VCSE health & wellbeing alliance

Association of Mental Health Providers

Rethink Mental Illness.

Centre for Mental Health

More than a number

Experiences of weight management among people with severe mental illness

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The National LGB&T Partnership

Race Equality Foundation

Contents

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The Association of Mental Health Providers, Centre for Mental Health, and Rethink Mental Illness, as members of the Mental Health Consortium, are leading on this project alongside HWA partners MindOut on behalf of The National LGB&T Partnership, and Race Equality Foundation. The project has involved extensive engagement with people with lived experience, the VCSE sector, NHS, Local Authorities, and academics. It will culminate in the production of a suite of resources.

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Foreword

Addressing the inequalities in health remains a priority and one area is doing more to support the physical health of those people living with severe mental illness. We know that people living with severe mental illness have a significantly higher prevalence of obesity than the general population. Listening to those living with severe mental illness highlights that, in many cases, their physical health is often neglected in favour of their mental health. This report captures the voice of people with severe mental illness and the issue of weight management and provides health care professionals, Clinical Commissioning Groups (CCGs) and providers with opportunities to 'improve'/'further' care and support.

People living with severe mental illness have additional challenges, compared to the general population, to overcome because of their illness and this qualitative research illustrates that in general physical health, particularly weight and the weight management journey is challenging. People can also feel isolated and stigmatised. By highlighting the experiences of people using these services, we anticipate that health care professionals, CCGs and providers will be able to take some of the opportunities as a result of reading this report. What has come to light is that those living with severe mental illness want a holistic approach to their care, with focus on both mental and physical health. Those living with severe mental illness may not be well at various timepoints and care providers can support them by having regular repeated conversations about healthier behaviours. This can go some way to supporting those living with severe mental illness in making small and sustained changes that will improve their overall health and wellbeing.

Public Health England is committed to improving the health of the nation and is a proud supporter of the VCSE Health and Wellbeing Alliance. The VCSE Health and Wellbeing Alliance is pleased to see the publication of this report as it follows a recent publication by Mental Health Consortium partner Rethink Mental Illness that shed light on the physical health of those living with severe mental illness, 'Managing a healthy weight in Secure Services'. These reports reflect the VCSE Health and Wellbeing Alliance and our partners' commitment to improving the health and wellbeing of those living with severe mental illness.

Public Health England

Executive summary

People with severe mental illness have a substantially reduced life expectancy compared to the general population. It is increasingly widely recognised that this inequality is unacceptable and there is growing determination to close the gap. This has led to commitments by government and national health organisations to make the physical health of people with severe mental illness a higher priority, and an important aspect of this is weight management.

Weight management is complex, and this is especially true for people with severe mental illness. They are more likely to have common risk factors for being overweight, such as reduced access to healthy food, lower incomes and health conditions that limit their mobility. In addition, they have risk factors not typically faced by the general population, such as weight gain related to psychiatric medication and admission to inpatient wards with few opportunities to be physically active.

This report explores key themes around weight management for people with severe mental illness based on the first-hand experiences of service users and professionals, as well as from published research.

In focus groups, interviews and workshops, we heard from people with severe mental illness about their experiences with weight management. These included: the difficulties of remaining motivated during fluctuations in their mental health; the complicated ways in which their eating was related to their emotions; and the lack of long-term support. We also heard from practitioners and commissioners about some of the challenges of providing weight management support to people with severe mental illness. These included: competing priorities, with attention being focused on the psychiatric side of care often at the expense of issues such as weight; and lack of clarity about who is responsible for coordinating physical health care of people with severe mental illness.

Even without these additional challenges, we know that sustained weight loss is hard to achieve. Our research suggests that, if this is the only criterion of success, we are setting people up for failure which, in turn, can lead them to become discouraged and feel a sense of hopelessness about weight management. More promising, however, are efforts that take the emphasis off numbers (e.g. kilograms lost or reductions in BMI) and prioritise:

1. **Weight gain prevention**: Maintaining a healthier weight is not only easier than losing weight, it also avoids the negative effects on physical and mental health caused by weight gain. The people we spoke to wanted services that were proactive, instead of reactive, and intervened early, for example when people are first diagnosed with a mental illness.
2. **Setting achievable goals**: Losing weight is difficult and takes time. For someone with a mental illness it may be especially difficult when they are unwell. But taking up healthy habits and maintaining weight can be important and more achievable markers of progress.
3. **Building people's intrinsic motivation to adopt healthier behaviours**: Weight management is a life-long process. People with severe mental illness told us about the challenges they encountered on this journey and of the things that helped them to stay motivated in spite of these setbacks, such as support from a trusted person, flexible options for engagement and more emphasis on enjoyment (for example of physical activities they liked) than on weight loss.

There are small-scale steps that health services can take to improve the experience of weight management for people with severe mental illness. However, systemic and cultural changes are also needed. Services that are proactive and co-ordinated in the support they provide from the outset, and that make weight management for people with severe mental illness a priority throughout their care, with a long term horizon and sustained partnership to help people to negotiate weight management, would provide the best possible foundations for effective change.

1. Introduction

The aim of this report is to introduce people to the key themes around weight management for people with severe mental illness. Based on the first-hand experiences of service users and published research, it brings into focus some of the challenges and complexities of this subject, and it provides a starting point for those looking to understand what is important to people with severe mental illness in terms of weight management support in the community.

In England, nearly two-thirds of adults are living with being overweight or obese (NHS Digital, 2018). People with severe mental illness face more challenges with weight management than the general population yet, until relatively recently, little guidance had been tailored to their needs (Teasdale, Samaras, Wade, Jarman & Ward, 2017; Coventry, Peckham & Taylor, 2019). The prevalence of overweight and obesity is significantly higher among people living with severe mental illness than the general population (PHE, 2018a).

Living with obesity is associated with a range of outcomes. These include:

- Metabolic conditions, such as diabetes, musculoskeletal disorders, cardiovascular disease and various cancers
- Functional problems, such as difficulties taking exercise
- Reduced mental wellbeing, often linked to a negative body image
- Reduced life chances, and, ultimately,
- Reduced life expectancy (Abdelaal, le Roux & Docherty, 2017).

These outcomes contribute to the now widely recognised mortality gap, with people with severe mental illness having a substantially reduced life expectancy compared to the general population (Firth *et al.*, 2019).

Definition of terms

Severe mental illness

Severe mental illness refers to psychological problems that are often severe enough to seriously limit a person's ability to work and do day-to-day activities. It includes, but is not limited to, severe and enduring psychotic disorders, personality disorders and mood disorders.

Diagnosable eating disorders are also widely recognised as severe mental illnesses; however, owing to the special clinical considerations of weight management in these cases, they will not be covered in this report.

Weight management

"Weight management is the process of adopting long-term lifestyle modification to maintain a healthy body weight based on a person's age, sex and height. Methods of weight management include eating a healthy diet and increasing physical activity levels." (Nature, n.d.)

While the above definition is useful and accurate, Public Health England (PHE) and the Health and Wellbeing Alliance acknowledge that for some people with mental health difficulties, maintaining their weight within the 'healthy weight range' may not be possible. Instead having realistic targets may be more helpful. These may include maintaining weight by preventing further weight gain or, if losing weight, then keeping off even a small amount – about 5% – can be beneficial. Working on setting achievable goals may also assist in helping a person to feel positive about themselves regardless of any weight loss (NICE, 2014).

Body Mass Index

Health care professionals use a measure called body mass index (BMI) to determine an individual's weight category. Body mass index (BMI) is used as an estimate of body mass and is calculated by dividing a person's weight in kilograms (kg) by the square of their height in metres (m^2). BMI can help assess a person's weight status and sometimes waist circumference is used in addition.

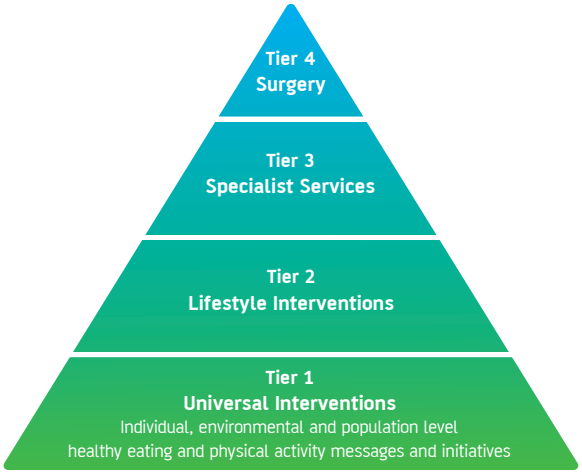
BMI is one of the criteria considered when assessing appropriate care and treatment. For example, where tier 2 weight management services are available, those with a BMI of 30kg/m2 or above may be eligible for referral.[1] The referral criteria are adjusted for ethnicity (to 27.5kg/m^2 or above) for people of black African, African-Caribbean and Asian (including South Asian and Chinese) family origin, as they are at an increased risk of conditions such as type 2 diabetes and cardiovascular disease (NICE, 2013).

Classification	BMI (kg/m^2)
Healthy weight	18.5–24.9
Overweight	25–29.9
Obesity I	30–34.9
Obesity II	35–39.9
Obesity III	40 or more

Weight management services

In England, local authorities and the NHS commission weight management services. These include approaches managed by the NHS in clinical settings and those delivered in community settings. PHE has published commissioning guidance based on NICE guidelines which commissioners are encouraged to adopt when developing weight management services (PHE, 2017d). Figure 1 shows the tiers of weight management services. Tier 1 includes universal prevention services, such as health promotion; tier 2 includes multicomponent lifestyle behaviour change and often takes the form of group-based support run by commercial providers; tier 3 is specialist multi-disciplinary weight management; and tier 4 includes bariatric surgery.

Figure 1: The weight management care pathway



[1] However, PHE guidance states that wherever possible service should also be offered to individuals with a BMI lower than 30 kg/m^2.

Policy and practice commitments

Tackling obesity and promoting a healthier weight in society is a priority for government and national health organisations.

The government and the NHS have made commitments to prevent obesity and promote a healthier weight in society (e.g. Department of Health, 2016; PHE, 2019). The road to achieving this requires a long-term approach that makes obesity everybody's business and for all organisations to work together (ADPH, 2019). All sectors have an important role to play, working with communities and providing coherent and consistent messages.

The causes of obesity are complex and are affected by many factors including our environment (Blackshaw & Van Dijk, 2019). Creating a healthier food environment will influence the food choices people make, whilst improvements to the design of a neighbourhood can promote physical activity such as walking or cycling. The rates of obesity have increased slowly over many years, and just as no single action can address this, it will not be 'solved' in the short term.

The NHS Long Term Plan outlined plans to provide targeted support and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ and to fund a doubling of the Diabetes Prevention Programme (NHS England, 2019).

Methodology

This project, commissioned by the VCSE Health and Wellbeing Alliance, reviews the existing literature and contributes new research with an emphasis on support in the voluntary and community sector and user-centred service design. The evidence base for this project has come from:

- A review of the literature, including peer-reviewed papers, briefings, policy documents and guidelines.
- A call for evidence issued through the networks of Association of Mental Health Providers, Centre for Mental Health, Rethink Mental Illness, and Health and Wellbeing Alliance partners The National LGB+T Partnership and Race Equality Foundation.
- Stakeholder interviews with GPs, nurses, mental health practitioners, public health consultants, dietitians, academics, commissioners and voluntary and community organisations.
- Focus groups with more than 50 people with severe mental illness held in locations across England via VCSE service providers.
- A workshop of 35 people with lived experience, VCSE service providers, NHS and other statutory service providers and commissioners, and Policy Leads in Government departments.

2. Factors affecting weight management among people with severe mental illness

People with severe mental illness are more likely than the general population to encounter a combination of factors that contribute to weight gain. These factors may interact with one another and they are often related to severe mental illness by more than one pathway. This section provides an introduction to these factors, some of the relationships between them and how they are experienced by the people we spoke to in their day-to-day lives.

Medication

Many antipsychotics, antidepressants and mood stabilisers are associated with weight gain (Serretti & Mandelli, 2010; Hasnain & Vieweg, 2013; Gafoor, Booth & Gulliford, 2018; Taylor, Barnes & Young, 2018; Alonso-Pedrero, Bes-Rastrollo & Marti, 2019; Marteene *et al.*, 2019). See Appendices 3 and 4 for more information about the level of risk with different antipsychotics and a summary of guidelines.

People who are starting psychiatric medication for the first time are at the highest risk and, for antipsychotics, the first few months after starting medication are when most weight is gained (Correll, Lencz & Malhotra, 2011; de Hert *et al.*, 2012). Moreover, those who gain the most weight in the first few months are at the highest risk of overweight and obesity in the longer term (Maayan & Correll, 2010; Bushe *et al.*, 2012; de Hert *et al.*, 2012).

"*Since starting on antipsychotics I've put on about four stone. It's not the medication's fault per se, but taking them means that I care less about things, while this is good for schizophrenia symptoms, it is not good for losing weight. I find that I am lethargic often, and the weight I've put on doesn't matter to me the way that it would've done before I started taking meds.*" – Service user

"*I think Venlafaxine has given me an increased appetite and I was always hungry while I did Weight Watchers. I attended for six months and this did not change over this time. It was very hard and required great self-discipline and determination which is incredibly hard when feeling mentally ill.*" – Service user

Nutrition

People with severe mental illness are more likely to have a poor diet, with a higher energy intake and poorer nutritional status than the general population (Firth *et al.*, 2018; Teasdale *et al.*, 2019). For the people we spoke to, this was linked to some of the factors discussed in more detail here, such as emotional eating (the food people typically turned to for comfort was calorie dense), adverse eating patterns and cravings linked to effects of their medication.

It was also linked to financial and environmental factors: people with severe mental illness have higher rates of poverty and are more likely to live in neighbourhoods with limited access to healthier food and activity options (PHE, 2018b). They may also have spent extended periods of time on inpatient wards, which have been identified in the research as environments likely to cause weight gain (Mangurian, Sreshta & Selilgman, 2013; Looijmans *et al.*, 2017; PHE, 2018b; Stubbs & Rosenbaum, 2018).

Furthermore, these risk factors affect certain groups more than others: for example, people of black and minority ethnicities are more likely to live in deprived neighbourhoods and they are overrepresented in psychiatric inpatient settings compared to other people with severe mental illness (Gajwani *et al.*, 2016; Weich *et al.*, 2017; HM Government, 2018).

"*My pain levels are really high today, I can't actually put a dinner together. I'll just have a ready meal or a packet of biscuits or something else, so for me it feels more like control is taken away, the healthy eating choices are not available some of the time and that just kicks me back into depression again.*" – Service user

"*Finance is also barrier – economic barriers to accessing fresh fruit and veg. A lot of users will have can of beans, toast, live on bread – cheapest available vegetables and meat.*" – Support group provider

Physical activity

There is evidence that people with severe mental illness engage in significantly less physical activity than the general population (Vancampfort *et al.*, 2017). People at the focus groups spoke about lethargy as both a symptom of their mental illness and a side effect of their medication, and many also had a physical health condition that affected their ability to be active, either because it limited mobility or meant they required special assistance. Because of these barriers, they found it especially difficult to motivate themselves to engage in physical activity for its own sake; the exercise needed to be something they also enjoyed. However, for many people, opportunities for enjoyable activity were lacking in their neighbourhoods.

Emotional eating and adverse eating patterns

Disordered eating patterns, such as binge-eating, fast eating, night-eating, emotional eating and continual snacking, may be more prevalent among people with severe mental illness (Teasdale *et al.*, 2017). Emotional eating was one of the strongest themes that emerged from our focus groups, and the foods that people used to manage their feelings were high in sugar and fat. Many people had turned to food for comfort since childhood. Others had started eating for comfort when their mental health problems worsened, to help them to cope with the boredom and isolation that often accompanied their illness. Sometimes food was a way of coping with more difficult feelings: when people were feeling suicidal, long-term goals didn't matter anymore, they just needed something to lift their mood enough to help them to get to the end of the day.

Another theme that emerged from the focus groups, relating to the psychological aspects of eating, was food as a form of self-harm. Some people had times when they felt worthless, as if they were good for nothing and would make a mess of everything. In this state of mind, they would binge-eat as if to say, 'Look how useless I am, I have no self-control' or 'I don't deserve to lose weight'.

Mental illness also affected people's eating patterns in other ways: for example, people at the focus groups spoke about being too depressed to cook meals or too manic to remember to eat.

"*I felt like most people who were overweight, it's not an addiction to food, it's an addiction to feeling better about yourself which food is, erm, fills the void, it fills the void in your life.*" – Service user

"*I think that for me personally it is a lot about how you feel about yourself really. If you're in a happy space and feel less depressed probably I would eat less.*" – Service user

"*I try and eat regular but it's just not easy [...] and when I'm hyperactive because I've got the bipolar so... when I'm really really manic, I forget to eat, I'm just off who knows where, doing who knows what [laughs] but then I don't think about eating so it's all hard on your system.*" – Service user

Low energy and low motivation

Some mental illnesses and some psychiatric medications have a negative effect on energy and motivation. However, our research indicates that it's important to make a distinction between different levels of motivation. The people we spoke to were clear that they were very motivated to lose weight and to engage in some of the activities needed to achieve that goal – and this appears to be true not only for the people we spoke to but for many people with severe mental illness, as demonstrated by the STEPWISE trial which achieved its recruitment target of 396 participants three months ahead of schedule and collected data from 340 participants 12 months later (Holt *et al.*, 2019).

However, mental illness and the sedating effects of medication often made it hard for people to take the very first step towards the overall goal of losing weight. For example, several people said that, once they were out of the house, they had few problems being active and enjoyed taking a walk; but finding the energy to get out of bed in the morning and leave the house sometimes felt impossible without support.

To help them 'get going' many of the people we spoke to said they relied on caffeine and sugary energy drinks, which added to their difficulties with weight management. If they had a week or two when their mental health was worse than usual, it could be enough to reverse any progress they had made. The more often these setbacks happened, the more hopeless they felt about being able to lose weight.

"*If my mental health is worse than usual, my motivation is weak, and I struggle to get out of bed, I feel lethargic and heavy.*" – Service user

"*One of my words [about weight management] was 'circular' and that kind of comes down to what you were saying, you know, you start to lose weight and then something goes wrong and it might be depression or it might be pain or it might be something else.*" – Service user

"*Patients say they want to be motivated by staff. They want to hear staff say let's go for a walk. It's hard to wake up in the morning because of the medication.*" – Provider of exercise and activity at a mental health trust

"*I actually really like healthy food, it's not that I don't like it, and I love cooking, it's just I think it's more with my mental health, it's just that when I'm depressed I get really suicidal and I don't care so I think right, I'm on the phone [for food] because I won't go out when I'm depressed.*" – Service user

Other health difficulties

People with severe mental illness are more likely than the general population to have a physical health condition (Hert *et al.*, 2011; PHE, 2018a). The people who attended the focus groups had diagnoses including arthritis, asthma, fibromyalgia, irritable bowel syndrome and diabetes. These conditions affected their ability to be physically active and access services if, for example, the building lacked disabled facilities.

"*Whilst I was doing that course, my pain levels were very high and I couldn't do any of the exercises [...] so there were weeks where I maintained my weight and they were really positive about that, they were like, 'Well, considering where you're at and where your pain levels are at, you're doing really well,' so I found that really helpful.*" – Service user

Box 1: Which people with severe mental illness are at the highest risk of weight gain?

Certain groups of people with severe mental illness have a higher risk of weight gain than others. These are:

- Young people with first episode psychosis
- People with limited previous exposure to psychiatric medication (drug naïve patients)
- People taking olanzapine or clozapine
- People who rapidly gain weight in the first six weeks of treatment with antipsychotic medication
- People with depression
- Women (Kinon *et al.*, 2005; Tek *et al.*, 2016; Dayabandara *et al.*, 2017; Rajan & Menon, 2017; PHE, 2018a).

3. The weight management experiences of people with severe mental illness

The people we spoke to had a range of experiences with weight management. For some people, it was a struggle they faced on their own; others had the support of family, friends and GPs; and some had accessed commercial weight loss services. Typically, the issues they experienced were the same as those that anyone would experience with weight management but were exacerbated by the challenges connected to their mental health.

Reactive services

A common experience among the people we spoke to was one of services only addressing weight gain after they had become overweight, instead of helping them to maintain their current weight status and prevent putting weight on. Gaining weight had negative effects on their physical and mental health. And even those who succeeded in losing weight did not always feel like they had been able to return to the person they were before the weight gain: they put weight on more easily than they had in the past and, if they had lost a large amount of weight, they had stretch marks and skin-flaps that affected their confidence.

"*There has been permanent changes made to my body as a result of medication. All the stretch marks that scar my body remind me of my journey. This is a permanent reminder of the damage that I can do to my body if I do not look after myself and continues to cause anxiety and self-critical and disgusted view at my own body when unclothed and after losing 10kg these have not gone away and the skin-flaps create extra weight which I have to carry about everywhere. I cry when I see pictures of my 50kg self and what I look like now in pictures, it makes me feel like I am trapped in somebody else's body and that I am being punished.*"
– Service user

Lack of follow-up and of long-term support

Some people had been asked about their weight by a health care professional. However, despite the issue being raised, they were not offered help with weight management. Signposting or monitoring without proactive support often failed to translate into the person taking action. For those who did manage to access a weight management service, the support was typically short-term and they found it hard to maintain the changes after it had ended.

"With my GP it was kind of, 'Oh well, you know you could do with losing a little bit of weight,' but you know, full stop. It's wasn't like, 'Well, I could refer you to a group that will help with weight management or I can get you a reduced access fee to a gym.'" – Service user

"I think some of the problem then comes because services are funded by a particular sector within the NHS or through the doctors surgery, whatever it is, they come to an end, so you are then left on your own to try and carry on those practices, and I find that I don't have enough mental stability to be able to carry on, I don't have the willpower to carry on without that support and that support just gets cut."
– Service user

Medication

As discussed above, starting antipsychotic medication for the first time is a high risk period for weight gain. It is also a time when a person is likely to be at their most unwell. Some of the people we spoke to had no recollection of being told about the weight gain potential of their medication. They said that, if they had known, this might have led them to make weight management more of a priority.

This was a worry among practitioners we spoke to as well, who expressed concerns that informing people about the risks their medication posed might discourage them from taking it. Some service providers told us that, to try to overcome this, they make a point of having repeated conversations about weight management and ways to support service users. There may also be a role for advocacy services in advising both service users and staff about how to negotiate this issue in a helpful way.

Too much emphasis on numbers

The people we spoke to felt that, in general, too much emphasis was put on numbers such as weight or BMI. These numbers didn't necessarily correspond to their own sense of wellbeing or personally meaningful goals. However, too often, numbers seemed to determine whether they qualified for certain services and falling numbers (i.e. reductions in weight or BMI) seemed to be the only recognised form of success.

Blaming and shaming

People living with obesity often felt judged by services and by society in general. They had received unhelpful advice along the lines of "just eat less and exercise more", and weigh-ins felt shaming, especially when they took place in front of a group. One service provider told us that she had worked with a woman who had thought her GP had been calling her an offensive name and had misheard a phrase which was interpreted as derogatory. This highlights the need for mindful communication between service providers and service users.

These experiences are not unique to people with severe mental illness. Weight stigma is still widespread in society and can have a negative effect on anyone's motivation to access a weight management service (Phelan *et al.*, 2015; Blüher, 2019, Rubino *et al.*, 2020). However, for the people we spoke to, who were already facing multiple challenges to engaging with support, it sometimes made the difference between persevering with weight management and giving up on it.

"*It's just that in this society you feel out of control when you're overweight, it feels like, they make you feel like you're a monster [...] I'm never gonna be that skinny person but that's alright, but you're making me feel negative and that negativity plays on you and then you just go like this [puts hand in the biscuit tin] – I have to feel better but you know you shouldn't do it but you reach for something to eat.*" – Service user

Not enough recognition of the psychological aspects of eating

As discussed above, one of the strongest themes that emerged from the focus groups was the emotional aspects of eating. For many people, food wasn't simply nutrition but a way of managing their feelings. In order to eat differently, they also needed support to feel differently. However, this support hadn't been available: they had been given diet plans and exercise plans, but little opportunity to work on their relationship with food.

"*They did mention about mental health, but they didn't go into it in any detail or anything, they obviously said it can affect you, but that was about it really.*" – Service user

"*I've not been overweight all my life, in fact I was very very skinny up to my early 30s, very healthy and very active, but I think trauma played a big part in my story quite heavily and that is when depression hit, because of depression and the feeling that I suddenly hated myself that I stopped caring about myself, and at the same time unfortunately I had an early onset of quite severe arthritis.*" – Service user

Box 2: Jeremy's story

"It's awful, especially the mental health side. I get more low days... I can't be bothered to get out of bed to eat three meals a day. It feels daunting. How am I gonna do that? Sometimes I can't be bothered, so skip breakfast, then lunch, I can't be bothered. Do I get hungry? I've gone past that. I think because of that, when I do eat my body holds on to the calories and I'm putting weight on.

I think the medications have affected my weight, especially the anti-depressants. Whether they make you feel better in yourself so you start eating more or they change your metabolism, I'm not sure, but I did start putting weight on when I started taking anti-depressants. I did speak with the GP about it, that I was concerned about weight gain – they said you start feeling better, so you'll eat more, but I thought, no, that doesn't make sense, I'm not eating in the daytime.

The barriers to doing exercise or activity is the pain – in my spine, and in my foot – I don't know if anything could help. I've been to physio but it was no help. For instance, yes I was naughty. The young girl said, 'Do these exercises'. I had a terrible week with the depression. The next week, when she asked me to do the exercises, she said I was doing them better, but I thought 'how can that be because I haven't done the exercises?' It made me think what a waste of time that was – I haven't done the exercises, I've been in bed all day. I don't know why she said I was getting better. I wasn't going to say I haven't done the exercises because I felt too ashamed to.

Feeling ashamed features in my domestic violence with my ex wife. That a man could be treated that way. And I felt ashamed about not coming out as gay. The domestic violence did make me put the weight on, it turned into a control thing, punishing myself for letting her abuse me and for hiding my sexuality. When I came out of the relationship I thought 'I've got to do something about my weight' – I watched a [hypnotherapy] video, and after that I didn't eat at all. Was it an eating disorder? Yeah, totally. I used to make myself sick after eating. I got addicted to losing weight.

I think they need to pour money into weight management. Which they are not going to do are they? I think there should be support groups – like with alcohol addiction, for someone who's obese, there's no support at all."

Name has been changed

4. What people with severe mental illness want from weight management services

More holisitic services

The people we spoke to wanted more holistic services that looked beyond the numbers (i.e. their weight and BMI). They felt that, if a service were to help them to lose weight, they needed to start by understanding why they were overweight in the first place. This included an understanding of the ways in which their mental illness affected their eating, activity and metabolism; it also included more recognition of the emotional, social and cultural importance of food in their lives. All of the participants in our study felt that the mind-body connection was a missed opportunity for services, with not enough been made of the evidence that being physically active and eating a balanced diet can support improvements in mental health as well as physical wellbeing.

"*The fact that they [weight management services] are only geared to your weight or in some cases a little bit holistic, but not always, but generally nothing to do with mental health, they have no concept of that.*" – Service user

"*Exercise is still rewarding and also helps to regulate my mood. If I leave it for a week or two then I find that I am in a worse/darker place than I would be with it. And it doesn't have to be the gym, as people are not always that confident when they're mentally ill. Just going for a walk can do wonders for your mood.*"
– Service user

Trusted and culturally competent support

For many people, it was more important that the person who was providing weight management support understood severe mental illness and was able to work with them in a respectful way, than that the person understood weight management but not mental illness and treated them disrespectfully. When accessing mainstream services, several people spoke positively about peer support: attending a group with someone else who had severe mental illness took away some of the feelings of being isolated and different.

In addition, as discussed above, for many of the people we spoke to, food and weight were sensitive and personal subjects connected to difficult emotions, traumatic experiences and mental health symptoms. Our focus groups indicate that this is especially true for service users from disadvantaged and marginalised communities who may experience stigma related not only to their mental illness and their weight but also to their sexuality, disability or ethnicity. In addition, food and weight may have particular meanings within these communities: for example, one of the people who participated in the focus groups spoke about being encouraged to put on weight because, in their culture, it was seen as an expression of being happy and loved; and another person spoke about their experience of feeling sexually unattractive within their community because of their weight. For these people, it was important that the person providing weight management support was both someone they could trust and someone who could understand the meaning of eating and weight within their cultures and communities.

"*it's difficult in the first place to go to doctor or nurse and say, 'I have this problem,' [...] and my relationship with my doctor is really good, but then for them to say, 'Well you have to phone this number and speak to some anonymous person that you've never met' and you don't like making phone calls anyway [laughs], you know part of my mental health thing is I hate being on the phone, I hate being on the phone.*" – Service user

"*Trust is key to supporting people to change; we learnt that trust is key, especially for people with mental health [difficulties].*" – Dietitian at a mental health trust

"*It is difficult to build trust with a person or a service, it would take time to build that bond to then open up about some very personal matters.*" – Service user

"*There is a fear of stigma. If you are in a situation where you are forced to disclose your reasons for attending a physical health programme, it can be brutal and have an effect on your mental health and self esteem.*" – Service user

"*How do I feel about weight? I hate it. I feel very unattractive. In the gay community you're judged by your weight. On the dating apps,... they don't see you as a person. And on the gay scene, I look at other people bigger than me with partners and I think 'What's wrong with me?' and the depression starts going again.*" – Service user

"*Sometimes people ask, 'Am I not part of my culture any more?' if they don't eat the food they have grown up with.*" – Provider of exercise and physical activity at a mental health trust

Options for engagement

People spoke about how their ability to engage with services and their preferences fluctuated along with their mental health. Sometimes they welcomed the opportunity to socialise and be part of the group; other times they couldn't face other people. Sometimes they felt confident and curious about new foods and activities; other times they needed to keep to a very strict routine with a lot of predictability. If the service couldn't accommodate these changes, then their engagement often ended when their mental health got worse. They valued services that were able to adapt and 'meet them where they were at' from week to week.

Less emphasis on weight, more emphasis on enjoyment

People were motivated to take part in activities and stick to plans if they found them enjoyable, instead of simply being a means to an end (i.e. focused on weight management). Many had negative feelings about diets and gyms, associating them with restriction, deprivation, unhappiness and failure. Activities that people had positive feelings about included walking groups, dancing, cookery classes and healthy food tasting sessions. Severe mental illness can be isolating so people particularly valued the opportunity to be with other people and several people said that being active, especially when it was part of being outdoors in nature, benefitted their mental health and gave them a sense of wellbeing. Even if these activities didn't result in as much weight loss as traditional weight management approaches, people were more likely to persevere with them in the long term.

Proactive support to take the first step

Although many people were motivated to lose weight, they found it difficult to begin to work towards this goal – and, without the first steps, none of the other steps followed. The first steps included, for example, making a self-referral, leaving the house or attending an activity for the first time. Many of the people we spoke to said that, because of their mental illness, they felt less able to do things without proactive support from someone else, no matter how motivated they felt to lose weight.

"*Having help to leave the house in the first place – once you're out, you can do something like walking but taking that first step is the issue so really the greatest assistance would be in this.*" – Service user

"*I still haven't been referred back for physio because you have to self-refer and... it's been difficult you know.*" – Service user

"*I think when you're depressed or you have any mental health problem, asking for help first really is a problem... but having to then have that thrown back at you, that you must do this yourself. In my case when I was depressed it took me a long time to say, 'I need help,' and then when I was offered some help, I needed to be helped to choose which avenue to go down, instead of saying, 'Well here is a list of such and such, try and identify yourself where you fit in.'*" – Service user

"*Someone is needed to support participation. Even if, for example, there were free gym memberships, people would be reluctant to take them up without support to attend.*" – Support group provider

"*To access exercise, people need 'hand holding' to bring them to the service, if they have another friend who will go with them together it makes a big difference – but in general there is a huge gap in services on this.*" – Support group provider

"*Patients say they want to be motivated by staff. They want to hear staff say let's go for a walk. It's hard to wake up in the morning because of the medication.*" – Provider of exercise and physical activity at a mental health trust

5. Challenges and opportunities for service providers

Competing priorities

The doctors and nurses we spoke to emphasised how difficult it is to make weight management a priority when someone is very mentally unwell. Attention is focused on the psychiatric side of care often at the expense of issues such as weight. When the person's mental health has improved, weight management resumes. However, often it is in these gaps that healthy habits lapse and weight is gained. People might find it harder to leave the house, buy and prepare healthier food and be active when they are mentally unwell; they might be admitted to hospital, further limiting their opportunities to be active; and they might be prescribed different medication. The unintended outcome is that when people are at their most mentally unwell, they are likely to face a host of risk factors for weight gain but receive the least weight management support.

Lack of clarity over responsibility

A review of barriers and facilitators to integrated physical and mental health care concluded that, although there is broad agreement about what needs to be done to improve the physical health of people with severe mental illness, there is less agreement about who should be responsible for coordinating this care in mental health settings (Rodgers *et al.*, 2018). This was supported by our research: primary care practitioners often felt that weight management for people with severe mental illness was best carried out by secondary care, and vice versa, with the result that no part of the health care system took responsibility.

Staff who are overweight

Obesity is prevalent among the NHS workforce (Kyle *et al.*, 2017). The stakeholders and service users we spoke to both raised this as a barrier to providing weight management support. When the person providing the advice – the 'expert' – was living with obesity, it was seen as undermining the credibility of the message. One focus group participant said that it could be an opportunity for more collaboration between staff and patients, working together as equals to manage their weight.

"*You go into the doctor surgery and when I went in and they said, 'So you know you're overweight and you need to get exercise,' and I said to my doctor, 'After you because you're twice my size.'*" – Service user

"*A lot of the ex-users and patients said we won't be listening to anyone not walking the walk.*" – Provider of exercise and physical activity in a mental health trust

Resources

Many of the stakeholders we spoke to wanted to provide more support but lacked the resources to do this. Some of these resources were financial; others were related to time and training. They felt that it was difficult to make a case to give more attention to weight management for people with severe mental illness because this would potentially come at the expense of meeting other targets. Some health care practitioners working in statutory services were able to use third sector support to bridge the gap in resources. Care navigators were able to play a role in signposting people to this support. However, because third sector provision varies from region to region, this was not an option for everyone we spoke to.

Variations in provision

There is not a single care pathway or evidence-based intervention available to support people living with severe mental illness and obesity, across all NHS trusts. As a result, there is variation in the quality and quantity of weight management support on offer. Some of the doctors and commissioners we spoke to were frustrated by what often seemed a 'piecemeal approach' with a few patients benefiting here and there when funding was made available for a particular geographical area, but without a national sustained effort that could make a difference to a large number of people in the long-term.

Box 3: A service provider's perspective

Kate Moffatt, Head of Nutrition and Dietetic Services at South London and Maudsley NHS Foundation Trust

"Trust is key to supporting people to change, especially for people with mental health problems. We changed our assessment for weight management to 45 minutes. We say this is about me getting to know you and what we can do for you. If it doesn't work for you that's fine, we will find another way - that's very important. We use motivational interviewing techniques, being supportive, validating and affirming. We acknowledge how challenging weight management is. Having this extra time at the assessment is important in building rapport, in trying to understand people's culture, and learning from the service user.

We explore with the service user what's most realistic, discuss challenges, use positive reinforcement and be realistic about challenges. We affirm success and talk about self-awards for success. When we get to the maintenance stage where people have met goals and done well, it's then about celebrating success and strategies to maintain this. If someone relapses, they are back into pre-contemplation or ready to act again. We explore what motivates a person to enhance that motivation, look at ways to overcome barriers that need to be overcome.

The biggest thing is the medication. People think it's the tablet that makes you put on weight. It can be. There are two, one increases appetite and another can cause sedation so you sleep a lot more. Then there is the nature of being unwell which can make them feel unmotivated. We encourage people to get active and be active, people keep a food diary. Then there are economic barriers. What's close by, what are the barriers and solutions? Can someone shop for them if they are unable to leave the house due to depression, paranoia, anxiety? We look at products that people can buy, but can people cook?

We talk about how much money they have to buy food, where they can shop, we are aware of where local black and minority ethnic food shops are. It's about knowing your area and the importance for understanding what local shops are available. You have to be realistic. For example in Deptford High Street there are a lot of takeaway shops. We think about what's the environment that is around that person.

When talking to people about change we have to be upfront with what that change will do; it might not change their weight straightaway, this is what to expect. We are working their way."

6. Key considerations for service providers and commissioners

Changes in wellness

The people we spoke to told us that their needs fluctuate according to their mental illness. As a result, to be successful in the long-term, a weight management plan must be appropriate both for times when they are well and for when they are unwell.

- **Motivation:** if someone lacks the motivation to prepare a meal, are there low effort healthier alternatives? For example, meals that have been pre-prepared and frozen or simple dishes that can be made in a slow cooker.
- **Planning**: if someone has times when they find it hard to think ahead and break tasks down, can these things be done in advance? For example, creating a meal calendar with easy-to-prepare meals set out in simple steps.
- **Safety**: if someone is unable to use knives, ovens or hot plates, are there safer alternatives for food preparation? For example, frozen, canned or pre-cut vegetables that can be steamed in a microwave.
- **Leaving the house:** if someone is unable to leave the house, are they able to find ways to stay active and eat a balanced diet? For example, no-equipment simple exercise routines; activities that can be accessed through digital media and grocery deliveries that can be booked online.
- **Going into hospital, leaving hospital and other service transitions:** if someone is moving between services, including being admitted to hospital, or discharged from hospital to home or from a community mental health service to primary care, are there plans/continuity of care in place to help them to continue with their weight management plan? For example, an advance statement stating a preference for medication with lower risk of weight gain to be tried before others if they need to be admitted to hospital.

Mental health stigma

People who are living with obesity and have severe mental illness face a double burden of stigma. There is a growing awareness internationally about the importance of tackling weight stigma (Rubino *et al.*, 2020). But this has not yet been applied to considerations of how it overlaps with mental health stigma. People at the focus groups spoke about worrying whether, if they accessed mainstream services, they would encounter prejudices about mental illness.

- **Experience**: Does the person providing the weight management support have experience of working sensitively and respectfully with people who have severe mental illness? For example, activities and advice provided by a mental health professional with weight management training.
- **Group members:** If someone is accessing a mainstream service, are other people in the group understanding and accepting of mental illness? For example, attending a group with a peer who also has experience of severe mental illness.

Commissioners of mainstream weight management services can help to address this by specifying their expectations of how they will work with people with a severe mental illness and briefing them on how to do this successfully.

Building a relationship

A trusting supportive relationship is especially important to enabling people with severe mental illness to engage with weight management services.

- **Peer support:** Is it possible to involve previous and current service users in providing support? For example, setting up a 'buddy' system where people arrange to attend an activity together and check in with the other person if they don't show up.

- **Mental health knowledge:** Have members of staff received training in working respectfully and sensitively with people with severe mental illness?
- **Continuity of care:** Is it possible to ensure the weight management support is provided by the same person from week to week? Is it clear who is responsible for co-ordinating the support? How is this managed when people move between services and settings (for example from hospital to home)?

Fear of failure

The impact that failure could have on mental health came up several times in the interviews and focus groups. For some people, the fear of trying to lose weight and failing was so great that it seemed safer not to try in the first place.

- **Setting achievable goals:** base goals on things that are more within a person's control. For example, attending an exercise class becomes the achievement that is celebrated, not the weight loss.
- **Celebrating maintaining weight:** seeing this as an achievement (no weight has been gained), instead of being seen as a failure to lose weight.

"*We screen for people who are motivated. If they are self-referring they are definitely contemplating at least. We are looking to work with people at the right state, if someone isn't ready for the weight management programme then the conversation needs to be broader. If they are not ready we are then setting them up to fail.*" – Dietitian at a mental health trust

"*I signed up to a gym and started pushing myself to go and do a high, intense workout. This had a negative effect on my mental health when I stopped being able to go and felt like a failure.*" – Service user

Early intervention

Preventative strategies work better than reactive ones. It is more difficult to lose weight than to maintain it. From this it follows that early intervention that aims to prevent weight gain is more likely to be successful.

- **Starting early:** develop a protocol to help health care providers to make weight management a priority as soon as someone receives a diagnosis of severe mental illness.
- **Age suitability:** design support services to appeal to younger people. The typical age of onset of severe mental illnesses such as schizophrenia and bipolar disorder is between 15 and 35 years old (de Girolamo, McGorry & Sartorius, 2018).
- **Building motivation:** if initially someone isn't motivated to engage with weight management while they are still a healthy weight, motivational interviewing techniques and honest conversations about the heightened risk of weight gain linked to severe mental illness may help them to engage at this earlier stage.
- **Targeting high risk groups/events:** design protocols to intensify early interventions when the risk of weight gain increases, for example, a weight management pathway that someone is referred into when they start antipsychotic medication for the first time.

7. Conclusion

Weight management is complex and this is especially true for people with severe mental illness. They are more likely to have a combination of factors that contribute to weight gain, such as reduced access to healthier food and activity options, and health conditions that limit their mobility. In addition, they have contributory factors not typically faced by the general population, such as weight gain related to psychiatric medication and admission to inpatient wards which often have less healthy environments when it comes to activity and food options.

Complexity doesn't mean there is nothing to be done – the situation is far from hopeless – and strategies to improve the environments people live, work and play in will benefit people living with severe mental illness. However, such strategies require thoughtful planning to ensure that they provide the greatest benefit possible to under-served or poorly served populations.

We know that achieving significant weight loss and maintaining a healthier weight for a sustained amount of time is hard to achieve. If we make this the only criterion of success, we are setting people and services up for failure; and, as our research has shown, this can act as a disincentive to trying in the first place, especially when feelings of failure carry the risk of worsening someone's hard won mental health.

With a clear message from the people we spoke to that help with weight management needs to be holistic and offer a range of options for engagement, it is also likely that voluntary and community organisations will have a significant part to play. Many offer a diverse range of approaches that may be less clinically focused than statutory bodies. Many of the examples of positive initiatives we heard about during workshops were from voluntary and community organisations, often working with local authority leisure and physical activity providers to enable access to facilities people with a mental illness might otherwise not receive.

Where might efforts have the greatest benefits? Two key areas have emerged from our research: first, preventing people with severe mental illness from gaining weight in the first place; second, if someone has gained weight, reframing weight management so that numbers (e.g. kilograms lost, reductions in BMI) are not the only focus, and that other aims, such as accessing healthier food options, being more active or spending more time outdoors, are also valued. While these are simple ideas, putting them into practice will require a significant shift from professionals, providers and commissioners of both mental health and weight management services to work cohesively together to achieve better results.

Preventing weight gain

Maintaining a healthy weight is not only easier than losing weight, it also avoids the negative effects on physical and mental health caused living with obesity. We know that people with severe mental illness are at a high risk for weight gain and we can identify times when this risk is even higher than average, a widely recognised example being the first few months after a person starts taking antipsychotic medication for the first time. As a result, we can begin to build up a picture of who might benefit most from early interventions and how intensive these interventions might need to be. Supporting people to continue existing healthy behaviours that they both enjoy and are already in the habit of doing – and, at times when the risk of weight gain increases, to build on these behaviours, instead of breaking off from them and having to start from square one – should be a key objective of weight management services.

Aligned with this it is important to acknowledge that in many cases rapid weight gain takes place when service users start antipsychotic medication for the first time, and they are likely to be experiencing other barriers to good physical health (e.g. worsening mental health, hospital admission). However, this is an opportunity for those supporting service

users to have repeated and regular supportive conversations about physical health (such as coping strategies and benefits of activity and healthier diets) and to explore the benefits of the differing forms/types of weight management approaches and reflect on readiness and relevance of these approaches.

Taking the emphasis off weight loss

Very few people can lose weight quickly in a linear and sustained way. For most it will be a long journey with ups and downs, and people with severe mental illness will experience more challenges and setbacks than average.

Services are more likely to succeed if they concentrate on achievable goals and build people's intrinsic motivation to adopt healthier behaviours. Examples of how this might be done include: celebrating achievements such as weight maintenance and regular attendance; building strong and trusting relationships, including peer support, that will help with enduring the ups and downs of weight management; encouraging activities such as walking outside in nature which, although unlikely to lead to dramatic weight loss, may be part of a gradual change in feelings of wellbeing and self-concept ("I'm someone who enjoys being active"); and empowering people to contribute to the way services are designed and run.

"*There is no one solution. There needs to be choice and there is a place for all the different types of support as long as it's not harmful and is evidence based. We need to be supporting people to do what they want to do. To support someone's needs we need to ensure our support is balanced, flexible, adaptable and sustainable for the person. We need to listen to what the service user wants to do, if the dietitian can support it then it's most likely to work. We need to respond, you can nudge and encourage etc. [but] at the end of the day it's a partnership.*"
– Dietitian at a mental health trust

What both insights – preventing weight gain and taking the emphasis off weight loss by itself – have in common is that they are user-centred, holistic and require a long-term perspective. This last point is important: because they are long-term, they need to be designed and delivered in such a way that they can adapt to changing circumstances and follow people as they transition in and out of different levels of care, change their psychiatric medications, and as they experience better and worse periods of mental health. This requires services to be proactive and coordinated in the support they provide from the outset. They need to make weight management for people with severe mental illness a priority throughout their care. And they need to keep going for however long it takes, through people's ups and downs, with help at hand in a way that is useful and relevant for each individual.

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Appendix 1: National resources for health professionals to support adults with managing their weight

Adult obesity: Applying All Our Health.
Information to help front-line health and care staff promote the benefits of achieving and maintaining a healthy weight: https://www.gov.uk/government/publications/adult-obesity-applying-all-our-health/adult-obesity-applying-all-our-health

Wellbeing and mental health: Applying All Our Health.
A resource which helps health professionals improve service users mental health and wellbeing: https://www.gov.uk/government/publications/wellbeing-in-mental-health-applying-all-our-health/wellbeing-in-mental-health-applying-all-our-health

Includes the **Make every contact count** resource, to have brief conversations with people about making positive changes: https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources

E-learning for Health Obesity programme.
An engaging e-learning programme for practitioners in the NHS and local authorities working in weight management: https://www.e-lfh.org.uk/programmes/obesity/

Equally Well UK.
An initiative which seeks to promote - and support - collaborative action to improve physical health among people with a mental illness: https://equallywell.co.uk/

National resources for adults to help support them in managing their weight

NHS website. Healthy Weight BMI Calculator.
To check BMI and to find out what weight category someone is. Provides a personal calorie allowance to help achieve a healthy weight safely: https://www.nhs.uk/live-well/healthy-weight/bmi-calculator/

NHS weight loss plan.
A free 12-week diet and exercise plan designed to help adults lose weight safely – and keep it off. Includes an online community forum to receive support from a social network – **HealthUnlocked:** https://www.nhs.uk/live-well/healthy-weight/start-the-nhs-weight-loss-plan/

One You.
A nationwide programme that supports adults in making simple changes that can have a huge influence on their health, such as through eating well, moving more and drinking less: https://www.nhs.uk/oneyou/

Includes home workout videos: https://www.nhs.uk/oneyou/for-your-body/move-more/home-workout-videos/ and couch to 5K app: https://www.nhs.uk/oneyou/apps/#one-you-couch-to-5k

NHS.UK.
The UK's biggest health information service which provides advice, tips and tools to help individuals make the best choices about their health and wellbeing: https://www.nhs.uk/

NHS Apps Library.
Apps and online tools to help manage health and wellbeing: https://www.nhs.uk/apps-library/

UK Chief Medical Officers' Physical Activity Guidelines 2019.
Infographics explaining the physical activity needed for general health benefits for adults and older adults: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/829884/3-physical-activity-for-adults-and-older-adults.pdf

The Eatwell Guide.
A tool which defines government recommendations on eating healthily and achieving a balanced diet: www.gov.uk/government/publications/the-eatwell-guide

The Eatwell Guide image and Eatwell Guide booklet are included in the list of resources.

Appendix 2: Select bibliography of recent publications relevant to weight management for people with severe mental illness

Service provision

- Report on the working group into joined up clinical pathways for obesity (NHS England, 2014)
- National mapping of weight management services: Provision of tier 2 and tier 3 services in England (PHE, 2015)

Evidence overviews and editorials

- Working together to address obesity in adult mental health units: A systematic review of the evidence and a summary of the implications for practice (PHE, 2017a)
- Promoting weight loss in people with schizophrenia: What do we still need to learn before implementing lifestyle interventions? (Coventry *et al.*, 2019)
- The Lancet Psychiatry Commission: A blueprint for protecting physical health in people with mental illness (Firth *et al.*, 2019)
- The management of obesity in people with severe mental illness: An unresolved conundrum (Holt, 2019)
- All-Party Parliamentary Group (APPG) on Obesity hosts regular events at Westminster to inform MPs and Peers on obesity related issues, aiming to ensure as many meetings as possible are open to the wider stakeholder community. Recent publication includes 'Positive Communication about Obesity' March 2020.

Guidance for services and stakeholders

- Changing behaviour: Techniques for tier 2 adult weight management services (PHE, 2017b)
- Health matters: Obesity and the food environment (PHE, 2017c)
- Managing a healthy weight in secure services (Rethink, 2018)
- Improving the physical health of people with serious mental illness: A practical toolkit (NHS England, 2016b)
- Local Government Association's (LGA) 'Healthy weight, healthy futures: Local government action to tackle childhood obesity' (February 2016)
- Healthy weight, healthy futures local government action to tackle childhood obesity (update 2018)

Clinical trials

- Structured lifestyle education for people with schizophrenia, schizoaffective disorder and first-episode psychosis (STEPWISE): Randomised controlled trial (Holt *et al.*, 2019)

Appendix 3: Antipsychotics and weight gain

From Taylor, Barnes and Young, 2018

Drug	Risk/extent of weight gain
Clozapine	High
Olanzapine	
Chlorpromazine	Moderate
Iloperidone	
Sertindole	
Quetiapine	
Risperidone	
Paliperidone	
Amisulpride	Low
Asenapine	
Brexpiprazole	
Aripiprazole	
Cariprazine	
Haloperidol	
Lurasidone	
Sulpiride	
Trifluoperazine	
Ziprasidone	

Appendix 4: Antipsychotics - guidelines for weight gain

The Maudsley Prescribing Guidelines for Psychiatry recommend that:

Patients starting antipsychotic treatment or changing drugs should, as an absolute minimum, be weighed and their weight clearly recorded. Estimates of body mass index (BMI) and waist circumference should, ideally, also be made at baseline and at least every 6 months. Weekly monitoring of weight is recommended early in treatment, for the first 3 months at least. Rapid weight gain in early treatment (≥5% above baseline after 1 month of treatment) strongly predicts long-term weight gain and should prompt consideration of preventative or remedial measures.

(Taylor, Barnes & Young, 2018)

The World Health Organisation (WHO) recommends:

For people with severe mental disorders who are overweight or obese or at risk of becoming overweight or obese, initiating a psychotropic medication with lower propensity for weight gain should be considered, taking into account clinical benefits and potential adverse effects.

For people with severe mental disorders who are overweight or obese, switching to a psychotropic medication with a lower propensity for weight gain may be considered, taking into account clinical benefits and potential adverse effects.

(WHO, 2018, p. 22)

And NICE recommends that the potential metabolic effects, including weight gain, of different antipsychotic drugs should be taken into account when choosing the most suitable medication (NICE, 2014a).

For people prescribed antipsychotic medication, switching to aripiprazole, ziprasidone, lurasidone or amisulpride may be associated with a small reduction in weight, but the data are limited (Mukundan, Faulkner, Cohn & Remington, 2010; Marteene *et al.*, 2019). Furthermore, the decision to switch needs to be balanced against the possibility of symptom exacerbation or treatment discontinuation
(Taylor, Barnes & Young, 2018).

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