# Pharmacy Services in Behavioral Health


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## Introduction

Pharmacists have long been considered the most accessible healthcare professionals, from the days of the independent community pharmacy with the lunch counter and ice cream soda jerk to present day. Pharmacists traditionally have held a distributive role, filling prescriptions that are written by physicians and presented to the pharmacy counter, either in the community or hospital pharmacy. Until 2000, a pharmacist may have held a Bachelor of Science Degree in Pharmacy; in that year, the Doctor of Pharmacy Degree became the entry-level degree program for the practice of pharmacy. While the general public often sees pharmacists in the distributive "prescription filling" role, the profession of pharmacy has been pushing pharmacists to take a broader role in patient care, including rounding with patient care teams in the hospital setting to medication therapy management in community pharmacies. In the past decade, the role of the pharmacist in patient care had expanded to providing medication-related services in outpatient and primary care clinics for a variety of disease states. A newer important area of practice is in transitions of care, with the pharmacist helping the patient move from the inpatient hospital to home with a greater understanding of their medications and how to take them. Pharmacists who practice in a more clinical role, whether in an inpatient or outpatient setting, are often residency-trained and board-certified in their area of practice. Pharmacists may specialize in the treatment of patients with mental disorders in the distributive and clinical practice settings.

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## Community Pharmacies

As more Americans rely on prescriptions to manage their health issues, community pharmacists often are one of the first health points of contact for families. Hence, it is important to understand their role as key from a behavioral and public health perspective.

### *Health System Pharmacies*

In addition to traditional independent and chain retail community pharmacies, there are pharmacies that are housed within outpatient clinics in health systems. These pharmacies generally fill prescriptions for patients who have appointments with providers within the health system or outpatient clinic and may also provide over-the-counter medications. These pharmacies are convenient for the patient, and the pharmacists and pharmacy technicians commonly have access to the patient medical records for the health system. This access to the medical record allows the pharmacist to see health conditions, laboratory monitoring, drug allergies, and prescription medications the patient is taking and is a more reliable way for the pharmacist to provide patient-centered care than asking the patient for this information in a traditional community pharmacy. It also permits the pharmacist to have easier access to the physician in case of questions about a prescription or need for refills.

Recent research has studied the role of the community pharmacy in providing earlier detection of mental disorders, specifically depression (Rubio-Valera, Chen, & O'Reilly, 2014). For the past few decades, pharmacists have been involved in screening for high blood pressure and diabetes, but few have ventured into screening for mental disorders. Stigma related to behavioral health conditions and discomfort in talking to patients about these disorders may be a significant reason. Studies of pharmacists and their comfort in providing medication counseling for various disease states have shown that pharmacists in general feel more confident in counseling about high blood pressure or diabetes medications than about behavioral disorders and medications (Phokeo, Sproule, & Raman-Wilms, 2004).

Improvement in didactic and experiential education in pharmacy school/college programs as well as redesigning community pharmacies to offer truly private patient counseling are areas of focus in the profession of pharmacy to impact these concerns (Calogero & Caley, 2017). Pharmacists who have been trained in the use of screening tools for depression feel more comfortable with patient interactions. They are accessible due to the lack of need for appointments and the opportunity in the community pharmacy to screen for depression, recognize patients who may be at-risk, and make appropriate referrals (Rubio-Valera et al., 2014). These screenings may be done in either traditional community pharmacies or in pharmacies within

health systems. As noted previously, pharmacists within health systems may have greater access to medical records and physicians than other pharmacists.

### *Pharmacies in Community Mental Health Centers (CMHCs)*

CMHCs may have pharmacies that are located within the clinic setting. Health systems may have a pharmacy in the outpatient clinic; some health systems also have an affiliated CMHC that has a pharmacy. Independent and chain retail pharmacies may partner with a CMHC to have a pharmacy located within the clinic. Pharmacy companies may specialize in placing a community pharmacy in a CMHC.

Genoa Healthcare is the most recognized of these pharmacy companies. In 2018, Genoa Healthcare had 418 pharmacies located in a CMHC, recorded about 650,000 patient encounters in their pharmacies, and had more than 250 psychiatrists working with their telepsychiatry services (www.genoahealthcare.com). Genoa Healthcare pharmacies can provide specialized packaging of medication, refill reminders, and medication delivery.

While the pharmacy is located in a CMHC, medications for primary care and other conditions are available in addition to behavioral health medications. A pharmacist is embedded in the outpatient treatment team to provide medication reviews and adherence information. A retrospective study comparing traditional community pharmacies and pharmacies integrated into CHMCs evaluated Medicaid claims and medication adherence. The results of the study showed that patients who filled medications in a CMHC integrated pharmacy had higher medication adherence, decreased rates of hospitalization, and decreased emergency department use, resulting in improved care and a decrease in the use and cost of acute care services (Wright, Gorman, Odorzynski, Peterson, & Clayton, 2016).

## Insurance Coverage

The Mental Health Parity Act of 1996 (MHPA) required that large group health plans provide mental health (MH) benefits that are equal to medical benefits in annual and lifetime benefits. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) clarified the MHPA to include substance use disorder (SUD) treatment and smaller health plans and group insurance coverage (The Center for Consumer Information & Insurance Oversight, 2018). The Affordable Care Act (ACA) added these benefits to individual health insurance coverage. The MHPAEA did not require health insurers to cover MH/SUD treatment; the parity law requirement applies to those plans that choose to provide these benefits. The ACA built upon the MHPAEA in requiring MH/SUD coverage as one of the ten essential health benefits.

## *Commercial Insurance*

Commercial insurance may come from employers or from the individual private insurance marketplace created by the ACA. Commercial insurance may be more likely than Medicaid and Medicare programs to be subject to more restrictive preferred drug lists, formularies, and prior authorizations for medications (covered in a later section). The Healthcare Marketplace is set up for individuals to obtain healthcare insurance that fits their needs and they can afford. Challenges exist for individuals in determining if their current healthcare provider is covered under a plan they may choose, which has resulted in patients not being able to keep their current provider or have the same medication coverage they may have had with previous insurance plans (www.cms.gov).

## *Medicare and Medicaid*

President Lyndon B. Johnson signed the Social Security Act Amendments that created Medicare and Medicaid in 1965. The Medicare program is designed to provide insurance coverage and healthcare treatment for people who are over the age of 65, are disabled, or have end-stage renal disease. In 2003, the Medicare Part D Prescription Drug Improvement and Modernization Act added Medicare Part D, which provides prescription drug insurance coverage for Medicare recipients.

Medicaid is a healthcare coverage program for people who are low-income, pregnant women, people with disabilities, and those who need long-term care services. The federal government provides funding to the states to administer Medicaid programs based upon the state decisions. In addition to providing for the Health Insurance Marketplace, the ACA 2010 allowed states to choose to expand their Medicaid programs to cover more people by raising the maximum low-income standard to a higher wage (www.cms.gov).

## *Preferred Drug Lists*

Preferred drug lists (PDLs) are employed by insurance programs to steer prescribers and patients toward lower-cost medications, including generic drugs. Insurance providers are often able to negotiate with drug manufacturers to obtain a lower price for their programs if a specific drug made by a manufacturer is considered to be preferred, even if it is not a generic. These are called “supplemental rebate programs”. Commercial insurance programs, Medicare, Medicaid, and the Veterans’ Administration each utilize this type of rebate program to lower costs. PDLs also decrease the cost of treatment per member of each insurance program. Managed care insurance programs, often utilized by state Medicaid insurers, are commonly

paid a set rate per member per month. This leads managed care and pharmacy benefits managers to search for the lowest-cost medication or treatment for a disease state. Co-payments for medication that are paid by the patient at the pharmacy can also impact the cost to the insurer. Co-payments are either a set amount per prescription or a percentage of the cost of the prescription. Medications that are considered to be first-tier on PDLs have co-payments that are lower in percentage or set price than medications that are second- or third-tier.

A literature review by Ovsag, Hydery, and Mousa (2008) evaluated the impact of PDLs in Medicaid on cost and quality of care. Problems with PDLs identified by this review include the influence of PDLs on the use of other healthcare services, potentially increasing overall cost, and the concern that restricting access to medication can lead to a decreased quality of care for a patient. A retrospective cohort study evaluated the impact of a new PDL on adherence to medication for Medicaid patients in Alabama, specifically focused on medications used for heart disease and elevated cholesterol. The results of the study identified an 82% increased odds of Medicaid patients becoming non-adherent to statin medications used to treat elevated cholesterol after the implementation of the new PDL (Ridley & Axelsen, 2006).

Another study focused on changes to Medicaid evaluated how a decrease in days' supply per prescription and an increase in co-payment affected adherence to cholesterol and hypertension medication. For those Medicaid patients who took nearly all of their medications prior to the change, there was a significant decline in adherence to these medication after the change (Amin, Farley, Maciejewski, & Domino, 2017). Overall, while PDLs are perceived by insurers to decrease short-term cost, a growing body of evidence suggests that quality of life and healthcare outcomes are negatively impacted by PDL programs.

### *Patient Assistance/Co-Payment Assistance Programs*

Drug manufacturers will often make patient assistance programs (PAPs) that provide either free or reduced cost medications available to patients who meet eligibility criteria. Patients who do not have insurance, are not eligible for Medicaid or other insurance programs, are low-income, or have insurance that does not cover certain medications may benefit from enrolling in a PAP program. PAP programs require an application, as well as proof of income, and occasionally citizenship, which can limit their widespread use. Pharmacists are in a position to be aware of PAPs and to aid patients in applying for them. Manufacturer websites generally provide information about available PAPs for their medications, and there are groups/websites that list more general PAP information. These groups/websites include RxAssist (www.rxassist.org), NeedyMeds (https://www.needymeds.org/pap), Paying for Senior Care (www.payingforseniorcare.com), and a list of pharmaceutical manufacturers at www.cms.gov.

One manufacturer, Janssen, provides a comprehensive assistance program known as Janssen Connect® for patients diagnosed with schizophrenia and prescribed a long-acting injection (LAI) made by the company. A recent evaluation of the program noted that nearly 80% of patients enrolled did not miss receiving their injection for more than 7 weeks and 87% were fully adherent with an every-4-week injection regimen (Benson, Joshi, Lapane, & Fastenau, 2015). The cost of co-payments can be a burden to patients, especially those who have co-payments based upon a percentage of the drug cost and those who are receiving expensive brand-name medications.

One study evaluated patients diagnosed with schizophrenia and the impact of Medicaid prescription co-payments on their use of antipsychotics as well as other medications for medical conditions. The study included fee-for-service Medicaid patients in 42 states and the District of Columbia. The study results suggested that as the co-payment cost increased, the number of medication refills decreased in a small, but statistically significant, way for antipsychotics. For medications for medical conditions, patients were 4–11 times less likely to fill prescriptions (Doshi, Li, Desai, & Marcus, 2017). Co-payments for prescriptions have risen significantly for the past several years and have become a significant burden for patients. The use of PAPs and co-pay assistance programs can help to decrease this burden and increase medication adherence.

## Clinical Pharmacy Services

### *The Clinical Pharmacist in the Inpatient Mental Health Setting*

For several decades, clinical pharmacists have been working in the inpatient treatment setting in mental health, rounding with prescribers, evaluating medication regimens, providing medication groups, and making recommendations for treatment changes and monitoring needs. Clinical pharmacists may have collaborative practice agreements (CPAs) with physicians in the inpatient setting to make medication adjustments and order laboratory monitoring under protocols. Most psychiatric clinical pharmacists have completed both a postgraduate year 1 residency in pharmacy practice and a postgraduate year 2 residency in psychiatric pharmacy. Board Certification in Psychiatric Pharmacy (BCPP) is available through the Board of Pharmacy Specialties, and this certification is held by most psychiatric clinical pharmacists.

In the past decade, research in this area has focused on improvement in medication adherence and cost-savings realized by utilizing a clinical pharmacist in the inpatient setting. An economic analysis reviewed clinical pharmacist interventions to evaluate cost-savings from the addition of a clinical pharmacist. The study results indicated that inpatient clinical pharmacists have a positive impact on hospital budgets, especially in the areas of prevention of adverse drug reactions, discontinuation

of unnecessary drugs, and a positive effect in high-cost environments, such as intensive care units (Dalton & Byrne, 2017; Gallagher, McCarthy, & Byrne, 2014). A comprehensive review of clinical pharmacy services in mental health noted that there is a significant potential for these services to improve clinical and quality of life outcomes through review of medication charts and laboratory monitoring, evaluation of physician prescribing, and the provision of education to patients and other healthcare professionals (Richardson, O'Reilly, & Chen, 2014).

## *Clinical Pharmacists in the Community Mental Health Setting*

More recently, psychiatric clinical pharmacists have taken roles as healthcare providers in outpatient clinic treatment settings. These pharmacists have also generally completed two postgraduate residency years and are BCPP certified. Outpatient psychiatric clinical pharmacists have CPAs with physicians that can range from focused medication management via protocol to independent medication management. Outpatient CPAs can be limited to seeing patients for medication regimen reviews, adherence, prescription refills, laboratory monitoring, and side effect evaluation. The outpatient clinical pharmacist CPA can also have a broad focus with independent medication management, including the ability to do the tasks in the limited CPA in addition to seeing patients for mental status assessments and addition, discontinuation, and adjustment of medications.

Outpatient psychiatric clinical pharmacists can also play a role in PAPs and copayment assistance programs. A recent Cochrane review of the effect of nondispensing roles for outpatient pharmacy concluded that the pharmacist role has expanded and the evidence supports medication management, patient counseling, patient education, and education outreach to physicians regarding prescribing practices (Nkansah et al., 2010). A retrospective study that evaluated 10 years of medication therapy management in an integrated healthcare system reviewed the medical records of more than 9000 patients for clinical pharmacist intervention. Cost-savings to the health system over 10 years from pharmacist intervention was approximately $700,000 (Ramalho de Oliveira, Brummel, & Miller, 2010).

## *Transitions of Care*

Increased hospital readmissions within 30 days has prompted health systems to evaluate their discharge practice and implement policies and practices that improve patient education about medications and treatment, improve follow-up treatment interactions, and reduce readmission rates. Pharmacists play a role on teams for transitions of care by providing discharge counseling on medications for clear patient understanding, ensuring that there are no duplicate prescription orders at the

pharmacy, and evaluating insurance coverage and the patient's ability to pay for medications in the outpatient pharmacy prior to discharge.

Some health systems have piloted transitions of care teams that are run by pharmacists and include communication between the inpatient and outpatient clinical pharmacists so that the outpatient treatment team is aware of the need for follow-up for the patient. A prospective study of 98 patients who had physician-initiated outpatient follow-up with pharmacist intervention compared 236 patients who had outpatient follow-up without pharmacist intervention. The patients who received pharmacist intervention had a hospital readmission rate within 30 days of 9.2% compared to a 19.4% 30-day readmission rate for those patients who did not have a pharmacist intervention (Arnold, Buys, & Fullas, 2015).

Cavanaugh, Lindsey, Shilliday, and Ratner (2015) studied patient outcomes for a pharmacist-coordinated multidisciplinary follow-up team that included a total of 140 patient visits. The 30-day readmission rate for the multidisciplinary team was 14.3% compared to 34.3% for patients who were followed up by the physician-only team (Cavanaugh et al., 2015). The implementation of services that are coordinated between inpatient and outpatient services can include an evaluation of the patient medication regimen prior to admission, performance of medication reconciliation, patient education on medications initiated during the hospitalization, and the initiation of affordable medication regimens that the patient would be counseled on and receive prior to discharge (Gilmore et al., 2015).

## Medication Factors for Successful Treatment

The term "adherence to treatment" assumes the patient and the healthcare provider have developed a plan for treatment and it is agreed upon by both parties. "Compliance with treatment" is a term often used interchangeably with adherence to treatment but assumes that the provider had determined a plan and the patient will follow it. Adherence implies a partnership and is a patient-centered approach, while compliance is following a plan for which the patient did not have input. Healthcare providers can use several tools to ensure that the patient understands and agrees to the plan and that the plan includes decisions made by the patient.

### *Motivational Interviewing (MI)*

MI is a tool that is collaborative, patient-centered, and relies on the provider to discover what will lead to behavioral change based upon the needs of the individual patient. MI uses the "OARS" approach to behavioral change: (1) open-ended questions, (2) affirmations, (3) reflective listening, and (4) summaries. Pharmacists are accessible healthcare professionals who are positioned to identify patient

nonadherence and can use the techniques of MI in any patient care setting, including the community pharmacy. Pharmacists who use MI can discuss the patient's understanding of their disease and medications, determine how the treatment plan includes patient goals, and engage the patient in communication about any resistance to the plan (Salvo & Cannon-Breland, 2015). In the past, pharmacists gave advice to patients based upon specific questions asked with drug or dosing information. The practice of MI is now taught in schools and colleges of pharmacy to enhance pharmacist communication and include patient-centered aspects of care.

A study by Luetsch and Burrows (2018) evaluated 89 pharmacists and their reflective journal entries after training and implementation of MI. The pharmacists were asked to reflect on their perceptions of practice changes related to emotional aspects of communication and success in difficult situations. Prior to the training and implementation, none of the reflections indicated transformative changes in their frame of reference toward patient-centered care. After the training, 38% of the journal reflections were considered to be transformational, indicating that MI techniques can be learned and are successful in improving communication in the pharmacy setting (Luetsch & Burrows, 2018).

## *Shared Decision-Making (SDM)*

In addition to MI, SDM is a communication tool that empowers patients to be active participants in treatment decisions. It is considered an important concept in mental health and a recovery-oriented system of care. SDM considers both the healthcare provider and the patient to be "experts" in the care of the patient. Each "expert" must share information, assess the advantages and disadvantages of a proposed treatment, and use collaboration to choose the intervention. In a study that evaluated 22 adults with mental health disorders, semi-structured focus groups evaluated how these patients perceived SDM (Grim, Rosenberg, Svedberg, & Schon, 2016). The focus group participants appreciated being included in discussion of their choices for treatment, the specifics of options, and the ability to be included in the decisions, especially related to their personal needs. The area for improvement noted by the participants was feeling prepared for this type of communication. Most participants did not feel prepared and felt that their choices were not trusted by the healthcare provider because they were not informed (Grim et al., 2016).

Psychiatric medication management is a specific area where SDM is useful. Mental health medications are a mainstay of treatment but often have significant adverse effects and less effectiveness than is hoped for by patients. Treatment with medications may be coerced, and patients may feel that they are being pressured to take medications in general or to agree to LAIs if they are not adherent to oral medications. SDM in the context of medication use may be subject to loss of true collaboration if the healthcare provider feels that the patient does not have insight or is

not able to make fully informed treatment decisions. This may lead to the patient feeling a lack of respect for their input and not initiating treatment or discontinuing a medication. SDM related to psychiatric medication use should include a discussion of all possible adverse effects, the risk versus benefit of taking the medication, an allowance for the patient to "test" a treatment regimen by adjusting doses to times that fit their schedule, and clear information about the risks of not taking medication (Morant, Kaminskiy, & Ramon, 2016).

While the technique of MI is a part of the curriculum in schools and colleges of pharmacy, the concept of SDM is not common. Younas, Bradley, Holmes, Sud, and Maidment (2016) studied the perception of SDM by mental health pharmacists in the United Kingdom, where national guidelines encourage the use of SDM in antipsychotic prescribing. Semi-structured interviews were performed with 13 mental health pharmacists who were currently in psychiatric practice settings. The results of the study suggest that the pharmacists considered SDM regarding antipsychotic medications to improve clinical outcomes and relationships with patients; barriers to implementation of more widespread SDM included a lack of training, staff time constraints, and the ability of the patient to participate in SDM (Younas et al., 2016).

## *Long-Acting Injectable (LAI) Antipsychotic Medication*

LAI antipsychotic medications are depot intramuscular injections that last from 2 weeks to 12 weeks depending on the medication and the formulation. Guidelines for the treatment of schizophrenia and bipolar disorder state that oral formulations should be tried first but that LAI antipsychotic formulations may be considered either after failure of oral medication or if the patient would benefit and agree to the LAI for convenience. The history of LAI antipsychotic use has often included coercion or pressure on the patient to agree to a LAI after not being adherent to oral medications, which has led to a lack of trust in healthcare providers who suggest these medications. More recently, healthcare providers have introduced the idea of LAI antipsychotics earlier in a course of treatment as a convenience to the patient, resulting in an increased use of LAI antipsychotics.

There is clinical evidence that LAI antipsychotics do improve adherence to medication and decrease the rate of hospitalization during a symptom relapse. A study by Marcus, Zummo, Pettit, Stoddard, and Doshi (2015) compared oral and LAI antipsychotic adherence and outcomes after release from a psychiatric hospitalization. Adherence to medication was better in the LAI group (adherence = 48.2%) versus the oral group (adherence = 32.3%). LAI participants also were less likely to be rehospitalized for relapse (19.1% vs. 25.3%) (Marcus et al., 2015). Research is lacking that compares the use of communication techniques such as MI and SDM with rates of adherence with oral or LAI antipsychotics.

## Barriers to Treatment

### *Dual Diagnosis Treatment*

Dual diagnosis in the context of mental health care includes the evaluation and treatment of both mental and substance use disorders in the same clinic setting. Historically, treatment for these disorders has been differentiated into separate clinical settings as if they are unrelated to each other or that one condition cannot be successfully treated without first addressing the other disease state. Despite evidence and awareness that integrated services for dual diagnosis are beneficial for the patient, there are a significant lack of healthcare providers who have taken this approach. A 2012 study assessed the availability of dual diagnosis capability in the United States using a sample of 256 programs. Only about 18% of the addiction treatment services and 9% of mental health programs met the criteria for dual diagnosis treatment services (McGovern, Lambert-Harris, Gotham, Claus, & Xie, 2014).

Dual diagnosis is very common; one study noted that people with drug dependence presented with a mental health disorder 4.9 times more frequently than individuals without an addiction diagnosis (Di Lorenzo, Galliani, Guicciardi, Landi, & Ferri, 2014). A retrospective analysis of demographic and other factors related to dual diagnosis found that the participants in this study more often suffered from a personality disorder, had a family history of mental health or substance use disorders, and had suffered trauma (Di Lorenzo et al., 2014). Dual diagnosis patients may have more chronic, disabling, and severe disease, requiring longer and more intensive treatment. Mental health and addiction programs often have different structures, assessment procedures, continuity of care, and treatment plans that may not meet the needs of dual diagnosis patients; collaboration of care between mental health and addiction providers is challenged by treatment access and coordination of care (Padwa, Guerrero, Braslow, & Fenwick, 2015). Pharmacists may bridge the gap in treatment by providing coordination of care related to medication use and access to treatment.

### *Lack of Mental Health Providers*

A significant concern for adequate mental health services is the lack of providers in rural and underserved patient populations. Starting in 2009, states enacted significant budget cuts to CMHCs, who are often the only provider of mental health services in rural areas. In addition, the MHPAEA of 2008 and the ACA 2010 required mental healthcare reform and parity that increased the number of persons able to afford treatment services. This increase in insured patients seeking services further stressed a mental health system with decreasing budgets (Larrison et al., 2011). In a

study evaluating racial and ethnic disparities in mental health care, the results showed a significant difference in access to care for Black and Latino patients relative to White patients. Minorities lived in counties with greater poverty and unemployment rates compared to Whites. The availability of insurance, CMHC treatment, and density of specialty providers benefited Black individuals. Increased racial and ethnic residential segregation is associated with shortages of psychiatrists for Latino patients (Lê Cook, Doksum, Chen, Carle, & Alegria, 2013).

Community pharmacies are present in nearly every community, providing an opportunity for community pharmacists to bridge the gap in access to mental health services. Barriers to the provision of this service exist, including heavy dispensing workloads, negative attitudes about individuals experiencing mental health disorders, and stigma (Calogero & Caley, 2017). Clinical pharmacists in outpatient mental health treatment settings can provide medication regimen review; interview patients about medication adherence, side effects, and effectiveness; and work under collaborative practice agreements to provide mental health medication management services to increase the time available to both primary care and mental health providers for mental health treatment (Rubio-Valera et al., 2014).

## Implications for Behavioral Health

Clinical psychiatric pharmacists have been practicing in the area of mental health for many years and are vital members of the treatment team. While inpatient clinical psychiatric pharmacists have been found in this practice area for some time, outpatient clinical psychiatric pharmacists have, for the past decade, begun to create roles within the clinic setting. Inpatient psychiatric pharmacists perform tasks related to medication regimen review, patient rounds, and transitions of care; outpatient psychiatric pharmacists provide medication management, adherence and side effect reviews, decreased medication overlap, and application for patient assistance programs under collaborative practice agreements with physicians. Because of a lack of mental health providers and decreased funding for CMHCs in rural areas, clinical pharmacists are filling the role of mental health provider in outpatient primary care settings.

Community pharmacists are the most accessible healthcare professionals and can provide evaluation of medication adherence, patient counseling, insurance assessments, and mental health screenings with referral to mental health providers. Education in schools and colleges of pharmacy has focused on decreasing pharmacist stigma and negative images of people with mental disorders and increasing the comfort level of the pharmacist for interacting with patients through the use of motivational interviewing and shared decision-making. Pharmacists are uniquely positioned to fill the gap in available mental health providers, both in the community pharmacy and clinical practice setting.

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