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Bridging the mental health workforce gap: The role of licensed social workers in addressing the US Youth Mental Health Crisis

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Abstract

The United States is facing a severe youth mental health crisis, marked by rising rates of depression, anxiety, disruptive behavior disorders, and suicidality among children and adolescents. This crisis is compounded by a shortage of pediatric mental health professionals, particularly in underserved urban, rural, and low-income areas. Licensed social workers (LSWs) represent a vital but underutilized segment of the mental health workforce, uniquely equipped to provide clinical care, address social determinants of health, and coordinate services across systems. This paper reviews the scope of the youth mental health crisis, outlines the essential contributions of LSWs in schools, community agencies, and integrated healthcare settings, examines systemic barriers limiting their full utilization, and highlights innovative service delivery models. Policy recommendations are offered to strengthen the role of LSWs in improving access to equitable, culturally competent care for young people nationwide.

Keywords: Evidence-Based Practice; Licensed Social Workers; Pediatric Mental Health; Policy Reform; Youth Mental Health Crisis

1. Introduction

Youth mental health in the United States has reached a critical inflection point, with national indicators consistently reflecting a growing crisis among children and adolescents. According to recent data from the Centers for Disease Control and Prevention (CDC, 2023), approximately one in six youth aged 6–17 is diagnosed with a mental health disorder each year. Even more troubling, suicide has become the second leading cause of death among youth aged 10–14, signaling increased not only clinical need but also an alarming breakdown in early identification and intervention efforts. Common conditions such as anxiety, depression, and disruptive behavior disorders are being identified at younger ages, and the prevalence of mental health conditions has surged in tandem with escalating stressors in the social environment (Bitsko et al., 2022).

The COVID-19 pandemic has served as both a magnifier and an accelerant of pre-existing mental health trends. Disruptions in school routines, reduced social interactions, economic instability, and increased exposure to familial stress have disproportionately impacted youth, particularly those already at risk due to poverty, discrimination, or chronic illness (Racine et al., 2021). The American Academy of Pediatrics, along with the American Academy of Child and Adolescent Psychiatry, declared a national state of emergency in children's mental health in 2021, citing compounding stressors and overburdened healthcare systems (AAP et al., 2021). Even before the pandemic, disruptive behavior disorders such as Attention-Deficit/Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) were among the most prevalent diagnoses in youth populations. These conditions are strongly linked to academic underachievement, increased school exclusion rates, and heightened risk of involvement in the juvenile justice system (Barkley, 2015; Loe & Feldman, 2007).

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Nevertheless, while the demand for pediatric mental health services continues to escalate, the capacity of the current system to deliver timely, equitable, and effective care remains inadequate. Reports show that children often face wait times of three months or longer to secure an initial appointment with a licensed mental health professional (Whitney & Peterson, 2019). This delay is even more pronounced for youth in need of specialty care, such as trauma-informed therapy or neurodevelopmental assessments. Geographic disparities further compound access issues—rural counties and low-income urban areas frequently lack the provider density needed to meet local demand, with many counties reporting no child psychiatrist or licensed behavioral health provider (Thomas et al., 2009). These systemic limitations undermine the efficacy of early intervention, prolong suffering, and increase the likelihood of adverse educational and psychosocial outcomes.

In this urgent need, licensed social workers (LSWs)—especially those with clinical credentials (LCSWs)—are emerging as a vital component of the solution. Social workers comprise the largest group of clinically trained mental health professionals in the US, and their graduate education includes extensive preparation in assessment, diagnosis, treatment planning, and delivery of evidence-based psychotherapies (NASW, 2021; Hoge et al., 2007). However, their contributions extend beyond clinical work. LSWs are uniquely trained to address the social determinants of mental health, including housing instability, food insecurity, family conflict, and community violence—factors that profoundly influence children's emotional well-being and treatment outcomes (McKay et al., 2005).

Furthermore, LSWs frequently operate in school-based programs, community agencies, pediatric practices, and telehealth platforms, placing them at the intersection of health, education, and family systems. Their ability to collaborate across sectors, advocate for marginalized youth, and navigate complex service systems makes them indispensable in addressing both the clinical and structural aspects of the mental health crisis. With proper policy support, investment in workforce expansion, and integration into multidisciplinary teams, licensed social workers can help transform the fragmented landscape of youth mental health care into a more accessible, coordinated, and culturally responsive system. This paper explores the current challenges facing the youth mental health system, the essential role of LSWs, and the innovative models and policy reforms necessary to maximize their impact.

2. Background and Literature Review

The growing youth mental health crisis in the United States is the result of several intersecting and persistent factors that affect service access, workforce capacity, and health equity. Epidemiological studies reveal that nearly 50% of all lifetime mental health conditions begin by age 14, with up to 75% manifesting by age 24 (Kessler et al., 2005; Merikangas et al., 2010). These findings underscore the importance of early identification and timely intervention to prevent long-term impairments in social, academic, and emotional functioning. Unfortunately, despite increasing awareness and need, a significant proportion of children with diagnosable mental health disorders do not receive appropriate or timely treatment (Whitney & Peterson, 2019).

One of the primary contributors to this treatment gap is the insufficient supply of trained behavioral health professionals, particularly those specializing in child and adolescent populations. According to the Health Resources and Services Administration (HRSA, 2022), the United States is projected to face a shortfall of more than 10,000 child and adolescent behavioral health providers by 2030, including psychiatrists, psychologists, counselors, and social workers. This shortage has already manifested in extensive waitlists, service deserts, and delays in care initiation, all disproportionately affecting underserved populations (Cantor et al., 2020). The workforce crisis is not simply one of insufficient numbers—structural imbalances in provider distribution also shape it.

Geographic maldistribution exacerbates this provider shortage. Rural and semi-rural communities are particularly affected, with over 60% of US counties lacking a single practicing child psychiatrist (Thomas et al., 2009). Many of these areas also have limited access to psychologists or master's-level mental health clinicians, including licensed social workers. The resulting disparities mean families must travel long distances, wait weeks or months for appointments, or forego treatment altogether. Telehealth has mitigated some of these barriers, but internet access, digital literacy, and provider licensure limitations still constrain its widespread impact (Oblath et al., 2023).

Financial and insurance-related obstacles also present a formidable barrier to care. Low Medicaid reimbursement rates for mental health services discourage many providers—especially those in private practice or small clinics—from accepting publicly insured patients. This dynamic significantly limits access for low-income families, who disproportionately rely on Medicaid for pediatric health and mental health services (Barry & Huskamp, 2011; Garfield et al., 2020). Furthermore, reimbursement models often favor medication management over psychotherapy, reducing the availability of psychosocial interventions that are especially effective for children.

Cultural and linguistic mismatches between families and providers further hinder engagement and retention in care. Families from racially, ethnically, and linguistically diverse backgrounds frequently encounter services that are not culturally competent, and face communication barriers that lead to misdiagnosis, mistrust, or premature dropout (Alegría et al., 2008; Parekh & Trinh, 2014). For instance, Latino and African American youth are less likely to receive specialty mental health services than their white counterparts, even when controlling for symptom severity and insurance status (Sheehan et al., 2024). This highlights the need for a diverse, culturally responsive workforce trained to deliver linguistically and developmentally appropriate interventions.

Amid these systemic challenges, licensed social workers (LSWs) have emerged as a critical solution to the mental health workforce crisis. Social workers are the largest group of clinically trained mental health providers in the United States, outnumbering psychiatrists, psychologists, and psychiatric nurses combined (National Association of Social Workers [NASW], 2021; Hoge et al., 2007). Their dual focus on clinical care and social determinants uniquely positions them to address youth and families' complex, layered needs.

Empirical studies have demonstrated that LSWs are highly effective in delivering evidence-based interventions for children and adolescents. These include Cognitive Behavioral Therapy (CBT), Trauma-Focused CBT (TF-CBT), Motivational Interviewing, and behavioral parent training programs—modalities that are foundational in the treatment of ADHD, ODD, depression, anxiety, and trauma-related disorders (Evans et al., 2018; Hoagwood et al., 2010; Murray et al., 2015). Their training also enables them to provide family engagement, case coordination, and advocacy, which are essential in achieving holistic mental health outcomes.

Moreover, LSWs are frequently the first point of contact for youth and families entering the mental health system, particularly in schools, community mental health centers, child welfare agencies, and pediatric care settings. Their presence in these accessible, non-stigmatizing environments increases the likelihood that youth will receive early support and continuity of care (McKay & Bannon, 2004; Teasley, 2004). In school-based mental health, for example, social workers are instrumental in linking students to broader systems of care, responding to crises, and implementing tiered behavioral interventions.

The existing literature supports the conclusion that LSWs represent an available and scalable workforce and are well-equipped to fill existing service gaps. Their clinical versatility, systems-level orientation, and community presence uniquely positioned them to lead efforts in bridging the mental health divide for children and adolescents across the United States.

3. The Role of Licensed Social Workers

Licensed social workers (LSWs) occupy diverse and vital roles across the child and adolescent mental health landscape. Their unique training in both clinical intervention and systems-level thinking enables them to provide holistic, trauma-informed, and culturally competent care across settings. From schools and community agencies to pediatric health systems and policymaking arenas, LSWs are well-positioned to address the growing mental health needs of youth in a comprehensive and accessible manner.

3.1. School-Based Mental Health

In schools, LSWs serve as the frontline mental health professionals for millions of students, particularly in low-income and high-risk districts. Their role goes far beyond traditional one-on-one counseling; it includes implementing school-wide positive behavior interventions, facilitating social-emotional learning (SEL) programs, supporting teachers through professional development, conducting risk assessments, and leading group interventions for grief, anxiety, or trauma. Their embedded presence reduces stigma associated with seeking mental health support, as students can access services in familiar and trusted environments (Franklin et al., 2009; Kelly, 2010).

Moreover, evidence shows that LSWs in schools have a measurable impact on student outcomes. Teasley (2004) found that school-based social work services were associated with improved school attendance, reduced disciplinary referrals, and greater academic engagement, particularly among students from marginalized backgrounds. LSWs are also crucial in crisis response and prevention, coordinating postvention strategies following community violence or student suicides. However, school social worker-to-student ratios remain far below recommended levels in most districts, highlighting the need for expanded investment in this workforce (National Association of Social Workers [NASW], 2021).

3.2. Community Mental Health Agencies

LSWs in community mental health settings play a foundational role in delivering outpatient therapy, crisis stabilization, and intensive case management services to children and families. These agencies often serve youth who are underinsured, living in poverty, or involved with child welfare or juvenile justice systems. In these contexts, LSWs provide direct clinical care and address the social determinants of mental health—such as housing instability, food insecurity, and caregiver unemployment—through resource linkage and advocacy (McKay et al., 2005; Bunger et al., 2014).

Additionally, LSWs frequently coordinate care across systems, working with schools, courts, and hospitals to ensure service continuity. Their relational approach and ability to engage caregivers and youth make them particularly effective in treatment planning and goal alignment. Studies have demonstrated that LSW-led interventions in community-based agencies lead to improved symptom reduction, increased service retention, and higher levels of family satisfaction (Chuang & Wells, 2010). In areas where psychiatric providers are limited, social workers often function as the primary point of contact for children in distress, making their presence essential to mental health equity.

3.3. Pediatric and Integrated Health Care

LSWs also serve critical roles in integrated pediatric behavioral health models, where they are embedded in primary care clinics and pediatric practices. These models allow for routine mental health screening during well-child visits and offer immediate access to in-house LSWs for follow-up. In this setting, LSWs conduct psychosocial assessments, deliver brief therapeutic interventions (such as motivational interviewing or cognitive-behavioral strategies), and coordinate care with physicians, psychiatrists, and specialists. This warm handoff process has been shown to reduce service delays, increase parental engagement, and improve the likelihood of follow-through with mental health referrals (Asarnow et al., 2015; Wissow et al., 2016).

Integrated care models are especially effective for young children, who may not yet present with diagnosable disorders but exhibit early signs of emotional or behavioral dysregulation. LSWs in these settings provide psychoeducation to caregivers, assist with behavioral management plans, and help families navigate insurance or service barriers. The collaborative model improves medical and mental health outcomes and is supported by evidence showing reductions in emergency department visits and increases in preventive care uptake (Kazak et al., 2010).

3.4. Policy and Advocacy

In addition to their clinical work, LSWs have a long-standing tradition of influencing mental health policy and systems reform. They are frequently involved in local, state, and national advocacy to expand access to services, improve funding mechanisms, and promote culturally and linguistically responsive care. LSWs draw upon case-level experiences and macro-level analysis to inform policy that reflects real-world needs. For example, they often participate in legislative testimony, coalition-building efforts, and developing best practice standards for youth mental health systems (Reisch & Jarman-Rohde, 2000; Strand et al., 2014).

Their training in social justice and community organizing uniquely positions them to challenge inequities in mental health access, including disparities based on race, socioeconomic status, immigration status, and gender identity. LSWs have been at the forefront of movements to implement trauma-informed schools, reduce police involvement in student crises, and eliminate exclusionary disciplinary practices. Their policy engagement amplifies the voices of vulnerable populations and ensures that mental health systems remain accountable, inclusive, and equity-driven.

4. Challenges and Barriers

Despite the immense potential that licensed social workers (LSWs) hold in addressing the youth mental health crisis, numerous structural and systemic barriers impede their full utilization within behavioral health systems. One of the most pressing issues is the persistently low reimbursement rates for social work services, particularly under Medicaid and many private insurance plans. Because social workers are often reimbursed at lower rates than psychologists or licensed professional counselors, agencies operating under budget constraints are disincentivized from hiring more LSWs, despite the cost-effectiveness and quality of care they provide (Barry & Huskamp, 2011). This financial barrier limits workforce growth and the sustainability of innovative service delivery models that rely heavily on LSWs for frontline mental health care (Andrews et al., 2013).

Another critical barrier is the unsustainable caseloads that many social workers manage, especially in public mental health systems and school-based programs. Due to workforce shortages and high demand, LSWs are frequently assigned

overwhelming numbers of clients, which reduces the frequency, depth, and personalization of care. High caseloads hinder LSWs' ability to deliver evidence-based interventions with fidelity, track client progress consistently, and engage in essential tasks such as parent coaching and interagency collaboration. Excessive workloads are directly linked to diminished job satisfaction, client engagement, and outcomes, as well as to burnout and attrition among mental health professionals (Lizano, 2015; Morse et al., 2012). This dilution of service quality undermines the effectiveness of LSW-led interventions and threatens workforce stability.

Licensing inconsistencies across states also present a significant obstacle to the mobility and effectiveness of the social work workforce. State-specific scope-of-practice regulations, supervision requirements, and licensure portability restrictions make it difficult for LSWs to relocate or provide services across state lines—an issue particularly problematic in the age of telehealth. The COVID-19 pandemic temporarily eased some restrictions, revealing the potential of national licensure compacts in promoting flexibility and access. However, without permanent legislative reform, these barriers will continue to fragment the profession and inhibit national workforce planning (Oblath et al., 2023). Uniform licensure standards would benefit LSWs and improve access to care in areas with chronic shortages.

Moreover, misconceptions about the clinical training and competencies of LSWs contribute to their underutilization in behavioral health care. Although LSWs are trained in psychotherapy, assessment, crisis intervention, and evidence-based practices, they are often viewed primarily as case managers or care coordinators. This misperception limits their involvement in clinical decision-making and can lead to underrepresentation in integrated care models and leadership positions. However, research consistently shows that when LSWs are included as full members of interdisciplinary teams, their therapeutic outcomes are comparable to those of other licensed mental health professionals (Webber, 2011; Green et al., 2014). Elevating the perception of the profession is therefore essential to maximizing the workforce's contribution to child and adolescent mental health.

Finally, limited access to ongoing professional development, clinical supervision, and advancement opportunities creates additional strain on the LSW workforce, particularly in under-resourced and rural settings. Many LSWs, especially early-career professionals, report difficulties securing regular supervision needed for clinical licensure, which delays career progression and reduces retention. Organizations risk losing skilled clinicians to burnout or roles outside direct practice without robust mentorship, training, and leadership pathways. Addressing this challenge requires funding and a shift in institutional culture to support continuous learning and growth (Craig & Muskat, 2013; Bride et al., 2007). These systemic constraints—if left unresolved—will continue to hamper the scalability and sustainability of LSW-led mental health interventions for youth.

5. Innovative Approaches and Models

In response to the youth mental health crisis and significant service gaps, licensed social workers (LSWs) are increasingly leading innovative models of care that expand access and improve outcomes for children and adolescents. These approaches harness the strengths of the social work profession—relational engagement, systems thinking, and cultural competence—within multidisciplinary and community-based frameworks. Among the most promising models are task-sharing, school-community partnerships, partial hospitalization programs, and tele-mental health interventions.

Task-sharing and collaborative care models have emerged as particularly effective strategies for integrating LSWs into multidisciplinary teams where they serve as frontline behavioral health providers. LSWs conduct initial assessments, deliver evidence-based interventions, and coordinate ongoing care with psychiatrists and pediatricians in these settings. This model extends psychiatric reach, especially in areas with few child psychiatrists, by allowing LSWs to manage routine mental health concerns while escalating complex cases to specialists as needed. Richardson et al. (2014) demonstrated that task-sharing can increase system efficiency without compromising quality, especially when LSWs are adequately trained and supported in these roles.

School-community partnerships represent another critical avenue through which LSWs are improving care continuity and responsiveness. Embedding LSWs within school settings enables early identification of behavioral and emotional issues, on-site crisis intervention, and smoother transitions between school-based and community-based services. Weist et al. (2012) emphasize that strong referral linkages and coordinated care planning between schools and local mental health agencies lead to improved attendance, reduced disciplinary incidents, and better academic performance. These models are especially effective in low-resource districts where students may not otherwise access services due to transportation, stigma, or lack of parental availability.

Lastly, tele-mental health services have significantly expanded the reach of LSWs into rural and underserved regions. Utilizing secure video platforms, LSWs can deliver therapeutic services, parent coaching, and crisis support remotely, reducing common barriers such as transportation and geographic isolation. Nelson et al. (2011) highlighted that tele-mental health improves appointment adherence and allows for continuity of care, particularly when integrated with school-based and primary care settings. During the COVID-19 pandemic, the rapid expansion of telehealth infrastructure proved that such models are feasible and essential to future service delivery.

Collectively, these innovative models underscore licensed social workers' adaptability and leadership potential in transforming youth mental health services delivery across diverse settings. As demand continues to outpace supply, investing in these scalable, evidence-based models will be critical to ensuring equitable access for all children, regardless of income or zip code.

6. Policy Recommendations

Addressing the escalating youth mental health crisis requires a robust and strategic investment in the licensed social work workforce. One of the most immediate and impactful steps would be to increase Medicaid reimbursement rates for social work services, particularly in behavioral health. Medicaid is the primary payer for mental health services among children in low-income families. However, reimbursement rates for services delivered by LSWs are often lower than those for other professionals. This disparity not only devalues the clinical expertise of social workers but also disincentivizes agencies from hiring or retaining LSWs. By aligning reimbursement with the scope and quality of care provided, states and federal agencies can enhance recruitment, reduce turnover, and ensure financial sustainability for agencies serving high-need populations.

Another vital policy strategy is to expand federal loan repayment and scholarship programs explicitly targeted at social workers willing to practice in underserved or high-need communities. Programs modeled after the National Health Service Corps, but tailored for LSWs, would help reduce the financial burden of graduate education and attract new talent to areas experiencing acute workforce shortages. This investment is significant for diversifying the field and increasing the number of bilingual and culturally competent providers who reflect the communities they serve. Such programs should prioritize graduates who commit to working in rural areas, inner-city schools, and public mental health settings.

In the education sector, policymakers should invest in school-based mental health infrastructure to place at least one licensed social worker in every K–12 school. Schools are often the first point of contact for children experiencing emotional or behavioral distress, and embedding mental health professionals directly into these settings enhances access, early intervention, and prevention efforts. Federal funding through initiatives like the Elementary and Secondary School Emergency Relief (ESSER) Fund should be extended or made permanent to support the long-term integration of LSWs into school communities. These professionals directly support students and serve as key liaisons to families, teachers, and outside service providers.

Promoting integrated care models that embed LSWs within pediatric primary care and behavioral health systems is essential to foster seamless, family-centered care. Integrated care—where physical and mental health services are co-located and coordinated—has improved treatment outcomes, reduced stigma, and streamlined referrals. LSWs in these models can conduct psychosocial assessments, deliver brief interventions, and coordinate follow-up care in collaboration with medical providers. Expanding grants and pilot programs that support integrated behavioral health in federally qualified health centers (FQHCs) and children's hospitals would allow more LSWs to operate in these innovative, multidisciplinary settings.

Finally, there is a pressing need to standardize scope-of-practice laws across states to ensure that LSWs can fully utilize their training and credentials. Current regulatory inconsistencies create barriers for LSWs moving between states and limit their ability to practice to the full extent of their education. Developing a national licensure compact for social workers—similar to those in nursing and counseling—would facilitate workforce mobility and address regional shortages more efficiently. Standardized practice laws would also reduce administrative burden for employers and clarify the roles LSWs can play in various settings, from schools to hospitals to telehealth platforms.

These policy changes, taken together, represent a comprehensive strategy to elevate the role of licensed social workers in youth mental health and expand their capacity to deliver timely, effective, and culturally competent care across the United States.

7. Conclusion

The escalating mental health crisis among US youth necessitates a coordinated, multi-sector strategy grounded in prevention, early intervention, and sustained care. Licensed social workers (LSWs) represent a highly qualified yet frequently underutilized component of the mental health workforce. With training encompassing clinical assessment, evidence-based intervention, care coordination, and systems-level advocacy, LSWs are uniquely positioned to meet the complex needs of children and adolescents, particularly those in low-income, Medicaid-eligible, and linguistically diverse populations. Their presence in schools, pediatric primary care, community mental health agencies, and telehealth platforms expands the reach of mental health services into the environments where youth live and learn.

Investing in the recruitment, training, and retention of LSWs—particularly in underserved regions—must be a national priority. Federal and state policies should support integrated care models that embed social workers in pediatric and school-based settings, ensure equitable service reimbursement, and promote licensure portability across states to address provider shortages.

Moreover, efforts to dismantle stigma and educate communities about social workers' competencies can elevate their visibility and increase trust among families seeking care.

A reimagined youth mental health system must fully harness the capabilities of LSWs as frontline providers, advocates, and change agents. With strategic investment and policy alignment, the United States can move toward a more equitable, accessible, and responsive mental health infrastructure that ensures all youth, regardless of background or zip code, have access to timely and culturally attuned support. This transformation is not only possible but imperative for the well-being of future generations.

References

[1] AAP, A., & CHA. (2021). Declaration of a national emergency in child and adolescent mental health. American Academy of Pediatrics.

[2] Alegría, M., Chatterji, P., Wells, K., Cao, Z., Chen, C., Takeuchi, D., … Meng, X.-L. (2008). Disparity in Depression Treatment Among Racial and Ethnic Minority Populations in the United States. Psychiatric Services, 59(11), 1264–1272.

[3] Andrews, C. M., Darnell, J. S., McBride, T. D., & Gehlert, S. (2013). Social work and implementation of the Affordable Care Act. Health & Social Work, 38(2), 67–71.

[4] Asarnow, J. R., Rozenman, M., Wiblin, J., & Zeltzer, L. (2015). Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: A meta-analysis. JAMA Pediatrics, 169(10), 929–937.

[5] Barkley, R. A. (2015). Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment (4th ed.). Guilford Press.

[6] Barry, C. L., & Huskamp, H. A. (2011). Moving beyond parity: Mental health and addiction care under the ACA. New England Journal of Medicine, 365(11), 973–975.

[7] Bitsko, R. H., Claussen, A. H., Lichstein, J., Black, L. I., Jones, S. E., & Danielson, M. L. (2022). Mental health surveillance among children—United States, 2013–2019. Morbidity and Mortality Weekly Report Supplements, 71(2), 1–42.

[8] Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. Clinical Social Work Journal, 35(3), 155–163.

[9] Bunger, A. C., Doogan, N. J., & Cao, Y. (2014). Building service delivery networks: Partnership evolution among children's behavioral health agencies in response to new funding. Journal of the Society for Social Work and Research, 5(4), 513–538.

[10] Cantor, J., McBain, R. K., Kofner, A., Stein, B. D., & Yu, H. (2020). Fewer Than Half Of US Mental Health Treatment Facilities Provide Services For Children With Autism Spectrum Disorder. Health Affairs (Project Hope), 39(6), 968–974. https://doi.org/10.1377/hlthaff.2019.01557

[11] Centers for Disease Control and Prevention (CDC). (2023). Children's mental health: Data and statistics on children's mental health.

[12] Chuang, E., & Wells, R. (2010). The role of interagency collaboration in facilitating receipt of behavioral health services for youth involved with child welfare and juvenile justice. Children and Youth Services Review, 32(12), 1814–1822.

[13] Craig, S. L., & Muskat, B. (2013). Bouncers, brokers, and glue: The self-described roles of social workers in urban hospitals. Health & Social Work, 38(1), 7–16.

[14] Evans, S. W., Owens, J. S., Wymbs, B. T., & Ray, A. R. (2018). Evidence-Based Psychosocial Treatments for Children and Adolescents With Attention Deficit/Hyperactivity Disorder. Journal of clinical child and adolescent psychology: the official journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53, 47(2), 157–198.

[15] Franklin, C., Kim, J. S., & Tripodi, S. J. (2009). A meta-analysis of published school social work practice studies: 1980-2007. Research on Social Work Practice, 19(6), 667–677.

[16] Garfield, R., Damico, A., & Orgera, K. (2020). The coverage gap: uninsured poor adults in states that do not expand Medicaid. Peterson Kaiser Family Foundation-Health System Tracker. Disponível em:. Acesso em29, 1–11.

[17] Green, C., Estroff, S. E., Yarborough, B. J. H., Spofford, M., Solloway, M. R., Kitson, R. S., & Perrin, N. A. (2014). Directions for future patient-centered and comparative effectiveness research for people with serious mental illness in a learning mental health care system. Schizophrenia bulletin, 40(Suppl 1), S1-S94.

[18] Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y., & Adams, N. (2007). An action plan for behavioral health workforce development. Cincinnati, OH: Annapolis Coalition on the Behavioral Health Workforce, 10.

[19] Hoagwood, K. E., Cavaleri, M. A., et al. (2010). Family support in children's mental health: A review and synthesis. Clinical Child and Family Psychology Review, 13(1), 1–45.

[20] Kazak, A. E., Hoagwood, K., Weisz, J. R., Hood, K., Kratochwill, T. R., Vargas, L. A., & Banez, G. A. (2010). A meta-systems approach to evidence-based practice for children and adolescents. The American psychologist, 65(2), 85–97.

[21] Kelly, M. S. (2010). School social work: An evidence-informed framework for practice. Oxford University Press.

[22] Kessler, R. C., et al. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders. Archives of General Psychiatry, 62(6), 593–602.

[23] Loe, I. M., & Feldman, H. M. (2007). Academic and educational outcomes of children with ADHD. Journal of Pediatric Psychology, 32(6), 643–654.

[24] Lizano, E. L. (2015). Examining the impact of job burnout on the health and well-being of human service workers: A systematic review and synthesis. Human Service Organizations: Management, Leadership & Governance, 39(3), 167–181.

[25] McKay, M. M., & Bannon, W. M., Jr (2004). Engaging families in child mental health services. Child and adolescent psychiatric clinics of North America, 13(4), 905–vii. https://doi.org/10.1016/j.chc.2004.04.001

[26] McKay, M. M., Lynn, C. J., & Bannon, W. M. (2005). Understanding inner city child mental health need and trauma exposure: Implications for preparing urban service providers. American Journal of Orthopsychiatry, 75(2), 201–210.

[27] Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., ... & Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). Journal of the American Academy of Child & Adolescent Psychiatry, 49(10), 980–989.

[28] Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. Administration and Policy in Mental Health and Mental Health Services Research, 39(5), 341–352.

[29] Murray, L. K., Skavenski, S., Kane, J. C., Mayeya, J., Dorsey, S., Cohen, J. A., ... & Bolton, P. A. (2015). Effectiveness of trauma-focused cognitive behavioral therapy among trauma-affected children in Lusaka, Zambia: a randomized clinical trial. JAMA pediatrics, 169(8), 761–769.

[30] National Association of Social Workers. (2021). Social work speaks (12th ed.). NASW Press.

[31] National Association of Social Workers. (2021). Social workers in mental health.

[32] National Association of Social Workers. (2021). Social workers in schools: Advocating for student success.

[33] Nelson, E. L., Bui, T. N., & Velasquez, S. E. (2011). Telepsychology: Research and practice overview. Child and Adolescent Psychiatric Clinics, 20(1), 67–79.

[34] Oblath, R., Twohy, E., Higdon, C., Duncan, A., Folk, J. B., Schiel, M. A., ... & Myers, K. (2023). The provision and utilization of telehealth within academic mental health clinics in North America during the COVID-19 pandemic. JAACAP open, 1(3), 218–229.

[35] Racine, N., McArthur, B. A., Cooke, J. E., Eirich, R., Zhu, J., & Madigan, S. (2021). Global prevalence of depressive and anxiety symptoms in children and adolescents during COVID-19. JAMA Pediatrics, 175(11), 1142–1150.

[36] Reisch, M., & Jarman-Rohde, L. (2000). The future of social work in the United States: Implications for field education. Journal of Social Work Education, 36(2), 201–214.

[37] Richardson, L. P., et al. (2014). Collaborative care for adolescents with depression in primary care. JAMA, 312(8), 809–816.

[38] Sheehan, A., Walsh, R., & Liu, R. (2024). Racial and ethnic trends in mental health service utilisation and perceived unmet need in the USA. J Epidemiol Community Health, 78(4), 228–234.

[39] Parekh, R., & Trinh, N. H. T. (Eds.). (2014). The Massachusetts General Hospital textbook on diversity and cultural sensitivity in mental health. (pp. 41–52). Springer. New York

[40] Strand, V. C., Abramovitz, R., Layne, C. M., Robinson, H., & Way, I. (2014). Meeting the Critical Need for Trauma Education in Social Work: A Problem-Based Learning Approach. Journal of Social Work Education, 50(1), 120–135. https://doi.org/10.1080/10437797.2014.856235

[41] Teasley, M. (2004). School Social Workers and Urban Education Reform with African American Children and Youth: Realities, Advocacy, and Strategies for Change. School Community Journal, 14(2), 19–38.

[42] Thomas, K. C., Ellis, A. R., Konrad, T. R., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of mental health professional shortage in the United States. Psychiatric services, 60(10), 1323–1328.

[43] Webber, M. (2011). Evidence-based policy and practice in mental health social work.

[44] Whitney, D. G., & Peterson, M. D. (2019). US national and state-level prevalence of mental health disorders and disparities of mental health care use in children. JAMA Pediatrics, 173(4), 389–391.

[45] Wissow, L. S., Van Ginneken, N., Chandna, J., & Rahman, A. (2016). Integrating children's mental health into primary care. Pediatric Clinics of North America, 63(1), 97.