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PRN OPINION PAPER

A call to action for ambulatory care pharmacists for the treatment of depression and anxiety in primary care: An opinion paper of the ambulatory care and central nervous system practice research networks of the American College of Clinical Pharmacy

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[Correction added on 4 April, 2025 after first online publication. The copyright line has been updated.]

Abstract

The need for mental health care has increased in recent years, especially due to the coronavirus disease 2019 pandemic. Simultaneously, the supply of mental health clinicians has declined alongside decreases in primary care clinicians. As management of depression and anxiety has increasingly moved to primary care, ambulatory care pharmacists must be equipped with the knowledge and skills needed to care for patients with these illnesses. The objective of this collaborative Opinion Paper of the Ambulatory Care and Central Nervous System Practice and Research Networks is to provide practical guidance on the role and educational needs of ambulatory care pharmacists in the management of depression and anxiety within primary care settings and to serve as a call for action. The authors performed a narrative review of the PubMed database from January 1, 1990 to November 10, 2024 using search terms pertaining to primary care pharmacists and mental health care. The reference lists of these articles were then reviewed for additional references. Ambulatory care pharmacists can help meet the increased need for mental health care in primary care. Their knowledge of evidence-based medicine, drug interactions, adverse effects, and other areas of pharmaceutical care, coupled with their training in interprofessional team-based care, make them an ideal addition to the primary care team to provide care for patients with depression and anxiety. A variety of educational programs are available for ambulatory care pharmacists to augment their mental health care knowledge and skills. Similarly, the training of pharmacists at all levels, from student to resident, should incorporate mental health experiences to prepare future pharmacists to address the mental health care needs of their patients. Ambulatory care pharmacists should leverage the skills and training they possess to fill the gap in care for patients living with depression and anxiety in primary care settings.

KEYWORDS

ambulatory care, mental illness, pharmacist, primary care

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1 | INTRODUCTION

Mental illness affects a significant portion of the population, with nearly 23% of adults in the United States having a mental, behavioral, or emotional disorder diagnosis in 2021.[1,2] Mental illnesses include, but are not limited to, anxiety, depression, bipolar disorder, post-traumatic stress disorder, and schizophrenia.[1] These illnesses, especially when untreated, can increase the risk of death and suicide. During the coronavirus disease 2019 (COVID-19) pandemic, anxiety and depressive episodes increased by 26% and 28%, respectively. Despite this high prevalence, less than half of this population received mental health care.[2] According to a Health Resources and Services Administration report from December 2023, more than half of the U.S. population resided in a designated Mental Health Professional Shortage Area where adequate mental health treatment was not easily accessible.[3] Access is even more limited among individuals residing in rural areas. Barriers to mental health care result from patient-level and clinician-level factors. Patient-level factors include stigma and financial barriers, while clinician-level factors include reimbursement challenges, clinician burnout, and differences in scope of practice among different professionals.

Optimization of mental health care within primary care is essential, especially as 60% of patients with depression are treated in primary care settings, and up to 75% of all mental health care takes place in these settings.[4] Nevertheless, depression care is often suboptimal, with subpar dosing of medications and follow-up care.[5,6] Of note, the U.S. faces a projected shortage of 17 800–48 000 primary care physicians by 2034.[7] Furthermore, a 32% shortage of psychiatrists is projected by 2030, demonstrating the need for additional health care clinicians to be available to care for persons with mental illnesses.[8] Pharmacists, as medication experts, are positioned favorably to help mitigate these shortages.[9] However, three-quarters of key pharmacy opinion leaders surveyed in 2023 projected that the demand for pharmacists with more advanced training in mental health will increase in the next 5 years. These leaders expressed shared concerns that health systems may struggle to meet this demand.[10] Ambulatory care pharmacists and psychiatric specialist pharmacists embedded within primary care practices are especially valuable and are in a unique position to help leverage this gap.

While limited recent literature regarding provision of mental health care by ambulatory care pharmacists within primary care is available, existing models of pharmacists providing mental health medication management in this setting have demonstrated improved adherence as well as statistically and clinically significant improvements in Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder 7-item (GAD-7) questionnaire scores for depression and anxiety, respectively.[11,12] In one evaluation, the mean change in PHQ-9 and GAD-7 scores at Week 12 compared with baseline was a decrease of 10 points ($p < 0.001$) and eight points ($p = 0.006$), respectively, indicating illness improvement.[11] In a United Kingdom study, the inclusion of a specialist mental health care prescribing pharmacist in a primary care network resulted in 180 of 199 patients reporting subjective improvement in their condition with GAD-7 scores decreasing from 15.9 to 8.0 ($n = 49$) and PHQ-9 scores decreasing from 18.5 to 8.9 ($n = 94$) on last assessment.[13] Furthermore, pharmacist management integrated into primary care has demonstrated improved access to mental health care, high patient satisfaction, and reduction in potentially inappropriate medications.[12,14] The need for ambulatory care pharmacists in this space is growing, with a call in the literature for additional guidance and resources to help optimize provision of care, including innovative practice models involving virtual care.[15]

The objective of this collaborative Opinion Paper of the Ambulatory Care and Central Nervous System Practice and Research Networks is to provide practical guidance on the role and educational needs of ambulatory care pharmacists in the management of depression and anxiety within primary care settings and to serve as a call for action. This paper represents the opinion of the Ambulatory Care and Central Nervous System Practice and Research Networks of the American College of Clinical Pharmacy (ACCP), but it does not necessarily represent an official ACCP commentary, guideline, or statement of policy or position.

2 | SEARCH STRATEGY

Data for this narrative review were identified by searching the PubMed database (January 1, 1990–November 10, 2024) using the following search terms: mental health, pharmacist, and primary care. The search was repeated using the following alternative terminology for mental health: behavioral health, mental disorders, mental illness, depression, and anxiety. Non-human articles and articles not published in English were excluded. Additional literature was obtained through a review of relevant references of the identified articles. The search strategy is outlined in Table 1.

3 | ROLE OF AMBULATORY CARE PHARMACISTS IN PRIMARY CARE

The ambulatory care pharmacist may practice in a variety of clinical settings and perform direct patient care through many models.[16] Pharmacists embedded in primary care traditionally focus on chronic disease state management of common conditions such as hypertension, diabetes, and hyperlipidemia. Meanwhile, within primary care, an opportunity exists to provide education, medication management, and transition of care services for patients with mental illnesses, particularly depression and anxiety. Considering the medical complexity of patients with mental illnesses and the ambulatory care pharmacist's knowledge of chronic disease management, pharmacists in this setting have the potential to provide holistic care to the patient.[17] They play an important role in improving adherence to medication, patient education, side effect management, and screening of patients for depression and anxiety. The positive impact on adherence to medication among these patients by pharmacists has been demonstrated in the literature.[17,18] Additionally, pharmacist knowledge about common

TABLE 1 Search strategy summary.

Items	Specification
Date of search	November 10, 2024
Databases and other sources searched	PubMed, Google Scholar
Search terms used	(Mental health or behavioral health or mental disorders or mental illness or depression or anxiety) and (pharmacist) and (primary care)
Timeframe	January 1, 1990 to November 10, 2024
Inclusion and exclusion criteria	Clinical trials, observational studies, systematic reviews, and meta-analyses. Animal data and non-English articles were excluded
Selection process	Search and selection of articles were conducted independently by investigators. Discrepancies were resolved through discussion and consensus
Additional considerations	Reference lists of identified articles were manually reviewed for additional relevant articles

co-occurring disease states such as pain syndromes and substance use disorders can lead to treatment optimization of these disorders, which in turn may have a positive effect on mental health, including depression and anxiety. Mental illnesses and substance use disorders often co-occur, and pharmacists working in primary care are well positioned to address both. Pharmacist intervention has been shown to reduce opioid and benzodiazepine doses as well as improve opioid tapering in patients with anxiety and other mental illnesses co-prescribed these agents.[19] With proper training either through school, residency, continuing education, or professional development, pharmacists can provide appropriate tapering plans when discontinuing medications, including antidepressants and benzodiazepines.

3.1 | Co-management of depression and anxiety via collaborative practice agreements

Ambulatory care pharmacists in the primary care setting may choose to pursue management of mental health illnesses via collaborative practice agreements (CPA). Several practice models have been described in the literature through which an ambulatory care pharmacist provides mental health services with a CPA.[20–22] Two examples of these models come from federally qualified health centers (FQHC). In one instance, CPAs were developed in an FQHC to allow pharmacists to initiate, change, and/or discontinue medications for depression, anxiety, and bipolar disorder, expanding the traditional chronic diseases managed by ambulatory care pharmacists in that clinic.[20] Demonstrating the pharmacists' impact in providing this care, nearly 300 psychiatric-related consults occurred in a 12-month period, with approximately 60% of interventions made by pharmacists involving initiation of a new medication. Additionally, implementation of this service resulted in a 25% decrease in dispensing of benzodiazepines, reflecting the pharmacist's ability to implement guideline-directed treatment. Even in settings where an ambulatory care pharmacist may not have a CPA specific to psychiatric disease states, studies show mental health conditions such as anxiety and depression serve as a common reason for referral. In one study that discussed implementation of clinical pharmacy services in an FQHC, approximately 30% of the pharmacist referrals were for depression or an anxiety disorder. Through comprehensive medication review and management visits, pharmacists in this study were able to positively impact PHQ-9 by 11 points ($p < 0.0001$) and GAD-7 scores by seven points ($p < 0.001$) among a sample of 25 patients.[21]

3.2 | Co-management of depression and anxiety without a collaborative practice agreement

Even without prescribing privileges, ambulatory care pharmacists can serve as a valuable resource to other clinicians in the primary care setting regarding care of depression and anxiety. Pharmacists can provide information about treatment options, therapeutic interchange, available dosage forms, dosing, drug–drug interactions, potential adverse effects, medication access (formulary, comparative pricing, patient assistance programs, prior authorization, drug shortages), as well as how to switch or taper psychotropic medications using a patient-centered approach.[23] The literature has demonstrated positive mental health outcomes as a result of pharmacists completing medication therapy management visits and providing recommendations to the treating clinician.[24] Ambulatory care pharmacists can also offer insight on new and emerging medications and other treatment modalities and assist patients in accessing these treatments. As a number of psychotropic medications have actionable gene-drug interactions, incorporating ambulatory care pharmacists into pharmacogenomic testing has the potential to augment psychiatric care.[25]

Additional opportunities for care, including via telehealth, are available for the ambulatory care pharmacist in primary care. Bhat and colleagues demonstrated the successful implementation of a pharmacist antidepressant telemonitoring service.[26] In this study, the pharmacist embedded in an internal medicine clinic completed telephone follow-up within 2 weeks of antidepressant initiation and addressed adherence, adverse effects, and screening for suicidal ideation. Pharmacists also assisted the treating clinician in transitioning patients from one antidepressant treatment to another. Similarly, a study by Locke and colleagues used pharmacists currently managing other chronic diseases in a primary care setting to provide a follow-up telephone call 2 weeks after a medication was started for depression or anxiety by a prescribing clinician (physician, physician's assistant, or nurse practitioner).[27] Pharmacists provided an intervention for 20% of the patients contacted including side effect management,

dose titration, or recommendation to change to an alternate medication.

3.3 | Opportunities for identification and mitigation of adverse effects

Among their many roles, ambulatory care pharmacists possess the expertise to identify and mitigate adverse effects secondary to psychotropic pharmacotherapy. Although limited laboratory monitoring is required for first-line antidepressants and anxiolytics, older adults are susceptible to hyponatremia with treatments that enhance serotonergic activity (e.g., selective serotonin reuptake inhibitors, serotonin and norepinephrine reuptake inhibitors, mirtazapine), and citalopram requires additional oversight because of QT prolonging risks. Later-line therapies, such as tricyclic antidepressants, necessitate cardiovascular monitoring (vital signs, electrocardiogram) thus requiring enhanced surveillance.[28] Additionally, metabolic complications including elevated lipids, blood glucose, and weight, as well as movement disorders including extrapyramidal syndromes and tardive dyskinesia, are common class effects of antipsychotics, even when used for non-psychotic disorders such as major depression. Screening and laboratory monitoring often remains unoptimized, and challenges can arise regarding whether primary care or psychiatry specialty clinicians should take primary responsibility for overseeing monitoring.[29] Clinical pharmacists have demonstrated positive outcomes in improving monitoring parameters, including both recommended antipsychotic monitoring and required monitoring for clozapine.[29,30]

3.4 | Opportunities for screening and assessment

Appropriate assessment of mental illnesses is extremely important. Self-rating scales such as the PHQ-9 and the GAD-7 can be used both as screening tools as well as to measure the response to treatment. The PHQ-2 has been used as an initial screen for depression followed by completion of the PHQ-9 if the PHQ-2 is positive. In patients without psychosis or cognitive impairment, self-administered symptom rating scales are usually highly reliable.[31] These questionnaires can be shown in the check-in and rooming process during primary care visits. Pharmacists can review the screening findings and make recommendations to the primary care clinician. In most clinical settings, diagnosis is not within the pharmacist's scope of practice. However, the pharmacist can use a clinical interview in patients screening positive for a depressive disorder to help decide whether to refer the patient to a clinician who has diagnosis of mental illnesses within their scope of practice. The clinical interview should address the pervasiveness of the symptoms and the impairment in daily functioning. Rating scales are not diagnostic, and patients must meet the Diagnostic Statistical Manual for Mental Disorders-5 TR criteria for a given disorder.[32] Potential comorbidities must be addressed as well as the possibility of a medical or substance associated disorder with depressive symptoms.

Standardized rating scales can also serve as an additional tool for ambulatory care pharmacists to use to monitor pharmacotherapy, both from an efficacy standpoint (e.g., PHQ-9) and a safety standpoint (e.g., Abnormal Involuntary Movement Scale). Multiple efficacy rating scales for depression and anxiety are available, however the PHQ-9 and the GAD-7 are most often used in primary care settings because of their ease of administration and limited need for additional training as compared with scales used in clinical research (e.g., Hamilton Depression Rating Scale). Additionally, both of these scales, and several others, are embedded within many existing electronic medical record systems for tracking or are available for free online. It is critical in mental illnesses such as depression and anxiety disorders to treat to remission as patients with residual symptoms likely still have impairment in functioning and are at higher risk of relapse,[33] and use of validated rating scales can verify whether remission has been achieved. Measurement-based care has been shown to improve clinical outcomes and should be used whenever possible.[34]

In patients with depression or anxiety disorders, it is critical to assess for potential suicidality. A suicidality assessment instrument such as the Ask Suicide-Screening Questions toolkit should be used to assess for suicidality and whether the patient is planning an attempt or has attempted suicide.[35] It is important for pharmacists to ensure that their primary care practice has a workflow for patients who screen positive for suicidal thoughts. Patients who are suicidal and have a plan should be referred immediately for emergency intervention. If patients have suicidal thoughts but no plan, then a safety plan should be put in place. In collaboration with the patient, the clinician should develop a safety plan that includes warning signs, internal coping strategies, people and places that provide distraction, people who the patient can ask for help, professionals who the patient can call during a crisis, and making the patient's environment safe. Whenever possible, family or close friends should be recruited so that they can assist in keeping the environment safe and provide support for the patient.

4 | EDUCATIONAL NEEDS OF NONSPECIALIST AMBULATORY CARE PHARMACISTS

It is likely that ambulatory care pharmacists without psychiatric training will need additional education and training to increase comfort level with these medications and illnesses. Previously identified needs include communication strategies, experience with patients, and education on psychiatric disorders.[36] Opportunities for additional education include self-education courses available through various pharmacy and other organizations. Examples include Mental Health First Aid (MHFA) training and other similar training programs, and continuing education across a variety of psychiatric and substance use disorders through the American Association of Psychiatric Pharmacists. The American Society of Health-System Pharmacists Mental Health Support Certificate is an educational program covering the major psychiatric and substance use disorders and their treatment,

TABLE 2 Training and educational resources for mental health activities.

Name	Description	Website
Mental Health First Aid	General training on assisting individuals experiencing a mental health challenge or crisis; appropriate for anyone regardless of medical training	https://www.mentalhealthfirstaid.org
Question, Persuade, Refer	Suicide prevention training providing a 3-step process	https://qprinstitute.com
Counseling on Access to Lethal Means	Suicide prevention training; part of a larger suicide prevention program (Zero Suicide)	https://zerosuicide.edc.org/resources/trainings-courses/CALM-course
Screening, Brief Intervention, and Referral to Treatment	Training for substance use disorder interventions; helps determine appropriate course of treatment	https://www.samhsa.gov/sbirt
REACH Mental Health Training	Training for primary care clinicians on methods for providing care to children and adults experiencing a mental health challenge	https://thereachinstitute.org/training/
American Society of Health-System Pharmacists Mental Health Support Certificate	Continuing education certificate program on screening, prevention, monitoring, and other clinical services for providing care to persons with mental illness	https://elearning.ashp.org/products/9230/mental-health-support-certificate
Arizona Pharmacy Association's Psychiatric Certificate Program	Continuing education certificate program covering the main psychiatric disorders and their treatment	https://azpharmacy.org/psych/
American Association of Psychiatric Pharmacists	National pharmacy organization that provides a variety of continuing education and other training programs related to mental illnesses	https://aapp.org

and the Arizona Pharmacy Association's Psychiatric Certificate Program is a practice-based activity designed for pharmacists in all practice settings. The REACH Institute provides intensive, behaviorally focused training and coaching programs to provide primary care clinicians with the tools needed to provide mental health care. Descriptions of these programs, and others, and their websites are provided in Table 2.

5 | CONNECTING PATIENTS TO SPECIALTY MENTAL HEALTH CARE

The ambulatory care pharmacist will not be able to provide care for all patients with mental illnesses in the primary care environment. Patients with psychosis and patients with bipolar disorder are challenging and should be referred to specialty mental health care. Patients with a substance use disorder co-occurring with another mental illness can present additional concerns, and these patients should also be considered for referral to specialty mental health care and likely substance use disorder treatment. Patients with a suicide plan represent a potential emergency. If a psychiatric pharmacist or other mental health clinician is present in the clinic, a direct hand off should occur. If not, then 911/988 or other local emergency mental health services should be called.

Consultation with a psychiatric pharmacist should occur in patients with depression or anxiety who have not improved substantially following two different medication trials of adequate dose and duration per treatment guidelines. Lastly, in all patients where the ambulatory care pharmacist has concerns about the appropriateness of the diagnosis, consultation with a psychiatrist or other clinician trained in psychiatric diagnosis should occur.

5.1 | Role of psychiatric pharmacists in primary care

Psychiatric pharmacists have specialized training in clinical psychopharmacology and broad expertise in both psychiatric and neurologic conditions. This includes their respective evidence-based pharmacotherapy, ranging from mental health diagnoses commonly encountered in primary care, such as depression and anxiety, and extending to specialized knowledge regarding treatments primarily coordinated by mental health specialists, such as treatments for schizophrenia. Their breadth of knowledge and experience often extends beyond initial treatment choices used for depression and anxiety to more nuanced treatments including augmentation and combination treatments. Psychiatric pharmacists are skilled to provide medication management, either directly or in consultative roles, for treatment populations that are refractory to standard treatment or present with additional psychiatric comorbidities. Although not considered specialists regarding nonpsychiatric pharmacotherapy, completion of a general post-graduate year one (PGY-1) residency program as a prerequisite to completing specialized training in psychiatry provides foundational knowledge and skills for psychiatric pharmacists to intervene for medication-related problems in chronic disease states commonly encountered in primary care and those potentially influenced

by psychiatric medications (i.e., hypertension, diabetes). Currently, 256 board-certified psychiatric pharmacists have dual credentialing as board-certified pharmacotherapy specialists, demonstrating aptitude and dual expertise to manage both psychiatric and medical comorbid disease states within primary care.[37] Successful utilization of psychiatric pharmacists to provide care for nonpsychiatric chronic disease states has been documented in the literature, and this model may decrease access barriers because comprehensive care can be bundled within one treatment setting.[20]

The integration of mental health care into primary care is an evidence-based practice to improve access to mental health services.[38] This is typically accomplished by placing master's-level therapists in the primary care setting, and the primary care clinician provides a direct hand off to the mental health clinician within the context of an existing medical appointment. If pharmacotherapy for the mental illness is needed, this may be provided by the primary care clinician, or by referral to a psychiatrist in more complicated situations. Appropriately trained and credentialled psychiatric pharmacists are well suited to be the clinicians providing psychotropic pharmacotherapy in integrated mental health in primary care settings. The Department of Veterans Affairs (VA) has been a leader in the integration of pharmacist mental health services into the primary care setting using a "mental health clinical pharmacy specialist" (MH CPS) designation with prescribing authority. Some regions within the Department of VA utilize a "mental health clinical pharmacist practitioner" (MH CPP) paired with a therapist for evaluation during virtual visits. Patients with an established mental health diagnosis may be directly referred to the MH CPP. This model has greatly improved Veterans' access to mental health services.[39] Notably, the majority of MH CPS have completed a post-graduate year two (PGY-2) residency in psychiatry and obtained board certification in psychiatric pharmacy; however, elements of the VA model could be incorporated into a primary care setting using a nonspecialist, as the MH CPS primarily focuses on depression, anxiety, and post-traumatic stress disorder (PTSD) using comprehensive medication management.[40] These examples from the VA demonstrate how psychiatric pharmacists, working collaboratively within the primary care team, can improve mental health care for patients.

6 | FUTURE CONSIDERATIONS

Training and educational offerings for pharmacy students and residents should include ambulatory management of depression and anxiety. The updated 2023 ACCP Pharmacotherapy Didactic Curriculum Toolkit has identified both depression and anxiety disorders as topics requiring broad exposure and training within Doctor of Pharmacy (Pharm.D.) curricula to ensure students are prepared to provide person-centered care for these illnesses upon licensure.[41] As both demand for depression and anxiety services remain elevated in the post-pandemic era, programmatic offerings need to be bolstered to address the growing mental health needs of the population.[42–44]

To enhance the skillset of the future workforce, trainees at all stages would benefit from additional exposure to psychiatric training, especially within experiential settings. Currently, psychiatric experiential rotations are not a required rotation by accrediting bodies overseeing Pharm.D. and PGY-1/PGY-2 ambulatory care programs for trainees in such programs. This differs from medical school curricula where a core psychiatric clinical experience is an accreditation requirement.[45] Similarly, we recommend that all Pharm.D. curricula include a mental health experience for all student pharmacists whenever possible. This could be accomplished either through Introductory or Advanced Pharmacy Practice Experiences (IPPE or APPE, respectively), exposure to patient encounters through use of standardized patients or simulation, or structured clinical skills assessments to improve their readiness to provide care to persons with mental illnesses upon graduation. Because of the large interface and influence of psychiatric diagnoses encountered across all medical disciplines, especially within primary care, PGY-2 ambulatory care programs should consider having residents complete a core mandatory psychiatric experience during their training.[46] This would ensure all ambulatory care pharmacists are trained to care for patients with psychiatric diagnoses, including both depression and anxiety; however, there can be barriers to embedding this required education experience. The feasibility and acceptability among stakeholders could be hindered by insufficient resources, lack of institutional buy-in, and shortage of pharmacists with expertise to oversee the rotation and training of residents. If it becomes feasible in the future, it would be ideal for these psychiatric experiences to become a core mandatory component within the PGY-2 ambulatory care residency standards to ensure the preparation of future clinical pharmacists to assist patients with mental illnesses, including depression and anxiety. Nevertheless, all training programs including both residency and Pharm.D. programs, regardless of stage of training, should strive to enhance and offer psychiatric elective experiences to ensure those that desire additional exposures are given the opportunity. Mental health experiences could be embedded within the primary care environment that would offer learners the necessary skills to provide mental health care in primary care. Additionally, these trainees could be incorporated into the practice as *practice extenders*, allowing for additional patient care activities for which the clinicians may not have sufficient time to address.

Mental health literacy and addressing stigma and attitudes toward individuals with mental health diagnoses are topics that all learners could benefit from with additional training.[47] Health professions students acknowledge challenges with their perceived confidence and comfort addressing mental health challenges, regardless of exposure in their professional coursework.[48] As mentioned above, MHFA is a standardized, early intervention education program that trains participants to recognize signs and symptoms associated with common mental health challenges, use nonjudgmental listening skills and techniques to provide reassurance, and assist a person in connecting with appropriate professional support from mental and behavioral health care clinicians. MHFA training programs have demonstrated positive benefits in improving knowledge about mental health issues, altering negative stigma associated with mental illness, and fostering

supportive responses to mental health challenges.[49] The training program provides a credential that must be renewed every 3 years. MHFA training programs have been implemented at several pharmacy schools, many of which were initially supported by grant funding.[50] To ensure sustainability of these programs, schools should consider embedding this training as part of their foundational curriculum or through co-curricular experiences.

One final area of consideration when incorporating mental health care into ambulatory care pharmacist practice includes logistics, particularly in light of other patient needs in this setting. Similar to the primary care providers with whom they work, ambulatory care pharmacists frequently have multiple disease states to consider with each patient. This could make finding time to include a patient's mental illnesses in a substantive manner difficult. While depression and anxiety assessments can be done quickly, particularly using the PHQ-9 and GAD-7 scales, interpreting and acting upon the results can take more significant time. Some patients may require more focused appointments for their mental health care with an ambulatory care pharmacist, much like focused appointments for diabetes, hypertension, and other illnesses require on occasion. Additional considerations include the cost of the pharmacists' visits and compensation for them. The concern of pharmacist billing for clinical services is outside the scope of this paper, but is certainly something to consider as ambulatory care pharmacists become more involved in the care of patients with depression and anxiety, as well as any other mental illnesses. However, considering that the Centers for Medicare and Medicaid Services have added multiple outcomes measures related to depression and anxiety care, and Accountable Care Organizations may have incentives for behavioral health integration, it may benefit the primary care clinic in a more general manner for ambulatory care pharmacists to improve the care of these patients, leading to increased revenue overall.[51]

7 | CONCLUSION

Ambulatory care pharmacists practicing in primary care settings, whether psychiatric pharmacist specialists or not, are positioned to optimize management of depression and anxiety, whether via care under a CPA or via consultative roles. Specific roles for the nonspecialist ambulatory care pharmacist include medication management, education, adverse effect management, screening, and transition of care management. Opportunities for education among these pharmacists, as well as for pharmacy trainees, are essential to increasing access to care for patients with mental health illnesses. Considering the increasing demand for mental health care and decreasing supply of mental health clinicians, as well as the high rates of mental illness treatment within primary care settings, utilization of ambulatory care pharmacists to address the mental health care needs of patients is a needed service. Based upon the information provided here, we call for pharmacists and trainees across all ambulatory care settings to increase their knowledge, skills, and willingness to assist in providing mental health care to the millions of patients living with mental illnesses, particularly depression and anxiety, presenting to primary care clinics each year.

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CONFLICT OF INTEREST STATEMENT

Dr. Crismon is the mental health vice chair of the steering committee, faculty member, and coach for the REACH Institute's Patient-Centered Mental Health in Pediatric Primary Care Program, and has received payment for teaching and facilitation activities within this program. All other authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

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