In the United States, outpatient private practice emerged as a distinct model for delivering mental health services in the latter half of the 1800s. Prior to that time, the young discipline of psychiatry was concerned almost exclusively with the care of severely disturbed individuals confined to asylums, and other mental health disciplines had not yet evolved (Brown, n.d.; Reisman, 1991). Since then, private practice has become a major vehicle for delivering mental health services. A brief summary of some of the key setting factors and antecedent events that contributed to the development of, and eventual boom in, outpatient private practice in the United States will be presented followed by an examination of contemporary private practice as a model for delivering mental health services to children, adolescents, and families.

From the late 1700s to the middle 1800s, post-Enlightenment concern for the less fortunate coupled with a growing respect for rationality and science contributed to a shift away from superstitious, inhumane, and pessimistic views of psychological disturbance, which led to the warehousing (or worse) of afflicted individuals, to more scientific, humane, and optimistic views that fostered a search for effective treatments (Reisman, 1991). Between 1869 and 1879, neurologists George Miller Beard and S. Weir Mitchell helped legitimize less severe forms of psychological disturbance, and neurologist William A. Hammond published a paper entitled, “The Non-asylum Treatment of the Insane,” thus helping to move the locus of mental health care from asylums to outpatient practices (Brown, n.d.).
In 1879, scientific psychology coalesced as a discipline, and not long afterward, in 1896, Lightner Witmer initiated the field of clinical psychology by opening a psychological clinic, the first of its kind in the world, at the University of Pennsylvania. Witmer’s clinic served primarily children and may be viewed as an early forerunner of child guidance clinics (Reisman, 1991). Adolf Meyer, a pathologist and director of the New York Psychiatric Institute, initiated the practice of psychiatric social work in 1904 (Reisman, 1991). Interest in psychoanalysis and other forms of psychological therapies rose in the United States after Sigmund Freud and Carl Jung delivered a series of lectures at Clark University in 1909 (Reisman, 1991). During the same year, social reformer, writer, and philanthropist Ethel Sturges Dummer, physician William Healy, and others created the Juvenile Psychopathic Institute in Chicago, considered by many to be the first child guidance clinic in the world (Jones, 1999; Reisman, 1991). Around 1917, states began legally recognizing psychologists as experts in mental retardation, much to the displeasure of psychiatrists and others in the medical profession interested in protecting what they considered their turf (Reisman, 1991). Demand for outpatient mental health services grew and then skyrocketed after World War II. The federal government responded by providing funding for graduate training in psychology, and predictably, the number of graduate programs increased. At about the same time (middle 1940s), states began enacting certification and licensing laws for psychologists, thereby allowing them to practice independently (Reisman, 1991).

The most recent boom in outpatient private practice began during the 1960s with the passage of “freedom-of-choice” legislation requiring third-party payers to provide reimbursement for services regardless of which licensed or certified professional (e.g., psychiatrist or psychologist) delivered the services (Routh, 1994). During the late 1970s and early 1980s, litigation resulted in at least two key court decisions that held that non-M.D. mental health practitioners were entitled to practice independently (i.e., without physician oversight) and to receive third-party reimbursement for their services (Reisman, 1991). Thus, during the 1960s, 1970s, and early 1980s, legislation and litigation provided another source of funding for psychologists in private practice; opened the doors of private practice to social workers, psychiatric nurses, professional counselors, marriage and family therapists, and others; and provided a major financial impetus for entrepreneurship in the delivery of mental health services.

Eventually, and not surprisingly, a tightening of the financial reigns became necessary when health care spending skyrocketed. With the rise of managed care in the 1990s, a new climate was created—a climate unsupportive of unfettered growth in the business of health care delivery. As a result, providers are now forced to compete for fewer dollars. During this period of adaptation, changes are bound to occur throughout the system that will alter the ways in which mental health services are delivered. For the time being, however, private practice continues to be an important and viable service delivery model.