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Review Article

The role of pharmacists in managing common mental health conditions in UK primary and secondary care settings: a scoping review

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Abstract

Introduction: Mental health (MH) conditions place a significant disease burden on the UK. Pharmacists are healthcare professionals and may contribute to addressing this burden; however, the evidence regarding their specific role in MH care in the UK is sparse.
Objective: The objective of this review was to assess the evidence regarding pharmacists' roles in managing common MH conditions within UK primary and secondary care settings.
Methods: A scoping review was conducted following the Arksey and O'Malley framework and Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines. PubMed, Scopus, PsycINFO, Web of Science, and the Web of Science (Core collection) databases for English-language studies published between 2004 and 2024 were accessed. Eligible studies were UK-based and reported pharmacists' involvement in MH care. Data were charted and synthesized into descriptive themes.
Key findings: Fourteen studies highlighted pharmacists' multifaceted roles in MH care across primary and secondary care settings. Key domains included prescribing and deprescribing, medicines management, patient education, team collaboration, and specialized services such as assessments, referrals, and social prescribing. Pharmacist involvement improved medication optimization, patient understanding, and interdisciplinary communication, though gaps in MH training and role standardization were noted.
Conclusion: Pharmacists play diverse roles in supporting MH services through medicines optimization, prescribing support, and multidisciplinary collaboration, and have positive impacts on adherence and medicines management, but limited evidence on effectiveness. Strengthening pharmacist integration, workforce training, and evaluation of scalable interventions is essential to enhance their contribution to MH care in the UK.

Keywords: pharmacist; mental health services; primary health care; secondary care; community pharmacies; hospitals; community mental health centres; United Kingdom

Introduction

Mental health (MH) disorders are a leading cause of global disease burden [1, 2]. In 2019, 970 million people worldwide were living with a mental disorder [3]. However, it is estimated that the numbers have increased significantly in the past few years due to the COVID-19 pandemic [1]. Nearly a billion people are currently living with MH disorders globally [4]. In England, one in six adults experiences a common MH problem each week [5, 6]. Among specific MH conditions, generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), and depression are the most frequently diagnosed, with ~8, 6, and 4 out of every 100 people receiving a diagnosis for these conditions each week, respectively [6–8].

MH disorders have major consequences on individuals, families, and society. People identifying as LGBTQIA+, those from ethnic minorities, young women, and socio-economically disadvantaged groups are at higher risk [6]. MH conditions significantly contribute to disability adjusted life years (DALYs) globally. DALYs encompass both years lived with disability and years of life lost to premature mortality. Globally, DALYs attributed to MH disorders rose from 80.8 million in 1990 to 125.3 million in 2019 [9]. Individuals with MH disorders often face challenges in maintaining education, employment, relationships, and social interactions, thereby impeding their overall quality of life. MH disorders are also associated with an increased risk of suicide. According to a report, 46% of people who died due to suicide had at least one known MH disorder [10].

MH disorders also have economic consequences. Globally, the economic costs of MH disorders are approximately USD 2.5 trillion [11], including both direct costs (treatment, diagnosis, clinic visits, hospitalization, etc.) and indirect costs (productivity loss, caring needs, absenteeism, early retirement, etc.). In the EU, costs exceed EUR 600 billion [12], while in the UK, they are estimated at £117 billion per year [13]. Given their impact, managing MH conditions is essential to improve health and economic outcomes. Both pharmacological and non-pharmacological treatments are used; however, the use of medicines is more common [5]. In England, 78 million prescriptions of antidepressants were issued in 2020, which further rose to 86 million in 2022/23 [14, 15]. Timely access to services is essential for diagnosis and treatment.

The National Health Service (NHS), founded in 1948, provides publicly funded healthcare across four separate healthcare systems of the UK, namely, NHS England, NHS Scotland,

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NHS Wales, and Health and Social Care (Ireland) [16]. It covers a wide range of services, including primary, secondary, and tertiary care, and delivers care free at the point of access to UK residents [17]. The NHS is under constant pressure and facing multiple challenges, including clinician shortages, increasing costs for healthcare delivery and support services, and medication-related morbidity and mortality.

MH services are usually delivered through both primary and secondary care. Primary care settings include general practices (GPs), community pharmacies, and primary care networks (PCN). PCNs are groups of GP practices working together in collaboration with other specialized services for a local community in the UK [18]. Secondary care includes community MH teams, MH hospitals, linked out-patient services, and specialist services. Despite increased funding and staffing, MH services remain inadequate, with longer waiting times, staff shortages and turnover, and unequal access for children, ethnic minorities, and people with complex needs [19]. Around 8 million people with MH needs are not in contact with the NHS [19]. A Royal College of Psychiatry survey reported longer waiting times for people needing specialist care [20]. Another survey reported that one in ten people waited over a year for psychological therapy, and more than half waited for 3 months [21]. Such delays in treatment can exacerbate emotional, behavioural, and physical health issues [22].

Policymakers are exploring ways to address these issues by expanding the roles of other health professionals, including pharmacists [23, 24]. The NHS Health Implementation Plan 2019–2024 [25], considered pharmacists an essential part of the health team to deliver MH services for fulfilling the commitments made under the NHS long-term plan [26]. Education and training standards for pharmacists have also changed recently to reflect the shift in policy, allowing all registered pharmacists to hold prescribing status from 2026, further expanding their roles in the health system. Professional organizations such as the Royal Pharmaceutical Society have also advocated a wider role for pharmacists in MH services [27].

Pharmacists know the medicines used in MH illnesses, including mechanisms of action, dosage, and adverse effects, making them well placed to support medication optimization and reduce polypharmacy. Pharmacists contribute to MH care in both primary and secondary care. In primary care, they are the first point of contact for patients, offering advice, medicine information, education, counselling, and referrals to appropriate services, making them highly accessible and trustworthy. Evidence highlights that patients have reported positive experiences when pharmacists involved them in treatment decisions and helped them manage the side effects of medications [28]. In secondary care, pharmacists contribute through medication reviews, patient education, and multidisciplinary collaboration.

Available evidence supports these roles. A review of 37 studies suggests that pharmacist-led counselling and medication reviews improved clinical outcomes in people with severe and persistent MH illness [29]. A UK-based study showed that the involvement of a MH pharmacist in delivering services, such as medication reviews, in a child and adolescent MH service—part of a secondary healthcare facility, resulted in savings of £97 000 per annum and persuaded that healthcare facility to employ four additional pharmacists to work as part of their community healthcare teams [30].

Currently, there is limited information in the literature on the topic, and to date, no review has explored the evidence of pharmacists' roles in delivering MH services in the UK healthcare sector. A scoping review is needed that could fill a critical gap in knowledge and serve as a foundational resource for policymakers, healthcare professionals, and researchers. The objective of this review was to assess the evidence regarding pharmacists' roles in managing common MH conditions within UK primary and secondary care settings. This review will map existing evidence on pharmacists' roles in delivering pharmacological and non-pharmacological MH services in UK clinical practice, and assess their impact on patient outcomes.

Methods

Design

A scoping review was conducted following the Arksey and O'Malley framework [31]. The process involved identifying a title and a research question, developing the eligibility criteria, designing and applying a search strategy, selecting relevant studies, and extracting the data. Extracted data were summarized and grouped into descriptive themes to present common patterns across studies. Reporting of the review followed the PRISMA-ScR guideline [32]. A standardized data extraction form was developed by the research team, informed by the literature [33]. The form captured study characteristics, namely, author, year, location, design, settings, population, perspective, pharmacist role, interventions, MH conditions, eligibility criteria, and outcomes. The extraction form was piloted in two studies and refined before full data extraction. The extraction form is available as a Supplementary file S1.

Search

The review started on the 1 October 2023 and was completed on the 29 June 2024. A set of keywords was developed by AN and MK with assistance from the academic liaison librarian for the Reading School of Pharmacy. The search strategy combined controlled vocabulary (e.g. MeSH terms) and free-text keywords. The notable keywords were pharmacists, pharmacies, roles, scope, mental health, United Kingdom, UK, England, Wales, Scotland, and Northern Ireland. The details of all keywords are presented in Supplementary file S2. The databases that were searched included PubMed, Scopus, Web of Science (All databases, or MEDLINE and Web of Science Core Collection individually), and PsycINFO. The initial search was conducted on 1 October 2023, and the final search on 15 July 2024. The search was refreshed on 27 August 2025 to identify any new relevant studies published since. In addition, manual searches of reference lists of included studies and relevant conference proceedings were also conducted. The detailed search strategy is also available in Supplementary file S2.

Research question

The review was guided by the following research question:

What roles do UK pharmacists play in delivering pharmacological and non-pharmacological MH services for common conditions such as depression and anxiety in primary and secondary care settings, and what impact do these roles have on patient outcomes?

The specific aims were:

1) To map existing evidence on UK pharmacists' contributions to MH care across primary and secondary care settings.
2) To describe the types of pharmacological and non-pharmacological services provided.
3) To report the impact of these roles on patient outcomes.

Eligibility criteria

Population

The scoping review included studies that reported on pharmacists' roles, whether examined in isolation or in the context of multidisciplinary teams involving other healthcare professionals, service users, or patients. The prime focus was on the role of pharmacists working around mental health, which includes common MH conditions such as depression and anxiety. The review also included studies that evaluated pharmacists' roles in general MH services, and not specific to any disease. The review was limited to the studies that focused on the services pharmacists provided for an adult (>18 years) population. Studies were eligible for inclusion if they evaluated the role of pharmacists in any clinical setting within the UK. This included primary care (community pharmacies, general practices, and primary care networks) and secondary care (hospitals, MH health trusts, outpatient clinics, and community MH teams). Eligible studies were those involving pharmacists who provided direct patient care or managed patients referred by other healthcare professionals. The review focused on studies examining pharmaceutical care delivered by pharmacists in these settings, either independently or as part of a wider multidisciplinary health team.

The expected pharmaceutical care provided by pharmacists in those settings may include medication management, prescription review, counselling, and collaboration within a multidisciplinary healthcare team, educational interventions, and any other pharmacist-led or pharmacist-included interventions focusing on improving patient outcomes. The demographics of study populations and their attitudes towards the service are reported in the review.

Type of studies

All original/primary studies, conducted in the UK, and published either as a full-length research article or as a conference abstract in a peer-reviewed journal were included. Also, studies published in the English language and within the last 20 years were included, i.e. from 2004. This cut-off was selected because pharmacist prescribing rights and expanded clinical roles were first introduced in the UK during this period [34]. Studies of any type of research design, such as qualitative, quantitative, mixed methods, and pilot studies, were included in the review.

Types of common MH conditions

The review focused on common MH conditions, specifically depression and anxiety. Studies were eligible if they examined these conditions either alone, together, or in combination with other MH disorders (e.g. bipolar disorder, psychosis, perinatal mental health). Studies focusing solely on other MH disorders without depression or anxiety, or on physical health conditions without a MH component, were excluded. Also, studies that focused on general MH services provided by pharmacists were included in the review.

Intervention

Pharmaceutical care provided by the pharmacists who work in these settings, either solely or as a part of the multidisciplinary health team, was considered.

Reported outcomes

Studies that reported clear results related to pharmacist-led MH service improvement, service indicators, patient satisfaction, patient health outcomes such as adherence, prescription verification, reduction in medication errors, reduction in hospital visits, and any other relevant clinical outcome were noted. Studies that focused on health literacy, systematic changes such as guidelines or frameworks development, and clearly lacked emphasis on what role the pharmacist had as a healthcare professional were excluded.

Study selection

All titles and abstracts were screened against the eligibility criteria using Rayyan systematic review software [35]. Screening was undertaken by all members of the research team independently in duplicate, with several meetings held to discuss and agree on inclusion/exclusion decisions. Full-text screening of potentially eligible studies was conducted independently by two reviewers (AN, MK). Two additional reviewers (LK, RS) verified these decisions for accuracy. No disagreements were reported.

Data extraction

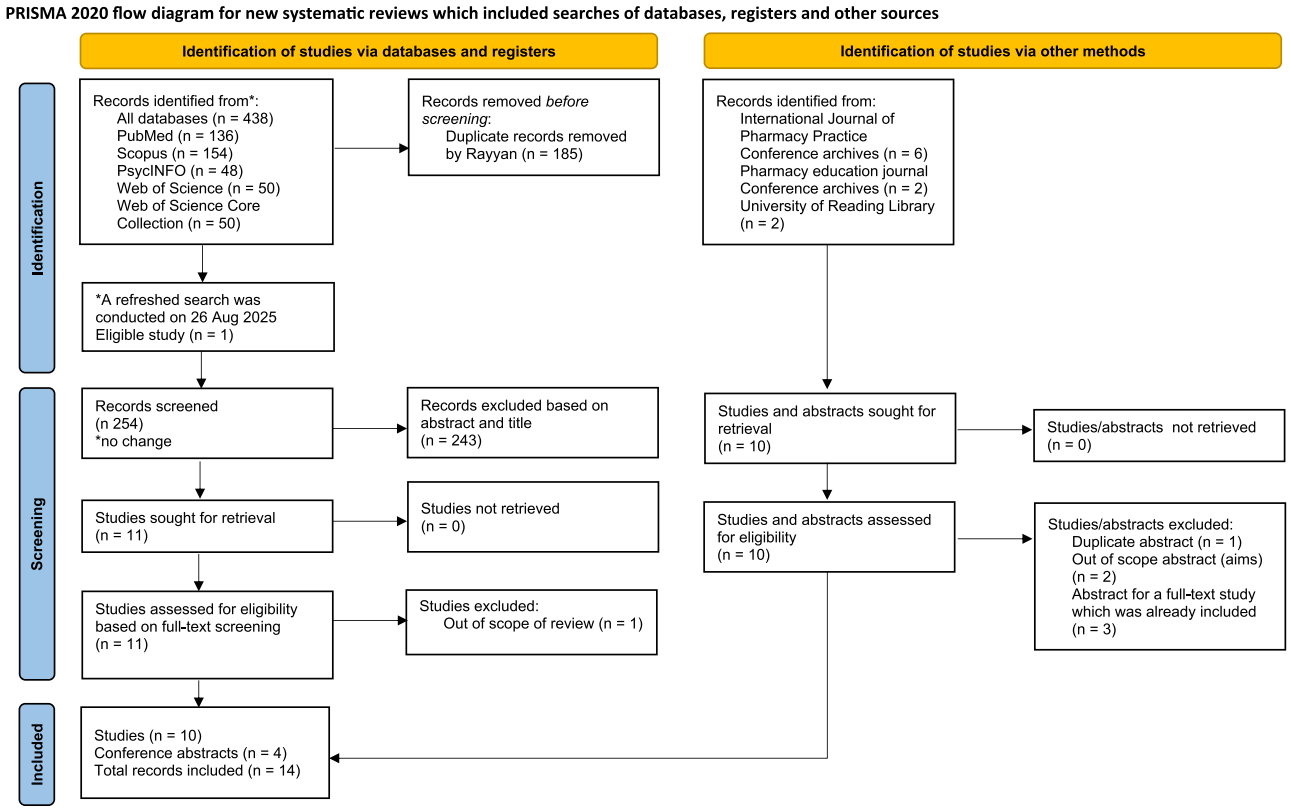
One reviewer (AN) carried out data extraction independently using the form and another reviewer (MK) verified these decisions. Both reviewers reconciled discrepancies in a meeting to produce a final version. The eligible studies had their information extracted using the variables namely author, year of publication, country of study (i.e. England, Wales, Scotland, Northern Ireland, OR The UK), study settings (i.e. hospital, GP practice, community pharmacy, etc.), the sample size of participants, demographics of pharmacists including their role, the MH condition(s) addressed by the pharmacist, and the assessor of pharmacists' role. Further, the variables of description of the role and outcomes from the study were also extracted. The other two reviewers (LK and RS) reviewed the data chart and rechecked with the included studies. No disagreements were reported. There was no missing data for the variables included in the data chart.

Data extraction and synthesis

The data extracted from the studies were synthesized into a narrative synthesis. The narrative synthesis helped in integrating findings from included studies of both quantitative and qualitative nature.

Results

A total of 438 records were identified from all databases. Additionally, 10 records were identified from other sources such as journal/conference archives and university records. The records identified were uploaded to Rayyan® [35]. The software identified and removed duplicates, reducing the number to 253. A further eligible record was added after the refreshed search, giving a total of 254. Further, two-tiered screening reduced the numbers to 14 studies, comprising 10 full-length research papers and 4 conference abstracts. The



Source: Page MJ, et al. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

Figure 1. PRISMA flow diagram.

selection of articles is further illustrated in the PRISMA flow diagram [36] (Fig. 1).

A total of 14 studies were included in the review (Table 1). The included studies were predominantly conducted in England ($n = 6$) [37–44], while one study was conducted in each of Scotland [45] and Wales [46]. The remaining studies mentioned the UK in their study, but did not specify the location [28, 47–49]. The research settings were divided between primary care ($n = 8$) and secondary care ($n = 6$). Primary care settings included community pharmacies [38, 40, 43, 47], GP practices [4, 5, 44], and PCNs [39, 42], while secondary care settings encompassed hospitals [28, 48], MH trusts [37, 41], community MH teams [4, 6], and outpatient services [49].

Study designs varied, with seven qualitative studies [28, 37, 40, 43, 46, 47, 49], five quantitative studies [39, 41, 42, 44, 48], and two mixed-method studies [38, 45] (Fig. S1). Sample sizes ranged widely from 40 [39], to 393 [44], for participants in quantitative studies, and between 10 [46] and 17 [43], in qualitative studies. The target populations included patients [28, 39, 44, 45], pharmacists [40, 41], pharmacy staff [48], GPs [2, 4], and various combinations of healthcare professionals and stakeholders [37, 38, 43, 46, 49] (Fig. S2). Studies were conducted from the perspective of the service users and patients [28, 43, 47], pharmacist [40, 41], MH trust [42, 48], stakeholder [4, 6], or multiple perspectives [28, 38, 43, 45] (Fig. S3).

The pharmacist roles represented in these studies were diverse. Community pharmacists were the focus of four studies [38, 40, 43, 47], as were specialist MH pharmacists [39, 44, 46]. Pharmacist prescribers (both supplementary and independent) were featured in four studies [28, 43, 45, 49]. Other roles included on-call pharmacists [41], chief pharmacists [4, 8], and pharmacists working in the MH trust [37], and primary care pharmacists within a former NHS Primary Care Trust (PCT) [42] (Fig. S4). These were regional organizations responsible for commissioning primary care services in England previously and were abolished in 2013.

Six studies did not specify a particular mental illness; instead evaluated pharmacists' roles in general MH care [37, 41, 44, 46, 48, 49]. Other conditions included in studies with common MH conditions were bipolar disorders, psychosis, and perinatal MH [28] (Fig. S5). Figures (S1-S5) are available as a Supplementary file S3.

The most common role was medicine management, which involved medicine optimization, conducting medicine reviews and reconciliation, monitoring of adverse events, and recommending treatment changes [45]. Studies also explored pharmacists' roles in medication prescribing and deprescribing, offering consultations, conducting screening and physical health checks, and providing referrals to secondary services [38, 43]. Patient-centred roles included educating patients, engaging them in decision-making processes, and improving accessibility and continuity of care [42, 47]. Supportive roles such as ensuring continuous medication supply, providing medicine advice, and record-keeping were also noted [48]. The duration and frequency of pharmacist interventions varied across studies.

The roles of pharmacists in MH services were multifaceted and were summarized into five broader categories (Fig. 2).

Table 1. Characteristics of included studies.

Study	Location	Design	Population (sample size)	Type of pharmacists involved	Perspective	Pharmacist role	Duration and frequency of intervention	Types of mental health conditions	Findings
Taylor et al, 2024 [43]	Community pharmacies and general practices in Bath, England	Interviews & focus group	17 (6 GPs, 6 CPs, 4 SP stakeholders, 1 member of the public)	Community pharmacists	Service and people	Social prescribing (SP)	N/A	Mild to moderate depression and anxiety	• Pharmacists perceived SP as part of their role. • Expanded the primary care team. • ↓ GP workload. • Pharmacy busyness was a barrier to pharmacists' involvement. • Pharmacists requested more MH training.
Buist et al, 2019 [45]	General practices in remote and rural areas of Scotland	Mixed methods study	75 patients referred by GPs	Independent prescriber pharmacists	Patient and care team	Treatment assessment and prescribing	12-month pilot service with 30-minute consultations for referred patients	Mixed depression and anxiety	• + feedback from patient and staff. • Most patients reported ↓ anxiety scores. • Enhanced service.
Silverio et al, 2023 [40]	Community pharmacies in urban settings across London, England	Focus group discussion	11 community pharmacists	Community pharmacists	Community pharmacists	Community pharmacists dealing with perinatal MH issues	N/A	Perinatal mental health	• Lack of confidence/knowledge. • Lack of a referral pathway. • Inadequate training.
Adam et al., 2022 [37]	A Mental Health NHS Trust in England	Interviews	13 health professionals (6 Pharmacists, 5 Medical-approved clinicians, 2 MH nurses)	Mental health pharmacists	Health professionals	Working as an approved clinician in the MH Trust	N/A	General mental health for adults and children, alcohol and eating disorders, etc.	• Restricted patient access. • Insufficient training. • Legislative barriers.
Patel et al, 2009 [42]	Primary Care Trust (PCT) in Walsall, England	Pre-post study	62 GP Practices	Primary care pharmacists	Organization (PCT)	Lead educational program co-delivered with other health professionals	7 months	Depression	• + impact on prescribing behaviour. • ↓ cost of prescribing. • Improved adherence to NICE guidelines. • Improved communication with healthcare professionals. • ↑ NHS savings.
Brydges et al., 2020 [47]	Community pharmacies and a university in the United Kingdom	Interviews	14 men with depression	Community pharmacists	Service users	General community pharmacy services and medication supply	Not specified	Depression	• Improved understanding and management of antidepressants. • Unmet information and support needs. • Hesitancy to engage with community pharmacists about MH. • Barriers to discussing concerns in a community pharmacy setting.

(Continued)

Table 1. Continued

Study	Location	Design	Population (sample size)	Type of pharmacists involved	Perspective	Pharmacist role	Duration and frequency of intervention	Types of mental health conditions	Findings
Cheeseman and Rutter, 2016 [41]	NHS acute hospitals and mental health trusts in England	Survey	116 chief pharmacists in NHS England	On-call pharmacists	Pharmacist	• Supply of medication • Providing medical advice • Documenting medicine advice calls	On-call service provided outside typical office hours.	Unspecified	• Varied frequency of calls (most trusts received <20 calls per week). • Significant variation exists in how NHS trusts resource on-call pharmacy services. • < 50% of trusts had a policy on documentation of medicine advice. • Professional standards are needed for on-call hospital pharmacy service delivery and training.
Deslandes et al. 2015 [28]	Secondary care outpatient mental health setting in the United Kingdom	Qualitative study using interviews and self-completion diaries	11 patients with mental illness	Pharmacist supplementary prescriber	Patient	• Medication management. • Providing medicine information, including side effects. • Involving patients in treatment decisions. • Prescribe medicine listed on the management plan.	• Patients managed for at least two consultations. • Diary entries were recorded over six weeks.	Depression, bipolar disorder, psychosis, etc.	• + experiences. • ↑ accessibility. • Trust in pharmacists' knowledge, sufficient information on treatment and side effects. • Active role in healthcare decisions. • ↑ satisfaction with the continuity and approachability of the pharmacist.
Kothari et al. 2016 [48]	Secondary care mental health organisations in all four nations of the United Kingdom	Survey	42 Chief pharmacists or equivalent professionals	Chief pharmacists, pharmacy technicians, and other pharmacy staff	Organisation	• Medicines reconciliation. • Compliance with NICE guidelines.	Medicines reconciliation	N/A	• Pharmacists and pharmacy technicians are mostly involved. • Most MH organisations comply with NICE guidance on medicines reconciliation in acute admission wards. • It is less frequently conducted in units admitting from primary care. • Reconciliation is rarely completed during patient transfers compared to admission. • Formal training and competency assessments are needed for those involved. • Current training practices vary, and adherence to best practice is inconsistent.
Gorton et al. 2022 [38]	Community pharmacies in Greater Manchester, England	Mixed methods involving clinical data extraction, content analysis, and survey	• 76 patients prescribed antidepressants for anxiety or depression. • 13 pharmacists interviewed (9 during initial consultation and 4 during follow-up)	Community pharmacists	Pharmacist and patient	• Medication management • Prescribing and adjusting medications • Monitoring physical health parameters • Conducting assessments and consultations	A series of consultations, up to three per patient, for five months	Depression and anxiety	• ↑ motivation of pharmacists to participate in the expanded role. • Patient acceptance and satisfaction were inferred indirectly through pharmacist consultation notes. • + reception from the support team. • Hesitancy to discuss suicide detected in notes, highlighting a stigma.

(Continued)

Table 1. Continued

Study	Location	Design	Population (sample size)	Type of pharmacists involved	Perspective	Pharmacist role	Duration and frequency of intervention	Types of mental health conditions	Findings
Shuker, 2022 [39]	Primary Care Network of GP practices in Surrey, England	Retrospective	40 people using the specialist MH pharmacist service	Specialist mental health pharmacist	Service	• Medication reviews, recommendations, and advice • Monitoring • Providing follow-up consultations • Referrals	57 appointments delivered to 40 people for 7 months	Depression and anxiety	• 80% recommendations accepted. • ↓ number of referrals to secondary care.
Attard et al., 2022 [44]	Virtual GP practice in London, England	Observational	393 patients newly identified with any mental illness	Specialist mental health pharmacist	Service	• Medication management and review. • Prescribing • Referrals	30-minute consultation for patients over 8 weeks	Unspecified mental illnesses	• ↑ patient attendance. • + feedback. • 43% of patients had medications prescribed by pharmacists. • Issues with the platform link for some patients.
Evans et al., 2022 [46]	Community Mental Health Teams (CMHTs) and a Health Board (HB) in Wales	Interview	10 in total (3 pharmacists, 2 consultant psychiatrists, 1 integrated manager, 2 clinical nurse leads, and 2 general managers)	Specialists MH Pharmacists' integration in the Community Mental Health Teams (CMHTs)	Stakeholders	Not specified	Not specified	Not specified	• + desire to integrate pharmacists. • + previous experience of working with pharmacists. • Lack of trained pharmacists available.
Jones & Western, 2009 [49]	Mental Health NHS Trust in the UK	Interview	12 healthcare professionals (7 doctors, 3 nurses, 2 social workers)	Supplementary prescriber pharmacists	Healthcare professionals	Not specified	Not specified	Not specified	• + feedback from patients and healthcare professionals. • Perceived benefits included more time for patient consultation and easier access. • ↑ collaboration between pharmacists and healthcare professionals. • ↓ workload for doctors. • Not very supportive of the independent prescribing role for pharmacists. • Lack of awareness of pharmacists' role in the service. • Lack of training.

Figure 2. Pharmacists' roles in mental health in UK clinical settings.

Outcomes of pharmacist involvement in MH services were generally positive. Patients reported satisfaction with pharmacist-led services, and GP practices where specialist MH pharmacists were practising had higher than expected patient attendance rates [28, 44]. Multidisciplinary teams responded positively to pharmacists' services, and most recommendations made by pharmacists were accepted [38]. Healthcare professionals perceived that pharmacists could dedicate more time to patient consultations, and patients trusted the pharmacists' knowledge [49]. Improved adherence to guidance from the National Institute for Health and Care Excellence (NICE) guidelines, better medicines management, lower costs, and enhanced understanding of medications were also reported [42].

From a service perspective, studies noted reduced GP workload [43, 49], shorter wait times for MH services [38], and fewer referrals to secondary care [45]. However, some challenges were identified. Some pharmacists reported lacking confidence and knowledge in MH care, citing insufficient training [40]. A lack of policy and legislative barriers to assuming an expanded scope of practice, such as working as a future approved clinician, were also mentioned as affecting the delivery of MH services by pharmacists [37, 41].

Discussion

This scoping review aimed to explore the contributions and impact of pharmacists in delivering MH services across UK clinical settings. Pharmacists were found to be involved in a wide range of MH services, primarily in medicines management, patient-centred care, advanced clinical services, and other supportive services. The findings highlight that while pharmacists' contributions were generally linked to positive outcomes, such as patient satisfaction, improved adherence to guidelines, higher-than-expected attendance in GPs, and more efficient medicines management, a gap still exists related to the quantitative evidence on the clinical effectiveness. However, challenges such as a lack of confidence among pharmacists, the need for specialized training, and legislative barriers were identified.

The review followed a systematic approach using multiple databases and duplicate screening, strengthening its rigour. However, several limitations must be noted. Most studies were qualitative, exploratory, or pilot in nature, with small sample sizes, which limited generalizability. Although grey literature was searched, a non-systematic search strategy may have resulted in omissions. The restriction to peer-reviewed studies published from 2004 onwards may have excluded studies reporting earlier work. This cut-off was chosen to reflect the introduction of pharmacists' prescribing rights and expanded clinical roles in the UK [34]. Further, the focus was on common MH conditions, which meant that findings cannot be extended to severe mental illness (SMIs) or substance use disorders. The diagnosis of MH conditions is sometimes not clearly defined or misdiagnosed in clinical practice, which may influence prevalence estimates and, consequently, the interpretation of pharmacists' roles in managing these conditions.

The findings are consistent with broader literature on pharmacists' role in MH services, although some differences in practices exist. In countries like the United States, Canada, and Australia, pharmacists have been similarly recognized for their role in medicines management, improving medication adherence, and reducing GP workload in the MH context, much like in the UK [50–54]. However,

several other roles reported in the international literature are not well-established or reported in the UK. For example, preliminary evidence from the US and Australia suggests that pharmacists can contribute to multidisciplinary health teams to improve medication management in MH hospital-at-home settings [55]. Furthermore, pharmacists' involvement in MH screening is limited in the UK, unlike other countries such as the US, where pharmacist-led depression screenings have demonstrated success in primary care settings [56–58].

While studies in the UK have demonstrated the benefits of pharmacist-led screening services in alcohol use disorder [56, 59–61], there remains an opportunity for growth where pharmacists could play a crucial role in the early detection of MH conditions like depression and anxiety. In contrast, prescribing rights are more limited or vary between states in Australia and the US, while supplementary and independent prescribing in the UK is widespread and growing, particularly in MH care delivery [62]. These differences may be attributed to differences in healthcare systems and demands, legislative frameworks, and educational and training standards. For instance, prescribing standards are now embedded in the UK educational and training standards, meaning that pharmacy graduates from 2026 onwards will hold prescribing rights at the time of their professional registration, further supporting the advanced role of pharmacists as set out in the NHS plans [25, 26, 63].

Building on the original NHS framework launched in 2011 [64, 65], the nationally commissioned NHS England pilot (2022–2024) extended the New Medicine Service (NMS) to include antidepressant therapy in selected community pharmacies across England [65]. The initiative highlights growing policy-level confidence in pharmacists' ability to support patients initiating treatment for MH conditions through counselling, follow-up, and adherence support. Preliminary data from the pilot indicate positive engagement from both patients and pharmacists, suggesting the feasibility and acceptability of this extended service. It is envisaged that antidepressants may be included in the NMS framework in 2025, subject to the evaluation of pilot data [64]. Although not captured within the scope of this review, it represents a key step towards integration of pharmacists in supporting common MH conditions in the primary care setting and may generate evidence to inform future service expansion.

It is worth noting that patients with SMIs such as schizophrenia or bipolar disorder often have comorbid depression or anxiety. Enhancing pharmacists' roles in common MH conditions could potentially benefit patients with SMIs as well. A systematic review of the literature suggests that pharmacist-led interventions could improve clinical outcomes with patients with SMIs, either individually or as part of a multidisciplinary team [29]. Future research could explore how pharmacists' skills in managing common MH conditions in primary care settings could be adapted or expanded to support patients with SMIs, particularly in monitoring for and addressing comorbid depression or anxiety. The barriers, such as lack of confidence and the need for specialized training, identified in this study highlight a crucial area for improvement. Similar issues have been reported in other studies [66, 67].

The findings show that pharmacists' roles in secondary care settings are relatively well-established. In hospitals, MH trusts, and community MH teams, pharmacists are actively involved in medication management, patient education, and collaborative care. However, their role in primary care settings is less established and more variable. While some studies [38, 44] showed promising initiatives in community pharmacies and GP practices, there is a clear need for more structured and widespread integration of pharmacists in primary MH care. The recent implementation of integrated care systems in the UK will advance the role of pharmacists in primary care through better integration into MH care pathways and fostering collaboration with multidisciplinary teams [68]. However, to fully utilize this potential, more research is required on developing and evaluating models for integrating MH pharmacists into primary care, with particular emphasis on improving patient outcomes, reducing gaps in service provision, alleviating pressure from GPs, and reducing the burden on secondary and tertiary care services.

This review identifies priority areas for training, service innovation, and evaluation, offering an evidence-informed foundation for workforce development and policy planning. Previous studies have shown that specialized training can improve pharmacists' confidence in delivering MH services [69, 70] and prepare future pharmacists for effectively delivering those services. Further training using collaborative care models, crisis management, and cultural competence could equip pharmacists to provide holistic MH care to UK population including ethnic minorities. Moreover, there is a need for longitudinal evaluations of the impact of such training to allow for further refinement and evolution to meet the changing needs of both pharmacists and patients.

There is a need to strengthen the pharmacy curriculum to enhance MH education. This could empower the new pharmacy graduates to better manage common MH conditions in UK population. In addition, a review of the postgraduate continuous professional development (CPD) activities in MH may be needed to upskill the current workforce. Further research is needed to understand the needs of the pharmacy workforce and the undergraduate pharmacy students, including their knowledge, attitudes, practices, and confidence, in managing these conditions.

The findings of this review highlight several important practice and policy implications. In practice, pharmacists are well-positioned to support MH services through their expertise in medication management, ability to offer consultations, and capacity to work collaboratively with multidisciplinary healthcare teams. To advance these roles, implementing targeted training programmes focused on MH conditions and patient-centred care is crucial. A greater integration of pharmacists supported by robust CPDs is needed in MH pathways. This would not only enhance pharmacists' contributions to this service but also align with broader NHS objectives of improving access to care and reducing workload on other areas of the healthcare system. Furthermore, there is a pressing need for research that develops and evaluates scalable pharmacist-led interventions aligned with national health priorities and the evolving scope of practice in the UK, including those that address the mental healthcare needs of ethnic minority populations.

Conclusion

This scoping review highlights the diverse roles of pharmacists in supporting MH services through medicines optimization, prescribing support, patient education, and collaboration

within multidisciplinary teams. The review identifies positive outcomes linked to pharmacist inclusion in MH services, such as improved adherence and medicines management, and positive patient and stakeholder perceptions, though evidence on clinical and cost-effectiveness remains limited. By consolidating fragmented evidence across clinical settings, this review contributes to a clearer understanding of how pharmacists can strengthen MH care provision within integrated health systems. It identifies key gaps in workforce training, service evaluation, and evidence generation that must be addressed to maximize the profession's contribution. The findings support continued policy efforts to integrate pharmacists in MH care. Further research that evaluates the outcomes of scalable pharmacist-led interventions that align with the stakeholders' plans and the evolving scope of practice in the UK is needed.

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Author contributions

A.A.N. formulated the research questions, designed the study, and led data analysis and interpretation. M.U.K. contributed to study design, data collection, and data analysis. L.K. and R.S. assisted with data analysis and writing, and reviewing the article. All authors provided critical revisions and final approval of the article for publication. All authors read and approved the final manuscript.

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Supplementary data

Supplementary data is available at *Journal of Pharmacy Practice* online.

Conflict of interest

The authors declare that there are no conflicts of interest.

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Data availability

The materials supporting the findings of this study are available with the manuscript.

Ethics

Ethical approval was not required for this study. This scoping review used only previously published and publicly available literature. It did not involve research with human participants, human samples, or personal data, and therefore falls outside the scope of ethical review as defined by the University of Reading's research ethics requirements.

Data access

The authors had complete access to the study data at all stages of the research process, including during analysis and manuscript preparation. Access to the data is ongoing to ensure continuity in post-publication inquiries and further analyses if needed.

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