

**AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS  
POSITION PAPER  
ON ENSURING ACCESS TO  
RECOVERY ORIENTED SAFETY NET PSYCHIATRIC SERVICES IN  
UNDERSERVED AND ECONOMICALLY DISTRESSED COMMUNITIES**

<b>Overview</b>
-----------------

The AACP believes mental health is essential to overall health and access to high quality culturally fluent, recovery oriented psychiatric care is an essential element of the health care safety net for socially excluded populations. These populations include ethnic/racial minorities and impoverished people living in underserved and economically distressed areas across the nation. Advocating for and assuring access to quality psychiatric care, including prevention and early intervention services, in these underserved areas is critically important, and must be a high priority for psychiatric professional organizations. Addressing these considerations requires an organized POPULATION HEALTH approach.

- This POPULATION HEALTH approach involves defining the global needs of a community or population. The community or population includes adults, children/adolescents, and older adults with mental illnesses and/or substance use disorders in underserved areas. Their needs are assessed in terms of impact on morbidity, mortality, disability and well being as well as the resources needed to promote mental health and foster recovery. Strategies are then developed for how to best meet the identified needs, utilizing the best mix attainable of the various categories and levels of psychiatric services.
- This population health approach also requires delineation of the dual role of the psychiatrist as a both a primary care behavioral health provider and a specialty secondary and tertiary behavioral health care provider among the safety net providers. In doing so, as the notions of the health care home and accountable care organization evolve, it becomes vital to establish the capacity for person centered health care teamwork and to determine which functions, including psychopharmacology functions, can best be performed by other providers with support of various kinds from psychiatrists. A determination of which functions can best be performed directly by psychiatrists, and through what mechanisms would also need to be conducted.
- Finally, this approach requires strategies to attract adequate numbers of primary health and behavioral health workers of all types to working in the safety net in rural and urban underserved areas. The strategy requires approaches specifically for attracting psychiatrists.

## Key Concepts

- I. Define the needs and available resources of the community or population:
  - A. Determine the epidemiology/prevalence of adult, child/adolescent, and older adult behavioral health disorders, the degree of disability present, anticipated threats to wellbeing, and the extent of medical co-morbidity. Then determine the corresponding health services needed to protect and promote health, promote mental health and foster recovery.
  - B. Ascertain the available resources for and the degree of penetration of direct and indirect psychiatric services (**See definitions below**) in underserved areas compared to average urban or rural areas (i.e., measure the service gap). Much of this information is currently collected by an assigned state agency for the HRSA shortage designation branch.
    1. **Available resources include:** behavioral health workforce, primary health workforce, physicians, allied primary care health professionals (particularly those with prescribing privileges), psychiatrists, other categories of psychiatric prescribers (e.g., psychiatric nurse practitioners, physician assistants, and clinical nurse specialists), and other mental health professionals. ***NB: In the remainder of this position paper, the term “psychiatric nurse practitioner” is used to represent all categories of psychiatric prescriber, for the sake of simplicity. However, this is not to indicate that other categories of psychiatric prescribers should not be considered.***
    2. **Direct and Indirect Psychiatric Services are functions commonly provided by psychiatrists.** In many instances, however, these functions can be offered through other categories of primary health prescribers (psychiatric nurse practitioners), and even by other mental health workers under supervision by or in consultation with psychiatrists or psychiatric nurse practitioners
      - a. Direct Psychiatric Services – psychiatric and general health assessment, engagement in recovery oriented activities such as person centered planning, shared decision making, medication prescription and management, hospital management, direct support for care givers, provision of emergency care, forensic evaluations, psychotherapy (for adults, children/adolescents, and older adults)
      - b. Indirect Psychiatric Services (except as noted, these functions are generally provided by psychiatrists)
        - consultation to and liaison with primary care physicians and allied health professionals (may be provided by psychiatric nurse practitioners and other mental health professionals)
        - consultation to and supervision of psychiatric nurse specialists working with adults, children/adolescents, or older adults, in states or areas where such consultation and supervision is required
        - forging an alliance with psychiatric nurse practitioners in states or areas where those prescribers are fully privileged

- engagement in teamwork with other non-medical front line behavioral health providers and interdisciplinary teams, including provision of mutual support, consultation, and where indicated, clinical oversight and supervision (may be provided by psychiatric nurse practitioners)
  - specific medical direction to behavioral health programs, provider organizations and systems (See <http://communitypsychiatry.org> for AACP Papers on the Role of the Community Psychiatrist and the Role of Medical Directors)
- II. Develop a strategic plan to fill these needs:
- A. AACP supports the availability of competent recovery oriented psychiatric services, including psychopharmacology services, through a combination of methods, such as:
- a. AACP recommends a variety of methods to expand direct access to psychiatrists and experienced psychiatric nurse practitioners (in-person and via telemedicine)
  - b. AACP recommends methods for expanding access to primary care practitioners who can provide psychiatric services with consultation
  - c. AACP advocates for expansion of on-site or telemedicine methodologies for ongoing clinical psychiatric consultative support to local primary care physicians or other categories of primary health prescribers (both those in Federally Qualified Health Centers [FQHCs] and those in other settings), early-career psychiatrists, psychiatric nurse practitioners, and allied mental health professionals who choose to practice in underserved urban, rural or frontier communities

<p><b>Recommendations to Improve Access to Recovery Oriented Safety Net Psychiatric Services in Underserved Areas</b></p>
---

- I. Improving Access to Psychiatrists in underserved areas:
- A. Strategies for Improvement of Recruitment and Retention of Psychiatrists:  
Creating Professionally Attractive Work Settings
1. Recognition that team work is critical to job satisfaction: the creation of team supports and activities can compensate for professional isolation; examples include involvement in interdisciplinary teams, clinical supervision, program development, and community consultation, i.e., not just direct service
  2. Development of standardized, fair and meaningful job descriptions
  3. Provision of time and resources for some direct service practice by psychiatrists, if they so desire
  4. Access to high-quality tele-psychiatry linkages
  5. Appropriate availability of support staff trained to work in a mental health and/or substance abuse treatment setting

6. Access to university faculty appointments and tele-linkage to departmental supports, including specialty consultation in areas such as addictions, child and adolescent, and geriatric psychiatry
  7. Connection to mentorship through resources like the AACP Mentorship Program, or to learning communities sponsored by the National Council of Community Behavioral Healthcare or other entities
  8. Access to appropriate formularies, given that some physicians are not attracted to work in environments where they do not have access to a full array of treatment approaches
  9. Access to web-based resources
  10. Facilitation of membership in AACP
- B. Strategies for Improvement of Recruitment and Retention of Psychiatrists:  
Economic Incentives
1. Reimbursement rates on par with other medical specialists, with enhancements for service in rural areas and federally designated underserved areas
  2. Expanded criteria for designation of underserved rural areas, which would require extensive review and re-opening of the consideration of psychiatry as a “primary care specialty”
  3. Reimbursements for telemedicine and for “tele-consultations” with primary care providers, physician assistants, and nurse practitioners in states that require the latter to have supervision
  4. Mechanisms for broadening the ability of FQHCs to oversee a broad array of community-based mental health services under the auspice of an enhanced reimbursement framework
  5. Similar mechanisms for health clinics in Native American tribal settings with 100% federal match for Medicaid
  6. Coordination of Federal and State loan repayment and J1 visa programs to ensure that participants and their provider agencies maximize potential benefits of financial support and immigration policies
- C. Strategies for Improvement of Recruitment and Retention of Psychiatrists:  
Regulatory Support
1. Federal and/or state guidelines defining a role for psychiatrists in underserved areas as a necessary component of safety net services in each local health system and within the population health framework;
  2. Creating expectations that local safety net systems should invest in the recruitment process. This may involve setting minimum thresholds of psychiatrists (or sample ratios for rural areas) needed to be part of a comprehensive delivery team that involves frontline behavioral health providers, allied mental health professionals, allied physical health professionals, and primary care providers.
  3. AACP and partner organizations such as the American Psychiatric Association (APA), American Public Health Association, and American College of Mental

Health Administration play a central role in determining these standards.

- D. Strategies for Improvement of Recruitment and Retention of Psychiatrists:  
Information Exchange
    - 1. Maintenance of job banks for vacancies in underserved areas by local psychiatric societies or public university departments of psychiatry
    - 2. Advocacy by stakeholder organizations for grants focused on connecting psychiatrists with jobs
    - 3. Support by AACP and/or APA for the recruitment personnel and processes for psychiatrists in public-sector agencies in underserved areas
  - E. Strategies for Improving Access to Psychiatrists in Underserved areas:  
Telemedicine
    - 1. Disseminate research that helps to establish standards for the practice of telepsychiatry as equivalent to face to face contact
    - 2. Identify methods for reimbursement of telepsychiatric practice
    - 3. Facilitate licensure requirements for out of state practice
    - 4. Develop methods for effective team work through tele-connection
    - 5. Create incentives for psychiatrists to combine regular tele-psychiatry with less frequent on site activity
    - 6. Provide grants (e.g., through health care reform and behavioral health/primary care integration funding) to support investment in telemedicine equipment to support telepsychiatry in underserved areas
- II. Improving access to medically trained allied mental health professionals with prescribing privileges (psychiatric nurse practitioners) in underserved areas,
- A. Define the skill and training of the various categories of allied mental health professionals with prescribing privileges
  - B. Describe the scope and limitations of their practice, which varies from state to state (especially with regard to psychiatric nurse practitioners)
  - C. Consider each item in the above section on psychiatrist recruitment and retention, and use them, as applicable, to train, recruit, and retain psychiatric nurse practitioners (including those with child/adolescent or older adult sub-specialization)
  - D. Model successful collaborations between psychiatric nurse practitioners and psychiatrists
    - 1. Ally with psychiatric nurse practitioners and their professional associations in states where they have full prescribing privileges
    - 2. Advocate for doctoral-level training for nurse practitioners where that extends scope of practice
    - 3. Advocate for expanding the number of states that allow unsupervised practice for psychiatric nurse practitioners
  - E. Provide the same incentives for psychiatric nurse practitioners to practice in underserved settings as for psychiatrists (see above)
  - F. Define mechanisms for psychiatry supervision, training, and support, including organized mechanisms for tele-consultation support by university departments of psychiatry, to enhance the capacity and functioning of psychiatric nurse

practitioners. This should include access to subspecialty consultation (e.g., addictions, child/adolescent and geriatric services).

- III. Improving access to competent and well-supported primary care physicians and physical health nurse practitioners who can provide psychopharmacologic services in underserved areas:
  - A. Make a major investment in primary care providers' training; ensure availability of consultation (including specialty consultation) through psychiatric societies or university departments of psychiatry in each state. (The New Mexico Rural Health Initiative coordinated by AACP member Chris Pedersen is an example of a systematic approach by a university department of psychiatry to build behavioral health competencies in rural primary care settings.)
  - B. Improve access to psychiatric Tele-consultation for primary care prescribers.
  - C. Build on the Health Resources and Services Administration's encouragement of behavioral health services development in FQHCs
  - D. Build behavioral health integration into primary care in underserved areas, with non-medical professionals to do assessments, primary care providers to prescribe, and tele-psychiatric consultations to offer expert support
  - E. Define and disseminate non-prescription primary care provider interventions, such as brief intervention for alcohol use disorders; and counseling for psychological aspects of trauma, loss, and family stress
  - F. Improve methods for the organization of teams of frontline adult, child/adolescent, and older adult behavioral health care providers integrated with primary health care providers and allied mental health professionals, with psychiatrists providing support to the whole team:
    - a. Psychiatric organizations hold a position that good team development of behavioral health professionals, psychiatrists, and primary care providers can enhance access to high-quality psychopharmacologic treatment in underserved areas
    - b. Such organizations, along with local psychiatric societies and local university departments of psychiatry, can support team-building efforts
  - G. Provide psychiatrists with training in collaboration with primary health practitioners and other allied professionals