Handbook of Mental Health Services for Children, Adolescents, and Families

Issues in Clinical Child Psychology

Series Editors: **Michael C. Roberts**, *University of Kansas—Lawrence, Kansas*
Lizette Peterson,‡ *University of Missouri—Columbia, Missouri*

HANDBOOK OF ADOLESCENT HEALTH RISK BEHAVIOR
Edited by Ralph J. DiClemente, William B. Hensan, and Lynn E. Ponton

HANDBOOK OF CHILD ABUSE RESEARCH AND TREATMENT
Edited by John R. Lutzker

HANDBOOK OF CHILD BEHAVIOR THERAPY
Edited by T. Steuart Watson and Frank M. Gresham

HANDBOOK OF CHILDREN'S COPING: Linking Theory and Intervention
Edited by Sharlene A. Wolchik and Irwin N. Sandler

HANDBOOK OF DEPRESSION IN CHILDREN AND ADOLESCENTS
Edited by William M. Reynolds and Hugh F. Johnston

HANDBOOK OF MENTAL HEALTH SERVICES FOR CHILDREN, ADOLESCENTS, AND FAMILIES
Edited by Ric G. Steele and Michael C. Roberts

HANDBOOK OF PSYCHOTHERAPIES WITH CHILDREN AND FAMILIES
Edited by Sandra W. Russ and Thomas H. Ollendick

HANDBOOK OF RESEARCH IN PEDIATRIC AND CLINICAL CHILD PSYCHOLOGY
Edited by Dennis Drotar

HANDBOOK OF SCHOOL MENTAL HEALTH: Advancing Practice and Research
Edited by Mark D. Weist, Steven W. Evans, and Nancy A. Lever

INTERNATIONAL HANDBOOK OF PHOBIC AND ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS
Edited by Thomas H. Ollendick, Neville J. King, and William Yule

MENTAL HEALTH INTERVENTIONS WITH PRESCHOOL CHILDREN
Robert D. Lyman and Toni L. Hembree-Kigin

SCHOOL CONSULTATION: Conceptual and Empirical Bases of Practice
William P. Erchul and Brian K. Martens

‡Deceased.

Handbook of Mental Health Services for Children, Adolescents, and Families

Edited by

Ric G. Steele
University of Kansas
Lawrence, Kansas

and

Michael C. Roberts
University of Kansas
Lawrence, Kansas

Kluwer Academic / Plenum Publishers
New York, Boston, Dordrecht, London, Moscow

Library of Congress Cataloging-in-Publication Data

Handbook of mental health services for children, adolescents, and families / edited by Ric G. Steele and Michael C. Roberts.
p. cm.—(Issues in clinical child psychology)
Includes bibliographical references and index.
ISBN 0-306-48560-5 (hbk.)—ISBN 0-306-48561-3 (eBook)
1. Child mental health services—United States. 2. Teenagers—Mental health services—United States. 3. Youth—Mental health services—United States. 4. Family—Mental health services—United States. I. Steele, Ric G. II. Roberts, Michael C. III. Series.

RJ501.A2H36 2004
362.2′083′0973–dc22

2004042177

ISBN 0-306-48560-5

233 Spring Street, New York, New York 10013

http://www.kluweronline.com

10 9 8 7 6 5 4 3 2 1

A C.I.P. record for this book is available from the Library of Congress

Printed in the United States of America

To Carol, for her love and support

—RGS

To my wife and children

—MCR

Contributors

Gerald J. August, Department of Psychiatry, University of Minnesota Medical School, Minneapolis, Minnesota 55454

Beth A. Auslander, University of Texas Medical Branch at Galveston, Galveston, Texas 77555

Barrie E. Berquist, Department of Psychiatry, University of Minnesota Medical School, Minneapolis, Minnesota 55454

Leonard Bickman, Department of Psychology, Peabody College, Vanderbilt University, Nashville, Tennessee 37212

Michael L. Bloomquist, Department of Psychiatry, University of Minnesota Medical School, Minneapolis, Minnesota 55454

Barbara L. Bonner, Center on Child Abuse and Neglect, Department of Pediatrics, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma 73164

Keri J. Brown, Department of Psychology, Columbus Children's Hospital, Columbus, Ohio 43215

Bryan D. Carter, Kosair Children's Hospital, University of Louisville School of Medicine, Louisville, Kentucky 40202

Bruce F. Chorpita, Department of Psychology, University of Hawaii at Manoa, Honolulu, Hawaii 96822

Ann M. McGrath Davis, University of Kansas Medical Center, Kansas City, Kansas 66160

Artemio de Dios Brambila, Division of Child and Adolescent Psychiatry, Department of Psychiatry, University of New Mexico School of Medicine, Albuquerque, New Mexico 87131

Christina Donkervoet, Child and Adolescent Mental Health Division, Hawaii Department of Health, Honolulu, Hawaii 96813

Glen Dunlap, Department of Child and Family Studies, Florida Mental Health Institute, University of South Florida, Tampa, Florida 33612

Rebecca Ettelson, Department of Psychiatry, University of Tennessee Health Science Center, Memphis, Tennessee 38105

David L. Fenell, Counseling and Human Services Program, University of Colorado at Colorado Springs, Colorado Springs, Colorado 80933

Jerry Flanzer, National Institute on Drug Abuse, Bethesda, Maryland 20892

Patricia A. Graczyk, Institute for Juvenile Research, Department of Psychiatry, University of Illinois at Chicago, Chicago, Illinois 60612

E. Wayne Holden, Applied Research Division, ORC Macro, Atlanta, Georgia 30329

Alan J. Hovestadt, Counselor Education and Counseling Psychology, Western Michigan University, Kalamazoo, Michigan 49008

Julie Heim Jackson, Department of Counseling, Developmental, and Educational Psychology, Boston College, Chestnut Hill, Massachusetts 02467

Anne K. Jacobs, Clinical Child Psychology Program, University of Kansas, Lawrence, Kansas 66045

T. Rene Jamison, School Psychology Program, University of Kansas, Lawrence Kansas 66045

Michelle R. Kees, Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma 73104

Bernadette M. Landolf, Behavior Therapy Center of Greater Washington, Silver Spring, Maryland 20901

Steven W. Lee, School Psychology Program, University of Kansas, Lawrence, Kansas 66045

Susanne S. Lee, Department of Psychiatry, University of Minnesota Medical School, Minneapolis, Minnesota 55454

Heidi J. Liss, National Rural Behavioral Health Center, University of Florida, Gainesville, Florida 32610

Robin Mathy, Department of Psychiatry, University of Minnesota Medical School, Minneapolis, Minnesota 55454

Trisha T. Miller, Disaster Mental Health Institute, University of South Dakota, Vermillion, South Dakota 57069

Shelagh Mulvaney, Department of Psychology, Peabody College, Vanderbilt University, Nashville, Tennessee 37212

William D. Murphy, Department of Psychiatry, University of Tennessee Health Science Center, Memphis, Tennessee 38105

Joseph E. Nyre, Department of Child and Adolescent Psychiatry, University of Chicago, Chicago, Illinois 60637; Department of Pediatrics, Southern Illinois University Medical School, Springfield, Illinois

Jacqueline Page, Department of Psychiatry, University of Tennessee Health Science Center, Memphis, Tennessee 38105

Diane Powell, Department of Child and Family Studies, Florida Mental Health Institute, University of South Florida, Tampa, Florida 33612

Beverly Pringle, National Institute on Drug Abuse, Bethesda, Maryland 20892

Camille Randall, Clinical Child Psychology Program, University of Kansas, Lawrence, Kansas 66045

Gilbert Reyes, Disaster Mental Health Institute, University of South Dakota, Vermillion, South Dakota 57069

Michael C. Roberts, Clinical Child Psychology Program, University of Kansas, Lawrence, Kansas 66045

Susan L. Rosenthal, University of Texas Medical Branch at Galveston, Galveston, Texas 77555

Rolando L. Santiago, Center for Mental Health Services, Substance Abuse, and Mental Health Services Administration, Rockville, Maryland 20857

Merritt D. Schreiber, Terrorism and Disaster Branch, National Center for Child Traumatic Stess, David Geffen School of Medicine at UCLA, Los Angeles, California

Mary B. Short, University of Texas Medical Branch at Galveston, Galveston, Texas 77555

Julianne M. Smith-Boydston, Bert Nash Center, Lawrence, Kansas 66044

Terry Stancin, Department of Pediatrics, MetroHealth Medical Center, Case Western Reserve University School of Medicine, Cleveland, Ohio 44109

Ric G. Steele, Clinical Child Psychology Program, University of Kansas, Lawrence, Kansas 66045

Robert L. Stephens, Applied Research Division, ORC Macro, Atlanta, Georgia 30329

Beth Todd-Bazemore, Disaster Mental Health Institute, University of South Dakota, Vermillion, South Dakota 57069

Patrick H. Tolan, Institute for Juvenile Research, Department of Psychiatry, University of Illinois at Chicago, Chicago, Illinois 60612

Luis A. Vargas, Division of Child and Adolescent Psychiatry, Department of Psychiatry, University of New Mexico School of Medicine, Albuquerque, New Mexico 87131

Eric M. Vernberg, Clinical Child Psychology Program, University of Kansas, Lawrence, Kansas 66045

Renee T. von Weiss, Children's Hospital of Minneapolis, Minneapolis, Minnesota 55404

Ngan Vuong, University of Kansas Medical Center, Kansas City, Kansas 66160

Mary E. Walsh, Department of Counseling, Developmental, and Educational Psychology, Boston College, Chestnut Hill, Massachusetts 02467

Contents

1

Mental Health Services for Children, Adolescents, and Families

Trends, Models, and Current Status

RIC G. STEELE and MICHAEL C. ROBERTS

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

RIC G. STEELE and MICHAEL C. ROBERTS • Clinical Child Psychology Program, University of Kansas, Lawrence, Kansas 66045.

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

health services for youth. As we describe below, these influences have not always acted in concert with professional, theoretical, or therapeutic goals.

FEDERAL INFLUENCES ON SERVICE DELIVERY

With the apparently changing appreciation for the mental health needs of children and adolescents, a number of federally initiated programs began to facilitate the development and implementation of services for youth and families, some of which continue to exert influence. Among the first federal influences on mental health service needs of children was the Joint Commission on the Mental Health of Children (JCMHC, 1969; Dougherty, Saxe, Cross, & Silverman, 1986). This commission, established in 1965, was specifically mandated to assess the prevalence of "emotional disorders" in children, including those with specific psychiatric diagnoses as well as those with impairments in social and educational functioning (JCMHC, 1969). Although earlier federal reports had suggested the need to develop new programs for emotionally disturbed children (e.g., White House Conference on Children in 1909), the 1969 report of the Joint Commission was the first to assess the degree to which children's mental health needs were being meet, and to detail specific recommendations to improve service delivery. These recommendations included the development of child advocacy systems, prevention and remediation services, integrated mental and physical health care systems, family-based treatment models, and mechanisms for increasing research into diagnosis and treatment (Dougherty et al., 1986). Although some of these recommendations have subsequently been implemented, the Joint Commission's 1969 report did not lead to any specific federal action.

A more focused federal initiative in 1975, the *Project on the Classification of Exceptional Children*, had more tangible results for specific subsets of children with mental health needs (cf. Hobbs, 1975). Perhaps building upon the earlier Joint Commission's findings, the Project recommended the establishment of advisory groups at the local, state, and federal levels that would provide input to agencies that coordinated mental health services for "exceptional" children. In addition to advocating specific attention to family support, improved residential care, and better organization and coordination of services, the Project also recommended that all children, regardless of ability, should have access to free and appropriate public education. These recommendations resulted in the passage of Public Law 94-142, the Education for All Handicapped Children Act of 1975.

Following closely on the heels of PL 94-142, the President's Commission on Mental Health (1978) and its Panel on Infants, Children, and Adolescents returned to the recommendations of the 1969 Joint Commission, reporting that little had been done to address several of the deficits in mental health coverage for youth and families. In particular, the Commission found that children of minority ethnic group membership and adolescents were particularly at risk for suboptimal mental health care. The President's

Commission made a number of recommendations that were consistent with the original report of the Joint Commission, including mandates to more fully integrate mental health care into overall health care, to realize the development of prevention services, to provide services to families of children with identified mental health needs, and to fund more basic and evaluation research.

However, unlike its predecessor, the 1978 Commission's report called attention to the mental health needs of minority populations, recognizing that some intervention or prevention efforts might need to be adapted with respect to differences across ethnic groups. Further, the President's Commission recommended the organization of services along a continuum of intensiveness, matching the needs of individual clients to specific levels of care, noting a particular deficit in adequate residential services for children and adolescents. It also called for the development of an integrated network of mental health services in schools, juvenile courts, neighborhood centers, and occupational centers that would address some of the specific needs of adolescents, such as depression and suicide, teenage pregnancy, delinquency, and substance abuse (Dougherty et al., 1986).

Although the President's Commission report resulted in the *Mental Health Systems Act of 1980*, specifically authorizing many improvements in the organization, coordination, and delivery of mental health services for children with severe emotional problems, the act was repealed in 1981 before it was implemented—being replaced by the Alcohol, Drug Abuse, and Mental Health (ADM) block grant (PL 97-35; Dougherty et al., 1986). The ADM block grant program moved the funding of children's mental health systems, including the monies allocated for funding community mental health centers, to the purview of state governments (Lourie, 2003). States were (and are) to use the grants to fund community mental health centers, emphasizing the specific programs that are most needed. Although PL 97-35 was well intended, some have suggested that the act was a step backward in terms of children's mental health care, on the grounds that there were no provisions specifically allocating funds to children's services (Knitzer, 1982; Lourie, 2003). This federal act represented a significant loss of targeted funds that had been allocated under the Mental Health Systems Act of 1980, and made no requirements of the State Mental Health Agencies to provide for specific services for youth or families.

In approximately the same time frame as the President's Commission on Mental Health (i.e., 1979–1982), the Children's Defense Fund commissioned Jane Knitzer, a psychologist, to survey federal and state agencies and provide a report on the current state of children's mental health services. The resulting document, *Unclaimed Children* (Knitzer, 1982), represented the most comprehensive assessment of services for children to date, and was the first empirically derived report dealing with youth and family mental heath care (Dougherty et al., 1986). In addition to providing estimates of the number of children in need of services, Knitzer noted current deficits in the organization and delivery of mental health services. Similar to the 1969 Joint Commission report, Knitzer highlighted inequitable

service delivery across demographic groups, such that children of minority ethnic group membership and children of lower socioeconomic status were more likely to receive no or inappropriate care. With regard to continua of services, she noted that the most expensive and restrictive level of care (i.e., psychiatric hospitalization) was the most accessible resource for children, and that alternatives to inpatient care were remarkably scarce. Knitzer also noted disorganization among state mental health service systems, as well as inadequate levels of child specialization in a majority of state mental health systems.

Based on her findings, Knitzer (1982) made six key recommendations that included changes in the organization, incentives, and regulation of state mental health agencies. In particular, she recommended that ADM block grant funds be specifically targeted for the development of programs for children and other underserved populations, that a federal child advocacy system be established that would help coordinate services for children, and that incentives be developed for creating and maintaining coordinated services for children.

As one important result of Knitzer's report, the National Institute of Mental Health funded the Child and Adolescent Service System Program (CASSP) as a means of coordinating service systems within the states. Under the encouragement of CASSP, states developed interagency *systems of care*, which would bring together mental health, special education, juvenile justice, and child welfare agencies. Consistent with the recommendations of several previous commissions, initial efforts were made to determine how these various systems could communicate with one another at the state (administrative) level. Subsequent efforts focused on creating community level systems of care that could provide youth and families with integrated and coordinated services. Much of the current understanding of and emphasis on systems of care in mental health service delivery is a direct result of CASSP (Day & Roberts, 1991; Knitzer, 1993). A second goal of CASSP was to enhance child and adolescent mental health policy focus and funding at the state level. In one sense, CASSP was mandated to reinstate the funds and policy focus that were done away with by the repeal of the Mental Health Systems Act of 1980.

The 1990s witnessed relatively few federal initiatives that would have a general impact on mental health service delivery to children and families. Rather, the Individuals with Disabilities Education Act (IDEA) of 1990, which was revised in 1997, would have a specific impact on mental health service delivery in the school environment. Under the provisions of IDEA (which was passed to amend PL 94-142), the U.S. Department of Education is mandated to assist states in providing all children with disabilities appropriate public education, and to prepare them for independent living and/or employment. As part of this mandate a number of mental health services may be provided, including psychological services, counseling and social work services, and parent counseling and training. Consistent with the previous calls for action, IDEA provided federal incentives for the integration of mental health and special education services for at least some youth and families.

Two additional federally initiated reports (i.e., *Report of the Surgeon General on Children's Mental Health* and *Healthy People 2010*) also have significantly highlighted child and adolescent mental health needs with potential influence on mental health service organization and delivery. However, because so little time has passed since their publication, their full impact has yet to be determined.

With regard to the first of these, in 2000, the U.S. Surgeon General David Satcher convened a meeting of experts from various disciplines and agencies involved with youth and family mental health service provision. In the ensuing report, the first of its kind from this federal office, the Surgeon General highlighted mental health promotion, early detection and assessment, and equal and universal access to mental health care as issues in need of continued attention (U.S. Public Health Service [US PHS], 2000). Specifically, he outlined a national action agenda with four guiding principles: promotion of mental health as an essential part of child health, integration of mental health into all systems that serve children and youth, encouragement of family and youth participation in planning and evaluation of mental health services, and development of public-private health infrastructures to support these efforts. These principles shaped the development of eight specific goals endorsed by the panel and the US PHS, which included provisions for eliminating racial/ethnic/economic barriers to mental health services, continuing efforts to coordinate services across agencies and professions, monitoring of access to and coordination of services, and training of competent providers.

Among the specific concerns evidenced by the Surgeon General's report is the movement of child and family mental health services toward a community health model that balances "health promotion, disease prevention, early detection and universal access to care" (US PHS, 2000, p. 14). Not surprisingly, this goal is echoed by the U.S. Department of Health and Human Services (US DHHS, 2000) in its most recent objectives for health promotion and illness prevention, *Healthy People 2010*. This document specifies a number of youth and family mental health objectives that are consistent with the general movement of integrating systems of mental health services (e.g., juvenile justice and mental health), as well as providing appropriate and competent services to a greater proportion of children in need. Although the *Healthy People* report is consistent with previous editions (e.g., *Healthy People 2000*), the emphasis appears to be slowly changing toward greater attention to the psychological service needs of children.

The recent history of federal initiatives regarding mental health service provision is complicated. On the one hand, similar recommendations have been repeatedly made since 1965, suggesting that more needs to be done in terms of *acting* on the many insightful reports that have been generated. On the other hand, although the language of the various reports is similar, some evolution of the calls for change in mental health service provision is evident. For example, the Surgeon General's report (US PHS, 2000) called for improvements in the systems of care to include systems of preventive care. This is an obvious advance over earlier calls for the creation of systems of

care, which were primarily oriented to remediation or therapeutic interventions for existing problems. Nevertheless, even as some hurdles are overcome, others must be met. For example, as one of the Surgeon General's panelist (Jane Knitzer) commented "...access to mental health services too often hinges on a child having the SED label. This is inconsistent with the emerging science of risk and resilience and makes it difficult to develop meaningful prevention" (US PHS, 2000, p. 43).

PROFESSIONAL/PRIVATE INFLUENCES ON SERVICE DELIVERY

In addition to the federal initiatives to improve the quality and accessibility of mental health services for children, adolescents, and families, there have been a number of private and professional influences on mental health care. Among these have been the sometimes interrelated effects of the American Psychological Association (APA), the American Academy of Pediatrics, and managed care organizations.

A number of initiatives sponsored by or affiliated with the APA already have had both direct and indirect effects on the provision of mental health service delivery. For example, in 1992, Section 1 of Division 12 (then the section on Clinical Child Psychology of the Division of Clinical Psychology of APA) and Division 37 (Child, Youth, and Family Services of APA) commissioned a joint task force to identify and characterize model programs in mental health service delivery. The resulting report (M. C. Roberts, 1996) identified 23 such programs as well as six characteristics common to the service programs. These characteristics (e.g., youth-centered philosophies and missions; contextual/ecological view of the child; collaborative, interagency approaches to problems; attempts to diminish barriers; accountability) appear consistent with the spirit of several earlier federal recommendations, and suggest that (1) some mental health programs had begun to respond to early federal communications regarding children's services, and (2) professional organizations had taken up the challenge to improve upon mental health service delivery.

More recently, Division 12 (the Society of Clinical Psychology of the APA) articulated a statement on the need for and evaluation of empirically supported treatments (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). This report went beyond earlier meta-analyses of treatment efficacy and proposed a method for establishing the degree to which specific treatments have empirical support. Chambless and colleagues (1996, 1998) further articulated criteria for establishing empirical support, and Kazdin and Weisz (1998) specifically applied the resulting criteria to child and adolescent populations. Divisions 53 (Society of Clinical Child and Adolescent Psychology) and 54 (Society of Pediatric Psychology) have dedicated a number of special articles to the identification and evaluation of empirically supported interventions (see, e.g., Lonigan, Elbert, & Johnson, 1998; Spirito, 1999).

Although still new and relatively controversial (see Steele & Roberts, 2003, for review), the movement toward empirically supported therapies (ESTs; or evidence-based therapy) has already provided an impetus for additional research into the effectiveness of interventions, as well as examination of cultural and economic moderators of treatment efficacy, as have been called for by federal reports for sometime. Perhaps, engendering some or much of the controversy, the EST initiative has also increased the accountability of service providers by providing regulatory and reimbursing agencies a benchmark by which to judge the success of programs and services. For example, implementation of the Felix Consent Decree in Hawaii (see Chorpita & Donkervoet, this volume) has resulted in a mandated reliance on ESTs as well as more systematic evaluation of mental health services.

Finally, the EST movement has had an effect on the availability and prioritizing of public research and training funds: Recent funding opportunities have been authorized with the specific intent of demonstrating the effectiveness of evidence-based therapies in the "real world" of the clinic (Foxhall, 2000). This is most evident in the National Institute of Mental Health's prioritization of research that translates findings from tightly controlled laboratory conditions (efficacy studies), to wider, more homogeneous populations (effectiveness studies), to clinics (practice), and finally to policy and financial decision making (systems research; Clinical Treatment and Services Research Workgroup, 1998). The proposed Child HealthCare Crisis Relief Act (HR 1359 and S 1223) also incorporates language to prioritize reimbursement of graduate loans to new mental health professionals who "have familiarity with evidence-based methods in child and adolescent mental health services" (lines 16–18, p. 6). Although the eventual impact of this legislation is uncertain (at the time of this writing, HR 1359 had been referred to the House Energy and Commerce Committee, Subcommittee on Health; see http://thomas.loc.gov for an update), it nevertheless represents a national recognition of the value of evidence-based practices that has been provided (in part) by professional organizations.

Ongoing APA efforts continue to work on a number of fronts to improve youth and family mental health services. In concert with the Surgeon General's report on children's mental health care (US PHS, 2000), the APA has chaired or participated in a number of consortia, coalitions, and work groups to find ways to specifically advocate for the mental health needs of children (Anderson, 2004). These have included the National Consortium for Child and Adolescent Mental Health, the President's New Freedom Commission on Mental Health, and the APA Working Group on Children's Mental Health. These various initiatives have been intended to incorporate evidenced-based interventions into integrated mental health systems for children, increase research and training funds that are specifically targeted for developmental and clinical child issues, and promote a primary mental health care system for children and adolescents. Consistent with these initiatives, the APA Council of Representatives recently adopted a resolution in support of the further development and

dissemination of evidence-based interventions—including specific development of culturally relevant services—for children and adolescents (American Psychological Association [APA], 2004).

Beyond the efforts outlined above, APA and the American Academy of Pediatrics (AAP), along with several other related organizations issued a joint consensus statement in 2000 regarding mental health and substance abuse services for children, adolescents, and families (AAP, 2000). In it, the professional organizations noted the current shortage of mental health services for youth and families, the lack of coordination across systems of mental health services, barriers to adequate service delivery, and problems with the current quality assurance measures. In addition to noting these deficits, the task force proposed a number of recommendations that could be implemented by the professional organizations themselves (e.g., training in and use of empirically supported therapies), as well as those that would require partnership with health management organizations (e.g., compensation for case management, elimination of mental health restrictions) or federal government agencies (e.g., increased support of training programs, mechanisms for dovetailing multiple funding streams for complicated cases).

As suggested above, a recent influence on the provision of mental health services for children has been the emergence of managed care. Although some commentators have suggested positive results of the business model on mental health services (e.g., increased accountability, reliance on ESTs; Stroul, Pires, Armstrong, & Meyers, 1998), many have been concerned that any gains that child services have made over the past several decades may be jeopardized (M. C. Roberts & Hurley, 1997; Stroul et al., 1998; Yanos, Garcia, Hansell, Rosato, & Minsky, 2003). Of particular importance is the impact of managed care on the range of services available to children, clinical decision making, and access to and quality of services.

A recent survey conducted by Stroul et al. (1998) attempted to address such questions. Specifically, they queried 10 state mental health systems regarding the impact of managed care on mental health service delivery to youth. Perhaps surprisingly, the results of the survey indicated little, if any, influence of managed care on quality of care or on accountability. However, Stroul et al. noted that the development and use of quality measurement or outcome data were "rare" (p. 131). This observation is consistent with a more recent review of the impact of managed care on children's mental health services: Hutchinson and Foster (2003) reported that no study was located that assessed the effect of managed care on quality of mental heath services for children and adolescents.

With regard to the impact of managed care on "systems of care," Stroul et al. (1998) reported that 6 of the 10 states surveyed indicated that managed care had improved the availability of case management, perhaps improving continuity of care. This effect seems to have been more pronounced among states with "carve-out" plans for mental health services. Dickey, Normand, Norton, Rupp, and Azeni (2001) have presented opposing data, indicating that continuity of care appeared to decline, at least in one sample of children with disabilities.

Stroul et al. (1998) reported that there had been mixed results with regard to access to services. Overall, they reported that more children had accessed mental health services under managed care, but children with serious emotional disorders had more difficulty obtaining appropriate services and placements. The authors linked this finding to the trend of children with serious emotional disturbance (SED) requiring services from multiple agencies, and at varying levels of intensity for longer periods of time. In particular, children with SED may be more likely to require inpatient services, which seem to have become more difficult to obtain under managed care.

Finally, the survey suggested that managed care may have a deleterious effect on the development of new services for children and families. Although states with "carve-out" plans had a more diverse array of services at different levels of intensity, interviewees reported that managed care organizations "expected providers to develop [new] services on their own initiative, but that providers were not willing to take such risks without knowing which services would ultimately be purchased by [managed care organizations]" (p. 128). If uncorrected, this trend could have a negative impact on the range of services provided to youth and families.

More recently, Stroul, Pires, Armstrong, and Zaro (2002) provided a qualitative case study, which prompted some speculation regarding the circumstances under which managed care might facilitate the systems-of-care philosophy that has come to represent the "ideal" held by many mental health professionals. Among the circumstances outlined, Stroul et al. specifically noted the utilization of stakeholder input in the planning and implementation of the managed care organization. Furthermore, Stroul et al. noted that the system-of-care philosophy was more likely to prevail when a broad array of services were available within the behavioral health system, and when provisions were made to encourage service coordination and interagency service planning activities. Finally, the authors noted the necessity of educating managed care organizations about the needs of children and adolescents (and their families) as well as how the system-of-care philosophy addresses those needs.

RANGE OF CURRENT SERVICES AVAILABLE TO CHILDREN, YOUTH, AND FAMILIES

Perhaps as a result of the federal, professional, and private influences just outlined, both the breadth and the depth of mental health services for youth and families have increased over the past several decades. Although some evidence suggests that the availability of inpatient care for youth with SED is still lacking (US PHS, 2000), the development of a range of outpatient services—including specialized and innovative programs—suggests that children and youth may now be better able to access appropriate services than ever before, but this is not a clear-cut or indisputable conclusion.

As characterized by Lyman and Wilson (2001), services available to youth and families vary along a number of dimensions, including restrictiveness or disruptiveness, effectiveness (including cost-effectiveness), and child-program compatibility. From least restrictive to maximally restrictive, programs may be characterized as *outpatient*, *day treatment* (or *partial hospitalization*), *shelter* or *respite care*, *foster care*, *group home*, *residential*, *inpatient hospitalization*, and *institutional*. Variables that define this progression include the degree to which daily routines are disrupted by the intervention itself, as well as the degree to which the programs focus on reentry into the community. Certainly, one of the challenging and ultimately vital aspects of service coordination and delivery is the selection of appropriate level (or levels) of care.

Although this volume is not organized along this continuum, the services and programs presented here represent interventions from across the spectrum of mental health settings. Chapters in the first section of this handbook are specific to a particular modality of service delivery. For example, Jacobs, Randall, Vernberg, Roberts and Nyre (chapter 4) provide coverage of a specific school-based intervention for children with SED, whereas Vargas and de Dios Brambila (chapter 9) outline the services subsumed under the heading of "inpatient and residential treatments." Each of the chapters in this section provides a perspective on how services are organized and delivered as well as how they are (or could be) evaluated.

Chapters in the second section outline an array of services for particular populations, and cover a range of service settings. For example, Kees and Bonner (chapter 10) focus on a range of prevention and intervention services for children who have been abused, and their families. Similarly, Murphy, Page, and Ettelson (chapter 15) address services for adolescent sex offenders, detailing the strengths of various service settings (e.g., outpatient, residential) and components of interventions. Both types of chapters demonstrate the variety and organization of various services among different populations. We anticipate that these chapters may generate creativity with regard to coordination of services within and across settings.

We devote the third section of the handbook to innovative or novel forms of service delivery. These chapters deal with specific services that are just emerging (e.g., Liss, chapter 19; Brown, chapter 20), as well as recent developments that have altered the ways in which services are delivered or evaluated (Chorpita & Donkervoet, chapter 21). Despite concerns that current funding strategies are not encouraging of the development of novel programs for youth, the selections for this handbook suggest that a number of talented people continue to expand the range of services that are available. How widespread are these innovations? The fact that they are considered innovative—oftentimes unique—and that they stand out from the other service delivery methods suggests that there remains room for them to develop in more locales.

Consistent with the system-of-care model, the final section of this book concerns the evaluation of mental health services. After a general

overview of program evaluation approaches and methods (Roberts & Steele, chapter 23), we present two chapters on specific large-scale program evaluations that, in addition to providing valuable conclusions regarding the targets of their respective evaluations, provide a useful guide for the subsequent conduct of program evaluations. We conclude with a brief look to the future organization of mental health service delivery, and proposal for areas of research.

CONCLUSION

Mental health services for children, adolescents, and families are expanding and changing due to the range of problems now presenting, and the recognition that traditional services and models have been relatively inadequate at addressing the needs. This handbook attempts to fairly comprehensively, but succinctly, present the range of services in a variety of settings for multiple problems presenting in childhood. Page limits preclude a fully comprehensive presentation of services for specific problems, so the particular service programs for a problem or population were selected for illustration. This organization reflects our ultimate goal of presenting these services in such a way as to encourage collaboration and coordination within and across mental health service systems. Further, the empirical basis of the handbook is designed to encourage further research that will have a maximum impact on service delivery (i.e., efficacy, effectiveness, practice, and systems research).

REFERENCES

American Academy of Pediatrics. (2000). *Insurance coverage of mental health and substance abuse services for children and adolescents: A consensus statement (RE0090).* Retrieved November 7, 2000 from http://www.aap.org/policy/re0090.html

American Psychiatric Association. (1999). *Issues affecting mental health coverage for children.* Washington, DC: American Psychiatric Association.

American Psychological Association. (2004, February). *Resolution on children's mental health.* Passed by Council of Representatives.

Anderson, N. B. (2004). Running commentary: Childhood mental health advocacy efforts. *Monitor on Psychology, 35*(1), 9.

Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P. (1996). Update on empirically validated therapies II. *The Clinical Psychologist, 51*, 3–16.

Chambless, D. L., & Hollon, S. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*, 7–18.

Clinical Treatment and Services Research Workgroup of the National Institute of Mental Health, National Advisory Mental Health Council. (1998). *Bridging science and service.* Bethesda, MD: National Institutes of Health. Retrieved July 15, 2003, from http://www.nimh.nih.gov/research/bridge.htm#br8

Costello, E. J., Angold, A., Burns, B. J., Erkanli, A., Stangl, D. K., & Tweed, D. L. (1996). The Great Smoky Mountains Study of Youth: Functional impairment and serious emotional disturbance. *Archives of General Psychiatry, 53*, 1137–1143.

Day, C., & Roberts, M. C. (1991). Activities of the Child and Adolescent Service System Program for improving mental health services for children and families. *Journal of Clinical Child Psychology, 20*, 340–350.

Department of Health and Human Services (1999). *Mental health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Department of Health and Human Services. (2000). *Healthy People 2010*. Retrieved January 18, 2004, from http://www.healthypeople.gov

Dickey, B., Normand, S. L., Norton, E. C., Rupp, A., & Azeni, H. (2001). Managed care and children's behavioral health services in Massachusetts. *Psychiatric Services, 52*, 183–188.

Dougherty, D. M., Saxe, L. M., Cross, T., & Silverman, N. (1986). *Children's mental health: Problems and services—A background paper*. Washington, DC: Office of Technology Assessment.

Foxhall, K. (2000). Research for the real world. *Monitor on Psychology, 31*, 28–36.

French, J. L. (1990). History of school psychology. In T. B. Gutkin & C. R. Reynolds (Eds.), *Handbook of school psychology* (2nd ed., pp. 3–20). New York: Wiley.

Hobbs, N. (1975). *The futures of children: Categories, labels, and their consequences*. San Francisco: Jossey-Bass.

Hutchinson, A. B., & Foster, E. M. (2003). The effects of Medicaid managed care on mental health care for children: A review of the literature. *Mental Health Services Research, 5*, 39–54.

Joint Commission on the Mental Health of Children. (1969). *Crisis in child mental health: Challenge for the 1970's*. New York: Harper & Row.

Kazdin, A. E., & Weisz, J. R. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology, 66*, 19–36.

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services*. Washington, DC: Children's Defense Fund.

Knitzer, J. (1993). Children's mental health policy: Challenging the future. *Journal of Emotional and Behavioral Disorders, 1*, 8–16.

Lonigan, C. J., Elbert, J. C., & Johnson, S. B. (1998). Empirically supported psychosocial interventions for children: An overview. *Journal of Clinical Child Psychology, 27*, 138–145.

Lourie, I. S. (2003). A history of community child mental health. In A. J. Pumariega & N. C. Winters (Eds.), *The handbook of child and adolescent systems of care* (pp. 1–16). San Francisco: Jossey-Bass.

Lyman, R. D., & Wilson, D. R. (2001). Residential and inpatient treatment of emotionally disturbed children and adolescents. In C. E. Walker & M. C. Roberts (Eds.), *Handbook of clinical child psychology* (3rd ed., pp. 881–894). New York: Wiley.

Peterson, L., & Burbach, D. J. (1988). Historical trends. In J. L. Matson (Ed.), *Handbook of treatment approaches in childhood psychopathology* (pp. 3–28). New York: Plenum.

Peterson, L., & Roberts, M. C. (1991). Treatment of children's problems. In C. E. Walker (Ed.), *Clinical psychology: Historical and research foundations* (pp. 313–342). New York: Plenum.

President's Commission on Mental Health. (1978). *Report to the President from the President's Commission on Mental Health*, vol.1 (Commission Report) and vol. 3 (Task Panel Reports). Washington, DC: U.S. Government Printing Office.

Roberts, M. C. Ed. (1996). *Model programs in child and family mental health*. Mahwah, NJ: Lawrence Erlbaum Associates.

Roberts, M. C., & Alexander, K. (1990). Programs and services for children's health care. *Child, Youth, and Family Services Quarterly, 13*(2), 13.

Roberts, M. C., & Hurley, L. K. (1997). *Managing managed care*. New York: Plenum.

Roberts, R. E., Attkisson, C. C., & Rosenblatt, A. (1998). Prevalence of psychopathology among children and adolescents. *American Journal of Psychiatry, 155*, 715–725.

Spirito, A. (1999). Introduction to special series on empirically supported treatments in pediatric psychology. *Journal of Pediatric Psychology, 24*, 87–90.

Steele, R. G., & Roberts, M. C. (2003). Therapy and interventions research with children and adolescents. In M. C. Roberts & S. S. Ilardi (Eds.), *Handbook of research methods in clinical psychology* (pp. 307–326). Oxford, UK: Blackwell.

Stroul, B. A., Pires, S. A., Armstrong, M. I., & Meyers, J. C. (1998). The impact of managed care on mental health services for children and their families. *Future of Children, 8*(2), 119–133.

Stroul, B. A., Pires, S. A., Armstrong, M. I., & Zaro, S. (2002). The impact of managed care of systems of care that serve children with serious emotional disturbances and their families. *Children's Services: Social Policy, Research, and Practice, 5*, 21–36.

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically validated treatments: Report and recommendations. *The Clinical Psychologist, 48*(1), 3–23.

U.S. Public Health Service. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: Department of Health and Human Services.

Witmer, L. (1996). Clinical psychology. *American Psychologist, 51*, 248–251. (Original work published in 1907 in *Psychological Clinic, 1*, 1–9)

Yanos, P. T., Garcia, C. I., Hansell, S., Rosato, M. G., & Minsky, S. (2003). Managed care and clinical decision-making in child and adolescent behavioral health: Provider perceptions. *Administration and Policy in Mental Health, 30*, 307–321.

2

Mental Health Services for Young Children[†]

DIANE POWELL and GLEN DUNLAP

In recent years, the national emphasis on school readiness has been accompanied by an increased appreciation for the crucial role assumed by healthy social and emotional development. It is now well understood that the foundations are laid during the earliest years for children to accomplish the developmental tasks of establishing emotional and behavioral self-regulation and social competency (Shonkoff & Phillips, 2000). Although most children proceed through this process smoothly, evidence has accumulated that significant numbers of young children experience social, emotional, and behavioral challenges and, without intervention, these problems are likely to persist. Increasingly, the importance of early mental health and behavioral services is recognized (New Freedom Commission on Mental Health, 2003); however, the multiple pathways and systems through which young children enter into and receive mental health services have developed largely in a haphazard manner, in isolation from each other, and with little attention to coordination or effectiveness. Furthermore, there is little research on utilization and service systems for young

DIANE POWELL and GLEN DUNLAP • Department of Child and Family Studies, Florida Mental Health Institute, University of South Florida, Tampa, Florida 33612.

[†] This chapter was prepared with support from the Center for Evidence-Based Practice: Young Children with Challenging Behaviors, Grant No. H324Z010001, funded by the Office of Special Education Programs, U.S. Department of Education. However, no endorsement of the authors' statements by the supporting agency should be inferred. Much of the content described herein, as well as additional sources of information, can be found on the Center's web site, www.challengingbehavior.org, work. In particular, the reader is referred to two documents posted on the web site: (1) Pathways to Service Utilization: A Synthesis of Evidence Relevant to Young Children with Challenging Behavior, by Diane Powell, Dean Fixson, and Glen Dunlap, and (2) Systems of Service Delivery: A Synthesis of Evidence Relevant to Young Children at Risk of or Who Have Challenging Behavior, by Barbara J. Smith and Lise Fox.

children with mental health needs to provide guidance for the systemic delivery of effective practices and strategies (Powell, Fixsen, & Dunlap, 2003; Smith & Fox, 2003).

This chapter provides a review of the ways in which children from birth to kindergarten are identified, referred, and receive mental health services. The scope and topography of mental health problems in infants and preschool age children are briefly explored, and information on the prevalence, course, and correlates of early emotional and behavior problems is presented. The pathways by which children with behavioral health problems are identified and enter into services, including the relevant evidence base, are described together with the national policies and funding streams within which these pathways are embedded. A description of the existing services and the mechanisms and strategies through which they are delivered completes this section. A final section is included to discuss recent policy, funding, and programmatic initiatives and innovations that contribute to the emergence of a more comprehensive system of care for young children.

SOCIAL/EMOTIONAL/BEHAVIORAL PROBLEMS IN YOUNG CHILDREN

The development of social competence during the early years is dependent on acquiring emotional, behavioral, and attentional self-regulation within the context of secure and nurturing relationships. However, determining what is developmentally normative behavior is not always easy. The persistence, intensity, and pervasiveness of problematic behavior, as well as the degree to which it interferes with other developmental tasks, are critical considerations in discriminating children who will grow out of emotional and behavioral difficulties from those whose behavior warrants intervention.

In infants and toddlers, disruptions of healthy social and emotional development are most often manifested as difficulties in establishing wake and sleep rhythms and feeding routines, attachment difficulties, and excessive crying and resistance to soothing. These processes are embedded in relationships and interactions between the child and caregivers, and disruptions may be a function of child factors, such as temperament, or caregiver factors that affect the ability to provide responsive nurturing care. In preschool age children, extremes of withdrawal and shyness, and of acting-out behaviors such as physical and verbal aggression, destruction, self-injury, and noncompliance, are indicators of problematic development (Smith & Fox, 2003).

Numerous studies have investigated the prevalence of social, emotional, and behavioral problems in young children. Though results vary depending on the methods, instruments, and populations used, studies of children aged 2–5 years within pediatric and preschool settings have found the rates of psychosocial problems to be between 9% and 23% (Campbell, 1995; Lavigne et al., 1996; Webster-Stratton & Hammond, 1998). These

findings validate the anecdotal reports of preschool teachers and childcare providers that increasing numbers of the young children display behavior problems of increasing severity (Yoshikawa & Knitzer, 1997).

For many young children, psychosocial problems are not transient, but rather persist over time. Approximately 50% of the children identified with problems as preschoolers continue to have problems into the school years (Campbell, 1995) and children whose disruptive behavior begins early are most likely to exhibit serious and intransigent antisocial problems in adolescence and adulthood (Campbell, Shaw, & Gilliom, 2000). However, despite such high prevalence and persistence rates, data for 1998 indicate that only 1–2% of preschoolers used any mental health specialty services during the year (Sturm et al., 2000).

Many circumstances in the lives of young children have been associated with psychosocial problems and poor outcomes, notably persistent poverty and chronic family adversity. These conditions act through direct effects on children and through contributions to family stress, and researchers have only recently begun to develop models that sort out relationships and interactions among these and other variables (Sameroff & Fiese, 2000). However, attention has increasingly turned to identifying those risk factors that are potent, causal, and amenable to change and thus should be the targets of intervention. These appear to be predominantly relationship-based factors, such as problematic parenting, parental mental health problems, poor bonding with parents, difficulties with teachers, and poor peer relationships (Huffman, Mehlinger, & Kerivan, 2000).

PATHWAYS TO SERVICES: IDENTIFICATION, REFERRAL, AND THE ROLE OF NATIONAL POLICIES AND FUNDING STREAMS

Children with social and emotional problems are most commonly identified through the various systems and programs that serve them. These include the primary systems of healthcare, and early care and learning programs. In addition, specific populations of young children may be identified through specialized service programs including early intervention, home visiting, and child welfare programs. A number of state and federal funding streams support these systems, and the laws and policies governing the funding streams influence the scope and configuration of identification and referral opportunities and, thus, the rates at which children are identified and receive services. These funding streams are spread across the areas of healthcare, early care and learning, child welfare, mental health, and early intervention for children with disabilities, with the federal programs administered by various entities within the U.S. Departments of Education and Health and Human Services. To a large extent, these funding programs are designed to identify and serve young children who are exposed to significant risk factors such as poverty, violence, and family disruption.

Healthcare

Because almost all young children come into contact with the healthcare system to receive immunizations and well-child care, it becomes a primary gateway for identification and entry into services. However, it is estimated that 14% of all children 0–6 years and 20% of low-income young children remain uninsured (Budetti, Berry, Butler, Collins, & Abrams, 2001), thus making identification of emotional and behavior problems through healthcare a difficult path to access for many young children.

Two federal programs, Medicaid and the State Children's Health Insurance Program, increase access to medical care by providing health insurance for low-income children. Medicaid mandates include the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program of services, which is intended to provide comprehensive preventive healthcare, including behavioral healthcare, to children. The periodic screenings must include a mental health screen, and all medically necessary services identified through the screening must be provided, including a wide array of behavioral health services, whether or not they are part of the state plan (Bazelon Center for Mental Health Law, 1999). However, despite mandates, most young children on Medicaid do not receive regular EPSDT screenings and even fewer receive the mental health screening component (Pires, Stroul, & Armstrong, 2000; U.S. General Accounting Office [USGAO], 2001).

Although the American Academy of Pediatrics (American Academy of Pediatrics Committee on Children with Disabilities, 2001), has developed a policy statement on developmental surveillance, screening and referral of infants and young children, these activities do not always occur within medical practices. Large proportions of behavioral health problems in young children are undetected by pediatricians, although the use of screening tools appears to increase identification rates (Stancin & Palermo, 1997). Even when psychosocial problems are identified, children may not be referred to services, and not all of those who are referred actually receive appropriate interventions (Horowitz, Leaf, Leventhal, Forsyth, & Speechley, 1992). Notable barriers to identification and appropriate referral include physician training variables, time constraints, financial disincentives, reluctance to label young children, and perceived lack of services (Navon, Nelson, Pagano, & Murphy, 2001; Relgado & Halfon, 2002; Stancin & Palermo, 1997).

Early Care and Learning

As large numbers of young children are cared for outside of their family home, early care and learning settings provide a second primary pathway for screening children and referral for further assessment and intervention. However, many children receive care in programs that do not necessarily provide routine developmental screenings. These include relative care, family childcare homes, and private center-based care. The government-funded programs of subsidized childcare, Head Start and Early Head Start,