

Informing the mental health strategy for England: Call for evidence document

RCPharm and CMHP response

Hospital to community

Effective partnership working at a community level is essential for the provision of person-centred care. These partnerships address the broad range of factors which can influence a person's mental health recovery, such as:

- physical health
- employment
- housing
- addiction
- social care

We are piloting [6 community-based mental health centres](#) across England to understand how services can better work together at a local level to improve people's outcomes. We would like to hear practical insights that support wider transformation of mental health care in communities.

We welcome practical examples and evidence on how mental health services can work more effectively across:

- the wider NHS, including new neighbourhood health centres
- services to support people with co-occurring mental health and neurodevelopmental conditions
- different sectors, including education, employers, local authorities and the voluntary, community and social enterprise (VCSE) sector

How can mental health services work more effectively across these areas? Please provide examples of cross-sector pathways in practice. (Optional, maximum 300 words)

Mental health services work most effectively across sectors when multidisciplinary neighbourhood teams include specialist mental health pharmacy expertise alongside primary care, social care, VCSE, housing and employment support. Medicines are often a key point of continuity or risk during transitions between hospital, community and primary care. Integrated pathways should therefore include medicines reconciliation after discharge, shared care arrangements for high-risk medicines such as lithium and clozapine, proactive physical health monitoring, and accessible specialist advice for GPs, community pharmacists and other professionals. This supports safer prescribing, reduces avoidable referrals and admissions, and helps people remain well in their communities.

Throughout this response, references to primary care include both general practice and community pharmacy unless otherwise stated. Community pharmacies are highly accessible healthcare settings, often engaging with people more frequently than any other part of the healthcare system, and can play an important role in medicines optimisation, early identification of deterioration, physical health monitoring, health promotion and signposting to wider support services

We welcome views or evidence on what further support, in addition to NHS services, should be provided for people with severe and enduring mental illness to:

- help them stay well
 - maintain participation in education, work and community life
 - avoid crisis and/or hospital admission
 - reduce length of stay in inpatient units
- What further support should be provided for people with severe and enduring mental illness? (Optional, maximum 300 words)

People with severe and enduring mental illness need coordinated support that goes beyond episodic clinical care. This should include proactive physical health monitoring, medicines optimisation, relapse prevention planning, peer support, access to psychological therapies, social prescribing, housing support, welfare and debt advice, and employment or education support such as Individual Placement and Support.

Medicines are a key component of continuity and safety for many people with long-term mental illness. Specialist mental health pharmacists and pharmacy technicians should be embedded within community mental health and neighbourhood teams to support shared decision-making, improve adherence, manage adverse effects, reduce problematic polypharmacy, support clozapine and lithium monitoring, and provide advice to patients, carers, GPs and community pharmacists.

Community Pharmacies should also be recognised as important partners in supporting people with severe and enduring mental illness. Many individuals have regular trusted contact with their community pharmacy, providing opportunities to identify emerging concerns, reinforce care plans, support medicines adherence, promote physical health interventions and facilitate access to other services before problems escalate.

Community-based support should also include rapid access to advice when people begin to deteriorate, proactive follow-up after discharge or crisis contact, and clear routes for carers and families to raise concerns. VCSE organisations, local authorities, housing providers and employment services should be treated as core partners rather than optional add-ons. For people with co-occurring substance use, neurodevelopmental conditions or physical health needs, integrated pathways should reduce the need to navigate multiple disconnected services.

The aim should be to help people stay well, maintain relationships, work or education where possible, and avoid crisis or hospital admission through timely, person-

centred support in the community. Cross sector pathways should also consider cultural, disability, neurodiversity and socioeconomic needs.

What are the main barriers to continuity of care across transitions between hospital and community services, and between different levels of care, including child to adult services?

Please provide examples from either side of the transition and outline how these barriers could be effectively addressed. (Optional, maximum 300 words)

Access to timely, accurate patient information is essential for safe, continuous care. Fragmented records and poor information sharing between mental health services, acute trusts, primary care and community pharmacy can lead to medicines-related harm, duplicated work and gaps in care. Wider adoption of interoperable digital systems and shared electronic health records is therefore critical. Community pharmacy should also be fully integrated into information-sharing pathways. Services such as the NHS Discharge Medicines Service show how structured transfer of medicines information at discharge can improve medicines reconciliation, reduce medication errors and support safer transitions between hospital and community care.

Effective integration and continuous care also rely on workforce capability. Mental health knowledge and confidence remain variable across healthcare professions, particularly outside specialist services. Limited undergraduate and postgraduate education can contribute to delays in recognising deterioration, managing severe mental illness and psychotropic medicines, identifying medicine-related harm, and addressing physical health needs. This variation can result in fragmented care, inappropriate referrals, delayed intervention and avoidable harm.

Transitions are often more challenging for people experiencing health inequalities, language barriers, digital exclusion, homelessness, racism, disability or neurodivergence. Care pathways should therefore include inclusive communication and reasonable adjustments.

National investment in multidisciplinary mental health education should accompany service redesign. Consistent undergraduate curricula and structured postgraduate training across healthcare professions would help reduce unwarranted variation in care. Programmes such as regional Southeast and west psychopharmacology courses and the College of Mental Health Pharmacy's Psych 1 and Psych 2 programmes demonstrate how high-quality multidisciplinary education can build workforce capability, improve confidence and support safer integrated care. These programmes also highlight the valuable role specialist mental health pharmacists can play in delivering education across community, primary and secondary care settings.

Analogue to digital

It's important that children and adults can benefit from the opportunities that digital technology can offer to boost mental health and wellbeing. However, this must be balanced with safety and protection from risks to mental health. We understand that many people would like:

- more personalised, tailored mental health support available digitally
- digital tools to be neuroinclusive (accessible and effective for people with neurodevelopmental conditions)

A 2025 report from Mental Health UK stated that [people are also increasingly turning to AI chatbots](#) for mental health advice.

We welcome evidence and innovative examples of how digital and AI tools can be safely used for adults and children to:

- improve mental health and wider societal outcomes
- support access to effective mental health support
- complement relational care

What evidence and innovative examples are there of digital and AI tools being used to achieve these outcomes? Please provide examples. (Optional, maximum 300 words)

Digital technology and artificial intelligence (AI) should complement, rather than replace, therapeutic relationships. Their greatest value lies in improving access, supporting self-management, identifying deterioration earlier and reducing administrative burden for clinicians. Digital tools should be designed inclusively, with attention to accessibility, language, digital literacy, neurodiversity, poverty, access to devices and data, and the risk of algorithmic bias.

How can data be used more innovatively to improve mental health and wider societal outcomes? Please provide examples. (Optional, maximum 300 words)

Interoperable records should allow clinicians to view medicines, physical health results, crisis plans, risk assessments and social care information regardless of organisational boundaries. This is particularly important for people receiving high-risk medicines requiring ongoing monitoring.

Predictive analytics may help identify individuals at increased risk of relapse, admission, medication non-adherence or physical health deterioration, enabling earlier intervention by multidisciplinary teams. Dashboards could monitor completion of metabolic monitoring, lithium and clozapine monitoring, vaccination uptake and cardiovascular risk reduction to promote targeted interventions across care interfaces.

Data governance must maintain public trust through transparency, robust information governance and appropriate patient involvement. Innovation should focus on supporting clinical decision-making and reducing inequalities rather than increasing administrative burden.

Sickness to prevention

The incidence and severity of mental health conditions has risen in recent decades, with young adults in particular now reporting substantially poorer mental health. Data from NHS England's [Survey of mental health and wellbeing, England 2023 to 2024](#) stated that 25.8% of young people are estimated to have a common mental health condition, up from 17.5% in 2007.

Many of the solutions to mental health problems involve education, employment, housing and participation in community life. Therefore, if prevention is to be effective, we need to think beyond the realms of clinical care and across the life course.

We are especially interested in how we can identify distress earlier and support people to maintain participation in education and work. Preventative approaches include:

- primary prevention - stopping mental health problems before they start
 - secondary prevention - supporting those at higher risk of experiencing mental health problems
 - tertiary prevention - helping people living with mental health problems to stay well
- We encourage examples of good practice within and beyond the health system, including in work and education settings where people with a co-occurring mental health and neurodevelopmental condition may particularly benefit.

Which preventative approaches have the strongest evidence for reducing incidence or severity of mental health problems and promoting good mental health? (Optional, maximum 300 words)

The strongest evidence supports a life-course approach combining primary, secondary and tertiary prevention, alongside action on wider determinants of mental health, including poverty, housing, education, employment, discrimination and structural inequalities. Preventative approaches should be culturally competent, trauma-informed and accessible to people experiencing racism, disability, neurodivergence, LGBTQ+ exclusion, language barriers or socioeconomic disadvantage.

Evidence-based interventions include school-based emotional wellbeing programmes, parenting support, early intervention for psychosis, Individual Placement and Support, smoking cessation, physical activity programmes, integrated treatment for co-occurring substance misuse, and timely access to psychological therapies. Pharmacists and pharmacy technicians contribute to

prevention through opportunistic identification of mental health concerns, medicines optimisation, deprescribing, smoking cessation, cardiovascular risk reduction and improving access to support within community pharmacy and primary care.

For people living with severe and enduring mental illness, preventing relapse and reducing avoidable hospital admissions requires regular structured medicines optimisation and review, proactive physical health monitoring, personalised care planning, peer support and follow-up after crisis or discharge. Physical health must be a core component of mental healthcare, including management of cardiovascular and metabolic risk, smoking, substance use, long-term conditions and medicines-related adverse effects. Specialist mental health pharmacists and pharmacy technicians play key roles in expert psychotropic medicines management, monitoring of high-risk medicines (lithium and clozapine), medicines reconciliation, optimisation of complex treatment regimens and support for adherence. They work across organisational boundaries, providing education to patients, carers and healthcare professionals, supporting independent prescribing, facilitating shared-care and improving care continuity.

These approaches are most effective when pharmacy professionals are embedded within multidisciplinary teams across primary care, mental health services, and local authorities. Fully utilising the pharmacy workforce can improve patient safety, reduce health inequalities, promote wellbeing and support people to remain well in their communities. Services should also ensure inclusive, person-centred care through interpreter access, reasonable adjustments, carer involvement and stigma reduction.

Which preventative approaches have the strongest evidence for reducing the numbers of lives lost to suicide? (Optional, maximum 300 words) The strongest evidence for suicide prevention combines high-quality clinical care with wider public health approaches. Effective interventions include restricting access to common means of suicide, timely follow-up after self-harm or psychiatric discharge, evidence-based treatment of anxiety, depression and psychosis, comprehensive safety planning, and medicines optimisation that incorporates suicide risk into prescribing decisions.

Recent patient safety activity surrounding propranolol prescribing demonstrates the importance of considering the toxicity of medicines in overdose when prescribing for people at risk of self-harm or suicide. Coroners' Prevention of Future Death reports, national patient safety investigations and local prescribing alerts have highlighted the need for greater awareness of medicines with significant toxicity in overdose, including propranolol, more careful risk assessment, consideration of prescribing smaller quantities where appropriate, and increased education for prescribers as to the evidence base for its use, particularly for mental health indications. Recent work

within Tees, Esk and Wear Valleys NHS Foundation Trust to address appropriate propranolol prescribing illustrates the importance and value of pharmacy working across interfaces in addressing such issues at scale and educating the healthcare system across interfaces.

Training healthcare professionals to recognise suicide risk, undertake collaborative safety planning and respond confidently to crisis is essential. Pharmacists and pharmacy technicians have important complementary roles within multidisciplinary teams, including medicines reconciliation, medicines optimisation, patient education, identifying prescribing risks, supporting safer supply of medicines, and facilitating continuity of care across hospital and community settings. Community pharmacy and primary care teams should be recognised as important partners in identifying concerns, providing mental health first aid and facilitating rapid access to mental health services.

How can services better support the 'missing middle' - those with sustained needs (that affect their participation in community life, for example, in education or work) who may not meet the criteria for NHS mental health services? Please provide examples. (Optional, maximum 300 words)

Innovative primary care mental health pharmacist roles demonstrate how specialist pharmacy expertise can bridge the gap between primary and secondary care. In Essex, community mental health transformation funding supported the development of six whole-time equivalent primary care mental health pharmacists embedded within Primary Care Networks. These pharmacists work alongside general practice teams with dedicated consultant psychiatrist support from community mental health services. They manage patients whose needs exceed routine primary care expertise but do not meet thresholds for specialist secondary care, reducing waiting times, improving medicines optimisation and preventing avoidable referrals into Community Mental Health Teams. Their roles include medication review, patient and carer education, professional education, physical health optimisation and consultant liaison when necessary. This model builds mental health capability within primary care, improves access to specialist advice closer to home and provides timely medicines optimisation for people who may otherwise fall between primary and secondary care services.

Community pharmacies also play an invaluable role supporting the missing middle, being highly accessible without appointments; they often have regular contact with people who do not meet the threshold for secondary care. They frequently also buck the inverse care law, with many located in areas with the greatest deprivation where health needs are greatest. This places them in a unique position to provide and signpost to accessible support, support medicines adherence and promote early interventions to those who may struggle to otherwise engage with services.

Commissioning should incentivise prevention and continuity rather than episodic activity. Success should be measured by improvements in employment, education, housing stability, physical health, patient-reported outcomes and reduced crisis presentations, rather than solely service utilisation.

Factors enabling good practice

Too often, we hear that services are hindered by administrative barriers that prevent innovative, integrated and person-centred care. We are interested in the underlying enablers of good practice around the country, and the role national government can play in creating the conditions for reformed models of mental health support. We are particularly interested to understand how access can be improved, for example through therapeutic support for certain groups such as women and girls subject to violence and/or child sexual abuse.

What commissioning, funding and oversight or accountability arrangements (nationally and locally) best support safe and integrated mental health services that improve outcomes across mental health, participation in work, education and community life, and social functioning? Please provide examples. (Optional, maximum 300 words)

Specialist mental health pharmacists should be commissioned explicitly as core members of community mental health teams, neighbourhood health centres and Primary Care Networks to improve medicines optimisation, physical health, patient safety and continuity of care. Evidence from emerging Primary Care Network mental health pharmacist services demonstrates their ability to improve medicines optimisation, build workforce capability, support shared care, reduce unnecessary referrals to specialist services and improve continuity across organisational boundaries. National commissioning guidance should encourage wider adoption and robust evaluation of these roles.

Interoperable digital infrastructure, common clinical standards and consistent shared care agreements are essential to support safe transitions and integrated care. National investment should prioritise workforce development, digital interoperability and evaluation of innovative service models.

National investment in multidisciplinary mental health education should accompany service redesign, with consistent undergraduate curricula and structured postgraduate training across all healthcare professions.

Community pharmacies should be recognised as key partners in the care of people with mental illness. To support this role effectively, greater consideration should be given to information sharing, including access to interoperable digital systems and shared electronic health records across primary care and wider healthcare services