mental health serv ice need and utilizatio n.

Method: Correlates of adolescent mental health service utilization, self-perceived need and unm et need were investigated in a general population sample of 1,120 Dutch adolescen ts aged 11 to 18 years (78 % response rate).

Results: 3.1 % of the sample had been referred for mental health services within the preceding year, and 3.8 % reported unm et need. 7.7 % of adolescents at risk for psychopathology, and 17.8 % of those indicatin g a need for help, had been referred. Family str ess and adoles cent's self-reported problems were most stro ngly associated with service need and utilization. Internalizi ng proble ms, female gender, and low education level were associated with self-perceived unm et need. Adolescent ethnicity and com petence in activities and school were associated with service use, but did not influence service need, while th e opposite effect was found for adolescent age and parental psychopathology.

Conclusion: In designing intervention programs aimed at increasing adolescent mental health serv ice use, distinctions should be made between efforts focused at adolescents not recognizing their problems, and those with unm et need.

Key Words: epidemiology, mental health services, adolescents, Youth Self- Report

Introduction

Stud ies have repeated ly shown that a substantial p roportio n of adolescents in the community meet criteria for emotional or behavioral psych opathology (Fergusson et al., 1993; McGee et al., 1990; Saund ers et al., 1994; Whitak er et al., 1990). Although these problems can hamp er everyd ay fun ctioning and well-being, many adolescents with disorder s do not receive specialist mental health services, while utilization of these serv ices in adolescence may be particularly salient for preventing persisten ce of psychopathology into adu lthood (cf. Feehan et al., 1993; Harr ington et al., 1996). Saunders et al. (1994) reported that 23 % of adolescents who identified themselves as having a mental health problem had sought profession al help in the preceding year. Likewise, 28 % of a sample of Finnish adolescents, whos e parents perceived them as having significant behavioral or emotional probl ems, had been in contact with mental health services. Of adolescents wh o perceived themselv es as having a serious problem, only 13 % had been referred (Souran der et al., 2001).

To understand the discrepancy between the proportion of adolescents with a psychiatric disorder, and the proportion receiving mental health care, it is important to investigate factors that influence the process leading to receiving professional help (Goldberg and Huxley, 1980; 1992; Verhulst and Koot, 1992). In an 8-year follow-up, Sourander et al. (2001) studied concurrent and predictive associations of several child and family factors and service use at age 16. At the age of 8, the most potent predictors of later referral were parent-reported total behavior problems and antisocial problems, the teacher's perception of the child's need for referral, and living in other than a biological two-parent family. At age 16, parent-reported externalizing, internalizing and total behavior problems, self-reported total competence, and family composition were associated with mental health service use.

Many studies on mental health service use for child and adolescent psychopathology treat help-seeking as a one-step process, i.e. they investigate whether or not help is being sought and which variables are associated with one or the other. However, because the majority of psychiatrically disturbed adolescents do not seek professional help, it is also important to know whether they feel the need to seek help but do not translate this need into help-seeking actions, or whether they do not at all recognize the problematic nature of their state. Therefore, to attain a more complete picture of the help-seeking process, studies should focus on correlates of mental health service need as well as utilization. Two studies that explicitly made this distinction are those by Saunders et al. (1994) and Verhulst and Van der Ende (1997). In a large school-based sample of adolescents, Saunders et al. found a history of abuse, poor self-rated physical health, suicidal ideation, and female gender to be related to adolescents' need for professional help. Actually obtaining professional help was associated with suicidal ideation, informal help-seeking, the interaction between race and socioeconomic status, parental marital status, and having had a medical check up within the previous year.

In a general population sample of children and adolescents aged 4 to 18 years, Verhulst and Van der Ende (1997) found the child's internalizing, externalizing, and academic problems, and family stress to be the most potent factors associated with mental health service need and utilization. Parental and family psychopathology, life events, the absence of siblings, child age, and the presence of a physical handicap in the child were associated with an increased chance of parent-reported mental health service need, but did not increase the likelihood of service utilization.

In addition to studying factors associated with mental health service need and utilization, it is also important to stud y correl ates of unmet need, which is defined as the presence of psychopathology and asso ciated fun ctional impairm ent, for which no mental health services have been receiv ed (Brewin et al., 1987; Flis her et al., 199 7). Seventeen percent of children and adolescents in the study by Flish er et al. met these criteria. Unm et need was significantly associated with indicators of socioeconomic disadvantage, parents' and children's opinions that the latter had poor mental health, parental psychopathology, poor school grades, and p arental beliefs regarding their child's opinion of mental health services.

We used a somewh at different definitio n of unm et need, as we did not includ e an objective measu re of psychopathology and functional impairment, but instead used adolescent self-reporting of a need for professi onal help without having obtained it as operatio nalization of unmet need. To distin guish between these different definitions of unm et need, we will refer to our operationalization as 'self-perceived unm et need'.

In our previous study cited above (Verhuls t and Van der Ende, 1997), we found that adolescents were especially reluctant to seek profession al help. The present study therefore aims at further unraveling factors influencing adolescent help-seeking.

Instead of treating help-seeking as a one-step process, the present stud y extends previous findi ngs by assessi ng three distinct aspects of adolescent help-seeking (mental health referral, need, and u nmet need) as related to characteristics of parents, adolescent, and family in a general populatio n sample of 1, 120 adoles cents aged 11 to 18 years. While our pr evious stu dy used parents as the main informants, the presen t study re lies on adolescent self-reports of service use and need and the presence of psychopathology, in addition to parental reports o f service use.

Method

Part icipants

The sample used in this article is part of a larger study on psych opathology and mental h ealth service use in a Dutch national sample of children and adolescents. We will describe the selection of the original sam ple (involving subjects aged 4 to 18 years), before describi ng the sample used in th e present study.

The target population for the original study consisted of all 4-to-18-year-olds who were of Dutch nationality and living in the Netherlands. Respondents were recruited using a stratified multi-stage cluster and random-sampling design. The population was stratified according to four country regions and four degrees of urbanization. A two-stage sampling procedure was followed, with a selection of clusters in the first stage, followed by a selection of individuals in the second stage. For each stratum, the number of clusters to be selected was determined. The eight largest cities were selected on the basis of cluster size and sampling fraction. Other municipalities were randomly selected within each of the strata with a probability of selection that was proportional to size. In this way, 81 municipalities were selected in addition to the eight largest cities. Municipalities were requested to send names and addresses of a specified number of subjects aged 4 to 18 years on January 1, 1993, equally divided across both sexes and selected randomly from municipal population registers that list all residents.

Trained lay interviewers with previous survey experience visited or phoned the parents to make an appointment for an interview, preferably with the mother. If parents were not initially reached, at least five callbacks were made on different days and at different times of the day. If the subject was 11 years or older, the interviewer handed out a copy of the Youth Self-Report (YSR, Achenbach, 1991c) and explained it to the adolescent. The adolescent was asked to complete the YSR in a room separate from the one where the parent was interviewed, to ensure that information from the adolescent was obtained independently from that of the parents. After the adolescent completed the YSR, it was checked for missing or incorrect information, and any questions were answered. Adolescents also completed a questionnaire concerning demographic features, self-perceived need for help, unmet need, and referral for mental health services. For a more detailed description of methodology, see Verhulst et al. (1997a).

A total of 1,120 adolescents aged 11 to 18 years (51.5 % boys, 48.5 % girls; response rate : 78 %) completed the questionnaires. Adolescents were included in the sample only if they were of Dutch nationality. Of the sample, 7.2 % had one or both parents who were of Mediterranean (mostly Hispanic, Turkish, or Moroccan) or non-Caucasian (mostly black or of Asian descent from former Dutch colonies) origin.

Parental education level was scored on a 7-point scale, with 7 being the highest level. The parent with the highest education level was used to dichotomize the sample in low education level (scores 0, 1, and 2), which comprised 33.7 % of the sample, and high education level (scores 3-7), which comprised 66.3 % of the sample. Adolescent education level was also dichotomized, resulting in 22.2 % scoring low (including no education, special elementary and secondary education for children with learning difficulties, and lower vocational education), and 77.8 % scoring high (ranging from general elementary to academic education).

Parental occupation level was scored on a 6-point scale, with 6 being the highest level (Van Westerlaak et al., 1975). If both parents worked, the score for the parent with the highest occupation status was taken. The sample was dichotomized, resulting in 54.2 % scoring low (scores 1-3), and 45.8 % scoring high (scores 4-6) on occupation level.

Measures

Youth Self-Report

The YSR (Achenbach, 1991c) was used to obtain standardized adolescent self-reports of problem behaviors and competencies over the preceding 6 months. The YSR has good reliability and discriminative validity in both American (Achenbach, 1991c) and Dutch samples (Verhulst et al., 1989).

The YSR scores were dichotomized into those in the normal range versus those in the borderline or clinical range of the distributions based on the Dutch normative sample. A *T* score of 67 was used as cutoff point for the syndrome scales, a *T* score of 37 as cutoff point for the competence scales, and a *T* score of 60 as cutoff point for the Total Problems, Internalizing and Externalizing scales (Achenbach, 1991c).

Current Demographic and Help-Seeking Features Interview

Three help-seeking variables were measured: (1) referral for specialized mental health services, (2) adolescent's report of having problems that are more serious than other adolescents' problems (problem recognition or need), and (3) adolescent's report of a need for professional help without having obtained it (self-perceived unmet need). Parent, family, and adolescent variables thought to be relevant for understanding the help-seeking process were assessed during the interview (table 3.1). All variables pertained to the 12 months preceding the assessment. All scores were dichotomized.

Table 3.1 Demographic and help-seeking variables included in the present study (N = 1,120)

Help-seeking variables
Adolescent report of referral for specialized mental health services (3.1 % yes vs. 96.9 % no)
Adolescent report of having problems that are more serious than other adolescents' problems (problem recognition or need) (10.5 % yes vs. 89.5 % no)
Adolescent report of need for professional help without having obtained it (self-perceived unmet need) (3.7 % yes vs. 96.3 % no)
Parent variables
Education level (66.3 % high [scored 0] vs. 33.7 % low [scored 1])
Occupation level (45.8 % high [scored 0] vs. 54.2 % low [scored 1])
Ethnicity (92.8 % Dutch [scored 0] vs. 7.2 % non-Caucasian or Mediterranean [scored 1])
Parental psychopathology (88.8 % normal range [scored 0] vs. 11.2 % at or above P90 [scored 1])
Family variables
One-parent family (8.1 % yes vs. 91.9 % no)
No. of children in family under 18 years (23.5 % one [scored 0] vs. 76.5 % more than one [scored 1])
Parent report of any change in family composition (3.0 % yes vs. 97.0 % no)
Adolescent variables
Gender (51.5 % boys [scored 1] vs. 48.5 % girls [scored 0])
Age (51.9 % 11-14 years [scored 1] vs. 48.1 % 15-18 years [scored 0])
Education level (77.8 % high [scored 0] vs. 22.2 % low [scored 1])

Note: All variables were entered as 1 = yes, 0 = no, unless noted otherwise

Statistical analyses

To determine the strength of the association between parent, family, and adolescent variables and the three help-seeking factors, simple logistic regression analyses were performed for each association separately.

Stepwise multiple logistic regression analyses were performed to determine the unique contribution of each of the parent, family, and adolescent variables to an increase in the likelihood of the help-seeking variables over and above the effect of all other variables. The hierarchical relationship of the eight YSR syndrome scales, the Externalizing, Internalizing, and Total Problems scale made it necessary to perform regression analyses on three different sets of variables: one including the Total Problems score, the second including Externalizing and Internalizing scores, and the third including the eight syndrome scales.

Results

Thirty-five adolescents (54 % boys; 46 % girls) reported a referral for mental health services in the 12 months preceding the assessment. This represents 3.1 % of the total sample. Of the 209 adolescents who scored in the deviant

range of the YSR Total Probl ems scale, only 7.7 % had been referred for mental health services. However, of the 35 adolescents who were referred, 45 % were in the deviant range on the YSR Total Problems scale.

Of the total samp le, 425 adolescents (37.9 %) perceiv ed themselv es as having a behavioral or emotional problem. Of these adolescents, only 6.4 % were referred for mental health services. Of the 118 adolescents (10.5 % of the total sample) who reported having a behavioral or emotional problem, more ser ious than other adolescen ts' problems, 17.8 % wer e referred.

Forty -two adolescents (3.8 % of the total sample) reported having a need for professio nal help, without having obtained it.

Simple logi stic regression analyse s

Results are listed in table 3.2. Only significant odds ratios are reported. Sociodemograph ic variables, such as eth nicity and adolescent education level, aspects of family composition, and adolescent problem and com petence scales were significantly related to mental health referral.

Adolescents' need for help was significantly associated with parental psych opathology, aspects of family compositio n, and all YSR problem scales. Girls and ol der adolesce nts were more likely t o report a need for help than boys and yo unger adolescents.

The likelihood of self-perceived unmet need was increased for girls, older, and less-educated adolescents. All YSR problem scales except for Wit hdrawn and Social Prob lems were identified as increasing the likelihood of self-perceived unm et need.

Table 3.2 Results from sim ple logistic regression analys es for three help-seekin g variables

	Mental healt h referral (N = 35)		Self-percei ved need for help (N = 118)		Self-percei ved unm et need (N = 42)	
	OR	95% CI	OR	95% CI	OR	95 % CI
Parent						
Education level						
Occupation level						
Non-Caucasi an or Mediterra nean	3.8	1.7-8.7				
Psyc hopathology			2.0	1.2-3.3		

- table 3.2 con tinues -

- table 3.2 con tinued -

	Mental healt h referral (N = 35)		Self-percei ved need for help (N = 118)		Self-percei ved unm et need (N = 42)	
	OR	95 % CI	OR	95 % CI	OR	95 % CI
Family						
One-parent family	3.2	1.4-7.2	2.3	1.4-4.0		
No. of children < 18						
Change in family compos itio n	5.5	2.2-14.1	4.7	2.5-9.1		
Adolescen t						
Gender			0.5[a]	0.4-0.8	0.4[a]	0.2-0.8
Age			0.4[b]	0.3-0.7	0.5[b]	0.3-0.9
Education level	3.4[c]	1.7-6.7			2.0[c]	1.0-3.8
YSR						
Activities	4.1	1.7-9.8				
Social	3.4	1.3-9.1				
School						
Total Comp etence						
Wit hdra wn			4.4	2.3-8.4		
Somatic Comp laints			2.8	1.4-5.5	3.0	1.1-8.1
Anxious/Depressed	5.3	2.3-12.3	6.5	3.8-11.1	4.2	1.9-9.5
Social Problems			2.9	1.6-5.5		
Thought Prob lems	5.2	2.2-12.4	4.9	2.7-8.8	2.7	1.0-7.1
Attention Proble ms	5.4	2.2-13.0	5.2	2.8-9.3	4.3	1.8-10.2
Delinquent Behavior	3.9	1.7-9.3	4.7	2.7-8.1	4.4	2.0-9.6
Aggressive Behavior	4.7	2.0-10.6	2.2	1.2-4.0	2.5	1.0-6.2
Internalizing	2.5	1.2-5.1	4.5	3.0-6.7	5.5	3.0-10.3
Externalizing	4.2	2.1-8.4	3.5	2.3-5.2	2.8	1.4-5.3
Tota l Prob lems	3.9	2.0-7.7	5.2	3.5-7.8	4.7	2.5-8.8

Note: All odds ratios we re significant at $p < .05$. Due to roun ding, some confidence interval s includ e the value 1.0, which was in fact somewh at larger. OR = odds ratio; CI = confidence interval; YSR = Youth Self-Report

[a] Greater likeli hood for gir ls versus boys

[b] Greater like lihood for older (15-18) versu s you nger (11-14) adolescents

[c] Greater likelihood for low versu s high education level

Multiple logistic regression analyses

Results are shown in table 3.3 for each of the three sets of variables separately. Only variables that were entered and not removed in the step wise regressi on procedure are listed. These variables contributed significantly to an increase in the likelihood of the presence of the help-seeki ng variable.

As in the simple logistic regress ion analyses, these analyses identified soci odemographic variabl es and aspects of family composit ion as significantly increasing the likelihood of mental health referral. YSR Total

Probl ems, Externalizing, two out of eight syndrome scales, and two com petence scales were also related to mental health referral.

The mult iple regression results for adolescen ts' need for help were similar to the simple regressi on results, with the exception that the effect of four YSR syndrome scales disapp eared when other variables wer e controlled for.

For sel f-perceived unm et need, the effects of adolescent age, Exter nalizing, and three YSR syndrom e scales disappeared in the multiple regression analys es, while the effects of adolescent female gend er, low educatio n level, YSR Total Problems, Internalizing, Anxious/Depressed and Delinquent Behavior remained significant.

Tabl e 3.3 Results from multiple logistic regressi on analyses for three help-seekin g variables

	Mental healt h referral (N = 35)		Self-percei ved need for help (N = 118)		Self-percei ved unm et need (N = 42)	
	OR	95 % CI	OR	95 % CI	OR	95 % CI
I. Analysis including YSR Total Prob lems						
Family						
One-parent family	3.6	1.5-8.7	2.3	1.3-4.1		
Change in family compos ition	9.5	3.3-27.2	6.5	3.2-13.5		
Adolescen t						
Gender			0.5[a]	0.3-0.8	0.4[a]	0.2-0.8
Age			0.5[b]	0.3-0.7		
Education level	2.9[c]	1.4-6.0				
YSR						
Activities	4.0	1.6-10.3				
School	0.2	0.0-0.9				
Tota l Prob lems	3.8	1.9-7.9	4.9	3.2-7.4	4.8	2.6-9.1

- table 3.3 con tinues -

- table 3.3 con tinued -

	Mental healt h referral (N = 35)		Self-percei ved need for help (N = 118)		Self-percei ved unm et need (N = 42)	
	OR	95 % CI	OR	95 % CI	OR	95 % CI
II. Analysis includ ing YSR Int and E xt						
Parent						
Non-Caucasi an or Mediterran ean	2.7	1.1-7.0				
Family						
One-parent family	2.9	1.2-7.3	2.8	1.6-5.0		
Change in family compos ition	7.3	2.5-21.6	6.0	2.9-12.4		
Adolescen t						
Gender			0.5[a]	0.3-0.7	0.4[a]	0.2-0.8
Age			0.4[b]	0.3-0.7		
Education level	2.8[c]	1.4-5.8			2.0[c]	1.0-3.8
YSR						
Activities	4.1	1.6-10.7				
School	0.2	0.0-1.0				
Externalizing	3.5	1.7-7.3	2.3	1.5-3.6		
Internalizing			3.6	2.3-5.7	5.6	3.0-10.6
III. Analysis includ ing YSR syndrom es						
Parent						
Non-Caucasi an or Mediterran ean	2.8	1.1-7.3				
Psyc hopathology			1.8	1.1-3.1		
Family						
One-parent family	2.5	1.0-6.4	2.2	1.2-4.1		
Change in family compos ition	5.5	1.9-16.0	5.7	2.7-12.1		
Adolescen t						
Gender			0.5[a]	0.3-0.8	0.4[a]	0.2-0.8
Age			0.5[b]	0.3-0.8		
Education level	3.2[c]	1.6-6.6			2.0[c]	1.0-3.8
YSR						
Activities	5.3	2.1-13.5				
Wit hdra wn			2.3	1.0-4.9		
Anxious/Depressed	4.0	1.5-10.5	4.0	2.1-7.8	3.9	1.7-9.2
Thought Prob lems	3.5	1.2-9.7	2.7	1.3-5.5		
Delinquent Behavior			3.2	1.8-6.0	3.3	1.5-7.6

Note: All odds ratios we re significant at $p < .05$. Due to rounding, some confidence intervals includ e the value 0.0, which was in fact somewh at larger. OR = odds ratio; CI = confidence interval; YSR = Youth Self-Report; Int = Internalizing; Ext = Externalizing

[a] Greater likeli hood for gir ls versus boys

[b] Greater like lihood for older (15-18) versu s you nger (11-14) adolescents

[c] Greater like lihood for low versus high educatio n level

Discussion

Of our total sample of Dutch adolescents, 3.1 % were referred for mental health services. This figure is lower than the 5.8 % reported by Saund ers et al. (1994) and the 7 % reported by Sourander et al. (2001). These differences may be ascribed to differences in definitions of mental health serv ice use, differences in prevalence rates for adolescent psychopathology between n ations (Verhu lst et al., 1993; Verhu lst et al., 2003), or differen ces in the organization of mental health services in the nations un der stu dy.

Of the adolescents scoring in the deviant range of the YSR Total Problems scale, 7.7 % had been referred for mental health services, whereas of the adolescents who perc eived themselves as having an emotio nal or behavioral problem, only 6.4 % had been referred. These findings are lower than the 13 % and 14 % referr al foun d for parent-reporte d Tota l Proble ms and parent reports of their child h aving a behavior al or emotional problem (Verhu lst and Van der Ende, 1997). The differences may partly be ascribed to the fact that the 1997 study involved children as well as adolescents, wher eas the present study involved only adolescents. However, a com parable difference in the predictive value of parent-reported versus adolescent-reported p roblems was found by Sourander et al. (2001), who found p arental perceptio ns of problems to be related to 2 8 % referral, wher eas adolescents' perceptions were related to 13 % referral. Appar ently, adolescents who recognize the problematic nature of their be havior and feelings are less likely than parents to translate their concern into help-seeki ng actions, and they are less able to single-handedly initiate mental health service use.

The finding that mental health s ervice use increased from 6.4 % for adolescents perceiving themselves as having an emotional or behavioral problem, to 17.8 % for adolescen ts who perceiv ed their problems to be seri ous, indicates the importance of adolescent problem recognition for mental health servic e use. However, probl em recognition is not a sole prerequisite for mental health servic e use, as 3.8 % of the total sample of adolescents reported a need for help, without having obtained it.

Our operationalization of unme t need resulte d in a considerably lower figure than Flish er and colleagu es' (1997) more objectiv e measure of this concept (3.8 versus 17 %). By using a self-report measu re of unmet need, adolescents with disorders who do not recognize the problematic nature of their state are not taken into account, resulting in an underestimation of unmet need. On the other hand, adolescen ts who report u nmet need

themselves are the ones who are best motivated to obtain care, and the use of a self-report measure will therefore help to identify those adolescents at whom interventions can be directed.

Remarkable is the finding that only 45 % of the adolescents who were referred for mental health services in the preceding year, also scored in the deviant range of the YSR Total Problems scale. This finding is in sharp contrast to the 71 % of referred children scoring in the deviant range on the CBCL Total Problems scale (Verhulst and Van der Ende, 1997). As was previously found (Sourander et al., 2001), parent evaluations of child symptoms are apparently more strongly associated with service use than adolescent self-reports, indicating the importance of parents in initiating mental health service use.

Parent factors

Simple as well as multiple analyses showed a significant effect of ethnicity on adolescent mental health referral. Adolescents from non-Caucasian or Mediterranean descent were more likely to have received mental health care than Caucasian youths. This finding is in contrast with previous studies (Cuffe et al., 1995; Cunningham and Freiman, 1996; McMiller and Weisz, 1996; Wu et al., 2001), in which ethnic minority status was associated with a lower likelihood of children and adolescents receiving mental health care. We should, however, keep in mind the relatively small number of adolescents from ethnic minorities in the present study (N = 81), and the probable differences in status and living conditions of ethnic minorities in the countries under study.

After controlling for the effect of other variables, parental psychopathology was significantly associated with adolescents' perceptions of serious problems, indicating that adolescents with parents who have psychiatric disorders may have lower thresholds for reporting problems themselves. However, parental psychopathology was not significantly related to mental health referral.

Previous studies have provided contradictory results regarding the effect of socioeconomic variables such as education and occupation level on help-seeking for child psychopathology. In general, the influence of these variables seems to depend largely on a country's health care system. In countries where health care is not readily available to everyone, financial constraints are likely to influence service use, and socioeconomic factors are likely to influence professional help-seeking. In countries like France

and the Netherlan ds, however, where the health care system is organized in such a way that there are no major financial constraints to receiving profession al help, socioeconom ic variables h ave been found n ot to influence mental health service use, even after controlling for the effect of these variab les on child psychopathology (Gasquet et al., 1997; 1999; Sourand er et al., 2001; Verhu lst and Van der En de, 1997). The present find ing that parental education and occup atio n levels do not exert an influence on any of the three help-seeking variables is in concordance with these previous findings.

Family factors

As was previously foun d (Gasquet et al., 1997; 1999; Laitin en-Kris pijn et al., 1999; So urand er et al., 2001; Verh ulst and Van der End e, 1997), family factors such as living in a one-parent family and ch anges in family com position made a unique contribution to adolescent mental health referral and the perception of problems, even after controlling for the influence of other variables.

Alt hough the presence of sibl ings has been found to decrease the chance of parents perceiving their child's behavior as prob lematic (Verhu lst an d Van der End e, 1997), family size did not influence adolescent problem recognitio n or help-seeking. Maybe adolescents are more likely to use their peers instead of siblings as frame of reference against which they judge their behavior, wher eas parents are more prone to form an opinion of their child's behavior by com paring their children with each other.

Adolescent factors

The adolescent's report of the prese nce of probl em behavior was asso ciated with mental health service need, self-perceived unm et need and referr al. However, although Verhuls t and Van der Ende (1997) found b oth parent-reported externalizing and internalizing problems to be asso ciated with service need and utilization, in the present study differential effects of internalizing and externalizing problems on the three help-seeking variables w ere found. Whereas both intern alizin g and externalizin g problems were associated with adolescents' reports of serious problems, internalizing problems did not increase the likelihood of referral over and above the effect of externalizing problems. While adolescents sufferi ng from internalizing problems did recognize the problematic nature of their state, their need was not converted into referral, which was also reflected in the significant effect of internalizing proble ms on self-perceive d unmet need.

In the multiple logistic regression analyses, two of eight YSR syndrom e scales were associated with adolescent mental health referral, and four YSR syndromes were associated with adolescent perception of serious probl ems. While adolescents with poor competence in activities (i.e. low participatio n and skill in sports, hobbies, and jobs) and better school resu lts were more likely to be referred, these YSR com petence scales were not significantly asso ciated with adolescents' perceptions of serio us probl ems. Although these adolescents do not perceive themselv es as having problems, they are probably more likely to follow their parents' or teac hers' a dvice to seek help.

Adolescent girls had higher rates of self-perceived seri ous problems than adolescent boys, a fin ding also reported by Saund ers et al. (1994). However, mental health referral rates did not differ significantly for boys versus girls. This mismatch between problem recognition and help-seeking can also be derived from the significant association bet ween female gender and se lf-perceived unm et need.

A similar effect was foun d for age: older adolescents perceived themselves as having serious problems more often than you nger adolescents, but this serv ice need was not effectuated into referral. This finding is in concordance with the elev ated non-effectuated parent-reported service need for older children found b y Verhulst and Van der Ende (1997). The authors hypothesized that this find ing could be ascribed to adolescents' striv ing for autonomy, which makes them reluctant to actually seek help from professionals. The present results provide confirmation for this statement.

Alt hough parental education level was not asso ciated with any of the help-seeki ng variables, adolescent education le vel was significantly rel ated to self-perceived unm et need and mental health referral in the multiple analys es. Adolescents with low education levels were more likely to experience a need for help without obtaining it, and were also more likely to be referre d for mental health se rvic es.

Limitations

Because of differences between countries' health care systems, caution should be exercised in generalizing these find ings to nations with systems unlike the Dutch one, in which no major financial constraints hamper availability of services, and in which the general practitioner fulfills a gate- keeping role and mental health care can be obtained only indir ectly.

The prese nt study w as cross-sectional, thereby limiting the possibility of establish ing the causal directionality of the associations found. Future longitud inal studies are needed to further unravel factors influencing the process leading to mental health service utilization.

The results of this study may also be limite d because of the reliance on self-report data. We relied on adolescents' judgments of the presence of emotion al or behavior al problems, and it is unknown how many adolescents would have met formal diagnostic criteria. On the other hand, an adolescent's report of the presence of emotional or behavioral problems is probably a valid indicator of the distr ess the adolescent experiences. Moreover, adolescen ts' self-reports have been found to b e valid and reliable (A chenbach, 1991 c, Verhuls t et al., 1989), and clinical r esear chers have suggested that adolescents' self-reports are critical for the study of emotion al disturbance (Edelbro ck, 1987; Weissman et al., 1980).

The present study did not specifically address possible reasons for service need not being effectuated into referral (e.g. demand exceeding supp ly), but a study curren tly being condu cted does.

Finally, our datas et did not contain an y informatio n about adolescen ts' use of informal sources of help, such as family and friends. Since several researchers (e.g. Rickwood and Braith waite, 1994, Saun ders et al., 1994) have shown the importance of informal help-seeking for adolescents, and have shown that factors that influence professional help-seeking are not necess arily the same as those that influence informal help-seeking, future studie s should explicitly involve bot h kinds of help.

Clinical implication s

The distinction made in the present article between need for help, unm et need, and m ental health serv ice utiliz ation is valuable for designing new intervention programs. Adolescents who do not recognize the probl ematic nature of their state (i.e. those scoring in the deviant range of a screening instr ument for psych opathology, but not indicatin g a need for help) could benefit from interventions focused at providing information about the nature of mental health problems and how common they are. Adolescents who rep ort unm et need should be provid ed with informatio n about how and wh ere to get professional help. The latter kind of intervention may also be important for adolescents who are less conscious of their unm et need, but who do report a need for help which is not effectuated into referr al.

Indicators of family stress and the presence of problem behaviors were the most pote nt factors associ ated with adolescent mental health service need and uti liz ation. Differential effects were found f or internalizing and extern alizing behavior problems: wh ile both typ es of problems were related to service need, internalizing problems did not increase the likelihood of referral over and above the effect of externalizing problems. Adolescents with internalizing problems apparently do recognize their probl ems, but these concerns are not effectuated into mental health referral. Mental health professi onals and ot hers worki ng with adolescents should therefore focus their efforts to redu ce adolescents' thresholds for mental health service use specifically at adolescents with internalizing problems.

4 Help-seeking for child psychopathology

Pathways to informal and professional services in the Netherlands

This chapter has been submitted for publication as:
Zwaanswijk, M., Van der Ende, J., Verhaak, P. F. M., Bensing, J. M., Verhulst, F. C. Help-seeking for child psychopathology: Pathways to informal and professional services in the Netherlands.

Abstract

Objective: To test a model describing the process of help-seeking for child psychopathology in professional and informal service settings.

Method: Using structural equation modeling, associations between several help-seeking stages, and the influence of child, family and context characteristics upon these stages were investigated in 246 Dutch children (4-11 years), who were selected for having emotional or behavioral problems from a representative sample of children registered in general practices.

Results: School personnel play an important role in the process of help-seeking for child psychopathology, both in influencing service need, and in the provision of and the referral for help. Although the Dutch GP is supposed to be gatekeeper in the provision of mental health care, his role in help-seeking for child psychopathology is limited. Various family characteristics are shown to influence service need, informal or professional help-seeking. The influence of child characteristics on the help-seeking process is limited.

Conclusions: Interventions aimed at increasing child mental health service use should focus on improving school personnel's abilities to detect and help children with psychopathology.

Keywords: mental health services, child, psychopathology, health behavior, social support

Introduction

The pathway that leads to professional mental health care for children with psychopathology is paved with obstacles, causing a discrepancy between the number of disordered children in the community and the number of these children receiving professional care (Burns et al., 1995; Flisher et al., 1997; Leaf et al., 1996; Pavuluri et al., 1996; Verhulst and Van der Ende, 1997). Understanding which factors are involved in the help-seeking process may provide suggestions on how to increase service use for these children. A fruitful way to integrate findings on help-seeking stages and their determinants is to include them in one comprehensive model. Although many models concerning the help-seeking process have been formulated (Aday and Andersen, 1974; Andersen, 1995; Andersen and Newman, 1973; Fischer et al., 1983; Goldberg and Huxley, 1980; 1992), few specifically apply to help-seeking for child and adolescent psychopathology.

A first example is the model by Verhulst and Koot (1992), who have adapted the Goldberg and Huxley model (1980; 1992) to make it

app licable for child and adolescent help-seeking. In this model, help-seeking is described as consisting of five subseq uent levels, each separated by a filter. The filters refer to (1) parental problem recognitio n and consultatio n of a general practitio ner (GP), (2) problem reco gnition by the GP, (3) referral to psyc hiatric care, and (4) referral to in-patient psych iatric care. Because of the gatekeeping function of Dutch and Britis h GPs in the provi sion of mental health care, a central role is att ributed to the GP.

Logan and King (2001) have expand ed this model by includin g parents' initial awareness of child problems as a stage preceding parental problem recognitio n. Their definition of problem recognition explicitly involves an evaluative element, in which parents acknowledge that the child's probl ems are severe enough to require help-seeking. In this respect, it resembles A nders en's (cf. 1995) construct of perceived n eed for help.

The focus on the parental side of the help-seeking process is broa dened by Costello et al. (1998), who str essed the importance of family, school and context in their compreh ensive model of access to child mental health services.

To our knowledge, researchers have thus far only investigated particular help-seeking stages in isolation from each other, without testing a help-seeking model as a whole. Our aim is to combine several exis ting help-seeking models and findings on determinants of help-seeking into one com prehensive model (figure 4.1). Testing this model will not only provi de insight into the influence of several determinants on stages of the help-seeking process, but will also clarify the way in which the help-seeki ng stages influence each other.

Our focus is on the parent-mediated pathway to child mental health care. This does n ot imply a disregard of the roles o ther adults can play in the help-seeking process. By inclu ding several family- and context-based determinants, we acknowledge the ecological nature of the process. Our model does not includ e adolescent help-seeking, as this is characterized by more autonomy and i s influenced by different factors tha n help-seekin g for child psychopathology (Zwaanswijk et al., 2003 a).

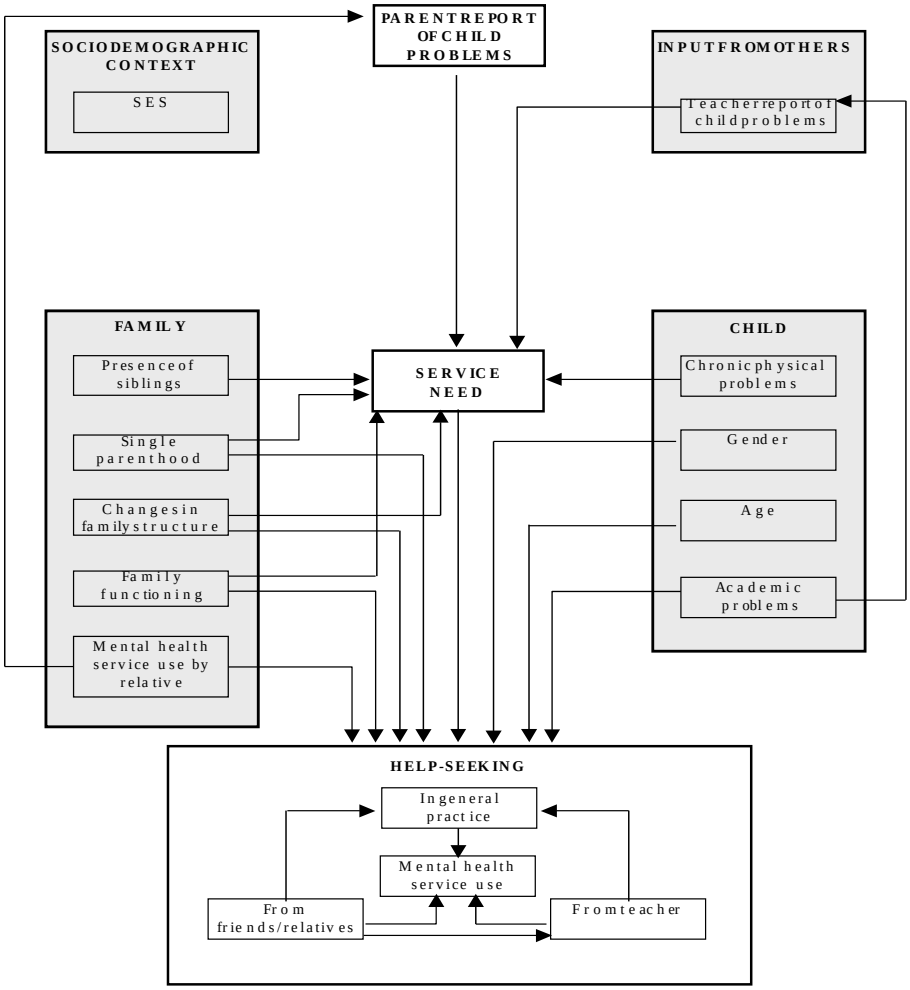

Figure 4.1 Theoretical model of the help-seeking process and its determinants

Following Logan and King (2001), the first step in the help-seeking process is assumed to be parents' initial awareness that their child shows problematic behaviors or emotions (Parent report of child problems, figure 4.1), followed by parents' need for services. Service need is defined as the presence of parent-reported psychopathology and associated functional impairment in the child (Brewin et al., 1987). This

operationalization is somewh at more objective than previously used measu res of service need, in which parents were directly asked wheth er their child w as in need of help (e.g. Verhulst and Van der End e, 1997).

Based on previous research and theor y (Logan and King, 2001; Verhulst and Van der End e, 1997), the following variables are expected to influence service need: child chronic physical problems, family fun ctioning, changes in family structure, single parenthood, the presence of siblings, and the teach er's perception of child psychopathology.

Help-seeking is investigated in both professio nal (general practice, mental health care) and informal service settings (teachers, friends /relatives). Because the threshold for seeking help from friends or re latives is considere d to be lower than for any other kind of service, we assum e this kind of help-seeking to precede the use of other services. By includi ng the GP as service provider, we acknowledge the gatekeeping role of Dutch GPs in the provis ion of mental health care, and have the opportu nity to explicitly examine this role.

Hel p-seeking is assumed to be i nfluenced by child gender, age, academic probl ems, family functioning, changes in family stru cture, single parenthood, and mental health service use by a relative (Briggs-Gowan et al., 2000; Feehan et al., 1994; Gun ther et al., 2003; Jensen et al., 1990; John et al., 1995; Lavigne et al., 1998; Rickwood and Braithw aite, 1994; Verhuls t and Van der Ende, 1997; Zah ner and Dask alak is, 1997).

Some differentiations regarding the influence of determ inants on the various components of the help-seeking process are includ ed. Firstly , based on previous results concerning the importance of the school in the detection of children with coexis ting academic problems and the provis ion of care to these children (Verhuls t and Van der Ende, 1997; Zahn er and Daskalakis, 1 997), acad emic problem s are expected to affect serv ice need through teach ers' perceptions o f child problems rather than through parents' report of child symp toms, and to be related to school serv ice use only.

Since the acquaintance with a relative who has used mental health care has been suggested to sensitize p arents to perceive problems in their child (Verhu lst and Van der Ende, 1997), an associatio n between this variable and parental rep ort of child problems is expected. Furthermore, mental health care use by a relative is assum ed to influence help-seeking

from friends or relatives only (Rickwood and Braithwaite, 19 94; Verhuls t and Van der Ende, 1997).

No major financial constraints hamper the availability of care in the Dutch health care system. In principle, all Dutch children are covered by private or public health insurance. As was found for co un tries with com parable financial availability of health care (Gasqu et et al., 1997; 1999; Sourander et al., 2001; Verhu lst and Van der Ende, 1997), the socioeconomic indicators includ ed in our model (edu catio n level, income, type of insurance) are expected not to affect service need or the utilization of service s directly.

Because of differe nces between health care systems, our theoretical model may not be directly applicable to nations in which health care depends more heavily on financial factors. In these coun tries, sociodemograph ic variables are likely to influence the help-seeking process (Briggs-Gowan et al., 2000; Pavuluri et al., 1996). Some systems als o provid e the oppor tun ity of consulting mental health care without GP referral. Nevertheless, we believe to provide a more generic method for studying help-seeking (i.e. by testi ng a compre hensive help- seeking model as a whol e instead of investigating its separate parts), whic h can be adapted to different health care systems.

Method

Part icipants

Our study involv ed a two-stage procedure. Data for the first stage were obtain ed from the Second Dutch Nation al Survey of General Practice, which examined morbidity and treatment in a representative sam ple of 104 general practices with 195 GPs and 385,46 1 listed patien ts, betw een April 2000 and Janu ary 2002 (Wester t et al., in press). A rando m sample of the practice p opulation (N = 12,699), inclu ding 1,497 parents of children aged 4-11 years, participated i n an extensi ve health intervie w survey (total respons e rate: 64.5 %). Particip ants of this survey were com parable to the practice population with respect to gend er, age, and place of residence (Westert et al., in press).

As part of the interview , 1,319 parents comp leted the Child Behavior Checklist (C BCL; Achenbach, 1991 a). Parents were also as ked permission to send the Teach er's Report Form (TRF; Achenbach, 1991b) to the teacher wh o was the most familiar with the child's functioning. Responses were receiv ed from 974 teach ers (180 respond ents refused to

give permission to contact the teacher, 64 teachers refused to coop erate, 96 teach ers did not respond, and 5 children were too young to attend school).

Childre n scoring in the borderline or clinical range on CBCL or TRF Total Proble ms scal e ($T \geq$ 60) were selecte d for partic ipation in the second st age of the study. Of the 362 selected children, 246 particip ated. Second stage respo ndents and non -res pond ents were com parable with respect to age, gender, a nd level of CBCL and TRF Total Proble ms scores. However, subjects who did not participate were more likely to be living in single-parent families (1 6 versus 8 %; p = .03), and to have parents w ith lower education leve ls (Z = -4.06; p = .00). Since these characteristics have been shown to be asso ciated with elevated levels of child problems, this study may und erestimate the prese nce of child psychopathology.

In the second stage, a stand ardized psychiatric interview (DISC-IV; Shaffer et al., 2000), was admin ister ed to the child's primary caregiv er to obtain psychiatric d iagnoses. Par ents were also asked details about their help-seeking actions.

Measures

Child Behavior Che cklist

The CBCL (Achenbach, 1991a) was used to obtain standardized p arents' reports of children's problem behaviors over the preceding 6 months. The CBCL has good relia bility a nd disc riminative validity in both American (Achenbach, 1991 a) and Dutch samples (Verhu lst et al., 1996).

Teacher's Report Form

The TRF (Achenbach, 1991b) was used to obtain stan dardized teach ers' reports of children's problems over the preceding 6 months. The good reliability and validity of the original TRF (Achenbach, 1991b) were confirmed for the Dutch version (Verh ulst et al., 1997b).

NIMH Diagnosti c Interview Schedu le for Children, versio n 4

This stru ctured interview (DISC-IV; Shaffer et al., 2000) is designed to assess ps ychiatric disorders in children and adolescents, using DSM-IV criteria (American Psychiatric Association, 1994). The presence of psych iatric sym ptoms as well as disor der-related impairment in fun ction ing is assess ed. Sections co ncerning anxiety disorders, mood disord ers, and disru ptive behavior disord ers were used to obtain an indication of servi ce need (see Statistical analyses).

Current Help-seeking Features Interview

Help-seeking from professional and informal sources in the preceding 12 months was measured, as well as several child, family and sociodemograph ic variables thought to be relevant for und erst anding the help-seekin g process (table 4.1). Parental education level was scored on an 11-point scale, with 11 being the highest level. The parent with the highest education level was used to tric hotomize the sample in low (scores 1-3), moderate (scores 4-8) and high (scores 9-11) education level. Family income was scored on a 5-point scale. Mean family income (2,168 euro) was comp arable to th e income of the general Dutch populatio n (Centraal Bureau voor d e Statis tiek, 20 05).

McMaster Family Assess ment Device

During the second-stage interview, the FAD General Fu nctioning scale (Epstein et al., 1983) was adm inistered to measure family functioning. This scale constitutes a reliable and valid global indicator of family fun ction ing (Byles et al., 1988).

Table 4.1 Characteristics of participants

		N*
Child		
Gender	43.9 % girls [scored 0]	246
Age	4-11; mean: 7.73; sd. 2.32	246
Academic problem s	38.9 %	244
Chronic physical problems	38.4 %	245
Family		
Presen ce of siblings	91.9 %	246
Single parenthood	8.4 %	237
Changes in family structure	10.2 %	245
Mental health servi ce use by relative	35.1 %	245
Soci odemograp hic context		
Type of insurance	53.5 % p ublic; 46.5 % private	243
Parental education level	13.1 % low; 51.0 % moderate; 35.9 % high	245
Family income	27.2 % ≤ € 1,849	235
	19.1 % € 1,850-2,249	
	26.0 % € 2,250-2,649	
	26.8 % € 2,650-3,149	
	0.9 % ≥ € 3,150	

* Numbers of re spondents for whom data were available

Statistical a nalyse s

Stru ctural equation mod eling (AMOS 4.0; Arbuckle and W othke, 1999) was used to test the applicability of the theoretical model (figure 4.1) to our data. Our model contained six latent variab les; all other variab les were included as observ ed variables. CBCL Inter nalizing and Extern alizin g scores made up the latent variable Parent report of child probl ems, whereas TRF Internalizing and Exter nalizing scores represented Teacher report of child probl ems. For the latent variable Family fun ctioning, the 12 items of the FAD General Fun ctioning scale were treated as obser ved variables. High scores reflect poor family fun ction ing. The laten t variable SES was measu red by variables indicating education level, family income, and type of insurance. Mental health service use was operationalized by tw o variab les indicatin g different types of mental health service use.

The latent variable Service need was operationalized by two DISC-IV variables, which indicated whether the child had *any* psychiatric diagnosis plus impairment on respectively inter nalizing (anxiety disord ers and mood disorders) or externalizing (disruptive behavior disord ers) diagnoses. Impairment was considered to be present when at least two out of six diagnosis-specific DISC-IV impairment items indica ting moderate, or one item indicating severe personal , soci al or academic difficulties were present. This operationalization of need corr esponds to the definition of impairmen t as a global rather than diagnosis-specific con cept (Bird et al., 2000).

Since chi-square has a tenden cy to indicate a significant probability level as sam ple size increases (generally above 200; Schumacker and Lomax, 1996), other fit indices were also inspected. Values of the Root Mean Square Err or of Approximation (RMSEA) < .05 were considered to indicate a close model fit (Browne and Cudec k, 1993). Values of the non-normed fit index (NNF I; Bentler a nd Bonett, 198 0), also known as the Tucker-Lewis coefficient (TLI; Tuck er and Lewis, 1973), close to 1 indicate a very good fit.

Results

To gain insight into the seriousness of child problems in our sample, numbe rs of childre n scoring in the deviant ra nge on CBCL and TRF Internalizing and Externalizing scales are reported in table 4.2. Note that contin uous rather than dichotomous scores on these scales were used in

the structural equation model. Rates of service need and service use are also reported in table 4.2.

Tabl e 4.2 Freq uencies of borderline/clinical Internalizing and Externalizing Probl ems, service need, and serv ice use

	Rater	%	N*
Internal izing problems	P	58.1	143 (246)
	T	33.3	69 (207)
Externaliz ing problems	P	52.8	130 (246)
	T	45.4	94 (207)
Internalizing + Externalizing problems	P	37.8	93 (246)
	T	17.9	37 (207)
Internalizing service need	P	15.0	37 (246)
Externaliz ing service need	P	20.3	50 (246)
Internalizing + Externalizing need	P	6.9	17 (246)
General practice	P	13.1	32 (245)
Mental health care	P	15.4	38 (246)
Teach er	P	28.6	70 (245)
Friends/relat ives	P	27.3	67 (245)

Note: P: parent; T: teach er

* In parentheses are the numbe rs of respondents for whom data were available

Figure 4.2 depicts, in a simplified vers ion of figure 4.1, the percentages of parents at various stages of the help-seeking process, thereby includ ing our assumptions concern ing the sequence of help-seekin g stages. For the sake of clarity, inter nalizing and externalizing disorders were combined. A total nu mber of 180 parents indicated th e presen ce of devian t internalizing and/o r externalizing problems in their child. To do justice to the notion that only some parents move from one help-seeking stage to the next, whereas others stay behind on a previous level (cf. Goldberg and Huxley, 1980; 1992), the percentages in figure 4.2 are hierar chically ordered. This means that 60 (33.3 %) of the children, who were regarded as having devia nt internalizing and /or externalizing problems, were *also* considere d to be in need for help. Twenty percent of children in need for help used mental health servi ces without consulting a GP, thereby passi ng by the gatekeeping role of the Dutch GP.

To increase our und erstan ding of the GP's gatekeeping role, we investigated pathways to mental health services from a retrospective point of view, i.e. with mental health service use as starting point. Of the 38 parents using mental health services for their children, 16 (43.2 %)

were referred by their GP, whereas 2 1 (56.8 %) of these parents ended up obtaining mental health care for their children through other pathways (information was not available for one child). Whereas one third of these parents reached mental health care directly, two thirds got there with the help of other servi ce providers, of which the majority came from school settin gs (school phys icians, school psychologists, edu cation al suppor t servi ces).

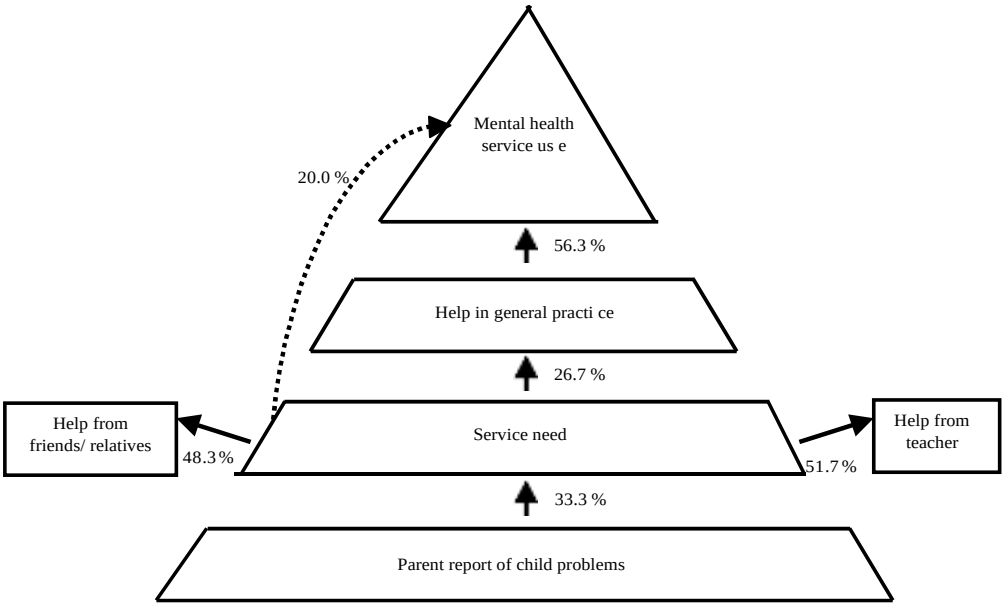

Figure 4.2 Percentages of parents at various stages of the help-seeking process

Evaluation of the structu ral equatio n model

Our initial theoretical model as depicted in figure 4.1 did not yield an adequate fit (χ^2 = 924.00; *df* = 498; $p < .001$; RMSEA = .059; NNFI/TLI = .957). To increas e model fit, some modificatio ns were made. Firstly, because of the considerable percentage of parents consulting mental health profession als directly rather than via the GP as gatekeeper (figure 4.2), the first modification include d addi ng a direct link bet ween servic e need and mental health service use, resulting in χ^2 = 907.73; *df* = 497; $p <$ .001; RMSEA = .058; NNFI/TLI = .958. Consequently, non-significan t

paths were deleted from the original model one by one, resulting in χ^2 = 934.82; df = 521; p < .001; RMSEA = .057; NNFI/TLI = .960. Finally, modification indices were inspected and only those with theoretical relevance and which resulted in a considerable improvement of model fit were imputed. Because these indices cannot be computed with incomplete data, they were computed for the part of the sample with complete data (N = 183). These indices suggested adding a path from Child gender to Teacher report of child problems, and adding correlations between (1) Child age and Academic problems, (2) Single parenthood and Changes in family structure, (3) Single parenthood and SES, and (4) Mental health service use by relative and Family functioning. This significantly increased model fit (χ^2 = 819.56; df = 516; p < .001; RMSEA = .049; NNFI/TLI = .970). Although a significant chi-square normally indicates an inappropriate model fit, we still perceive the model as appropriate, as indicated by other goodness-of-fit measures.

The structural part of this final model is depicted in figure 4.3. For a decrease in the complexity of this figure, parameters associated with the measurement model are not included. Within the measurement model, factor loadings for each observed variable were positive and significant at p < .001. Standardized loadings ranged from .35 to .85, with a median of .59.

Discussion

This study was aimed at investigating in one overarching model the process of help-seeking for child psychopathology in both professional and informal service settings. By means of structural equation modeling, characteristics of the child, family, and context were investigated as determinants of various stages in the help-seeking process.

In general, structural equation modeling proved to be a fruitful method for concurrently testing associations between various stages in the help-seeking process and their hypothesized determinants. We believe the merits of this method not to be restricted to countries with comparable health care systems, but consider it also useful as a more generic approach for clarifying the help-seeking processes in other countries. Although it is likely to produce different results depending on the health care systems in which it is used, a general use of this approach will increase comparability of results.

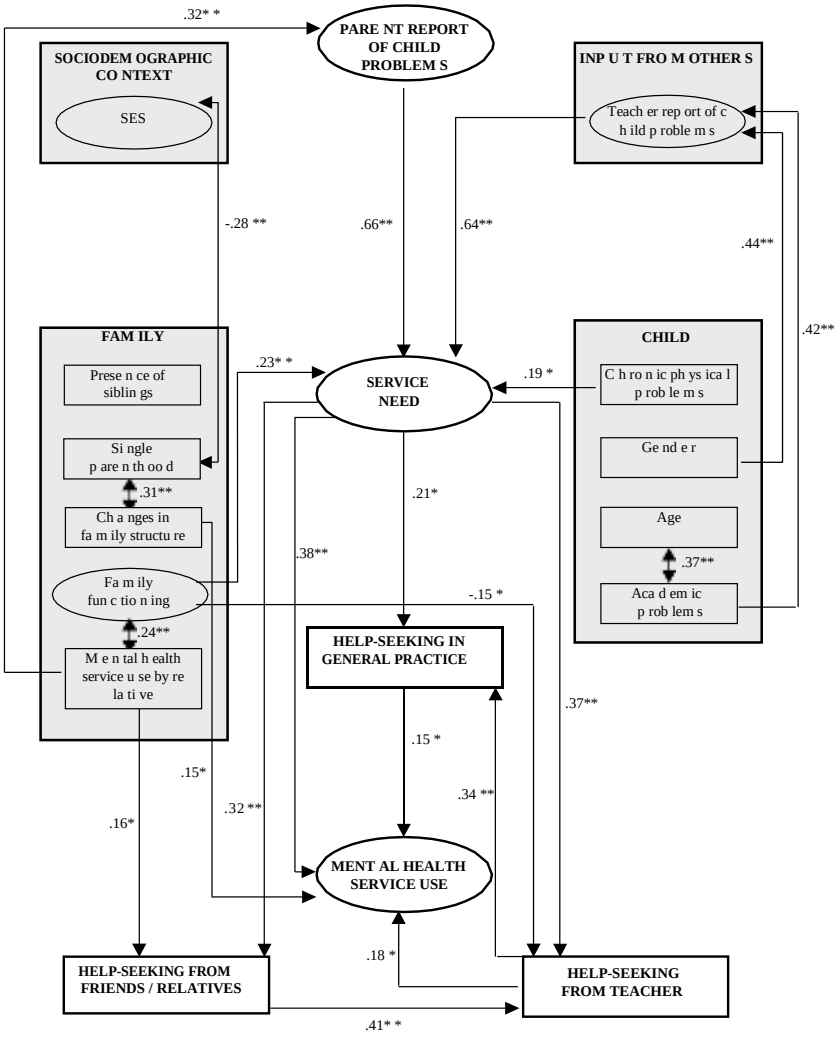

Figure 4.3 Final structural model. Rectangles and ellipses represe nt obser ved and latent variables, respectively. Presented are corr elatio ns (double-headed arro ws) and stan dardized regression weights (single-headed arrows). Param eters asso ciated with the measurement model were not includ ed to decrease the complexity of the figure. * $p < .05$ ** $p < .01$

Based on his gatekeeping role in the Dutch health care system, the GP was expected to play a central role in our model. Contrary to expectatio n however, both the percentages of parents at subsequent stages of the help-seeking process (figure 4.2), as well as the regress ion weights in our help-seeking model (figure 4.3) indicated that only a minority of children who are considered to be in need of help, actually received help from their GP. Apart from using the GP as a gatekeeper, many parents enter the mental health car e system dir ectly or with the help of other servi ce providers.

An explanation for parents seeking help from mental health serv ices without GP referral could be the fact that these help-seeking actions involved follow-up consultations for persis ting child problems. In that case, GP referral might have taken place over a year ago and therefore have fallen outsid e the time range assesse d in our study. Ho wever, of the 21 children who entered mental health care without GP referral, only 4 (19.0 %) had used the same kind of mental health care in the period *before* the year of asse ssment, and were therefore likely to be in long-term contact with these services. For th e remaining 81 %, this possibility was ruled out.

The limited role of the GP in the help-seeking process might be explained by the previously reported limitations of GPs in adequately recognizing emotion al and behavior al problems in young children (Kramer and Garralda, 1998). Future research is needed to investigate the influence of GP-characteristics on the help-seeking process. Results may provide suggestions on how to increase the importance of the GP in help-seeking for child psychopathology.

A considerable num ber of children entered mental health care with the help of school-bas ed service providers instead of the GP. During primary education, most Dutch children are routinely screene d for physi cal and psych osocial prob lems by school physicians and nurses. This screening app arently plays an importa nt role in the detection and referral of child psych opathology. In add ition to this, the teach er was found to be an importan t source of help. These findings are in concordance with previous studies, in which the edu cation secto r was indicated as the mos t common ly used source of help for child psychopathology (Burns et al., 1995; Farmer et al., 2003; Ford et al., 2003).

Several variables in child, family, and context were investigated as determinants of the help-seeking proce ss. Remarka bly, the impact of

child characteristics appeared to be marginal. Some of these variables (child gender and coexis ting academic problems) did exert their influence on the help-seeking process only indirectly, through their impact on the teac her's perception of child probl ems, whereas child age influenced neither service need nor help-seeking. The only child characteristic directly influencing the help-seeking process was th e prese nce of coexis ting chronic physical problems, whic h was associated with an increas ed service need (cf. Verhulst and Van der Ende, 1997).

Family characteristics had a stronger impact on the help-seeking process, although the previo usly found influence of family stru cture and size (i.e. single parenthood and th e presence of sibl ings; Briggs-Gowan et al., 2000; Jensen et al., 1990; Verhulst and Van der Ende, 1997) could not be detected in our data. Changes in family structure were shown only to influence mental health servic e use, without affecting service need or help-seeking in other settings.

Remarkable is the differential effect of family functioning on service need and help-seeking. Although service need is significantly presen t in poorly functioning families, parents in these families seem to experie nce barriers in act ually seeki ng teachers' help. In contrast with previous findings (Lavign e et al., 199 8; Verhu lst and Van der Ende, 1997), family fun ctioning was not directly related to other types of help-seeking.

As expected (Verhu lst and Van der Ende, 1997), the acquaintance with a relative who had used mental health serv ices increased the likelihood of parents perceiving problems in their child without directly increasing serv ice need. It also increased the chance of parents using support of family and fr ien ds (cf. Rickwood a nd Braithw aite, 1994). The presence of a relative who has consulted mental health services may indicate certai n willin gness to discuss mental health matters in the family system, which may facilitate help-seeking for child psychopathology within this system .

An important context factor influencing the help-seeking process is th e teac her's perception of child proble ms. This variable is almost as strongly related to service need as parents' own report of child problems, which is remarkable considering the limited agreement between parents' and teachers' reports of child probl ems (Achenbach et al., 1987). This find ing again indicates the influential role of teachers in the help-seeking process.

Sociodemograph ic context variables (pare ntal education level, family income, type of insurance) were confirmed not to influence the help-seeki ng proce ss directly. This finding can probably be ascribed to the Dutch health care syste m in whic h there are no major financial constraints on the availability of care.

Limitation s

Because of differences between coun tries' health care systems, cautio n should be exercised in generalizing these results to nations with syste ms unlike the Dutch one (i.e. with financial constraints for receiving care and without the GP as gatekeeper). We therefore advocate using our method with help-seeking models adapted to other health care systems.

Although the assump tions in our model were based upon theor y and asso ciations establish ed in previous research, and our final model adequately fit the data, we acknowledge the relatively data-driven nature of model-adjustment (e.g. removing non-significant asso ciatio ns and add ing some associations suggested by modification indices). Therefore future studies, preferably longitu dinal ones, are needed to confirm our find ings and estab lish causal directionality o f the asso ciations fo und. Longitudin al studies, as the on e by Farmer et al. (2 003), could also shed more light on the sequences of help-seeking stages.

The results of this study may be biase d because of the reliance on parent reports of service need and utilization. Our indicator of service need is more objective than used in previous stud ies, in which parents are directly asked whether their child is in need of help. Whereas our measu re corresponds better with formal diagnostic criteria, a more direct reflection of parents' need for services may give a better view of parents' own reality. However, the finding that parents' report of the presence of child problems exerts its influence on the four help-seeking variables only indirectly - through service need -, suggests that our measu re of serv ice need discriminates between parents who do experience probl ems in their child but are able to manage these problems without help, and parents for whom the impact of child problems is strong enough to requ ire outside help.

Wit h respect to the parental reports of service utilization, we believe parents to be the best informants on service use for this young age group. Prev ious evi dence suggests that parental reports are reason ably accurate, com pare d to administrative records (Fendrich et al., 1999). However, as

parents may have difficulties discriminating among multiple service settings (Bean et al., 2000), rates of service utilization may be biased. Including additional sources of data may strengthen our findings.

Clinical implications

Considering the importance of school personnel in influencing service need, as well as in the provision of help and the referral for mental health services, interventions aimed at increasing mental health service use should strengthen school personnel's possibilities in adequately handling these issues (e.g. by increasing attention for detection of child psychopathology in teachers' education or additional courses on referral possibilities). However, improving the detection and referral of child mental health problems is only useful if services are sufficiently available to meet the demands of children. By structurally including school psychologists into school teams, some children with less serious problems may be able to be helped within schools. Moreover, these school psychologists can support teachers in detecting child problems and referring the more serious cases to specialist mental health care.

5 The process of help-see king for adolescent internalizing psyc hopathology in the Netherlands

This chapter has been submitted for publication as:
Zwaanswijk, M., Van der End e, J., Verhaak, P. F. M., Bensing, J. M., Verhuls t, F. C. The process of help-seeking for adolescent internalizing psych opathology in the Netherlands.

Abstract

Objective: To increase insight into the process of help-seeking for adolescent internalizing psychopathology by investigating stages and actors involved in this process.

Design: Based on a cross-sectional health interview survey, adolescents with internalizing problems were selected for a subsequent interview.

Setting: Participants were patients registered in a representative sample of 104 Dutch general practices.

Participants: 114 Adolescents scoring in the borderline/clinical range on the Child Behavior Checklist, Teacher's Report Form, or Youth Self-Report Total Problems scale ($T \geq 60$), and their parents, selected from an original sample of 934.

Main outcome measures: Structural equation modeling was used to evaluate a path model of the help-seeking process, with service need and help-seeking from professional (general practitioner and mental health care) and informal sources (teacher and friends/relatives) as dependent variables.

Results: The sequence of stages and the actors involved in help-seeking for adolescent internalizing psychopathology were similar across gender. Parents and adolescents had comparable impacts on the help-seeking process. The first obstacle on the pathway to care was the acknowledgement of the seriousness of problems. Whereas the general practitioner functioned as gatekeeper for mental health care, the teacher's role in the process was limited.

Conclusions: Considering parents' and adolescents' impacts on the help-seeking process, interventions aimed at increasing service use should include both. A starting point may be the distinction between adolescents with sufficient resources to cope with their internalizing problems and those who need additional help. Intervention efforts could best be focused on general practitioner's role in detection and referral.

Introduction

Although a substantial number of adolescents in the community suffer from emotional or behavioral disorders (Verhulst et al., 1997a), the majority of these adolescents do not receive specialist mental health care (Sourander et al., 2001; Zwaanswijk et al. 2003a), whereas treatment of these disorders may prevent them from persisting into adulthood (cf. Feehan et al., 1993; Harrington et al., 1996). Adolescents with internalizing problems (i.e. problems reflecting internal distress, such as anxiety, depression, withdrawal, and somatic complaints) seem to be particularly unlikely to be identified by others or to be referred (Cohen et

al., 1991; Fergusson et al., 1993; Logan, 2000). Moreover, although these adolescents do recognize their problems themselves, their concerns are not effectuated into mental health referral (Zwaanswijk et al., 2003a). Insight into the process leading to service utilization for these adolescents may offer directions for the development of intervention programs focused on increasing service use.

The present study aims to empirically test a model concerning the process of help-seeking for adolescent internalizing psychopathology in professional and informal service settings (figure 5.1).

Based on previous models on help-seeking in general (Andersen, 1995; Goldberg and Huxley, 1992), and help-seeking for child and adolescent psychopathology in particular (Costello et al., 1998; Logan and King, 2001; Verhulst and Koot, 1992), we assume the help-seeking process to consist of a sequence of stages. Parents' or adolescents' global notion of the presence of adolescent internalizing problems is assumed to initiate the help-seeking process, followed by the acknowledgement that these problems are serious enough to require outside help (service need). Help-seeking is investigated in both professional (general practice, mental health care) and informal service settings (teachers, friends /relatives). Because the threshold for seeking help from friends or relatives is considered to be lower than for any other kind of service, we assume this kind of help-seeking to precede the use of other services. By including the general practitioner (GP) as service provider, we acknowledge the gatekeeping role of Dutch GPs in the provision of mental health care.

The model in figure 5.1 not only depicts our assumptions regarding the stages involved in the process of help-seeking for adolescent psychopathology, but also depicts the roles different actors play in this process. Whereas parents continue to play an important role in initiating service use for adolescents (cf. Sourander et al., 2001; Zwaanswijk et al., 2003a), as they did for younger children, adolescents' increasing autonomy strengthens their influence on the help-seeking process. Adolescents may be particularly reluctant to seek help, as can be seen from their generally negative attitudes towards seeking help (Garland and Zigler, 1994) and their reluctance to consult mental health services even when they acknowledge the presence of problems (Zwaanswijk et al., 2003a).

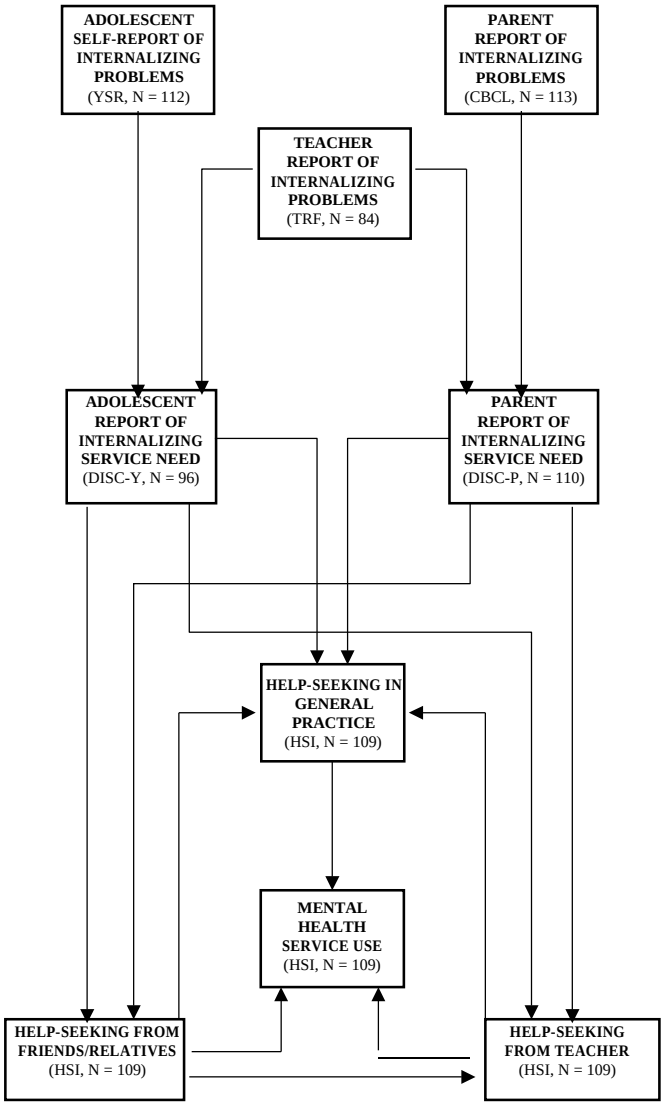

Figure 5.1 Theoretical model of the help-seekin g process for adolescen t internalizing psychopathology. In parentheses are measures used for each var iable an d numbers o f respond ents for who m data were available. HSI: Help-seeking interview.

Because teachers may be able to increase the awareness of the need to seek help (cf. Stanger and Lewis, 1993), their perception of the presence of problems is also included in the model.

By testing a model that simultaneously includes several help-seeking stages and service providers, this study will provide a more complete picture of the help-seeking process than previous studies, which have investigated these help-seeking stages in isolation from each other. Furthermore, previous research has mainly focused on mental health service use, whereas utilization of other service providers, particularly informal ones (Rickwood and Braithwaite, 1994; Saunders et al., 1994), may also be important in the process of help-seeking for adolescent internalizing psychopathology.

Since internalizing problems are generally found to be more prevalent in adolescent girls than boys, differences may exist in the help-seeking processes of both genders. Therefore, the applicability of the help-seeking model across gender is investigated.

Methods

Study population and procedures

Data for this paper were derived from a broader study on help-seeking for child and adolescent psychopathology in general. This study involved a two-stage procedure. Data for the first stage were obtained from the Second Dutch National Survey of General Practice, which examined morbidity and treatment in a representative sample of 104 general practices with 195 GPs and 385,641 listed patients, in the period between April 2000 and January 2002 (Westert et al., in press). A random sample of the practice population (N = 12,699), including 934 adolescents (12-17 years), participated in an extensive health interview survey (total response rate: 64.5 %). As part of this interview, parents completed the Child Behavior Checklist (CBCL; Achenbach, 1991a), and adolescents completed the Youth Self-Report (YSR; Achenbach, 1991c). Responses were received for a total number of 830 adolescents (data were available for 810 parents and 814 adolescents). Respondents were asked permission to send the Teacher's Report Form (TRF; Achenbach, 1991b) to the teacher who was the most familiar with the adolescent's functioning. Responses were received from 507 teachers (213 respondents refused to give permission to contact the teacher, 28 teachers refused to cooperate, 67 teachers did not respond, 13 adolescents did not attend school, and 2 teachers could not be contacted due to incompleteness of school address).

Adolescents scoring in the borderline or clinical range on the CBCL, TRF or YSR Total Problems scale ($T \geq 60$) were selected for participation in the second stage of the study. Of the 191 selected adolescents, 114 (50.9 % boys, 49.1 % girls) agreed to participate. Available were 113 CBCL's, 110 YSR's, and 84 TRF's. Adolescents for whom TRF data were available did not differ from adolescents with missing TRFs on any of the study variables.

Second stage respondents and non-respondents were comparable with respect to age, gender, CBCL and TRF Internalizing Problems scores. However, subjects who did not participate had higher YSR Internalizing Problems scores (means 11.0 versus 14.2; $t = 2.63$; $df = 182$; $p = .01$). This may indicate that adolescents with high levels of internalizing problems felt more reluctant to cooperate.

In the second stage, a standardized psychiatric interview (DISC-IV; Shaffer et al., 2000) was administered to the adolescent and his/her primary caregiver to obtain adolescent psychiatric diagnoses. Data from this psychiatric interview were available for 96 adolescents and 110 parents. Parents were also interviewed about help-seeking for adolescent problems in the preceding 12 months. Data were available for 109 parents.

Measures

Parent, adolescent, and teacher perceptions of the presence of adolescent problems over six months preceding the first stage assessment were measured by validated Dutch translations of the CBCL (Achenbach, 1991a), YSR (Achenbach, 1991c), and TRF (Achenbach, 1991b). These instruments consist of 120 problem items (102 for the YSR), which yield Total Problems, Internalizing, Externalizing Problems, and eight specific syndrome scores. The Internalizing Problems scores were used as indicators of parents', teachers', and adolescents' global notions of the presence of internalizing problems (see figure 5.1).

Adolescent and parent perceptions of service need were assessed by the National Institute of Mental Health Diagnostic Interview Schedule for Children, version 4 (DISC-IV), parent-version and youth-version. This structured interview is designed to assess psychiatric disorders in children and adolescents, using DSM-IV criteria (American Psychiatric Association, 1994). For this report, sections concerning anxiety disorders and mood disorders were used. Our measure of service need was

com posed of the informant's perception of the prese nce of internalizing psych opathology and ass ociated function al impairment (cf. Brewin et al., 1987). Impairment was considered to be present when at least two out of six diagnosis-specific imp airment items indicating moderate, or one item indicatin g sever e personal distress, social or academic difficulties were present. This indicator correspo nds more with formal diagnostic criteria than measures of need used in previo us studies, in which responden ts are directly asked whet her they are in need for help.

Help-seeking from professional and informal sources in the preceding 12 months was assess ed by items from the second -stage parent interview.

Statistical a nalyse s

Stru ctural equation mod eling (AMOS 4.0; Arbuckle and W othke, 1999) was used to test the app licability of the theoretical model to our data. To ensure an adequate amount of estimated parameters in relation to the limited sample size (N = 114), only observ ed variables were included in the model. After testing and modifying the general model (figure 5.1) to increase fit, multi-grou p analys es were performed to test the applicability of the model across gend er.

Results

Table 5.1 shows the percentages of adolescents perceived to have bord erline or clinical internalizing problems and service need by separate informants. Parents of 57 adolescents (50.4 %) re ported CBCL Internalizing Probl ems scores in the borderline or clinical range ($T \geq$ 60), wher eas 24 adolescents (21.8 %) reported YSR Internalizing Problems in this range. Teach ers reported borderline or clinical TRF Internalizi ng Problems fo r 32 adolescen ts (38.1 %).

Based on parent report of the presence of internalizin g psychopathology includ ing functional impairment (see Measures), internalizing need was considere d to be present in 16 adolescents (14.5 %). Adolescent self-reports indicated a total number o f 10 adoles cents (10.4 %) as having internalizing need (table 5.1).

Table 5.1 Perce ntages of adolescents with borderline/clinical internalizing problems or serv ice need, as reported by separate informants, and ove rlap between informants

		Boys		Girls		Total	
		%	N*	%	N*	%	N*
Internalizing problems	Parent (P)	51.7	30 (58)	49.1	27 (55)	50.4	57 (113)
	Adolescen t (A)	21.1	12 (57)	22.6	12 (53)	21.8	24 (110)
	Teach er (T)	32.6	14 (43)	43.9	18 (41)	38.1	32 (84)
	P + A	15.8	9 (57)	17.3	9 (52)	16.5	18 (109)
	P + T	16.3	7 (43)	14.6	6 (41)	15.5	13 (84)
	A + T	4.7	2 (43)	7.7	3 (39)	6.1	5 (82)
	P + A + T	2.3	1 (43)	7.7	3 (39)	4.9	4 (82)
Service need	P	12.3	7 (57)	17.0	9 (53)	14.5	16 (110)
	A	6.3	3 (48)	14.6	7 (48)	10.4	10 (96)
	P + A	2.1	1 (47)	2.2	1 (45)	2.2	2 (92)

Note: Data on service need were obtained from paren ts and adolescen ts only

* In parentheses are the numbe rs of respondents for whom data were available

Agreement between informants' perceptions of the presence of borderline or clinical internalizing proble ms or service need was limite d (table 5.1). Rates of service use in the four settings are reported in table 5.2.

Table 5.2 Rates of service use in four settings

	Boys (N= 57)		Girls (N= 52)		Total (N= 109)	
	%	N	%	N	%	N
General practice	14.0	8	15.4	8	14.7	16
Mental health care	14.0	8	19.2	10	16.5	18
Teach er	26.3	15	23.1	12	24.8	27
Frie nds/re latives	26.3	15	28.8	15	27.5	30

Of the 57 adolescents whose parents indicated the presence of borderline or clinical internalizing symptoms, 11 were also regarded as having serv ice need by their parents. Of the 24 adolescents who reported the presence of internalizing problems themselves, merely 4 also reported serv ice need.

Differences between girls and boys were non-significant, except for YSR Internalizing Probl ems; girls reported sig nifica ntly more internalizing problems than boys (means: 13.1 versus 9.1; t = 2.79; df = 108; p = .01). However, these elevated scores for girls remained mainly in the normal range, as girls did not score in the borderline or clinical range significantly more often than boys.

Evaluation of the path model

The initial theoretical model (figure 5.1) did not yield an adequate fit (model A, table 5.3). To increase model fit, non-significant paths were deleted from the model one by one, resulting in model B (table 5.3). Conseq uently, modification indices were computed for the part of the total sample, for which complete data were available (N = 66). Only one of the suggested associations, a covariance between parent and adolescent reports of internalizing problems, was theoretically relevant and was therefore added to the model (Model C, table 5.3).

Table 5.3 Fit measures of subsequent models in the process of improving model fit

Model	χ^2	df	p	NNFI/TLI	RMSEA	90 % CI
A	58.81	20	.00	.863	.131	.093-.171
B	61.87	26	.00	.903	.110	.075-.146
C	35.71	25	.08	.970	.062	.000-.104
D	20.92	17	.23	.985	.045	.000-.101
E	23.58	20	.26	.988	.040	.000-.094
Multi-gro up						
F	47.54	40	.19	.976	.041	.000-.080
G	50.21	46	.31	.988	.029	.000-.071

Note: NNFI/TLI: non-normed fit index /Tucker-Lewis coefficie nt; RMSEA: Root Mean Square Error of Approxi matio n; CI: confidence interval

Since all assumed associations involving teacher report of inter nalizing problems were foun d to be non-significant an d therefore deleted, and no other theoretically relevant asso ciatio ns were suggested by the modificatio n indices, the variable was deleted from the model (model D, table 5.3).

Finally, regression weights of equivalent associations for parents and adolescents (i.e. associatio ns between parent/adoles cent reports of internalizing proble ms and service need; between parental/ adolescent

serv ice need and GP-consultation; and between parental/ adolescent serv ice need and help-seeking from friends/relatives) were constrained to be equal. Results of a chi-square difference test, which showed no significant differences between the resulting model E (table 5.3) and the unco nstrained model D (χ^2 = 2.66; df = 3; p > .05), were in favor of the more parsim onious model E.

To test the appli cability of our model across gend er, multi-group analys es were performed on the general model (model E). We first te ste d a model in which all paths were estim ated in depend ently for boys an d girls. Thus, the constraints that were imposed in model E were retain ed *within* the grou ps of boys and girls, but *between* these groups the parameters were allowed to vary. The resulting model adequately fit the data (model F, table 5.3). Next, regression coefficients were constrained to be identical *between* boys and girls, only wh en this resulted in a significant improvement of model fit. All regression coefficients could be constrained to be equal across gend er, except for the association between seeking help from the teacher and mental health service use, which was stron ger for girls than for boys (figure 5.2). Because no significant differen ces were found between th e resulting model G (table 5.3) and the model without constraints between genders (χ^2 = 2.67; df = 6; p > .05), the more parsimonious model G was chosen as the best fitting model.

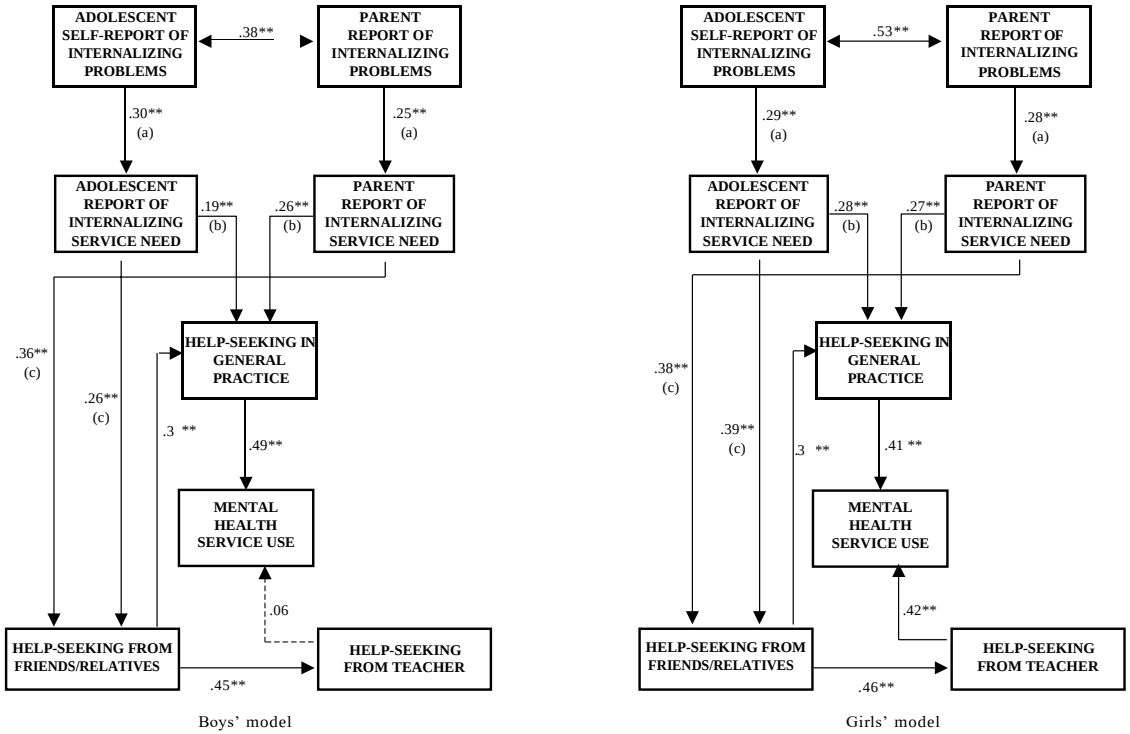

Figure 5.2 Final model of the help-seeking process for adolescent inter nalizing psychopathology, reported separately for boys and girls. Presented are standard ized regressio n weights (single-headed arro ws), correlations (double-headed arrows), and a non-significant association (dashed line).

Pat hs with (a), (b), and (c) were constrained to be equal across paren ts and adolescen ts. ** $p < .01$

Comment

This study was aimed at investigating the process of help-seeking for adolescent intern alizin g psycho pathology. By means of structural equation modeling, a path model that takes into account the sequential nature of help-seeking and the involvement of multiple actors and serv ice provider s was tested.

Our results confirmed adolescents' increasing autonomy as well as parents' continu ing influence on the help-seeking process, as both exerted a considerable influence on the help-seeking process. Taking into account t he assum ed difficulties of parents in recognizing internalizing problems in their adoles cent offspring (Logan, 2000), and the limited over lap between adolescent and parent perceptions of the presence of internalizing problems or need, the influences of both were remarkably similar. These comparable impacts un derscore the need for interven tion programs to be directed at both parents and adoles cents.

A first obstacle in the help-seeking process is the acknowledgement of a need to seek help when inter nalizing problems are prese nt. Only a minority of adolescents with bord erline or clinical internalizing problems (19.3 % based on parent report, and 16.7 % based on adolescent repor t) were regarded also to be in need of services. On the other hand, some adolescents (n= 4 for parent report, and n= 6 for adolescen t report) were reported to be in need of services, without their internalizing problems reaching borderline or clinical level (data on the prese nce of internalizing probl ems were unavailable for one of these parents). These find ings indicate that internalizing problems may to some extent be regarded as normal for adolescence, and not requiri ng special care. Although some adolescents will ind eed have enough resources to cope with their probl ems, others may benefit from care, even when they do not acknowledge a servic e need, or when their problems do not reach a clinical level. In designing intervention programs, it is important to find ways to distinguish between these groups of adolescents, and adjust intervention activities to their respective needs.

Mobilizing teachers to increase parents' or adolescents' awareness of a need to seek help when internalizing probl ems are present does not seem to be the best strategy, however. In contrast with findi ngs for elementary school children (Zwaanswijk et al., submitted-a), teachers' perception of probl ems did not appear to influence service need. Perhaps teachers'

ability to identify internalizing problems is hampered by the limite d time they spend with their adolesce nt pupi ls.

The less promi nent role of the teac her was accompa nied by a more important role of the GP. In contrast with find ings for young children (Zwaanswijk et al., submitted-a), the Dutch GP functio ns more according to his formal role as gatekeeper to mental health care in the process of help-seeking for adolescent internalizing psychopathology. Both the regression weights in our path model (figure 5.2) and the retrospective inspection of mental health referrals confirmed this: 61 % of adolescents (comp ared to 41 % of young children) in mental health care h ad entered this care by GP referral. This increase in the GP's role m ight be explained by an associatio n between adolescent internalizing probl ems and somatic com plaints (Kramer and Garralda, 1998), which could increase GP consultatio n in general.

The robustness of our model was demonstrated by its consistency across gender. Although adolescent girls reported more internalizing problems than boys, their help-s eeking proces ses were remarkably similar. This find ing is in concordance with previous results, in which the elevated self-perceived probl ems in girls were not accompa nied by elevated referr al rates (Saund ers et al., 1994; Zwaanswijk et al., 200 3a). The only differe nce bet ween genders wa s the stronger association bet ween help- seeking from the teacher and mental health care use for girls.

Our limited sample size prohibited the concurre nt testing of determinants of the help-seeking process. Further research on this matter will improve our understand ing of variab les influencing adolescent help-seek ing, thereby possibly providing directions for interve ntions. Replication of our resu lts in future stud ies, preferably longitud inal ones, is als o require d to confirm the findings and est ablish causal directio nality of the asso ciations found.

Caution should be exercised in generalizing the present find ings to health care systems in which the GP does not fun ction as gatekeeper to mental health care. We believe, however, the merits of this method not to be restr icted to coun tries with comparable health care systems, but consider it also useful as a more generic appro ach for clarifying the help-seeking processes in other countries, as it takes into account the multiple stages and actors involved in these process es. We therefore advocate using our method with help-seeking models adapted to other health care systems.

Moreover, we believe our results concer ning parents' and adolescents' impacts on the help-seeking process, and the generalizability of the model across genders to be of more general value.

Generalizability may be hampered by the fact that adolescents with high self-reported internalizing problems were less likely to participate in our study. Non-respo nding adolescents may be reluctan t not only to participate in a study on help-seeking, but also to see k help in general, which co uld have caused an overes timation of help-seeking rates i n this study.

One of the stre ngths of this stu dy is the inclusion of parent and adolescent reports of internalizing problems and serv ice need. However, informatio n regarding service use was obtained from parents only, wh ich may not adequately reflect adolescent service use. Reports of utilization of friends/ relatives are particularly likely to vary, because of differences bet ween social networks of parents and adolescents. Since this type of help is regarded as importa nt for adolescents as part of their increasing autonomy (cf. Rickwood and Braith waite, 1994; Saund ers et al., 1994), future studies should include adolescent reports of serv ice use.

Consideri ng the differential roles of teachers and GPs in the help-seeking processes of children and adolescents, interventions aimed at increasing serv ice use should be adapted to the age range of the target population. For children, efforts can best be focused on strengthening school personnel 's abilities to detect problems and provide help. Screening for psych osocial problems b y school physicians may be a promising optio n for these children (Brugman et al., 2001). For adolescen ts, however, efforts should be focused on the role of primary care practitioners in detection and referral.

What this study adds

Adolescents with internalizing problems seem to be particularly unlikely to be identified or referred to specialist mental health care. Improving our unders tanding of the help-seek ing process of these adolescents is cr ucial for designing interventions to increase servi ce use. This study t akes into account t he complex nature of help-seeking by test ing a model that sim ultaneously includ es several subsequent help-seeking stages and the involvement of multiple actors and serv ice providers (professional and informal). With respect to the first obstacle on the pathway to care – the acknow ledgement of the seriousn ess of problems –, finding ways to

distin guish between adolescents with sufficient resource s to cope with their problems and those in need of additional help is useful for designing interventions. The find ing that both parents and adolescents had considerable impacts on the help-seeking process ind icates the necess ity of includ ing both in interventio ns. Considering the roles of teachers and general practitioners in the help-seeking process, intervention efforts could best be focused on the latter.

6 Consultation for and identification of child and adolescent psychological problems in Dutch general practice

This chapter has been submitted for publication as:
Zwaanswijk, M., Verhaak, P. F. M., Van der Ende, J., Bensing, J. M., Verhuls t, F. C. Consultation for and identification of child and adole scent psyc hological probl ems in Dutch general practice.

Abstract

Background : Child and adolescent psychological problems are rarely brought to the attention of GPs. Children and adolescents with psyc hological probl ems who do visit t heir GP are sel dom identified as such by the GP.

Objective: To investigate in a general population sample of 2,449 Dutch children and adolescents (4-17 years) GP consultation and GP diagnoses of child psychological problems, and the influence of child and family characteristics upon these variables.

Methods: The degree to which par ent, teacher, an d adolescent reports of the presence of child psychological problems are in concordance with GP diagnoses of these problems was deter mined. Logistic regressi on analyses were used to exam ine correlates o f GP consultation and psychological diagnoses.

Results: Approxim ately 80 % of children and adolescents with psych ological prob lems had visited their GP within the preced ing year. GP consultatio n was most strongly associated with child/a dolescent chronic ph ysical disorders. Concordance between GP psychological diagnoses and parent, teacher, and ad olescen t reports of psychological problems w as limited. Children and adolescents with psychological probl ems accord ing to parent or teacher report, children with school problems, young boys, ad olescen ts with negativ e health percep tions, and adolescents from single parent families were more likely to be diagnosed with psychological pr oblems by GPs.

Conclusion: Improving GPs' interview techniqu es, introd ucing stan dardised scre ening measu res in general practice, increasing GPs' aware ness of the possible presence of psych ological problems in children consulting for phys ical problems, and stren gthening collabor atio n bet ween GPs and mental health professi onals may increase GP identification of child psychological probl ems and enhance access to care for those in need.

Keywords: mental health, child developm ent, consultatio n, clinical diagnosis, pu blic h ealth

Introduction

Alt hough psychological probl ems are relatively common in children and adolescents, they are rarely brought to the attentio n of general practition ers (GPs). Ford et al. (2003) found that merely 24 % of children with ICD-10 diagnoses of psychiatr ic disorders (World Health Organization , 1993) h ad been in contact with primary health care for these problems over a 18-month period. Using a less restr ictive measure

of the presence of child psychological problems and consideri ng GP consultatio n in general, Foets et al. (1996) found that 69 % of children with a Child Behavior Checklist To tal Problems sco re (Achenbach, 1991a) in the clinical range had been in contact with their GP in the preceding year. Rates of GP consultation did not differ significantly bet ween children with and wit hout scores in the clinical range.

In add ition to the fact that not all children with psychological probl ems come into contact with their GP, a significant nu mber of these children who do visit their GP are not identified as such by their physi cian (Costello et al., 1988; Kelle her et al., 1997). Dulcan et al. (1990) found th at merely 17 % of psychiatrically disor dered children were identified as such by their pri mary care paediatrician. Alt hough parents' specifically mentioning their child's problems to the paediatrician increased identification, 67 % of disordered children remained uni dentified. The study by Dulcan et al. was con ducted in the US health care system, in which general practitioners are not designated as gatekeepers to mental health care, as they are in the Netherlan ds and the UK. However, the authors acknowledged that primary care physicians performed this role increasingly often. A more recent British study showed that parents' explicit expressi on of concer n about child mental health problems durin g consultation increa sed GPs' identification of both cases and non-cases (Sayal an d Taylor, 200 4).

The limited identification of psychological problems by GPs is also found in adult populations (Goldberg and Huxley, 1992). GPs' lack of skil ls, the limited duratio n of consultations, the co-occurre nce of physical and psyc hological symptoms, patients pr esenting primarily with physical complai nts instead of psyc hological ones, and patie nts' tende ncy to normalise symptoms, have been mentioned as possible reasons for low identificatio n in adults (Kessler et al., 1999; Kirm ayer et al., 1993; Wittchen et al., 2002).

As most children atten d their GP on a regular basis, GPs are strategically well placed to detect child mental health problems and to motivate their families to obtain care when needed. However, the Dutch GPs' formal role as gatekeeper is not always as pronoun ced as expected (Zwaanswijk et al., submitted-a), and only a minority of children and adoles cents with psyc hological proble ms enter specialist mental health care (Burns et al., 1995; Leaf et al., 1996; Verhu lst and Van der Ende, 1997; Zwaansw ijk et

al., 2003a), which suggests that obstacles affecting children's progress on the pathway to care may exist in general practice.

So far, studies have mainly focused on factors associated with consultation for child psychological problems, where as factors associated with GP identification of such problems have received little attention (Zwaanswijk et al., 2003b). The present study aims to investigate GP consultation and GP diagnoses of child psychological problems in a large general population sample. The degree to which parent, teacher, and adolescent reports of the presence of psychological problems are in concordance with GP diagnoses of these problems is determined. Various child and family characteristics are investigated as correlates of GP consultation and GP psychological diagnoses.

Methods

Participants

Our sample consisted of 2,449 children and adolescents and their primary caregivers, of whom 1,507 were children (4-11 years), and 942 were adolescents (12-17 years). Data were obtained from several databases. An overview of the numbers of respondents for each of these databases is presented in figure 6.1. The main source of data was the Second Dutch National Survey of General Practice, which examined morbidity and treatment in a representative sample of 104 general practices with 195 GPs and 385,461 listed patients (67,264 were 4-17 years of age) (Westert et al., in press). In this sample, GP consultation and psychological diagnoses were assessed by means of the contact registration, in which participating GPs electronically recorded each diagnosis made during patient contacts. Data collection took place during one calendar year, in the period between April 2000 and January 2002. Morbidity data of eight practices were excluded because of incomplete data collection.

A random sample of the practice population was asked to participate in a health interview survey (total response rate: 64.5 %), which contained questions on socio demographic characteristics, health care utilisation etc. Participants were comparable to the practice population with respect to gender, age, and place of residence (Westert et al., in press). The interviews were carried out between December 2000 and December 2001, spread over a whole year to avoid seasonal patterns. For children aged 4-11 years, a proxy interview was administered to one of the parents, whereas adolescents (12-17 years) answered the questions themselves.

During the health interview, parents completed the Child Behavior Checklist (CBCL; Achenbach, 1991a), and adolescents com pleted the Youth Self-Report (YSR; Achenbach, 1991 c) to screen for the presence of psych ological problems. Responses were received for a total num ber of 2,149 children and adolescen ts. Respond ents were asked permission to send the Teacher's Report Form (TRF; Achenbach, 1991b) to the teach er who was the most familiar with the child's functioning. A total numbe r of 1,481 teachers respo nded (485 parents/adolescen ts or teach ers refused to coop erate, 163 teach ers did not respond, 18 ch ildren did not atten d school, and 2 teach ers could not be contacted due to incom plete school addresses). Children and adolescents with available and missing TRF data were compa rable with respect to gender, CBCL and YSR Total Probl ems scores, and presence of school problems.

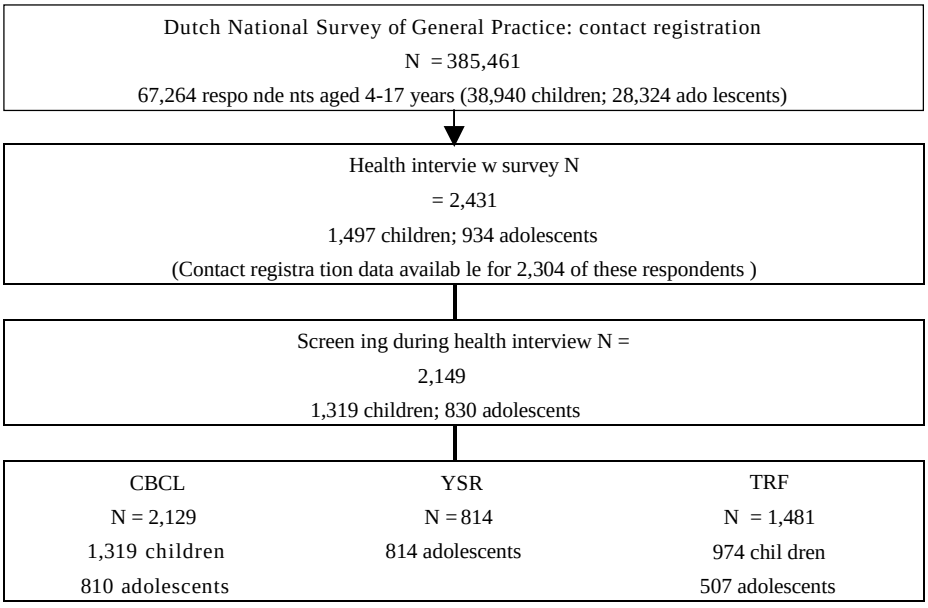

Figure 6.1 Num bers of respo nde nts for each aspect of the study. Due to incomple te overla p bet ween databases, t he tota l sample on which analyses were performed included 2,449 children and adolescents.

Instrument s

Parent, adolescent, and teacher perceptio ns of the presence of child and adolescent psychological probl ems over six m onths preceding assessm ent were measured by validate d Dutch translations of the CBCL, YSR, and TRF. These instrum ents consis t of 120 problem items (YSR: 10 2), which

yield Total Problems, Internalizing and Externalizing Problems, and eight syndrom e scores. These scales are hierarchically ordered; the Internalizing Problems score consists of the sum of scores for the syndrom es Anxious/ Depressed, Somatic Complaints, and W ithd rawn, wher eas the Exter nalizing Problems scale comprises the syndrom es Delinqu ent Behavior and Aggressiv e Behavior. The Total Pr oblems score is computed by sum ming the Inter nalizing and Externalizing scores, an d scor es for the syndrom es Social Problems, Thought Problems, and Atte ntion Proble ms. Scores on the CBCL, YSR, and TRF Tota l Proble ms, Internalizing, and Externalizing scales can be dichotom ise d into those in the clinical versus normal range of the distributions bas ed on Dutch normative samples, using a *T* scor e > 63 as cut-off point. The clinical cut-off point has been found to discriminate between children showing similar ities with childr en who were and who w ere not referred to mental health care (Ach enbach, 1991 a; b; c). Since children scorin g just belo w the clinical cut-off point may also show problems t hat require special care, the instrum ents also includ e a deviant range, referring to both bord erline and clinical scor es, with a *T* score of 60 as cut-off point. Because analyses were performed mainly using the dichotomisation into deviant and normal groups, results refer to this dichotomisatio n, except when t he clinical range is explicitly mentioned.

The health intervie w assessed chil d and fa mily characteristics thought to be associ ated with GP consultation and GP psyc hological diagnoses (table 6.1). During this interview, parents were asked to indicate the prese nce of child chronic physical disord ers on a 19-item lis t, includi ng probl ems such as migraine, asthm a, and sev ere neck/shoulder ailments (Van den Berg and Van der Wulp, 2003).

Table 6.1. Characteristics of participating children (*N* = 1507) and adolescents (*N* = 942)

	Children		Adolescen ts	
	%	N*	%	N*
Child				
CBCL Internalizing	23.2	304 (1311)	15.1	122 (806)
Externalizing	18.8	246 (1311)	16.9	136 (805)
Tota l Prob lems	20.4	268 (1311)	14.3	115 (806)

- table 6.1 con tinues -

- table 6.1 con tinued -

		Children		Adolescen ts	
		%	N*	%	N*
TRF	Internalizing	16.1	157 (974)	16.2	82 (507)
	Externalizing	19.7	192 (974)	15.8	80 (507)
	Tota l Prob lems	17.2	168 (974)	14.8	75 (507)
YSR	Internalizing	-	-	10.1	82 (808)
	Externalizing	-	-	9.3	75 (808)
	Tota l Prob lems	-	-	7.9	64 (808)
Male gender		52.0	783 (150 7)	47.6	448 (942)
Chronic physical disord ers		28.5	427 (149 7)	33.8	316 (934)
School proble ms		23.0	343 (149 1)	-	-
Moderate/bad general health impression		4.6	68 (1493)	5.1	48 (933)
Family					
Parental mental health problems		25.1	375 (149 6)	-	-
Education level: Low		14.1	211 (149 5)	19.2	177 (922)
	Moderate	48.7	728 (149 5)	47.1	434 (922)
	High	37.2	556 (149 5)	33.7	311 (922)
Constellatio n:	Two-parent	91.9	1322 (143 8)	89.4	813 (909)
	Single parent	8.1	116 (143 8)	10.6	96 (909)
Insurance:	Public	56.4	820 (145 4)	51.5	470 (912)
	Private	43.6	634 (145 4)	48.5	442 (912)

Note. Figures for CBCL, TRF, and YSR refle ct children and adolescen ts scoring in the deviant range.

* In parentheses are the numbe rs of respondents for whom data were available.

Parents' general impression of child health was assessed by means of a five-point self-report item, derived from the Short-Form 36 (SF-36; Ware and Sherbo urne, 1992). General im press ion of adolescent health was assess ed by adolescent self-report. Responses were dichotomised into good (scor es 1-3) vers us moderate/bad (scores 4-5).

The presence of parental mental health problems wa s measure d by a validated Dutch translation of the 12-item version of the General Health Questionn aire (GHQ; Goldberg, 1972). The GHQ has been widely used to measu re general psychological distress, with a total score of 2 or more reflecting the prese nce of probl ems. This variable was assessed in parents of children aged 4-11 years only.

Parental education level was scored on an 11-point scale, with 11 being the highest level. The parent with the highest education level was used to trichotomise the sample in low (scores 1-3), moderate (scores 4-8), and high (score s 9-11) educat ion level.

GP diagnoses of child and adolescent psy chological pro blems were determined by codes from the International Classification of Primary Care (ICPC; Lamberts et al., 1993), which were electr onically r ecor ded by GPs durin g patient contacts. In the Netherlan ds, the ICPC is the standard for coding morbidity in general practice. It is included in all electronic patient recor d based morbidity record ing systems, and train ing to use the classification system is organised on a regular basis. To ensure accurate coding, GPs also received ma nual s and a li st on whic h all ICPC-codes were briefly specified. More over, t he electronic recording system e nabled searching for ICPC-codes by means of keywords. The quality of coding was demonstrated by the high concordance (on average: 81 %) between codes given to 30 fictitio us patients by participating GPs and a panel of four GPs with specific expertise in using ICPC (Van der Linde n et al., 2004).

Only ICPC-codes referring to psychological problems (P-codes) and social probl ems (Z-codes) were selected as relevant for our stud y. In our analys es, a dichotom ous variable was used, ind icating whether or not a child had received such a code.

Statistical a nalyse s

Since child and family variables w ere derived from differ ent sources depend ing on the age range of the participant (parent report for children aged 4-11 years; adolescent self-report for resp ond ents aged 12-17 years), analys es were performed for children and adolescents separately. To clarify this distinction, children aged 4-11 years will be referred to in our results as ‘young childre n’ as oppose d to ‘adolescents’.

Concor dance betw een parent, teach er, and adolescent reports of psyc hological proble ms and GP psychol ogical diagnoses was assessed by determining percentages of respond ents scoring in the deviant range on CBCL, TRF, and YSR Total Proble ms scales, who also rece ive d a GP diagnosis of psyc hological proble ms. To investigate whether seve rity of child proble ms affected GP identification, concordance with GP psych ological diagnos es was also assesse d for children and adolescents

scoring in the clinical range on CBCL, TRF, and YSR Total Proble ms scales.

To determine the associatio n of child and family characteristics with GP consultatio n and GP psycholo gical d iagnoses, logistic regressi on analyses were performed. Since multilevel analyses t esting the effect of clustering within general practices did not show significant effects of clusters, tra ditio nal simple logistic regression analyses were performed for each asso ciation separately. Subsequ ently, step wise multiple logistic regression analyses were performed to determine the unique contribution of each of the child and family variables to an increase in the likelihood of GP consultation and GP psy chological diagno ses over and above the effect of all other variables. The hierarchical relationship of the CBCL, TRF, and YSR scales (see Instrum ents) made it necess ary to perform regression analyses o n two different sets of variables: (1) inclu ding the Tota l Problems scores, (2) i nclud ing Externalizing and Internalizing scor es.

Results

Over all, 73.9 % of young children, and 76.2 % of adolescen ts had been in contact with their GP during the year of assessm ent. Of those who had visited th eir GP, 7.1 % of young children and 6.7 % of adolescen ts received a psyc hological diagnosis. The most frequently occ urri ng diagnoses for young children were: specific lear ning problem s/delay in development (P24; 18.9 % of all child P- and Z-diagnoses), enuresis (P1 2; 16.2 %), and over activ e/ hyperkinetic child (P21; 14.9 %). Adolescen ts were most frequently diagnosed with: enuresis (P12; 15.2 % of all adolescent P- and Z-diagnoses), relationship problems with parent/other family member (Z20; 13.0 %), and feeling anxio us/nerv ous/tense (P01; 8.7 %).

Freq uencies of children and adolescents scoring in the deviant range of the CBCL, TRF, and YSR proble ms scales are presented in table 6.1. Agreement bet ween parent, teacher, and adolescent reports of the presence of problems was limited; approxim ately one third of children and adolescents with devia nt CBCL Total Proble ms scores also ha d TRF or YSR Total Pro blems scores in the deviant range, whereas 13.7 % of adolescents scor ed in the deviant range on both YSR and TRF Total Problems.

Children and adolescents with psychological problems in the deviant range suffered significantly more frequently from additional difficulties such as chronic physical disord ers, moderate/bad general health, school probl ems, and the presence of a parent with mental health problems (table 6.2).

Of childre n and a dolescents scoring in the devia nt range of the CBCL Tota l Problems scale, 80.1 % and 86.0 % had been in contact with their GP, respectively. Consultatio n rates were com parable for children and adolescents rated as deviant by their teacher (7 9.1 % and 86.1 %) and by adolescent self-report (86.9 %).

Concor dance between parent, teach er, and adolescent reports of the presence of child psychological problems and GP psychological diagnoses was limited, both when Total Problems scores in the deviant range as whe n scores in the clinical range were taken into account (table 6.3). Percentages of children and adolescents who scored in the normal range of the CBCL, TRF, and YSR Tota l Proble ms scales, and who were also diagnosed with GP psych ological problems are reported in table 6.3 as well.

Table 6.2 Additional problems of children and adolescents scoring in the deviant versus normal range of the CBCL, TRF, and YSR Total Problems scales

	Child					Adolescent				
	CBCL					CBCL				
	deviant		normal			deviant		normal		
	%	N	%	N	χ^2	%	N	%	N	χ^2
Chronic physical disorders	41.6	111 (267)	24.5	253 (1034)	30.8**	51.8	59 (114)	30.4	208 (684)	20.0**
School problems	45.3	120 (265)	17.2	178 (1032)	93.6**					
Moderate/bad health impression	10.9	29 (266)	2.5	26 (1032)	36.6**	7.0	8 (114)	4.1	28 (683)	1.9^{ns}
Parental mental health problems	47.0	125 (266)	19.8	205 (1034)	82.4**					
	TRF					TRF				
	deviant		normal			deviant		normal		
	%	N	%	N	χ^2	%	N	%	N	χ^2
Chronic physical disorders	33.5	56 (167)	25.0	201 (804)	5.2*	44.6	33 (74)	30.3	130 (429)	5.9*
School problems	47.3	79 (167)	17.2	138 (801)	71.9**					
Moderate/bad health impression	9.0	15 (167)	2.1	17 (801)	20.3**	6.8	5 (74)	4.0	17 (429)	1.2^{ns}
Parental mental health problems	31.7	53 (167)	23.0	185 (804)	5.7*					

- table 6.2 continues -

- table 6.2 continued -

	Adolescent YSR				
	deviant		normal		
	%	N	%	N	χ^2
Chronic physical disorders	54.7	35 (64)	31.7	233 (736)	14.0**
Moderate/bad health impression	15.6	10 (64)	4.1	30 (735)	16.5**

Note: Child school problems and parental mental health problems were not assessed in adolescents. In parentheses are the number s of respondents for whom data were available. * $p < .05$; ** $p < .01$; ns = non-significant

Table 6.3 Percentages of concordance between CBCL, TRF, and YSR Total Problems and GP psychological diagnoses

	Child				Adolescent					
	Deviant		Normal		Deviant			Normal		
	CBCL	TRF	CBCL	TRF	CBCL	TRF	YSR	CBCL	TRF	YSR
GP psychological diagnosis	12.8	14.5	5.0	4.0	14.4	11.9	23.1	4.6	5.8	5.1

	Clinical		Normal		Clinical			Normal		
	CBCL	TRF	CBCL	TRF	CBCL	TRF	YSR	CBCL	TRF	YSR
GP psychological diagnosis	15.2	19.5	5.4	4.2	14.9	14.3	25.0	5.1	6.0	5.5

Childre n with devia nt CBCL or TRF Total Problems sc ores who did not receive a GP psychological diagnosis, were mainly diagnosed with warts (S03; 6.1 % of all child ICPC codes exclu ding P- and Z-codes), upp er resp iratory tract infectio n (R74; 5.1 %), and cough (R05; 4.9 %). The most frequently occurring diagnoses for adolescents with unidentified psych ological prob lems were upper re spirator y tract infection (R 74; 4.2 % of all adolescent ICPC codes exclu ding P- and Z-codes); hayfever/ allergic rhinitis (R97; 3.0 %), and family plann ing/oral contraceptive (W11; 3.0 %).

Logistic regre ssion analy ses

Results of simple logistic regressi on analyses are listed in table 6.4. Only significant odds ratios are reported. Results of multiple logistic regression analys es are shown in table 6.5 for the two sets of variables separately. Only variables that were entered and not rem oved in the stepw ise regression procedure are reported.

Table 6.4 Sim ple logistic regression analyses: child and family characteristics influencing GP consultatio n and child psych ological diagnoses by the GP

	GP consultation		GP psych ological diagnoses	
	Child	Adolescen t	Child	Adolescen t
Child gender	-	0.6 (0.4-0.8) [a]**	2.6 (1.5-4.4) [b]**	-
Child chronic physical disorders	2.7 (2.0-3.6)**	2.8 (1.9-4.1)**	1.9 (1.2-3.0)*	3.3 (1.8-6.0)**
Child school problems	-		3.3 (2.1-5.3)**	
Gen. impressio n of child health	3.8 (1.6-8.9)**	-	-	6.9 (3.2-15.1)**
Parent mental health problems	-		2.0 (1.2-3.3)**	
Parental education level				
Moderate	-	-	0.5 (0.3-0.9) [c]*	0.4 (0.2-0.8) [c]*
High	-	-	-	-
Family constellation	-	-	2.0 (1.0-4.1) [d]*	2.3 (1.1-5.0) [d]*
Type of insurance	-	-	-	-
CBCL				
Internalizing	-	1.8 (1.1-3.0)*	1.9 (1.1-3.3)*	3.6 (1.8-7.3)**
Externalizing	-	1.8 (1.1-3.0)*	2.4 (1.4-4.1)**	-
Total Prob lems	1.6 (1.1-2.2)**	2.2 (1.3-3.8)**	3.1 (1.8-5.2)**	4.1 (2.0-8.2)**

- table 6.4 con tinues -

- table 6.4 con tinued -

	GP consultation		GP psych ological diagnoses	
	Child	Adolescen t	Child	Adolescen t
TRF				
Internalizing	-	-	-	2.6 (1.1-6.2)*
Externalizing	-	-	5.7 (3.0-10.9)**	3.3 (1.4-7.9)**
Total Prob lems	-	2.1 (1.0-4.2)*	4.4 (2.3-8.5)**	-
YSR				
Internalizing		-		5.3 (2.6-10.8)**
Externalizing		-		3.0 (1.4-6.6)**
Total Prob lems		2.3 (1.1-4.8)*		6.3 (3.0-13.3)**

Note: Table entries are od ds ratios with 95 % confidence interval s in parentheses. Du e to rou nding, some confidence interval s inclu de the value 1.0, which was in fact somewh at larger. Child school proble ms and parental mental health problems were not assesse d in adolescen ts. * $p < .05$; ** $p < .01$

[a] Greater likeliho od for girls vers us boys

[b] Greater like lihood for boys versus girls

[c] Greater like lihood for low versus moderate education le vel

[d] Greater like lihood for childre n from single parent families

Table 6.5 Multiple logistic regression analyses: child and family characteristics influencing GP consultation and GP psychological diagnoses

	GP consultation		GP psychological diagnoses	
	Child	Adolescent	Child	Adolescent
I. Analysis including Total Problems				
Child gender	-	-	2.2 (1.1-4.6) [a]*	-
Child chronic physical disorders	2.8 (1.8-4.2)**	2.8 (1.6-4.7)**	-	-
General impression of child health	-	-	-	7.2 (2.2-23.3)**
Total Problems (parent report)	1.5 (1.0-2.3)*	-	2.5 (1.3-5.1)**	5.0 (2.1-12.2)**
Total Problems (teacher report)	-	-	3.0 (1.5-6.1)**	-
Family constellation	-	-	-	3.2 (1.1-8.6)[b]*
II. Analysis including Int and Ext				
Child chronic physical disorders	2.9 (1.9-4.4)**	2.8 (1.6-4.7)**	-	-
Child school problems	-		2.5 (1.3-4.8)**	
General impression of child health	-	-	-	6.7 (2.1-21.4)**
Internalizing (parent report)	-	-	-	3.9 (1.6-9.6)**
Externalizing (teacher report)	-	-	4.6 (2.4-9.0)**	-
Family constellation	-	-	-	3.7 (1.3-10.2)[b]*

Note: Table entries are odds ratios with 95% confidence intervals in parentheses. Due to rounding, some confidence intervals in clude the value 1.0, which was in fact somewhat larger. Int = Internalizing; Ext = Externalizing. Child school problems were not assessed in ad olescents.

* $p < .05$; ** $p < .01$.

[a] Greater likelihood for boys versus girls

[b] Greater likelihood for adolescents from single parent families

Discussion

Of our sample of Dutch children and adoles cents with psychological probl ems, approxim ately 80 % had been in contact with their GP during the year of assessm ent. This figure is higher than the 69 % reporte d in a previous Dutch stud y (Foets et al., 1996). However, the latter figu re was based on parent report s of GP contac ts rat her than contact registrat ion data. Altho ugh the previous stud y (Foets et al., 1996) also used contact registration data, consultation rates cannot be compared due to differe nces in lengths of registration periods (3 months for the previous versus 1 year for the present stud y).

Children and adolescents appeared to visi t their GP mainly because of physi cal disorders, as individu als with these disorders were more likely to have consulted their GP. The presence of psychol ogical probl ems also increased the chance of young children consulting their GP (cf. Dulcan et al., 1990; Sayal and Taylor, 2004), but this effect was not found fo r adolescents (cf. Potts et al., 2001).

Alt hough the find ing that youn g children with psychological problems were more likely to visit their GP is promising, GP identification of these probl ems was limited, both for children and adolescents. On average, one in seven children and one in eight adolescents who were considered by their parents or teachers to have psychological problems in the deviant range received a psychological diagnosis from their GP. When GP diagnoses were com pared with adolescent self-report of psychological problems, conco rdance increas ed to 23 %, which is comp arable to previous findings (Kramer and Garralda, 1998). This higher concor dance may be attribute d to the fact that adolesce nts are increasingly able to directly d iscuss their ow n concerns about psychological pr oblems with the GP.

Severity of probl ems hardly affected GP identification of psychological probl ems, as concordance figures increased only slightly when only clinical CBCL, TRF, and YSR proble m scores were considered.

The limited con cordance betw een GP diagnoses and others' reports of psyc hological probl ems may be due to pare nts' reluctance to explicitly mention their concerns about child problems during consultation (Dulcan et al., 1990; Lynch et al., 1997; Sayal and Taylo r, 2004). Due to increases in the frequency with which Dutch patients consult their GP and in Dutch GPs working part-time, GPs' workload has increased substantially

(Van den Berg et al., 2004 b). The resulting limited len gth of consultation s (on average < 10 minu tes) (Van den Berg et al., 2004b) m ay contribute to parents' reluctance, as more time is needed to discuss psychological issues (Horwitz et al., 1992; Van den Berg et al., 2004b). Improving GPs' skills in using psyc hologically orie nted interview techniques, whic h facilitate par ental disclos ure of sensitive information concern ing child mental health, and in actively eliciting parental concerns, may increase GP diagnoses (Sayal and Taylor, 200 4; Wissow et al., 1994). Id entification may also be enh anced by the introductio n of standardised screening measu res in general practice (H orwitz et al., 1992).

Efforts to improve GPs' skills may, however, be hampere d by the fact that GPs' task conception regarding coun selling in case of pedagogical or edu cational difficulties is rather limited and has decreased marked ly duri ng the previous decade. Whereas 3 % of Dutch GPs percei ved this kind of coun sellin g hardly or not at all as their task in 1 987, this figure rose to 18 % in 2001. Merely 21 % of Dutch GPs believed ped agogical or edu cational couns elling to fall largely or com pletely within their role as GP in 2001, wher eas 57 % of GPs had this opinion in 1987 (Van den Berg et al., 2004 b).

Another explanatio n for the limited concordance may be reluctance on the side of the GP to diagnose a child or adolescent with psychological probl ems because of the stigma asso ciated with the diagnosis. Particularly when the likelihood of obtaining specialist mental health care following referral is limite d due to waiting lists, GPs may not see the benefit of diagnosing children with these problems. Strengthening collaboration between GPs and mental health p rofessionals may prov e useful in this resp ect.

Thirdly, con cordance figures might have been under estimated since children and adolescents with parent, teacher, or self-reporte d psych ological prob lems may tru ly have consulted their GP for physical instead of psychological com plaints. This possibility is even more likely because chronic physical disord ers were found to be elevated in those with psychological problems, and were associated with an increased chance of GP consultatio n. Since our study was part of a larger stud y on morbid ity and treatment in general practice, data were collected on GP consultatio n in general, and we were not able to deduct whether GP assis tance was sought for child psychological problems specifically. This means that GPs ind eed might have been aware of the presence of

psych ological prob lems, but did not register them as reason fo r consultatio n. However, restricting future analyses to consultatio ns for psych ological pro blems only could produce a too narro w focus, because previous research has shown t hat even if parents do express concerns abou t their child's psychological problems to the GP, they generally do this in the context of medical problems, instead of directly relating to the actu al problems (Foets et al., 199 6; Garralda, 1990).

The finding that child psychological problems w ere often accompan ied by chronic psychical disorder s could be an indication of somatisatio n. GPs may have difficulty disentan gling physical and psychological sympt oms and may be more inclined to record the ove rt physica l instea d of the under lying psych ological symptom s, thereby redu cing identification of psyc hological proble ms. The fact that the diagnoses occurring most frequently among children and adolescents with unid entified psychological p roblems were primarily purel y physical ones, argues against the possib ility of GPs bein g aware of under lying psyc hological probl ems.

Some of the children and adolescents identified as having psychological problems by parent, teach er or self-report may be able to function adequately, which co uld partly explain why they wer e not identified by their GP. The limited consistency between parent, teacher, and adolescent reports of such problems (Achenbach et al., 1987) implies that there are no uneq uivocal criteria to define the distinction between normal and pathological behaviour. However, our finding that the presence of psyc hological proble ms is associ ated with a range of additional difficulties may indicate a redu ced sense of well-being among children with psychological problems.

The probability of GPs diagnosing children and adole scents with psych ological problems was increased for those whose parents also reported such problems in their child. Inspection of the specific types of proble ms associ ated with GP diagnoses shows a pattern that could be expected based on age-related differences in prevalence rates of the probl em types: young children with externalising, and adolescents with internalisi ng probl ems had better chances of being diagnosed.

Of the add itional pro blems assess ed in our study, only school problems (for young children) and moderate/bad perceived health (for adolescents) significantly increased the chance of receiving a GP psychological

diagnosis. The presence of chronic physical disor ders, which did increase the likelihood of contact with the GP, did not affect the chance of receiving a psyc hological diagnosis whe n other variables were controlled for. Since chronic physical disor ders occurred significantly more frequently in children and adolescents with psychological problems in the deviant range, increasing GPs' awareness of the association bet ween chronic physical illness and the risk for psychiatric disord ers (Meltzer et al., 2000; Rutter et al., 1970) might elevate identificatio n.

The chance of receiving a psychological diagnosis was increased for youn g boys. This effect was only found in the multip le regress ion analys is including To tal Prob lems, but disapp eared in the analys es includ ing Internalizing and Externalizing scores.

The only family characteristic associated with GP psychological diagnoses after controll ing for the effects of other variable s was family constellatio n, and this effect was foun d in adolescents only. Adolescents from single parent families were more likely to receive a GP psyc hological diagnosis. Appare ntly, GPs have an intensified focus on the possib ility of psychological problems in these youngsters.

Alt hough not all children and adolescents with psychological probl ems need add itional care, the limited detection of disorders may prevent or delay the receipt of app ropriate care for the ones who do. Efforts to improv e GP detection of child and adolescent psychological problems may enh ance access to care. Because Dutch GPs' task conceptio n regarding the management of psychological problems has b een narro wed in the last decade, and they ten d to refer patients with psychological problems to other service p roviders (e.g. primary car e psychologists, social wo rkers) more frequently (Van den Berg et al., 2004 b), such efforts should be accompanied by good referral possibilities.

7 Change in children's emotional and behavioural problems over a one-year perio d

Associatio ns with parental pr oblem recognition and service use

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Abstract

Although children with emotional or behavioural problems are at increased risk for future probl ems, knowledge of factors asso ciated with persistence and change in child problems once these problems exist is limited. Using repeated meas ures analyses of variance, the present stud y investigated the association of parental proble m recognition, professional and i nformal servi ce use, and socio demograph ic factors with change in child problems over a one-year per iod, in a sample of 360 children and adolescents with emotional and behavioural problems. Higher overall probl em levels were found for children (aged 4-11 years at baseline) versus adolescents (aged 12-1 7 years), for boys, and for children with less edu cated parents, which indicates the need to address preventive actio ns at these groups. Children who had been in contact with general practitioners or mental health services ha d higher overall proble m levels, suggesting that children who need it most end up receiving professio nal care. Although child emotio nal and behavioural problems decreased significantly over time, this change was not asso ciated with utilisation of professi onal or informal services. Our findings imply the need for methodologically so und research into the effectiven ess of professio nal and informal servi ces for child emotional and behavioural problems.

Keywords: child and adolescen t psychopathology, problem r ecognitio n, serv ice use, longitu dinal change

Introduction

Children with emotional or behavioural problems are at increased risk for persisten ce of problems in follo wing years (Verhu lst and Van der Ende, 1992). Little is known, however, abo ut factors associated w ith persisten ce and change in child problems once these problems exist. In a sample of children referred to a psychiatric clinic, improvement in child problems was positively associated with male gend er, child age, and length of follow-up i nterval. The stro ngest predicting factor for later psych opathology was previous child psychopathology, and few other child, family, and trea tment-rela ted factors ha d additional predictive val ue (Heijmens Visser et al., 2003).

Alt hough Heijmens Visser et al. investigated the associatio n of service use with later child psyc hopathology, their focus was restric ted to mental health service use only. Since only a minority of children with emotional or behavioural problems receiv e mental health car e (Burns et al., 1995 ; Leaf et al., 1996; Verhuls t and Van der Ende, 1997; Zwaanswijk et al., 2003 a), and parents of problematic ch ildren tend to seek h elp from a

variety of sources besides mental health care (e.g. informal care, primary care), it is interesting to investigate the association of these various types of care with change in child problems over time. The present study aims to provide a reflection of this multi-faceted nature of service use for child emotional and behavioural problems by investigating the extent to which utilisation of professional (general practitioner, mental health care) and informal services (teacher, friends or relatives) is associated with change in children's problems over a one-year period. Parents' acknowledgement of the presence of emotional or behavioural problems in their child (problem recognition) and sociodemographic factors (child gender, age group, parental education level) are also investigated as possible correlates of change in children's problems.

Methods

The sample used in this article is part of a larger study on help-seeking for child emotional and behavioural problems. For a more detailed description of the methodology of this study, see Zwaanswijk et al. (submitted-a; b). Data were obtained from the Second Dutch National Survey of General Practice, in which 2,431 parents of children (aged 4-17), who were randomly chosen from a representative sample of Dutch general practice patients, participated in an extensive health interview survey (Westert et al., in press). The patients listed in the participating general practices were comparable to the general Dutch population with respect to age, gender, and type of health insurance (Westert et al., in press). As part of the health interview, children were screened for the presence of emotional or behavioural problems by means of the Child Behavior Checklist (CBCL; Achenbach, 1991a), Teacher's Report Form (TRF; Achenbach, 1991b), and Youth Self-Report (YSR; Achenbach, 1991c). Parents of children scoring in the deviant range of the CBCL, TRF, or YSR Total Problems scales based on the cut-off points suggested by Achenbach (1991a; b; c), were asked to participate in an interview on help-seeking (T1). Parents of 360 of the originally 553 selected children participated (65.1 %). Children of respondents and non-respondents did not differ significantly in age, gender, CBCL and TRF Total Problems scores, but participating parents were more highly educated (Mann-Whitney *U*-test; $p < .01$) and their children had lower YSR Total Problems scores (*T*-test; $p < .05$).

One year after the first interview, 317 respondents (response: 88.1 %) again filled in the CBCL, YSR, and a questionnaire on help-seeking (T2). No significant differences between respondents and non-respondents

were found for child gende r, child age, parents' education le vel, CBCL Total Problems score, and contact with professio nal or informal services on T1.

At both tim e points, parents were asked wheth er or not they had used help for child emotional or behavioural problems from general practitioners (GPs), mental health care, teachers, and fri ends or relatives durin g the year preceding assessm ent. Parental problem recognition was assess ed at T1 by asking whether the child had an emotional or behavioural problem.

To investigate factors associated with change in the level of problem scor es, repeated measures analyses of variance were used, with the variable s listed in table 7.1 as bet ween-subjects factors. Based on child age on T1, the sample was dichotomised into children (aged 4-11 years) and adolescents (aged 12-17 years). Because of the effect of parental education leve l on T1 participation, we controll ed for this variable in the analys es. Analyses were restr icted to parent reports of child problems (CBCL Total Proble ms), because TRF data were not obtaine d at T2, and the numb er of respondents for who m YSR Total Prob lems scor es were available for both time points was limited (N = 87).

After testing the strength of the association of each variable with change in problem scores ind ependen tly, variables with significant effects were entered into a multiple analys is to determine their unique contribution over and above the effects of all other variables. When a significant effect was found for parental educatio n level, dummy variables were subsequently includ ed in the model to test whether the patterns of change for children from highly and moderately edu cated parents differed significantly from the pattern for children from parents with low education leve l.

Table 7.1 Descriptives of factors include d in the present study, and their within-subjects and bet ween-subjects effects on the change in the CBCL Total Proble ms score s

			Total Proble ms					
			Mean s		Within		Between	
	N	%	T1	T2	F	p	F	p
Child gender	360	54.4 % boys	39.35	31.33	.38	.54	4.08	.04
		45.6 % girls	34.02	24.62				

- table 7.1. con tinues -

- table 7.1 con tinued -

			Total Proble ms					
			Mean s		Within		Between	
	N	%	T1	T2	F	p	F	p
Child age group at T1	360	68.3 % child	38.76	29.97	.01	.93	7.98	.01
		31.7 % adolescen t	32.96	24.26				
Parental education								
level	357	13.4 % low	39.81	33.00	.82	.44	5.14	.01
		50.1 % moderate	38.35	30.65				
		36.5 % high	34.08	23.45				
Parental problem								
recognition	354	42.9 % yes	43.39	37.04	.03	.87	2.21	.14
		57.1 % no	32.23	21.44				
Service use								
General practitioner	311	17.4 % yes	50.24	44.72	.10	.76	7.27	.01
		82.6 % no	34.36	24.98				
Mental health servi ces	311	18.0 % yes	47.09	41.95	1.53	.22	4.11	.04
		82.0 % no	34.89	25.18				
Teach er	311	36.0 % yes	44.20	37.68	.14	.71	.10	.75
		64.0 % no	33.14	23.08				
Frie nd s or relatives	311	34.4 % yes	45.45	38.82	.16	.69	2.82	.09
		65.6 % no	32.75	22.83				

Note: Service use was assessed at T1 and/or T2

Results

Since our sample was screened for the presence of emotional or behavioura l proble ms, the overall mean CBCL Total Proble ms scores at T1 (36.9; sd. 18.3) and at T2 (28.3; sd. 20.9) were above th e means of a Dutch normative sample (Verhuls t et al., 1996). However, because screening was based on deviant Total Probl ems scores on at least one of three separate measures (CBCL, TRF, and YSR), not all, but 244 c hildre n (68 %) in our sample had deviant CBCL Total Proble ms scores at T1.

Overall, CBCL Tota l Proble ms scores decreased significa ntly ove r a one- year p eriod (*T*-test; $p < .01$). In 43.3 % of our samp le, scor es changed from deviant to normal level durin g the assessm ent period, w hereas in 2.2 % scor es deteriorated from the normal to the deviant range. Comparable percentages of children remained in either the deviant (33.3 %) or the normal range (30.2 %).

When asked directly whether their child had an emotional or behavioural problem (parental problem recognition), 42.9 % of parents confirmed the presence of such problems. This percentage was somewhat higher (48.8 %) for parents whose children scored in the deviant range of the CBCL Total Problems scale at T1. Children with deviant CBCL Total Problems scores combined with parental problem recognition scored significantly higher on all CBCL syndrome scales (except for Somatic Complaints; *T*-tests; $p < .05$) than deviant scoring children without parental problem recognition.

Frequencies of professional and informal service use for the total sample are presented in table 7.1. Children who had used services had significantly more problems at baseline than those who had not used the same type of services, both when CBCL Total Problems were assessed continuously (*T*-tests; $p < .01$) and when they were dichotomised into deviant versus normal range (χ^2-tests; $p < .05$). Within the group of children scoring in the deviant range of the T1 CBCL Total Problems scale, service utilisation was significantly more frequent among those with additional parental problem recognition (χ^2-tests; $p < .01$; data not shown in table 7.1). Users and non-users showed significant reductions of
Total Problems scores over time (*T*-tests; $p < 0.5$). These effects were found for professional as well as informal services.

When assessed independently, all factors had significant within-subjects or between-subjects effects on the change in the CBCL Total Problems scores, and were therefore included in the multiple repeated measures analysis of variance. Results of the latter analysis are listed in table 7.1.

After controlling for the presence of other variables, none of the variables included in the analysis had significant within-subjects effects on the change in CBCL Total Problems scores. Child gender, child age group at baseline, parental education level, contact with GP, and mental health service use had significant between-subjects effects. Higher Total Problems scores were therefore found for children (aged 4-11 years at baseline) versus adolescents (aged 12-17 years), for boys, and for children who had used help from GPs or mental health services at T1 and/or T2. Children from parents with low education level had significantly higher CBCL Total Problems scores than children from highly educated parents.

Discussion

The present study was aimed at investigating the extent to which parents' recognition of child emotional and behavioural problems, professional and informal service use for these problems, and sociodemographic factors were associated with change in child problems over a one-year period.

In general, emotional and behavioural problems decreased significantly over the course of one year, both in the sample as a whole and in children who had used professional or informal services. However, the mean CBCL Total Problems scores for the total sample and for service users remained above the normative mean after one year, indicating the problematic nature of the sample.

The finding that children who had used services had significantly more emotional and behavioural problems at baseline than children who had not used services (cf. Angold et al., 2000; Heijmens Visser et al., 2003), suggests that, in part, children who need it the most end up receiving care. This was confirmed by the finding that, after controlling for other variables, children who had been in contact with GPs or mental health care had significantly higher problem scores over the course of one year.

Whereas service use was significantly more frequent for children with emotional or behavioural problems in the deviant range, parents' acknowledgement of the presence of such problems had an additional influence on the frequency of service use within the deviant scoring group. Considering the fact that less than half of the parents who reported child problems in the deviant range also acknowledged the presence of these problems when asked directly, parents' non-recognition of child problems could constitute a first reason for parents not seeking help. On the other hand, children with deviant CBCL Total Problems scores who were also recognised as problematic by their parents had more serious problems than children without parental problem recognition. The concept of parental problem recognition may therefore distinguish between children with emotional or behavioural problems who are able to function adequately, and those requiring special attention.

The elevated problem scores in boys, younger children and children from less educated families indicate the need to address preventive actions at those groups. This is even more salient since children from lower educated families were underrepresented in this study and problem

levels in those children may therefore have been underestimated. Moreover, the previous finding of older children showing more improvement in emotional and behavioural problems over a six-year interval (Heijmens Visser et al., 2003) underscores the need to focus preventive interventions at young children.

An intriguing question is whether children with emotional or behavioural problems need some sort of care to ensure them to develop towards less problematic behaviour, or whether their problems would anyhow reduce over time. The absence of an association between any of the four types of service use and the change in child problems found in the present study might be interpreted as evidence for the latter assumption. However, we believe that this finding does not automatically imply the ineffectiveness of professional and informal services in reducing child emotional and behavioural problems. Service use may have affected aspects of the child's development not covered by our outcome measure, and the limited time span of the study may have prevented detection of any associations between service use and change in child problems. More importantly, our study contained limitations that are typical for naturalistic designs, such as the impossibility of random assignment to conditions, inclusion of a broad range of treatments, and the presence of many possibly confounding factors, which restricts the possibility of drawing firm conclusions about the effectiveness of services in reducing child symptoms. The chronicity of child psychopathology and the limited use of empirically validated treatments may, on the other hand, indeed prevent services from being effective. What our findings do imply, therefore, is the need for methodologically sound research into the effectiveness of professional and informal services for child emotional and behavioural problems, with large samples, multiple data waves, and assessment of outcomes on multiple domains (Angold et al., 2000).

8 Summary and di scussion

Summary

After summarising the study design and its main results, findings of the present study are discussed in the light of theoretical considerations and previous results. Based on the limitations of this study, some recommendations for future research are presented. The chapter ends with implications of the results for clinical practice.

Background, research questions, and method

The main aim of the study presented in this thesis was to investigate the process of help-seeking for child and adolescent psychopathology. The general help-seeking model by Goldberg and Huxley (1980; 1992), and adaptations of this model to the situation of child and adolescent psychopathology (Costello et al., 1998; Logan and King, 2001; Verhulst and Koot, 1992) were used as central framework. In these models, the help-seeking process is defined as a sequence of stages proceeding towards increasingly intensive forms of care for mental health problems, ranging from the general community, in which no special care is provided, through consultation and problem recognition in general practice, to treatment in mental hospitals. This pathway towards mental health care is hypothesised to include several filters, which represent selection processes that determine at which stage treatment will be obtained. Progress on the pathway is influenced by characteristics of the child, his or her parents, the family, and the broader social context.

In this thesis, we investigated the contribution of various characteristics of child, family, and broader social context on (1) parents' need for help for child emotional or behavioural problems, (2) help-seeking in general practice for these problems, (3) identification of child emotional and behavioural problems by the GP, (4) help-seeking in mental health care, and (5) help-seeking from informal sources of care. Additionally, change in children's emotional and behavioural problems over a one-year period was studied in association with parental problem recognition and utilisation of professional and informal services.

The study consisted of three stages. In the first stage, which was part of the Second Dutch National Survey of General Practice, GP contacts and morbidity presented to the GP were electronically recorded during one calendar year for patients registered in 104 Dutch general practices. A random sample of 2,431 children and adolescents aged 4 to 17 years participated in an extensive health interview survey. Data for children aged 4 to 11 years were obtained by means of a proxy interview

adm inistered to one of the parents, wher eas adolescents aged 12 to 17 years were interviewed themselves. The interview include d questions concerning sociodemograph ic characteristics, health ind icators, health care utilisation, life style, soci al context charac teristics, opinions about health care, and a screening for the prese nce of child emotional and behavioural problems.

Children and adolescents who were scree ned positive for the prese nce of emotional or behavioural problems were selected for participation in the second sta ge of the study. A tota l nu mber of 360 particip ated (response rate: 65.1 %). By means of a standardised psyc hiatric interview, adm inistered to the child's primary caregiver (for all participants), and to the adolescent himself (for participants aged 12 to 17 years), psychiatric diagnoses were obtained. In addition to this, parents were interviewed abou t child and fam ily characteristics, problem recognitio n, and help-seeking for child emotional or behavioural problems in the preceding twelve months.

One year after the previous data collection, participants were contacted again by mail. Parents were asked to indicate the presence of emotional and behavioural problems in their child, and were asked to complete a questionn aire concer ning problem recognition and help-seeking for these probl ems in the preceding year. Adolescents aged 12 years and ol der were also asked to indicate the presence of any emotional or behavioural problems. Of the or iginal sample, 317 (88.1 %) particip ants resp onded.

Chapter 3 of this thesis was bas ed on data obtained in a previous study on psych opathology and mental health service use, conducted by the Department of Child and Adolescent Psychiatry of the Erasmus MC-Sophi a Children's Hospital in Rotterdam, the Netherlands (Verh ulst et al., 1997 a; Verhu lst and Van der Ende, 1997).

A revie w of recent findings on help-seeking fo r child and adolescent emotional and behaviou ral problem s (chapter 2)

First, a literature review was condu cted to gain insight into recent find ings concer ning the help-seeking process for child and adolescent psychopathology, focusing on determinants of parental and adolescent probl em recognition and help-seeking, and problem recognition by the GP. Searches for emp irical stud ies pu blis hed betw een 1992 and 2001 in Psych lit and Medline databases yielded a total number of 47 relevant publicatio ns.

Several variables in the child (age, the presence of medical and school-related proble ms, adolescents' informal help-seeking), and the parents or family (past mental health service use by pare nts or other relative s, family size, an d type of child maltreatmen t) were found to influence parental or adolescent problem recognition and/or help-seeking, whereas refinements were found for the effects of type of child psychopathology, child gend er, adolescent attitud es and personality, parental psychopathology, social suppor t, and sociod emograph ic variab les. Problem recognitio n by the GP proved to be influenced by child gender, child age, past treatment for child psychosocial problems, school p roblems, family com position, life events, the type of visit, and acquaintance with the child.

The results of the literature r eview called fo r further research in to problem recogn ition by the GP and the role of school person nel in the detection and referral of, and prov isio n of help for child and adolescen t psych opathology. The results also implied the necess ity to differentiate between professional an d informal so urces of care in future studies.

Factors associated with adolescent mental health service use, self-perceived need for care, and unmet need (chap ter 3)

Whereas parents are usually the ones who initiate servi ce use for you ng children's emotio nal or behavioural probl ems, help-seeking in case of adolescent mental health problems also involves the adolescents themselves. Chapter 3 was specifically focused on adolescents' help-seeking. Parent, family, and adolescent characteristics were investigated as correlates of adolescent mental health service utilisation, self-perceived need for care, and unm et need, using a general population sample of 1,1 20 Dutch adolescents aged 11 to 18 years.

Appro ximately 3 % of the adolescents in this sample were referred for mental health ser vices, and almos t 4 % of adolescents reported an unm et need for help. Adolescent mental health ser vice utilis ation and self-perceived need were most strongly assoc iated with adolescents' self-reported problems and indicators of family stress (single parenthood and changes in family com posit ion). Adolescents with low education level, poor com petence in activities and better school results, and adolescents from non-Caucasian or Mediterranean descent, were more likely to be referred to mental health care. The chance of adolescents reporti ng self-perceived need for services was increased in girls, older adolescents, and adolescents who had parents with psychiatric dis orders. Unm et need was

significantly associated with adolescents' self-reported problems, female gender, and low adolescent edu catio n level. Results showed the rel uctance of adolescents to consult mental health servi ces, even when they ack nowledged the presence of emotio nal or behavioural problems. Particularly adolescent girls, adolescents with internalising problems, and older adolescen ts were at risk for not effectuating their concerns into mental health care utilisatio n.

The help-seeking process for children aged 4-1 1 years (cha pter 4)

In previous studies, help -seek ing for child emotio nal and behavioural probl ems has been studied mainly by investigating separate help-seeking stages in isolatio n from each other, instead of investigating the help-seeking process as a wh ole. We believed the inclusion of multiple help-seeking stages, professio nal as well as informal serv ice providers, and various characteristics of the child, family, and context as possib le determinants of the help-seeking proce ss to be essential for unders tanding the comp lex nature of help-seekin g. Therefore, structural equation modelling was used to empirically test a com prehensive model of the help-seekin g process for child psych opathology in a sample of 246 children aged 4 to 11 years, who w ere selected for havin g emotio nal or behavioural problems.

The Dutch GP was found to p lay a limited role in this help-seeking process, both as service provi der as well as gatekeeper to mental health care. Although Dutch children are suppose d to enter mental health care only after referral by their GP, many children entered mental health care directly, or with the help of other service providers. Par ticularly school-based personnel (sch ool physicians, school psychologists, education al suppor t services) w ere influential in this res pect. The importance of the child's school in the help-seekin g process was also demonstrated by the find ing that teachers were often used as service providers. Parents frequently consulted friends and re latives for their child's problems as well.

Inspection of the influence of child, family and co ntext variables on the help-seeking process showed the marginal impact of child characteristics. Only the presence of coexisting chronic phys ical problems in a child was directly related to the help-seeking process, as children with these probl ems were more likely to be considered in need of care. Child gend er and coexisting academic problems did exert their influence on the help-seeking process only indirectly, through their impact on the teacher's

perception of child problems, where as child age influenced neither serv ice need nor help-seeking. Family characteristics had a stronger impact on the help-seeking process, with changes in family structure, family fun ctioning and the acq uaintan ce with a relativ e who had used mental health care influencing several aspects of the pathw ay to care. An important context factor affecting the help-seeking process was the teacher's perception of emotio nal or behavioural probl ems in the child, which affected service need almost as strongly as parents' own perception of child problems. The abse nce of any effects of sociod emograph ic context variables (pare ntal education level, family income, and type of insurance) on the process of help-seeking can probably be ascribed to the nature of the Dutch health care system.

The help-seeking process fo r adolescent s with internalising problems (chapter 5)

Because of the app arent obstacles for adolescents with internalising probl ems on the pathw ay to mental health care (chapter 3), chapter 5 specifically addressed help-seeking for this grou p of adolescents. This was done by empirically testing a path model of the help-seeking process, which was comparable to the model for children used in chapter 4 with resp ect to the help-seeking stages and service providers included. Due to limited sample size, determinants of the help-seeking process could not be taken into accoun t. Since adolescents were expected to exert an increased influence on the help-seeking process, the model in chapter 5 include d not only parents' and teachers' perceptions of proble ms, but also adolescents' perception of the presence of internalising problems and their need for services. Participants for this part of the study were 114 adolescents aged 12 to 17 years, who were selected for having emotional or behavioural problems.

Alt hough adolescent girls reported more internalising problems than boys, th e help-seeking m odel was demonstrated to be consis tent across gender. Results confirmed adolescents' increasing autonomy as well as parents' contin uing influence on the help-seeking process. The acknowledgement of the need to seek help when problems are present was detected as the first obst acle on the pathway to care for adolescents with internalising problems. Mobilising teachers to increase parents' or adolescents' aware ness of the need to seek help was shown not to be the best strategy, however, as, in contrast with find ings for younger children (chapter 4), teac hers' perception of proble ms did not influence service need. The less promine nt role of the teacher in the help-seeking proce ss

for adolescent internalising psychopathology was accompanied by an increasingly important role of the GP, who functioned more according to his formal role as gatekeeper in the help-seeking process for adolescents than for younger children.

The role of the GP in the help-seeking process (chapter 6)

Because the GP's role was found to be different in help-seeking for child versus adolescent psychopathology (chapters 4 and 5), this role was further investigated in chapter 6. Child and family characteristics were investigated as correlates of GP consultation and GP diagnoses of child psychological problems in a general population sample of 2,449 children and adolescents (aged 4 to 17 years) and their primary caregivers.

Results showed that although approximately 80 % of children and adolescents with psychological problems had been in contact with their GP during the year of assessment, they appeared to have consulted their GP primarily because of the presence of chronic physical disorders. Concordance between parent, teacher, and adolescent reports of the presence of psychological problems, and GP diagnoses of such problems was limited. The likelihood of being diagnosed with psychological problems by the GP was increased for children and adolescents whose parents or teachers also reported such problems, for children with school problems and young boys, for adolescents with negative health perceptions, and for adolescents from single parent families.

Although not all children and adolescents with psychological problems need additional care, the limited consultation for child mental health problems and the limited detection of disorders by GPs may prevent or delay the receipt of appropriate care for the ones who do.

Correlates of change in children's and adolescents' emotional and behavioural problems over a one-year period (chapter 7)

Although children and adolescents with psychopathology are at increased risk for future problems, knowledge of variables associated with persistence and change in child problems once these problems exist is limited. In chapter 7, the change in child emotional and behavioural problems over a one-year period was investigated in association with parental recognition of the presence of such problems, utilisation of informal and professional services, and socio demographic variables (child gender, age group, and parental education level), in a sample of

360 children and adolescents selected for having emotional or behavioural problems.

Elevated overall problem levels were found for children (aged 4-11 years at baseline) versus adolescents (aged 12-17 years), boys, and children with less educated parents. Furthermore, children who had received help from the GP or mental health services had generally higher emotional or behavioural problem scores than non-users. This indicates that, in part, children who need it the most end up receiving care.

Whereas service use was significantly more frequent for children with emotional or behavioural problems in the deviant range, parents' explicit acknowledgement of the presence of child problems had an additional influence on the frequency of service use within the deviant scoring group. Less than half of the parents who reported child problems in the deviant range also acknowledged the presence of these problems when asked directly. The concept of parental problem recognition appears to distinguish between children with emotional or behavioural problems who are able to function adequately, and those requiring special attention.

Although child emotional and behavioural problems decreased significantly over the course of one year, this change was not associated with utilisation of professional or informal services.

Discussion

The results of this thesis confirm previous findings concerning the limited use of mental health care by children and adolescents with emotional and behavioural problems (Burns et al., 1995; Flisher et al., 1997; Ford et al., 2005; Leaf et al., 1996; Pavuluri et al., 1996; Saunders et al., 1994; Sourander et al., 2001; Verhulst and Van der Ende, 1997). Even in a sample selected for having emotional and behavioural problems, approximately 16 % of children and adolescents had used mental health services in the preceding year. This figure is only slightly higher than the 13 % mental health referral found in a Dutch general population sample for which data were obtained a decade ago (Verhulst and Van der Ende, 1997). Considering the fact that prevalence rates for child emotional and behavioural problems have not increased over a ten-year period (Achenbach et al., 2003; Sourander et al., 2004; Verhulst et al., 1997c), the absence of any change in Dutch child mental health care use is not surprising. It is also in line with findings by Achenbach et al. (2003), who

reported no change in rates of child mental health service utilisatio n from 1989 to 1999, either for a nation al American samp le, or for children with deviant CBCL Total Proble ms scores.

A study con ducted in Finland (S ourander et al., 2004), however, repor ted a considerable increase in servi ce use for child emotional and behavioural problems b etween 1989 and 199 9, even though no increas e in child problems had taken place. This find ing led the authors to conclude that parents' atti tudes towards use of services for child mental health problems had changed positively. However, since servic e use rates in the study by Sourand er et al. includ ed school health services and social s ervices for child emotion al or behavioural problems, compar ison between these figures and our rates of specialist mental healt h care is hamp ered.

Filte rs on the pathway to care

To increase our unders tan ding of the limited number o f disord ered children and adolescents in mental health care, the present stud y investigated the process of help-seeking for child emotio nal and behavioural problems. By studying help-seeking as a process including various stages and ser vice providers, several filters on the pathway to mental health care were detected. In the following sections, these filters are considered in terms of the Goldberg and Huxley model (1980; 1992).

Filt er 1: Recognition of the impact of child emotion al or behavioural problems

Goldberg and Huxley's first filter included problem recognition as well as the decision to consult a GP for child problems. In chapter 2, a distinction bet ween these two aspects of the first filter was advocated, and this distin ction is also app lied here. Following Angold et al. (1998), we believe that it is not so m uch parents' recognitio n of the presence of child emotional or behavioural problems per se that leads them to use specialist mental health care, but rather their experience of burden asso ciated with the prese nce of such problems. Although perceived burden was not directly assess ed in the study described in this thesis, we believe that our measures of proble m recognition and servic e need reflect to some degree the difficulties in the lives of parents and children caused by child emotional and beh avioural problems. Because both indicators fun ction ed as the link between parent and adolescen t reports of the presence of child symptoms (CBCL or YSR proble ms scores in the devia nt range) and service utilisation (chapters 4, 5, and 7), they appeared to

discriminate betw een parents and adolescents who do perceive the presence of child problems but consider themselves able to manage these problems without h elp, and those for w hom the impact or burden of child probl ems is strong enough to require outsid e help. The acknowledgement of the burden of child emotional or behavioural problems therefore constitutes the first filter on the pathw ay to care.

The distinction between the mere presence of child symptoms and parents experie ncing these symptoms as a burden was illustrated by the finding that less than half of the parents who re porte d CBCL Total Probl ems in the deviant range also acknowledged the prese nce of an emotion al or behavioural prob lem in their child when asked directly (parental problem recognition; chapter 7). Moreover, in the sample of childre n aged 4 to 11 years, 67 % of those with devia nt CBCL Total Probl ems scores were not regarded to be in need of services by their parents (chapter 4). This figure was even higher for adolescents with internalisi ng problems in the deviant range, as more than 80 % of them were not regarded to have a need for care (chapter 5).

The importance of recognition of the severity of problems was also demonstrated in chapter 3, in which adolescen ts' percep tions of problems were taken into consideration. Mental health referral rates of adolescents who recognised the problematic nature of their emotio ns or behaviour were considerably lower than previous results in which parental problem recognitio n was taken into acco unt (cf. Soura nder et al., 2001; Verhulst and Van der Ende, 1997). This indicates that adolescen ts who recognis e the presence of their probl ems are less li kely than parents to translate these concerns into help-seeking actions. This may partly be ascribed by adolescents' limited ability to initiate service use without their parents' involvement, but it may also reflect adolescents' reluctance to seek help for emotional or behavio ural problems.

Filt er 2: Consulting the general practitioner for child emotion al and behavio ural problems

Results of this thesis confirm previous findings concerning the limited consultatio n of GPs in case of child emotio nal and behavio ural problems (Foets et al., 1996; Ford et al., 2003). In chapter 6, contact registration data from a large general populatio n sam ple of children and adolescents were used to investigate rates of GP consultatio n. About three quarters of the sample had been in contact with their GP duri ng the year of assessm ent, whereas approxim ately 80 % of children and adolescents

with emotional or behavioural problems in the deviant range had contacted their GP. Although these consultation rates seem promisingly high, GP consultatio n appear ed to have occurred primarily because of chronic physical disord ers. The presence of emotio nal or behavioural problems in creased the likeliho od of GP consultation in children aged 4 to 11 years only.

The data presented in chapter 6 reflected GP consultation in general and could therefore not be used to draw firm conclusions about consultation rates for child emotional or behavioural problems i n particul ar. This informatio n was, however, available for the sample that was selected for the presence of these problems (chapters 4 and 5). Consultation rates for this selective sample were considerably lower than those found in the general population sample. Merely 13 % of children and 15 % of adolescents had visited their GP for emotio nal or beh avioural problems in the year preceding assess ment, which is even less than the 24 % primary health car e consultatio n previously found for children with ICD 10 (World Health Organ ization, 1993) diagnoses of psychiatric disord ers (Ford et al., 2003).

Because the Dutch GP is supposed to fun ction as gatekeep er to mental health care, and diso rdered children and adolescents are supposed to enter mental health services only after referral by the GP, the limited GP consultatio n can be regarded as the next filter on the pathway to specialist care for children and adolescents with emotio nal and behavioural problems.

Filt er 3: Identification of child emotion al and behavioural problems in general practice

In chapter 6, merely one in seven children and one in eight adolescents wh o were considered to have emotional or behavioural problems by their parents or teachers, were diagnosed with psyc hological proble ms by their GP. Concordance between adolescent self-reports and GP diagnoses w as somewh at higher, but still, 77 % of adolescents with self-reported probl ems in the deviant range did not receive a psychological diagnosis from their GP. These findings may be interpreted as limited recognition of child emotional and be havioural proble ms by GPs, but several alternative explanations can be noted. Par ents' reluctance to explicitly mention their concerns regarding child mental health problems may, for instance, have decreas ed concor dance between parents' and GPs' reports of the presence of such problems in the child. Furthermore , GPs' reluctance to diagnose

children with mental health problems because of fear of stigma or limited referral possibi lities, parents consultin g for physical con cerns instead of psych ological ones (Fo ets et al., 1996; Garral da, 2002), GPs' difficultie s in dise ntangling physical and psychological symp toms, and the possib ility of children functio ning adequately despite the presence of psychological probl ems, may be reasons for limited concordance. Still, since the data presented in this thesis co nfirm previous findings concerning the limited recognitio n of child emotional and behavioural problems in general practice (Cos tello et al., 1988; Dulc an et al., 1990; Kelleh er et al., 1997 ; Sayal and Taylor, 200 4), we believe this to be another filter on th e pathway t o specialist care.

Filt er 4: The GP as gatekeeper in referral to mental health care

The limited consultatio n of GPs in case of child or adolescent psych opathology and the limited recognition of child problems by the GP restr ict GPs' opportun ities for referri ng disor dered children and adolescents to mental health care, thereby creating a fourth obstacle on the pathway to specialist care.

For children aged 4 to 11 years, the Dutch GP was found to fun ctio n less accor ding to his formal role as gatekeeper to mental health care than was expected. This is in contrast with results from a recent study in the UK (Ford, 2004), in which contact with primary care was strongly related to contact with mental health servic es. One could question whether the limited gatekeeping role of the GP really constituted an obstacle on the pathway to care, since parents still managed to find their way into child mental health care, either by direct ly contacting these services or by entering these services with the help of other service provi ders. Nevertheless, mental health care utilisation rates continu ed to be low, as merely 15 % of children who were selected for having emotional or behavioural probl ems had used these services in the preceding year.

The GP's role in referring adolescents with internalising problems to mental health care was stron ger than for younger children. Sixty-one percent of adolescen ts, opposed to 4 1 % of children aged 4 to 11 years, had entered mental health care after GP referral . The explanation for this differe nce is not entirely clear at this stage and require s further investigatio n. We hypothesis ed that the greater importance of GPs might be attributed to a higher prevalence of somatic problems among adolescents with internalising problems (Kramer and Garralda, 1998), which might increase GP consultation in general. The likelihood of

consultatio n in general practice was indeed shown to be elevated for children and adolescents with chronic somatic disord ers and an asso ciation between the presence of psychological and physical problems was shown (chapter 6). Still, rates of GP consultatio n did not differ substantially between children and adolescents, neither whe n GP contact in general nor whe n contact specifically for child emotio nal or behavioural problems was considered. Elevated identification of adolescent mental health prob lems by the GP could neither account for the stronger gatekeeping role of the GP in case of adolescent internalising probl ems, as concordance between parents' or teachers' reports of the presence of emotion al or behavio ural prob lems and GP psychological diagnoses was as limited for adolescents as for young children.

The importance of informal care, particula rly school-based services

The literature review (chapter 2) demonstrated the necess ity of includ ing informal sources of care for child emotio nal and behavioural problems in studi es on help-seeking. The informal servi ce providers inclu ded in the present stud y (teachers and fri ends or relatives) indeed proved to fulfil an important role in the process of help-seeking for child and adolescent psych opathology, as utilisation of these service provi ders was considerably more frequent than utilisation of more formal sources of care, such as the GP and mental health serv ices (chapters 4 an d 5). These find ings are in line with previous stud ies (Burns et al., 1995; Cohen et al., 1991; Farmer et al., 2003; Ford et al., 2003; Leaf et al., 1996; Zahner and Daskalakis, 1 997).

The specific significance of school- based service provi ders was also demonstrated in a recen t Finn ish study (So uran der et al., 2004). Wh en parents were asked whom they would consult in case of future concern s abou t child emotio nal or behavioural probl ems, teachers were mentioned as second m ost preferre d source of help, following the spouse. About 80 % of parents also mentioned other school-based ser vice provider s, such as school health professionals, school health nu rses, school psych ologists, and s chool physician s, as certain or most likely source s of consultatio n. Whereas these contacts with school-based services may partly occur because of the consequences of child psychopathology for the child's edu cation al function ing (Ford et al., 2005), their frequent occurrence can probably also be at tributed to the lower threshold for seeking help within the school system as oppos ed to general practice or mental health care.

Ack nowledgement of the importance of the school was also reflected in a recen t publication b y the Dutch Education C ouncil (Onderwijsraad, 2004), who recommend ed an increase in the role of schools in order to achieve a more coherent system of services for children and adolescents with psychosocial pro blems. According to th e Council, schoo ls should not only be involved in identifying and referring children with emotional and behavioural prob lems and in preven ting their problems, b ut should also collaborate with outside professio nal service provid ers in provid ing care to these youn gsters (Onderwijsraad, 2004).

Based on findings of the present study, howeve r, a differe ntiation regarding the importance of the school in the process of help-seeking for child and adolescent emotio nal and behavioural problems could be made. School personnel play ed a considerable part in the help-seeking process for children aged 4 to 11 years, both in influencing service need, and in the provisio n of and the referral for help. As far as the function of gatekeeper to mental health care was concerned, the importance of school perso nnel even exceeded the role of the GP, since the majority of children, who were not referred to mental health serv ices by their GP, had entered these services with the help of school-base d service provider s, such as school physicians, school psychologists or education al suppor t services.

For adolescents aged 12 to 17 years, however, a rather different picture emerged, with teachers not influencing parents' or adolescents' need for serv ices, and utilisation of teachers as servi ce provid ers bei ng less frequent than for you nger children. This was accompanied by a stro nger influence of the GP on the process of help-seeking for adolescents.

A comparable difference bet ween the roles of schools in the processes of help-seeking for children and adolescents was foun d in a study by Ford et al. (2005), in which parents of younger children were more likely to have been in contact with teachers, even though psychiatric disorders were more commo n in older children. This finding can probably b e ascribed to the fact that, in contrast with second ary school pupils, pr imary school children have one teacher, who may therefore have a greater opport unity to get well acquainted to his pu pils. Moreover, primary school children are often taken to and from school, whic h facilitates informal contact between teachers and par ents. We should, however, keep in mind th at our results on adolescent help-seeking concerned adolescents with

internalisi ng problems only. Teachers may play a more important part in help-seeking for adolescent externalising problems, because such probl ems cause more direct disturbance in the classroom and may therefore be more easily detected by high school teachers.

Factors influencing progress on the path way to care

The results of the present study provid e confirmation for the model proposed by Brann an et al. (2003), who hypothesised that mental health serv ice use is one of many possible ways in whic h parents respond to the stress ors they face when having a child with emotional or behavioural probl ems. The mere presence of child symptoms can be a considerable source of str ess, as was illustrated by the asso ciation b etween parents' and adoles cents' repor ts of the presence of problems and th eir need for serv ices and subsequent utilisation of services. The amount of stress caused by the presen ce of child problems appears to be inde pendent from the specific type of problems. Both internalizing and externalizing probl ems were asso ciated with adolescents' need for services (chapter 3). Prev ious research (Verhulst and Van der Ende, 1997) showed a comp arable finding for parents' need for services for youn ger children's problems.

Parents may face add itional stress ors not directly related to child psych opathology. When these stressors pile u p and exceed paren ts' ability to cope with problems, parents may decide they need outside help. The finding that addit ional stressors, such as having a child with chronic physical problems or school problems, or experiencing family stress (e.g. because of poor fam ily fun ction ing, single parenthood, or recent changes in family composi tion), were also associ ated with a need for care, confirmed this notion. Most of the additional stressors were also asso ciated with utilisation of professional services, which im plies that children and adolescents using these services are likely to come from families with multi ple problems. The finding that poor family fun ctioning was not associated with a greater likelihood of utilisation of serv ices even though it did lead to an increased need for care – on the contrary, it decreased the chance of parents seeking advice from the child's teacher – is, however, in contrast with the latter statement.

Another group at risk for not translating their concerns abou t their mental health into service use were adolescent girls. Despite their elevated need for care, these girls did not show an increased likelihood of mental health serv ice utilisation, but they did report an unmet need for services. A

com parable risk was found for old er adolescents and adolescents with internalisi ng problems. Apparently, these adolescents face additional barr iers on the pathw ay to care, which redu ce their chance of getting the help they need.

Confirmation was found for the access ibility of Dutch health care in terms of financial and soc iodemograp hic characteristics. Variables such as parental education level, family income, type of insurance, and parental occup ation level were found n ot to influence the help-seek ing proces s directly (chapters 3 and 4).

In addition to stud ying variables influencing service need and utilisation of professional and informal services, we also investigated factors asso ciated with GP identification of child emotional and behavioural probl ems, because his formal gatekeeping role puts the Dutch GP in a crucial positi on along the pathway to specialist mental health care. Alt hough children and adolescents appeared to visi t their GP mainly because of chronic physical disord ers, the presence of such disorders did not increase the chance of being diagnosed with psychological probl ems by the GP.

Children and adolescents who were per ceived to have emotio nal or behavioural problems b y their parents or teachers were more likely also to be identified as such by their GP. The specific types of problems asso ciated with GP diagnoses showed a pattern that could be expected based on age-related differences in prevalence rates of the problem types: youn g children with externalising, and adolescents with internalising probl ems had better chances of being diagnosed by their GP.

The prese nce of add itional stressors (e.g. for young children: school probl ems, for adolescents: negative health perceptio ns, and li ving in a single parent family) not only increased the likelihood of service need and utilisation, – as was described above – but was also associated with an increased chance of children and adolescents bei ng diagnosed with psyc hological proble ms by their GP. Addition ally, youn g boys were more likely to receive a psychological diagnosis.

Effectiveness of services

Efficacy of treatments for child emotional and behavioural problems has repeatedly been demonstrated (Weisz et al., 1995; Weisz and Jensen, 2001). However, the conditions und er which these studies have been

cond ucted (i.e. in highly controlled settings, with groups of carefully selected indivi duals) bare little resemblance to the comple x reality of serv ice use, with a heterogeneous group of disordere d children receiving less stru ctured care, u sually from both profession al and informal caregivers, and limited availability of mental health care. Evidence for the effectiveness of clinical treatments in naturalistic settings is, nevertheless, limited (We isz et al., 1995; Weisz and Jensen, 2001).

Stud ies as the one presented in this thesis can provide suggestions on how to increase rates of serv ice utilisation for children and adolescents with emotional or behavioural problems (see Clinical implications). Policy decisions regarding such efforts could be strengthened when the effectiveness of these services was demonstrated. Even though utilisatio n of neither professi onal nor informal servic es was associ ated with change in child problems over a one-year period in the present stud y (chapter 7), methodological limitations prohibited us to automatically interpret these resu lts as indicatio n of the ineffectiveness of service use. Still, Angold et al. (2000) argued that effectiv eness of out-patien t mental health care in a naturalistic setting can be demonstrated, provi ded that the sample being studi ed is large enough, outcome measures inclu de key symptoms that lead to referral for treatment, and differences in disord er trajectories bet ween treated and untreated subjects are taken into accoun t by includ ing multiple data waves.

Limitations of the study and implication s for future research

The present study has yi elded a number of interesting results regarding the process of help-seeking for child and adolescent psychopathology. Future studies, preferably longitud inal ones, are needed to confirm our find ings and establish causal d irectio nality of the associations found. In the following sectio n, some aspects of the stud y that warrant further attention are disc usse d in term s of recommendations for future research.

Characteristics of the Dutch health care system may limit generalisability of the results found in this study. First of all, utilis ation of health car e serv ices in the Netherlands is largely inde pend ent from financial constraints, as in principle all Dutch children are covered by publ ic or private health insurance. Almost all Dutch inh abitants are registered within general practices, which are accessible to all and close to the com munity. General practice is the formal point of entry into mental health car e and the Dutch GP is suppo sed to fun ction as gatek eeper. The find ings and help-seeking models tested in this thesis m ay therefore not

be directly applicable to nations in whic h major financial constraints hamper the availability of care, or in which mental health care is accessible without referral. Nevertheless, the merits of using stru ctural equation modelling as a means of investigating the help-seeking process as a whole – inclu ding multiple stages and actors – are not restricted to coun tries with comparable health care systems. This method is also useful as a more generic approach for clarifyi ng the help-seeking process es in other countries.

International comparison s of help-seeking processes may be useful for unders tanding th e consequ ences of certain health care po licies. Investigatio n of causes for incongruence in find ings from coun tries with com parable health care systems may also provide useful insights in this resp ect. For instance, the strong associatio n between consultation in primary care and mental health car e utilis ation found in the UK (Ford, 2004) and the limited association fo und in th e present stud y requires further investigation. Studying the causes of the increase in service use for child emotional and beh avioural problems in Finland between 1989 and 1999 (Sourand er et al., 2004), an d the consequ ences of recent Finn ish policy to give rat her exce ssive re source s to child psyc hiatric care (Sourander, personal communi cation) may also be informative for policy makers in o ther coun tries.

A second limitation of the present study is the fact that responden ts from non-Western descent were underre presented in the health interview survey (Westert et al., in press). Although the Second D utch National Survey of General Practice inclu ded an additional health interview survey among non-native individu als from Turkey, Moro cco, Surinam and the Dutch Antilles, this surv ey was conducted only amon g respo ndents aged 18 years and older. Ethn icity was therefore not taken into consideration in the present thesis, except in chapter 3, in which data from another samp le were used. Results from a recent s tud y showed that non-native children in the Netherlan ds are less likely to be treated for behavioural proble ms than natives, even whe n differe nces in proble m behaviour and impairment are taken into account (Zwirs et al., 2004). This negative asso ciation between ethnic minor ity status and service utilis ation was also foun d in previous stud ies (Barker and Adelman, 1994; Costello et al., 1997 ; Cuffe et al., 1995; Cunningh am and Freiman, 1996; McMiller and Weisz, 1996; Wu et al., 2001; Zahn er and Daskalakis, 1997), but seemed to disapp ear wh en socioeconomic variab les were controlled for (Pumariega et al., 1998). In chapter 3, however, adolescen ts

from non-Caucasian or Mediterranean origin were found to be more likely to have received mental health care than their Caucasian peers. Considering these contrasting results, the effect of ethnicity on service utilisation in case of child and adolescent emotional and behavioural problems merits further investigation.

Service need was measured in a rather indirect way in this thesis. In chapter 3, it was operationalised as adolescents' reports of having problems that are more serious than other adolescents' problems, whereas chapters 4 and 5 used parents' and adolescents' reports of the presence of psychiatric symptoms and associated functional impairment as indicator of service need. Although the validity of these measures was demonstrated by their importance in the process of help-seeking, inclusion of a more direct evaluation of parents' and adolescents' need for care would be informative.

Service utilisation rates were mainly based on parent reports, which may have biased the results of this thesis. Although previous evidence suggests that parent reports are reasonably accurate compared to administrative records (Fendrich et al., 1999), parents may have difficulties discriminating among multiple service settings (Bean et al., 2000). In chapter 6, this problem was avoided because of the use of contact registration data concerning consultation in general practice. However, these data reflected GP consultation in general, and we were not able to deduct contact rates specifically for child emotional or behavioural problems, which hampered comparison between these figures and the ones obtained through parent report.

Another limitation of using parents' reports of service utilisation is that these reports may not adequately reflect adolescents' utilisation of services, particularly when informal service providers such as friends are concerned. Since seeking help from informal sources is regarded as important for adolescents as part of their increasing autonomy (cf. Rickwood and Braithwaite, 1994; Saunders et al., 1994), future studies should include adolescent reports of service use.

Help-seeking for child emotional and behavioural problems is a complex process, and although we tried to capture some of its key aspects in this thesis, many others would deserve attention in future research. Whereas the present study was primarily focused on stages, actors and determinants involved in the process of help-seeking, parents' and

adolescents' reasons for not seeking help were not directly assessed. Progress on the pathway to care can, for instance, also be hindered by characteristics of the health care system (e.g. waiting lists, availability of care) or by parents' or adolescents' perceptions of services or service providers (cf. Pavuluri et al., 1996). The conceptual model by Brannan et al. (2003), which focuses on these various aspects of the pathway to service utilisation, could be useful for planning future studies. Furthermore, instead of treating mental health service utilisation as an end point, future investigations should also focus on processes of help-seeking once children have entered mental health care. Information on continuity in care, sequencing of services, and amount of services used (cf. Brannan et al., 2003; Farmer et al., 2003) may also be valuable.

As was argued before, arguments for the implementation of measures to increase rates of child mental health service use could be strengthened when effectiveness of service use was demonstrated. Because of methodological limitations of this study (i.e. the limited time span between data waves, the impossibility of random assignment to conditions, inclusion of a broad range of treatments, and the presence of many possibly confounding factors), no firm conclusions concerning the effectiveness of services could be drawn. There is, however, a strong need for research on effectiveness in naturalistic settings, in which not merely effects on child mental health problems, but also possible side effects of service utilisation (e.g. parental satisfaction, parents' and children's sense of competence) should be taken into account.

Clinical implications

The findings presented in this thesis provide a number of suggestions on how to increase rates of mental health service utilisation for children and adolescents with emotional or behavioural problems, which are discussed in the following sections. Interventions to improve detection and referral of child mental health problems are only useful if services are sufficiently available to meet the demands of children. Mental health referral per se should not be perceived as the ultimate goal of interventions, however. It is essential also to consider help-seeking pathways of children once they have been referred to mental health care. Families often need additional assistance and guidance to ascertain their actual access into mental health care and their adherence to ongoing treatment (cf. Harrison et al., 2004).

In general, the results imply that interventions aimed at increasing service use should be adapted to the age range of the target population.

For children, efforts can best be focused on strengthening school personnel's abilities to detect problems and provide help, whereas for adolescents, efforts should be focused on the role of GPs in the detection and referral of mental health problems.

Because the results of this thesis confirmed adolescents' as well as parents' influence on the help-seeking process, interventions focused on increasing service use have to be directed at both. First, educating parents and adolescents about the nature and prevalence of child behavioural and emotional problems is essential to raise their awareness of the possible presence of such problems. Acknowledgement of the presence of problems is particularly salient, because, unless children's lives are severely threatened, children can be referred to specialist services only with their parents' consent. Moreover, previous research has shown the importance of parents' explicit request for referral in accessing specialist services (Ford et al., 2005; Sayal et al., 2002), which also underlines the importance of parents' acknowledgement of the presence of problems in their child.

Secondly, parents and adolescents who do feel a need for care which is not translated into service use, may be provided with information on the availability and accessibility of care. Adolescents with internalising problems, adolescent girls, older adolescents, and children from poorly functioning families were identified as particularly at risk for not effectuating the need for care into actual service utilisation. For these groups, a more actively outreaching approach may be useful to overcome barriers on the pathway to mental health care utilisation.

In general, the pathways into care have become more transparent with the recent changes in the Dutch system of youth welfare work, which made Youth Welfare Work Offices the only entrance points into all youth welfare services. Further research is needed to investigate whether these innovations indeed reduce the obstacles along the pathway to specialist care.

Since the need for and utilisation of services was not only associated with the mere presence of child psychopathology, but also with the presence of additional stressors, clinicians and others working with disordered children should try to assess whether parents' resources are sufficient to cope with the demands of having a disordered child. For some parents, reducing strain by offering assistance for some of the additional stressors

may be enough to avoid utilisation of more intensive and more specialised services for child problems.

Implications for general practitioners

A possible way to increase rates of child mental health service utilisation is the improvement of GPs' skills in detecting child mental health problems. In studies conducted in the UK and Finland (Cockburn and Bernard, 2004; Heikkinen et al., 2002), GPs rated many of their skills in handling children with psychiatric disorders as inadequate. Teaching GPs to use psychosocially oriented interview techniques, which facilitate parental disclosure of sensitive information concerning child mental health, and educating them to actively elicit parental concerns about child mental health problems may increase identification of these problems (cf. Sayal and Taylor, 2004; Wissow et al., 1994). Training may also be needed to acquire the special skills needed to elicit adolescents' concerns during consultation. In general, evaluations tend to show benefits of training by increasing skills and confidence (e.g. Gledhill et al., 2003; Luk et al., 2002), but trials have not been methodologically rigorous and need to be elaborated (Garralda, 2004). Identification of child and adolescent mental health problems may also be enhanced by the introduction of standardised screening measures in general practice (cf. Horwitz et al., 1992).

Parents consult their GP mainly because of child physical problems, and even if they do express their concerns about their child's behavioural or emotional problems, they generally do this in the context of medical problems, instead of directly relating to the actual problems (Foets et al., 1996; Garralda, 2002). Therefore, increasing GPs' awareness of the association between chronic physical illness and the risk for psychiatric disorders (Meltzer et al., 2000; Rutter et al., 1970) may also elevate identification of child mental health problems.

Because Dutch GPs' task conception regarding counseling in case of pedagogical/educational difficulties is limited (Van den Berg et al., 2004b), efforts to increase GPs' identification of child mental health problems should be accompanied by good referral possibilities. In general, direct contact between GPs and mental health professionals facilitates referral and accelerates access to services (cf. Luk et al., 2002), because it provides the opportunity to directly discuss the availability of specialist care.

Direct contact between GPs and mental health care specialists should also be encouraged because of its consultative functi on. Although rece nt innovations in the Dutch health care system gave Dutch GPs the oppor tun ity of consulting mental health professionals for information regarding mental health problems, this meas ure is predominantly used in the case of adult psychological pr oblems (Ver haak et al., 2003).

Implications for schools

Consideri ng the results of this study, strengthening the role of school perso nnel in the process of help-seeking for child emotio nal and behavioural probl ems appears to be a fruitful way to make sure that a greater number of disordered children receive care. This is particularly salient for elementary school children. In this respect, we follow the suggestions of the Dutch Education Council (Onderwijsraad, 2004), which advocates a continuum of care for children and adolescents with psych osocial prob lems, in which schools sh ould be equipp ed to provid e care to these youngsters as long as possib le. To accomplish this, schools are recommende d to liaise with exte rnal agencies in so-called operational teams, in which a broad range of external professionals (e.g. mental health car e provider s, youth health care workers, police) p articip ate. These teams should gather on a regular and structured basis to discuss child problems and exchange expertise. By doing this, teachers' skills i n detecting and handling child emotional and behavioural problems may be ameliorated. In addition to this, the professio nals in the operational teams could assis t in the provision of less intensive forms of care within schools. The school setting probably offers a sense of familiarity, accessibility and acceptability to children and parents, which may be harder to achieve in an out-patient mental health clinic. When school-based care is not sufficient to manage child problems, t he direct contact between sch ools and mental health care profession als shortens the pathway t o specialist care and is expected to facilitate referral.

Another way to detect and refer disord ered children is the routine screening for physical and psy chosocial prob lems provided by Dutch child health care. The finding that a considerable num ber of elementary school children entered mental health care with the help of school-based serv ice provi ders instead of the GP suggests the importance of this type of screening. Due to financial cutbacks, however, the frequency of screening is heavily debated. This is remarkable, considering the fact that child health care is able to reach the majority of children living in the Netherlands, thereby providing an excellent opportun ity for detecting

child problems and increasing mental health service use for children in need. The Rotterdam Youth Monitor, whic h is an initiati ve of the Rotterdam Municipal Health Service, is an example of the way in which routine screening for child physi cal and psych osocial problems can be used to detect children who need further assistance (GGD Rotterdam en omstreken, 2005).

Integrated care

The multitude of services available for youth in general and youn gsters with emotio nal or behavioural problems in particular create the risk of a fragmented system of care, in which families have to deal with a wide variety of services, each with their own rules, staff, procedure s etc. Because the majority of children and adolescents with emotional or behavioural problems us e a combinatio n of services (Farmer et al., 2003; Ford et al., 2005), inter agency collabo ration amon g the education sector, primary health care, and specialty mental health services is cr ucial. By the introd uctio n of family coaches, who are commission ed to keep an over view over the various services provi ded to children and to ensure adequate matching between these servi ces, the new Law on Youth Welfare Work (Mi nisterie van Volksgezondh eid, Welz ijn en Sport, Minister ie van Justitie, 2 004) aims to accomp lis h this. Another initiativ e in this respect is Operatio n Young (Ministerie van BZK et al., 2004), which is aimed at, among other things, achieving linked chains of the wide array of services available for Dutch youths, and at identifying and reso lvi ng obstacles within these chains. Future studies are required to evaluate whether these recent initiatives succeed in producing an integrated system of care for youth with emotional and behavioural problems.

9 Samenvatting

Samenvatting

In dit proefschrift wordt een nadere beschouw ing gegeven van het proces dat ertoe leidt dat oud ers hulp zoek en voor emotionele pro blemen of gedragsproblemen van hun kinderen. Ook de rol die jongeren zelf spelen in dit proces komt aan bod. Er wordt aandacht best eed aan het zoeken van hulp in zowel professi onele als meer informele settings en aan variabelen die h et hulpzoekproces beïnvloeden. Dit hoofdstuk bevat een Nederlandstalige samenvatting van de opzet en hoofdvragen van het onderzoek en gaat in op de belangrijkste on derzoeksresu ltaten.

Achtergrond, onderzoeksvragen en methode (hoofdstuk 1)

Een aanzienlijk aantal jeugdigen vertoont emotionele problemen of gedragsproblemen. Ondanks het feit dat deze problemen een ernstige belemmerin g kunn en vor men voor het dagelijks functioneren, worden zij zeld en onder de aand acht gebracht van huisartsen of hulpverleners in de geestelijke gezondh eidszorg (GGZ). Vroege identificatie en behand eling van de problemen kunnen het voortbestaa n ervan in de late adolescentie en volwassenheid mogelijk voor komen. Het is d aarom van groot belang om inzicht te verkrijgen in het proces dat leidt tot het zoeken van hu lp voor d ergelijke prob lemen en in mogelijke obstak els die ouders en jeugdigen tegenkom en op hun weg naar de zo rg.

Het Nederlands e gezo ndheids zorgsysteem w ordt gekenm erkt door toegankelijkheid en bereikbaar heid. Vrijwel alle Nederlanders zijn geregistreer d in een huisartspraktijk en in principe heeft elke Nederlander een ziektekosten verzekeri ng. Hierdoor hangt de toegankelijkheid van de gezo ndh eidszorg niet sterk af van financiële mid delen, zoals bij voorb eeld in de Verenigde Staten het geval is. Formeel gezien fungeert de huisarts als poortwachter van de GGZ. Momenteel vind en er echter ver and eringen plaats in het Nederlandse jeugdzorgsysteem als gevolg van de nieuwe Wet op de Jeugdzorg, die in werking trad op 1 januari 2005. Vanaf die datum zijn de Bureaus Jeugdzorg de enige toegang tot alle voorzieningen van jeugdzorg. Huisarts en verliezen hiermee in principe hu n poort-wachtersfun ctie bij het verwijzen van kind eren en jongeren met psych ische problemen. Omdat het onder zoek dat in dit proefschrift wordt beschreven plaatsvond voordat de nieuwe wet in werking trad, is nog niet dui delijk welke gevolgen deze vrij drastisch e veranderin gen in de stru ctuu r van de jeugdzorg zullen hebben voor het hulp zoekproces.

Het theoretische kader van dit proefschrift wordt gevorm d door Goldberg en Huxley's (1980; 199 2) algemene model van het hu lpzoekproces en

recen te aanp assin gen aan dit model (Costello et al., 1998; Logan en King, 2001; Verhulst en Koot, 1992). Deze modellen bes chrijven het hulpzoek-proces als een opeenvolging van fasen met steeds intensievere vormen van zorg voor psychische problemen, variër end van psychische problem en in de algemene populatie waarvoor gee n speciale zorg wordt gebod en, via consultatie van en probleemh erkenn ing door de huisar ts, naar behand eling in residentiële GGZ-instellin gen. De fasen worden van elkaar gescheiden door filters. Deze filters representeren een selectieproces, waardoor sommige persone n doorgaan naar een volgende fase in het hulpzoekp roces, terw ijl anderen achterblijven in de voorgaand e fase. Voortgang in dit proces wordt beïn vloed door kenm erken van het kin d, zijn of haar oud ers, het gezin en de bredere soci ale context.

In dit proefschrift is onderzocht wat de invloed is van verscheidene kenm erken van kind, gezin en bredere sociale context op (1) de behoefte van ouders aan hulp vo or emotionele proble men en gedragsproble men van hun k ind, (2) het zoeken van hulp voor deze pro blemen in de huis artsp raktijk, (3) herkenn ing van emotio nele problemen en gedragsproblemen van kinder en door de huisar ts, (4) het zoeken van hu lp voor deze problemen in de GGZ en (5) het zoeken v an hulp van informele hulpbronn en (leerkrachten, familieleden of vriend en). Verder is nagegaan in hoeverre de aanwezigh eid van emotio nele problemen en gedragsproblemen verandert over de periode van een jaar en in welke mate deze verand ering in verb and staat met probleemher kenning door de ouders, het gebruik van professionele en informele hul p en sociodemografische variabelen.

Het onderzoek be stond uit drie fasen. In de eerste fase, die deel uitmaakte van de Tweede Nationale Studie naar ziekten en verrichtingen in de huis artsp raktijk, werd en gedurend e een kalen derjaar in 104 Nederlandse huis artsp raktijken alle co ntacten van ingeschreven pa tiënten met hun huis arts en aan de huisarts gepresenteerde gezo ndh eidsprobleem en geregistreer d. In een gerandomis eerde steekpro ef van 2431 kinder en en adolescenten van 4 tot en met 17 jaar oud werd een uitgebreid gezo ndh eidsinterview afgenom en. Bij respo ndenten van 4 tot en met 11 jaar werd het interview afgenomen bij een van de ouders, terwijl adolescenten van 12 tot en met 17 jaar oud zelf geïnterviewd werden. Het interv iew bevatte vragen over sociod emografische kenm erken, gezondh eidsindicatoren, gebruik van zorgvoo rzieningen, levensstijl, kenm erken van de sociale context en meningen over de gezond heidszorg.

Tevens werden kind ere n en jongeren tijdens dit interview gescree nd op de aanw ezigheid van emotionele problemen en gedragsproblemen.

Kinderen en jongere n bij wie de screening wees op de aanw ezigheid van emotionele problemen of gedragsproblemen werden vervo lgens geselecteerd voor d eelname aan de tweede onder zoeksfase. Van de 553 geselecteerd e kind eren en jongeren d eden er in totaal 360 m ee aan de tweede fase (respons: 65,1 %). Met behu lp van een gestand aar diseerd psych iatrisch interview, afgenomen bij een van de ouders (voor de hele onderzoek sgroep) en bij de adolesce nt zelf (voor jo ngeren van 12 tot en met 17 jaar oud) werden psychiatrische diagnoses voor d e deelnemend e kind eren en jongere n bepaald. Hiernaast werden in een interview met de ouder verscheidene kenmer ken van het kind en het gezin, probleemher kenn ing door de oud er en zorggebru ik voor de emotio nele probl emen en gedragsproblemen van het kind in de afgelopen 12 maan den vastgesteld.

Een jaar na deze dataverzameling werden deelnemers voor een derde keer benaderd, deze keer per post. Ouders kregen vragen voorgelegd over de aanwezigh eid van emotionele pr oblemen en gedragsproblemen bij hun kind en het zorggebr uik voor d eze problem en in het voorgaande jaar. Adolescenten van 12 jaar en ouder kregen ook zelf vragen over d e aanwezigh eid van emotio nele problemen en gedragsproblemen voorgelegd. De onderzoeksgro ep bestond uit 31 7 respon denten (88,1 % van de oorsp ronkelijke groep).

Het zoeken van hulp voor emotionele problemen en gedrags-problemen van jeugdigen: een overzicht van recente onderzoeks-resultaten (hoofd stuk 2)

Om een beeld te krijgen van recent e bevind ingen over het hulp zoekproces voor emotio nele problemen en gedragsproblemen van kinder en en jongeren werd een liter atuurstu die uitgevo erd. Daarb ij werd vooral aandacht besteed aan recente onderzoeksr esultaten over determinanten van probleemherkenn ing en het zoeken van hulp door ouders en adolescenten, en deter minanten van probleemherk enn ing door de huis arts. De liter atuurb estanden Psychlit en Med line werden doorzocht op empirische studies die gepubliceerd w aren tussen 1992 en 2001. Dit resu lteerde in een totaal van 47 relevante pu blicaties.

De literatuurstudi e leverde verscheidene nieuw e inzichten op over d e determinanten v an probleemh erkenning en het zoeken van hulp. Ten

eerste werd een aantal nieuw e variabelen aan het licht gebracht die van invloed bleken te zijn op probleemherkenn ing en/of hulpzoeken door ouders of adolescenten. Versc heidene kind kenmerk en (leeftijd, d e aanwezigh eid van medische problemen of schoolproblemen, en het zoeken van informele hulp door adolescenten) en kenm erken van ouders en gezin (eerder gebruik van GGZ-voorzien ingen door ouders of andere familieleden, gezinsgrootte en type kind ermishandeling) bleken in dit opzicht van invloed te zijn. Hiernaast kon kenn is over de effecten van al bekend e determinanten (type psy chopathologie en geslacht van het kind, attitud es en perso onlijkheid van de adolescen t, psychopathologie van de ouder, soci ale ste un en sociode mografische variabel en) op probl eemherkenn ing en het zoeken van hulp aangescherpt worden met behu lp van de bevin dingen uit de literatuurstu die.

Probleemher kenn ing door de huisar ts bleek te worden beïnvloed door de kind variabelen geslacht, leeftijd, eerdere behandeling voor psychosociale probl emen en de aan wezigheid van schoolprobl emen. Ook de gezinssam enstelling, belangrijke levensgebeurtenissen, het type huis artsbezoek en de bekendh eid van de huisarts met het kind bleken van invloed op de probleemh erkenn ing door de hu isar ts.

Uit de literatuurstudie kwam naar voren dat de aand acht van onderzoek ers vooral uitgegaan is naar determinanten v an probleemher kenn ing en het zoek en van hulp door ouders of adolescenten, terwijl er relatief weinig bekend is over determinanten van probleemher kenn ing door huis artsen. Dit is opmerkelijk, gezien de belan grijke rol van de huisar ts in het hulp zoekproces. De resultaten van de literatuu rstud ie tonen daarom aan dat nader ond erzoek naar probleemher kenn ing door de hu isarts n odig is. Ook de rol van schoolperso neel in de opsporing en verwijzing van jeugdigen met emotionele probl emen en gedragsproblemen en in het bieden van hu lp aan deze jeugdigen dient nader onderzocht te worden. Daarnaast werd de noodzaak aangetoond van een differentiatie tussen professio nele en informele hu lp in toekom stig ond erzoek.

Factoren die samenhangen met GGZ-gebruik, erva ren hulpbehoefte en onvervulde hulpbehoefte van adolescenten (hoofd stuk 3)

Wann eer jonge kind eren emotionele problemen of gedragsprobl emen vertonen, zijn het meestal de ouders die het initiatief nemen tot het zoeken van hulp. Wanneer adolescenten dergelijke problemen vertonen, zijn zij ook zelf actiever b etrokken bij het hu lpzoekproces. Hoo fdstuk 3 is

specifiek gericht op het hul pzoekproces van adolescenten. In dit hoofdstu k werd in een steekpro ef van 1120 jongeren (11-18 jaar oud) uit de algemene Nederlandse bevolking onderzocht in hoeverre verscheidene kenm erken van oud ers, gezin en adolescen t gerelateerd war en aan het gebruik van GGZ-voorzieningen, de ervaren hulpbehoefte en de onvervu lde hulpbehoefte van jongeren. De data voor d it deel van het onderzoek waren afkomstig uit een eerder ond erzoek naar psych opathologie en het gebruik van de GGZ, dat werd uitgevoerd door de Afdeling Kinder- en Jeugdpsy chiatrie v an het Erasmus MC - Sophia Kinderziekenhuis in Rotterd am.

Ongeveer 3 % van de jongere n in deze onderzoeksgroep was verwezen naar de GGZ, terwijl bijna 4 % van de adolescenten aangaf dat hu n behoefte aan gespecialiseerde hulp niet vervuld was. Zelfger apporteerd e probl emen en indicatoren van gezinsstr ess (zoals het leven in een eenoud ergezin en wijzigingen in de gezinssam enstellin g) waren het sterkst gerelateerd aan gebruik van de GGZ en de ervar en hulpbehoefte van adolescenten. Jongere n met een laag opleidingsniveau, slechte competentie in activiteite n en goede schoolresultaten en jongeren van allochtone afkomst hadd en meer kans om verwezen te zijn naar de gespecialiseerde GGZ. Meisjes, oudere adolescenten en adolescenten met een ouder met psychiatrische problemen liepen meer kans om een behoefte aan hulp te rapporter en, ter wijl een onvervulde hulpbehoefte significant samenhing met door de adolescenten zelf gerapp orteer de probl emen, vrouwelijke sekse en een laag opleidingsniveau.

Uit het ond erzoek b leek dat jongeren een bepaalde w eers tand hebben tegen het zoeken van hulp bij de GGZ, zelfs als zij wel degelijk zelf erkenn en emotionele problemen of gedragsproblemen te hebben. Vooral adolescente meisjes, jongere n met internaliserende problemen en oudere adolescenten lopen het risico hun zorgen omtrent dergelijke problemen niet om te zetten in gebru ik van de GGZ.

Het hulpzoekproces voor kinderen van 4-11 jaar oud (hoofdstuk 4)

Eerdere onderzoeken naar het zoeken van hulp voor emotion ele probl emen en gedragsproblem en van kind eren hebben zich vooral gericht op afzonderlijke fasen in het hu lpzoekproces, zonder expliciet aand acht te besteden aan het hulpzoekproces als geheel. Een goed inzicht in de comple xiteit van het hul pzoekproce s kan echter alleen verkregen worde n als er tegelijkertijd aand acht wordt besteed aan ver scheidene fasen in dit proce s, aan het hul paanbod va n zowel professionele als informele

hulpverleners en aan verschillend e kenm erken van kind, gezin en context als mogelijke determinanten van het proces. Daarom werd gebruik gemaakt van de tech niek van str uctureel modelleren om een uitgebreid model van het hu lpzoekproces voor emotionele pr oblemen en gedragsproblemen van kinder en te toetse n. Dit model werd getoetst in een steekproef van 246 kin dere n van 4 tot en met 11 jaar, die geselecteerd waren op de aanwezigh eid van emotionele problemen en gedragsproblemen.

Resultaten v an dit onderzo ek wezen uit dat de Nederlandse huisar ts slechts een beperkte rol speelde in het hul pzoekproce s van deze kind eren; zijn rol als hulpverlener en poortwachter van de GGZ was gering. Hoewel de GGZ in princi pe alleen toegankelijk is na verwijzing door de huisar ts, bleken veel kin deren hier op andere manieren terechtgeko men te zijn. Sommigen kregen direct, zond er tusse nkomst van de huisarts, toe gang tot de GGZ, terwijl anderen de GGZ bereikten door tussenkoms t van and ere hulpverleners. Voora l aan sc hole n gerelateerde hulpverleners zoals schoolarts en, schoolpsy chologen en medewerkers van schoolbegeleidingsd ienste n bleken hierbij een belangrijke rol te spelen. Het belan g van de school in het hulpzoekproces van kinderen werd daarnaast nog geïllustreerd door het feit dat leerkrachten vaak gebruikt werden als hulp verleners. Ouders s chakelden ook vaak de hu lp van vrienden en fam ilieled en in voor de emotio nele problemen of gedragsproblemen van hu nkind.

Kindkenmer ken blek en slech ts een geringe invloed te hebben op het hulp zoekproces. Alleen wann eer kinderen naast emotio nele problemen of gedragsproblemen ook chronische lichamelijke probl emen vertoond en, had dit een directe invloed op het hul pzoekproce s, omdat bij deze kind eren vaker een behoefte aan hulp gerap porteerd werd. Het geslacht van het kind en de aanw ezigh eid van schoolproblemen beïnvloedd en het beeld dat de leerkr acht had van de aanw ezigheid van emotio nele probl emen of gedragsproblem en in een kind. Deze variabelen waren daardoor alleen op indirecte w ijze van invloed op het hu lpzoekproces. De leeftijd van het kind h ad in het geheel geen invloed op de hulpbehoefte of het zoeken van hu lp.

Kenm erken van het gezin bleken het hulpzoekproces in een sterkere mate te beïnvloeden. Het functioneren van het gezin, wijzigingen in de gezinssam enstelling en het kenn en van een familielid dat eerder GGZ

gebruikt h ad, hadden invloed op versc hillende aspecten van het hulp zoekproces.

Het beeld dat de leerkracht had van de aanwezigh eid van emotio nele problem en of gedragsproblemen in een kind bleek een belangrijke contextfactor die van invloe d was op het hulpzoekproce s. Deze va riabele had een even sterke invloed op de hulpbehoefte als het beeld dat oud ers zelf hadd en van de aan wezigheid van dergelijke p roblemen in hun k ind. De afwezigheid van effecten van sociodemografische contextfactoren (het opleidingsniveau van ouders, h et gezinsinkomen en de verzekerings-vorm) op het hulpzoekpr oces kan waarschijnlijk toeges chreven worden aan de aard van het Nederlandse gezon dheidszorgsysteem.

Het hulpzoekproces voor adolescenten met internaliserende problemen (hoofd stuk 5)

Omdat de weg naar de zorg voor jongeren met internalisere nde problem en bepaalde barrières bleek te bevatten (hoofdstu k 3), werd in hoofdst uk 5 specifiek aandac ht besteed aan het hul pzoekproce s van deze groep jongeren. In dit hoofdstuk werd een padmodel van het hulp zoekproces em pirisch getoetst. Naast verschillende fasen in het hulp zoekproces bevatte dit model het hu lpaanbo d van zowel professi onele als informele hulpverleners. Wat dat betreft was het model vergelijkbaar met het hulpzoekmodel dat in hoofdstuk 4 gebruikt werd voor jo ngere kind eren. Vanwege de beperkte steek proefgroo tte in dit deel van het onderzoek kond en echter – in tegenstelling tot in het model voor jonge kind eren – geen mogelijke determinanten van het hulpzoekp roces opgenomen worden in het model voor jongeren met internaliserende probl emen.

Omdat verwacht werd dat adolescenten een toenemend e invloed uitoefenen op het hulp zoekproces, bevatte h et model in hoofdstuk 5 niet alleen de percepties van oud ers en leerkr achten wat betreft de aanwezigheid van problemen bij deze adolescenten, maar werden ook het beeld dat adolescenten zelf hadd en van de aanwezigheid van problemen en hun hu lpbehoefte opgenomen in het model. Analys es werden uitgevoerd in een steekproef van 114 adolescenten van 12 tot en met 17 jaar oud, die geselecteerd waren op de aanw ezigh eid van emotio nele probl emen en gedragsproblemen.

Hoe wel adolescente meisjes meer internaliserend e problemen rapp orteerd en dan jongens, bleken de hulpzoekprocess en voor beide

seks en vergelijkbaar te zijn. Toetsing van het theoretische model bevestigde de toegenomen rol van adolescenten in het hulpzoekproces, maar liet ook zien dat ouders een invloedrijke rol blijven spelen bij het zoeken van hulp.

Een eerste obstakel op weg naar de zorg bleek de erkenning van een hulpbehoefte of van de noodzaak tot het zoeken van hulp. Zelfs voor jongeren die een aanzienlijke mate van internaliserende problemen vertoonden (een score in het klinische gebied of grensgebied in vergelijking met scores van Nederlandse normgroepen), werd slechts zelden ook een hulpbehoefte gerapporteerd.

Het inzetten van leerkrachten om ouders en jongeren meer bewust te maken van de noodzaak tot het zoeken van hulp bleek echter niet de meest geëigende strategie te zijn. In tegenstelling tot wat gevonden werd voor jongere kinderen (hoofdstuk 4), bleek de hulpbehoefte van ouders en jongeren niet beïnvloed te worden door het beeld dat de leerkracht had van de aanwezigheid van emotionele problemen of gedragsproblemen. Deze mindere uitgesproken rol van de leerkracht in het hulpzoekproces van jongeren met internaliserende problemen ging gepaard met een belangrijkere functie van de huisarts. In vergelijking met zijn rol in het hulpzoekproces voor jongere kinderen functioneerde de huisarts voor deze jongeren meer in overeenstemming met zijn formele rol als poortwachter in het hulpzoekproces.

De rol van de huisarts in het hulpzoekproces (hoofdstuk 6)

Vanwege de gevonden verschillen in het belang van de huisarts in de hulpzoekprocessen van kinderen en jongeren (hoofdstukken 4 en 5), werd in hoofdstuk 6 meer aandacht besteed aan de rol van de huisarts. De relatie tussen huisartsbezoek en verschijnende kenmerken van het kind en het gezin werd onderzocht. Daarnaast werd nagegaan in hoeverre deze kenmerken gerelateerd waren aan het krijgen van een psychologische diagnose van de huisarts. Voor dit deel van het onderzoek werd een steekproef gebruikt van 2449 kinderen en jongeren (4 tot en met 17 jaar oud) en hun ouders.

Hoewel ongeveer 80 % van de kinderen en jongeren met emotionele problemen of gedragsproblemen in het onderzochte jaar contact had met de huisarts, bleken deze contacten vooral plaatsgevonden te hebben vanwege chronische lichamelijke problemen. Er was een geringe overeenstemming tussen de oordelen van ouders, leerkrachten, jongeren

zelf en huisartse n over de aan wezigheid van psychologische problemen in het kin d. Kinderen en jongere n bij wie ouders, leerkr achten of adolescenten de aanwezigheid van psychologische probl emen rapp orteerd en, kregen zelden ook een psychologisch e diagnose van de huis arts. De kans op het krijgen van een dergelijke d iagnose was wel groter wanneer ouders en leerkrachten de aanwezigheid van psych ologische pro blemen ra pporteer den. Ook kinder en met school probleme n, jonge jongetjes, adolesce nten met een negatief beeld van hun ei gen gezondhei d en adoles centen die afkomstig waren uit eenoud ergezinnen liep en meer kans een psychologische diagnose te krijgen van hun huis arts.

Hoewel niet alle kinderen en adolescenten met psychol ogische probl emen gespecialiseerde hulp nodig hebben, kan zowel het feit dat de huis arts zeld en geconsulteer d wordt voor psychologische problemen, als de beperkte herkenn ing van dergelijke problem en in de huisartspraktijk het krijgen van gepaste hulp voo r degenen die deze hulp wel n odig hebben vertragen of zelfs verhinderen.

Factoren ge relateerd aan veranderi ngen in emotionele problemen en gedragsproblemen van jeugdigen over een periode van een jaar (hoofdstuk 7)

Hoe wel de aanw ezigheid van emotio nele problemen en gedrags-probl emen in de kind ertijd en adolescentie een verhoogd risico oplevert op het bestaan van dergelijke problemen in de volwassenh eid, is er weinig bekend over factoren d ie gerelat eerd zijn aan het voortbe staan en de verand ering van deze problem en als ze eenm aal bes taan. In hoofdstu k 7 werd onderzocht in hoeverre de aanw ezigh eid van emotion ele problem en en gedragsproblemen verander t over de perio de van een jaar en in welke mate deze verandering in verband staat met probleemher kenn ing door de ouders, het gebruik van professionele en informele hul p en soci odemografische variabelen (gesl acht en leeftijdsgroep van het kind en opleidingsniveau van de ouders). Dit werd onderzoch t in een steekpro ef van 360 kind eren en jongeren die geselecteerd waren op de aanwez igheid van emotio nele prob lemen en gedragsproblemen.

Kinderen (4-11 jaar oud) bleken over het algemeen meer problemen te hebben dan adolescenten (12-17 jaar oud). Verder werden op beide meetmomen ten hogere probleemn iveaus gevond en voor jongen s en voor kind eren van ouders m et een laag opleidingsniveau. Het feit dat kind eren

en jongeren die hu lp van de huisarts of van de GGZ gekregen hadden over het algemeen ook hogere probleemscor es vertoonde n, suggereert dat degenen die het het meest nodig hebben ook daadw erkelijk in de zorg terechtkomen.

Ouders we rd niet alleen gevraag d om op een vragenlijst aan te geven welke problematische gedragingen en emoties hu n kind vertoon de, maar hen werd ook direct gevraagd of zij vonden dat h et kind een emotion eel probleem of gedragsprobleem had (probleemh erkenning). Min der dan de helft van de ouders d ie een aanzienlijk aantal problematische gedragingen en emoties rapporteerde op de vragenlijst (scores in het klinisc he gebied of grensgebied), was ook van mening dat hun kind een emotioneel probl eem of gedragsprobleem vertoonde als hier direct naar gevraagd werd.

Kinderen en jongere n met emotionele probl emen en gedragsproblem en in het klinische gebied of grensgebied bleken vaker gebruik gemaakt te hebben van hulpvoorzieningen. Als ouders daar naast ook expliciet het bestaan van de problemen erkend en als hen hiernaar direct gevraagd werd, bleek dit de kans op hulpgebru ik ver der te vergroten. Kennelijk k an op basis van de directe probleemh erkenning van ouders een on derscheid gemaakt worden tussen kin deren met emotio nele problemen en gedragsproblemen die daarv an geen beperkingen ervaren in hun fun ctioneren, en kind eren die wel extra zorg nodig hebben.

Hoe wel de emotio nele problemen en gedragsproblemen van kinder en en jongeren significan t afnamen over de duur van een jaar, bleek deze afname niet gerelateer d te zijn aan het gebruik van informele of professi onele zorg. Vanw ege methodologische beperkingen van dit deel van het onderzoek kon deze bevind ing echter niet automatisch opgevat worden als een indicatie van de ineffectiviteit van de zorg.

Discussie (hoofd stuk 8)

In hoofdstuk 8 werd een samenvatt ing gegeven va n de belangrijkste resu ltaten v an dit ond erzoek en werden deze res ultaten b eschou wd in het licht van eerder onderzoek en de gehanteerde theoretische modelle n. Eerdere bevindin gen wat betr eft het beperkte gebruik van de GGZ door kind eren en jongere n met emotio nele problemen en gedragsprobl emen werden bevest igd. Zelfs in een stee kproef van jeugdigen die geselecteerd waren op de aanwezigh eid van dergelijke problemen, had slechts 16 % in het voorafgaande jaar gebr uik gemaakt van GGZ-voorzien ingen.

Door het hulpzoekproces te beschouwen als een opeenvolging van vers cheidene fasen, waari n verschillend e soorten hulpverleners en determinanten een rol spelen, werden vers cheidene filters of obstakels op de weg naar de zorg ontdekt.

Ten eerste werd aangetoond dat de aanleiding tot het zoeken van hul p niet zozeer ligt in de aanw ezigheid van emotionele problemen of gedragsproblemen op zich, maar meer in de belasting die de aanwezigh eid van deze problemen oplevert. Sommige ouders en adolescenten zijn zich wel degelijk bewust van het bestaan van emotionele probl emen en gedragsproblemen, maar voelen zich goed in staat om deze problemen het hoofd te bieden zonde r hul p van buitenaf. Op andere ouders en adolescenten heeft de aanwezigheid van de problem en een zodanig grote invloed dat zij wel hulp van anderen nodig hebben. Het al of niet ervaren van een belasting als gevolg van de probl ematiek van het kind kan daaro m gezien worden als een eerste filter op weg naar de zorg.

Een tweede filter op weg naar de gespecialiseerde GGZ heeft betrekking op het feit dat de huisarts zelden geconsulteerd wordt voor emotion ele probl emen en gedragsproblem en van jeugdigen. Hoewel ongeveer 80 % van de kind eren en jongeren met deze probl emen in het afgelopen jaar in contact was geweest m et hun huis arts, blek en deze contacten vooral te hebben plaatsgevond en vanw ege chronische lichamelijke problemen. Als specifiek gek eken werd naar hu isar tscontacten voo r emotio nele problem en en gedragsproblemen, bleek slech ts 13 % van de kinder en en 15 % van de jongeren met dergelijke problemen hierv oor in het voorgaand e jaar contact met hun hu isarts te hebben gehad.

Slech ts een op de zeven kind eren en een op de acht adolescenten bij wie ouders of leerkr achten de aanw ezigheid van emotio nele problemen of gedragsproblemen rappor teerden, kreeg ook een psychologische diagnose van de huisarts. Van de adolescenten die zelf het bestaa n van proble men rapp orteerden, kreeg 77 % geen psychologische diagnose van de huis arts. Deze resultaten kunn en erop wijzen dat emotionele problemen en gedragsproblemen van jeugdigen in beperkte m ate als zodanig herkend worden door de huisar ts. Er kunnen echter v erscheidene alter natiev e verk larin gen aangevoer d worden voor de geringe overeenstemming, zoals het feit d at ouders hun bezorgdh eid over psychische problemen van hun kind n iet graag expliciet uiten tegenover de huisarts, of een aarzeling van

de kant van de huis arts om een psychologische diagnose te stellen uit angst voor stigmatisering of vanw ege beperkte verwijzingsmogelijkheden. Omdat de gegevens van dit onderzoe k echter in overeenstemmi ng zijn met eerdere onderzoeksresultaten wat betreft de beperkte herkenning van emotionele en gedragsmatige proble matiek door de huis arts, beschouwen wij dit als een derde filter op de weg naar de gespecialiseerde GGZ.

Nederlandse kind eren en jongeren met emotionele problemen en gedragsproble men hebben formeel gezien allee n toegang hebbe n tot de GGZ na verwijzing door de huisarts. Het feit dat huisartsen zelden geconsulteerd worden voor emotionele problemen en gedragsprobl emen van jeugdigen en hun ge ringe herke nning van deze proble men beperken tegelijkertijd de mogelijkheden van huisarts en om te verwijzen naar de gespecialiseerde GGZ. Dit kan gezien worden als het vierde filter op de weg naar de gespecialiseerde zorg. De resu ltaten van dit ond erzoek wezen ind erdaad uit dat de Nederlandse huis arts slechts in beperkte mate fungeert als poortwachter van de GGZ voor kinderen met emotio nele probl emen en gedragsproblemen. Deze rol was iets geprononceerder voor adolescenten met inter naliser end e problemen.

Dit ond erzoek toonde het belan g aan van informele hulpverleners, zoals leerkr achten, familieleden en vriend en. Ouders s chakel den vaker de hulp van deze inform ele bronnen in dan de hulp van meer form ele hulpverleners, zoals de huisarts en de GGZ. De rol van d e school in het hulp zoekproces bleek afhankelijk van de leeftijd van het kind. Terwijl schoolgerelateer de hulpverleners van groot belang bleken te zijn in het hulp zoekproces van kinderen van 4 tot en met 11 jaar, was hun rol aanzienlijk minder groot in het hulpzoekproces van jongere n met intern alis erende pro blemen.

Het ervaren van een hulpbehoefte en het zoeken van hu lp kun nen beschouwd worden als het res ultaat van een opee nsta peling van stress oren in het leven van ouders en kinderen. Wanneer de aanwezigheid van emotionele of gedragsmatige problematiek samengaat met allerlei andere stressoren die niet direct gerelateerd zijn aan de stoorn is van het kind (zo als chronisch e lichamelijke problemen of schoolproblemen van het kind, w ijzigingen in gezinssa menstelli ng of het leven in een eenoud ergezin), kan dit de copingmogelijkh eden van ouders te bove n gaan en hen ertoe aanzetten hul p te zoeke n. De aanwez igheid van dergelijke stressoren bleek niet alleen gerelateerd te zijn aan

hulpbehoefte en hulpgebruik, maar vergrootte oo k de kans op het krijgen van een psychologisch e diagnose van de huisarts.

De toegankelijkheid van de Nederlandse gezon dheidszorg in termen van financiële en sociodemografische kenm erken werd in dit onderzoek bevestigd. Variabelen zoals het opleidings- en beroepsniveau van de ouders, het gezinsin komen en de verzeker ingsvorm bleken geen directe invloed uit te oefenen op het hu lpzoekproces.

Aanbevelingen voor to ekomstig ond erzoek

Aan de hand van een reflectie op de methode van het ond erzoek werden in hoofdstu k 8 vervolgens enkele aanbevelingen voor toekomstig onderzoek geformuleerd. Internatio naal vergelijkend ond erzoek zou belan grijke inzich ten kunnen opleveren over de gevolgen van bepaalde belei dsmaatregelen op het gebruik van zorgvoorzie ningen. Hiernaast zoud en beleidsbes liss ingen over eventuele pogingen om het GGZ-gebruik door jeugdigen met emotio nele en gedragsmatige problematiek te stimu leren onder bouwd kunn en worden op grond van onderzoek naar de effectiviteit van zorg in naturalistische settings. Aand acht voor het effect van etniciteit op het hulpzo ekproces, een directere beoord eling van de hulpbehoefte, het geb ruik van jongeren zelf als informanten over hun hulpgebru ik, aand acht voor de redenen die ouders en adolescenten hebben voor het afzien van het zoeken van hulp en aand acht voor processen die plaatsvind en zodra kinderen toegang hebben tot de GGZ kunne n verder bijdragen aan het inzicht in de comple xite it van het hulp zoekproces.

Aanbevelingen voor de pr aktijk

Op gron d van de resultaten van het onderzoek werd een aantal suggesti es gedaan om het gebr uik van GGZ-voorzieningen door jeugdigen met emotionele problemen en gedragsproblemen te bevor deren. Interventies die bedoeld zijn om meer jeugdigen met emotionele problemen en gedragsproblemen op te spore n en te verw ijzen zijn echter alleen zinvol als er voldoend e plaats en voor d eze jeugdigen beschikbaar zijn in de hulpverlening. Dergelijke interventies dienen aangepast te worden aan de leeftijd van de doelgroep. Voor ki ndere n in de basi ssc hoolleeftijd liggen de mogelijkheden vooral in het versterken van de rol van de school en van aan de school gerelateerd e hulpverlen ers bij het opsporen van probl emen en het bieden van hulp. Interventies voor adolescenten kunne n zich daarentegen beter richten op de huisarts.

Wat betreft het versterken van de rol van de school in het hulpzoekp roces volgen wij het advies van de Onderwijsraad, die een con tinuüm van zorg voor kinderen en jongeren met psych osociale prob lemen voors telt, waarin scholen uitgerust moeten worden om deze jeugdigen zo lang mogelijk van zorg te voor zien. Dit kan bewerkstelligd word en door samenw erking met externe professi onals, die advies, bijscholing en mind er intensieve vormen van hulp binn en de scholen kunn en bieden. Het directe contact tussen de school en professionals u it de hulpverlening verkort bovend ien de weg naar meer gespecialiseer de hulp als de minder intensieve hu lp niet voldoet.

Een andere mogelijkh eid om kinderen en jon geren met emotio nele probl emen en gedragsproblemen op te spore n en te verwijzen is de routi nematige scree ning die wordt uitgevoe rd door de jeugdgezondhe ids-zorg.

Verbetering in de herkenn ing van emotio nele problemen en gedragsproblemen door huisar tsen kan bewerkstelligd worden door bijscholing in het gebruik van meer psychosociaal georiënteerde interviewtechnieken en techn ieken die oud ers en adolescenten de gelegenh eid bieden hun zorgen over de geestelijk e gezondh eid te uiten. Ook de introductie van gestand aardiseer de screeningsinstrum enten in de huis artsp raktijk zou de herkenn ing van emotio nele en gedragsmatige probl ematiek van kind eren en jongeren kun nen bevordere n. Hiernaast zou men huisarts en meer bewust moeten m aken van het verband tussen chronische lichamelijke ziektes en het risico op psychiatrische stoorn issen.

Omdat d e Nederlandse hu isarts het b ieden van hulp bij opvoedingsmoeilijkheden steeds minder tot zijn takenp akket rekent, is het noodzakelijk om pogingen om de herkenn ing van emotio nele en gedragsmatige problematiek door de huisarts te verbeteren te combineren met goede verwijsmogelijkheden. Direct contac t tusse n huisa rtsen en hulpverleners in de GGZ kan verwijzing vergemakkelijken en toegang tot voor zien ingen vers nellen. Daarn aast kan dit directe contact een consultatieve functie hebben.

Omdat uit het o nderzoek naar voren kwam dat zowel ouders als adolescenten een rol spelen in het hulpzoekproces, is het van belang dat interventies zich richten op beide groepen. Het voorli chten van ouders en adolescenten over d e aar d en de prevalentie van emotionele probl emen

en gedragsproblemen is belangrijk om hen meer bewust te mak en van de mogelijke aanwezigheid van deze problemen. Hiernaast zoud en ouders en adolescenten van wie de behoefte aan hulp zich niet vertaalt in hulpgebruik gebaat kunn en zijn bij het krijgen van informatie over de beschikba arheid en toegankelijkheid van zorg. Bepaal de groe pen die ondanks hu n hulpbehoefte het risico lopen om niet in de GGZ terecht te komen (kind eren uit slecht fun ctionerend e gezinn en, adolescente meisjes, oudere adolescenten en adolescenten met inter nalisere nde probl emen) moeten mogelijk op een actievere manier gestimuleerd worden om bepaalde drempels op de weg naar de zorg te overwinnen. Clinici en and eren die betrok ken zijn bij de zorg voor jeugdigen zoud en boven dien na moeten gaan in hoeverre oud ers zelf de belasting van de zorg voor een problem atisch kind aanku nnen. Voor sommige oud ers kan het krijgen van hulp bij een aantal and ere stress oren vold oende zijn om het gebruik van intensievere en gespecialiseerdere hulp te voorkom en.

Tot slot is samenw erki ng tusse n de verschillend e instan ties die betrokken zijn bij de zorg voor kind ere n en jongere n met emotionele problemen en gedragsproblemen (de onderw ijssector, eerstelijns gezon dheidszorg en gespecialiseerde GGZ) van groot belang om versnipp ering van het hulp aanbod te voor komen en zorg op elkaar af te stemmen.

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Appendix 1

Gedragsvragenlijsten

De informatie in appendix 1 is ge baseerd op d e volgende bronn en:

Achenbach TM (1991), *Manual for the Child Behavior Checklist/4-18 and 1991 Profiles* . Burlington: University of Vermont Department of Psych iatry

Achenbach TM (1991), *Manual for the Teach er's Report Form and 1991 Profiles* . Burlington: Universi ty of Vermont Department of Psychiatry

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Child Behavior Checklist: schalen en bijbehorende items

Probleemschalen

Teruggetrokken:	42, 65, 69, 75, 80, 88, 102, 103, 111
Lichamelijke klachten:	51, 54, 56a , 56b, 56c, 56d, 56e, 56f, 56g
Angstig/Depressief:	12, 14, 31, 32, 33, 34, 35, 45, 50, 52, 71, 89, 103, 112
Sociale Problemen:	1, 11, 25, 38, 48, 55, 62, 64
Denkproblemen:	9, 40, 66, 70, 80, 84, 85
Aandachtsproblemen:	1, 8, 10, 13, 17, 41, 45, 46, 61, 62, 80
Delinquent Gedrag:	26, 39, 43, 63, 67, 72, 81, 82, 90, 96, 101, 105, 106
Agressief Gedrag:	3, 7, 16, 19, 20, 21, 22, 23, 27, 37, 57, 68, 74, 86, 87, 93, 94, 95, 97, 104
Internaliseren:	12, 14, 31, 32, 33, 34, 35, 42, 45, 50, 51, 52, 54, 56a, 56b, 56c, 56d, 56e, 56f, 56g, 65, 69, 71, 75, 80, 88, 89, 102, 103, 111, 112
Externaliseren:	3, 7, 16, 19, 20, 21, 22, 23, 26, 27, 37, 39, 43, 57, 63, 67, 68, 72, 74, 81, 82, 86, 87, 90, 93, 94, 95, 96, 97, 101, 104, 105, 106
Totale Probleemscore:	1, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56a, 56b, 56c, 56d, 56e, 56f, 56g, 56h, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113

GEDRAGSVRAGENLIJST VOOR KINDEREN VAN 4-18 JAAR

Dit is een lijst met beschrijvingen van bepaalde gedragingen en eigenschappen van kinderen. Bij iedere beschrijving die van toepassing is op uw kind zoals hij/ zij nu is of ooit binnen de afgelopen zes maanden is geweest, = rdt u verzocht het rondje onder 2 zwart te maken als de beschrijving duidelijk of vaak van toepassing is op uw kind. Het rondje onder 1 zwart te maken als de beschrijving een beetje of soms van toepassing is op uw kind. Als de beschrijving helemaal niet van toepassing is op uw kind, maak dan het rondje onder de 0 zwart. Beantwoord a.u. b. alle vragen zo goed mogelijk, ook al lijken sommige vragen niet op uw kind betrekking te hebben.

0 = HELEMAAL NIET VAN TOEPASSING (voor zover u weet) 1 = EEN BEETJE OF SOMS VAN TOEPASSING 2 = DUIDELIJK OF VAAK VAN TOEPASSING

0 1 2
0 0 0 1. Gedraagt zich te jong voor zijn/haar leeftijd.

0 0 0 2. Allergie (geef aan) _____

0 0 0 3. Spreekt veel tegen of maakt veel ruzie.

0 0 0 4. Astma.

0 0 0 5. Gedraagt zich als iemand van het andere geslacht

0 0 0 6. Doet ontlasting (poept) burten de w.c. of in de broek.

0 0 0 7. Opscheppen, stoer doen.

0 0 0 8. Kan zich niet concentreren, kan niet lang de aandacht bij iets houden.

0 0 0 9. Kan bepaalde gedachten niet uit zijn/haar hoofd zetten: obsessies (geef aan):

0 0 0 10. Kan niet stil zitten. onrustig of overactief.

0 0 0 11. Klampt zich vast aan volwassenen of is te afhankelijk.

0 0 0 12. Klaagt over zich eenzaam voelen.

0 0 0 13. In de war of wazig denken.

0 0 0 14. Huilt veel.

0 0 0 15. Wreed voor dieren.

0 0 0 16. Wreed, pesterig of gemeen voor anderen.

0 0 0 17. Dagdromen of gaat op in zijn/haar gedachten

0 0 0 18. Verklaart vaak dat ze zich opzette lijk of doet ze moordpogingen.

0 0 0 19. Eist veel aandacht op.

0 0 0 20 Vernielt eigen spullen.

0 0 0 21 Vernielt spullen van andere gezinsleden of anderen.

0 0 0 22 Is thuis ongehoorzaam.

0 0 0 23. Is ongehoorzaam op school.

0 0 0 24 Eet niet goed.

0 0 0 25. Kan niet goed opschieten met andere jongens/meisjes.

0 0 0 26. Lijkt zich niet schuldig te voelen na zich misdragen te hebben.

0 0 0 27. Snel jaloers.

0 0 0 28 Eet of drinkt dingen die eigenlijk niet eet- of drinkbaar zijn, *geen snoep* (geef aan):

0 0 0 29. Is bang voor bepaalde dieren, situaties of plaatsen, uitgezonderd de school (geef aan):

0 0 0 30. Is bang om naar school te gaan.

0 0 0 31. Is bang dat hij/zij iets ondeugends of slechts zou kunnen doen of denken.

0 0 0 32. Vindt dat hij/zij perfect moet zijn.

0 0 0 33. Klaagt erover of heeft het gevoel dat niemand van hem/haar houdt.

0 0 0 34. Heeft het gevoel dat anderen het op hem/haar gemunt hebben.

0 0 0 35. Voelt zich waardeloos of minderwaardig.

0 0 0 36. Krijgt vaak ongelukken en/of verwondingen.

0 0 0 37. Vecht veel.

0 0 0 38. Wordt veel geplaagd.

0 0 0 39. Gaat om met jongens/meisjes die in moeilijkheden verzeild raken.

0 0 0 40. Hoort geluiden of stemmen die er niet zijn (geef aan): _____

0 0 0 41. Impulsief of handelt zonder na te denken.

0 0 0 42. Is liever alleen dan met anderen.

0 0 0 43. Liegen of bedriegen.

0 0 0 44. Nagelbijten.

0 0 0 45. Zenuwachtig of gespannen.

0 0 0 46. Zenuwachtige bewegingen of trekkingen (geef aan): _____

0 0 0 47. Nachtmerries

0 0 0 48. Andere jongens/meisjes mogen hem/haar niet.

0 0 0 49. Obstipatie, houdt ontlasting op, last van verstopping.

0 0 0 50. Is te angstig of te bang.

0 0 0 51. Last van duizeligheid.

0 0 0 52. Te veel last van schuldgevoel.

0 0 0 53. Eet te veel.

0 0 0 54. Oververmoeid.

0 0 0 55. Te dik.

56. Lichamelijke problemen zonder bekende medische oorzaak:

0 0 0 a. pijnen (geen hoofdpijn)

0 0 0 b. hoofdpijn

0 0 0 c. misselijkheid

0 0 0 d. oogproblemen (geef aan): _____

0 0 0 e. huidproblemen of andere huidaandoeningen

0 0 0 f. maagpijn, buikpijn of buikkrampen

0 0 0 g. overgeven

0 0 0 h. andere problemen (geef aan): _____

Geslacht kind: **0** Jongen **O** Meisje

Leeftijd kind: [IJ

Ingevuld door: **0** Moeder **O** Vader **O** Ander (geef aan):

Nummer (op beide bladzijden invullen): [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

4493

GED RA GSVRAGE NLI J ST VOO R KINDEREN VAN 4-18 **JAAR**

0=HELEMAAL NIET VAN TOEPASSING (voor zover u weet) 1=EEN BEETJE OF SOMS VAN TOEPASSING 2=DUIDELIJK OF VAAK VAN TOEPASSING

0 0 0 57 . Valt anderen lichamelijk aan.

0 0 0 58. Neuspeuteren, pulkt of trekt veel aan huid of aan andere lichaamsdelen (geef aan): ______

OOO 59. Speelt met eigen geslachtsdelen in het openbaar.

0 0 0 60. Speelt te veel met eigen geslachtsdelen.

OOO 61. S lechte schoo lresultat en .

0 0 0 62. O n h an dig of s lechte coördinatie.

OO6 63 . Is lieve r samen met oudere jongem;./meis jes.

0 0 0 6 4. Is lie ve r samen met jongere jongens/meisjes.

0 0 0 65. We ige rt om te praten.

0 0 0 66. Herhaalt alsmaar bepaalde handelingen, dwanghandelingen (geef aan): ______

000 67 . Loopt weg van huis.

0 0 0 68. Schreeuwt of gilt veel.

OOO 69. Ge slo ten , ande ren vveten niet goed wat er in hem/haar omgaat

0 0 0 70. Ziet dingen die er niet zijn (geef aan): ______

0 0 0 71. Schaamt of geneert zich gauw.

0 0 0 72. Brandstichten.

OOO 73. Seksue le problemen (geef aan welke): ______

0 0 0 74. Raar of 'gek' doen om de aandacht te trekken.

0 0 0 75. Verlegen of schuchter.

0 0 0 76. Slaapt minder dan de meeste leeftijdgenoten.

0 0 0 77. Slaapt meer dan de meeste leeftijdgenoten overdag en/of 's nachts (geef aan): ______

0 0 0 78. Smeertop speelt met de ontlasting.

0 0 0 79. Spraakproblemen (geef aan): ______

0 0 0 80. Kijkt met een lege of 'wezenloze' blik.

0 0 0 81. Steelt van huis.

0 0 0 82. Steelt buitenshuis.

OOó 83 . Opsparen van dingen die hij/zij niet nodig heeft (geef aan vvelke): ______

0 0 0 84. Vree md of raar ge drag (gee f aan): ______

000 85. Vreemde of rare gedachten (geef aan): ______

000 86. Koppig, stuurs of prikkelbaar.

000 87. Ve ran de rt plotse ling van stemming.

000 88. Mokken, pruilen.

óóó 89. Achterdochtig.

000 90. Vloeken, schuttingtaal.

000 91. Praat erover dat hij/zij zichzelf wou willen doden.

000 92. Slaapwandelen of hardop praten in de slaap (geef aan): ______

0 00 93. Praa t te v ee l.

000 94. Plaag t vee l.

000 95. Driftbu ien of sne l driftig.

000 96 . Denkt te veel aan seks.

000 97. Bedreigt andere mensen.

000 98. Duimzuigen of zuigen op vingers.

000 99. Is teveel bezig met netjes en schoonzijn

0 00 100. Slaapproblemen (geef aan): ______

0 0 0 101. Spijbelen. schoo erzuim.

00 0 102. Te weinig actief, bevveegt zich langzaam , of gebrek aan energie.

0 0 0 103. Ongelukkig, verdrietig, gedeprimeerd.

0 0 0 104. Is erg luidruchtig.

0 0 0 105. Gebruikt alcohol of drugs (geef aan): ______

OOO 106. ...

0 0 0 1 07 . Broekp lassen over dag .

000 10 8 . Bedp lasse n.

0 0 0 10 9 . D re in e r ig , jengel ig .

0 0 0 11 0 . Wi l graag van het andere geslacht zijn.

0 0 0 111. Teruggetrokken, komt niet tot contact met anderen.

0 0 0 112. Maakt zich zorgen.

113. Geeft u a.u.b. verder nog aan ieder ander probleem dat hierboven nog niet aan de orde is gevveest:

999 ______

000 ______

000 ______

W li t u a.u.b. controleren of u bij Iedere vraag één rondje zwart heeft gemaakt?

4493

C,T M À(:henbe,:;h R9p rcxfue9dby piiSIQn

NedEt!EtidSe Y!;ttalr'lQF C Verhuist

P05tbui 2000. X-00C8 Rcm,rdm

Numme r (op beid e bladz ijde n invu llen): 1 1 1 1 1 1 1 1 1 1

Teacher's Report Form: schalen en bijbehorende items

Probleemschalen

Teruggetrokken:	42, 65, 69, 75, 80, 88, 102, 103, 111
Lichamelijke klachten:	51, 54, 56a , 56b, 56c, 56d, 56e, 56f, 56g
Angstig/Depressief:	12, 14, 31, 32, 33, 34, 35, 45, 47, 50, 52, 71, 81, 89, 103, 106, 108, 112
Sociale Problemen:	1, 11, 12, 14, 25, 33, 34, 35, 36, 38, 48, 62, 64
Denkproblemen:	9, 18, 29, 40, 66, 70, 84, 85
Aandachtsproblemen:	1, 2, 4, 8, 10, 13, 15, 17, 22, 41, 45, 49, 60, 61, 62, 72, 78, 80, 92, 100
Delinquent Gedrag:	26, 39, 43, 63, 82, 90, 98, 101, 105
Agressief Gedrag:	3, 6, 7, 16, 19, 20, 21, 23, 24, 27, 37, 53, 57, 67, 68, 74, 76, 77, 86, 87, 93, 94, 95, 97, 104
Internaliseren:	12, 14, 31, 32, 33, 34, 35, 42, 45, 47, 50, 51, 52, 54, 56a, 56b, 56c, 56d, 56e, 56f, 56g, 65, 69, 71, 75, 80, 81, 88, 89, 102, 103, 106, 108, 111, 112
Externaliseren:	3, 6, 7, 16, 19, 20, 21, 23, 24, 26, 27, 37, 39, 43, 53, 57, 63, 67, 68, 74, 76, 77, 82, 86, 87, 90, 93, 94, 95, 97, 98, 101, 104, 105
Totale Probleemscore:	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56a, 56b, 56c, 56d, 56e, 56f, 56g, 56h, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113

GEDRAGSVRAGENLIJST VOOR KINDEREN VAN 4-18 JAAR

INFORMATIE LEERKRACHT

Dit is een lijst met bescrijvingen van bepaalde gedragingen en eigenschappenvan leerlingen. Bij iedere beschrijving die van toepassing is op de leerling zoals hij/zij nu is of ooit binnen de afgelopen twee maanden is geweest, 1Wrdt u verzocht het rondje onder de 2 zwart te maken als de beschrijving du idelijk of vaak van toepassing is op de leerling. Hetrondje onder de 1 zwart te maken als de beschrijving een beetje of soms vantoepassing is op de leerling. Alsde beschrijving helemaal niet van toepassing is op de leerling, maak dan het rondje onder de 0 zwart. Beantwoord a.u.b. alle vragen zo goed mogelijk, ook al lijken sommige vragen niet op deze leerling betrekking te hebben

0=helemaal niet van toe passing (voaz<>1er u we et) 1=een beetje of soms vantoepassing 2= duidelijk of vaak van toepassing

0 1 2
0 0 0 1. Graagachtegjong voor zijn/haar leeftijd.
0 0 0 2. Bromt of maakt andere vreemde geluiden tijdens de les
0 1 2
0 0 0 3. Spreekt veel tegen of maakt veelruzie.
0 0 0 4. Maakt niet af waar hij/zij mee begint.
0 1 2
0 0 0 5. Ged raa g t zichals iemand van het anderegeslacht.
0 0 0 6. Uitdagend, geelt brutale antwoorden.
0 1 2
0 0 0 7. Opsche ppen, stoer doen.
0 0 0 8. Kan zich niet conoentreren, kan niet lang de aandacht bij iets houden.
0 1 2
0 0 0 9. Kan bepaalde gedachten niet uit zijn/haar hoofd zetten; obsessies (geef aan): _____

_____

0 1 2
0 0 0 10. Huilt vaak, niet de
0 1 2
0 0 0 11. Is te afhankelijk of is te afhankelijk.
0 0 0 12. Klaagt over zich eenzaam voelen.
0 1 2
0 0 0 13. In de war of wazig denken.
0 0 0 14. Huilt veel.
0 1 2
0 0 0 15. Onrustig, 'Mebelen of friemelen.
0 0 0 16. Wreed, pesterig of gemeen voor anderen.
0 1 2
0 0 0 17. Dagdromen of gaat op in zijn/haar gedachten.
0 0 0 18. Ver1Wndt zichze ff opzette lijk of doe t ze ffmoord pogingen.
0 1 2
0 0 0 19. Eist veel aandacht op.
0 0 0 20. Vernielt eigen spullen.
0 0 0 21. Vernielt spullen van anderen.
0 0 0 22. Vindt het moeilijk om aan'Mjzingen op te volgen.
0 1 2
0 0 0 23. Is ongehoorzaam op school.
0 0 0 24. Stoort andere leerlingen.
0 1 2
0 0 0 25. Kan niet goed opschieten met andere leerlingen.
0 0 0 26. Lijkt zich niet schuldigte voelenna zich misdragen te hebben.
0 1 2
0 0 0 27. Snel jaloers.
0 0 0 28. Eet of drinkt dingen die eigenlijk niet eet- of drinkbaarzijn. geen snoep (geef aan):_____

0 1 2
_____
0 0 0 29. Is ar voor bepaalde dieren, situaties of plaatsen, uitgezonderd de school (geef aan): _____

0 1 2
_____
0 0 0 30. Is ga Itgna
0 0 0 31. Is bang dat hij/zij iets ondeugends of slechts zou kunnen doen of denken.
0 1 2
0 0 0 32. Vindt dat hij/zij perfect moet zijn.
0 0 0 33. Klaagt erover of heelt het gevoel dat niemandvan henvhaar houdt.
0 1 2
0 0 0 34. Heelt het gevoel dat anderen het op hem/haar gemunt hebben.

0 1 2
0 0 0 35. Voelt zich waardeloos of minderwaardig.
0 0 0 36. Krijgt vaak ongelukken en/of verwondingen.
0 0 0 37. Vecht veel.
0 1 2
0 0 0 38. Wordt veel geplaagd.
0 0 0 39. Gaat om met jongens/meisjes die in moeilijkheden verzeild raken.
0 0 1 2 40. Hoort geluiden of stemmen die er niet zijn (geef aan):

_____

_____

0 1 2
0 0 0 41. Impulsief of handelt zonder na te denken.
0 0 0 42. Is liever alleendan met anderen.
0 1 2
0 0 0 43. Liegen of bedriegen.
0 0 0 44. Nagelbijten.
0 1 2
0 0 0 45. Zenuwachtig of gespannen.
0 0 0 46. Zenuwachitge bewegingen of trekkingen (geef aan):

_____

_____

0 0 1 2 47. Neemt regels te strikt,
0 0 0 48. Andere leerlingen mogen hem/haar niet.
0 1 2
0 0 0 49. Heelt moeilijkheden met leren.
0 0 0 50. Is te angstig of te bang.
0 1 2
0 0 0 51. Last van duizeligheid of voelt zich licht in het hoofd.
0 0 0 52. Te veel last van schuldgevoel.
0 1 2
0 0 0 53. Praat voor zijn/haar beurt.
0 0 0 54. Oververmoeid zonder duidelijke redenen.
0 1 2
0 0 0 55. Te dik.

56. Lichamelijke problemen *zonder bekende medische oorzaak:*

0 1 2
0 0 0 a. pijnen *(geen* hoofdp ijn)
0 0 0 b. hoofdpijn
0 0 0 c. misselijkheid
0 0 0 d. oogproblemen (geef aan): _____

_____

0 1 2
0 0 0 e. huidaandoeningen of andere huidaandoeningen
0 0 0 f. maagijn. buikpijn of buikkrampen
0 0 0 g. overgeven
0 0 0 h. andere problemen (geef aan): _____

_____

Geslacht kind: O Jongen O Meisje Ingevuld door: O Leerkracht O KlassementorO Ander (geef aan)

4909

Leeftijd kind: [IJ

Nummer (op beide bladzijden invullen): [ ][ ][ ][ ][ ][ ][ ][ ][ ]

GEDRAGSVRAGENLIJST VOOR KINDEREN VAN 4-18 JAAR

INFORMATIE LEERKRACHT

0 = HELEMAAL NIET VAN TOEPASSING 1 = EEN BEETJE OF SOMS VAN TOEPASSING 2 = DUIDELIJK OF VAAK VAN TOEPASSING

0 1 2 57. Valt anderen lichamelijk aan.

0 1 2 58. Peutert, plukt of trekt veel aan huid of aan andere lichaamsdelen (geef aan): ____________________

0 1 2 59. Slaapt tijdens de les.

0 1 2 60. Onverschillig, lusteloos of ongemotiveerd.

0 1 2 61. Slechte schoolresultaten.

0 1 2 62. Onhandig of slechte coördinatie.

0 1 2 63. Is liever samen met oudere jongens/meisjes.

0 1 2 64. Is liever samen met jongere kinderen.

0 1 2 65. Weigert om te praten.

0 1 2 66. Herhaalt alsmaar bepaalde handelingen, dwanghandelingen (geef aan): ____________________

0 1 2 67. Veroorzaakt onrust in de klas.

0 1 2 68. Schreeuwt of gilt veel.

0 1 2 69. Gesloten, anderen weten niet goed wat er in hem/haar omgaat.

0 1 2 70. Ziet dingen die er niet zijn (geef aan): ____________________

0 1 2 71. Schaamt of geneert zich gauw.

0 1 2 72. Werkt slordig.

0 1 2 73. Gedraagt zich onverantwoordelijk (geef aan) ____________________

0 1 2 74. Raar of 'gek' doen om de aandacht te trekken.

0 1 2 75. Te verlegen of schuchter.

0 1 2 76. Explosief en onvoorspelbaar gedrag.

0 1 2 77. Wensen moeten onmiddellijk ingewilligd worden, snel gefrustreerd.

0 1 2 78. Onoplettend, makkelijk afgeleid.

0 1 2 79. Spraakproblemen (geef aan): ____________________

0 1 2 80. Kijkt met een lege of 'wezenloze' blik

0 1 2 81. Kan niet tegen kritiek.

0 1 2 82. Steelt.

0 1 2 83. Opsparen van dingen die hij/zij niet nodig heeft (geef aan welke): ____________________

0 1 2 84. Vreemd of raar gedrag (geef aan): ____________________

0 1 2 85. Vreemde of rare gedachten (geef aan): ____________________

0 1 2 86. Koppig, stuurs of prikkelbaar.

0 1 2 87. Verandert plotseling van stemming.

0 1 2 88. Mokken, pruilen.

0 1 2 89. Achterdochtig.

0 1 2 90. Vloeken, schuttingtaal.

0 1 2 91. Praat erover dat hij/zij zichzelf zou willen doden.

0 1 2 92. Presteert beneden eigen niveau.

0 1 2 93. Praat te veel.

0 1 2 94. Plaagt veel.

0 1 2 95. Driftbuien of snel driftig.

0 1 2 96. Denkt te veel aan seks.

0 1 2 97. Bedreigt andere mensen.

0 1 2 98. Komt te laat op school of in de les.

0 1 2 99. Is te veel bezig met netjes of schoon zijn.

0 1 2 100. Voert opgedragen taken niet uit.

0 1 2 101. Spijbelen, schoolverzuim zonder opgaaf van reden.

0 1 2 102. Te weinig actief, beweegt zich langzaam, of gebrek aan energie.

0 1 2 103. Ongelukkig, verdrietig, gedeprimeerd.

0 1 2 104. Is erg luidruchtig.

0 1 2 105. Gebruikt alcohol of drugs (geef aan): ____________________

0 1 2 106. Wil het te graag het de ander naar de zin maken.

0 1 2 107. Heeft een hekel aan school.

0 1 2 108. Is bang om fouten te maken.

0 1 2 109. Dreinerig, jengelig.

0 1 2 110. Onverzorgd uiterlijk.

0 1 2 111. Teruggetrokken, komt niet tot contact met anderen.

0 1 2 112. Maakt zich zorgen.

113. Geeft u a.u.b. verder nog aan ieder ander probleem dat hierboven nog niet aan de orde is geweest:

0 1 2 ____________________

0 1 2 ____________________

0 1 2 ____________________

NB: Wilt U a.u.b. controleren of U bij IEDERE vraag ÉÉN rondje zwart heeft gemaakt?

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C,T M À(:henbe,:;h R9p rcxfue9dby piiSIQn

NedEt!EtidSe Y!;ttalr'lQF C Verhuist

AcaCIO!TI!iGlhZ1ekQhu; Ron17Clamrêrasmus.URMKi-('ilt Rotlgrch.rn

P051bur 2000. X:00C8 Rcm,rdill

Nummer (op beide bladzijden invullen): | | | | | | | | | | |

Youth Self-Report: schalen en bijbehorende items

Competentieschalen

Activiteiten:	I, II, IV
Sociaal:	III, V, VI
School:	VI

Totale Competentiescore: I, II, III, IV, V, VI, VII

Probleemschalen

Teruggetrokken:	42, 65, 69, 75, 102, 103, 111
Lichamelijke klachten:	51, 54, 56a , 56b, 56c, 56d, 56e, 56f, 56g
Angstig/Depressief:	12, 14, 18, 31, 32, 33, 34, 35, 45, 50, 52, 71, 89, 91, 103, 112
Sociale Problemen:	1, 11, 25, 38, 48, 62, 64, 111
Denkproblemen:	9, 40, 66, 70, 83, 84, 85
Aandachtsproblemen:	1, 8, 10, 13, 17, 41, 45, 61, 62
Delinquent Gedrag:	26, 39, 43, 63, 67, 72, 81, 82, 90, 101, 105
Agressief Gedrag:	3, 7, 16, 19, 20, 21, 23, 27, 37, 57, 68, 74, 86, 87, 93, 94, 95, 97, 104
Internaliseren:	12, 14, 18, 31, 32, 33, 34, 35, 42, 45, 50, 52, 51, 54, 56a, 56b, 56c, 56d, 56e, 56f, 56g, 65, 69, 71, 75, 89, 91, 102, 103, 111, 112
Externaliseren:	3, 7, 16, 19, 20, 21, 23, 26, 27, 37, 39, 43, 57, 63, 67, 68, 72, 74, 81, 82, 86, 87, 90, 93, 94, 95, 97, 101, 104, 105
Totale Probleemscore:	1, 3, 5, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 50, 51, 52, 53, 54, 55, 56a, 56b, 56c, 56d, 56e, 56f, 56g, 56h, 57, 58, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 74, 75, 76, 77, 79, 81, 82, 83, 84, 85, 86, 87, 89, 90, 91, 93, 94, 95, 96, 97, 99, 100, 101, 102, 103, 104, 105, 110, 111, 112

ZELF IN TE VULLEN VRAGENLIJST VOOR MEISJES EN JONGENS VAN 11 -18 JAAR

VOORNAAM	ACHTERNAAM		SOORT WERKVAN DE OUDERS *(a.u.b. zo duidelijk mogelijk - bijvoorbeeld automonteur, onderwijzer, metaal-arbeider, schoenverkoper* enz., ook *al wat men je niet bij je ouders)*
GESLACHT ☐ Jongen ☐ Meisje	LEEFTIJD	NATIONALITEIT: LAND VAN HERKOMST:	SOORT WERK VAN VADER:
DATUM VAN INVULLEN: Dag___ Maand___Jaar_____		GEBOORTEDATUM: Dag___ Maand___Jaar _	SOORT WERK VAN MOEDER:
SCHOOL OF OPLEIDING WELKE KLAS ☐ IK ZIT NIET OP SCHOOL OF VOLG GEEN OPLEIDING		EVENTUEEL SOORT WERK VAN JEZELF:	Graag dit formulier invullen zoals JIJ de dingen ziet ook al zijn anderen het daar niet mee eens. Je kunt gerust naast de vragen of op bladzijde 2 en 4 **dingen die je belangrijk vindt opschrijven**.

A.u.b. aankruisen wat van toepassing is.

1. Vermeld hier de sporten die Je beoefent. Bijvoorbeeld voetballen. zwemmen fietsen. **rolschaatsen vissen. paardrijden enz**.	Vergeleken met leeftijdgenoten, hoeveel tijd besteed Je aan elk van deze sporten?			Vergeleken met leeftijdgenoten, hoe goed ben je in elk van deze sporten?		
○ geen	Minder dan gemiddeld	Gemiddeld	Meer dan gemiddeld	Minder dan gemiddeld	Gemiddeld	Beter dan gemiddeld
a ----------	☐	☐	☐	☐	☐	☐
b ----------	☐	☐	☐	☐	☐	☐
c	☐	☐	☐	☐	☐	☐

II. Vermeld hier Je favoriete hobby's of bezigheden (behalve sport). Bijvoorbeeld: postzegels. kaarten. piano. boeken. **handenarbeid enz. (uitgezonderd radio en TV).**	Vergeleken met leeftijdgenoten, hoeveel tijd besteed Je aan elk van deze hobby's of bezigheden?			Vergeleken met leeftijdgenoten, hoe goed ben je daarin?		
○ geen	Minder dan gemiddeld	Gemiddeld	Meer dan gemiddeld	Minder dan gemiddeld	Gemiddeld	**Beter** dan gemiddeld
a ----------	☐	☐	☐	☐	☐	☐
b ----------	☐	☐	☐	☐	☐	☐
c	☐	☐	☐	☐	☐	☐

111. Geef hier aan de clubs, verenigingen (of andere organisaties) waar Je lid van bent of toe behoort.	**I j t fti noten** actief ben Je in elk van deze clubs of verenigingen?		
○ geen	Minder dan gemiddeld	Gemiddeld	Meer dan gemiddeld
e. ----------	☐	☐	☐
b ----------	☐	☐	☐
c	☐	☐	☐

IV. Vermeld hier de baantjes en (huishoudelijke) karweitjes die Je hebt of doet. Bijvoorbeeld: krantenwijk. cppas. autowassen. bed opmaken. in winkel werken. enz. (Het gaat hierom zowel betaalde als onbetaalde baantjes of karweijes).	Vergeleken met leeftijdgenoten, hoe goed doe Je dit werk of karweitje?		
○ geen	**Minder dan** gemiddeld	Gemiddeld	Beter dan gemiddeld
a ----------	☐	☐	☐
b. ----------	☐	☐	☐
c ----------	☐	☐	☐

V. 1. Ho evee l goede, echte vrienden en/of vriendinnen heb Je? (broers en zussen niet meegerekend) — 0 geen — D Zof 3 — 0 4 of meer

2. Hoeveel keren per week doe je Ietsmet vrienden en/of vriendinnen bullen normale schooltijden? **(broers en zussen niet meegerekend)** — **0 minder dan 1** — **0 3 of meer**

VI. Vergeleken met leeftijdgenoten , hoe goed:

	minder goed	**ongeveer** hetzelfde	beter	
a. **kan je opschieten met je broers en zussen?**	D	D	D	0 ik heb geen broers of zussen
b. kan je opschieten met andere jongens en meisjes van je leeftijd?	D	D	D	
c. kan je met je ouders opschieten?	D	D	D	
d. kan je in je eentje **bezig** zijn met iets?	D	D	D	

VII. Huidige schoolresultaten

D **Ik zit** niet op school omdat -

		onvoldoende	zwak	voldoende	goed
	a. Taal of Nederlands	D	D	☐	☐
	b. Geschiedenis	D	☐	D	D
	c. Rekenen of Wiskunde	D	☐	D	☐
	d. Wereldori ntatie of Aar drijk skunde	D	☐	☐	D
Andere vakken. zoals:	e. ______________	D	☐	D	D
natuurkunde vreemde talen , bi ologie. **GEEN**	**f.** ______________	D	☐	☐	☐
vakkenzoals gym. muzi ek, tekenen enz.	g. ______________	D	☐	☐	☐

Heb Je een llchamellJke ziekte of handicap? D Nee D Ja (geef aan):

Beschrijf hier Je eventuele zorgen of problemen die Je hebt wat betreft school:

Beschrijf hier eventuele andere zorgen die Je hebt:

Beschrijf hier datgene van Jezelf waarover Je het meest tevreden bent:

ZELF IN TE VULLEN VRAGENLIJST VOOR MEISJES EN JONGENS VAN 11-18 JAAR

Hieronder staat een lijst met vragen die slaan op hoe je nu bent of ooit binnen de afgelopen 6 maanden bent geweest
Wil je iedere vraag goed lezen en iedere vraag beantwoorden? Wil je dan bij iedere vraag het rondje onder de 0, 1 of 2 zwart maken en wel:
de 2 als je vindt dat de vraag duidelijk of vaak op jou van toepassing is. Het rondje onder de 1 maak je zwart als de vraag een beetje of soms van toepassing is. Als de vraag helemaal niet op jou van toepassing is, maak dan het rondje onder de O zwart Bij iedere vraag steeds één rondje zwart maken.

O=helemaal niet van toepassing 1=een beetje of soms van toepassing 2= duidelijk of vaak van toepassing

0 1 2
O O O 1. Ik gedraag me te jong voor mijn leeftijd.
0 0 0 2. Ik heb een allergie (geef aan): _____

0 1 2
O O O 3. Ik maak veel ruzie.
0 0 0 4. Ik heb astma.

0 1 2
O O O 5. Ik gedraag me als iemand van het andere geslacht
0 0 0 6. Ik houd van dieren.

0 1 2
0 0 0 7. Ik schep op of doe stoer.
0 0 0 8. Ik heb moeite me te concentreren. of om lang mijn aandacht bij iets te houden.

0 1 2
0 0 0 9. Ik kan bepaalde gedachten maar niet uit mijn hoofd zetten (geef aan): _____

0 1 2
O O O O Ik heb last van [illegible] itten.
0 1 2
O O O 11. Ik ben bang voor [illegible] lwassenen.
O O O [illegible] eezaam
0 1 2
O O O [illegible] ar
O O O 14. Ik huil veel.

0 1 2
0 0 0 15. Ik ben nogal eerlijk.
0 0 0 16. Ik ben gemeen voor anderen.

0 1 2
0 0 0 17. Ik dagdroom veel.
0 0 0 18. Ik probeer mezelf opzettelijk te verwonden of doe zelfmoordpogingen.

0 1 2
0 0 0 19. Ik probeer veel aandacht te krijgen.
0 0 0 20. Ik vern ie l mijn eigen spullen.

0 1 2
0 0 0 21. Ik verniel de spullen van anderen.
0 0 0 22. Ik ben ongehoorzaam aan mijn ouders.

0 1 2
0 0 0 23. Ik ben ongehoorzaam op school.
0 0 0 24. Ik eet niet zo goed als zou moeten.

0 1 2
0 0 0 25. Ik kan niet met andere jongens en meisjes opschieten.
O O O 26. Ik voel mij niet schuldig als ik iets gedaan heb wat ik eigenlijk niet had moeten doen.

0 1 2
0 0 0 27. Ik ben jaloers op anderen.
0 0 0 28. Ik ben bereid andere n te helpen wanneer zij hulp nodig hebben.

0 1 2
0 0 0 29. Ik ben bang voor bepaalde dieren, situaties of plaatsen, uitgezonderd de school (geef aan):
_____
_____

0 1 2
0 0 0 30. Ik ben bang om naar school te gaan.
0 0 0 31. Ik ben bang dat ik misschien iets slechts zou kunnen doen of denken.

0 1 2
0 0 0 32. Ik vind dat ik perfect moet zijn.
0 0 0 33. Ik heb het gevoel dat niemand van mij houdt.

0 1 2
0 0 0 34. Ik heb het gevoel dat anderen de pik op mij hebben, het op mij gemunt hebben.
O O O 35. Ik voel me waardeloos of minderwaardig.

0 1 2
0 0 0 36. Ik raak vaak per ongeluk gewond.
0 0 0 37. Ik vecht veel.

0 1 2
0 0 0 38. Ik word vaak gepest.
0 0 0 39. Ik ga om met jongens en meisjes die in moeilijkheden raken.

0 1 2
0 0 0 40. Ik hoor geluiden of stemmen die er volgens andere mensen niet zijn (geef aan): _____
_____

0 1 2
0 0 0 41. Ik doe zomaar iets zonder er bij na te denken.
0 0 0 42. Ik ben liever alleen dan met andere.

0 1 2
0 0 0 43. Ik lieg of bedrieg.

0 1 2
0 0 0 44. Ik bijt op mijn nagels.
0 0 0 45. Ik ben zenuwachtig of gespannen.

0 1 2
0 0 0 46. Ik heb trekkingen of zenuwachtige bewegingen in delen van mijn lichaam (geef aan): _____
_____

0 1 2
O O O 47. Ik ha[illegible]acht. erries
O O O 48. [illegible] jongeijes[illegible]gen mij niet.

0 1 2
O O O 49. Ik doe sommige dingen beter dan de meeste van mijn leeftijdgenoten.
0 0 0 50. Ik ben te angstig of bang.

0 1 2
0 0 0 51. Ik heb last van duizeligheid.

0 0 0 52. Ik heb te veel last van schuldgevoel.

0 1 2
0 0 0 53. Ik eet te veel.
0 0 0 54. Ik voel me oververmoeid.

0 1 2
0 0 0 55. Ik ben te dik.

56. Lichamelijke problemen zonder bekende medische oorzaak:

0 1 2
0 0 0 a. pijnen (**geen** hoofdpijn)
0 0 0 b. hoofdpijn
0 0 0 c. misselijkheid
0 0 0 d. oogproblemen (geef aan): _____
_____

0 1 2
0 0 0 e. [illegible] slag of andere huidaandoeningen
0 0 0 f. maagpijn, buikpijn of buikkrampen
0 0 0 g. overgeven
0 0 0 h. andere problemen (geef aan): _ _ _ _ _

5002

Geslacht: **0** Jongen **O** Meisje

Leeftijd: [IJ

Nummer (op beide bladzijden invullen): 11.111.111.111 . . . . . .

ZELF IN TE VULLEN VRAGENLIJST VOOR MEISJES EN JONGENS VAN 11-18 JAAR

0=helemaal niet vantoepassing 1=een beetje of soms vantoepassing 2= duidelijk of vaak vantoepassing

0 1 2
0 0 0 57. Ik val anderen lichamelijk aan.
0 0 0 58. Ik peuter veel in mijn neus, of pulk of trek veel aan mijn huid of aan andere lichaamsdelen (geef aan):

0 1 2
00059. Ikkan best aardig zijn.
00060. Ikvind het leuk om nieuwe dingen te proberen.
0 1 2
000 61. Mijn schoolresultaten zijn slecht.
00062. Ikben onhandig.
0 1 2
00063. Ikben liever samen met oudere jongens of meisjes dan met leeftijdgenoten.
00064. Ikben liever samen met jongere jongens of meisjes dan met leeftijdgenoten.
0 1 2
00065. Ikv,eiger om te praten.
00066. Ikhebalsmaatbepaalde handelingen (geef aan):

0 1 2
000 67. Ik loop van huis weg.
00068. Ikschreeuw of gil veel.
0 1 2
000 69. Ik ben gesloten; anderen welen niet goed wat er in meomgaat.
00070. Ikzie dingen waarvan anderen denken dat ze er niet zijn (geef aan):

0 1 2
0 0 0 71. Ik schaam me gauw, voel me gauw opgelaten.
0 0 0 72. Ik sticht brandjes.
0 1 2
00 0 74. Ik doe raar of "gek" om de aandacht te trekken.
0 1 2
0 0 0 75. Ik ben verlegen.
0 0 0 76. Ik slaap minder dan de meeste van mijn leeftijdgenoten.
0 1 2
0 0 0 77. Ik slaap meer dan de meeste van mijn leeftijdgenoten overdag en/of 's nachts (geef aan):

000 78. Ik heb een goede fantasie.
0 1 2
0 0 0 79. Ik heb een spraakprobleem (geef aan):

0 0 0 80. Ik komvoor mi jzelf op.
0 1 2
000 81. Ik steel van huis.
0 0 0 82. Ik steel buitenshuis.
0 1 2
0 0 0 83. Ik spaar dingen op die ik niet nodig heb (geef aan):

0 1 2
000 84. Ik doe dingen die andere mensen vreemd of 'gek' vinden (geef aan):

000 85. Ik heb gedachten die andere mensen vreemd of 'gek' zouden vinden (geef aan):

0 1 2
000 86. Ik ben koppig.
000 87. Mijn stemming of gevoelens veranderen plotseling.
0 1 2
000 88. Ik vind het leuk om samen met anderen te zijn.
000 89. Ik ben achterdochtig.
0 1 2
000 90. Ik vloek of gebruik schuttingtaal.
000 91. Ik denk erover een eind aan mijn levente maken.
0 1 2
000 92. Ik vind het leuk anderen aan het lachente maken.
000 93. Ik praat te veel.
0 1 2
000 94. Ik plaag anderen veel.
000 95. Ik ben snel driftig.
0 1 2
000 96. Ik denk te veel aan seks.
000 97. Ik dreig andere mensen pijn te doen.
0 1 2
000 98. Ik vind het fijn anderen te helpen.
000 99. Ik maak me teveel zorgen of ik netjes of schoon ben.
0 1 2
000 100. Ik heb problemen met slapen (geef aan):

000 101. Ik spijbel.
0 1 2
0 0 0 103. Ik ben ongelukkig, verdrietig of gedeprimeerd.
0 1 2
0 0 0 104. Ik maak meer lawaai dan andere jongens of meisjes.
0 0 0 105. Ik gebruik alcohol of drugs (geef aan wat en hoeveel):

0 1 2
000 107. Ik hou van een goede grap.
0 1 2
0 0 0 108. Ik hou van een plezierig en makkelijk leven.
0 0 0 109. Ik probeer andere mensen te helpen.
0 1 2
000 110. Ik ben liever van het andere geslacht.
0 0 0 111. Ik probeer zo weinig mogelijk met anderen te maken te hebben.
0 1 2
0 0 0 112. Ik pieker veel, maak me veel zorgen.

KIJK NOG EENS GOED NA OF JE ALLE VRAGEN HEBT BEANTWOORD.

Nummer (op beide bladzijden invullen): 1 1 1 1 1 1 1 1 . . . . . .

Appendix 2

Vragenlijsten voor gezinsfunctioneren en geestelijke gezondheid va n de ouder

De informatie in appendix 2 is ge baseerd op d e volgende bronn en:

Epstein NB, Baldw in LM, Bishop DS (1983), The McMas ter Family Assessm ent Device. *J Marital Fam Ther* 9:171-180

Goldberg DP (1972), *The Detection of Psych iatric Illness by Questionnaire*. London: Oxford Univer sity Pr ess

The McMaster Family Assessm ent Device – General Functioning

Hierond er staan twaalf beweri ngen over gezinn en. Wilt u een ro ndje zetten om het cijfer dat aangeeft in welke mate u het eens of oneens bent met iedere bewering? Neem daarbij uw eigen gezin in gedach ten.

	Helemaal mee eens	Mee eens	Niet mee eens	Helemaal niet mee eens
1. Planne n maken om iets met het gezin te gaan doen is moeilijk omdat we elkaar verkeerd begrijpen	-1-	-2-	-3-	-4-
2. Wanneer er moeilijkheden z ijn kunnen we op elkaars steu n rekenen	-1-	-2-	-3-	-4-
3. We kunnen niet met elk aar praten over h et verd riet dat we voelen	-1-	-2-	-3-	-4-
4. Anderen worden geaccepteer d zoals ze zijn	-1-	-2-	-3-	-4-
5. Wij vermijd en het om over o nze angsten en zorgen te prate n	-1-	-2-	-3-	-4-
6. Wij kunne n gevoelens naar elkaar toe uiten	-1-	-2-	-3-	-4-
7. Er zijn heel wat nare, pijnlijke gevoelens in het gezin	-1-	-2-	-3-	-4-
8. Wij voelen ons geaccepteerd zoals wij zijn	-1-	-2-	-3-	-4-
9. Beslissen is een probleem vo or ons gezin	-1-	-2-	-3-	-4-
10. Wij kunne n beslissi ngen nemen over hoe we problemen moeten oplossen	-1-	-2-	-3-	-4-
11. Wij kunne n niet goed met elkaar opschieten	-1-	-2-	-3-	-4-
12. Wij vertrouwen op elkaar	-1-	-2-	-3-	-4-

General He alth Questionnaire, 1 2-item vers ie

1. Bent u de laatste tijd door zorgen veel slaap tekort gekomen?

- [ ] helem aal niet
- [ ] niet meer dan gew oonlijk
- [ ] iets meer dan gewoonlijk
- [ ] veel meer dan gewoonlijk

2. Heeft u de laats te tijd het gevoel gehad dat u voortdurend ond er druk stond?

- [ ] helem aal niet
- [ ] niet meer dan gew oonlijk
- [ ] iets meer dan gewoonlijk
- [ ] veel meer dan gewoonlijk

3. Heeft u zich de laatste tijd kunnen co ncentreren op uw bezigh eden?

- [ ] beter d an gewoonlijk
- [ ] net zo goed als gewoonlijk
- [ ] slechter dan gewoonlijk
- [ ] veel slechter dan gewoonlijk

4. Heeft u de laatste tijd het gevoel gehad zinvol bezig te zijn?

- [ ] zinvoller dan gewoonlijk
- [ ] net zo zinvol als gewoonlijk
- [ ] minder zinv ol dan gewoonlijk
- [ ] veel minder zinvol dan gewoonlijk

5. Bent u de laats te tijd in staa t geweest uw problemen onder ogen te zien?

- [ ] beter (in staat) dan gewoonlijk
- [ ] net zo goed (in staat) als gewoonlijk
- [ ] iets mind er goed (in staat) dan gewo onlijk
- [ ] veel minder goed (in staat) dan gewoonlijk

6. Voelde u zich de laatste tijd in staat om beslissin gen (over dingen) te nemen?

- [ ] beter in staat dan gewoonlijk
- [ ] net zo goed in staat als gewoonlijk
- [ ] iets minder goed in staat dan gewoonlijk
- [ ] veel minder goed in staat dan gewoonlijk

7. Heeft u de laatste tijd het gevoel gehad dat u uw moeilijkheden niet de baas kon?

- [ ] nee, ik had dat gevoel helemaal n iet
- [ ] niet mind er de baas dan gewoonlijk
- [ ] iets minde r de baas dan gewoonlijk
- [ ] veel minder de baas dan gewoonlijk

8. Heeft u zich de laatste tijd alles bij elkaar redelijk gelukkig gevoeld?

- [ ] gelukkiger dan gewoonlijk
- [ ] even gelukkig als gewoonlijk
- [ ] minder gelu kkig dan gewoonlijk
- [ ] veel minder gelukkig dan gewoonlijk

9. Heeft u de laats te tijd plez ier kun nen belev en aan uw gewon e, dagelijkse bezigheden?

- [ ] meer dan gewoonlijk
- [ ] evenveel als gewoonlijk
- [ ] iets mind er dan gewoonlijk
- [ ] veel min der dan gewoonlijk

10. Heeft u zich de laatste tijd ongelukkig en neersl achtig gevoeld?

- [ ] helem aal niet
- [ ] niet meer dan gew oonlijk
- [ ] iets meer dan gewoonlijk
- [ ] veel meer dan gewoonlijk

11. Bent u de laatste tijd het vertrouw en in uzelf kwijtgeraakt?

- [ ] helem aal niet
- [ ] niet meer dan gew oonlijk
- [ ] iets meer dan gewoonlijk
- [ ] veel meer dan gewoonlijk

12. Heeft u zich de laatste tijd als een w aardeloos iemand beschou wd?

- [ ] helem aal niet
- [ ] niet meer dan gew oonlijk
- [ ] iets meer dan gewoonlijk
- [ ] veel meer dan gewoonlijk

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Curriculum Vitae

Mariek e Zwaanswijk was born in Egmond aan Zee, the Netherlands, on July the 16th, 1974. Sh e followed her second ary education (VWO) at th e Petrus Canis ius College in Alkmaar, from which s he gradu ated in 1992. She subsequently stud ied Educatio nal Sciences at Utrecht University, with majors in 'Child psychosocial problems' and 'Adoption/ non-genetic parenthood', and graduated with h onours in 1997 . From 1998 to 2000, she worked at the University of Amsterd am, condu cting a study o n influences of non-shared environm ent on similariti es and differe nces in the develop ment of young siblin gs. Since 2001 s he has been employed at the Netherlands Institute for Health Services Research (NIVEL), cond ucting the study on help-seeking for child and adolescent emotional and behavioural problems, which is reported in this thesis. At present, she is involved in a study on communic atio n and role delineatio n in paediatric oncology at the NIVEL Institute.