

# Assessment of parenting and developmental problems in toddlers: development and feasibility of a structured interview

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## Abstract

**Background** Assessment of (early signs of) parenting and developmental problems in young children by preventive child health care (CHC) workers is recommended, but no validated instruments exist. The aim of this project was to develop and test an instrument for early detection and assessment of problems in toddlers, using the perspectives and experience of both the parent and the professional.

**Methods** Using an iterative process, we adapted and expanded a structured interview on need for parenting support into the Structured Problem Analysis of Raising Kids (SPARK). The SPARK consists of 16 subject areas, ranging from somatic health to family issues. The SPARK was tested in daily practice for feasibility and discriminative capacity. The sample consisted of all toddlers aged 18 months living in Zeeland, a province of the Netherlands, during the study period ( $n = 1140$ ).

**Results** The response rate was 97.8%. Although the median level of support needed according to the SPARK was low, 4.5% of the toddlers and their parents required intensive help or immediate action. The risk assessment showed 2.9% high, 16.5% increased and 80.6% low risk for parenting and developmental problems. The risk assessment of the CHC professional was associated with known risk factors for child maltreatment.

**Conclusions** This study shows that a structured interview, named the SPARK, is feasible in daily practice and clarifies risks and care needs for parenting and developmental problems in toddlers.

## Keywords

development, parenting, parents, pre-school children, prevention, professionals

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## Introduction

Prevention and early detection of parenting problems in young children have received considerable attention in recent years. There is agreement in the field that the early detection of parenting problems and problems in the psychosocial development of young children is vital (Bricker *et al.* 2004; Moran *et al.* 2004; Hermanns *et al.* 2005; van Leerdam *et al.* 2006; Department for Children, Schools and Families 2009; Hertzman *et al.* 2010). Subsequent required interventions are sup-

posed to be more effective when they are carried out earlier (Carneiro & Heckman 2003; Junger 2004; Tremblay *et al.* 2004; Hermanns *et al.* 2005; Bouwmeester-Landweer 2006; Barlow *et al.* 2008).

The Dutch preventive child health care (CHC) services have a population-based preventive approach that reaches almost all children in the Netherlands during a period of several years (Hermanns *et al.* 2005). Therefore, preventive CHC is highly suited to fixed schedule assessments of parenting and developmental problems.

Children in the age group of approximately 18 months are in the transitional phase from baby to toddler. Early detection of problems at this age should focus on early signs of attachment, behavioural and development problems, on existing parenting, health, psychosocial and developmental problems and on (a lack of) capabilities and skills needed for the subsequent toddler phase (Belsky 1997; Ministry of Health Welfare and Sports 2002; Hermanns *et al.* 2005; Barlow *et al.* 2008). In our opinion, this risk analysis requires a careful assessment, preferably in dialogue with the parents, as proposed by Glascoe (2000) and Puura and colleagues (2002).

Initially, an instrument was sought to improve and professionalize risk assessment of parenting and child developmental problems by CHC nurses. However, it was not possible to find a comprehensive and valid instrument that targets such risk assessment for toddlers through dialogue with the parents during home visits. Existing parent-reported questionnaires (de Brock *et al.* 1992; Briggs-Gowan *et al.* 2004; Squires *et al.* 2005a, b), checklists filled out by CHC nurses (Caldwell & Bradley 1984; Grietens *et al.* 2004) and instruments that do take into account concerns of parents (Glascoe 2000; Puura *et al.* 2002) all missed one or more elements that we considered necessary: a broad scope that includes both the child and its family and environment, a systematic approach of querying concerns and care needs, interaction between the parent(s) and professional, information about the true nature of experienced problems, and agreement between parent and professional about the aim and content of any subsequent care.

The aim of this project was to develop and test an instrument for early detection and assessment of (early signs of) manifest parenting and child developmental problems by using the perspectives and experience of both the parent(s) and the CHC professional. This instrument should fit within the goals of preventive CHC and be useful for the younger age group.

We first describe the development of such an instrument, followed by the initial test results with respect to its feasibility and discriminative capacity.

## Methods

### Instrument

Based on a literature review and suggestions from experts, we adapted and expanded the existing Dutch structured interview 'Vragenlijst Onvervulde Behoeften en Opvoedingsondersteuning' (VOBO, Unfulfilled Needs for Parenting Support) for use in home visits to parents of young children (Bertrand *et al.* 1998). The VOBO is an instrument that addresses 12 areas (appropri-

ate to the age of the child) of parenting and child development during a structured interview of 20–30 min with the parent or parents. The VOBO has been used in several populations, including Dutch families with both low and high educational backgrounds (Bertrand *et al.* 1998), Moroccan and Turkish immigrants (Leseman & Hermanns 2002) and on the island of Curaçao (Zeeman *et al.* 2007). These empirical studies found significant correlations with parenting stress, supporting the construct validity of the VOBO.

The VOBO needed further development in four areas: (i) the content and order of the subject areas should be suitable for the age group of 18 months; (ii) the current severity of any problems should be assessed by the parent(s) as well as the CHC professional; (iii) the CHC professional should make an overall risk assessment; and (iv) the content of subsequent care is suited to the problems and agreed upon by parent(s) and CHC professional. The VOBO was adapted in close collaboration with an expert group of experienced CHC nurses. Each of the 10 regional CHC teams in Zeeland province contributed one member to the expert group. With an interactive and iterative process of testing and feedback between the researchers and the expert group of CHC nurses, an adapted and expanded version of the VOBO was developed. This adapted and expanded version is called *Structured Problem Analysis of Raising Kids (SPARK)*.

The SPARK consists of 16 subject areas (or topics) in the following order: infancy review; somatic health; motor development; language, speech and thought development; language use of parents (second language, mother tongue); emotional development; contact between child and others (both children and adults); child behaviour; parenting approach; developmental stimulation and early/pre-school education; how the child spends his/her time; living environment in and outside the home; social contacts and informal support; day care for the child; concerns communicated by others; family issues; and lastly a question about whether any topic was forgotten or needed further attention.

Two topics need further clarification. The first topic, 'infancy review', has three goals: beginning the interview with an 'easy' topic familiar to both parent(s) and CHC nurse, reviewing past issues and discussing any problems from the infant period that are still relevant (Staal *et al.* 2005). 'Family issues' includes a wide range of topics concerning family members: health problems, addiction, psychiatric problems, relational problems, financial problems, divorce, death and additions to the family.

The SPARK uses a three-step model: Step 1: detection of problems and concerns; Step 2: clarifying the characteristics and seriousness of problems and concerns in dialogue with the parents; Step 3: analysis and a decision on what to do next. This

type of three-step model has previously been suggested as being suitable for investigating parenting and development problems (Hermanns *et al.* 2005). For each topic, the CHC nurse starts with a short description of the topic with examples, and asks the parents if they have experienced any concerns, questions or problems in the last 6 months (Step 1). Parents are requested to assess the seriousness of these concerns on a 5-point Likert scale presented on a printed card, ranging from 'no concern at all' to 'very concerned'. If concerns are cited, respondents are asked to elaborate on the exact nature of concerns, questions or problems, and whether or not professional and/or informal help – if offered – was sufficient. Each topic ends with the parents assessing their current perceived need for support, on a 6-point Likert scale: (1) no help needed; (2) information wanted; (3) personal advice; (4) counselling; (5) intensive help; and (6) immediate intervention required. The CHC professional then makes the same assessment (Step 2). After all the subject areas have been covered, the CHC nurse discusses with the parents the amount and content of care needed in the following months (Step 3). Intensive help or immediate action mostly leads to a referral to professionals outside preventive CHC, while information wanted/personal advice/counselling are often done by the CHC nurse, if possible during the same home visit as the SPARK exercise. After this, the CHC nurse ends the home visit and subsequently makes an overall risk assessment, assigning the child to low, increased or high risk for parenting and development problems. The CHC nurse bases this overall risk assessment on the information from the interview, and on an elaboration of factors that might influence this risk assessment positively or negatively. This structured elaboration includes the observed interaction between parent(s) and child(ren) and the observation of growth, development, manifest problems and living environment.

### Study design

The goal of the next phase was to test the feasibility and discriminative capacity of the SPARK in daily practice with 1000 toddlers. Approval for this study was obtained from the Medical Ethical Review Committee of the University Medical Center Utrecht. Prior to the start of this test phase, all 63 CHC nurses from Zeeland province were trained in using the SPARK. Training was done in three groups of 15–25 nurses. In daily practice, the expert group members functioned as a first-line support for their team members.

The CHC nurse then contacted parents for the regular check-up at the age of 18 months, consisting of a home visit by the CHC nurse, and included an information letter on the goal

of the study. The home visit started with the structured interview (SPARK), with the primary goal of deciding together with the parent(s) which type of (health) care was needed by child and parent(s). The interview was followed by a request (verbal + written) for informed consent to use the information recorded in the SPARK for scientific research. This order was chosen on purpose, as it may be very difficult to talk about parenting problems and care needed after informed consent has been denied.

The SPARK was tested in daily practice by all 63 CHC nurses of the three preventive CHC organizations in Zeeland. In the period from April to November 2006, 1140 eligible children aged 18 months were included.

### Data analysis

To assess the association between the different questions in the SPARK, we computed Spearman correlations between concerns, perceived need for support, risk assessment by the professional, and known demographic risk factors for child maltreatment. Summary scores for concerns and perceived need for support were computed by summing the scores for all subject areas and dividing by the number of areas. For each subject area, we assessed the differences between parents and professionals on the 6-point scale for perceived need of support, using the Wilcoxon signed ranks test. We calculated a 'known risk factor' summary score by summing the presence of the following risk factors (Kijlstra *et al.* 2002; Sidebotham *et al.* 2005): large family (>four children), single parent, young parent (<20 years at birth of child), very low educational background of parents, parents not speaking Dutch at home, unemployed or unemployable parents.

Furthermore, we assessed discriminative validity by testing differences in parent and family characteristics between the groups with low, increased and high risk. These between-group differences were assessed with an ANOVA or Kruskal–Wallis, depending on the variable. All analyses were done using *SPSS* 15. Differences and correlations were considered to be statistically significant if  $P < 0.05$ .

### Results

Response was high, with only 0.3% no contact and 1.9% no consent. Data concerning 1115 children were used in the analyses. In 99.6% of the cases, the SPARK was filled in during a home visit, while 0.4% of the children and their parent(s) were interviewed during a visit to the CHC centre. The mother was most often present during the interview (98.5%); fathers were less

often present (19.6%). During 19.1% of the SPARK interviews, both parents were present. In 4.8% of interviews, someone else was present (another family member or guardian). Other children from the same family were present in about a quarter of the interviews (25.3%). The mean duration of the home visit was 66 min [standard deviation (SD) = 20 min], while completing the SPARK took on average 37 min (SD = 13 min).

The first step of the SPARK is to ask the parents if they have experienced any concerns or problems and whether there were unfulfilled needs. The median summary score of the topics on experienced concerns by the parents was 1.6 [interquartile range (IQR) = 1.3–1.9; see Fig. 1]. Almost all parents had questions concerning child raising or the development of their child. Topics most mentioned were the ‘infancy review’ and ‘family issues’ (see Table 1; first column). In general, mothers perceived the concerns or problems as more severe than fathers, with the exception of ‘family issues’. Fathers reported more unfulfilled needs when discussing the topics ‘living environment’ and ‘how the child spends his/her time’. Mothers mentioned most unfulfilled needs regarding the topics ‘family issues’, ‘emotional development’, ‘child behaviour’ and ‘parenting approach’. The two-parent list showed stronger concerns with regard to ‘infancy review’, ‘social contacts’, ‘concerns communicated by others’ and ‘family issues’. Furthermore, when both parents were present, more serious concerns were recorded in response to the last point, ‘whether any topic was forgotten or needed further attention’.

The second step of administering the SPARK consists of asking both the parents and the professional for the current

perceived need for support. The median summary score of the parents was 1.1 (IQR = 1.0–1.3) and of the professionals 1.3 (IQR = 1.1–1.5; see Fig. 2). Parent(s) and CHC professional mostly agreed on which topics needed further support, but generally professionals indicated a higher level of support needed (see Table 1; for most domains  $P < 0.001$ ). This occurred most frequently on topics such as ‘child behaviour’, ‘parenting approach’, ‘emotional development’, ‘language, speech and thought development’, where the professional is able to initiate interventions by him/herself. Differences between the assessments of parent and professional were most frequent in the categories ‘information wanted’, ‘personal advice’ and ‘counselling’, and not in the more serious categories ‘intensive help’ and ‘immediate intervention required’ (see Table 1; column 2–5). This is exemplified by the finding that there are no significant differences between assessments from parents and professionals in the group labelled as ‘high risk’.

Intensive help or immediate action as reported by the professionals was needed by 4.5% of the children and their parents on one or more areas, while 38.7% of the children and their parents wanted personal advice or counselling on one or more areas. Topics with the highest levels of support needed were ‘family issues’, ‘living environment’, ‘motor development’, ‘day care for the child’ and the final question regarding whether anything had been forgotten or needed further attention. In response to this last question, topics mentioned included problems experienced by the parents and vaccinations, the behaviour of other children (often the eldest child), child protective services/guardian, school choice for older child, combination of an

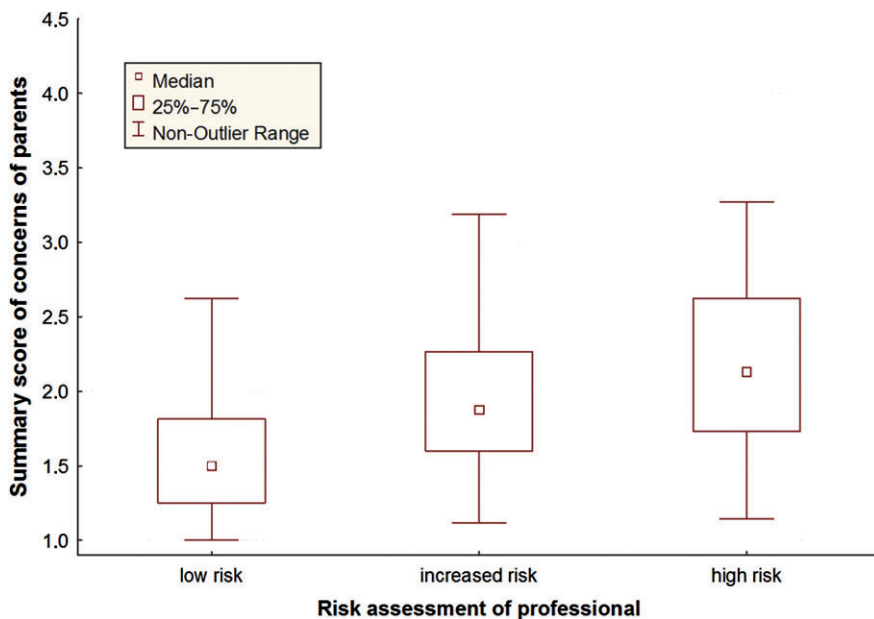
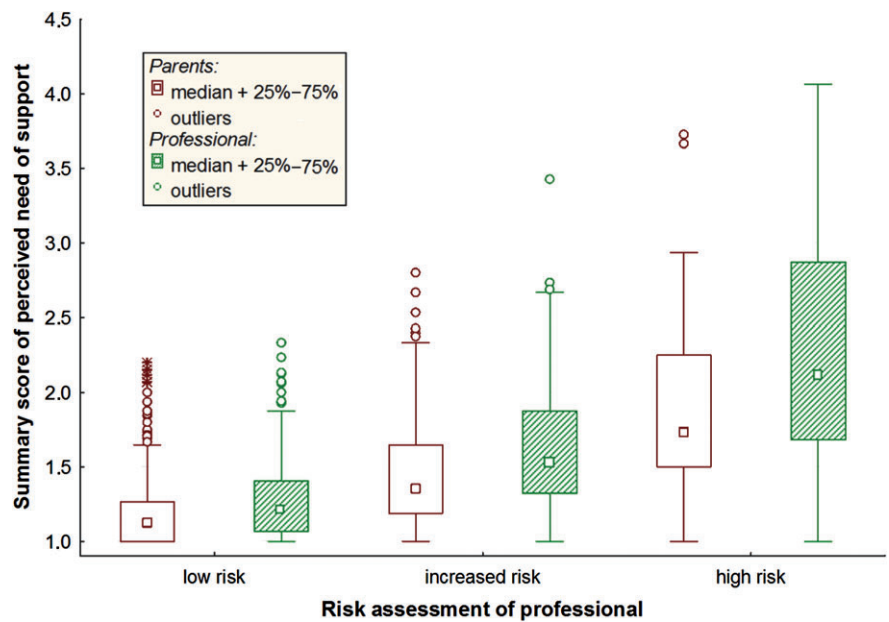


Figure 1. Box plot of parents' concerns.

**Table 1.** Concerns experienced by parents, assessment of level of support needed by parents and professional, per area (one-parent list)

Domains	Parent concerns Concerned/very concerned	Perceived need of support				P-value*
		Parents assessment*		Professional assessment*		
		Information wanted/personal advice/counselling	Intensive help/immediate intervention required	Information/personal advice/counselling	Intensive help/immediate intervention required	
Infancy review	17.3%	9.3%	1.5%	11.1%	1.0%	0.2
Somatic health	8.4%	17.3%	1.0%	23.6%	1.0%	<0.001
Motor development	1.7%	14.5%	1.0%	23.4%	0.8%	<0.001
Language, speech and thought development	0.9%	21.9%	–	39.4%	0.1%	0.03
Language use of parents	2.2%	10.5%	0.3%	23.7%	0.3%	<0.001
Emotional development	4.8%	25.8%	0.7%	43.7%	0.6%	<0.001
Contact between child and others	1.8%	10.6%	0.2%	20.8%	0.1%	<0.001
Child behaviour	6.1%	34.9%	0.8%	53.0%	1.3%	<0.001
Parenting approach	5.1%	32.7%	1.0%	47.3%	1.0%	<0.001
Developmental stimulation	0.5%	15.6%	–	28.5%	–	<0.001
Time spending	1.8%	16.3%	0.1%	16.3%	0.1%	<0.001
Living environment	4.7%	3.9%	0.7%	8.8%	0.9%	<0.001
Social contacts	2.2%	5.2%	0.6%	8.9%	0.6%	0.001
Day care for child	2.3%	5.7%	0.2%	9.3%	0.1%	<0.001
Concerns communicated by others	2.5%	4.9%	0.2%	6.7%	0.5%	<0.001
Family matters	11.4%	9.8%	2.1%	14.4%	2.6%	<0.001
Was any topic forgotten?	4.4%	12.2%	1.0%	13.6%	1.5%	0.1

\*The 6-point assessments of parents and professional were dichotomized for readability; category ‘no help needed’ was omitted. The comparison using Wilcoxon signed ranks test was on the full 6-point scale.



**Figure 2.** Box plot of perceived need of support.

adolescent and a toddler living in the same house, and unemployment. Interestingly, parents from the high-risk group did not report concerns on all areas, in contrast with the low- and increased-risk group parents. This lack of concern con-

trasted with the intensity of care required: the percentage of ‘intensive help’ and ‘immediate intervention’ was 1.5 to 15 times higher in the high-risk group than in the increased-risk group.

**Table 2.** Correlations between assessments and risk factors

Assessments	Parent assessment of perceived need of support	Professional assessment of perceived need of support	Risk assessment professional	Sum of risk factors*
Parent concerns	0.43†	0.41†	0.33†	0.11†
Parent assessment of perceived need of support		0.73†	0.38†	0.14†
Professional assessment of perceived need of support			0.41†	0.20†
Overall risk assessment professional				0.29†

\*Risk factors: 4 or more children, one-parent household, parents younger than 20 years, very low education level of the parents, parents not speaking Dutch at home, parents are unemployed/unemployable.

†Correlation is significant at the 0.01 level (two-tailed).

The third step of the SPARK concerns an analysis and a decision on what to do next. Most of the follow-up actions can be done by the CHC professionals themselves within their regular contacts (83.1%), while for 16.6% of the children, additional contacts are required, and 0.3% of the children need fewer contacts than the regular set of appointments (Ministry of Health Welfare and Sports 2002).

Finally, the professional assigns an overall risk assessment after having analysed which factors influence this risk estimation positively or negatively. The risk assessment showed 2.9% high, 16.5% increased and 80.6% low risk. The mean sum of risk factors was low: 0.41 (SD = 0.9).

The association between the different questions was examined by correlation coefficients (Table 2) and by box plots (Figs 1 & 2). The correlation coefficients between concerns, perceived need of support and risk assessment are moderate, and varied between 0.33 and 0.41. The correlation coefficients between the SPARK questions and the sum of known risk factors for child maltreatment are low, with exception of the moderate correlation of the sum of known risk factors with the risk assessment ( $r = 0.29$ ). Figure 1 shows graphically that a higher risk assessment is associated with an increase in summary score of concerns reported by parents, and Fig. 2 an increase in summary score of perceived need of support by parents and professional.

In Table 3, population characteristics, broken down to clarify risk factors, were presented per risk assessment group. There were no significant differences in child characteristics between the different risk assessment groups. However, family and parent characteristics did show significant differences between risk assessment groups. Increased risk and high risk were associated with family composition, age of mother at birth, non-Dutch ethnicity, language spoken (non-Dutch), low education for both parents and mother's employment status (all  $P < 0.01$ ).

## Discussion

Using an iterative process and in close cooperation between research and practice, we adapted an existing structured interview on the need for parenting support and expanded it into an instrument for early detection and assessment of parenting and developmental problems in young children. This new instrument combines the perspectives of the parent(s) and the professional and fits within the goals of preventive CHC.

The SPARK was feasible to use as a population-based preventive approach in children aged 18 months. The majority of the children were labelled by the CHC nurse as having low risk for parenting and developmental problems. About 16% of the children were identified as having increased risk, while almost 3% were assessed as being at high risk for parenting and developmental problems. Almost half of the population needed some help, ranging from personal advice to immediate action. About 5% of the children and their parents needed help or immediate action on one or more topics, mostly requiring a referral to professionals outside the preventive CHC. Almost all parents had questions concerning child raising or the development of their child, and needed support at some point in their parenting career (Moran *et al.* 2004; Hermanns 2009). This study shows that these questions, if discussed appropriately, can be detected by the CHC professional. The SPARK provides relevant information about problems experienced and care needs, which can immediately be put to use. Both agreement and disagreement between scores of parents and professional are useful for deciding which follow-up actions to take. This type of information can also be useful for personal reflection and for coaching, monitoring and reliability checks. In our opinion, the SPARK helps CHC nurses to acquire a more professional attitude towards early detection of parenting problems.

The risk assessment of the CHC professional was associated with known risk factors for child maltreatment. Children from

**Table 3.** Population characteristics per risk group

Child characteristics	Low-risk group	Increased-risk group	High-risk group	P-value*
Male/female	54.4%/45.6%	55.4%/44.6%	51.5%/48.5%	0.8
Place in family order				0.1
First child	44.0%	37.1%	32.3%	
Second child	36.2%	39.2%	32.3%	
Third child	13.3%	14.5%	25.8%	
Fourth or higher child	6.5% (max 10 children)	9.1% (max 7 children)	9.7% (max 6 children)	
Family characteristics				<0.001
Two-parent household	96.3%	78.9%	66.7%	
One-parent household	1.4%	11.7%	16.7%	
Shared household	1.5%	4.4%	6.7%	
Other (foster family/adoption/ divorcement/grandparents)	0.9%	5.0%	10.0%	
Parent characteristics				
Age mother (mean in year, SD)	30 (SD = 4.7)	29 (SD = 5.2)	28 (SD = 5.3)	<0.001
Mother age <20 years by birth of this toddler	0.8% (n = 7)	4.9% (n = 9)	9.7% (n = 2)	<0.001
Age father (mean in year, SD)	33 (SD = 5.2)	33 (SD = 6.6)	31 (SD = 5.7)	0.21
Father age <20 years by birth of this toddler	0.2% (n = 2)	1.7% (n = 3)	–	0.02
Ethnicity: non-Dutch mother	7.0%	20.4%	9.1%	<0.001
Ethnicity: non-Dutch father	6.1%	18.3%	12.1%	<0.001
Language: non-Dutch used at home by mother	6.3%	20.4%	9.1%	<0.001
Language: non-Dutch used at home by father	5.5%	14.0%	6.1%	<0.01
Education				<0.001 mother <0.001 father
Low education	19.0% mother (including 2.2% very low) 23.3% father (including 1.8% very low)	36.9% mother (including 11.2% very low) 43.1% father (including 9.0% very low)	50.0% mother (including 26.7% very low) 57.1% father (including 10.7% very low)	
Intermediate education	53.8% mother 47.9% father	43.0% mother 35.9% father	36.7% mother 21.5% father	
High education	27.2% mother 28.8% father	20.1% mother 21.0% father	13.3% mother 21.4% father	
Employment				<0.001 mother 0.8 father
Employed	71.9% mother 93.4% father	43.0% mother 77.4% father	48.5% mother 60.6% father	
Unemployed	0.8% mother 0.4% father	5.4% mother 3.2% father	6.1% mother 12.1% father	
Unemployable/unable to work	0.1% mother 0.1% father	2.7% mother 3.8% father	6.1% mother 3.0% father	
Housewife/house husband	21.3% mother 0.2% father	33.9% mother 1.1% father	33.3% mother –	

\*Using Kruskal–Wallis test, with exception of age and family order: using ANOVA.

families with a single-parent household, non-western families, low education level, unemployed mother and younger aged mother were, according to the SPARK, at increased risk for parenting and developmental problems.

Other studies showed that among children aged 14 months to 4 years of age, about 7.6–9.4% of the children were identified by the preventive CHC professional as having psychosocial problems (Reijneveld *et al.* 2004; Klein Velderman *et al.* 2009).

Dossier analysis of families with at least one child aged 0–3 years found that 18% of the families had a risky problem situation regarding one or more domains: the child, the parents, or the interaction between parent and child and the environment (Tenhaeff *et al.* 2004). All these studies emphasized the need to improve both the identification of problems and follow-up actions by the preventive CHC professionals. Zeijl and colleagues (2005) studied the age group 0–12 and reported that

most children in the Netherlands are doing well. At the most, 5% had to deal with multiple problems. However, the group with one severe problem was bigger and varied between 6% and 15%. The percentage of children with problems, as identified by the SPARK, is in accordance with these findings from the literature.

Child health care in the Netherlands has a population-based preventive approach, reaching about 98% of all children in the first years of life (Shuller *et al.* 2004). This strength of preventive CHC resulted in a very high response rate. The response is similar to other CHC studies in the Netherlands, which have shown response rates of 92% to 95% (Reijneveld *et al.* 2004; Klein Velderman *et al.* 2009).

This study has a number of limitations. First, completing the SPARK takes more time (on average 37 min) than is usually available during a regular appointment at the well-baby clinic (15 to 20 min). Further research should clarify whether this extra time results in improved outcomes. Second, the association of concerns and perceived need of support with known risk factors for child maltreatment was weak. This was expected, as the SPARK was meant for use in the general population and has a broad scope, and is not intended to measure risk for child maltreatment. On the other hand, parenting problems may lead to child maltreatment, so the significant association between the overall risk assessment and known risk factors was expected.

Third, the validity of the SPARK was only partially assessed. Content validity was obtained in the current study by developing the SPARK in close cooperation with an expert group of experienced CHC nurses. Furthermore, the SPARK was based on an existing questionnaire, the VOBO. The findings in this study about which problems and concerns parents perceive as most significant are consistent with the results obtained by the VOBO (Bertrand *et al.* 1998; Leseman & Hermanns 2002; Zeeman *et al.* 2007). The next step in research on the SPARK would be to assess reliability, validity and diagnostic accuracy. Further results will contribute to the discussion as to whether broad, careful assessment in dialogue with the parents is worthwhile and feasible.

## Conclusions

This study shows that the SPARK is a feasible instrument with a discriminative capacity for the early detection of parenting and developmental problems in toddlers. The SPARK has a broad but structured scope and combines the perspectives of parent and professional. We recommend further study of the validity and reliability of the instrument and evidence for the risk assessment.

## Key messages

- There is a lack of validated instruments for early detection of parenting and developmental problems of young children, suitable for broad use in preventive CHC.
- We developed an instrument that addresses a broad range of topics, using a three-step model, and includes the perspectives and experience of both the parent(s) and the CHC professional.
- The Structured Problem Analysis of Raising Kids (SPARK) is a structured interview for early detection and assessment of parenting and developmental problems in young children.
- The SPARK is feasible in daily practice, is discriminative, and clarifies concerns, problems experienced and care needs, which can immediately be put to use in preventive CHC.

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