ALIGNMENT FOR PROGRESS

Building the

Mental Health and Substance Use Disorder

Workforce We Need

Policy Issue Brief

Prepared

September 2024

THE KENNEDY FORUM

Acknowledgments

This report was made possible thanks to many organizations' and individuals' input and contributions.

Dr. Erin Parks, Equip
Stuart Archer, Oceans Healthcare
Anthony Carter, National Council for Mental Wellbeing
Chris Kennedy McKelvy, K-Ventures
Eric Paul, Health Centers of America
Dr. Michelle Spurlock, Acadia Healthcare
Gabe Diop, Rula Healthcare
Kyu Rhee, National Association of Community Health Centers
Dr. Helen Egger, Little Otter
Dr. Harsh Trivedi, Sheppard Pratt
Dr. Stephanie Ruckman, Wellpath
Dr. Kevin Doyle, Hazelden Betty Ford Graduate School of Addiction Studies
Jennifer Carvalho, Your Behavioral Health
Karen Johnson, Universal Health Services
Dr. Teresa Garate, Health Management Associates
Paul Fleissner, Health Management Associates
Courtney Thompson, Health Management Associates
Rachel LaFlame, Health Management Associates
720 Strategies
Healthsperien

About

thekennedyforum.org

@kennedyforum

linkedin.com/company/
the-kennedy-forum

Co-founded by former Congressman Patrick J. Kennedy and his wife, Amy L. Kennedy, The Kennedy Forum (TKF) is creating a future where all people can access effective prevention and treatment of mental health and substance use disorders (MH/SUD).

TKF uniquely cultivates relationships with key leaders to advance sweeping change for major MH/SUD issues, including inequity in insurance coverage and the escalating youth mental health crisis.

Table of Contents

Ten-Year Goal: 90-90-90 by 2033

The Kennedy Forum's strategic initiative, Alignment for Progress, sets forth a ten-year 90-90-90 goal by 2033:

90%

of individuals screened for MH/SUDs

90%

receiving evidence-based treatment

90%

managing symptoms and achieving recovery

One element of the Alignment for Progress is its National Strategy for Mental Health and Substance Use Disorders, a reference for federal policymakers to attain better access to MH/SUD care for all.

The Shortage Affects Us All

Expanding the Workforce Enhances Outcomes

The shortage of mental health and substance use disorder (MH/SUD) professionals and other providers in the healthcare workforce is exacerbating the MH/SUD crises facing the United States. Individuals experience this shortage in various ways, including long wait times for services, limited access to care in underserved areas, inadequate staffing levels, and challenges in meeting the diverse needs of those seeking MH/SUD treatment.

The scarcity of skilled professionals and other providers in this field impacts the quality and availability of services, leading to gaps in care that compound the existing challenges of rising MH/SUD needs.

For mental health healthcare providers, barriers to education and licensure are detrimental to not only the profession, but to health outcomes across the board. The effect on health outcomes due to lapsed or inadequate mental health outcomes is not only dangerous, it is expensive.

It is projected that by 2040 we will have lost $76B to treat chronic health conditions due to a lack of investment in mental health.[1]

This report will:

- Present examples of key challenges and opportunities for careers in the MH/SUD workforce, with a focus on:
  - Certified peer support specialists
  - Certified alcohol and drug counselors
  - Licensed clinical social workers
  - Psychiatric nurse practitioners
- Examine the extend of the shortage
- Provide policy recommendations in:
  - Payment and reimbursement
  - Licensure and standardization
  - Education and training
  - Data and technology

Careers in the MH/SUD Workforce

Examples of Opportunities and Challenges

The MH/SUD workforce is made up of a diverse range of professionals and other providers.[2] Each member of the workforce brings unique skills and expertise to fill different and important roles. For example, psychiatrists and psychiatric nurse practitioners have the ability to prescribe medications, while psychologists and clinical social workers may be more focused on providing therapy, while peer support specialists and addiction counselors may work to connect people to other supportive services for their recovery.

Each role also faces unique challenges and opportunities. This includes different levels of training and related costs, from training programs to doctoral level degrees; different levels of compensation and benefits; and different pathways for licensing and certification. By addressing barriers and capitalizing on opportunities, policymakers can unleash the full potential of the MH/SUD workforce.

This report presents examples of the pathways, as well as the opportunities and challenges, facing four careers in the MH/SUD workforce:

Certified Peer Support Specialist

Certified Alcohol and Drug Counselor

Licensed Clinical Social Worker

Psychiatric Nurse Practitioner

Building a Mental Health and Substance Use Disorder Care Career

Pathways, Pitfalls, and Progress

Certified Peer Support Specialist

A certified peer support specialist is a mental health professional who has personal experience with a mental health condition, substance use disorder, or both and has been trained to help others with similar challenges.

EDUCATION

$0-$2,000

4 YEARS

EXPERIENCE

Typically no direct cost

0-2 YEARS

FIELD EXPERIENTIAL TRAINING

$500-$2,000

WEEKS TO MONTHS

LICENSE/ CERTIFICATION

$100-$300

3-6 MONTHS

POTENTIAL COSTS

POTENTIAL RETURN ON EDUCATIONAL INVESTMENT

Range of Total Cost ($600-$4,300)

Salary Range ($35,000-$45,000)
ANNUALLY

ISSUES FOR CONSIDERATION

- FINANCIAL BARRIERS
- ACCESS TO EDUCATION AND TRAINING
- CERTIFICATION AND LICENSURE REQUIREMENTS
- STIGMA AND PERSONAL CHALLENGES
- EMPLOYMENT OPPORTUNITIES
- SUPPORT AND SUPERVISION
- PERSONAL AND PROFESSIONAL SKILLS
- LEGAL AND REGULATORY ISSUES

Explore these issues and potential solutions in the rest of the report and in the online career pathways at **TheKennedyForum.org/MH-SUD-Career-Paths**.

Building a Mental Health and Substance Use Disorder Care Career

Pathways, Pitfalls, and Progress

Certified Alcohol and Drug Counselor

A certified alcohol and drug counselor (CADC) is a trained and certified professional who specializes in providing support and guidance to individuals struggling with substance use disorders.

EDUCATION

$5,000-$30,000

6-8 YEARS

EXPERIENCE

$0-$5,000

6M-1 YEAR

FIELD EXPERIENTIAL TRAINING

$1000-$5,000

1-3 YEARS

LICENSE/ CERTIFICATION

$300-$800

EVERY 1-2 YEARS

POTENTIAL COSTS

POTENTIAL RETURN ON EDUCATIONAL INVESTMENT

Range of Total Cost ($6,300-$40,800)

Salary Range ($40,000-$60,000)
ANNUALLY

ISSUES FOR CONSIDERATION

- FINANCIAL BARRIERS
- ACCESS TO EDUCATION AND TRAINING
- CERTIFICATION AND LICENSURE REQUIREMENTS
- STIGMA AND PERSONAL CHALLENGES
- EMPLOYMENT OPPORTUNITIES
- SUPPORT AND SUPERVISION
- PERSONAL AND PROFESSIONAL SKILLS
- LEGAL AND REGULATORY ISSUES

Explore these issues and potential solutions in the rest of the report and in the online career pathways at **TheKennedyForum.org/MH-SUD-Career-Paths**.

Building a Mental Health and Substance Use Disorder Care Career

Pathways, Pitfalls, and Progress

Licensed Clinical Social Worker

A licensed clinical social worker is a specialized and licensed professional in the field of social work who focuses on the mental health and emotional well-being of individuals, families, and groups.

EDUCATION

$50,000-$170,000

10-12 YEARS

EXPERIENCE

$0-$10,000

2-3 YEARS

FIELD EXPERIENTIAL TRAINING

$200-$1,500

1-2 YEARS

LICENSE/ CERTIFICATION

$300-$600

3-6 MONTHS

POTENTIAL COSTS

POTENTIAL RETURN ON EDUCATIONAL INVESTMENT

Range of Total Cost ($50,500-$182,100)

Salary Range ($60,000-$85,000)
ANNUALLY

ISSUES FOR CONSIDERATION

- FINANCIAL BARRIERS
- ACCESS TO EDUCATION AND TRAINING
- CERTIFICATION AND LICENSURE REQUIREMENTS
- STIGMA AND PERSONAL CHALLENGES
- EMPLOYMENT OPPORTUNITIES
- SUPPORT AND SUPERVISION
- PERSONAL AND PROFESSIONAL SKILLS
- LEGAL AND REGULATORY ISSUES

Explore these issues and potential solutions in the rest of the report and in the online career pathways at **TheKennedyForum.org/MH-SUD-Career-Paths**.

Building a Mental Health and Substance Use Disorder Care Career

Pathways, Pitfalls, and Progress

Psychiatric Nurse Practitioner

A Psychiatric-Mental Health Nurse Practitioner (PMHNP) is an advanced practice registered nurse (APRN) specializing in mental health care.

EDUCATION

$74,000-$320,000

10-12 YEARS

EXPERIENCE

$0-$5,000

1-2 YEARS

FIELD EXPERIENTIAL TRAINING

$300-$3,000

2-4 YEARS

LICENSE/ CERTIFICATION

$495-$900

3-6 MONTHS

POTENTIAL COSTS

POTENTIAL RETURN ON EDUCATIONAL INVESTMENT

Range of Total Cost ($75,000-$330,000)

Salary Range ($120,000-$160,000)
ANNUALLY

ISSUES FOR CONSIDERATION

- FINANCIAL BARRIERS
- ACCESS TO EDUCATION AND TRAINING
- CERTIFICATION AND LICENSURE REQUIREMENTS
- STIGMA AND PERSONAL CHALLENGES
- EMPLOYMENT OPPORTUNITIES
- SUPPORT AND SUPERVISION
- PERSONAL AND PROFESSIONAL SKILLS
- LEGAL AND REGULATORY ISSUES

Explore these issues and potential solutions in the rest of the report and in the online career pathways at **TheKennedyForum.org/MH-SUD-Career-Paths**.

The Extent of the Shortage

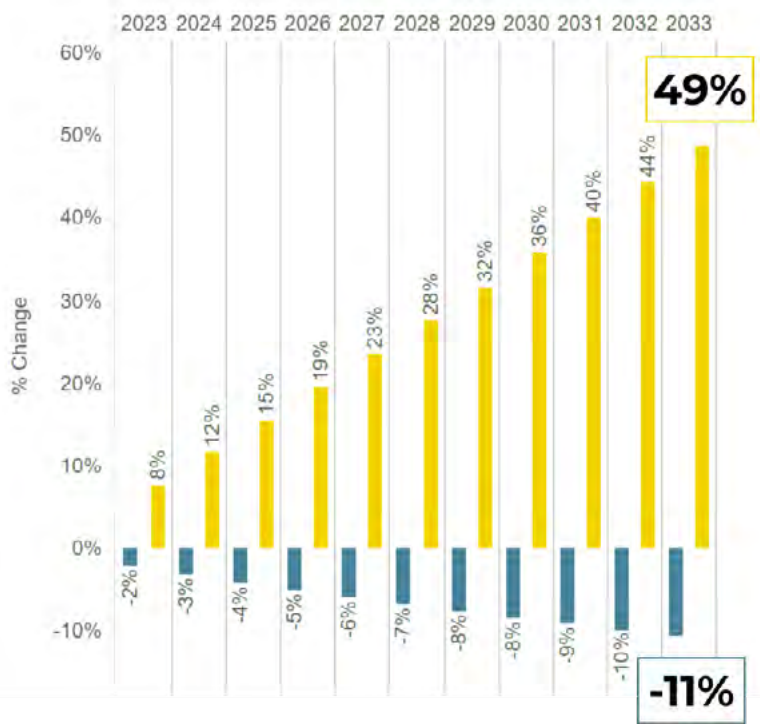
Gaps Exist Across the Country

In 2024, 122 million people in the U.S. lived in federally-designated mental health professional shortage areas.[3] These shortage areas generally reflect larger inequities, with the largest shortages concentrated in areas that are lower income; predominately Black, Indigenous, and people of color; or rural.

Nationally, the U.S. Health Resources and Services Administration (HRSA) estimates that over 6,000 additional mental health professionals are needed to fill gaps. In addition to more providers, the MH/SUD workforce needs more diversity as it fails to be representative of the people treated, leading to inequities and gaps in culturally and linguistically appropriate care.

The workforce shortages are only expected to get worse in coming years. By 2033, HRSA projects a 49% increase in demand for MH/SUD care and an 11% decrease in the supply of MH/SUD professionals.[4] As a result, the MH/SUD workforce is only projected to be 60% adequate in meeting the need for care, which will further exacerbate existing significant inequities in access.

Across the health workforce as a whole, the gap is much smaller – by 2033, HRSA projects that the U.S. will have 89% of the providers needed to meet overall health care demand, with some specialties exceeding the professionals required to meet projected demand. We need policy action to achieve an adequate and equitable MH/SUD workforce.



Projected Supply and Demand of MH/SUD professionals

Cumulative Percent Change Over Time

Demand

Supply

Source: Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections.

The Need for Policy Action

Addressing the Shortages

When MH/SUD is not treated, physical health symptoms may worsen. However, currently, for every 10 mental health providers that health organizations hire, 13 of those providers leave.[5] MH/SUD workforce shortages are at a crisis level and we need to act now to change the course of healthcare in the future.

Lack of MH/SUD care treatment has been shown to have an effect on cardiovascular disease, diabetes, strokes, and even premature death.[5] The impact of the shortage of MH/SUD professionals echoes throughout the rest of the healthcare system, while also still having profound consequences for those who need MH/SUD services and treatment.

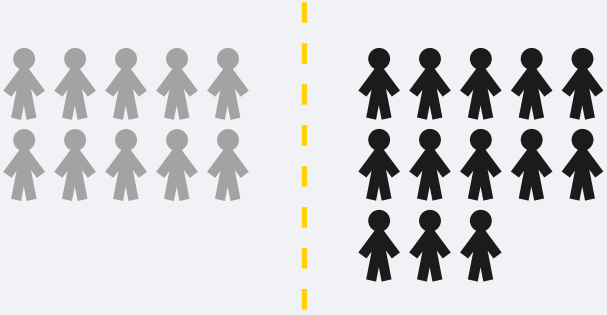
In patients that have a serious mental illness, life expectancy can fall 10-25 years shorter.[6] Not only do medical surgical providers lack integrating mental healthcare into their practices, but the same can be true for psychiatrists, with them not often being cognizant of treating physical health symptoms.

In mental health professional shortage areas (HPSAs), suicide rates increased by 6% from 2010-2018 compared to non-HPSAs.[7] In rural areas, HPSAs are common in both medical/surgical specialties, and mental health. The mental health shortage, however, is much greater. In order to save lives from both suicide and physical health diseases and disorders, we must address these gaps in access to MH/SUD professionals and other providers.

This report offers guidance for policymakers to tackle critical issues in:

- **Payment and reimbursement**
- **Licensure and standardization**
- **Education and training**
- **Data and technology**

For every **10** mental health providers hired at an organization, **13** of those leave.



Payment and Reimbursement

Fair and reasonable compensation is a critical part of recruiting and retaining people to any workforce, and MH/SUD care is no different. Right now, people in the MH/SUD workforce are often paid less than other areas of healthcare. A recent report from RTI International analyzing health insurance claims data found that the "average reimbursement for all medical/surgical clinician office visits was 21.7% higher than for all behavioral health clinicians."[8] These disparities in payment in part account for the workforce shortages we see today.

Fortunately the Mental Health Parity and Addiction Equity Act (MHPAEA) requires commercial health insurers and Medicaid managed care organizations to equitably reimburse MH/SUD providers. A new MHPAEA regulation published in 2024 offers further guidance on parity in reimbursement.

New regulations also make more reimbursement data available for regulators, providers, and consumers to understand the extent of MHPAEA compliance in reimbursement rates, although the data is currently difficult to analyze.[9] Additional attention is needed to fully implement MHPAEA and make available data actionable to support parity in reimbursement.

Congress should invest in the Department of Labor (DOL) and the Department of Health and Human Services (HHS) to build tools that make data on reimbursement parity actionable for regulators, employers, providers, and consumers. With these tools, federal and state regulators can more systematically implement MHPAEA, while employers will be better equipped to evaluate parity compliance for their health insurance offerings. Providers and consumers will have what they need to challenge disparities in reimbursement. With greater parity in reimbursement rates, compensation will increase and more people will be attracted to and remain in the MH/SUD care workforce.

The average medical/surgical office visit reimbursement is higher than MH/SUD clinicians by

↑ 21.7%

National Strategy Policy Recommendations

Reform the physician fee schedule. Congress and the Centers for Medicare and Medicaid Services (CMS) should change how Medicare sets reimbursement in order to remedy the historic – and ongoing – undervaluing of primary care and mental health and substance use disorder (MH/SUD) care throughout our entire healthcare system.	Source
Pass the Medicaid Bump Act. Congress should require that the Centers for Medicare and Medicaid Services (CMS) reimburse evidence-based mental health and substance use disorder (MH/SUD) treatments at their true cost. Specifically, federal lawmakers should pass the Medicaid Bump Act.	Source
Require GAO report on MH/SUD reimbursement rates. Congress should require the Government Accountability Office (GAO) to report to Congress on current reimbursement rates paid for mental health and substance use disorder (MH/SUD) services by Medicare, Medicaid, individual and group health plans, and other types of health coverage, both in and out of network. Rates should be assessed for their sufficiency to increase in the supply of participating providers and pipeline for clinicians entering MH/SUD fields, as well as compared to physical health reimbursement.	Source
Increase Medicare payment rates for care integration. Congress should increase Medicare payment rates for mental health and substance use disorder (MH/SUD) integration services to help defray a portion of the startup costs that providers incur when they begin delivering care through models that integrate MH/SUD and primary care.	Source

Licensure and Standardization

Workforce standards, such as professional licenses and certifications, can help to promote high quality care by ensuring competency in core areas. However, needlessly complex or discriminatory systems of workforce standards can decrease workforce availability and create inequities without improving quality. It is critical that policies governing workforce standards center equitable access to effective care as the goal, and promote a diverse workforce able to meet people's needs.

One challenge, for example, is differences in provider credentialing requirements across states and even across health insurers in the same state. Many different and conflicting requirements can make it difficult for members of the workforce to move states, provide telehealth across state lines, or serve populations covered by different kinds of insurance. This can create a barrier for the full MH/SUD workforce to be engaged in reaching underserved populations and promoting equitable access.

Congress should establish a National Coordinator for the MH/SUD Workforce to align states, health insurers, and training programs, ensuring an adequate and equitably accessible workforce nationwide. Similar to the National Coordinator for Health Information Technology,[10] the National Coordinator for the MH/SUD Workforce could work with stakeholders to set common standards and streamline processes. The National Coordinator could also highlight gaps and ensure that the distribution of providers currently in practice and in the pipeline is on track to meet future needs, with a focus on equity.

National Strategy Policy Recommendations

Eliminate out-of-state licensure requirements. To address the continued need for provider flexibility and remove federal barriers to meeting workforce demands, Congress should permanently eliminate the out-of-state licensure requirements under Medicare and Medicaid. Congress should also direct the Department of Health and Human Services (HHS) to convene	Source
Streamline enrollment of out-of-state providers in Medicaid. Congress should require a streamlined and uniform process for enrolling out-of-state providers in state Medicaid programs to deliver care to individuals under 21.	Source
Create a special DEA registration. The Drug Enforcement Administration (DEA) should create a special registration to allow for one DEA registration in coordination with a valid medical license in each state the practitioner is practicing medicine, rather than a separate medical license and DEA registration in every state.	Source
Improve standardization and data of peer support. Congress should improve standardization and the availability of data relating to peer support specialists to facilitate peer support specialist workforce development. Peer support specialists should also be included in any Medicaid workforce demonstration projects.	Source

Education and Training

Education and training are an integral part of building the MH/SUD workforce. Those interested in being MH/SUD providers currently have significant barriers to training that make the profession unattractive to young people. The cost of becoming a MH/SUD provider is burdensome for most, and many people take out student loans for their education. In 2019, social workers had $67,000 in student loan debt on average.[11] Student loans are an enormous burden to carry in a specialty where the reimbursement rates are uneven and providers are overworked due to the shortage.

While some resources exist for addressing the burden of student loans, they are inadequate for promoting equitable MH/SUD workforce growth. The eligibility for student loan repayment programs under the National Health Service Corps, for example, does not include bachelor-level social workers or drug counselors. **Congress should expand that eligibility to include the full range of MH/SUD providers necessary to address shortages and encourage people to join the MH/SUD workforce.**

Policymakers also have a range of other strategies to increase workforce training and recruitment in shortage areas, as well as increase the diversity of providers. For example, they can offer particular incentives by building on the Minority Fellowship Program.

Another means of support to the MH/SUD workforce is ensuring that training programs are equipped with the latest information that enable effective, whole-person, and culturally and linguistically appropriate care. **The Department of Health and Human Services should develop model programs for training and support equitable implementation to promote an effective MH/SUD workforce.**

$67,000

The average social worker's student loan debt as of 2019

National Strategy Policy Recommendations

Expand eligibility for loan repayment programs. Congress should expand funding the eligibility criteria for national and state loan repayment programs to include bachelor-level social workers, health and human services providers, and certified drug and alcohol counselors, while also expanding service delivery location sites to include more home, school, and community-based	Source
Fund the Minority Fellowship Program. Congress should appropriate at least $36.7 million for the Minority Fellowship Program (42 U.S.C. 290ll) to increase providers' knowledge of issues related to prevention, treatment, and recovery support for mental health and substance use disorders (MH/SUDs) among racial and ethnic minority populations.	Source
Issue guidance on workforce capacity in shortage areas. Congress should require the Department of Health and Human Services (HHS) to issue Medicaid guidance to increase mental health and substance use disorder (MH/SUD) provider education, recruitment, and retention and improve workforce capacity in rural and underserved areas.	Source
Develop culturally competent guidelines for providers. The Substance Abuse and Mental Health Services Administration (SAMHSA) should develop culturally competent guidelines for mental health and substance use service providers, particularly those serving predominantly underserved communities—particularly Black/African American; Hispanic/Latino; Asian American, Native Hawaiian, and Pacific Islander; American Indian and Alaska Native; lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) communities—through inclusive and responsive community engagement.	Source

Data and Technology

Data and technology are a fundamental part of supporting the MH/SUD workforce. Currently, without proper electronic health record (EHR) systems in MH/SUD care settings, care integration becomes strenuous because of unorganized records management. EHRs not only track vital patient information, but they measure outcomes and collect valuable data that is essential to improving the efficacy of care, decreasing provider burdens, and making the case for greater investment.

Congress should pass the Behavioral Health Information Technology Coordination Act so that EHRs will become standard in MH/SUD care settings. This legislation would designate $100 million over five years to supplement MH/SUD providers' cost in obtaining and maintaining EHR systems, which would be revolutionary for integrated care and navigating patient data across care facilities. Policymakers can then build on this foundation to ensure MH/SUD providers can access the full range of technological tools that would benefit care.

Telehealth is another important technological tool for the MH/SUD workforce. With telehealth, access to care has become easier, though barriers remain. Telehealth may not be covered by all insurers, which creates a service gap in rural communities and for those who are unable to attend MH/SUD care appointments in person. A telehealth model would expand the reach of the MH/SUD workforce and improve equitable access.

DATA AND TECHNOLOGY

National Strategy Policy Recommendations

Create a common MH/SUD data model. Federal departments and agencies should make mental health and substance use disorder (MH/SUD) data collection and reporting a top priority by finalizing a proposed rule to require states to report on MH/SUD measures in Medicaid, creating a common MH/SUD data model and reporting portal that all recipients of federal MH/	Source
Develop telehealth data best practices. Congress should fund research through the National Institutes of Health on the efficacy of mental health and substance use disorder (MH/SUD) services provided via telehealth, with outcomes studied by service type (e.g., crisis response) and demographic groups, including underserved communities.	Source
Maintain telehealth access post COVID-19. Congress should pass legislation to ensure the availability of mental health and substance use disorder (MH/SUD) services via telehealth, which is critical to expanding access to treatment.	Source
Expand EHR utilization in MH/SUD. Congress should pass legislation like the Behavioral Health Information Technology Coordination Act to advance adoption of electronic health records (EHRs) among mental health and substance use disorder (MH/SUD) providers.	Source

ALIGNMENT FOR PROGRESS

Explore more of the National Strategy recommendations:

strategy.alignmentforprogress.org

End Notes

1 Dawes, Daniel E, Jay Bhatt, Nelson J Dunlap, Christian Amador, Kulleni Gebreyes, Brian Rush. “The projected costs and economic impact of mental health inequities in the United States.” Deloitte Center for Health Solutions (2024). https://www2.deloitte.com/us/en/insights/industry/health-care/economic-burden-mental-health-inequities.html

2 Counts, Nathaniel Z. “Understanding the U.S. Behavioral Health Workforce Shortage.” Commonwealth Fund (2023). https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforce-shortage

3 “Health Workforce Shortage Areas.” data.HRSA.gov. U.S. Health Resources and Services Administration (2024). https://data.hrsa.gov/topics/health-workforce/shortage-areas

4 “Workforce Projections.” data.HRSA.gov. U.S. Health Resources and Services Administration (2024). https://data.hrsa.gov/topics/health-workforce/workforce-projections

5 Dawes, Daniel E, Jay Bhatt, Nelson J Dunlap, Christian Amador, Kulleni Gebreyes, Brian Rush, et al. “The projected costs and economic impact of mental health inequities in the United States.” Meharry School of Global Health and Deloitte Health Equity Institute (2024). https://meharryglobal.org/wp-content/uploads/2024/05/DI_CHS_Cost-of-MH-inequities.pdf

6 Ku, Benson S., Jianheng Li, Cathy Lally, Michael T. Compton, and Benjamin G. Druss. "Associations between mental health shortage areas and county-level suicide rates among adults aged 25 and older in the USA, 2010 to 2018." *General hospital psychiatry* 70 (2021): 44-50.

7 Fiorillo, Andrea, Giovanni de Girolamo, Ivona Filipcic Simunovic, Oye Gureje, Mohan Isaac, Cathy Lloyd, Jair Mari et al. "The relationship between physical and mental health: an update from the WPA Working Group on Managing Comorbidity of Mental and Physical Health." *World Psychiatry* 22, no. 1 (2023): 169.

8 Mark, Tami L, William J Parish. “Behavioral health parity – Pervasive disparities in access to in-network care continue.” RTI International (2024) https://www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue

9 Counts, Nathaniel Z., and Ashwin Vasan. "Advancing mental health parity to ensure children’s access to care." npj Mental Health Research 3, no. 1 (2024): 28.

10 “About ASTP/ONC.” HealthIT.gov. The Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (2024). https://www.healthit.gov/topic/about-astponc

11 “Mental Health Professionals Workforce Shortage Loan Repayment Act (S. 462/H.R. 4933).” National Association of Social Workers (2024). https://www.socialworkers.org/Advocacy/Policy-Issues/Student-Loan-Debt-Relief-for-Social-Workers/Mental-Health-Professionals-Workforce-Shortage-Loan-Repayment-Act

THE KENNEDY FORUM

Learn More:
thekennedyforum.org

Get Updates:
thekennedyforum.org/about/stay-connected

Follow Us:

@kennedyforum

linkedin.com/company/the-kennedy-forum

About

Co-founded by former Congressman Patrick J. Kennedy and his wife, Amy L. Kennedy, The Kennedy Forum (TKF) is creating a future where all people can access effective prevention and treatment of mental health and substance use disorders (MH/SUD).

TKF uniquely cultivates relationships with key leaders to advance sweeping change for major MH/SUD issues, including inequity in insurance coverage and the escalating youth mental health crisis.