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Mental Health Services for Children, Adolescents, and Families

Trends, Models, and Current Status

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In 1999, the American Psychiatric Association reported that approximately 13 million children (or about 18% of children in the United States) were in need of mental health or substance abuse services. This estimate is consistent with other recent reports of psychiatric or psychosocial morbidity (e.g., Costello et al., 1996; R. E. Roberts, Attkisson, & Rosenblatt, 1998), with reports of children with diagnosable or distressing conditions ranging from 16% to 22%, depending on type of condition, diagnostic specificity, and demographic characteristics. Although variations in measurement may account for some of the differences, the current estimates of children in need of services are significantly higher than those reported by Jane Knitzer (1982) in her landmark publication, Unclaimed Children. In this first comprehensive report on the state of child and adolescent mental health and services, Knitzer noted that, although the need is great, as many as two thirds of the children with mental health problems did not receive services.

Since the early 1980s, public and private initiatives have exerted considerable efforts toward meeting these needs. Nevertheless, the U.S. Surgeon General’s Office recently reported that less than one third of the children with diagnosable mental disorders receive services in a given year (Department of Health and Human Services, 1999). The purpose of

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this chapter is to introduce the historical and contemporary influences on mental health service delivery, and to characterize the range of services that are available to children, youth, and families—many of which are represented in the chapters of this volume.

**BRIEF HISTORY OF SERVICE DELIVERY TO CHILDREN**

Parenting, education, and treatment of children and adolescents have evolved over recorded history (Peterson & Roberts, 1991). Early “interventions” with children, who exhibited disordered behavior frequently, were harsh and were aimed at eliminating innate evil tendencies or the influences of evil forces (e.g., demons, or Satan), and the treatments designed to remedy the condition often resulted in harm or greater impairment to the child. It was not until the mental hygiene movement of the late 19th and early 20th centuries that changes in attitudes and social policy resulted in observably better treatment for children and youth with mental health needs. Reforms were made toward more humane and enlightened treatment of adults (and to some degree, children) with mental disorders in hospital settings and treatment centers of a variety of types.

As part of this movement, Lightner Witmer established what many consider to be the first psychology clinic at the University of Pennsylvania in 1896—interestingly, mandated to serve the needs of the public while training graduate students in the new field of “clinical psychology” (Witmer, 1907/1996). Indeed, the field of school psychology also traces its origins to Witmer because of his orientation to education interventions (French, 1990). As noted by Witmer, a specific objective of the University of Pennsylvania Psychological Clinic was “the offering of practical work to those engaged in the professions of teaching and medicine, and to those interested in social work, in the observation and training of normal and retarded children” (Witmer, 1996, p. 249).

Another significant change in treatment came in the social reform efforts resulting in the first Juvenile Psychopathic Institute in Chicago (now Institute for Juvenile Research) and later the Judge Baker Guidance Center in Boston. These centers provided more intense psychiatric and psychological assistance to children and families than had been provided in the past. Douglas Thom’s Habit Clinic was established shortly thereafter to apply behavioral principles to discrete problematic behaviors. These types of child treatment centers were replicated and adapted into a number of child guidance clinics across the country.

Since then, various theoretical orientations have guided the contexts of psychotherapeutic interventions, and have also led to a diverse range in the organization of service delivery systems (Peterson & Burbach, 1988; Peterson & Roberts, 1991). However, these influences (i.e., theoretical orientation and therapeutic context) have not been the only forces in the evolution of mental health service delivery. Various financing arrangements (M. C. Roberts & Alexander, 1990) as well as public and private policies have frequently dictated the nature and availability of mental